TASK FORCE ON MENTAL HEALTH CRISIS SERVICES

FINAL REPORT

Presented to:

Centre County Commissioners & State College Borough Council

Tuesday, November 10, 2020

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EXECUTIVE SUMMARY

The status of the nation's mental health system is under welcome, much needed, and long-overdue scrutiny along the entire continuum of prevention, crisis intervention, treatment, and recovery services to improve accessibility, treatment effectiveness, and cultural responsiveness. Sobering statistics bear witness to the need for action.

- 1 in 5 US adults experience mental illness each year.
- 1 in 25 US adults experience serious mental illness each year.
- 19% of US adults with mental illness also have a substance use disorder.
- 1 in 6 US youth aged 6-17 experience a mental health disorder each year.
- High school students with depression are more than twice as likely to drop out of school.
- 8.4 million Americans provide care to an adult with an emotional or mental illness.

National Alliance on Mental Illness (https://www.nami.org/mhstats)

It is important to state that improving preventive care and services is by far an essential and preferred step in reducing the potential use of crisis intervention services for those in need. When intervention is needed, a coordinated and effective crisis care system is crucial.

According to the National Guidelines for Crisis Care, published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA, 2020), "Effective crisis care that saves lives…requires a systemic approach." It provides a "line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources." The Treatment Advocacy Center estimates that at least one in four fatal encounters with police involved a person with an untreated severe mental illness, according to The Philadelphia Inquirer (November 1, 2020). The risks are compounded when race, both Black and Latino, is a factor.

Bringing about change is a challenging undertaking requiring coordinated leadership at national, state, and local levels, involving government, health care, law enforcement, mental health and social services, education, community organizations, and those individuals most impacted and their families.

In Centre County, the increasing need for mental health services is no exception, as is the pressure on the crisis intervention service system to meet growing and diverse needs. From January through September, 2020, 870 mental health calls were responded to by police officers from three municipalities, Penn State, and Pennsylvania State Police. The Center for Community Resources received 7,646 calls on its Helpline, 238 walk-ins to the Center, and made 134 mobile visits to home, schools, or other sites to meet with individuals. Mount Nittany Medical Center had 1200 mental health Emergency Department visits.

Following the tragic shooting death of Osaze Osagie on March 20, 2019, during a law enforcement response to a mental health 302 warrant service and the subsequent concerned community response during a well-attended public meeting in June seeking action to address concerns, the Centre County Commissioners and the Borough of State College appointed the Task Force on Mental Health Crisis Services.

The charge to the Task Force focuses on that one critical component of the overall mental health system in Centre County. This report and its recommendations address the continuum of services when crisis intervention is needed, both its strengths and potential enhancements to the system. The charge specified examining four areas: Crisis Intervention Services (Mobile), Delegate Services, Police Officers' Role in Responding, and Mount Nittany Medical Center Emergency Department.

Section I of the report describes the system and the work process.

Centre County residents are served by a crisis intervention system including a 24/7 walk-in center, a telephone crisis line, and a mobile response unit at the Center for Community Resources and Delegate services through Service Access & Management, Inc., when an involuntary commitment warrant service is indicated. More than six municipal police departments, Centre County Sheriff, the Pennsylvania State Police, Penn State, and the Centre County Correctional Facility are directly involved in responding to mental health calls, warrant services or needs. The Emergency Department responds to those in need of mental health care. A descriptive data picture of the usage of these services is included in the report.

The system was mapped from point of entry to exit to describe how the system's component services interact, as well as their functions, overlaps, and transitions. It is a document to aid elected officials, decision makers, and stakeholders as the recommendations are studied and implemented.

The Task Force conducted a concentrated work process that included the perspectives, expertise, knowledge, and skills of its members. Members analyzed a consultant's report of structured interviews with 60 representatives of identified key

populations. They were educated on the processes of the four areas, and considered data, best practices, research, regulations, and diverse resources during the many months of work. Using a Strengths, Gaps, Opportunities, and Barriers organizing format, the draft recommendations were produced.

Two updates were provided to the Centre County Commissioners and State College Borough Council in public meetings. In addition, two virtual public meetings attended by more than 100 people were held to solicit input on the draft of the Key Recommendations. The final report with the Key Recommendations is being presented in a joint virtual public meeting of the Commissioners and the Council.

Section II of the report contains the Systemwide Key Recommendations.

Six inter-related themes clearly emerged and are central to the recommendations. They are not hierarchical but are firmly embedded in the content of the enhancements. They are **care, cultural responsiveness, communication, collaboration, coordination, and consistency.**

There are 11 systemwide recommendations, organized by Enhancements Through Coordination of Care; Through Training, Education, and Data; and, Through Advocacy. Separate Key Recommendations, of which there are eight, address enhancements for Crisis and Delegate Services, Law Enforcement, and the Emergency Department. Finally, there are two Key Recommendations for Implementation. The chart lists each recommendation, provides brief explanatory/descriptive information, and supporting examples and resources.

The Task Force was guided by its charge and its commitment to a report that is accurate, forthright, thorough, evidence-based, where possible, culturally responsive and, most of all, actionable. These recommendations are a start. They represent steps built on the basic crisis system foundation that exists in Centre County. Some are more easily implemented, require current or redirected resources, and simple accountability measures. Others are more complex, require study for adaptation to Centre County, resource sharing and acquisition, and challenging data management for future assessment of effectiveness. Also, some involve regulatory and funding issues that exceed direct local control but involve active advocacy in the hope of influencing positive change.

