TUCSON CRISIS INTERVENTION CONSENSUS PROJECT:

FINAL REPORT

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Our community, like many others across the country, is confronted with increasing contact between law enforcement and people in behavioral health crisis. The unfortunate outcome of these frequent encounters is that individuals in behavioral health crisis are often inappropriately booked into jail and do not receive the treatment and care they need. Moreover, these encounters can be dangerous for the law enforcement officer as well as the individual in crisis and all too often it seems they result in unnecessary injury or death. The Crisis Intervention Team (CIT) program is a model program that has been implemented in numerous communities, large and small, across the country. This program involves: (1) special law enforcement training, (2) special dispatch procedures, (3) the availability of appropriate, timely, and law enforcement-friendly acute crisis care alternatives to jail, and (4) effective aftercare and follow-up.

Process

The *Crisis Intervention Consensus Project*, comprised of a large diverse panel of community stakeholders, met from June 2002 until May 2003. The mission the panel set itself was to develop a model system for pre-booking jail diversion and crisis response in Pima County that assists adults and minors in behavioral health crisis that are involved with law enforcement agencies to receive timely, appropriate treatment instead of jail.

Panel members included local consumers, advocates, and family members as well as representatives from local criminal justice, behavioral health, and medical agencies and organizations. The panel utilized a consensus building approach that was facilitated by the University of Arizona and involved four phases: (1) Vision and Team Building, (2) Information Gathering, (3) Planning Development, and (4) Report Adoption & Dissemination. During the consensus building process a number of techniques were utilized, including: small group sessions, facilitated discussion, expert panel presentations, community briefings/updates, and sub-committees.

Outcomes

During the nearly yearlong series of meetings the panel accomplished a number of key objectives.

- Adopted a mission, guiding principles, and operating guidelines.
- Developed a working flowchart of the Tucson/Pima County crisis system, encountered from the perspective of a law enforcement officer responding to a behavioral health crisis call in the field.
- Formed two sub-committees to develop recommendations on: (1) how to improve the protocols to streamline and coordinate law enforcement, acute crisis care, and behavioral health; and (2) a public awareness and education plan.
- Revised and approved the sub-committee recommendations.
- Developed implementation plans in sub-committee and approved these in full panel.
- Developed and approved recommendations regarding law enforcement dispatch.

Training: Recommendation Overview (see full report for details)

- Enough officers should be trained to support dispatching CIT officers to CIT calls and to ensure adequate coverage of CIT officers on shifts.

Dispatch: Recommendation Overview (see full report for details)

- Identify in the nature of the call that a CIT officer is needed.
- Provide education and training for potential 911 callers to provide appropriate information.
- For priority 1 level calls the closest available officer should be dispatched; but if this officer is not CIT trained, then a CIT officer should also be dispatched.
- For non-priority 1 calls, a strong attempt should be made to dispatch CIT officers to all behavioral health related calls.
- Law enforcement training and scheduling should aim to develop capacity in those geographic areas where it is most needed.
- Update or modify the 911-call system such that dispatchers can identify available CIT officers.
- If it is not possible to dispatch a CIT officer to a call, CIT trained officers should be used as a resource to assist the responding officers.
- Dispatchers should be trained in how to identify possible behavioral health crisis calls and protocols for dispatching officers in the field.

Diversion to Services: Recommendation Overview (see full report for details)

- SAMHC should continue to provide a 24-hour number for law enforcement to obtain assistance in connecting an individual to their behavioral health provider.
- Law enforcement officers should be encouraged to contact a hospital in advance if the individual they are going to transport is violent and/or poses a potential security issue and hospitals should be prepared to address these issues when the officer arrives.
- Behavioral health providers should provide a single supervisory-level contact number to assist officers in the field who are assisting their clients.
- The Pima County Attorney's Office should produce an involuntary petition instructional booklet for distribution to law enforcement and hospital staff.
- Law enforcement and hospital staff should be cross-trained on when an officer can leave the emergency room after transporting an individual in crisis.
- Hospitals should be encouraged to develop specialized secure places and protocols for providing services for persons in behavioral health crisis in the emergency room.
- At least one Urgent Care Center with the capacity to provide medical clearance be created in Pima County to add to the continuum of care the ability to address behavioral health emergency care when the individual has medical complications.

Aftercare: Recommendation Overview (see full report for details)

- Hospitals to fax evaluation/treatment information to the behavioral health provider or SAMHC, who are to provide a single, fax number to a machine in a secure location.
- Providers receiving a fax that a client has been seen for crisis services should provide appropriate follow-up and clinical interventions.

I. Introduction

Our community, like many others across the country, is confronted with increasing contact between law enforcement and people in behavioral health crisis. The unfortunate outcome of these frequent encounters is that individuals in behavioral health crisis are often inappropriately booked into jail and do not receive the treatment and care they need. Moreover, these encounters can be dangerous for the law enforcement officer as well as the individual in crisis and all too often it seems they result in unnecessary injury or death. The Crisis Intervention Team (CIT) program is a model program that has been implemented in numerous communities, large and small, across the country. This program involves: (1) special law enforcement training, (2) special dispatch procedures, (3) the availability of appropriate, timely, and user-friendly acute crisis care alternatives to jail, and (4) effective aftercare and follow-up.

The *Crisis Intervention Consensus Project*, comprised of a large diverse panel of community stakeholders, met from June 2002 until May 2003. The panel utilized a consensus building approach that was facilitated by the University of Arizona. Panel members actively participated in the process and included local consumers, advocates, and family members as well as representatives from local criminal justice, behavioral health, and medical agencies and organizations. The mission the panel set itself was to develop a model system for pre-booking jail diversion and crisis response in Pima County that assists adults and minors in behavioral health crisis that are involved with law enforcement agencies to receive timely, appropriate treatment instead of jail. This report aims to document the background to this effort, the process utilized, and the outcomes achieved.

II. Background

This section provides a brief background to the work of the *Crisis Intervention Consensus Project*. First, the growing problem of law enforcement involvement with individuals in behavioral health crisis is outlined. This is followed by a brief discussion of national and local efforts to address this problem. The source of funding and support for the project are identified. And finally, the key project goals are outlined.

A. Law Enforcement, Criminal Justice, and Behavioral Health

Law enforcement involvement with people who have behavioral health problems has been increasing in communities across our country due to inadequate behavioral health care, restrictive civil commitment procedures, the deinstitutionalization of people with mental illness, growing drug abuse problems, and the criminalization of drug offenses. (Green, 1997; Lamb et al, 2002) Approximately 7% of all police contacts involve people with mental illness. (Deane et al, 1999) Substance abuse, the effects of which often make it indiscernible from mental illness, is also frequently encountered by law enforcement officers in the field. Individuals using drugs and/or drinking are not only likely to come into contact with law enforcement, they are also more likely to be arrested. Approximately two-thirds of all arrestees test positive for one or more drugs and over half of arrestees have recently engaged in binge drinking. (Pastore and Maguire, 2001) According to a recent *Arizona Republic* article, incidents between the police and people with mental illness are on the rise in Phoenix, AZ. (Villa and Steckner, 2003) The increased contact between law

enforcement and people with behavioral health problems has led to two significant and growing problems: (1) the criminalization of persons with behavioral health problems, and (2) police shootings of persons in behavioral health crisis.

The criminalization of persons with behavioral health problems involves the arrest, prosecution, and incarceration of these individuals for what are often petty or nuisance crimes. Law enforcement officers may not feel adequately trained to respond to individuals with behavioral health problems and as a result they resort to arresting and jailing these individuals. Law enforcement officers also identify a lack of access and to, and responsiveness by behavioral health and medical facilities as factors contributing to their arrest and incarceration of these individuals. (Borum et al, 1998) These cases result in an increased burden on the criminal justice system—contributing to overcrowding in jails and courts and increasing costs. It is estimated that over 7% of people in jails suffer from serious mental illness. (Steadman et al, 1999) In many communities, jails and prisons are frequently identified as the largest providers of mental health services. Within these facilities, however, the quality and appropriateness of available mental health treatment services is very limited, if available at all. The criminalization of people with behavioral health problems increases the stigmatization of these individuals who require treatment and help.

The most tragic consequence of increased encounters between law enforcement and persons in behavioral health crisis involve shootings of the individual in crisis, which unfortunately are often lethal. Some shootings involve what is known colloquially as suicide by cop, which occurs when an individual in a behavioral health crisis (e.g., a depressed person) intentionally engages in aggressive or life threatening behavior in order to provoke law enforcement to respond with deadly force. Other shootings involve individuals who due to their behavioral health condition (e.g., psychosis) are unaware that their behavior may be perceived as aggressive or threatening and puts them at risk of grave harm. There have been a number of police shootings of individuals in behavioral health crisis within the past few years in Tucson and Pima County and, in fact, one of these shootings served as the initial impetus for this project and the mobilization of advocates and agencies within our community. According to the *Arizona Republic* over 10% of police shootings in Phoenix since 1996 have involved persons with mental illness and 14% of fatal police shootings involved suicide by cop. (Villa and Steckner, 2003) People with mental illness are four times more likely to be shot in an encounter with law enforcement. (Walsh, 2003)

A significant, but often overlooked problem, is the impact that the criminalization of the mentally ill and police shootings have on family members of people with mental illness. Family members are understandably reluctant to seek the assistance of law enforcement for fear that their family member who is mentally ill will be booked into jail instead of receiving needed treatment, or worse yet that they could be injured or killed in an encounter. This places burdens on family members to attempt to deal with difficult and potentially dangerous situations in lieu of contacting law enforcement for assistance.

B. National Efforts

In response to these problems, many communities have developed alternatives to arrest, prosecution, and incarceration of mentally ill/substance abusing defendants, particularly those individuals committing low level misdemeanors and, in some cases, non-violent felonies. Falling

under the general rubric of jail diversion programs, these initiatives involve interagency collaboration between mental health, law enforcement, and criminal justice systems to reduce the criminalization of individuals with behavioral health problems through community-based crisis stabilization, treatment, and care. Jail diversion programs can be categorized according to when the diversionary activities are implemented as either *pre*-booking or *post*-booking. Pre-booking approaches are those that divert the individual prior to arrest, while post-booking approaches divert the individual from jail after arrest. Post-booking programs are well suited to deal with the problem of the criminalization of people with behavioral health problems, however they do little to assist first responders, such as law enforcement officers, to cope with the increased contact in the field with people in acute behavioral health crisis. Due to the earlier intervention point pre-booking programs are better suited to reducing the likelihood of violent confrontations between law enforcement and those in behavioral health crisis and, like post-booking programs, they also help to reduce the criminalization of individuals with behavioral health problems.

The purpose of the present proposal was to develop community consensus on the adoption of a model of pre-booking jail diversion that recent research and expert opinion support as an exemplary practice**.** Accordingly, we will restrict our discussion here to pre-booking jail diversion model description. Pre-booking jail diversion programs identify individuals with behavioral health needs in crisis prior to formal arrest and booking and attempt to link these individuals with appropriate treatment in lieu of arrest and prosecution. Three distinct pre-booking jail diversion program models have been identified in the literature (Deane et al, 1999; Borum et al, 1998):

(1) **Police-based specialized mental-health response model:** the police department employs trained mental health professionals in the field to assist officers in responding to mental health related calls
(2) **Mental-health-based specialized mental health response model:** mobile crisis units, established through partnerships with local mental health agencies, provide independent assistance to police officers in the field responding to mental health calls
(3) **Police-based specialized police response model:** the police department trains sworn officers to provide immediate front-line response to mental health calls

The best-known example of a police-based specialized police response model is the Crisis Intervention Techniques (CIT) program that was developed in Memphis in 1988. This nationally recognized program has four essential components (Steadman, 2001).

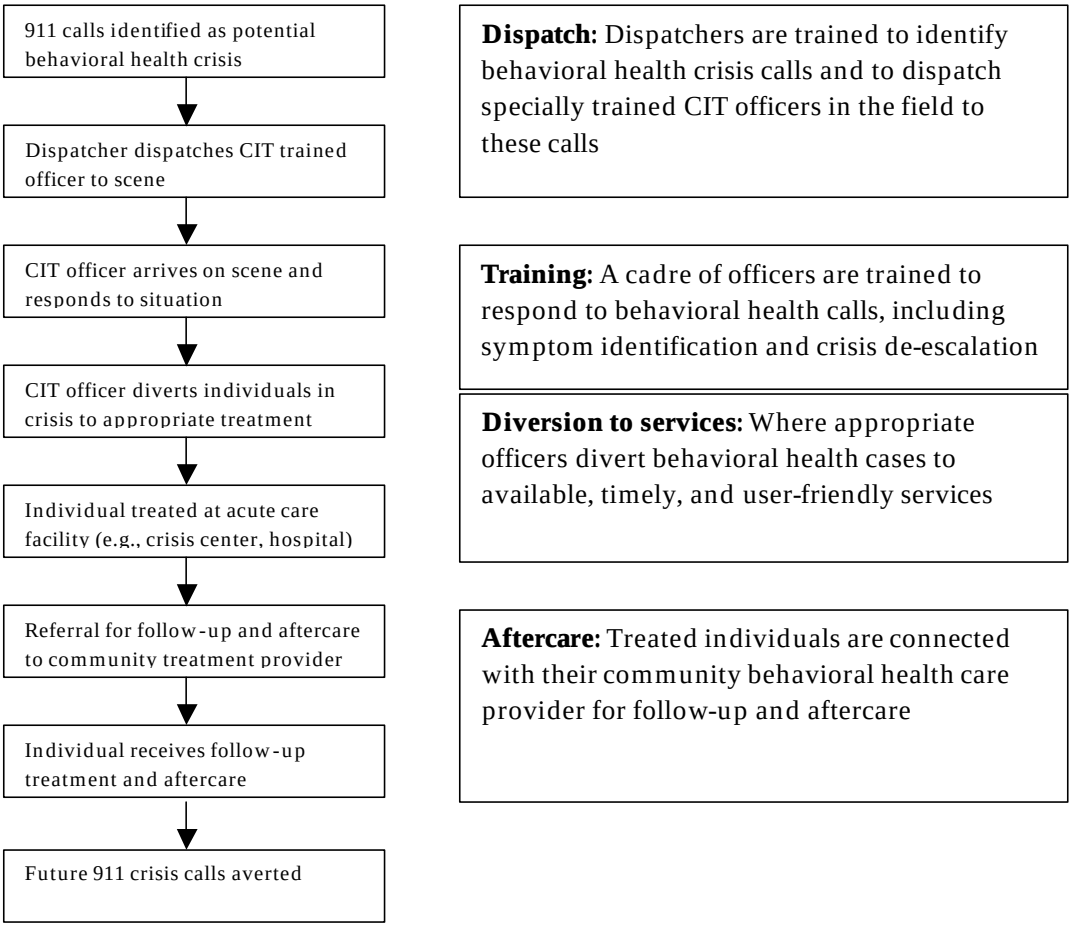
(1) **Training:** A subset of officers receive intensive specialized training in mental health assessment skills, crisis de-escalation, and the use of non-lethal weapons.
(2) **Dispatch and control:** Dispatch procedures utilize trained officers to quickly respond to mental health related calls and authorizes these officers to take control of the situation.
(3) **Drop-off facilities:** The availability of safe, secure, and properly staffed and equipped no-refusal crisis stabilization units for law enforcement personnel to quickly drop-off individuals experiencing a mental health crisis.
(4) **Aftercare:** The establishment of enhanced follow-up and aftercare treatment linkages from emergency crisis care facilities to community treatment providers.

