Roadmap to the Ideal Crisis System: Making the Vision Real

Margie Balfour, MD, PhD

Chief of Quality & Clinical Innovation - Connections Health Solutions

Associate Professor of Psychiatry - University of Arizona

margie.balfour@connectionshs.com

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connections

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INDIANA MENTAL HEALTH AND ADDICTION CONFERENCE

Learning Objectives

- Define the essential elements of a comprehensive behavioral health crisis system.
- Describe examples of successful community approaches to reducing criminal justice involvement for people experiencing behavioral health emergencies.
- Discuss how recent policy and funding developments can support improved crisis care.

MHAC
INDIANA MENTAL HEALTH AND ADDICTION CONFERENCE

Every day in America…

"I'm having chest pain."

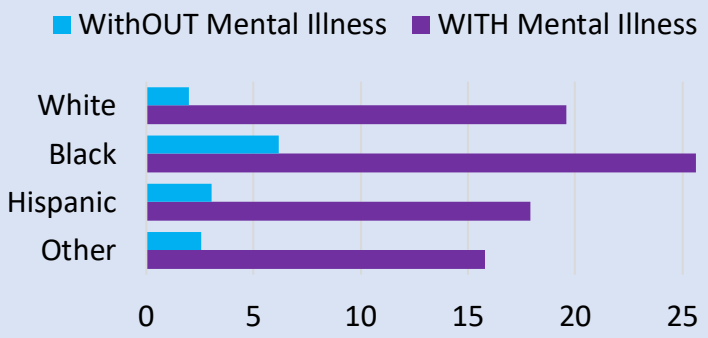
"I'm suicidal."

911: What happens after the call?

Police-Involved Deaths

- **One Quarter** of police involved shooting deaths involve mental illness
- Half occur in the person's home
- Black Americans with Mental Illness have the highest rates of death
- …and are less likely to call 911 for help with a mental health emergency

US Death Rate by Police per million



Jails: The New Asylums

- **The "Divert to What?" Question**
- Prevalence of mental illness in our jails & prisons is 3-4x that of the US population
- Inmates with mental illness
  - Often do not get needed treatment
  - Incarcerated 2x as long at 2x the cost
  - 3x more likely to be sexually assaulted in jail
  - More likely to be homeless, unemployed, re-arrested upon release

ED Boarding

- 62% of EDs report they have no psychiatric services available
- Without treatment, inpatient is the default disposition, and people wait for hours for transfer to a psych hospital

  - Increased risk: Assaults, injuries, self-harm
  - Increased cost: $2300/day
  - Poor patient experience: Nontherapeutic environment with untrained staff

Saleh AZ, Appelbaum PS, Liu X, Scott Stroup T, Wall M.(2018) Deaths of people with mental illness during interactions with law enforcement. *Int J Law Psychiatry* 58:110–6

Steadman HJ et al. (2009) Prevalence of serious mental illness among jail inmates. *Psychiatric Services*. 60(6):761-5.

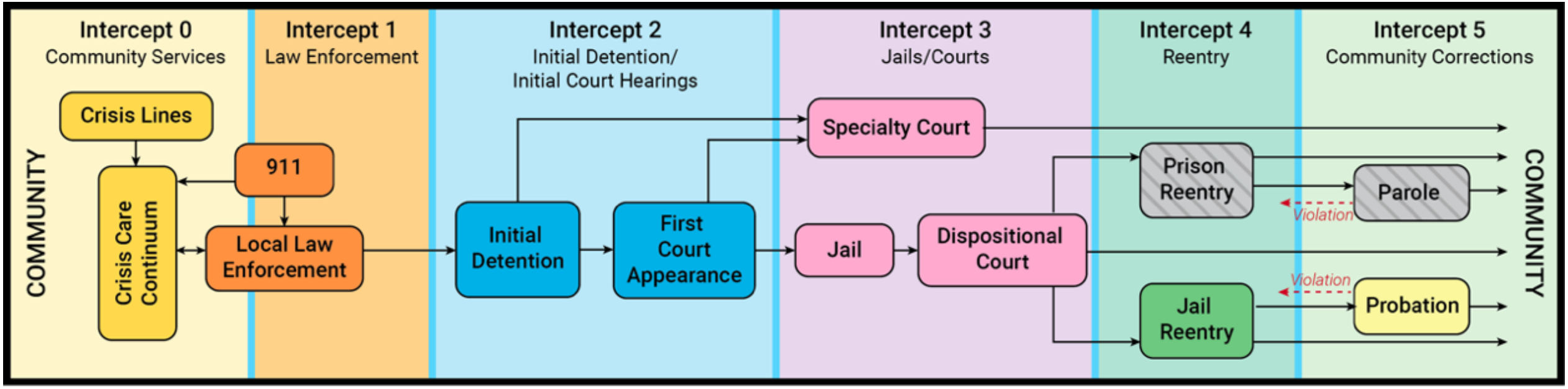
Glaze LE, James DJ. (2006) Mental Health Problems Of Prison And Jail Inmates. Bureau of Justice Statistics.

Nordstrom K et al.. West J Emergency Med. 2019 Jul 22;20(5):690-695.

Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. *Emerg Med Int*. 2012;2012:360308.

The Sequential Intercept Model

Intercepts 0 and 1 focus on *preventing police interactions & arrest*



911: WHAT'S YOUR EMERGENCY?

"I'm having chest pain."

"I'm suicidal."

SAMHSA's Vision

"Someone to call"

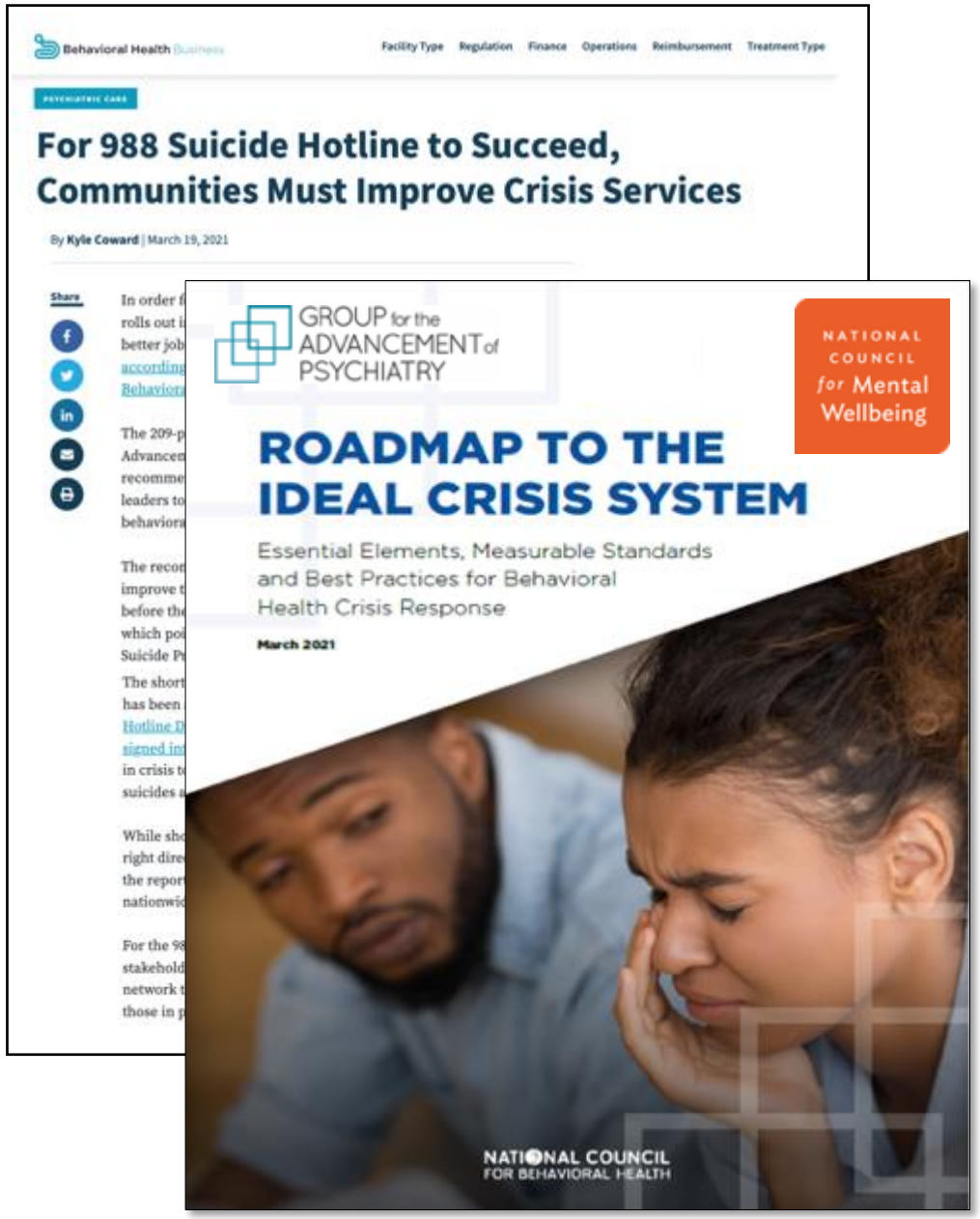
988 SUICIDE & CRISIS LIFELINE

"Someone to respond"
(mobile crisis)