Finally, the Task Force findings, on behalf of those individuals and families living with the wrenching, life limiting and life threatening impact of serious mental illness, as well as the confounding damage caused by implicit bias and racial inequity, provide a significant opportunity for Centre County to answer the question posed by Dr. Martin Luther King, Jr. “Life’s most persistent and urgent question is ‘what are you doing for others?’”

To this end, the Task Force included two implementation recommendations. Upon acceptance of the report and taking the first steps of identifying and assigning responsible parties, agencies or committees to pursue implementation by the Commissioners and the Council, the Task Force offers to convene a sub-group to follow up through quarterly meetings and offer additional assistance that may be needed in reviewing progress. The members of the Task Force appreciate the opportunity provided by the Centre County Commissioners and the State College Borough Council to contribute to this effort to enhance the crisis services system in Centre County.

> "It's not differences that divide us. It's our judgments about each other that do."
> Margaret Wheatley

TASK FORCE

A. History and Formation

The formation of the Task Force on Mental Health Crisis Services was born out of the tragic shooting death of Osaze Osagie on March 20, 2019, during a law enforcement response to a mental health 302 Warrant service and the subsequent community questions, concerns, and response. The County held a Mental Health public meeting on June 27, 2019, which was widely attended with many residents sharing personal, family, and professional experiences, concerns, and challenges with aspects of the mental health system. As a result, the Centre County Commissioners and the State College Borough Council jointly proposed involving the community in examining and enhancing the provision of mental health crisis services to prevent a violent outcome as a response to a person in need of help. Additional community response was sought to identify recommendations for enhancement and changes that would positively impact any individual seeking mental health crisis services.

The Task Force on Mental Health Crisis Services began its work in September, 2019, with the leadership of Dr. Billie Willits as chair. The 32 members represent a broad base of experience, knowledge, and expertise. They include those with personal lived experience with using the system, those whose professions provide direct mental health services and support, those in law enforcement, and those who educate, volunteer and advocate for mental health support from across the county. The full roster of Task Force members is below.

In January, 2020, Dr. Patricia Best was appointed to chair the Task Force, due to the untimely passing of Dr. Willits. A work plan was developed to analyze each of the four areas specified in the charge using small work groups and a Strengths, Gaps, Opportunities, Barriers organizing system, with a projected completion date of July, 2020. With the advent of COVID-19 restrictions, meetings were postponed until the work plan was revised, moved to a virtual platform, and resumed in May.

B. Task Force Roster

Title	First Name	Last Name	Agency/Position
Dr.	David	Brown	Community Member
Dr.	Jeanie	Burns	Bellefonte Area School District
Dr.	Tiffany	Cabibbo	Mount Nittany Health
Attorney	Bernie	Cantorna, Esq.	District Attorney, Centre County
Dr.	SeriaShia	Chatters-Smith	State College Area School District
Rev.	Carol Thomas	Cissell	Community Member
	Natalie	Corman	Centre County Government
	Mike	Danneker	Municipal Government/Law Enforcement
Dr.	Dan	Duffy	Community Member
	Laura	Gardner	Centre County Mental Health/Intellectual Disabilities/Early Intervention Advisory Board
	Michelle	Henry	Centre County Government
	Jeff	Hite	Corrections
	Darlene	Hoy	National Alliance on Mental Illness (NAMI) of Central PA
Chief	Tyler	Jolley	Municipal Law Enforcement
	Levent	Kaya	Centre County Mental Health/Intellectual Disabilities/Early Intervention Advisory Board
	Isak	Kim	Ph.D. Candidate, Counselor Education & Supervision, Penn State
	Thomas	King	Municipal Government
Chief	Kent	Knable	Emergency Medical Services
	Leslie	Laing	Community Member
Dr.	Benjamin	Locke	Penn State Counseling & Psychological Services (CAPS)
	Centrice	Martin	Community Member
Dr.	Nicole	Morgan	Community Member
Dr.	Brian	Newcomb	Mount Nittany Medical Center Emergency Department
Corporal	Derek	Pacella	State Law Enforcement
	Lexy	Pathickal	Penn State UPUA Student Body Vice President
	Angie	Roland	Pennsylvania Office of Mental Health and Substance Abuse Services
Dr.	Scott J.	Scotilla	Psychologist, Private Practice
	Tracy	Small	Crisis Intervention Team
Dr.	Elana	Szczesny	Penn State Counseling & Psychological Services (CAPS), Licensed Psychologist
	Marisa	Vicere	Jana Marie Foundation
	Nicole	Wade	PeerStar, LLC
Dr.	Patricia	Best	Task Force Chair

C. Charge

The charge to the Task Force is to recommend enhancements to, and identify strengths of, the mental health crisis delivery system in Centre County. The Task Force will examine the continuum of mental health crisis services, including:

a. Crisis intervention services (Mobile)

b. Delegate crisis services

c. Involuntary commitment warrant procedures

d. Police officers' role in responding to mental health calls and 302 warrant procedures

e. Emergency Department procedures

f. Post-Emergency Department services

WORK PROCESS

Consultant, James Fouts, LSW, of Forensic Systems Solutions, Family Training and Advocacy Center, was hired in October to assist in conducting a comprehensive review of mental health crisis services across the county and to produce a System Process Mapping. Task Force members assisted in identifying agencies and individuals to be interviewed and reviewed the question protocols.

Interviews were conducted from mid-December, 2019 through mid-February. 2020. Sixty interviews were conducted with stakeholders, individuals and family members, provider agency representatives, police departments, Pennsylvania State Police, 911 dispatchers, Centre County Correctional Facility, Mount Nittany Emergency Department, and Centre County MH/ID/EI/D&A. These results were summarized and provided to the Task Force in March, 2020 and used in its deliberations. The final report is found in Appendix A.