While not every CIT program will incorporate all of these features in exactly the same manner (e.g., some communities utilize a single facility for drop-off, others utilize multiple facilities), they each serve an important role in an effectively functioning CIT program.

Enhanced training typically consists of 40 hours of post-academy training in recognizing and understanding mental health symptoms and syndromes, developing de-escalation techniques through role plays, and the provision of information and tools for utilizing community mental health resources. Enhanced training is the foundation of all CIT programs and without effective training the rest of the enhancements would be of little use. Dispatch procedures involve special training for dispatchers to recognize behavioral health related calls and to utilize appropriate scripts and protocols to identify calls as such. Information technology systems are adapted to identify CIT trained officers and with this information in hand dispatchers are able to dispatch CIT officers to behavioral health related calls whenever possible. At least one secure 24 hour medically equipped facility with expertise in treating individuals in a behavioral health crisis provides officers with a community resource that can serve as an appropriate alternative to jail—providing individuals in crisis with the treatment they need. Some communities have relied on a single centralized drop-off facility, while others have relied on multiple facilities. In either case, what is crucial is that the facility or facilities have appropriate security, expertise, and quick turnaround time for law enforcement. (Steadman et al, 2000; Steadman et al, 2001) Finally, to ensure that these efforts to divert people from jail to treatment have an impact, and do not simply lead to a revolving door for individuals in crisis, it is essential that there be adequate follow-up and aftercare. Linkages to the individual's community behavioral health treatment provider help to ensure that they are receiving the continuing care that they need to avert future crises.

These program components are depicted in the figure below.

CIT response to individuals in behavioral health crisis and corresponding program components



The early intervention point in pre-booking programs, such as CIT, has a number of distinct and unique benefits: (1) it allows for quick response by trained officers thereby reducing the likelihood of police shootings and increasing the likelihood that the individual will receive treatment; (2) it not only avoids the costs associated with incarceration, but also the court costs incurred in post-booking programs. Research shows that law enforcement officers in CIT programs have higher levels of perceived effectiveness than officers in other types of law enforcement/crisis response programs and partnerships. (Deane et al, 1999; Borum et al, 1998)

Another important advantage of CIT programs is that the responsibility for the various program components are shared among a number of systems and partners. Training is a joint responsibility of virtually all the parties in a CIT program. While law enforcement is involved in organizing the training, local experts from the behavioral health field and many others are involved in developing and presenting the individual sessions. Dispatch is the responsibility of law enforcement to implement. Ensuring that there are adequate available, timely, and user-friendly services to which to divert individuals in crisis is the responsibility of various acute care providers (such as crisis centers and hospitals). Finally, aftercare is the responsibility of community behavioral health providers. CIT programs can be implemented at relatively low cost, but require

high levels of collaboration. The need for cooperation among key stakeholders makes consensus building an ideal approach for developing a community CIT program.

Indeed, similar efforts at the national level highlight the importance of these problems and issues. The *Criminal Justice/Mental Health Consensus Project* (see **http://consensusproject.org/**) is an effort among nationally recognized experts constituting four advisory boards in law enforcement, courts, corrections, and mental health to develop policy statements to guide efforts "to improve the criminal justice system's response to people with mental illness." (*Criminal Justice/Mental Health Consensus Project*, p. xiv) This ambitious project addresses the full criminal justice continuum from law enforcement to corrections as it relates to people with behavioral health problems. The following *Criminal Justice/Mental Health Consensus Project* policy statements, which pertain to contact with law enforcement, thus provide strong support for the local efforts of the *Crisis Intervention Consensus Project* to address these problems in our community.

***Criminal Justice/Mental Health Consensus Project* Policy Statements**

(1) Involvement with the Mental Health System: Improve availability of and access to comprehensive, individualized services when and where they are most needed to enable people with mental illness to maintain meaningful community membership and avoid inappropriate criminal justice involvement.

(2) Request for Police Service: Provide dispatchers with tools to determine whether mental illness may be a factor in a call for service and to use that information to dispatch the call to the appropriate responder.

(3) On-Scene Assessment: Develop procedures that require officers to determine whether mental illness is a factor in the incident and whether a serious crime has been committed - while ensuring the safety of all involved parties.

(4) On-Scene Response: Establish written protocols that enable officers to implement an appropriate response based on the nature of the incident, the behavior of the person with mental illness, and available resources.

(5) Incident Documentation: Document accurately police contacts with people whose mental illness was a factor in an incident to promote accountability and to enhance service delivery.

(6) Police Response Evaluation: Collaborate with mental health partners to reduce the need for subsequent contacts between people with mental illness and law enforcement.

C. Local Efforts

In Arizona, public behavioral health services are coordinated by five Regional Behavioral Health Authorities (RBHAs), which serve as managed mental health care payers for all public behavioral health services (including mental health and substance abuse treatment and prevention services). Public services within the Tucson Metropolitan area are organized by the Community Partnership of Southern Arizona (CPSA), the state designated RBHA for five southern counties of the state. CPSA oversees a budget of $137 million and in FY 01-02 provided behavioral health services to 30,244 persons through a variety of subcontracted providers, including three comprehensive service networks in Pima County that serve adults with behavioral health disorders. CPSA contracts with the Southern Arizona Mental Health Center (SAMHC) to provide crisis services in the greater Tucson area. For those individuals eligible through the Arizona Long

Term Care System (ALTCS), Pima Health System (PHS) offers a complete range of behavioral health services in Pima and Santa Cruz counties. Pima Health System is a licensed behavioral health agency that provides comprehensive treatment services to meet the behavioral health needs of adults and children either directly through its own team of professional staff or through contracts with community agencies to provide specialized services.

Under the current system, persons experiencing a behavioral health crisis may access crisis response services through a variety of mechanisms. First, low level crisis and crisis prevention telephone support services are available through the Peer Mentor program, a consumer run and consumer operated program providing "warm line services" seven days per week, 6 hours per day. Additionally, Help on Call provides more traditional, crisis call services 7 days per week, 24 hours per day. SAMHC, the RBHA designated behavioral health crisis center, is licensed as a Level I Sub-Acute facility and provides 24-hour crisis call services, walk-in crisis counseling and stabilization services, and, as of February 2003, a limited number of short-term (72-hour) crisis beds. SAMHC also manages Mobile Acute Crisis (MAC) Teams. These are two person mental health crisis response teams that may be requested by individuals, their family members, and law enforcement officers. In-home crisis counseling services are available for children and their families through a variety of agencies. Individuals who are enrolled in the public behavioral heath system may have a case manager with whom they have more frequent contact and who may be able to defuse potential crisis situations.

As noted above, persons in behavioral crisis are frequently confronted by local law enforcement officials responding to 911 calls associated with disturbances of peace and disorderly conduct, reports of domestic violence, and other similar citizen- initiated requests. While responding officers have a number of available options in the field, each has its limitations. First, officers may call upon the MAC Team to provide assistance and back up, but use of MAC Team is limited in some cases due to safety issues and timeliness of response. For instance, in situations where any form of weapon is present the officer must ensure that the threat posed to the safety of the Team is removed before the Team can be utilized. Though the MAC Teams consist of highly skilled behavioral health professionals, their limited numbers often mean long response times for officers who must deal with a situation in the field that requires immediate attention. Second, law enforcement officers may also choose to transport individuals in crisis to one of the area's six hospital emergency departments. However, delays in the hospital's accepting custody of the individual result in increased "down time" for the officers, along with a lack of uniform procedures and paperwork at the different area hospitals, create strong deterrents to seeking treatment as an alternative to jail.

The importance of the issue of jail diversion is well recognized within the Tucson community. Due in part to previous grant funding from SAMHSA (Cooperative Agreement # SM5216-03-1), a post-booking jail diversion program has been developed and expanded. This post-booking diversion program includes the establishment of a specialized court for mental health cases and the development of an integrated management information system between the RBHA and the county jail, to facilitate the rapid identification and diversion of individuals currently enrolled in the behavioral health system. The RBHA and provider networks facilitate diversion of selected individuals with staff placed in city and county court offices who work in conjunction with the court, the prosecutor's office, and the public defender to assist in identifying and processing cases. This program plays an important part in the collaboration between behavioral

health and criminal justice agencies. In April 2001, the Tucson City Court consolidated all mental health cases under the care of a single judge in the Mental Health Court. This has simplified the court calendar and allowed the participants to organize the exchange of information more effectively, expediting the release of mental health defendants from custody. From January 2000 to May 2003 the Mental Health Diversion Program has enrolled more than 4000 defendants. At this date 2658 defendants have completed the program, a success rate of 82%. The program has reduced the average jail stay for mentally ill defendants from 22 days in 1999 to 7.4 days in 2003, resulting in 20,957 jail days saved and a cost savings of $1,048,131 to the City of Tucson. These accomplishments were the result of the coordinated efforts of attorneys in the City Prosecutor's Office and City Public Defender's Office. Other justice agencies have also participated in the program's success. The staff of the Pima County Jail has assisted in early identification of defendants with mental illness, co-occurring disorders, and other developmental disabilities (e.g., mental retardation) and facilitation of their scheduled releases to case managers and family members. As a result of the savings in jail costs, the Tucson Police Department agreed in May 2000 to underwrite a portion of the cost of administrative support for the Mental Health Diversion Program. Significantly, the program has operated without other additional funding from city government.

It is evident that the greater community of Tucson has been actively engaged in a comprehensive approach to addressing the needs of individuals with behavioral health issues that come into contact with the law enforcement and criminal justice systems. Three community groups—the Pima County Forensic Task Force, the Crisis Consortium, and the Crisis Intervention Network—have each addressed issues relating to the interface of individuals in behavioral health crisis with law enforcement and the criminal justice system. All three groups have had as guests or members, representatives from a number of local law enforcement entities. The Forensic Task Force developed out of a group originally convened by CPSA that was adopted by the behavioral health and criminal justice community and has continued to meet in an effort to identify mechanisms that will improve coordination and communication between both systems. The Crisis Consortium is a forum co-facilitated by CPSA and SAMHC, whose emphasis is on enhanced crisis response among the diverse groups and entities throughout the community who respond or interface with individuals in behavioral health crisis (the work of the Crisis Consortium is not limited to criminal justice). The Crisis Intervention Network is a grassroots organization that was founded in 2000 by concerned family members and consumers, in response to the police shooting of a man during a behavioral health crisis. CIN has about 50 members and has been very active in advocating for the development of a CIT program in Tucson and Pima County—e.g., it has made presentations about CIT programs to local officials and has sponsored meetings with various stakeholders. The work of CIN was a driving force behind this project and grant application, as well as law enforcement officer CIT training.

In a supporting role for this project, the University of Arizona, in collaboration with the Tucson Police Department and Pima County Sheriff's Department, conducted a survey of uniformed patrol officers to assess their experiences and needs in responding to calls involving persons in behavioral health crisis. Some results of the survey are summarized in the table below.

Law Enforcement Officer Survey Highlights

		TPD	PCSD
Average number of mental health crisis calls/month/officer		**7.4**	**2.0**
How well prepared do you feel when handling people with mental illness in crisis?	Not at all or somewhat	**34%**	**33%**
	Moderately or very	**66%**	**67%**
How effective do you believe your department's response in minimizing the amount of time officer spend on these types of calls?			
	Not at all or somewhat	**73%**	**60%**
	Moderately or very	**27%**	**40%**
How big of a problem are people with mental illness in crisis for your department?	Not at all or somewhat	**34%**	**67%**
	Moderately or very	**66%**	**33%**
Officers indicating a desire for more mental health training		**29%**	**42%**

While most officers feel well prepared there is a substantial portion that feel they could be better prepared. This should not perhaps come as a surprise given that officers respond to quite a few behavioral health related calls, but only receive a few hours of academy training on behavioral health issues. Consequently, a substantial portion of officers indicated a desire for more training in responding to calls involving people with mental illness. The Tucson Police Department and Pima County Sheriff's Department responded by taking a proactive role to enhance officer training, which will be described in greater detail in a subsequent section of this report.

D. The UA and SAMHSA Community Action Grant

In response to the mobilization within the Tucson community regarding law enforcement shootings and the work of the Crisis Intervention Network, the University of Arizona submitted a Phase I Community Action Grant to the Substance Abuse and Mental Health Services Administration (SAMHSA) in October 2001. The purpose of SAMHSA's Community Action Grant (CAG) program is to promote the adoption of exemplary mental health practices in communities around the country. Phase I grants support consensus building efforts among key stakeholders, while Phase II grants support implementation. The UA was awarded a Phase I grant in April 2002. This $150,000 grant provides support to convene key stakeholders in a community-wide consensus building process and to evaluate this process. The consensus building effort supported by this grant became known as the *Crisis Intervention Consensus Project*. A number of city and county agencies have had an active role in this project—including, representatives from the City Court, County Administrator's Office, the Community Partnership of Southern Arizona, County Attorney's Office, the City of Tucson Police Department, the County Sheriff's Department, Pima Health Systems, and Kino Community Hospital—as well as a wide variety of community stakeholders, including the National Alliance for the Mental Ill of Southern Arizona (NAMISA), and others. The University of Arizona's Applied Behavioral Health Policy Division served as the fiscal agent for the grant and provided facilitation and staff support for the project, including project evaluation efforts.