"A safe place to go"
(specialized facilities)

The conditions are right for an unprecedented expansion in crisis care

- **988 is catalyzing the development of crisis response systems across the nation**
  - *Like how 911 catalyzed the development of the EMS & trauma care systems that we take for granted today*
  - All states received planning grants as part of the 988 implementation
- **Strong bipartisan support for mental health**
  - Over $400 million in 988 & covid relief bills so far
  - CCBHCs, crisis set-aside, increased Medicaid match
  - More pending legislation next session
- **Broad agreement that police shouldn't be the default first responders to behavioral health emergencies.**
  - Local communities looking for alternatives
  - DOJ and SAMHSA grants for co-responders and other alternatives to police responses



Roadmap Vision

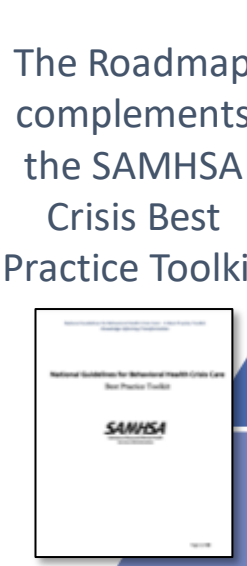
- **An excellent Behavioral Health Crisis System is an essential community service, just like police, fire, & EMS.**
- Every community should expect a highly effective crisis response system to meet the needs of its population.
- **A crisis system is more than a single crisis program.**
- It is an organized set of structures, processes, and services that are in place to meet all types of urgent and emergent BH crisis needs in a defined population or community, effectively and efficiently.

Joint project of the National Council & Group for the Advancement of Psychiatry.
Download at www.CrisisRoadmap.com

Roadmap to the Ideal Crisis System

The report describes how implementation of successful systems requires **3 interacting design elements**, along with measurable indicators for the components of each.

The Roadmap complements the SAMHSA Crisis Best Practice Toolkit



Implementation tools include the **Crisis System Report Card**

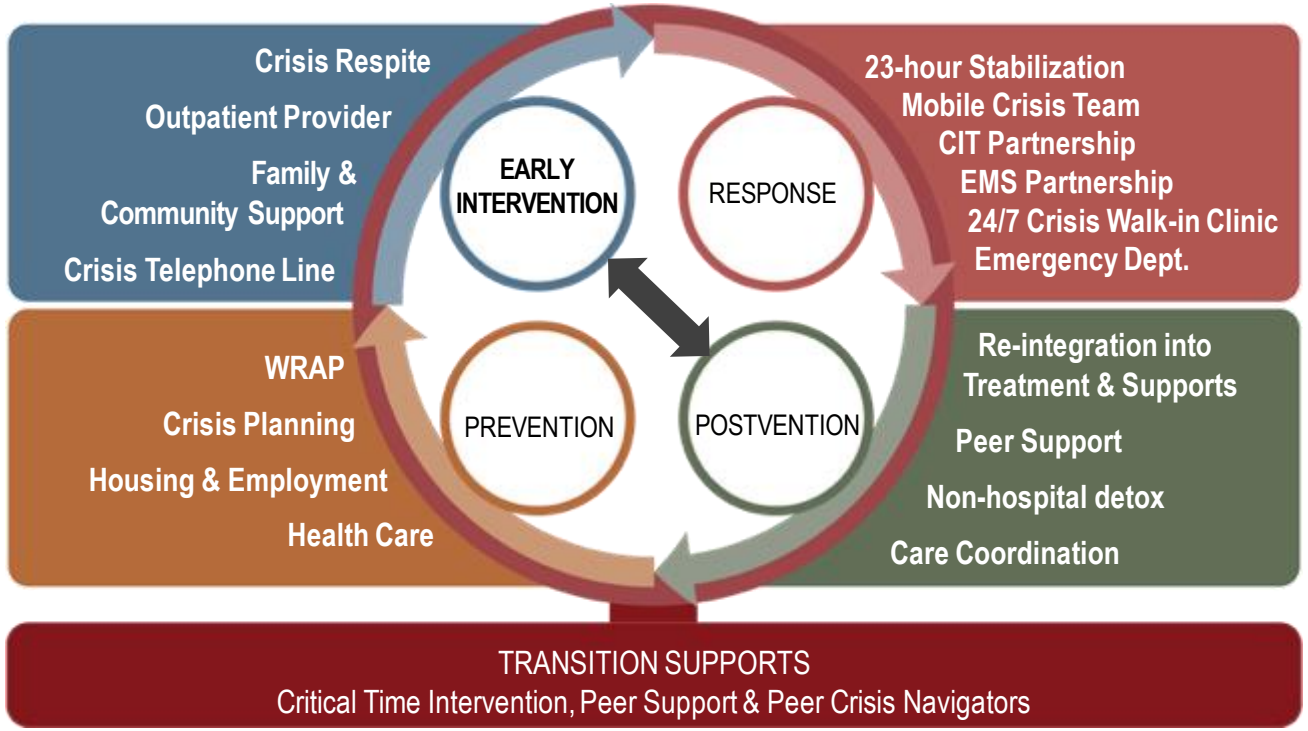
An instrument to assist communities to assess their current status on each of the elements of an "ideal crisis system," and to help prioritize next steps.

More info at www.CrisisRoadmap.com

Key Feature: Systems Thinking

Systems Thinking

A crisis system is
more than a collection of services.



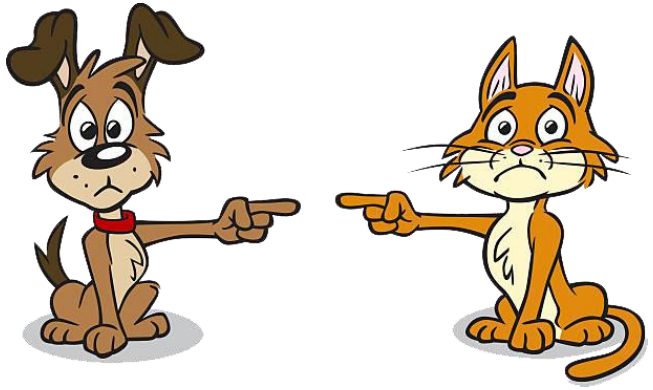
Adapted from: Richard McKeon (Chief, Suicide Prevention Branch, SAMHSA). Supercharge Crisis Services, National Council for Behavioral Health Annual Conference, 2015.

In a crisis **SYSTEM**,
the services
work together
to achieve
common goals.

The system is
more than the sum of its parts.