In June through August, the Task Force organized into a Core Group of ten members with two to three representatives from each of four small teams, i.e., Crisis Interventions Services (Mobile), Delegate Services, Law Enforcement, and Emergency Department. Each Task Force member was part of a small team. From June through August, meeting bi-weekly, each Core Group session focused on one of the four areas of the charge and a summary session. Small team members participated in their respective sessions; thereby, engaging the full Task Force.

Informational presentations by service providers introduced each work session. Presenters included Shanon Quick, the Director of the new Center for Community

Resources, (Crisis Intervention Services - Mobile) and Dan Tice, Director of Service Access & Management, Inc. (Delegate Services); task force members, Chief Tyler Jolley, Patton Township Police Department, District Attorney Bernie Cantorna (Law Enforcement); and, Dr. Tiffany Cabibbo and Dr. Brian Newcomb (Mount Nittany Emergency Department). Task Force members provided input via the SGOB worksheet. Resources also included the consultant's report, relevant research, professional standards, effective models/best practices, as well as pertinent laws and regulations, and the considerable experience and expertise of the Task Force members.

In September and October, deliberation focused on developing and fine tuning the recommendations. The Task Force affirmed its commitment to cultural responsiveness in its decision-making process. Task Force member Dr. Seria Chatters, facilitated the discussion of racial equity, cultural sensitivity and implicit bias, including the intersectionality of racial, ethnic, gender, sexual identity, socio-economic, and the full range of serious mental illnesses, as they impact access to and provision of mental health crisis services.

The Key Recommendations draft was presented during two virtual public meetings in October with over 100 participants (*Public meeting recordings are available at the Borough website). The Task Force was encouraged that most of the comments were in support of the draft recommendations and implementation. We reviewed all comments and noted some concerns beyond our charge; there is a short summary in Appendix C. This final report will be presented to the Centre County Commissioners and the State College Borough Council at a joint public meeting on November 10, 2020.

SECTION I: CURRENT DESCRIPTION OF THE SYSTEM

A. The Usage of the System

The following data points provide an overview of the use of the system in Centre County provided through Crisis Intervention (Mobile), Delegate Services, Law Enforcement, including CIT-trained responses, and the Emergency Department from January, 2020 through September, 2020.

1. Crisis Intervention (Mobile)

This table shows monthly mental health contacts to Center for Community Resources from January 2020 to September 2020.

	1-20	*2-20*	*3-20*	*4-20*	*5-20*	*6-20*	*7-20*	*8-20*	*9-20*	*Avg*
Initial Phone	917	953	776	816	919	939	161	1010	1155	938
Mobile	26	31	10	10	5	13	9	10	20	14
Walk-In	35	37	24	10	10	24	22	41	35	25

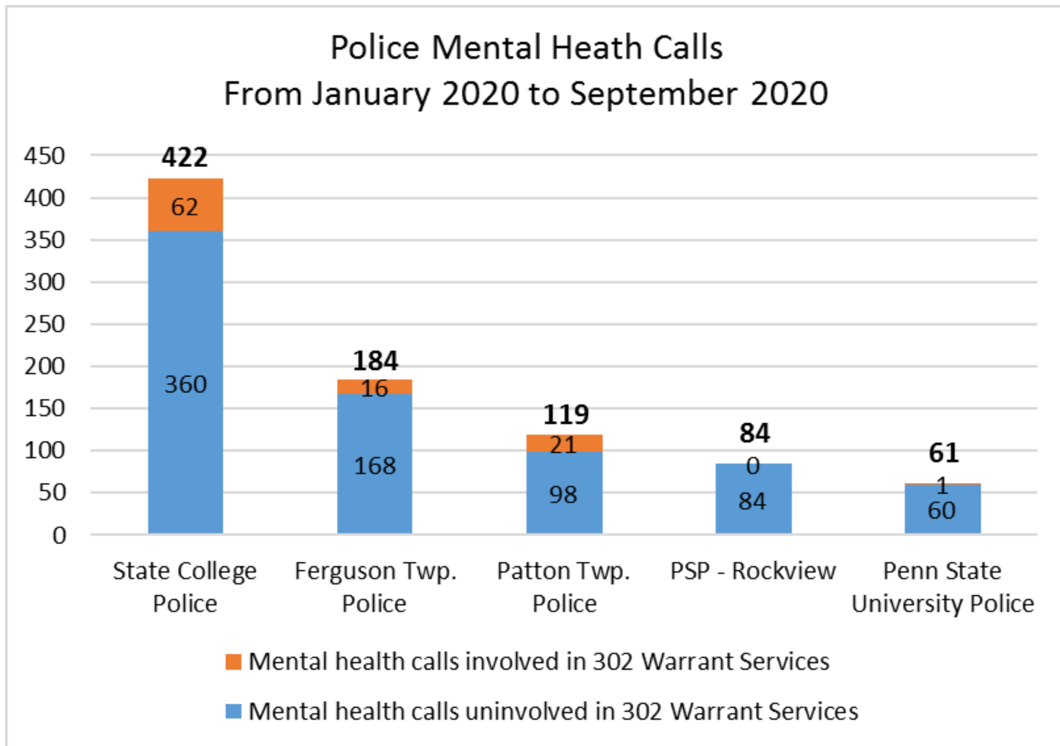
2. Delegate Services: Applications for 302 Warrants for Involuntary Emergency Examination and Treatment

This table shows quarterly applications for and dispositions of 302 Warrants from January 2020 to September 2020.