E. Key Project Goals

The overall objective of the *Crisis Intervention Consensus Project* was to conduct a process of consensus building, strategic planning, and public education leading to the implementation of a

model of pre-booking jail diversion and crisis response for persons in behavioral health crisis. The specific objectives stated in the grant proposal for the project include:

(1) Convening and supporting a group of key stakeholders within the Tucson/Pima County community to meet on a monthly basis.
(2) Facilitating a structured consensus building and decision support process resulting in the identification of and agreement on a CIT model pre-booking diversion program for implementation within the greater Tucson community.
(3) Evaluating the consensus building process utilized by the Consensus Panel.
(4) Enhancing public awareness and educational efforts to increase attention to the needs of individuals in behavioral health crisis, key characteristics and outcomes of CIT programs, and the need for CIT in Tucson.

III. Process

In this section the processes utilized during the *Crisis Intervention Consensus Project* are discussed, including: the consensus building approach, stakeholder issues, meeting facilitation, an overview of the meetings, the primary project phases, and challenges to reaching consensus.

A. The Consensus Building Process

Consensus building is a form of participatory decision making among multiple stakeholders, the aim of which is to reach consensus on an outcome that is fair and produces mutual gains. (Susskind et al, 1999; Fisher and Ury, 1991) To reach consensus it is important that stakeholders focus on their interests rather than take positions. (Susskind et al, 1999; Fisher and Ury, 1991) Position taking tends to harden and solidify conflicts, whereas a focus on interests facilitates a collaborative search for mutually beneficial outcomes.

Consensus building processes employ a wide range of activities and techniques to achieve consensus, including: conflict assessment, identifying and convening stakeholders, visioning, meeting facilitation and planning, building trust, gathering information, forming task forces, dispute resolution and negotiation, and techniques to generate and evaluate options. (Susskind et al, 1999) While reaching consensus may be difficult, consensus building has a number of potential advantages as a form of decision making, among them are that: it empowers stakeholders who are often left out of other forms of decision making; it can foster dialogue, understanding, and information sharing across diverse stakeholder groups; it can yield innovative solutions to difficult problems; and it can produce stable, effective, and fair agreements that are more likely to be implemented.

B. Stakeholder Involvement and Identification

A central part of any consensus building process is identifying and involving the appropriate stakeholder groups and representatives. Stakeholders are those (a) with a defined interest in the outcomes under deliberation and (b) those with the resources to influence the adoption of those outcomes. In the case of a service provided by local government and its partners the stakeholder groups thus include organizations and agencies who provide the service, the service recipients, and those who partner and interact with the service provider and recipients.

A number of stakeholder groups had been identified as part of the early pre-grant efforts to explore the development of a CIT program in Tucson/Pima County. These groups and some additional stakeholders were identified in the grant application. However, to ensure that as many appropriate stakeholder groups as possible were identified efforts were made during the first few meetings of the *Crisis Intervention Consensus Project* panel to identify additional stakeholder groups. Members of the panel were asked about other groups, organizations, and agencies that should be present. Invitations to participate in the process were extended to these parties. The commitment required by stakeholders in the process—to attend a nearly yearlong series of monthly all-day meetings served to ensure that those participating in the process did indeed have a defined interest in the issues involving front-end diversion for those in a behavioral health crisis.

Once the relevant stakeholder groups have been identified it is important to identify the appropriate stakeholder representatives. Representatives are necessary since it would be impractical to include every single individual stakeholder in a consensus building process. Appropriate representatives are those with adequate knowledge and decision-making authority who can participate and speak on behalf of the group that they represent. With respect to organizations these individuals are readily identifiable in terms of the authority invested in them in virtue of the positions that they occupy. However, with respect to larger and more amorphous constituent groups (such as consumers and family members), these representatives can be more difficult to identify. While no single consumer or family member has the authority to make decisions on behalf of the rest, there are readily identifiable groups and organizations that advocate on behalf of these constituents. Special efforts were made to ensure that consumers and family members had a voice in the process. Agencies that advocate for consumers and family members were invited and became active participants in the process. About one-fifth of the participants were consumers, advocates, or family members. See *Appendix A* for a complete list of panel members.

C. Meeting Facilitation and Structure

In addition to writing the grant, which provided funds to engage the local community in this consensus building process, the Applied Behavioral Health Policy Division at the University of Arizona was also actively involved in the facilitation of the process throughout the duration of the grant. With a long history of involvement in the behavioral health services field the Applied Behavioral Health Policy Division has the resources and expertise to effectively serve as a support team for this project. Moreover, the University's independence and neutrality is an important asset in coordinating a consensus building process among diverse stakeholders. A neutral party best supports consensus-building processes without a direct stake in the outcome. (Susskind et al, 1999)

To provide expert facilitation support the UA contracted with a Phoenix-based management-consulting firm to provide meeting facilitation services. The role of this consulting firm was to chair the panel meetings, facilitate discussion, produce a meeting summary, and assist with meeting planning. The importance of good meeting facilitation in the consensus building process cannot be overemphasized. Moreover, the involvement of this consultant, who was not attached to the Tucson community, ensured an extra layer of neutrality.

Meetings were generally held monthly at varying locations within the local community, from 9:30 am to 3:00 pm with a 45-minute break for lunch. Sub-committee meetings were three hours long and held from 9:00 am to 12:00pm and/or 1:00 pm to 4:00 pm. All panel members were

provided with a binder in which to keep all meeting related materials and an electronic mailing list was set up at the University of Arizona to facilitate communication among the panel. The electronic mailing list was utilized to inform panel members of meeting times and locations, to distribute meeting materials such as agendas and summaries, and for general communication and discussion among panel members.

Meetings typically began with a welcome, introductions, and review of the agenda followed by a review of the meeting summary for the previous meeting and a summary of the evaluation results of the previous meeting. The meeting facilitator would then conduct the meeting following the items listed on the agenda. Though a variety of consensus building techniques were utilized during meetings, perhaps the most common approach involved facilitated and structured discussion among the full panel. The need for ample discussion posed a significant challenge in keeping meetings on schedule. While discussion among the full panel was often vigorous and spirited, people were respectful of the views of one another, which made for an atmosphere in which all panel members from all stakeholder groups appeared comfortable and willing to contribute their views and insights. In addition to full panel discussion, a number of other techniques and approaches for reaching consensus were utilized. Small group sessions were used (particularly during early meetings) to generate ideas and encourage free thinking and full participation among panel members. These small groups would then report back to the full panel. To communicate information to the full panel many sessions involved use of power point presentations and handouts. Individual panel members with particular knowledge or expertise were often asked to brief the full panel about issues of relevance and concern to the full panel. These presentations were typically followed by questions and additional discussion. Sometimes these presentations involved a number of individuals in the form of a small panel. Eventually it became evident that for progress to be made on specifics it would be necessary to form sub-committees or task forces. These sub-committees were formed with the input of the full panel and charged with a specific task. The sub-committees met a number of times and reported back with a set of recommendations to the full panel. This process ensured full group input, yet also provided for greater attention to specifics and details that work in smaller groups allows.

D. Overview of Meetings

A total of 11 monthly meetings were convened as a part of this process. During eight of these months the meetings involved convening the full panel. During the other 3 months sub-committees were convened. The dates and the goal of these meetings are outlined in the table below.

Meeting date	Goal for the meeting
June 19, 2002	**Full panel meeting:** To provide an overview of the Crisis Intervention initiative, goals, objectives, timelines, support functions, and establish the panel structure and schedule of meetings and actions.
July 24, 2002	**Full panel meeting:** To establish a solid foundation for the work of the panel through definition of the mission, guiding principles, and operating guidelines, to finalize the membership and establish communication protocols.
August 29, 2002	**Full panel meeting:** To adopt the mission, guiding principles, and operating guidelines and to define the current model of the behavioral health crisis system.
September 18, 2002	**Full panel meeting:** To review the flow charts of the current system and identify

	opportunities for improvement, to learn about jail diversion programs in other jurisdictions, and to identify and commit to a plan of action for the panel. (*Dr. Henry Steadman, guest speaker and consultant*)
October 23, 2002	**Full panel meeting:** Assess the status of the project and establish goals for the remainder of the project.
November 20, 2002	**Procedures/protocols sub-committee:** Identify current processes/protocols for the interface of law enforcement, hospital/crisis facilities, and behavioral health providers and to identify opportunities for coordination and streamlining of these systems.
December 18, 2002	**Procedures/protocols sub-committee:** Develop recommendations for coordinating and streamlining protocols/processes for transitioning individuals in BH crisis between law enforcement, crisis facilities, and behavioral health providers. **Public awareness sub-committee:** Develop the framework for a public awareness campaign including purpose, target population, message, and method(s) of delivery.
January 22, 2003	**Full panel meeting:** Review the sub-committee recommendations and reach agreement on a final set of recommendations from the full panel.
February 19, 2003	**Procedures/protocols sub-committee:** To follow-up on questions/clarifications raised at the January full panel meeting and to develop an operational plan for implementation of the approved recommendations. **Public awareness sub-committee:** Follow-up on questions/clarifications raised at the January full panel meeting and develop an operational plan for implementation of the approved recommendations.
March 26, 2003	**Full panel meeting:** Review and finalize the sub-committee implementation plans and review an outline for the final report.
May 28, 2003	**Full panel meeting:** Review, revise, and finalize the final report.

E. Project Phases

In the grant application a four-phase consensus building process was identified. While this four-phase process was useful as a plan or road map for the project, it was necessary to continually modify it in light of the exigencies of the process in order to facilitate the movement toward consensus. Below the four-phases of the process and the modifications that took place during the course of the project are briefly described.

Phase 1: Vision and Team Building This first phase of the process had two primary objectives: (1) to bring together the stakeholders and build effective working relationships; and (2) to develop a coherent and focused vision for the project. The first of these objectives is particularly important in the context of a consensus building process involving an ad hoc assembly. An ad hoc assembly consists of stakeholders drawn from a multitude of diverse groups with little or no working history. While many of the stakeholder representatives had some familiarity with one another they had a limited history of working together and represented groups with different interests, beliefs, and values. This posed a challenge and made it essential to work to develop trust and cooperative relationships before significant progress toward consensus could be made.

To facilitate the building of trust and cooperation small group sessions were frequently utilized during the first few months of the project. These small groups, which were changed each time, would involve the panel members working together toward a specific well-defined end (e.g., to develop a mission statement). The changing make-up of the group ensured that people had an opportunity to meet new people on the panel. Many of the panel members commented favorably on the interactions within these small groups and the opportunities they provided to network with

their peers and associates. We had anticipated that team building would take about two months, but it took closer to four months for these working relationships to solidify. Part of the reason for this likely had to do with the changing make-up of the panel during these first months—new members were identified and some initial participants left the process. By four months the make-up of the group had largely stabilized.

The second objective of this phase was to develop a coherent and focused vision for the project. Some of the panel members had previously worked on these issues for a considerable period of time, while others were familiarizing themselves with them for the first time. The development of a vision for the panel required everything from a mission statement to guiding principles to concrete operating guidelines. In the July meeting sessions were held to develop a mission, guiding principles, and operating guidelines. These were finalized during the August meeting. The panel adopted the following mission statement:

> **Mission Statement: Crisis Intervention Consensus Project**
> To develop a model system for pre-booking jail diversion and crisis response in Pima County that assists adults and minors in behavioral health crisis that are involved with law enforcement agencies to receive timely, appropriate treatment instead of jail

The guiding principles sought to identify the values that would guide the panel in their work on developing a set of recommendations. The guiding principles adopted include the following.

> **Guiding Principles: Crisis Intervention Consensus Project**
> *Accessibility*—The crisis system is seamless, allowing for easy access to services for the person in crisis regardless of who the first responder is or where the person in crisis enters the system.
> *Aftercare*—The provision of after care services assists in maintaining treatment progress and will result in reduced recidivism and future legal involvement.
> *Effective communication*—Accessible and timely communication among the systems enhances appropriate decision making.
> *Consensus model*—A system developed through consensus will respond to the community need resulting in community wide acceptance and commitment. A coordinated, cooperative effort among all stakeholders is critical to implementing a system that responds to multiple community perspectives.
> *Efficient resource allocation*—Limited financial resources require a prioritization of needs, simplification of complex processes and coordination among all systems.
> *Individualized assessment and treatment*—The response to the specific needs of the person in crisis must be individualized from first response to stabilization to ongoing assessment and treatment.
> *Least restrictive most appropriate level of care*—The system can only be effective in the long term if services are provided in the least restrictive most appropriate level of care which ensures the safety and health of the individual and the safety of the community.
> *Non-lethal crisis intervention*—First responders need the training and tools for intervention, which will result in the safety of the individual in crisis and the responder.
> *Prevention of arrests*—Options and tools must be available for first responders to divert individuals in crisis from arrest to treatment.
> *Respect and dignity*—In order for a successful system to be implemented, respect at all levels and for all persons must be demonstrated.
> *Safety of all*—The system must provide reasonable certainty that neither the individual with behavioral health needs or those who intervene are injured or killed.

Timely service—The system must provide appropriate services in a reasonable amount of time to reduce decompensation and decrease morbidity and mortality.
Training—Training must be provided on an ongoing basis for officers and behavioral health treatment providers in order to maintain an effective system in the long term.
Uniform approach—From intervention in a behavioral health crisis through the provision of aftercare, there needs to be a standard protocol used across the system. Use of a standard protocol will enhance coordination, communication, and cost-effectiveness.

Operating guidelines to facilitate the consensus process during the meetings were also adopted by the panel. The operating guidelines adopted by the group are summarized below.

Operating Guidelines: Crisis Intervention Consensus Project
Start and end meetings on time
Allow for different opinions on the table
Accept responsibility for "give and take"
Create a "parking lot" of issues to be addressed at a later date
Bring in subject matter expertise as needed
Make decisions by consensus
Treat each other with respect and dignity
Listen to each other
Have open communication
Use "person first" language
Not interrupt when someone is speaking
Use first names to address each other
Work to understand each other's constraints
Make additions to these Guidelines if needed

Additional accomplishments of the first phase of the project include the identification and engagement of additional stakeholders in the process and the establishment of an electronic mailing list to facilitate communication among the panel members and for the purposes of meeting organization. The plan called for the formation of sub-committees to work on various issues pertaining to the establishment of a front-end diversion program. However, sub-committees were not formed. The group was not ready to form sub-committees until the team building process was complete. In addition there was a sense among the panel members that the panel as a whole needed to more firmly establish a vision before the formation of sub-committees would be an appropriate step.