3 Key Ingredients for a SYSTEM

Accountability



- Who is *responsible* for the system?
- Governance and financing structure
- System values and outcomes
- Holding providers accountable

Collaboration

- Broad inclusion of potential customers, partners, & stakeholders
- Alignment of operational processes & training towards common goals
- Culture of communication & problem solving

Data

- Are we achieving desired outcomes?
- Performance targets & financial incentives
- Continuous quality improvement
- Data driven decision making

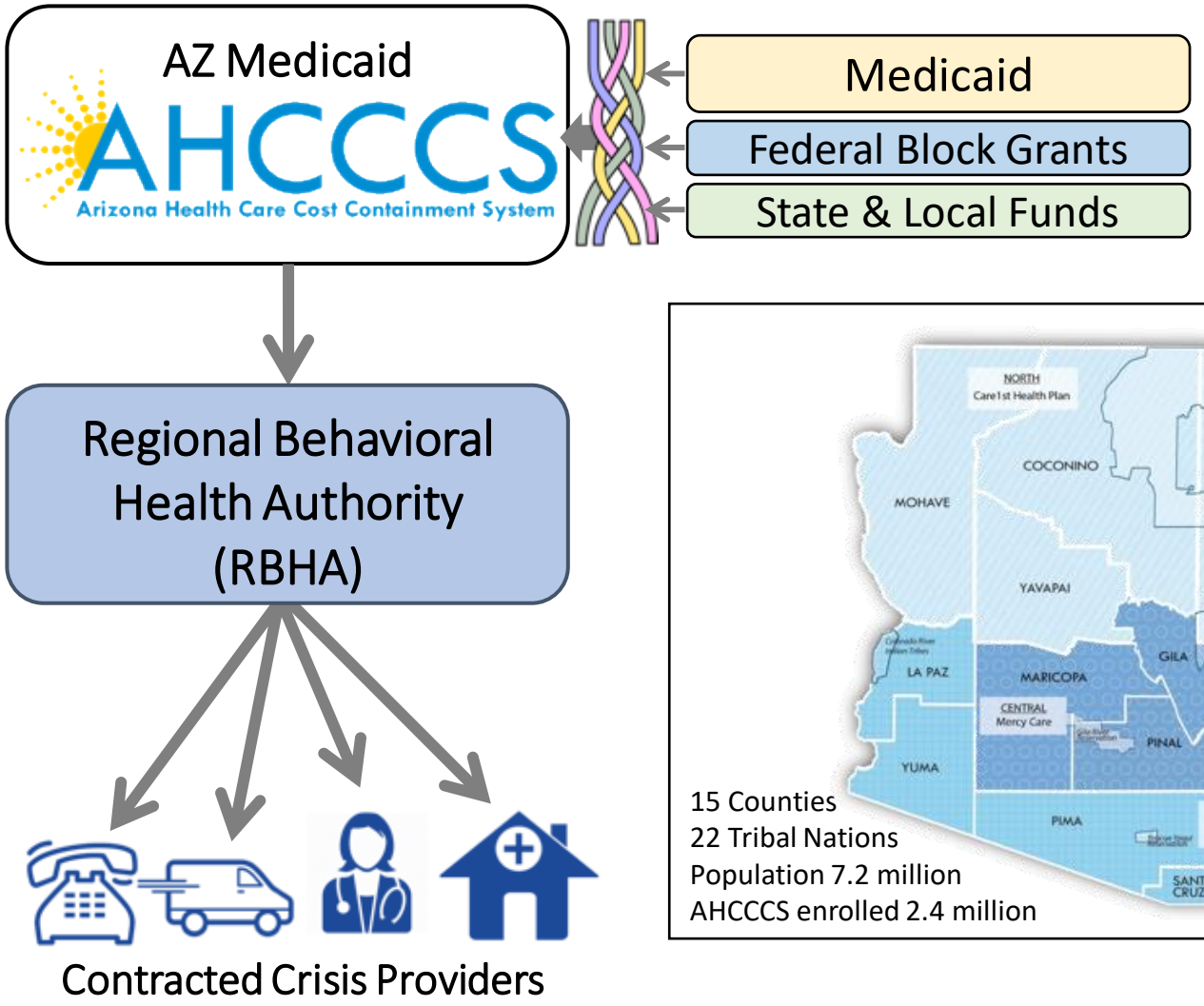
Arizona Crisis System Financing & Governance Structure

creates the foundation for an organized, coordinated, & sustainable system

- A **"braided" funding** model maximizes the impact of multiple funding streams, creating a sustainable system that can serve everyone regardless of payer.

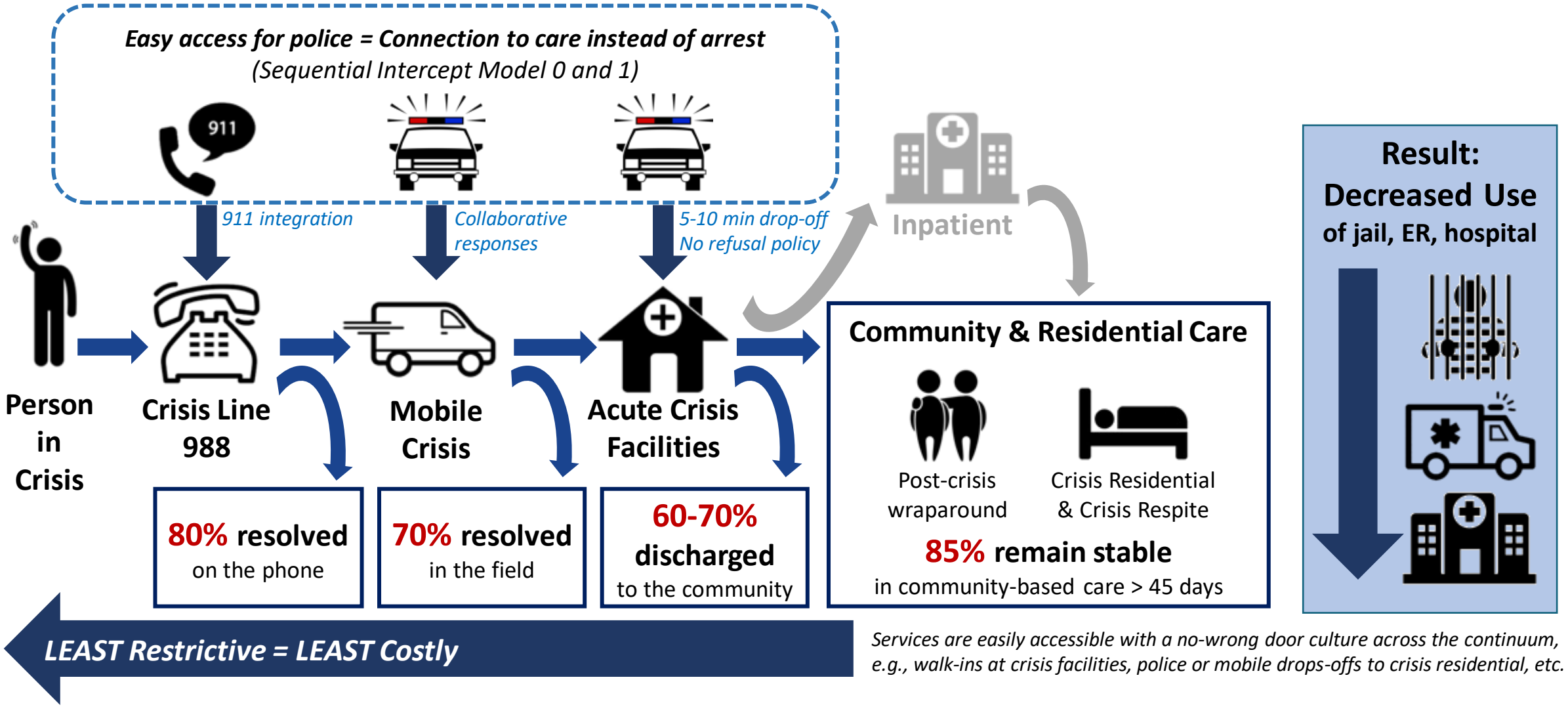
- A single **"accountable entity"** creates the structure for strategic planning and oversight.

- Contracted services are **aligned towards common goals** that are both clinically desirable & fiscally responsible:
  - **DECREASE use of ER, Hospital, Jail**
  - **INCREASE community stabilization**



Alignment of crisis services toward common goals

care in the least restrictive (and least costly) setting



Services are easily accessible with a no-wrong door culture across the continuum, e.g., walk-ins at crisis facilities, police or mobile drops-offs to crisis residential, etc.

Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

Someone to call

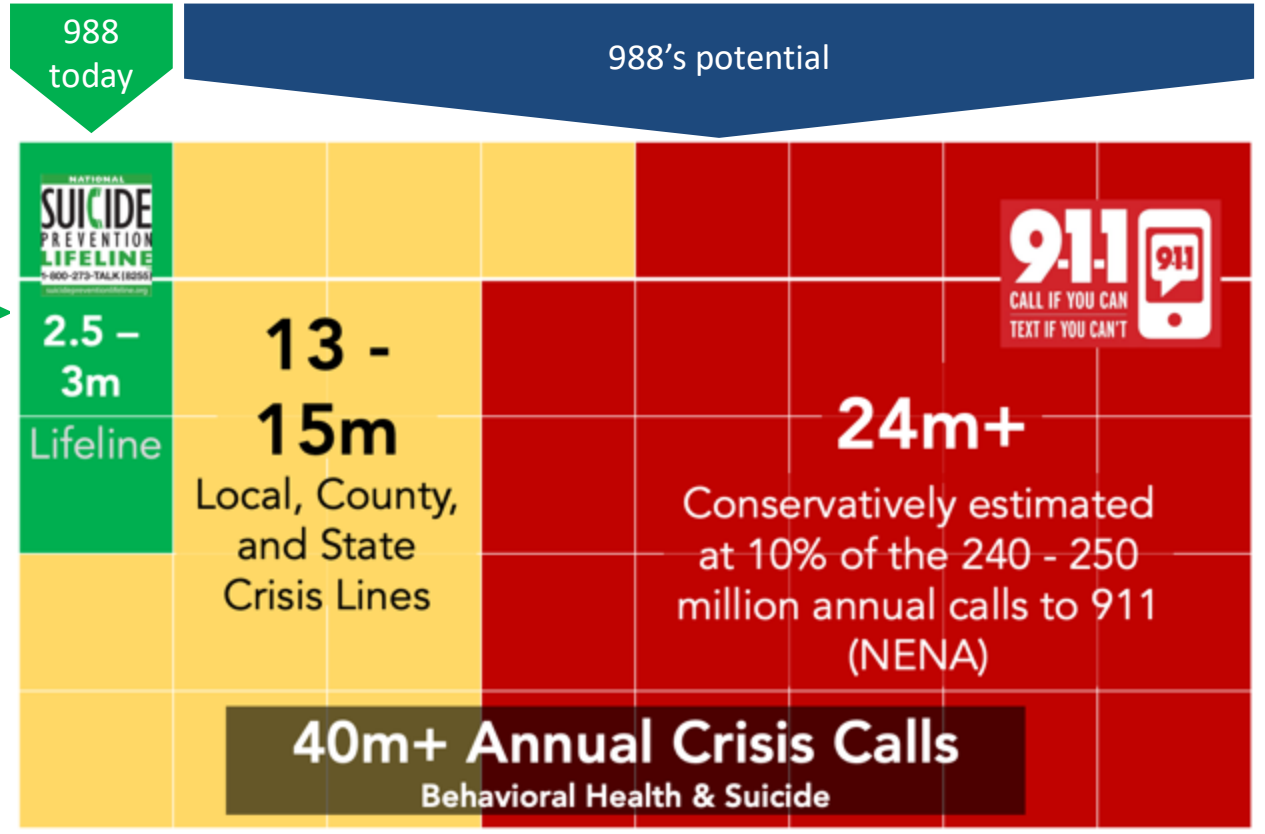
- Crisis Contact Centers
- 988
- Phone / text / chat

988 is the new nationwide 3-digit number for BH emergencies

- Launched July 2022!
- **Connects to the National Suicide Prevention Lifeline (formerly 1-800-273-TALK)**
- Network of nearly 200 call centers with call-takers trained in suicide/crisis intervention
- 24/7 call, text, or chat (988lifeline.org)
- National standards
  - SAMHSA oversight
  - single national administrator
    Vibrant Emotional Health: www.vibrant.org
- More info at samhsa.gov/988

Today, we can't imagine 911 without thinking of the response system that goes with it (EMS, fire, ERs, trauma centers, etc.)

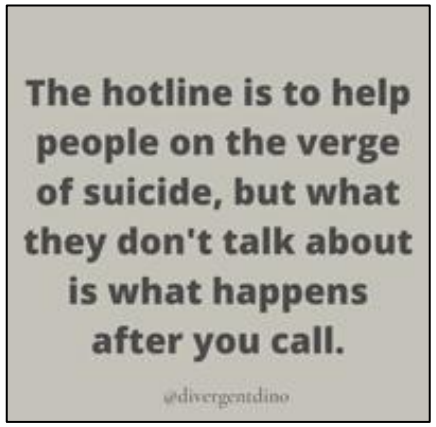
988 is the first step towards a comparable emergency response system for people with MH/SUD emergencies.



https://talk.crisisnow.com/wp-content/uploads/2021/04/01-Universe-of-potential-988-calls-2020-10-21.pdf

Public concerns re what happens after the 988 call

At launch



Present day

Pew

Most U.S. Adults Remain Unaware of 988 Suicide and Crisis Lifeline

Survey reveals few people know emergency number's purpose 9 months after launch

ARTICLE | May 23, 2023 | By: Tracy Velázquez | Read time: 5 min

Projects: Mental Health and Justice Partnerships

Percent Indicating They Had Concerns About Using 988 for Following Reasons:

Law enforcement would be sent	41%
Would be forced to go to the hospital	40%
The call would not remain private and others might find out	37%
Would end up being charged for services that they couldn't pay	36%
988 responders wouldn't be able to handle the issue I contacted them about	34%
Would end up in jail	23%

Source: The Pew Charitable Trusts/Ipsos Public Affairs poll

https://www.pewtrusts.org/en/research-and-analysis/articles/2023/05/23/most-us-adults-rer

While many said they would use 988, concerns remain

Pew asked people whether they had heard of the new 988 service; those who responded yes were asked when someone should use it. Awareness of 988 was measured as answering yes to having heard of the service as well as providing an answer for when to contact 988 besides "don't know" or "not sure." Although 18% said they had heard of 988, over a fourth of these individuals (26%) indicated they didn't know or weren't sure when someone should contact it. This translated into about 13% of people who had the knowledge of both 988's existence and purpose.

What happens after the 988 call depends on where you live.

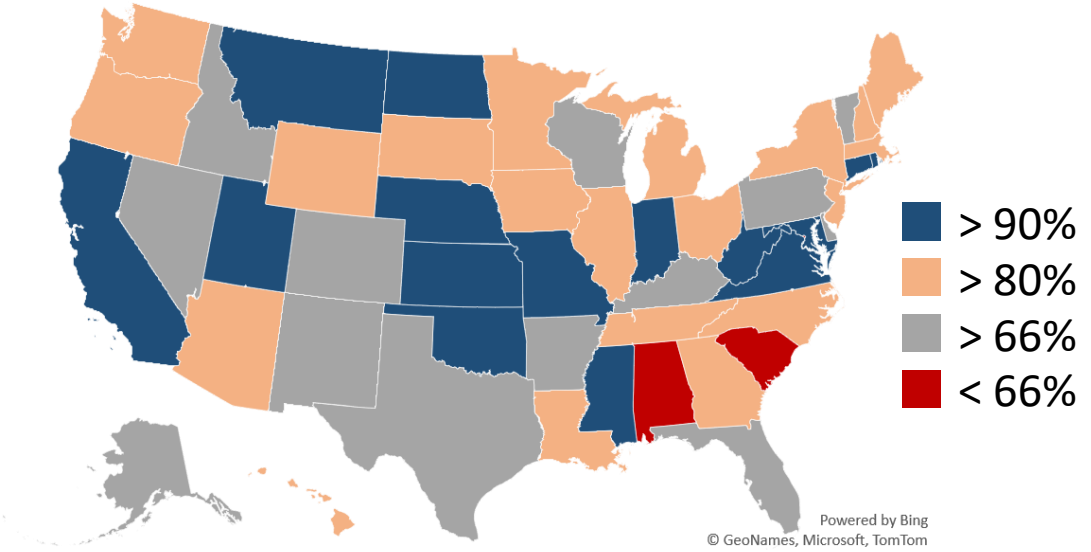
For the ideal outcome, 988 callers need to

- Be routed to a **local call center**
- Connect to **local crisis services** *(someone to respond, a safe place to go)*

Challenges:

- Calls are routed based on the area code of the caller's phone, not their geolocation
- Variable call center performance across states
- Inconsistent access to crisis services across communities