	1-20 ~ 3-20	*4-20 ~ 6-20*	*7-20 ~ 9-20*	*Total*
302 Applications Submitted	94	73	86	253
Total Number of Individuals	93	70	84	247
Approved 302s	52	43	44	139
Denied 302s (voluntary, outpatient, denied)	41	30	42	113

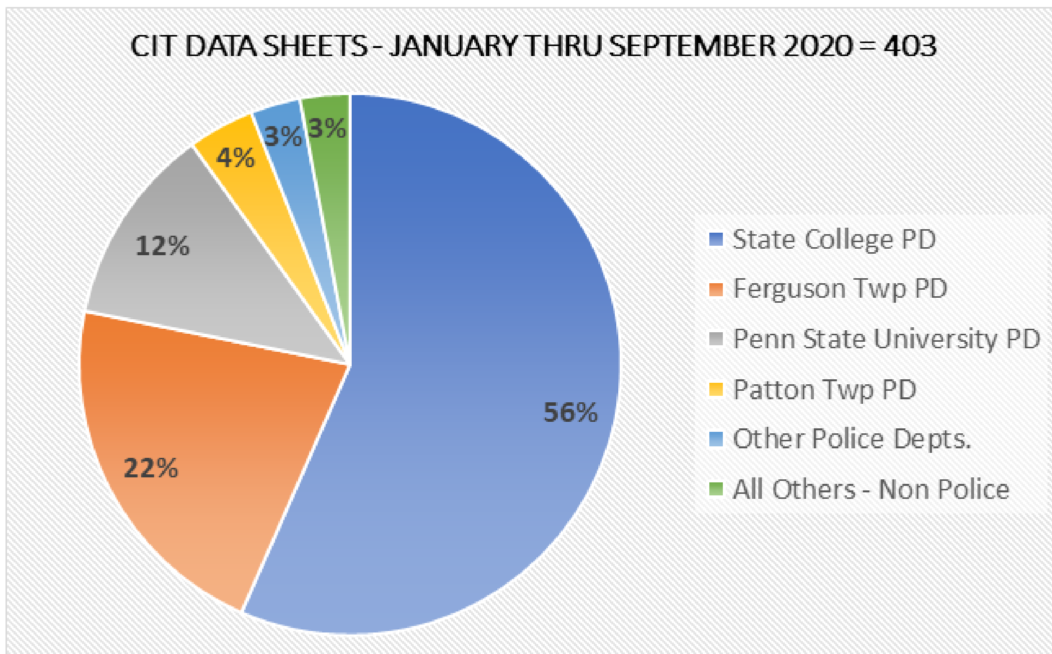
3. Law Enforcement

In the period from January to September 2020, the Police Departments of State College Borough, Ferguson Township, Patton Township, PSP-Rockview, and Penn State received the following mental health calls, some of which also involved 302 warrant service.

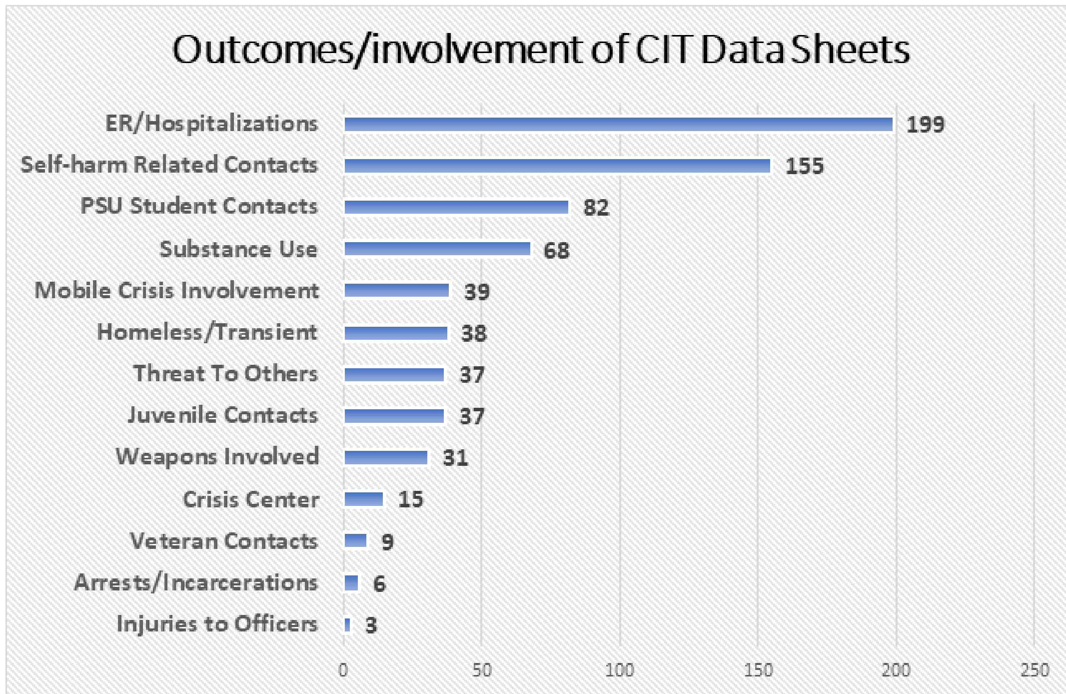


4. Crisis Intervention Team (CIT-trained officers)

This chart shows CIT data sheets reported by CIT-trained officers from January 2020 to September 2020.



This chart shows outcomes of the CIT data sheets from January 2020 to September 2020.



Note: Between January 2020 and September 2020, there were no injuries to persons receiving mental crisis services from CIT officers.

5. Centre County Correctional Facility

People diagnosed with mental illness are part of prison populations. This table shows monthly mental health patients housed in the Centre County Correctional Facility from the past year, September 2019 to September 2020.

