Tailoring Crisis Response and Pre-arrest Diversion Models for Rural Communities

INTRODUCTION

This brief is the first of three Action Briefs developed from the SAMHSA Pre-arrest Diversion Expert Panel, convened in January 2018. Each brief addresses one of the three primary themes that emerged from the Expert Panel: modifications of early diversion models for rural areas, covered here; the role of hospital emergency departments; and information sharing.

The Issue

Rural communities face unique challenges in implementing existing crisis response and pre-arrest diversion models for people with mental and substance use disorders. These include wide geographic areas served, limited availability of crisis services, gaps in treatment and social services, and constrained financial and staffing resources.[1,2] These challenges necessitate innovations in current crisis response or pre-arrest diversion interventions that show promising or proven results in other jurisdictions. Across the United States, rural communities have adapted crisis response and pre-arrest diversion strategies to address their unique challenges and meet the need for services in their jurisdictions.[3] These strategies fall within Intercept 0 and Intercept 1 of the Sequential Intercept Model, a conceptual framework for intervention. In Intercept 0, crisis response professionals and law enforcement, acting in a "guardian" role, work to move people into treatment and services in order to avoid criminal justice involvement; in Intercept 1, law enforcement diverts individuals with mental and substance use disorders from arrest.[4]

This brief features a few current strategies and technologies that rural communities can adopt to increase opportunities for crisis response and pre-arrest diversion of individuals with mental and substance use disorders from the local criminal justice system.

AT A GLANCE

Adapted Strategies for Rural Communities

- Leverage technology in collaborative law enforcement and behavioral health responses.
- Build on established programs instead of developing new interventions.
- Match resources to the community's needs.

Essential Technologies and Staffing

- Telehealth
- Mobile applications
- Mobile tablets
- Dedicated call lines
- Cell phones
- Peer support

Adapted Strategies for Rural Communities

Rural communities that have shaped existing diversion initiatives to meet their needs use the following three approaches:

1. Leverage technology in collaborative law enforcement and behavioral health responses.

Partnerships and technology are critical components of crisis response and pre-arrest diversion in many rural areas. Rural communities can share limited or expensive resources between multiple jurisdictions and across wide geographic areas. Partnerships between neighboring towns and counties, private service agencies with large service areas, and others can increase the capacity of agencies to provide services; enable sharing of information and ideas across similar, rural communities; and help those communities to access expensive resources that otherwise would not be cost-effective.

Advancements in technology have resulted in a variety of resources that may require an upfront expenditure but which can be shared and used across large, rural areas to maximize the return on investment. Incorporating technology into mental health and substance use treatment services may require programs to shift to less traditional staffing models (e.g., remote employees that are not based in one central location), bolster their electronic infrastructure, and make other changes to support a shift towards virtual service delivery. However, these shifts can ensure the financial investment in these resources results in higher usage rates, increased on-scene resolution of crises, less demand for services on emergency response systems, reduced use of costly transportation, and quicker delivery of critical services to individuals in crisis or presenting with mental and substance use disorders.

Improving consumer access through telehealth services

Telehealth services enable the remote delivery of services, overcoming the geographic and transportation challenges experienced in many models for rural delivery of care. Telehealth uses conference calls, virtual chat, text messaging, video conferencing, and electronic file-sharing to exchange information and provide virtual services.[5] Many individuals experiencing a mental health crisis can benefit from immediate, virtual crisis counseling provided remotely by a licensed mental health professional; indeed, virtual assessments may provide more accurate information than phone calls alone. Integrating telehealth into mental and substance use crisis responses builds upon preexisting structures to expand the community's ability to provide critical and time-sensitive treatment and services without requiring travel.

Mobile applications

Some programs create mobile applications (apps) that can be installed on any law enforcement officer's, case manager's, clinician's, or patient's phone, mobile tablet, or computer. Such mobile apps provide a portal through which users can get information, contact a nurse or mental health clinician, or access other face-to-face telehealth services securely and remotely. Some programs provide telehealth through these apps on a 24-hour basis, linking users to mental health professionals in a variety of locations, rather than opening and staffing a centralized 24-hour facility.