988 In-State Answer Rate

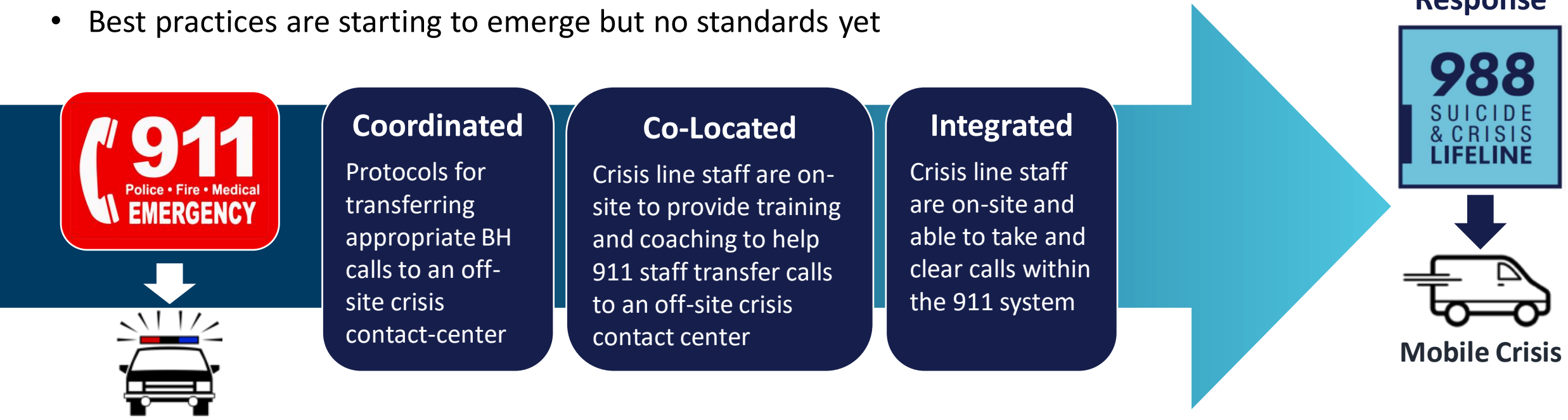


April 2023. Source: https://988lifeline.org/our-network/

911 Integration:
Routing BH calls to a “health-first” response

No One-Size-Fits-All Approach

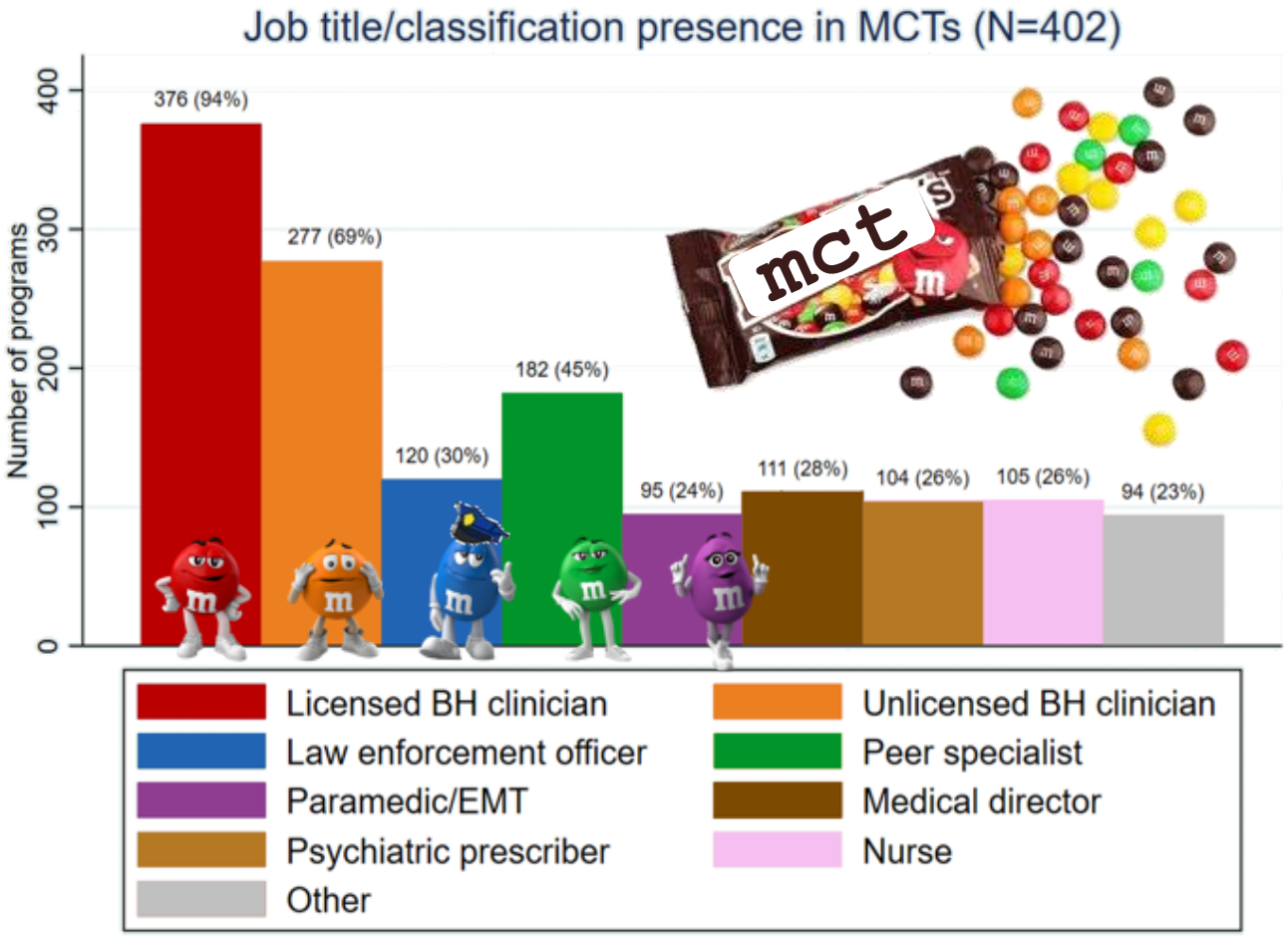
- Over 9000 Public Safety Answering Points (PSAPs) across the US
- Local crisis lines & PSAPs are experimenting on ways to identify & re-route BH calls
- Different solutions for different situations (urban vs. rural, availability of crisis services, etc.)
- Best practices are starting to emerge but no standards yet



Someone to respond

- Mobile Crisis Teams
- Co-responders
- Multi-disciplinary Response Teams

Mobile Crisis Teams (MCTs) come in many combinations



Preliminary results from a survey of over 400 mobile crisis teams in the US. Courtesy Preston Looper & Matt Goldman. http://doi.org/10.1176/appi.ps.20220449

Clinician-only MCTs (most common)

- Licensed BH clinician + unlicensed clinician or peer

Rural areas: 1 person teams +/- telemed backup

Co-Responder Teams

- Law enforcement + BH clinician or peer

- Civilian only: EMT + BH clinician
  CAHOOTS (Eugene, OR); STAR (Denver)

Multi-Disciplinary Response Teams (MDRT)

- BH Clinician + Paramedic + Officer
  RIGHT Care (Dallas)

Choosing a mobile crisis model

More research is needed to determine best practices and if/when one model is preferable to another. In the meantime, communities need to adapt to local needs, capabilities, & preferences.

BIG QUESTION: Role of Police

Studies show that clinician-only MCTs:

- Decrease hospitalization
- Decrease ED utilization
- Are cost effective

Outcome studies of police co-responder teams are mixed.

In qualitative studies:
Most people report they prefer clinician only or co-responder teams to police-only responses. In particular, they value de-escalation and a compassionate and non-criminalizing approach.

When designing crisis systems:

- Acknowledge the distrust of 911, police and healthcare systems in BIPOC communities
- Law enforcement should not be the default or primary responders.
- ➢ **Employ a "Health First" approach**
  - **Civilian-led with clinicians and peers**
  - **Police involved only when necessary, with clearly defined roles**
- Central role for peers in service delivery and design
- Workforce that reflects the community they serve

https://www.fountainhouse.org/reports/from-harm-to-health

https://www.vera.org/civilian-crisis-response-toolkit

For review see: Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

Choosing a mobile crisis model

Who will respond to the most acute individuals?

Exclusionary Criteria for Co-Responder Models

	Will Respond to Calls That Include		
Program Name	Reported Violence	Reported Presence of Weapons	Person Reportedly Under the Influence
B-Heard Response Program, New York City, New York (Civilian Only)	X	X	X
Behavioral Health Responder Program, Albuquerque, New Mexico (Civilian Only)	X	X	✓
CAHOOTS, Eugene, Oregon (Civilian Only)	X	X	✓
Crisis Response Team, Abilene, Texas (MDRT Model)	✓	✓	✓
Rapid Integrated Group Healthcare Team Care, Dallas, Texas (MDRT Model)	✓	✓	✓
Street Crisis Response Team (SCRT), San Francisco, California (Civilian Only)	X	X	X*
Support Team Assisted Response (STAR). Denver, Colorado (Civilian Only)	X	X	✓

*May respond to persons under the influence depending on other case variables, including need for medical care and safety to responders.