Month-Year	*9-19*	*10-19*	*11-19*	*12-19*	*1-20*	*2-20*	*3-20*	*4-20*	*5-20*	*6-20*	*7-20*	*8-20*	*9-20*	*Avg*
ADP[a] *(Total)*	252	251	247	246	244	223	224	184	141	128	157	159	179	203
Psych Meds[b]	126	119	132	140	142	147	184	152	114	85	100	99	107	127
Active TRT[c]	96	139	122	128	112	119	118	91	83	79	88	101	135	109
SMI[d]	20	27	34	34	33	33	27	23	17	13	20	16	20	24

Note. a= Average Daily Population
b= Number of patients on psychiatric medications.
c= Patient is currently active in treatment with the mental health department (e.g., undergoing counseling, utilizing medication management services, and/or a having a history of suicide attempts or psychiatric hospitalizations in the past 2 years).
d= Patient has been diagnosed with a Serious Mental Illness (SMI) and/or exhibits significant adjustment/behavioral concerns.

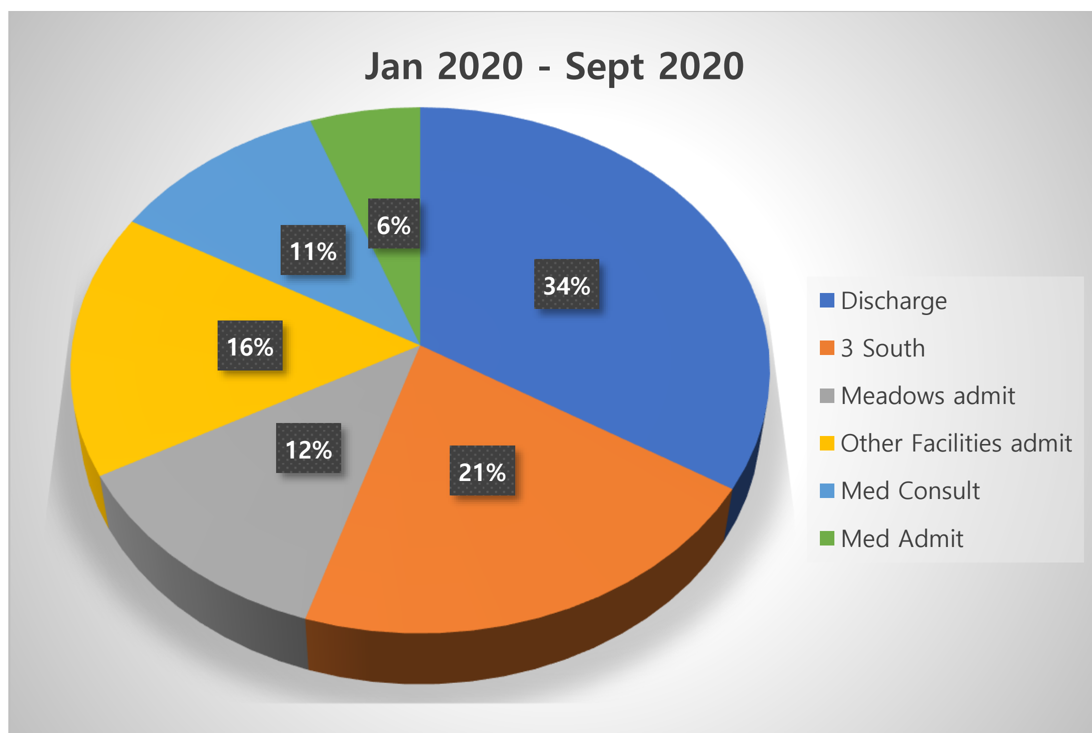
6. Emergency Department

This table shows the monthly mental health visits to the ED from January 2020 to September 2020.

Month-Year	*1-20*	*2-20*	*3-20*	*4-20*	*5-20*	*6-20*	*7-20*	*8-20*	*9-20*	*Avg*
Monthly Cases	157	187	132	82	103	120	143	124	152	133

Note. Reflects the impact of COVID-19.

This graphic shows the disposition of mental health clients visiting the ED from January 2020 to September 2020.