Phase 2: Information Gathering. This phase was planned to take place during the third through the sixth month of the project. Once the panel members had established effective working relationships and a mission, it was expected that they would require some time to gather information that would later assist them in developing a set of recommendations. In the grant application it was anticipated that much of the necessary information would come from other communities with front-end diversion programs. The plan called for bringing in national experts to assist us with these information needs and sending panel members to other communities on fact-finding missions.

Dr. Henry Steadman, director of the GAINS Center and a leading national expert on jail diversion programming, addressed the group during the September meeting. A number of panel

members had previously made site visits to other communities with front-end diversion programs, such as: Memphis, TN, Albuquerque, NM, Seattle, WA, and San Francisco, CA. These panel members were able to share their experiences and insights regarding these programs with the rest of the panel. Most of the panel's information gathering activities, however, focused on gathering local information. With the adoption of a mission statement, there emerged agreement among the panel members regarding the desirability of a front-end diversion program for our community. But it was recognized that the model adopted within our community must be responsive to the unique needs and resources within our community and not simply a model that is employed in another community. The information needs of the panel, therefore, required a shared and more complete understanding of how the law enforcement, medical, and behavioral health systems within the greater Tucson community interacted.

To meet this need the panel developed a flowchart depicting the intersection of law enforcement and the behavioral health crisis system. If law enforcement was contacted regarding an individual experiencing a behavioral health crisis, what were the steps and decision points through the criminal justice and behavioral health system that led to the various possible outcomes, including: release, transport to a hospital or crisis facility, referral to a behavioral health provider, or transport to jail? During the August meeting the panel worked on developing this flowchart. Given that individual panel members represent diverse segments of these systems, the flowchart was beneficial in providing all panel members with a broad overview of the total system. In particular, it helped to reveal the complexity of the systems involved as well as the multitude of safety, legal, and clinical issues confronting the various professionals involved in these systems. This common understanding and appreciation of the complexity of the involved systems made the flowchart exercise well worth the trouble.

The flowchart (see *Appendix B*) was subsequently used in the September meeting as the panel worked in small groups to identify opportunities for improvements in responding to and serving individuals in behavioral health crisis. A multitude of issues were identified by these groups. Two key issues that created great debate emerged at this meeting, revolving around the need for a single or multiple drop-off points and the extent to which emergency medical care services are required at such a site(s). Most of the other issues identified in the small groups revolved around the lack of coordination among the various systems (law enforcement, emergency medical, and behavioral health). Due to the controversy over single or multiple drop-off points and the issue of emergency medical care, at this point there was considerable uncertainty about how the panel ought to proceed.

Phase 3: Planning Development The aim of this phase was to articulate a set of specific recommendations for action regarding a front-end diversion program. However, a number of obstacles stood in the way to developing specific recommendations. The issue of whether to designate or establish a centralized drop-off center remained controversial. Furthermore, the issue of law enforcement dispatch also emerged as a controversial issue. During the October meeting an effort was made to bring into focus the political and resource realities of our community and to create a clearer sense of direction for the panel. At about this same time, the Pima County Board of Supervisors began discussions regarding the future focus of Kino Community Hospital and the prospects of expanding the mental health and psychiatric service capacity of the county hospital. The uncertainty surrounding the Kino situation led the panel to temporarily set aside the controversial issues of single versus multiple drop-off points and the need for emergency medical

care, and the issue of law enforcement dispatch. Regardless of how these issues would eventually be resolved, a consensus emerged about the need to develop recommendations that would help to coordinate and streamline the processes among the different systems involved in responding and providing services to individuals in behavioral health crisis—including, first responders (Police, Fire, EMT), primary care ED/ER providers, and behavioral health care providers.

Accordingly, the panel formed two sub-committees at the October meeting: (1) the Field Decision, Reception, and Aftercare (FDRA) Sub-Committee and (2) the Public Awareness and Education (PAE) Sub-Committee. The panel determined the agenda and membership for each sub-committee. The FDRA Sub-Committee was charged with developing recommendations for coordinating processes between three systems: (1) law enforcement, (2) hospitals, crisis centers, and detox facilities, and (3) behavioral health care providers. The PAE Sub-Committee was charged with developing recommendations on a plan for enhancing public awareness and education efforts, including: desired outcomes, a target population, a message, and a method of delivery.

The FDRA Sub-Committee met in November and December to identify opportunities for coordinating and streamlining processes. Three focused panel discussions occurred during the November meeting: (1) a Field Decision Panel consisting of law enforcement representatives; (2) a Reception Panel consisting of hospital and crisis/detox facility representatives; and (2) a Follow-up/Aftercare Panel consisting of behavioral health provider representatives. Each panel, in conjunction with the rest of the sub-committee, identified a number of opportunities for improving the processes and linkages within their area of focus. During the December meeting the sub-committee utilized these areas of opportunity to develop specific recommendations related to each of the three panel areas (e.g., field-decision, reception, and aftercare).

The PAE Sub-Committee met in December and developed a plan for enhancing public awareness and education, which identified: a set of desired outcomes, a target population for each outcome, a message for each target population, and a method of delivery for each message. See *Appendix C* for details.

Each of the sub-committees presented their recommendations to the full panel at the January meeting for review and adoption. The majority of these recommendations were approved by the panel, while a few were rejected as unnecessary or already in place and clarification was called for on a few others. The sub-committees met again in February to address these clarifications and to develop specific action steps for operationalizing each of the recommendations.

In March the full panel met again to review the clarifications and the implementation plan. The recommendations requiring clarification were approved (or in a few cases slightly modified) and the implementation plan was also approved. A primary objective of the panel, and indeed the project, had been achieved.

Phase 4: Report Adoption & Dissemination The final phase of the project involves adopting and disseminating a final report. At the March meeting the panel reviewed and approved an outline for the final report. The final report was drafted and circulated to the panel members on the electronic mailing list in May. The panel members reviewed the final report and offered comments and feedback during the May meeting. Revisions to the report were made and the report was again circulated on the electronic mailing list for any additional minor revisions.

At the May meeting follow-up plans for the project were discussed. Panel members stressed the importance of sustaining the project and implementation efforts. The possibility of continuing follow-up work in SAMHC/CPSA's Crisis Consortium was discussed. The electronic mailing list will be maintained to allow continued communication among panel members. The University of Arizona also agreed to reconvene the panel for a follow-up meeting sometime around September and would investigate the possibility of applying for a SAMHSA Phase II: Implementation Grant.

F. Challenges to Consensus

In this section the challenges encountered in attempting to reach consensus are briefly discussed. Some of these challenges have already been mentioned in sections above, while others are reported here for the first time. Two broad types of challenges arose: (1) challenges involving the processes employed in attempting to reach consensus, and (2) challenges involving substantive disagreements among the stakeholders about the issues on which they were attempting to reach consensus.

Challenges involving the process One of the first challenges involved the conflict between, on the one hand, identifying all the relevant stakeholder groups and representatives and, on the other hand, keeping the panel and meeting size workable. Increases to group size beyond a certain threshold can have a significant impact on meeting dynamics. The more individuals involved the more difficult team building becomes, the less opportunity there is for each individual to contribute to discussion, and the more intimidated some individuals become in participating. Large group sizes also lead to simple logistical problems such as locating an adequately sized meeting facility, ensuring that all individuals can hear one another, and coordinating catering services. Early *Crisis Intervention Consensus Project* meetings involved quite large groups (approx. 40-50 individuals). As the process went on the meeting size dropped to a more manageable and appropriate size of about 30-35 individuals.

A second challenge involved locating adequate meeting facilities. As already mentioned, the large group size made finding a suitable facility difficult, but there were other challenges as well. First, the facility must be centrally located, easy to find, have adequate parking, and be available. These criteria proved surprisingly difficult to meet. In addition, the facility should have comfortable seating, adequate temperature control, good acoustics, and a kitchen for catering. The issue of acoustics proved to be a significant problem at one particular meeting and may well have impacted the success of that particular meeting. The move from location to location was due to the attempt to locate a facility that best met all of these requirements.

A significant challenge in conducting a yearlong consensus building process is the time and commitment required of the participants in the process. Participation on the *Crisis Intervention Consensus Project* panel involved attending a full-day meeting once a month. Attempting to choose a single day each month to meet revealed that many individuals had regular conflicts and the choice, therefore, had to involve compromise. One day a month is a significant amount of time for many of the busy professionals involved in this process. Hence, due to other commitments they occasionally had to miss meetings. Despite the time challenges involved most participants made every effort to attend meetings.

Conflicts among the stakeholders are a challenge in virtually any large consensus building group. There are two reasons for this. First, there would be no need to gather for consensus

building if there were not already some issue about which there is less than full agreement. Second, the stakeholders represent very different interests with different cultures and values. These differences often lead to personality clashes until the groups have had an ample opportunity to develop a mutual understanding. For instance, in our consensus building process this manifested itself over the need individuals in crisis would have for emergency medical care—family members and medical personnel stressed this need, while providers and others believed these cases to be the exception rather than the rule.

Challenges involving the issues The first significant challenge involving the issues, and one that persisted throughout the process was whether the group ought to include within its focus children in a behavioral health crisis. The panel's mission statement includes juveniles. After all, children with behavioral health problems are likely to be encountered by law enforcement. But what happens to children once they are encountered by law enforcement is quite different from what happens to adults: the issue of guardianship arises with children, if apprehended they would be brought to juvenile detention rather than to jail, and the service providers and services are quite different for children (including medical and crisis care). During the process of stakeholder identification a number of agencies and organizations involved with juveniles were identified and invited to participate. Some, though not all, of these individuals participated in the process and where they thought it appropriate kept the focus on the juvenile issue. Despite the fact that many on the panel would have liked to work on developing improvements for juveniles in a behavioral health crisis, panel members came to the realization that this was likely beyond their ability in this forum. Hence despite the panel's mission statement, the primary efforts of the panel were on diversion for adults in a behavioral health crisis.

A second challenge involving the issues concerned the extent of consumer involvement in the training of law enforcement officers. This issue predates this grant and began during the planning for CIT training at a Crisis Intervention Network sub-committee meeting. Some consumers and advocates were adamant that consumers should be utilized for role-play trainings. Law enforcement was uncomfortable with the idea of utilizing consumers in this capacity and believed that utilizing trained actors would be safer and more effective for role-plays between officers and individuals in a behavioral health crisis. Some consumers and advocates believe that law enforcement was reluctant to utilize consumers in other aspects of the training. Law enforcement insists that their only concern is utilizing consumers in role-plays and that they have no objection to consumer input and consumer involvement in non-play aspects of the training. This issue seems to have involved some miscommunication and personality clashes. Unfortunately, the conflict over this issue carried over into a few early meetings of the consensus panel. However, the training evaluations conducted by the University of Arizona helped to dampen the conflict. The trainings were very highly rated by law enforcement participants. Trained actors were brought in from Albuquerque, NM and in the process trained a cadre of local actors in crisis role-plays. These sessions were among the most highly rated of the evaluations. The consumer and family panel, which allows consumers and family members to convey their experiences to law enforcement officers, was also very highly rated and serves to demonstrate that the law enforcement trainings do value the participation of consumers. Consumers have also been involved in other sessions as well.

The issue of law enforcement dispatch procedures also posed a challenge. The issue of law enforcement dispatch is complex, involving multiple dimensions, and understandably law

enforcement agencies are reluctant to make or revise dispatch policies based on the recommendations of an ad hoc community panel. On the other hand, the issue of dispatch is critical to the work of the panel—after all, officers specially trained in responding to behavioral health crises are of little use if they are not the ones responding to those calls. Due to the controversial nature of this topic it was not until toward the end of the process that we were able to get everyone to discuss it. This discussion helped the panel to come to an agreement on a set of recommendations regarding the dispatch of officers to behavioral health crisis calls.

A final and significant challenge involving the issues concerns the need for a designated medically equipped crisis drop-off facility within the community. Some communities, which have CIT programs, such as Memphis, have a single facility where law enforcement officers can drop-off an individual in crisis and within 15 to 30 minutes return to service. The development of streamlined alternatives to jail is a key feature of diversion programs. The issue of contention concerned whether there needs to be a single or centralized facility to serve in this capacity or whether multiple existing facilities could be utilized instead. Those opposed to a single facility cited the challenges posed by the dispersed geography of the Tucson/Pima County region and the need to work with the existing and available resources within the community. Those in favor of a single facility pointed out the benefits of having medical experts in a facility properly equipped to handle behavioral health crises and with a streamlined intake. The issue was largely put on hold due to uncertainty about the status of Kino Community Hospital—a facility that could possibly serve as a crisis drop-off. The plan to develop a set of recommendations to help streamline law enforcement drop-off proceeded on the basis that the existing array of facilities would all continue to be utilized. However, in the end a de facto compromise was reached when the panel recommended that in addition to the existing complement of facilities a medically equipped behavioral health urgent care would also help to meet the needs of law enforcement and individuals in crisis.

IV. Outcomes

This section discusses the outcomes of the consensus building process. Each of the sub-committees developed a set of recommendations that was subsequently approved by the full panel. The sub-committees then reconvened to develop implementation plans. These implementation plans were also approved by the full panel. The recommendations and implementation plans are outlined in the sections below. Finally, unresolved issues, additional needs, and future efforts are briefly discussed. For those few recommendations were there was opposition and disagreement, this is noted in Section IV.G.

A. Training: Status and Recommendations

The Tucson Police Department and Pima County Sheriff's Department had already initiated training of their officers prior to the initiation of this consensus panel. Subsequently, three additional cohorts of officers have been provided with this training, for which the UA has served as evaluator. *Appendix D* provides a sample curriculum for these trainings.

Training date	Number of personnel trained

March 25-29, 2002	24
July 15-19, 2002	32
October 21-25, 2002	33
April 28-May 2, 2003	38
Total trained to date	**127**

The evaluations of the trainings indicate that the trainings have been very well received by the participating officers and deputies. The table below briefly highlights some of these results.