MEADOWS MENTAL HEALTH POLICY INSTITUTE

Other considerations

- Involuntary commitment statutes
- Rural, frontier, & tribal communities
- Existing infrastructure
- Short term vs long term planning

Take home message:
There is no one-size-fits-all solution.

Above slide courtesy Andy Keller https://static.coreapps.net/iacp2022/handouts/e9b8f5bb-35df-49c5-8093-72c3410ffad4_1.pdf

For review see: Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

A safe place to go

- “Crisis Stabilization Units”
- PES
- EmPATH Units
- 23-hour observation
- CPEP
- Crisis residential
- Living Rooms
- …and others

“Crisis Stabilization Units” & Facility-Based Crisis Services – An Imperfect Guide

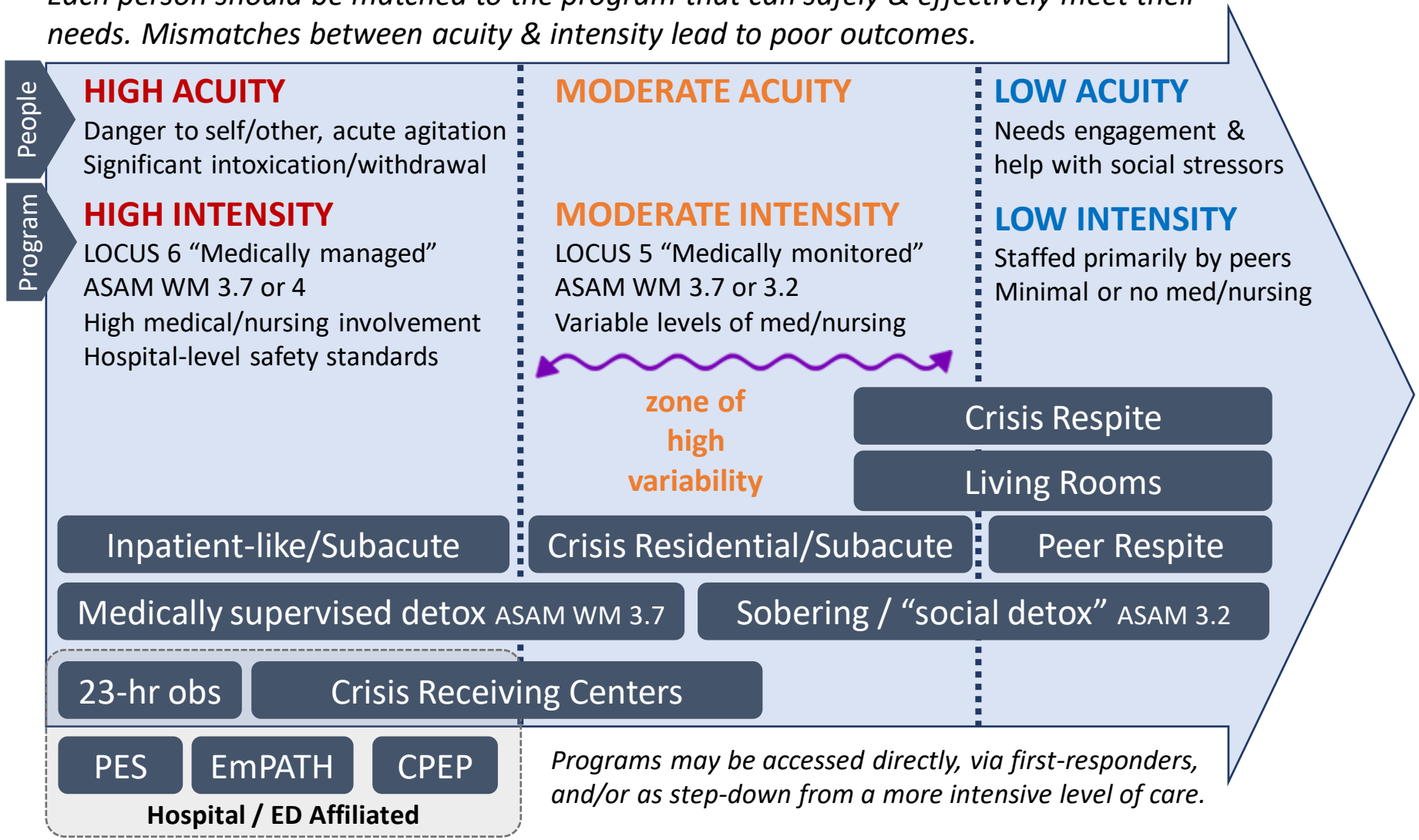
Lots of local variation in:

- Licensing
- Nomenclature
- Reimbursement
- Involuntary process
- Locked vs unlocked
- Police drop-offs
- Length of stay

But ALL should provide

- Crisis intervention/treatment *(vs holding to await transfer to another level of care)*
- Safe and therapeutic milieu
- Peer support & engagement
- Care coordination and help with social determinants of health
- Trauma-informed approaches
- Capability of addressing co-occurring MH and SUD needs

Each person should be matched to the program that can safely & effectively meet their needs. Mismatches between acuity & intensity lead to poor outcomes.



Programs may be accessed directly, via first-responders, and/or as step-down from a more intensive level of care.

Balfour ME. (2023) An Imperfect Guide to Crisis Stabilization Units: Matching the Right Level of Care to Individual Needs. *Psychiatric Times*. https://www.psychiatrictimes.com/view/an-imperfect-guide-to-crisis-stabilization-units-matching-the-right-level-of-care-to-individual-needs

The Crisis Response Center

- Built with Pima County bond funds in 2011
  - County owns the building, services funded by the RBHA
  - Alternative to jail, ED, hospitals
  - Serving 12,000 **adults** + 2,400 **youth** per year
  - Managed by Connections since 2014
- Services include
  - 24/7 walk-in **urgent care**
  - **23-hour observation**
  - Short-term adult **subacute inpatient**
- Police drop-offs with **NO WRONG DOOR that TAKES EVERYONE**
- Space for co-located community programs
- Unique Campus: CRC is adjacent to
  - Crisis Line Call Center
  - Banner University of Arizona Medical Center
    - Emergency Department
    - 66-bed inpatient psychiatric unit that performs most of Pima County's civil commitment evals
  - Mental health court

A Solution to the "Divert to What?" Question
Culture of Treating LE as a "preferred customer"

CIT Recommendations for Mental Health Receiving Facilities[1]

1. Single Source of Entry
2. On Demand Access 24/7
3. **No Clinical Barriers to Care**
4. **Minimal Police Turnaround Time**
5. Wide Range of Disposition Options
6. Community Collaboration

Studies show this model:

- Critical for pre-arrest diversion[2]
- Reduces ED boarding[3,4]
- Reduces hospitalization[3,4]

These two are the hardest to do well.

It means

- **Be easier to use than jail.**
- Drop off time less than 10 min
- Never turn police away.
- Take everyone:
  - High acuity: No such thing as "too agitated" or violent
  - Can be highly intoxicated
  - Involuntary or voluntary
  - Without using security guards

1. Dupont R et al. (2007). Crisis Intervention Team Core Elements. The University of Memphis School of Urban Affairs and Public Policy
2. Steadman HJ et al (2001). A specialized crisis response site as a core element of police-based diversion programs. Psychiatr Serv 52:219-22
3. Little-Upah P et al. (2013). The Banner psychiatric center: a model for providing psychiatric crisis care to the community while easing behavioral health holds in emergency departments. Perm J 17(1): 45-49.
4. Zeller S et al. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med 15(1): 1-6.

Quick and Easy Access for Law Enforcement

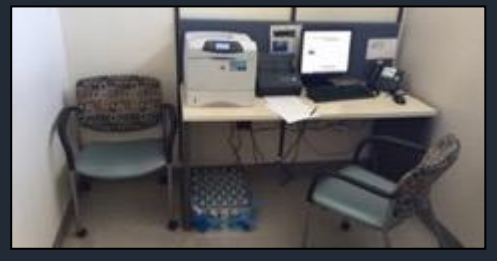
so that we're the preferred alternative to jail or the emergency room

Officers don't like:

- Waiting
- Being turned away
- Taking their guns off
- Parading people through the front lobby

Dedicated police entrance with secure gated sally port & workspace

Crisis Response Center - Tucson AZ



Studies show this model is critical for pre-arrest diversion,[2] reduces ED boarding,[3,4] and reduces hospitalization.[3,4]

In Tucson…

"For both officer-initiated events and 911 calls, the odds of arrest were lower for mental health/medical incidents than for violent crimes. This finding may be partly due to the role of Tucson's Crisis Response Center, which provides an alternative to arrest and jail booking… the odds of arrest for mental health/medical versus violent crimes were far lower concerning officer-initiated events than 911 calls."