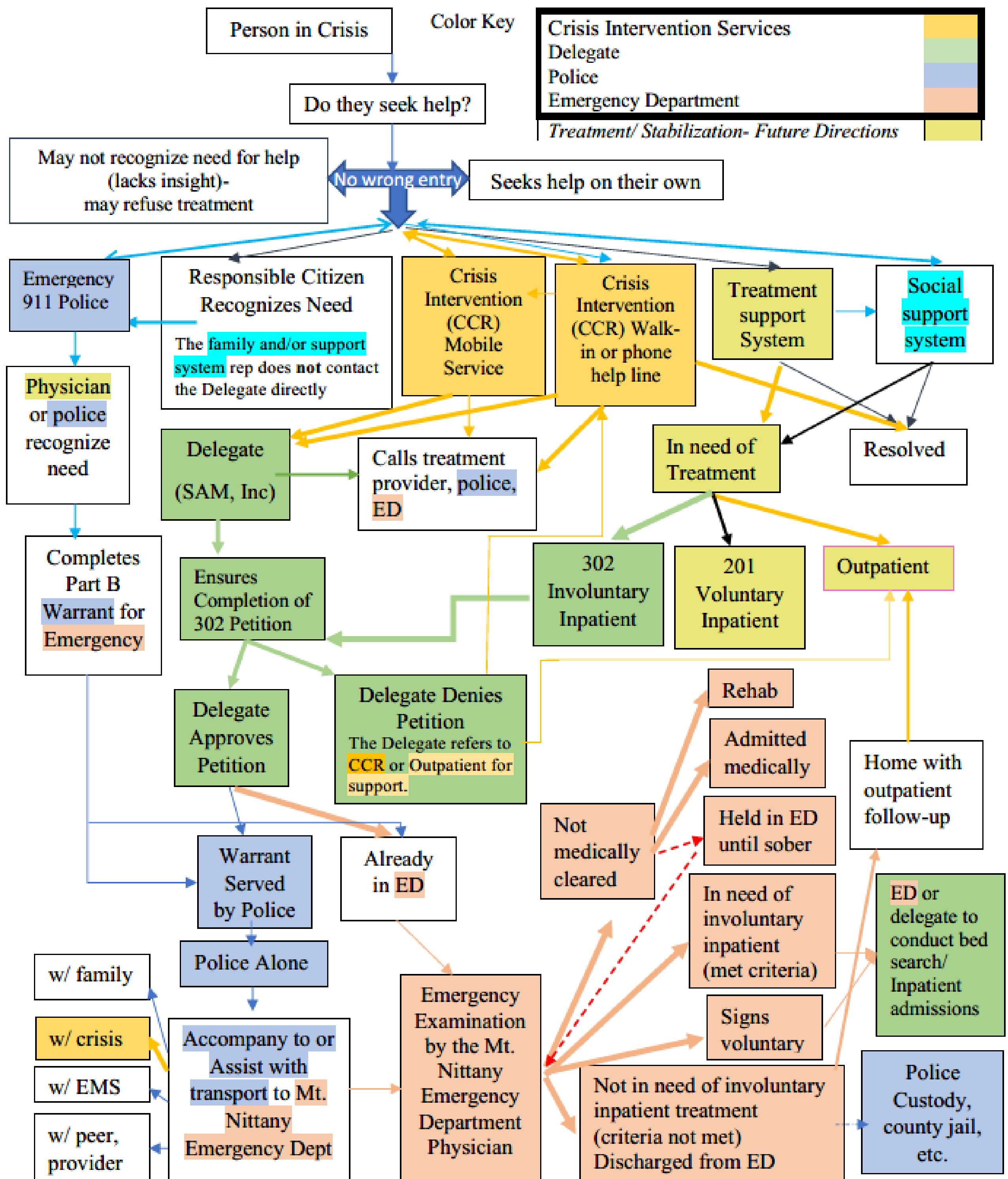
B. Process Mapping

The Task Force charge included examining the continuum of mental health crisis services, including Crisis Intervention Services (Mobile), Delegate Crisis Services and 302 Warrant Procedures, Police Officers' Role in responding to mental health calls and 302 Warrant Procedures, and Emergency Department Procedures and Post-Emergency Department Services.

The following process map is a graphic depiction from a point of entry to point of exit from the crisis system. This map was developed as a guide for the Task Force in describing and studying how the crisis system works and as a document to aid the elected officials, decision makers, service providers, and stakeholders illustrating the respective components of the system, functions, overlaps, and transitions.

The map is color-coded for the four services. The arrows indicate interactions. It is a complex system, with each part governed by regulations, policies, and procedures. It presents opportunities for increased communication, coordination, collaboration, and consistency to address the needs of those seeking care.

Continuum of Care – Crisis Services Process Mapping



Note. Crisis services are within the bold block.

C. Strengths Within the System

The Task Force identified existing strengths within the crisis response system. A significant strength of the current system is the dedication and client focus of the many individuals providing the wide variety of services within each part of the system. Anecdotal accounts described positive, supportive, caring interactions within all four areas. Centre County benefits from broad local expertise in many of the areas related to effective mental health crisis services, within the community and from Penn State.

Another strength is a good foundation for communication within the involved partners. Crisis intervention (Mobile), delegate services, law enforcement, and the emergency department have organized methods of communicating that can be enhanced significantly. These partners have also indicated their strong willingness to improve the system through expanding channels of communication and collaboration and formalizing structures to facilitate coordination.

Since 2011, police officers in Centre County are provided yearly Crisis Intervention Team (CIT) training. CIT is designed to promote collaboration between law enforcement personnel, the community mental health system, individual and family advocates, and other stakeholders to improve safety. Centre County has the highest percentage of CIT trained police officers in Pennsylvania at 95-97%. The system has also benefitted from regular training and education for personnel in each agency. Crisis services and delegates receive annual trainings in intervention, de-escalation, and crisis resolution. Law enforcement training includes crisis intervention, de-escalation, implicit bias, and special populations. Emergency department staffs are trained with non-violent crisis intervention and resolution.

The 2013 renovation of the Emergency Department at MNMC has provided improvements in space, privacy, security, and separation for caring for mental health patients. Case Managers are a part of the 24/7 staffing in the Emergency Department; they are currently cross-trained to provide care and support to mental health patients and facilitate follow up. In January, 2020, a new Centre County Crisis Intervention Service, the Center for Community Resources (CCR), providing 24/7/365 mental health crisis services. These include a walk-in center welcoming any resident/family/friend with mental health concerns to visit, talk with a provider, and use and access materials and resources. It is free and open to all. Services include a telephone Helpline and mobile services to visit a home, school, or other site at need. The CCR replaces the former CanHelp service of Universal Community Behavioral Health Corporation. Additional information for CCR can be found at https://ccrinfo.org.

D. Gaps and Opportunities Within the System

As part of the study, the Task Force reviewed the continuum and identified Gaps within the system. The consultant James Fouts' report was utilized, including the interview summaries. Information was provided by representatives of each of the four service areas in dedicated meetings with the Task Force. In addition, members provided their broad-based experience, knowledge, and expertise, as well as resource materials. A working chart was produced.