Mobile tablets

Mobile tablets can assist law enforcement officers and individuals in connecting with "face-to-face" crisis counseling and assessment services by using the camera feature or a mobile app (see "mobile applications"). Providing mobile tablets to law enforcement to deliver crisis counseling and assessment can reduce response time in rural areas and improve the availability of limited mental health services. Some communities also provide mobile tablets to patients with high levels of need or significant transportation barriers to reduce the utilization of emergency response systems and emergency departments for non-acute mental health crises or care needs.

Dedicated phone lines

Rural communities that establish a dedicated phone line for law enforcement officers to directly access behavioral health services can reduce the time in the field needed to determine next steps in serving the person in crisis, increase the likelihood of diversion, and expedite the delivery of care to the person in crisis. Communities may choose to have a direct line to their local crisis response center, the local mental health authority, or another provider that can link officers with information and support as they triage an encounter with a person in crisis. After speaking by phone, the officer may transport the person to a crisis center or conduct a warm handoff to service providers deployed to the scene.

> "One advantage with younger officers is they buy into the technology, especially when it is designed to get officers back into service. We cover 16 counties and the farthest department is a 2-hour drive."
>
> *Arnold Remington,* Program Director, Targeted Adult Service Coordination

Cell phones

Rural communities may consider providing cell phones to key staff to facilitate communications between agencies and between staff and patients. For example, providing a cell phone to a dedicated case manager enables law enforcement officers to engage in warm hand-offs using text messages and phone calls. Cell phones also allow patients to contact a case manager directly instead of calling the local service provider's offices and leaving a message or waiting to be transferred.

2. Build on established programs instead of developing new interventions.

Rather than developing entirely new programs, rural communities may find it beneficial to expand existing programs to improve opportunities for crisis response or pre-arrest diversion. This approach may include supplying new tools and resources to current staff and providing specialized training for responders to address a broad range of crises effectively.

For example, counties piloting opioid overdose reversal kits with Crisis Intervention Team (CIT)-trained law enforcement officers have found those officers to be early adopters and promoters of these kits. By providing law enforcement officers who are already involved in a diversion strategy (e.g., CIT) with the training and tools to address an overdose, the benefits of the kits are more quickly recognized and more officers across the agencies begin to use the overdose reversal kits in their work.

> "Once the deputies started carrying [overdose reversal kits], they began to see that they were saving people's lives and realized this was one of the reasons they went into law enforcement in the first place."
>
> *Lee Ann Watson,* Associate Director, Clermont County Mental Health and Recovery Board

Rural first responders may need to be trained to handle a broader spectrum of issues than expected in a suburb or a city, due to limited resources and response time. This may involve cross-training with non-traditional partners, such as behavioral health or substance use treatment providers; emergency medical services partnerships to facilitate timely medical clearances or other medical services; or additional specialized responses that can be incorporated without requiring a new program or additional staff.

Peer support

Expanding the types of professionals available to provide services to people with mental and substance use disorders can enhance the capacity of rural communities to address mental and co-occurring disorders. Peers (peer support staff, peer support specialists, or peer recovery coaches) are individuals with the lived experiences of mental illness, substance use disorders, or justice involvement and are trained or certified to provide supportive services. Rural communities may consider incorporating peers into their crisis response and post-crisis outreach models. Peers can work alongside law enforcement officers as part of a

IMPLEMENTATION SPOTLIGHT: R.E.A.L. (RESPOND, EMPOWER, ADVOCATE, AND LISTEN), NEBRASKA

- **Operational since:** 2011
- **Description:** The Mental Health Association of Nebraska provides the R.E.A.L. program in partnership with law enforcement, community corrections, and local human service organizations. This program formalized a referral process where service providers may link people with an identified or potential mental health concern to trained peer specialists. The peer staff provide free, voluntary, and non-clinical support with an end-goal of reducing emergency protective orders and involuntary treatment placement. After 3 years, the program found that participants were 44 percent less likely to be taken into emergency protective custody by law enforcement.
- **More information:** About R.E.A.L.

multidisciplinary crisis response team, or they can conduct outreach in the community, following up on referrals from law enforcement.