Vera INSTITUTE OF JUSTICE

Figure 6.2.6: Tucson, AZ. Predictors of arrest: Officer-initiated events

	OFFICER-INITIATED EVENTS			
	Adjusted odds ratio	*p*-value	N	Percentage
PREDICTORS OF INTEREST				
Incident type				
Violent crime	Reference	Reference	729	0.3
Domestic violence	0.75	.059	625	0.3
Property crime	0.85	.146	4,298	1.9
Other crimes	2.21	<.001	5,102	2.3
Proactive	0.34	<.001	44,564	19.9
Police operations	11.87	<.001	2,593	1.2
Traffic-related	0.31	<.001	124,063	55.4
Service assignments	0.93	.492	3,657	1.6
Mental health/medical emergency	0.13	<.001	5,673	2.5

…n, AZ. Predictors of arrest: 911 calls

	911 CALLS			
	Adjusted odds ratio	*p*-value	N	Percentage
	Reference	Reference	8,268	1.4
	2.02	<.001	39,259	6.7
	0.62	<.001	48,030	8.2
	0.92	.034	75,972	12.9
	0.21	<.001	1,233	0.2
	2.34	<.001	1,409	0.2
	0.54	<.001	31,572	5.4
	1.39	<.001	15,537	2.6
	0.61	<.001	67,030	11.4

Neusteter RS et al. (2020) Understanding Police Enforcement: Multicity 911 Analysis. Vera Institute of Justice. https://www.vera.org/downloads/publications/understanding-police-enforcement-911-analysis.pdf

1. Dupont R et al. (2007). Crisis Intervention Team Core Elements. The University of Memphis School of Urban Affairs and Public Policy
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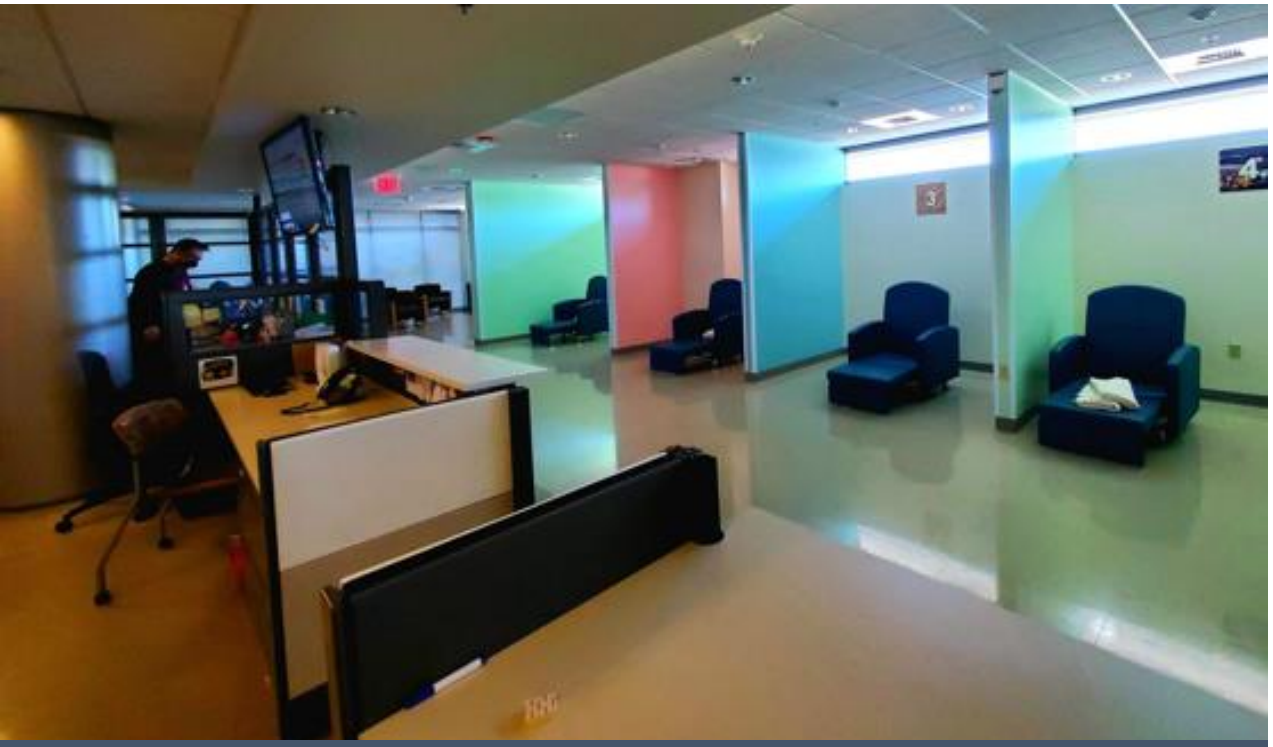
23-Hour Observation: Open design that creates a safe & therapeutic environment



The open design facilitates:

- Safety: Continuous observation
- Therapeutic milieu: Open area for therapeutic interactions with others
- Flexibility: Ability to accommodate surges in volume

Interdisciplinary care starting with the *assumption that the crisis CAN BE resolved*

Interdisciplinary Teamwork

- 24/7 psychiatric provider coverage (MD, NP, PAs)
- Peers, nurses, techs, case managers

Early Intervention

- Door to doc time 90 min
- Meds, detox/MAT
- Peer support & groups

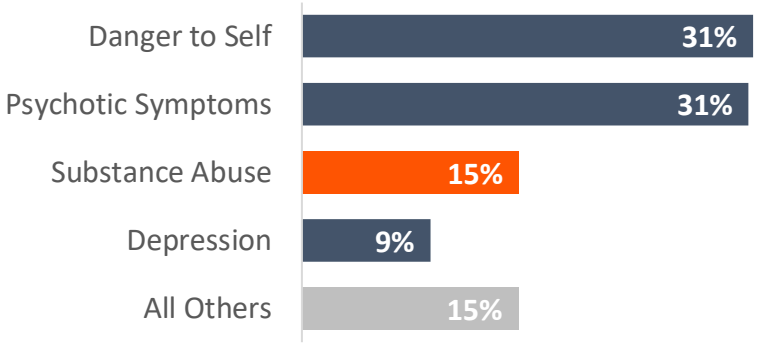
Proactive discharge planning

- Coordination with clinics, community & family supports

~60% discharged to community-based care
~70% converted to voluntary status

MH and SUD services are fully integrated at the payer level, which gives crisis providers the flexibility to treat co-occurring SUD based on the individual's needs.

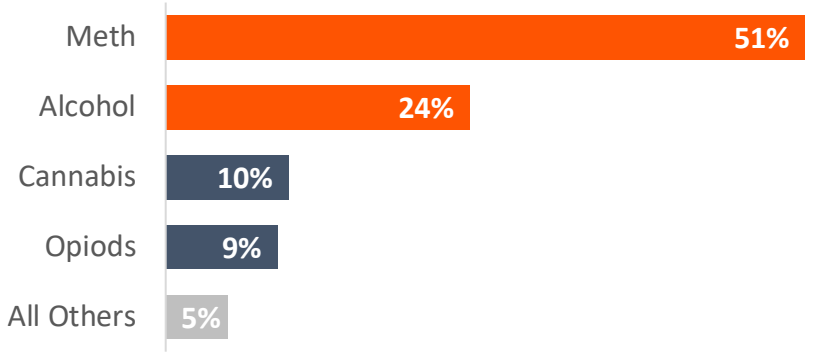
15% of CRC adults present with **SUD as the primary concern,**



but…

65% have a **SUD diagnosis or positive toxicology results.**

Meth & alcohol account for **three quarters of SUD diagnoses.**



Crisis observation units provide

- Medically supervised detox
- Initiation of MAT
- SUD counseling & peer support
- Naloxone kits distributed at discharge

Youth and SUDs

- **28%** of CRC youth obs patients have a SUD diagnosis or positive toxicology result.
- The most common diagnoses are **Cannabis** (66%) followed by **Alcohol** (12%) and **Opiates** (11%).