Flowing from the Gaps, but also extending possibilities, the Task Force, as a next step, identified Opportunities for enhancements to the system. From these two working documents, further study and discussion provided the basis for the formation of the Key Recommendations (See Appendix D for working charts).

E. Barriers Within the System

As part of this work, Barriers were also identified. These areas included lack of funding for mental health programming, recruitment and retention of licensed mental health professionals, lack of cultural diversity among service providers, data collecting and sharing, shortage of intensive outpatient services, shortage of inpatient beds, outdated mental health law (MHPA, 1976), and complications, restrictions, and unintended consequences of HIPAA compliance in coordinating individual care.

SECTION II: RECOMMENDATIONS FOR THE FUTURE SYSTEM

The Task Force worked to produce recommendations that are thorough, accurate, forthright, evidence-based, where possible, culturally responsive, and actionable. As we discussed, processed, and analyzed the crisis services system, six inter-related themes clearly emerged. They are **care, cultural responsiveness, communication, collaboration, coordination, and consistency**. These themes are embedded throughout these recommendations. They are not in a hierarchy; they are integral to the effective implementation of the Key Recommendations.

The Key Recommendations from the Task Force are divided into **three sections:**

A. Systemwide Key Recommendations 1-11

B. Separate Key Recommendations for Crisis Services (Mobile) and Delegate Services 12-14; Law Enforcement 15-18; and, Emergency Department 19

C. Implementation 20-21

Within these sections, the recommendations are grouped by **Coordination of Care; Coordination of Training, Education, and Data; and, Coordination of Advocacy.**

A. Systemwide Key Recommendations

Recommendation	Explanation	Supporting Information
Enhancements to Service Systems Through Coordination of Care		
1. Create a countywide co-responder model, involving a combination of law enforcement and mental health professionals OR a fully civilian mental health response unit for crisis engagement.	Mental health crisis co-responder programs have developed in communities to partner a mental health crisis professional with law enforcement in responding to calls involving a mental health concern. There are many variations on the programs adapted to community needs. OR Some communities have developed co-responder programs that pair mental health professionals and crisis workers to provide a first response through the 911 dispatch system, when it is deemed a police presence is not required.	CAHOOTS is one of the most well-known co-responder models across the nation. The Crisis Assistance Helping Out On The Streets program provides a unique response to non-violent situations. The (911) dispatcher is trained to route non-violent calls with a mental health crisis component to a team of a medic and a crisis worker to respond, assess, stabilize, and transport to the next step in treatment. https://whitebirdclinic.org/what-is-cahoots/

Recommendation	Explanation	Supporting Information
		Albuquerque and Bernalillo County partner in a co-responder mobile crisis team (MCT) model. A trained law enforcement officer and a trained master's level behavioral health clinician respond to calls in the 911 system. An officer in the field can call and request an MCT team. https://www.bernco.gov The Franklin County PA Mental Health Co-responder program provides for a mental health professional to accompany police officers on mental health crisis situations and was recognized for a Justice Public Safety Achievement Award in 2018 by the National Association of Counties. https://franklincountypa.gov/index.php?section=mental-health_coresponder
2. Form a Crisis Services Coordinating Committee (CSCC), with membership sufficiently inclusive that individuals and family members are represented in meaningful numbers to have a voice and meeting often enough to build trust, knowledge, and organizational effectiveness.	a. Encouraging community partnerships to strengthen the continuum of care for mental health and substance abuse services. b. Making recommendations related to data sharing to identify who, when, and where people in crisis are served and the results of those services, while protecting individual privacy. c. Creating a repository of evidence-based practices, providing technical assistance to providers and law enforcement on crisis response strategies. d. Promoting education and awareness of alternative	Recommendation from James Fouts, LSW, Forensic Systems Solutions, Consultant to the Task Force, as part of the final report 2020. (Appendix A Part 1): "The CSCC can periodically assess and make recommendations to the overall crisis system. The Committee would focus on identifying and implementing best known strategies for crisis care while reducing avoidable visits to emergency departments and involvement

Recommendation	Explanation	Supporting Information
	community crisis resources to the use of the emergency department. e. Advocating for policy and funding changes to help break down barriers associated with accessing care.	with the criminal justice system."
3. Enhance communication with families in need during crisis, including connecting with groups that specifically serve marginalized populations to integrate research-based practices and processes that improve communication to and among marginalized groups and increasing accessibility to mental health crisis resources for families/supporters of those in crisis.	Using data and best practices, assess the effectiveness of current methods of communicating with families in crisis across all groups and develop strategies that employ cultural responsiveness in differentiating approaches where indicated to increase accessibility for vulnerable and underrepresented groups.	Examining our communication approaches with families in a culturally responsive way increases understanding of beliefs, values, perceptions, and attitudes that impact seeking and responding to treatment, especially mental health treatment.
4. Enhance current communication/collaboration among these four internal entities in the mental health crisis response system by establishing a formal, quarterly meeting of **Centre County Mental Health/Intellectual Disabilities/Early Intervention/Drug & Alcohol** (MH/ID/EI/D&A), **Crisis Intervention** (Center for Community Resources), **Delegate services** (Service Access Management, Inc.), **Law Enforcement, and Mount Nittany Medical Center Emergency Department** (ED case manager and Behavioral	a. Coordinating services where possible. b. Capitalizing on resource allocations, grants, funding opportunities. c. Sharing data on effective practices/processes/intake tools and forms. d. Standardizing forms where appropriate to improve intake processes by more consistency of information to providers, less repetition for client/families, and shared records by involved providers, where appropriate and permitted.	Elevate the purpose of this ongoing committee to include primary responsibility for the tasks described in this recommendation by the Task Force and other related areas as assigned with a goal of strengthening working relationships across the system.