> "Although the county would have liked a mobile crisis unit or a co-responder team, we did not have the volume of calls to justify the financial cost."
>
> *Sarah Petersen,* Director, Codington County Welfare Office

3. Match resources to meet the community's needs.

In areas where demand may not be high enough to justify the financial cost of creating or sustaining a program, stakeholders should draw on local resources to develop services that meet the community's needs. For example, rather than implementing a program to be available on a 24 hours a day, 7 days a week basis, programs can be made available to the community only during the times that crisis services are most needed, such as evening or weekend hours. Other rural communities may not have the resources to send a clinician out with law enforcement but can afford to staff a clinician to provide follow-up services the day following the crisis encounter. This outreach worker can engage with the individual and assist with accessing essential supports, with the goal of minimizing future encounters with law enforcement.

Training strategies may also need to be adjusted for rural jurisdictions compared to urban approaches. Training targets (the number or proportion of staff trained in a particular diversion program or practice) may differ due to the funds and time required to participate in training. For example, small agencies in rural communities may involve all of their officers in CIT trainings, rather than only 25 to 30 percent of their agency, in order to ensure that a CIT-trained officer is always available to respond to calls. Communities that face significant funding challenges for trainings may find grant support through partnerships with local mental health advocacy organizations.[6]

IMPLEMENTATION SPOTLIGHT: GRAND LAKE MENTAL HEALTH CENTER (GLMHC), OKLAHOMA

- **Operational since:** 1977
- **Description:** GLMHC is responsible for providing integrated health care to 288,000 people over an area of 4,500 square miles. Mobile tablets are provided to hospitals and law enforcement agencies to expedite the delivery of services to individuals during an encounter with law enforcement by quickly linking first responders and law enforcement with licensed mental health professionals. GLMHC also provides mobile tablets to people with high-risk needs or significant transportation barriers to increase access to services. GLMHC partners with a technology firm, which created a GrandCare mobile application suite to provide first responders, hospitals, and individuals in treatment with 24-hour, face-to-face communication with treatment providers. These efforts have reduced inpatient stays from 1,115 in 2015 to 402 in 2017. The reduction in emergency department and inpatient use over 2 years has resulted in an estimated health care cost savings of $6,560,700.
- **More information:** GLMHC's Use of Mobile Technology to Increase Access and Grand Lake Mental Health Outpatient Services (video)

Endnotes

1. Michael T. Compton, Beth Broussard, Dana Hankerson-Dyson, Shaily Krishan, Tarianna Stewart, Janet R. Oliva, and Amy C. Watson. "System- and Policy-Level Challenges to Full Implementation of the Crisis Intervention Team (CIT) Model." *Journal of Police Crisis Negotiations* 10, no. 1–2 (2010): 72–85, https://doi.org/10.1080/15332581003757347.

2. Melissa Reuland, Laura Draper, and Blake Norton. *Tailoring law enforcement initiatives to individual jurisdictions*. (New York: Council of State Governments Justice Center, 2010). https://www.bja.gov/publications/csg_le_tailoring.pdf

3. National Association of Counties. *Reducing mental illnesses in rural jails.* (Washington, DC: National Association of Counties, 2016). http://www.naco.org/sites/default/files/documents/Reducing%20Mental%20Illness%20in%20Rural%20Jails_FINAL.pdf.

4. Dan Abreu, Travis W. Parker, Chanson D. Noether, Henry J. Steadman, and Brian Case. "Revising the Paradigm for Jail Diversion for People with Mental and Substance Use Disorders: Intercept 0." *Behavioral Sciences & the Law* 35, no. 5–6 (2017): 380–95. https://doi.org/10.1002/bsl.2300.

5. T.C. Chang, J.D. Lee, and S.J. Wu. "The Telemedicine and Teleconsultation System Application in Clinical Medicine." In *The 26th Annual International Conference of the IEEE Engineering in Medicine and Biology Society*, 4: 3392–95. San Francisco, CA, USA: IEEE, 2004. https://doi.org/10.1109/IEMBS.2004.1403953.

6. David Skubby, Natalie Bonfine, Meghan Novisky, Mark R. Munetz, and Christian Ritter. "Crisis Intervention Team (CIT) Programs in Rural Communities: A Focus Group Study." *Community Mental Health Journal* 49, no. 6 (2013): 756–64. https://doi.org/10.1007/s10597-012-9517-y.