CIT Training Evaluation Highlights

	March 2002	July 2002	October 2002	April/May 2003
Did the variety of topics meet your needs?	54%	83%	85%	84%
The total length of training was?				
Too long	35%	10%	9%	8%
About right	61%	80%	82%	84%
Too short	4%	3%	3%	0%
Did you learn something that you can immediately apply?	88%	93%	94%	87%
Overall rating of training (1= poor, 5= excellent)	3.74	4.71	4.59	4.55

(Note that percentages may not sum to 100, due to non-response of some survey respondents)

The first training, while still rated quite well, received the lowest ratings. The law enforcement officials responsible for coordinating the training utilized the feedback they received from this training to make some modifications to the sessions, the content, and the trainers. The impact of these improvements is evident in the evaluation results for the subsequent trainings. TPD and PCSD officials have stated that they intend to continue the training and to conduct 3 trainings per year. Two additional trainings are scheduled for later this year: in August School Resource Officers will be trained and in December there will be another general training.

Training: Recommendation 1

Enough officers should be CIT trained to support adequate dispatching of CIT officers to CIT calls. Seasoned CIT officers should be on every shift to ensure adequate response to CIT calls.

The panel supports AZPOST's plan to voluntarily develop a four-hour mental health training for officers in the academy. However, the panel feels strongly that local law enforcement should continue to provide post-academy training. The panel greatly values the commitment local law enforcement agencies have made to training their officers and commends them for the effective training program that they have designed and implemented.

B. Dispatch: Status and Recommendations

Dispatch is the second critical component of effective CIT programs. Dispatch refers to the implementation of specific procedures that allow CIT-trained officers to be directed to incidents, which may involve an individual in behavioral health crisis. Once on the scene, the CIT officer

assumes control of the situation and becomes the officer in charge. As such, implementation of appropriate dispatch procedures requires modification of the manner in which dispatch operators receive and triage incoming calls, the computer software that is used to identify available officers and their status, and law enforcement procedures and policies regarding situation command.

Due to the limited number of officers who have been trained up to this point formal procedures for dispatching CIT officers to crisis calls are not yet in place in Tucson/Pima County. Despite the absence of formal specialized dispatching procedures anecdotal feedback from law enforcement suggests that CIT trained officers are utilizing their skills in the field and assisting other officers who have not been CIT trained. Informal dispatching, where a dispatcher or responding officer puts out a call over the radio requesting CIT officer assistance, reportedly sometimes occurs. The majority of panel members, however, felt strongly that the development and utilization of formal, specialized dispatch procedures are essential to making effective use of CIT trained officers and to the ultimate success of the program. The panel developed the following recommendations to best ensure that CIT trained officers respond to all behavioral health related calls.

Dispatch: Recommendation 1

Identify in the nature of the call that a CIT officer is needed. This will allow CIT officers in the field to respond as a backup if they are available.

Dispatch: Recommendation 2

Provide education and training for potential 911 callers (family members, providers, etc) that it is important to say that a CIT trained officer is needed. Call takers be trained to determine, based on the circumstances described, if a CIT trained officer is needed.

Dispatch: Recommendation 3

For priority 1 calls (highest priority, e.g., suicide), the panel recommends the following: (1) first available officer responds; if this officer is not CIT trained, then an available CIT officer is also assigned; the CIT officer becomes the lead officer at the scene; (2) CIT officers to be dispatched across geographic boundaries as needed; (3) first responding officers can call for CIT assistance.

Dispatch: Recommendation 4

For 100% of non-priority 1 behavioral health related calls, law enforcement agencies should make a strong attempt to dispatch CIT trained officers as primary responders.

Dispatch: Recommendation 5

Law enforcement scheduling and training plan should reflect as a priority having CIT trained officers in each team (Tucson Police) or district (Pima County Sheriff's) and to develop CIT capacity in those areas where it is most needed.

Dispatch: Recommendation 6

Update or modify the 911-computer system such that dispatchers can identify available CIT officers. If the information cannot be made available through the computer system, the dispatcher should have the ability to specifically put out a call for a CIT-trained officer.

Dispatch: Recommendation 7
If for whatever reason it is not possible or reasonable to dispatch a CIT Officer to a call, that CIT trained officers should be used as resource to assist the responding officers.

Dispatch: Recommendation 8
Develop and provide CIT training designed for dispatchers on how to identify CIT officers in the system, scripts to use to identify behavioral health crisis calls, and the protocols for dispatching CIT officers.

These recommendations regarding dispatch should make evident the importance that the panel attaches to the issue of dispatch and should also provide local law enforcement agencies with helpful guidance about how to better respond to the needs of individuals in behavioral health crisis as they continue to develop and expand the CIT program.

C. Diversion to Services: Status and Recommendations

The availability of adequate services to which individuals in a behavioral health crisis can be diverted is the third critical component of CIT programs. Unless such services are available, timely, and user friendly for law enforcement officers they will continue to have incentives to book individuals in behavioral health crisis in jail for minor crimes. As previously described, Tucson and Pima County have a diffused network of behavioral health crisis services that includes SAMHC as the designated behavioral health crisis center, the six hospital emergency departments located throughout the greater Tucson community, Kino Community Hospital, and various treatment and service locations of the three adult service provider agencies (CODAC, COPE, and La Frontera).

Currently, law enforcement officers may chose to take an individual in behavioral health crisis to the nearest hospital and attempt admission through the ED. However, the variation in the procedures that the hospitals employ in accepting these individuals, particularly when the individual being admitted is unruly or aggressive, and the difficulty in identifying when the transferred individual has been admitted so that the officer is free to leave have been repeatedly identified as issues for law enforcement officers. Additionally, the recent expansion and relocation of SAMHC may serve to facilitate law enforcement drop-off at their new facilities. In particular, the addition of 72-hour crisis beds and expanded size, along with the co-location of the Compass detoxification treatment facility are significant enhancements to the crisis system of care. Finally, Kino Community Hospital has special behavioral health expertise and capabilities and handles all of the Court Ordered Petitions in Pima County. Throughout this consensus process representatives from Kino stated that the hospital was studying the possibility of opening a psychiatric urgent care center, allowing for individuals in behavioral health crisis to be treated outside of the formal structure of the emergency room. Additionally, during the latter half off this process, the County Administrator's Office unveiled its proposal to revamp Kino and to expand significantly its psychiatric bed capacity. However, the operation of Kino's psychiatric services and its proposed expansion has not appeared to have been implemented in conjunction with, or coordinated with the Regional Behavioral Health Authority, CPSA. Historically, the relationships between county hospitals and the RBHAs, each mandated with specific services to the indigent population, has been a source of strain, not only in Pima County, but throughout the state as well. The county's

proposed expansion of their psychiatric bed capacity, while responding to a perceived need, comes at a cost that may be borne by the RBHA system of care. In October 2002 the County Administrator released a report recommending that psychiatric services at Kino be enhanced and that inpatient medical/surgical services be terminated. This recommendation generated considerable controversy in the community and a series of public meetings were scheduled during the winter of 2002/2003. Various alternatives for Kino Hospital were explored. On May 16, 2003 the County published a request for proposals to provide emergency and urgent care services at Kino, in addition to a behavioral health urgent care to include a "fast track" capability for law enforcement. Submissions were reviewed by the County and on June 17, 2003 the Board of Supervisors unanimously voted to approve contracts and leases for private companies to begin providing services, including a $19.8 million two year contract with Spinnaker Healthcare to provide behavioral health urgent care services. The County Administrator's proposal to seek a vote on a $55 million bond package to construct a new psychiatric hospital and public health services building, along with renovations to the main hospital, was not acted upon at the time of this report.

Against such a backdrop, the panel articulated the following series of recommendations that are reflective of the realities of the greater Tucson community and our diverse network of access points. These recommendations aim to streamline and enhance the linkages between law enforcement officers responding to behavioral health crisis calls in the field and the various service options available to them.

Diversion to Services: Recommendation 1

SAMHC continue to provide a 24-hour number for law enforcement officers to contact to obtain assistance in connecting the individual to their behavioral health provider. SAMHC would act as the liaison by contacting the behavioral health providers, ALTCS provider, and/or the Division of Developmental Disabilities (DDD) as appropriate and having the provider contact the officer rather than releasing information directly to the officer.

Diversion to Services: Recommendation 2

Encourage law enforcement officers to contact a hospital in advance if the individual they are going to transport is violent and/or poses a potential security issue. Encourage hospitals to be prepared to address the security issues when the officer and individual arrive. (Implement this recommendation by including this information in the officer training and by training the appropriate emergency room staff at the hospitals.)

Diversion to Services: Recommendation 3

Behavioral health providers are to provide a single phone number for a supervisory level (on-call) contact who can assist officers in the field encountering their clients. This person would provide officers with information to assist in re-establishing client contact with treatment and let officers know where to take the consumer. (This recommendation assumes that the officer has information about who the behavioral health provider is.)

Diversion to Services: Recommendation 4

Pima County Attorney's Office to produce an involuntary petition instructional booklet for distribution to law enforcement and hospital staff. This booklet would outline the involuntary petition process, provide

sample forms, provide instructions for filling out forms, and identify responsibilities of the various parties in the process.

Diversion to Services: Recommendation 5
Hospital staff and law enforcement officers should be cross-trained regarding when officers can leave the emergency room after transporting an individual in behavioral health crisis.

Diversion to Services: Recommendation 6
Hospitals should be encouraged to develop specialized secure places and protocols for providing services for persons in behavioral health crisis in the emergency room including, but not limited to, the provision of security as needed regardless of how the individual gets to the hospital (i.e. on their own, with a family member, transported by police or EMS, etc).

Diversion to Services: Recommendation 7
At least one Urgent Care Center with the capacity to provide medical clearance be created in Pima County to add to the continuum of care the ability to address behavioral health emergency care when the individual has medical complications. Continue to develop expertise in urgent and emergency care for persons in behavioral health crisis at hospitals throughout Pima County.

Our community has a wide complement of available behavioral health crisis services, however, this poses a challenge to law enforcement officers seeking to divert individuals in a behavioral health crisis: What kind of help does this person need? Where do I take them? What do I do when I get there? As officers, particularly CIT trained officers, accumulate more experience with the behavioral health system this will help to improve the diversion process. However, there is also much that can be done to assist law enforcement officers in the field to identify the appropriate services for individuals in crisis and to facilitate transfer of the individual to those services. The above recommendations aim to provide guidance to the many behavioral health service providers in our community on how to better serve law enforcement officers who are attempting to serve individuals with behavioral health needs.

D. Aftercare: Status and Recommendations

The fourth and final critical component of a CIT program is to provide appropriate follow-up and aftercare to those individuals who are diverted to behavioral health treatment by law enforcement officers. Even if training, dispatch, and diversion to services are effectively implemented, if there is not adequate follow-up and aftercare then individuals suffering an acute behavioral health crisis are more likely relapse and encounter a cycle of law enforcement contacts. The aim of diversion is not just to divert the individual to treatment, but also to keep them out of the criminal justice system. Working to establish linkages from acute crisis care services (such as SAMHC, Compass, and the area hospitals) to community behavioral health providers (such as CODAC, COPE, and La Frontera) was therefore recognized to be of great importance by the panel. In addition to the RBHA behavioral health community providers, Arizona Long Term Care System (ALTCS), as well as the Division for Developmental Disabilities (DDD), provide follow up services when necessary and contracts for crisis situations with local agencies.

Community treatment provider networks are contracted by CPSA and others to provide ongoing regular behavioral health care, including acute crisis services. The community treatment provider networks in turn either offer acute crisis services directly to their members or subcontract with SAMHC, Compass, and local area hospitals. Once an individual is seen by any of these agencies for an acute behavioral health crisis it is essential that the appropriate information flow back to the provider networks so that ongoing and follow-up care can be provided as necessary. Currently, in our local system these linkages exist between SAMHC and the providers. However, there is a significant possibility that for individuals seen in local hospital emergency rooms the connection to their behavioral health network provider will not be made. Recognizing the importance of continuing care to the treatment of behavioral health problems the panel developed the following recommendations to assist community treatment providers in their effort to provide quality aftercare. However, these recommendations only apply to individuals receiving behavioral health services within the RBHA, ALTCS, and DDD networks. Though individuals enrolled in these networks may cover the majority of individuals in behavioral health crisis treated in local emergency rooms the inability to link non-enrolled individuals to aftercare and follow-up was recognized by the panel to be a shortcoming that unfortunately could not be addressed within the present system.

Aftercare: Recommendation 1
Hospitals to fax evaluation/treatment information to the current behavioral health provider or to SAMHC for people referred to SAMHC for follow-up and information about any referrals made upon discharge from the ER. Providers and SAMHC to provide a single fax number to a fax machine in a secure location and to follow-up with the consumer.

Aftercare: Recommendation 2
Providers receiving a fax that a client has been seen for crisis services at SAMHC or a local emergency room should provide appropriate follow-up and clinical intervention(s).

While the organizations and individuals in our community's behavioral health crisis system provide essential services with great expertise, due to the multitude of systems and organizations involved in providing these services it is sometimes the case that there is less coordination among these systems and organizations than is necessary to ensure the effective provision of follow-up and aftercare. The above recommendations from the panel should provide helpful guidance to hospitals and community behavioral health providers on how to better coordinate the provision of follow-up and aftercare.

E. Public Awareness and Education: Status and recommendations

The development and implementation of a new program within a community as sizable as Tucson/Pima County requires public awareness and education efforts to ensure the success of the program—unless individuals, agencies, and organizations who benefit from or are involved in a program have knowledge of the program it will not be utilized, nor function effectively. The panel asked the PAE Sub-Committee to identify the following: (1) a set of goals or desired outcomes, (2) a target population, (3) a message, and (4) a method of delivery. The recommendations developed

by the PAE Sub-Committee are briefly outlined below (for a full statement of the target population, message, and method of delivery please see *Appendix C*).

Public Awareness and Education Goals

Goal I: To create awareness of the work and recommendations of the panel
Goal II: To help current users of the system to understand the specific changes taking place
Goal III: To help the broader community to understand that there is a behavioral health crisis system, how it works, and how to access it
Goal IV: To improve community understanding of mental illness and behavioral health, including efforts to reduce stigma

Goal I (to create awareness of the work and recommendations of the panel) primarily targets the organizations and agencies that would be providing services associated with the four key components of a CIT program in the Tucson/Pima County area. In addition, this goal also targets elected officials and local government who may also be instrumental in assistance with the implementation of this program. Unless the relevant stakeholders and potential supporters of a CIT program are made aware of the need for such a program in our community and the necessary steps to make it a reality it is unlikely that such a program will be realized. The primary method for reaching these individuals and organizations is to distribute this report (either in its full version or the executive summary), make presentations, and hold a press conference.