Law Enforcement Collaboration

- Training
- CIT
- Co-responders
- Dedicated vs Designated Teams
- Tucson MHST Model
  (Mental Health Support Team)

Tucson's Police-MH Collaborative Response Model

Prevention

- Outreach
- Follow-up
- Multiple touches
- Lower urgency

Response

- De-escalation
- Intervention
- Discrete event
- Higher urgency

Breaking the Crisis Cycle

Outreach & follow-up can "break the cycle" by ensuring that the person is connected to the care they need to stay well in the community. Community-based peers and/or clinicians work with LE to help with engagement and navigating the mental health system.

Health-First Response

With 911/crisis line integration, calls are **triaged to a clinician-only response as early and often as possible**, with law enforcement involvement reserved for cases with higher safety risk or criminal nexus. Responding officers are CIT-trained and can request additional assistance if needed.

Safety Risk	Outreach & Follow-up	Acute Response
	Collaborative ***Dedicated LE specialty teams working with peer co-responders*** - Follow-ups after OD or SUD deflection - Public safety risks: investigations & f/u - Homeless outreach	**Collaborative** ***CIT Trained Officer + assistance from the crisis system to fit the situation*** - CIT officer transport to CRC - Mobile crisis assist at suicidal barricades
	Clinician-Only ***BH System is responsible*** - "Second responders" - Case management - Timely access to needed care	**Clinician-Only** ***BH System is responsible*** - Crisis Line/988 - Mobile Crisis Teams - Transport to CRC/crisis facilities

Urgency

New Report: Quality Measurement in Crisis Services

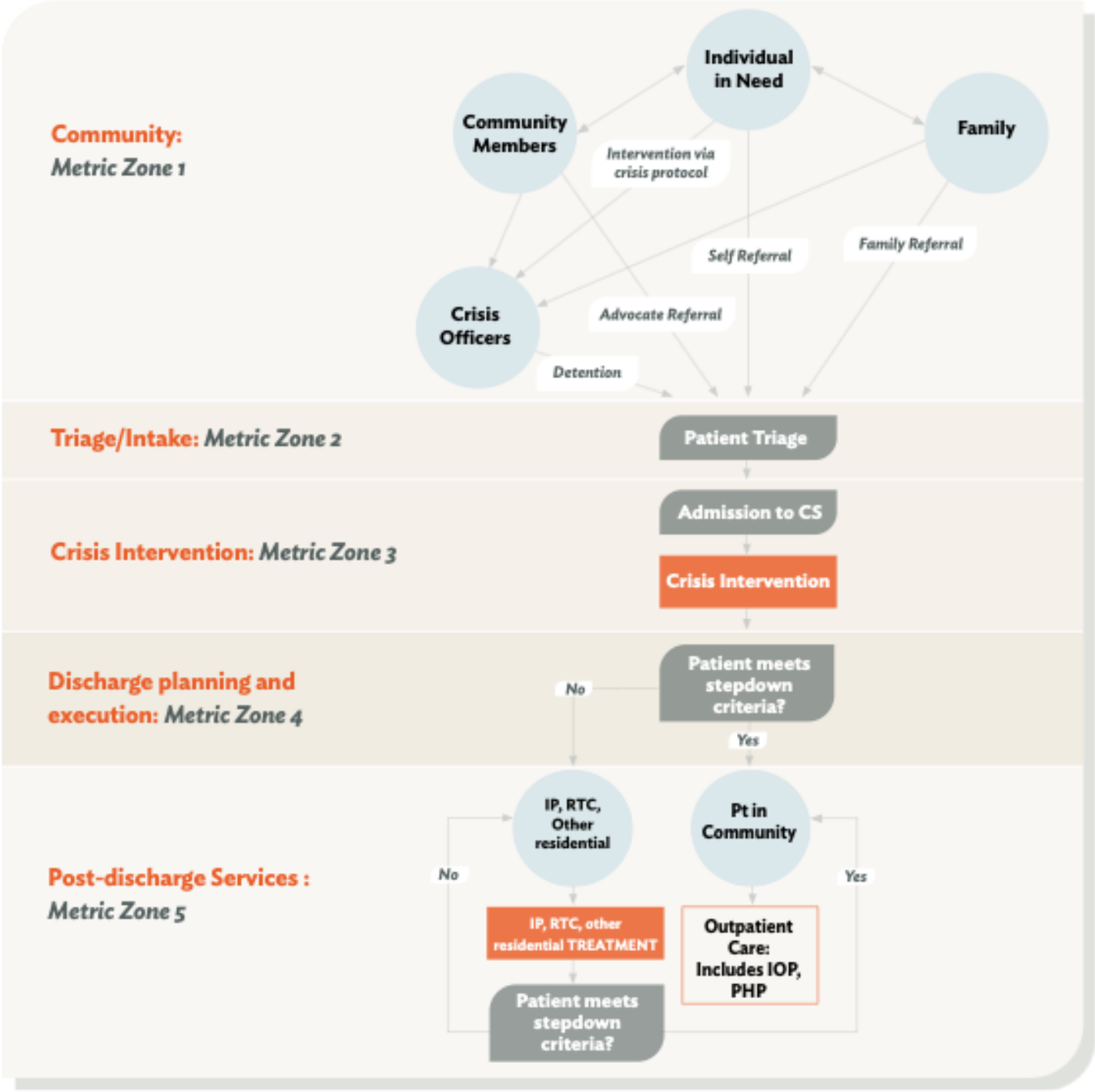
NATIONAL COUNCIL for Mental Wellbeing®

Medical Director Institute
Crisis Services Committee

A companion to
Roadmap to the Ideal Crisis System
www.CrisisRoadmap.com

Conventional Framework

- Based on process engineering methods.
- Map the flow of the person in crisis through the system.
- Consider the inputs, outputs, gaps, and best practices that should occur in each “zone.”



Person-Centered Approach to Crisis Metrics

	Value	Meaning	Examples
A	*Accessible/ Affordable*	I am welcomed wherever I go. I am not turned away.	• Percentage of help-seekers who receive appropriate care vs. all who have sought care. • Percentage of persons seeking care who are turned away due to lack of coverage vs declined due to not being able to afford care.
C	*Collaborative*	Helpers work in partnership with me, my family, my caregivers, and other responders.	• The programs assess consumer/family satisfaction surveys and/or net promoter scores.
C	*Comprehensive*	I get help for all my issues that are part of the crisis.	• Access to medical screening. • Able to treat co-occurring substance use disorder (SUD), intellectual/developmental disorder (I/DD), etc.
E	*Equitable*	The quality of services I receive are not affected by my race, ethnicity, gender, sexual orientation, etc.	• Stratify outcome metrics (e.g., return to crisis centers, access to care) by race/ethnicity and other key demographics (e.g., ZIP code). What percentage of poor outcomes are disproportionately influenced by performance in underrepresented populations?
S	*Safe*	My experience of help is safe and not harmful. I am never traumatized by asking for help.	• What percentage of individuals presenting in crisis end up injured, hurt or killed while doing so?
S	*Successful*	The care I receive meets my needs.	• Readmission rates. • Symptom reduction.

	Value	Meaning	Examples
T	*Timely*	I get help quickly enough to meet my needs.	• Time to intervention (e.g., call answer times, mobile dispatch times, facility door-to-doctor times). • Abandonment rate (e.g., call abandonment, left without being seen, etc.). • Lag time between seeking care and receiving care.
O	*Ongoing*	I receive help to move from my crisis situation to ongoing support that wrap around me to help me thrive.	• Successful linkage to continuing care at adequate intensity: 3-, 7-, 30-, 60-, 90-day follow up.

	Value	Meaning	Examples
H	*Hopeful*	I am helped to feel more hopeful, and I make better decisions as a result.	• Decrease in suicide, violence, self-harm. • Personal Outcome Measures (POMS).
E	*Engaging*	I am treated as a valuable customer, with respect and dignity.	• Complaints, adverse incidents, escalation.
L	*Least Intrusive*	I receive help in a place that is designed to meet my needs.	• Avoidance of inappropriate emergency department use or arrest diversion, voluntary conversion.
P	*Publicized*	I know who to call and/or where to go.	• Information about call lines and walk in centers, increased use of 988 vs. 911.

Thank you!

Margie Balfour, MD, PhD

Chief of Quality & Clinical Innovation - Connections Health Solutions

Associate Professor of Psychiatry - University of Arizona

margie.balfour@connectionshs.com

CONNECTIONS

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