

Designing a Law Enforcement-Friendly Crisis Service

Candace Allen, M.S., Senior Director, Adult Intensive Mental Health Services, Helen Ross McNabb Center, Tennessee
Captain Donald Jones, Knoxville Police Department, Knoxville, Tennessee

WEBINAR SUPPORTING DOCUMENT

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Q1: Was it easy to establish a working relationship with law enforcement?

It took more time to build this relationship than with other partners. By the time that we started the Behavioral Health Urgent Care Center (BHUCC), the Helen Ross McNabb Center Behavioral Health Center had been working alongside of law enforcement for 7 years through Crisis Intervention Teams (CIT), so that provided a firm foundation. I will also say that it takes a behavioral health center that has an overall philosophy and willingness to enter into law enforcement culture with the aim of understanding and providing support and input as time progresses.

Q2: Has this model been attempted in small communities?

I am not sure about this particular program format in smaller communities since it is unique in that it directly diverts from jail those who have been arrested, but several communities have a drop-off location where officers can bring individuals who are experiencing a mental health crisis and these work extremely well.

Q3: Can the Knoxville program explain where they received their funding from?

Initially— in the first year—we had funding from the Tennessee Department of Mental Health and Addiction Services and our local city and county governments.

Presently, it is funded completely through our city and county government.

Q4: When looking at your programming, how has it impacted recidivism?

We collect data through individual identification numbers from those who have been incarcerated for a period of time pre- and post- BHUCC. Each individual tells a different story—1 woman who had been incarcerated over 500 times reduced her incarcerations to only 2 times in the past year.

The overall data benchmark is that 68 percent return to incarceration. In our second year, we are looking at an overall reduced rate of 52% returning.

Q5: How do you keep adults and children separated in the facility for safety reasons?

We do not admit children. The age for the program is 18 years or older so children are not eligible.

Q6: Do you utilize Peer Support Specialists (PSS) on the ground for hands on connection with law enforcement?

Yes, we have employed PSS in several programs working directly with law enforcement. At the BHUCC, we have a PSS who works on the unit and often assists law enforcement when someone comes in and also interacts with them while on the unit. We also have a peer on our forensic assertive community treatment (FACT) case management team.

Q7: Any suggestions for rural areas to provide co-responders to assist?

If you have any funding from the state or other entities for criminal justice staff, crisis response etc., you can look at creative ways to utilize this staff. It may start with pairing select individuals to be home visited by law enforcement and behavioral health staff. I would be glad to discuss this with you so please feel free to contact me—candace.allen@mcnabb.org—since there are so many ways to go about this given the particular resources that you have.

Q8: Often law enforcement doesn't know if mental illness is involved until they arrive on scene, so how can treatment providers be involved?

We encourage law enforcement to call us and triage with any questions- 24/7/365. Our mobile crisis Teams can also come on site if indicated to assist. The biggest impact has been the CIT training and development of teams to rely upon each other and call when needed.

Q9: At the 23-hour observation unit, if someone arrives very agitated and psychotic, how quickly can they be medicated?

After the initial nursing evaluation, which is conducted as soon as they arrive, we have access to agitation protocols that can be implemented immediately.

Q10: Are the receiving officers in uniform?

Yes.

Q11: Can you talk about the "No Wrong Door" results, with regards to acuity, substance use, etc? How are staff handling these type of scenarios once an individual arrives? How are staff trained or prepared to manage these individuals?

Typically, "No Wrong Door" approaches can take several years to implement when you have had mental health and addiction services that have been siloed due to location, training, and funding. We have prioritized this concept for the past 18–20

years and it still is a work in progress. Training is paramount for staff who work with clients with co-occurring disorders and one of the factors is to hire staff that meet these qualifications. That may sound like a “no brainer,” but I have seen really negative results in just assuming that clinicians have these skills. Also, I believe that there are certain kinds of staff that enjoy crisis work and thrive on acuity. It is very important to ensure that those are the staff that are being hired in these positions.

Q12: Ms. Allen talked about having a holistic approach, and I was wondering if she could elaborate more on what that entails.

I was primarily talking about the ability to consider all dynamics of a person's behavioral health—mental health and addiction issues as well. In the past, these have been separated to an extent where at times they were treated separately and one was viewed more importantly than the other. In learning especially from the BHUCC programs, someone in the past who came in would have often been seen as having only a substance use problem when in actuality they had equally important mental health issues—and vice versa examples.

In addition, the discharging process and the case management services are looking at all areas of someone's life to assist in identifying the barriers and solutions (e.g., transportation, housing, food, employment).

Q13: For the Knoxville program, do people have to be competent in order to be "handed off" to the jail diversion program on eligible misdemeanors?

If we are able to complete an assessment, they are eligible for the program.