Goal II (to help the current users of the system understand the changes that place) targets those who provide the services associated with a CIT program as well as those who utilize those services. This includes a wide variety of organizations and individuals, including: behavioral health case managers; hospital emergency room staff; law enforcement officers, commanders, and dispatchers; crisis workers; consumers; family members; and many others. It will be essential to provide specific information about the changes that take place, their implications for service, and, in particular, how those services will be provided and accessed. To obtain full impact from a CIT program it is essential that providers and users alike understand how they fit into and interact with the system to ensure efficiency. There are many methods for reaching these individuals and organizations, including: brochures, newsletters, trainings and orientation, presentations, staff meetings, etc.

Goal III (to help the broader community to understand that there is a behavioral health crisis system, how it works, and how to access it) is concerned with reaching out to the wider community to educate them about the behavioral health crisis system. New individuals are continually encountering and entering the behavioral health crisis system. A greater awareness of the availability of various behavioral health services (including, but not limited to, the CIT program) will help these individuals to more quickly and easily find the help they need. Moreover, early intervention and help will also help to avoid the escalation of behavioral health issues to a full-blown crisis, requiring the intervention of law enforcement. The target population is the entire population of the community, however certain special populations, who are more likely to encounter an individual who requires behavioral health care (such as, physicians, teachers, clergy, social workers, etc.), may require additional focused outreach efforts. The method of delivery may involve newsletters, brochures, public service announcements, advertisements, and other methods.

Of critical importance is to select outreach methods that are the most cost-effective, particularly for reaching the special populations.

Goal IV (to improve community understanding of mental illness and behavioral health, including efforts to reduce stigma) is the broadest of the goals identified by the panel—it targets the entire community with general information about mental illness and behavioral health. Unfortunately, people with mental health and behavioral health problems are frequently the victims of misunderstanding and stigma. They are all too often categorized by their illnesses and not treated as people first. Misunderstandings of mental and behavioral health issues lead to inappropriate treatment of people with mental and behavioral health problems. Education about mental and behavioral health issues is one way to reduce stigma and misunderstandings, as well as to provide insight into the needs and experiences of people with mental and behavioral health problems.

The panel also prioritized these four goals in terms of their importance in future public awareness and education efforts. It was agreed that they should be prioritized in the order presented above (i.e., Goal I highest priority and Goal IV lowest priority). This priority reflects the specific efforts and work of the panel (Goals I and II) and gives lower priority to issues, which extend beyond the specific focus of the panel (Goals III and IV). The panel recognized the great importance of community education about the mental health system and how to access it, as well as the importance of attempts to reduce stigma. But it was also felt that the limited budget available for public awareness and education would quickly exhaust these types of efforts with limited overall impact. Goals I and II are much more manageable and realistic goals that directly relate to the panel's mission. Finally, the panel also believed that Goal IV could and should be incorporated into all other efforts involving Goals I, II, and III.

F. Implementation Plans and Efforts to Sustain the Process

The implementation plans drafted by the sub-committees and revised by the full panel are contained in *Appendix E*. For each recommendation the implementation plans developed by the panel aim to identify: (1) the specific action steps or tasks that are necessary to carry out the recommendation; (2) the persons and organizations who would need to oversee and carry out those action steps; (3) a recommended time frame for when those steps should occur; (4) any additional resources that would be required; (5) additional partners; and (6) any issues for follow-up. The implementation plans are, at this stage, in draft form—the panel has filled them out where they have been able to, but they are not yet completed. To fully complete the implementation plans would require additional implementation phase efforts on the part of the panel or its members.

In addition to developing implementation plans the panel also discussed the issue of how to sustain the effort and process once the SAMHSA Community Action Grant that has supported the process has expired. The panel recommended the following five mutually inclusive possibilities to sustain the effort:

1. Develop an Implementation/Oversight Panel
2. Request continued University of Arizona Support
3. Request that U of A apply for a SAMHSA Implementation Grant if that funding becomes available
4. Request CPSA Support

5. Design a pilot to evaluate if this model is working

A volunteer implementation/oversight panel is particularly important in sustaining the effort. To fully develop a CIT program in the Tucson/Pima County region requires community buy-in and support and nothing reflects this commitment better than the formation and active involvement of a local volunteer panel. Behavioral health advocates, consumers, and family members have an especially important role to play in this process and should have a voice on any such panel. Many of the participants on the panel are well suited to continue the panel's efforts in this capacity—given their knowledge, expertise, resources, and authority.

G. Unresolved Issues, Other Needs, and Future Efforts

Despite the improvements that have been implemented to date, there are still a number of key needs that have not yet been met and issues that have not been resolved. One significant issue concerns the role of Kino Community Hospital. Individuals in behavioral health crisis who do not require seclusion, restraint, or emergency medical care can be treated by SAMHC—the Regional Behavioral Health Authority contracted crisis facility—but more serious and complicated cases require hospital treatment. Kino Hospital already plays a significant role in the community in the provision of behavioral health care. For instance, a report by the County Administrator shows that 46% of all inpatient cases at Kino are behavioral health cases. Kino handles more behavioral health inpatient cases than any other hospital in Tucson. Kino also has the lowest inpatient admissions for services other than behavioral health of any acute care hospital in Tucson. Finally, psychiatric care at Kino accounts for 30% of gross hospital billing. (PCHS, 2002)

In light of the reality that the current service utilization at Kino reflects a need and demand for behavioral health services, in conjunction with a substantial loss of revenue in its inpatient medical and surgical services, the County Administrator proposed in an October 2002 Report to the Board of Supervisors that the mission of Kino Community Hospital be revised to reflect this situation. He specifically recommended that, among other changes, Kino close its medical/surgical inpatient services and enhance its behavioral health services. Many members of the local community voiced objections to this plan and as a result the Pima County Board of Supervisors called for a series of public meetings to seek public input and comment on the County Administrator's proposal. During this process the possibility of a takeover of Kino Community Hospital by University Physicians, Inc. was raised. A request for proposals was put out by the County in May 2003 to provide services at Kino Community Hospital, including the provision of "an urgent care service for individuals of all ages with medical and/or behavioral health conditions to include a 'fast track' process designed to reduce the time law enforcement must spend away from public safety activities while dealing with individuals who need medical treatment." While the future of Kino Community Hospital is still under deliberation, on June 17, 2003 the Board of Supervisors voted unanimously to proceed with the transition of Kino Hospital to private health care providers beginning in July, 2003, including a $19.8 million two year contract with Spinnaker Healthcare to provide behavioral health urgent care services. The County Administrator's proposal to seek a vote on a $55 million bond package to construct a new psychiatric hospital and public health services building, along with renovations to the main hospital, was not acted upon at the time of this report. In any event it seems likely that Kino Community Hospital will play an

important role in the implementation of a CIT program in Tucson/Pima County, but this has not been finalized at the time this report was written.

The input of the panel may have had an impact on this process. The panel recommended that at least one behavioral health urgent care center with the capacity to provide medical clearance be created in Pima County to provide the ability to address behavioral health emergency care when the individual has medical complications. While the panel did not explicitly recommend that Kino Community Hospital serve in this capacity, it would clearly be one appropriate possibility. However, some organizations, representing a minority view on the panel, are opposed to the establishment of a special behavioral health urgent care center. The Community Partnership of Southern Arizona (the Regional Behavioral Health Authority that serves the Tucson/Pima County area) and SAMHC (a 24 hour behavioral health crisis center, funded by CPSA) believe that our community-wide crisis system is easily accessible and responsive to law enforcement and that the current system of utilizing area hospitals for law enforcement drop off is the best option for Pima County. In formulating their recommendations members of the panel focused on how to improve the current system, specifically on how to enhance law enforcement utilization of area hospitals for drop off by developing improved protocols, given that little could be done by the panel on the drop-off issue until the Kino issue was resolved. However, the majority of the panel felt strongly that a specialized behavioral health urgent care center would offer law enforcement and individuals in behavioral health crisis who require medical care an important community resource. Such a facility would provide a number of enhancements, that are not provided in a typical crisis care center or hospital emergency room setting, such as: a separate entrance for behavioral health cases; a secure and quiet waiting room; special areas for seclusion and restraint, if needed; quick access to trained behavioral health staff, including psychiatrists; and a full complement of medical care. Currently there is no facility in the Tucson/Pima County area that can meet all of these requirements. Moreover, evidence from other communities suggests that a behavioral health urgent care center would provide law enforcement officers with a 15-30 minute drop-off and quickly return them to service, instead of having to contend with the long waits in hospital ERs they typically face.

Law enforcement dispatch has been a sensitive issue throughout the consensus process. Consumers, advocates, and family members felt strongly that dispatch was critical to the success of a CIT program—unless trained officers were dispatched to calls they insisted that they would feel uncomfortable contacting law enforcement in the event of a situation involving a behavioral health crisis. Initially, law enforcement was reluctant to get involved in discussions regarding dispatch since very few officers had been trained, making it infeasible. And they approached the prospect of implementing dispatching procedures and protocols with some caution due to the complexities involved, including necessary modifications to the local 911 call systems. These opposing positions posed challenges to open communication and seemed to lead to misunderstandings between the parties about the desires of consumers, advocates, and family members and the intentions and plans of law enforcement. While there remain issues to be worked out, considerable progress has been made and law enforcement is planning to take steps toward enhancing its dispatching procedures to utilize CIT trained officers. Law enforcement had two primary concerns: (1) that its priority call system required that the nearest available officer respond and that it is not always possible to guarantee that that officer would be CIT trained; and (2) that officers are not normally dispatched across geographic boundaries, except for the most serious and urgent of calls where

extra assistance is needed. Panel discussions seemed to indicate that panelists wanted the first responding officer to be CIT trained and that CIT officers should be dispatched across geographic boundaries. The final recommendations reflect an attempt by the panel to accommodate these law enforcement concerns. For instance, *Dispatch Recommendation 3* acknowledges that for priority 1 calls the first responding officer may not be CIT trained and that a CIT officer be sent as a backup. Moreover, this recommendation limits the practice of cross-geographic dispatching to priority 1 calls. While law enforcement intends to update its systems to accommodate dispatching and to take positive steps toward dispatching CIT trained officers now that our community is approaching a level where a sufficient number of officers have been trained, there remain additional challenges and issues to be worked out. The dispersed geography, particularly in the areas patrolled by the Sheriff's Department, makes dispatch a difficult undertaking.

While many of the recommendations of the panel would have a favorable impact on juveniles who encounter law enforcement in the course of a behavioral health crisis, this was not an explicit focus of the panel. Indeed, juveniles pose special problems and have special needs that the panel was not able to address. The organizations and agencies that serve juveniles are in many instances different from those that serve adults (e.g., in criminal justice and behavioral health) and the legal requirements and protocols involving juveniles are also unique (e.g., issues of guardianship and consent for medical care). As a consequence it is clear to the panel that a special effort to address the needs of juveniles in behavioral health crisis is warranted and much needed in our community. A similar effort on the part of the key stakeholders that are involved with juvenile justice and behavioral health issues could readily build on the work of this panel and enhance the provision of services to this population.

V. Conclusion

A wide variety of stakeholders have come together as part of the *Crisis Intervention Consensus Project*. Over the course of the year the panel has worked hard to develop and reach consensus on a set of recommendations that utilize our community resources to enhance the ability of our community to respond to the needs of individuals in a behavioral health crisis. An excellent training program of law enforcement officers is underway. If, as additional officers are trained, special dispatch procedures are implemented, then this will help to ensure that these trained officers are effectively utilized in the field by responding in a timely manner to potential behavioral health crisis calls. The panel has made some recommendations about what dispatch procedures would be appropriate. The availability of timely and user-friendly treatment alternatives to jail for responding officers in the field is essential if front-end jail diversion is to be effective. Accordingly, the panel has made a number of recommendations on how to enhance the behavioral health information available to officers in the field and to assist officers with the transfer of individuals in crisis to the appropriate facility. Finally, aftercare and follow-up is critical if future behavioral health crises are to be averted. The panel has made some recommendations about how to ensure an effective linkage between acute crisis care treatment and continuing care within the community. The panel has also made a number of recommendations for how a public awareness and education campaign could proceed to inform stakeholders of: (1) the work of the panel, (2) the specific changes that take place in the system, (3) our local behavioral health system and how to access it, and (4) how to avoid the stigmatization of individuals with behavioral health problems.

These recommendations reflect the true collaborative spirit of the consensus building process in that they do not fall squarely on any single group of stakeholders. The development of a CIT program and the recommendations contained in this report require the cooperation of: (1) law enforcement with training and dispatch, (2) crisis centers and hospitals with enhancing the availability of services; (3) community behavioral health providers with enhancing aftercare and follow-up; and (4) advocates, consumers, and family members with public awareness and education efforts. If these stakeholders, in conjunction with support from local government and officials, demonstrate the same level of commitment to implementation efforts that they displayed during the consensus building process, then we can have high hopes that our community will offer significant enhancements to the services it provides to those individuals in a behavioral health crisis who encounter law enforcement officers.

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APPENDIXES:

Appendix A: Panel Members

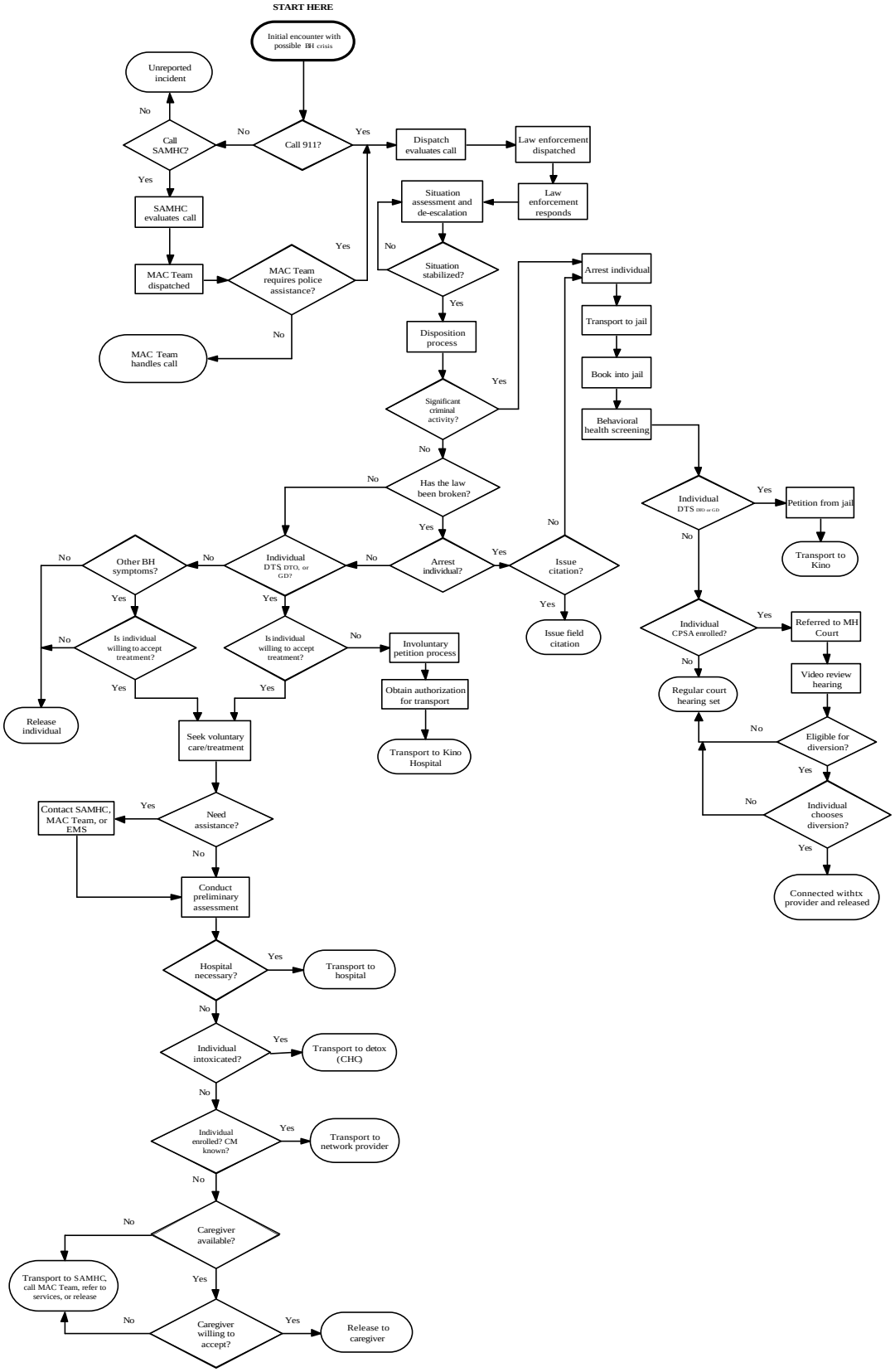
A very wide cross-section of individuals and organizations were involved in and attended the panel meetings. In an effort to be as inclusive as possible membership on the panel was not restricted. Early in the process the initial panel members (based on those who had participated in various pre-panel efforts and those identified by the University of Arizona as stakeholders) were asked to identify additional stakeholders. These individuals and organizations were invited to participate in the process. During the process members were identified as those who attended the monthly panel meetings. However, for the purposes of this report to identify those individuals (or organizations) that attended only a single meeting as members would not accurately reflect "membership" on the panel. Hence for the sake of the list below we have identified those individuals/organizations who have attended at least 3 panel meetings as members. The majority of these individuals/organizations attended many more than 3 meetings.

Panel Member	Organization or affiliation
Susan Agrillo	Pima County Attorney's Office
Chris Anderson	Carondelet Health Care Systems
Michael Barr	Sonora Behavioral Health Hospital
Stella Bay	Tucson Police Department
Laura Benchik	COPE Behavioral Health Services
Mindy Bernstein	Our Place Clubhouse
Sue Brandt	Child Protective Services
Jim Caldwell	COPE Behavioral Health Services
Laurie Canacakos	Kino Community Hospital
Pat Carnes	Compass Health Care, Inc.
Wendy Cartier	Northwest Medical Center
Marge Casterline	Advocate
Chelsea Chesen	University of Arizona Medical Center
Charlie Danella	Mentally Ill Kids in Distress
Karen Fields	Pima Health System & Services
Juan Garcia	Rural Metro SW Ambulance
Mitch Gluck	Kino Community Hospital
Elia Gonzalez	Pima County Sheriff's Department
Eddie Grijalva	Compass Health Care, Inc.
Angela Guida	Community Partnership of Southern Arizona
Ken Karrels	DES, Division of Developmental Disabilities
Regina Koch-Mart	Helping Ourselves Pursue Enrichment, Inc.
Judy Kowalick	National Alliance for the Mentally Ill, Southern AZ
Steve LeGendre	CODAC Behavioral Health Services
Michael Lex	Tucson City Court
Carol Little	SAMHC

Sandy Loomis	Pantano Behavioral Health
Lupe Martinez	Southern Arizona VA Healthcare System
Lynn Mayer	SAMHC
Leslie McDermott	Pima County Attorney's Office
Joan McNamara	Compass Health Care, Inc.
Bob Medeiros	Superior Court, Pretrial Services
Joe Mucenski	Crisis Intervention Network
Margaret Mucenski	Crisis Intervention Network
John O'Dowd	Attorney at Law
Honey Pivirotto	Pima County Administrator's Office
Dorothy Porter	Rural Metro SW Ambulance
LT Pratt	Pima County Sheriff's Department
Dan Ranieri	La Frontera Mental Health Center
Melanie Roberts	Arizona Center for Disability Law
Jim Rocha	El Dorado Hospital
Dina Rosengarten	Community Partnership of Southern Arizona
Rachel Sainz	Pima County Juvenile Court
Marty Scheinkman	National Alliance for the Mentally Ill, Southern AZ
Ellie Schorr	National Alliance for the Mentally Ill, Southern AZ
Marilyn Smith	El Dorado Hospital
Mindie Jo Snyder	Mental Health Association of Arizona
Karen Villasenor	Pima County Pre-Trial Services
Laura Waterman	SAMHC
Rich Wilson	Community Partnership of Southern Arizona

Support Team	**Organization**
Julie Arendt, Evaluator	Applied Behavioral Health Policy Division, UA
Linda Cannon, Facilitator	Cannon and Gill, Inc.
Emma Cortez, Administrative Support	Applied Behavioral Health Policy Division, UA
Ken O'Day, Project Coordinator	Applied Behavioral Health Policy Division, UA
Dona Rivera, Project Support	Applied Behavioral Health Policy Division, UA
Michael Shafer, Project Director	Applied Behavioral Health Policy Division, UA

Appendix B: Crisis System Flowchart



Appendix C: Public Awareness and Education Plans

Goal I: To create awareness of the work and recommendations of the panel

Target population:

- ASU School of Social Work
- Board and Care Homes
- County Supervisors
- CPSA and behavioral health field
- Current users of the system – enrolled members and families
- DES
- DHS
- Elected Officials not specifically defined in this list
- EMS/EMTs
- Funding bodies (Legislature/Governor's Office – DHS/DES)
- Governor's Office
- Homeless shelters
- Hospitals
- Mayor's Office/City Council
- Law enforcement
- People that constitute the political/educational system
- People who are part of the system
- Pima Community College
- Provider and advocacy organizations
- School Systems
- University of Arizona (President, Board of Regents, Management and Support Systems)

Message:

To generate support for the importance of the issue by promoting the following:

- Consensus process – comprehensiveness
- Outcomes and recommendations
- Changes implemented and what is to come
- Options for transfer to other communities
- No additional cost for many recommendations – some do have costs associated
- Diverse involvement – identify participants

Method of delivery:

- Final Report
- Executive Summary Report
- Personalize cover letter identifying what we want them to do in follow up
- Presentation to local government: Mayor/Council, Supervisors, Police Chief
- Press conference
- Newsletter – CPSA, Providers) – provide template article (canned series of articles to put in)
- May is Mental Health Month (tag to other events)
- Websites
- Libraries – the Long Rangers may be able to help with materials distribution at libraries

Goal II: To help current users of the system to understand the specific changes taking place

Target population:

- Current users / family members / providers and their staff
- Current participants – system people
- Criminal Justice: Jails / Probation officers
- EMS providers
- Schools
- Universities
- See Goal I for additional users of the system

Message:

- Law enforcement officers have been trained in effective crisis intervention strategies
- There is a focus on diversion to treatment instead of jail
- Improved system is more consumer and family friendly
- Share kinds of information that is needed by 911 and dispatchers
- State-of-the-art – new, different, already working in other areas – more effective
- Link to this message to the messages about how to access – can use the CPSA Road Map or develop condensed versions of the CPSA Road Map
- Use "Proven to be effective" versus best practice or evidence based
- Educate probation officers about system options – divert to treatment rather than going back to jail
- Probation officers that have full caseloads of persons with serious mental illnesses (SMI) should be specifically targeted for educational activities

Method of delivery:

- Brochure
- NAMISA newsletter/brochure
- Provider organization brochure
- Resource table
- Presentations
- Integrate into current training
- Consumer organization
- New member orientation
- CPSA training manuals (roadmap)
- Flyers
- Newsletters and other media
- In-service training
- Meetings with judges
- Probation officer conferences
- Report to jails and probation officer organizations

Goal III: To help the broader community to understand that there is a behavioral health crisis system, how it works, and how to access it

Target population:

1. Community-wide – public education
2. Specific populations
   - Adult Protective Services
   - Attorneys
   - Board and Care Homes
   - Care Givers Association
   - Child Care Centers
   - Clergy
   - Court System
   - DES workers
   - Doctors
   - EAP Programs
   - Food Banks
   - Government Officers
   - Private Practitioners
   - Psychiatrists
   - Lay/health workers
   - Neighborhood
   - Pima Council on Aging
   - Public Health
   - Social Services/ Human Services Agencies
   - Social Workers
   - Teachers
   - Utility Companies

Message:

- It's your system
- Assessment
- Accessible, confidential services
- Welcoming

- The people in the system care
- You are not alone
- Phone number: 622-6000
- Provide the address – invite people to come

Method of delivery:

- Bill boards
- Flyers/brochures – distribute to target population organizations
- Newspapers
- Newsletters
- Bus benches – bus placards
- Advertisements at movie theaters
- Radio advertisements
- TV News – Health Beat
- Prescriptions pads – preprinted with information (pharmacy sponsorship)
- Libraries
- Synagogues
- Churches, etc.
- PSAs

Goal IV: To improve community understanding of mental illness and behavioral health, including efforts to reduce stigma

Target population:

Everyone: Include the following information in all of the presentations / products developed

Message:

- There is something you can do
- Person first language
- There are appropriate alternatives to jail
- There are effective ways to respond (knowing this will reduce stigma)
- Only _X_% of people in need of behavioral health services – of those only X % are ever in a police involved crisis situation in Pima County
- There is no difference in criminal behavior for people with mental illness and the general population
- Provide Pima County and national data
- One in five people have mental illness – one in ten have substance abuse problems
- Be clear on the appropriate use of the terms "mental health" versus "behavioral health"
- Importance of intervening early
- Assistance is confidential and affordable

Method of delivery:

Incorporate in all other public awareness and education efforts

Appendix D: CIT Training Curriculum

Day 1 Topics:

Mental Illness Introduction (2 hours)
System Overview (1 hour)
Juvenile Services (1 hour)
Communication and Active Listening (4 hours)

Day 2 Topics:

Personality Disorders (2 hours)
Coping with Co-Occurring Disorders (1 hour)
Focus on Meds (1 hour)
Crisis Intervention (1 ½ hours)
Kino Tour (1 ½ hours)

Day 3 Topics:

Suicide (2 hours)
Traumatic Brain Disorders (1 hour)
Special Populations: Elderly (½ hour)
Special Populations: Homeless (½ hour)
Developmental Disabilities (3 hours)
Developmental Disabilities Panel (1 hour)

Day 4 Topics:

Consumer and Family Panel (4 hours)
Petitioning (2 hours)
Court and Legal Issues (2 hours)

Day 5 Topics:

Role Plays (7 hours)
Officer Safety (1 hour)

Appendix E: Implementation Plans

Diversion to Services: Recommendation 1

SAMHC to provide a 24-hour number for officers to contact to obtain assistance in connecting the individual to their behavioral health provider. SAMHC would act as the liaison by contacting the behavioral health providers, ALTCS provider and/or the Division of Developmental Disabilities (DDD) as appropriate and having the provider contact the officer rather than releasing information directly to the officer.

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. Provide 24/7 phone number.	SAMHC	Ongoing			Complete
II. Incorporate DD and ALTCS into the process	SAMHC, Laura Waterman, Karen Fields, Ken Karrels	June 2003			
• DD and ALTCS Personnel to provide SAMHC with the contact numbers					
• DD, ALTCS and SAMHC to define on-call process and what DD or ALTCS can do when receiving a call					
• Define what DD and ALTCS would do					
• SAMHC/DD/ALTCS to connect the provider or on-call person in the office					
III. Ensure officers have easy access to the SAMHC phone number	SAMHC / Law Enforcement	June 2003 and Ongoing			
• SAMHC to send notice with information to law enforcement – Tucson Police Depart. /Sheriff's about what SAMHC does					
• Law Enforcement contacts to ensure information is available to officers					
IV. Ensure officers know what to expect when they call SAMHC	SAMHC/Law Enforcement	June 2003 and Ongoing			
• Include information about SAMHC in a letter to law enforcement					
• Law enforcement agencies to disseminate					
• CIT officers distribute information to other officers					
• 6 minute training					
• Include in CIT Training					Complete –already part of CIT Training
V. Explore possibility of SAMHC having access to DD and ALTCS database from confidentiality standpoint	SAMHC, Laura, Karen Fields, Ken Karrels	June 2003			

Diversion to Services: Recommendation 2

Encourage law enforcement officers to contact a hospital in advance if the individual they are going to transport is violent and/or poses a potential security issue. Encourage hospitals to be prepared to address the security issues when the officer and individual arrive. (Implement this recommendation by including this information in the officer training and by training the appropriate emergency room staff at the hospitals.)

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. Encourage law enforcement …	Law enforcement agencies	June 2003			
• Policy change for law enforcement					
• Law enforcement to review and consider policy implications					
• Determine methods for including in briefings					
• Include in CIT training					
II. Encourage hospitals – all emergency rooms	Consensus Panel / U of A	June 2003			
• Send written information to hospitals (include who to contact for additional information)					
III. Each hospital define their options and ability to be prepared	Hospitals	July – August 2003			
IV. Establish follow-up with hospitals	Implementation Oversight Panel	September 2003			

Diversion to Services: Recommendation 3

Behavioral health providers could provide a single phone number for a supervisory level (on-call) contact who can assist officers in the field dealing with their clients. This person could provide officers with information to assist in re-establishing client contact with treatment and let officers know where to take the consumer. (This recommendation assumes that the officer has information about who the behavioral health provider is.)

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. Each provider designate the supervisory level contact and phone number	Each Network	June 2003			
II. Get information to:	Each Network	June 2003		SAMHC	
• SAMHC – see Recommendation I – update information currently available at SAMHC					

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
• Officers				Law Enforcement	
III. Maintaining the list – each network to ensure law enforcement and SAMHC have current contact information on an ongoing basis.	Each Network	Ongoing			

Diversion to Services: Recommendation 4

Pima County Attorney's Office produces an involuntary petition instructional booklet for distribution to law enforcement and hospital staff. This booklet could outline the involuntary petition process, provide sample forms, provide instructions for filling out forms, and identify responsibilities of the various parties in the process.

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. Look at existing resources/documents	County Attorney's Office	July 2003		ERs, CPSA	
Prepare draft booklet	County Attorney's Office	July 2003	Explore the possibility of this as a graduate class Project		
III. Review with CPSA, Officers, Hospitals, Networks, SAMHC, Hospital and obtain input	County Attorney's Office	August 2003			
IV. Define dissemination plan for final product	County Attorney's Office	August 2003	Funding to be determined	ERs, CPSA	
V. Disseminate	County Attorney's Office	September 2003		Law Enforcement, ERs, CPSA	
VI. Emergency rooms to add information needed to individualize to each hospital	Emergency Room / Hospital Representatives	September 2003			
VII. Define ongoing maintenance / update process	County Attorney's Office	September 2003			
VIII. Determine how to include in CIT training	TPD/ Sheriff's Office	September 2003			

Diversion to Services: Recommendation 5

Hospital staff and law enforcement officers should be cross-trained regarding when officers can leave the emergency room after transporting an individual in behavioral health crisis.

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. Include information in the petition instruction booklet about when law enforcement can leave the ER	County Attorney's Office	July 2003			
II. In Non Petition Situations					
A. Hospitals – develop protocol regarding when officers can leave and how officers will be informed.	Hospitals	July 2003			

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
• Include this request in the letter to ER directors which transmits the report of the panel	U of A	June 2003			
B. Establish a communication method between hospital staff and officers to ensure each know that the officer can leave once the situation is secure.	Hospitals	July 2003			
• Hospital has accepted the patient – officer may leave	Emergency Rooms				
• Consider log book in emergency room	Emergency Rooms				
III. Educate officer as to communication method developed	Law enforcement Agencies	July 2003			
IV. Emergency room staff to be informed about when officer can leave	ER Directors	July 2003			
V. Follow-up with emergency rooms to determine if the communication method has been defined and implemented.	Panel	August 2003			

Diversion to Services: Recommendation 6

Hospitals should be encouraged to develop specialized secure places and protocols for providing services for persons in behavioral health crisis in the emergency room including but not limited to provision of security as needed regardless of how the individual gets to the hospital; i.e. on their own, with a family member, transported by police or EMS, etc.

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. Highlight this recommendation in the hospital letter which transmits the report and recommendations of the panel	U of A	June 2003			
II. Follow-up	Implementation Oversight Panel (To be developed)	August 2003			

Diversion to Services: Recommendation 7

At least one Urgent Care Center with the capacity to provide medical clearance be created in Pima County to add to the continuum the ability to address behavioral health emergency care when the individual has medical complications. Continue to develop expertise in urgent and emergency care for persons in behavioral health crisis at hospitals throughout Pima County.

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. Send to all other hospitals	U of A Panel	June 2003			

Aftercare: Recommendation 1

Hospitals to fax evaluation/treatment information to the current behavioral health provider or to SAMHC for people referred to SAMHC for follow-up and information about any referrals made upon discharge from the ER. Providers and SAMHC to provide a single fax number to a fax machine in a secure location and to follow-up with the consumer.

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. Draft sample form	Dan Ranieri	June 2003		ALTCS, DD, Karen Fields and Ken Karrels	
II. Letter to hospital	Ken O'Day	June 2003			
• This is the recommendation					
• Here is a sample form					
III. Providers to identify the fax numbers and establish their internal processes	Networks	June 2003			
IV. Provide fax information to hospital with cover letter explaining why the information is being provided	Ken O'Day	July 2003			
V. Hospital to ensure they have a release of information in place	Hospitals	July 2003			
VI. Determine timeline for faxing information – upon release from emergency room	Hospitals	July 2003			
• Consider having the hospital evaluator send the form					
VII. Follow-up	Implementation Oversight Panel	August 2003			

Aftercare: Recommendation 2

Providers receiving a fax that a client has been seen for crisis services at SAMHC or a local emergency room should provide appropriate follow-up and clinical intervention(s).

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. After receiving crisis services – follow-up is provided	Networks/providers	Ongoing			
II. Each network to define the process for insuring information gets to the right person for follow up.	Networks	June 2003			
III. Networks to define how information received on the weekend / nights will be received and acted upon by the provider	Networks	June 2003			

Public Awareness and Education

GOAL I: TO CREATE AWARENESS OF THE WORK AND RECOMMENDATIONS OF THE PANEL.

ACTION STEPS/TASKS	PERSON (S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. Review draft report	Consensus Panel	May 2003			
• Revisions		June 2003			
II. Executive Summary	U of A	June 2003			
III. Create a cover letter by to transmit the Executive Summary (provide a mix of information – some informational and some specific if recommendation relates to them • Hospitals • CPSA Management • Provider Networks • EMS • Mayor's Office • Board of Supervisors • City Council	U of A	June 2003			
IV. Send special thank you letter to Law Enforcement for guidance, support and implementation	U of A	June 2003			
V. Include recognition of participants in the panel – This is a Community wide effort	U of A	June 2003			
VI. Presentation – Present the report to specific organizations – include specifically what we want the organizations to do.	U of A Panel Members	June/July 2003			
• Sheriff, TPD					
• Mr. Huckleberry & the Board of Supervisors					
• City Council					
• Develop Schedule					
• Identify members of panel to participate in presentation					
VII. Press Conference – combined with presentation	Panel Members / U of A	July 2003			
• The Goal is to create a lead in to getting increased interest and exposure for the issue and changes.					
• Emphasize that solutions identified					
• Prepare news release					
• Schedule Press Conference					

ACTION STEPS/TASKS	PERSON (S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
o Representatives of each type of organization that participated in the panel & family members					
o Encourage community participation					
o Presentation and availability of people to talk with					
o Give examples of how effective the training has been					
o Involve Bob Gilmartin on weekly talk show on public safety on KVOY					
VIII. Newsletters – Include recommendations in newsletters	U of A	July 2003 Ongoing		Panel	
• Plan a quarterly update for the first year					
• Develop draft news letter articles for use in multiple news letters					
• Send to listserv for integration on ongoing basis					
IX. Include this information in whatever ways the panel members become involved in May Mental Health Month	Panel Members	May 2003			
X. Web Site – Post the recommendations and newsletter updates to the web sites of various organizations	Panel Members	July - Ongoing			
• U of A					
• CPSA					
• NAMISA – link to U of A website – all panel members					
• Ken to send link to everyone and put it on					
• Include information about results from follow-up with officers					
• Include information about the web sites in the cover letter transmitting the report / recommendations					
XI. Follow-up	Panel Members	August - Ongoing			
• Keep getting information disseminated					
• Keep distributing provider information to the community					

Background Information for Goal I:

Target Populations

- Arizona State University School of Social Work – Full Report
- Board and Care Homes, ALFs
- County Supervisors
- CPSA and behavioral health field, ALTCS, DDD
- Current users of the system – enrolled members and families
- DES
- DHS
- Elected Officials not specifically defined in this list – Legislators, Judges,
- EMS/EMTs
- Funding bodies (Legislature/Governor's Office – DHS/DES, AHCCCS)
- Governor's Office
- Homeless shelters
- Hospitals
- Mayor's Office/City Council
- Law enforcement
- People that constitute the political/educational system
- People who are part of the system
- Pima Community College
- Provider and advocacy organizations
- School Systems – School Nurse Association
- University of Arizona (President, Board of Regents, Management and Support Systems)
- Tribal Communities

Message

To generate support for the importance of the issue by promoting the following:

1. Consensus process – how comprehensive
2. Outcomes and recommendations
3. Changes implemented – more to come
4. Options for transfer to other communities
5. No additional cost for many recommendations – some do have costs associated
6. Diverse involvement – identify participants

GOAL II: TO HELP CURRENT USERS OF THE SYSTEM TO UNDERSTAND THE SPECIFIC CHANGES TAKING PLACE.

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. Develop information about what callers should say when contacting 911.	Consensus Panel Members	June 2003			
• Mental Health Crisis • Agitated • May be violent • If known, diagnosis • If known, medical complaint					
II. Distribute the information	Consensus Panel Members	June 2003 Ongoing			
• Articles in newsletters					
• Family to Family / Advocacy					
• Treatment Teams					
• Incorporate into the CPSA - Roadmap to the System					
III. Develop information specifically to include the following messages for current users and family and others attempting to assist persons in behavioral health crisis • Law enforcement agencies are in the process of training CIT officers in effective crisis intervention strategies • There is a focus on diversion to treatment instead of jail. • Improve system that is more consumer and family friendly • State-of-the-art – new, different, already working in other areas – more effective • Use "Proven to be effective" versus best practice or evidence based (need to avoid professional jargon)	Consensus Panel Members	July 2003			
IV Implement through brochures, newsletters, provider organizations, resource tables, presentations, and training.	Consensus Panel Members	July 2003 & Ongoing			

Background Information for Goal II:

Target Population

- Current users / family members / providers and their staff
- Current participants – system people
- Criminal Justice: Jails / Probation officers
- EMS providers
- Schools
- Universities
- See Goal I

Message

- Current users and family and others attempting to assist persons in behavioral health crisis
- Law enforcement officers have been trained in effective crisis intervention strategies
- There is a focus on diversion to treatment instead of jail.
- Improve system that is more consumer and family friendly
- Share kinds of information that is needed by 911 and dispatchers
- State-of-the-art – new, different, already working in other areas – more effective
- Link to this message to the messages about how to access – can use the CPSA Road Map or develop condensed versions of the CPSA Road Map
- Use "Proven to be effective" versus best practice or evidence based (need to avoid professional jargon)

Method of Delivery

- Brochure
- NAMISA newsletter/brochure
- Provider organization brochure
- Resource tables
- Presentations
- Integrate into current training
- Consumer organizations
- New member orientation
- CPSA training manuals (roadmap)

GOAL III: TO HELP THE BROADER COMMUNITY TO UNDERSTAND THAT THERE IS A BEHAVIORAL HEALTH CRISIS SYSTEM, HOW IT WORKS, AND HOW TO ACCESS IT.

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
I. In developing materials for Goal I and II, include the recommendations regarding this message in each document and presentation.	**See Goal I and II**				
Messages to be included: • It's your system • Assessment • Accessible, confidential services • Welcoming • The people in the system care • You are not alone • Phone number: 622-6000 • Provide the address – invite people to come by					
II. Continue to include this information in current material developed by NAMISA, SAMHC, CPSA	Consensus Panel Members	June 2003 & Ongoing			
III. Include Community Information and Referral in the dissemination of material	Consensus Panel Members	June 2003 & Ongoing			
IV. Make sure that all messages are consistent and complement each other.	Consensus Panel Members	July 2003			
Dissemination methods include: • Flyers/Brochures • Newspapers – from press conference • Newsletters • Bus Placards • Radio • TV News • Magnets with numbers and message					
V. Movie Theaters – obtain costs	Laura B	June 2003			
VI. Define consistent message.	Panel	June 2003			
VII. Obtain Graphics	Kino	July 2003			

ACTION STEPS/TASKS	PERSON(S)	TIME FRAME	RESOURCES	PARTNERS	FOLLOW UP- STATUS
VIII. Obtain Printing/production of brochures and Magnets.	U of A SAMHC	August 2003			

Background Information for Goal III

Target Populations

Community-wide – public education

Specific populations

- Adult Protective Services
- Attorneys
- Board and Care Homes
- Care Givers Association
- Child Care Centers
- Clergy
- Court System
- DES workers
- Doctors
- EAP Programs
- Food Banks
- Government Officers
- Private Practitioners
- Psychiatrists
- Lay/health workers
- Neighborhood
- Pima Council on Aging
- Public Health
- Social Services/ Human Services Agencies
- Social Workers
- Teachers
- Utility Companies

GOAL IV: TO IMPROVE COMMUNITY UNDERSTANDING OF MENTAL ILLNESS AND BEHAVIORAL HEALTH, INCLUDING EFFORTS TO REDUCE STIGMA.

- Increase public awareness / understanding of the needs of people in behavioral health crisis.
- Understanding that crisis mental health treatment is part of public safety – safety of individual and others. Information that most people in mental health crisis are not a threat to others.

The implementation of the plans for Goals I, II and III will lead to improved community understanding.

Target Population – Everyone: Include the following information in all of the presentations / products developed.

Message

1. There is something you can do
2. Person first language
3. There are appropriate alternatives to jail
4. There are effective ways to respond (knowing this will reduce stigma)
5. Only _X_% of people in need of behavioral health services– of those only X % are ever in a police involved crisis situation in Pima County
6. There is no difference in criminal behavior for people with mental illness and the general population
7. Provide Pima County and national data
8. One in five people have mental illness– one in ten have substance abuse problems
9. Be clear on the appropriate use of the terms "mental health" versus "behavioral health"
10. Importance of intervening early
11. Assistance is confidential and affordable