Recommendation	Explanation	Supporting Information
Health inpatient case manager).		
5. Create standardized protocols, Best Practices in Mental Health Crisis Intervention, across the larger system, including 911 dispatch, Crisis Intervention (CCR), Delegate services (SAM, Inc.), mental health transport provider(s), Centre County MH/ID/EI/D&A, Law Enforcement, MNMC Emergency Department, and the Meadows.	Expand the cooperative work to include those involved in parts of the larger crisis system to explore standardized protocols to increase effective practices and efficient procedures.	Review best practice professional standards for opportunities to standardize and coordinate protocols. Substance Abuse and Mental Health Services Administration (SAMHSA), US Dept. of Health and Human Services. National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. 2020 https://www.samhsa.gov
6. Develop and implement a countywide transportation plan for those in mental health crisis to assist with transportation to receive crisis services.	There is a significant gap in the availability of transportation to treatment centers unless a medical situation requires an ambulance, or police are involved, or the mobile crisis unit from CCR. This is compounded for those in poverty or isolated rural areas.	The geographic size of the county, the location of mental health crisis services, and lack of a transportation system restrict accessibility to individuals and families.
7. Identify and develop additional community resources available for those not held for mental health treatment, including those who refuse inpatient services.	Centre County has a basic network of community resources. As mental health needs have grown, resources and outpatient providers have diminished causing delays in access to services. In addition, the following areas could be explored: Stabilization and Assessment Centers, Recovery Response Centers, LEAP (listen-empathize-agree-partner) Training, Early Psychosis Programming	Mental Health Services in Centre County: A Guide to Mental Health Services and Support (Purple Book), 2020 http;//centrecountypa.gov Additional recommendations from the consultant's report, 2020.(Appendix A Part 1), should be included for further consideration and possible future implementation. SAMHSA: National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit, 2020 LEAP Institute. Dr. Xavier Amador, Ph.D.

Recommendation	Explanation	Supporting Information
		https://www.LEAPInstitute.org
Enhancements to Service Systems Through Training, Education, and Data Collection		
8. Create and implement a plan for common/shared trainings, where appropriate, across agencies/departments involved in the crisis response system.	a. Develop a common language and definitions for communication. b. Include cultural sensitivity, mental health manifestations, regulatory and procedural knowledge, intersectionality, de-escalation, and intervention strategies.	Shared trainings enhance communication, understanding, and opportunities for collaboration across agencies charged with varying responsibilities in the crisis system.
9. Build a data collection, repository, and sharing system to be used for evaluating the effectiveness of the current system, while observing required and ethical privacy practices.	a. Census data b. Sociodemographic characteristics c. Triggers of crisis patterns d. Pre-existing mental health conditions and episodes e. Advanced directives f. Arrest records g. Mortality h. ED visits/duration i. Distance to inpatient beds	The Health Insurance Portability and Accountability Act (HIPAA) of 1976, the Privacy Rule (2000), is "to assure an individual's health information is properly protected, while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being." It does permit certain important uses of the information that could assist in this recommendation. (See Summary of the HIPAA Privacy Rule, US Dept. of Health and Human Services.) http://www.hhs.gov
Enhancements to Service Systems Through Advocacy		
10. Identify limitations or barriers and advocate for updating of the PA Mental Health Procedures Act (MHPA, 1976).	Examine trusted professional reports for analyses and recommendations, e.g., Grading the States: An Analysis of U.S. Psychiatric Treatment Laws by the Treatment Advocacy Center, which includes Pennsylvania recommendations re: extended timelines for involuntary	Grading the States: An Analysis of U.S. Psychiatric Treatment Laws, Treatment Advocacy Center, 2020. https://www.treatmentadvocacycenter.org

Recommendation	Explanation	Supporting Information
	commitments; changing language and clearer guidance for practitioners, law enforcement, and families; expand criteria for danger to self and danger to others, grave disability and psychiatric deterioration.	
11. Advocate for increased state/local funding for additional adult and adolescent inpatient hospital beds, including co-occurring substance abuse and serious mental illness (SMI).	MNMC has 12 inpatient beds for patients 18 and over; the Meadows has 119 total beds serving patients 4 and over in various units. There are 7 beds reserved for Centre County in the state hospital in Danville. 1200 patients made mental health visits to MNMC ED in 2020; approximately 2/3 were admitted. 16% of those admissions were out of the area. The population of Centre County is 162,000.	When there is no availability locally, a bed search is conducted across the state to find a space, requiring distance transportation for patients, restricted family support, and out-of-county providers less familiar with local follow-up supports.

B. Separate Key Recommendations

Recommendation	Explanation	Supporting Information
Crisis Intervention (Mobile) and Delegate Services ***Enhancement Through Coordination of Care and Training***		
12. Develop and implement practices assuring all relevant individual information is consistently identified, gathered, organized, and communicated to involved Law Enforcement and Emergency Department personnel.	Both providers are new to the Centre County crisis system in 2020. To increase communication and collaboration, these recommendations address reviewing these three areas after this first year of serving Centre County for adjustments and enhancements. While these are addressed to these two services, they are essential building blocks for the overall systemwide effort.	Centre County MH/ID/EI/D&A will work with current contracted providers of crisis intervention and delegate services, Center for Community Resources and Services Access Management, Inc. on these three recommendations.

Recommendation	Explanation	Supporting Information
13. Review and assure that all assessment tools, interview protocols, and practices reflect cultural responsiveness and are evidence-based.	CCR relies on a set of standardized screening measures: C-SSRS[1], NSPL[2], ACEs[3], PHQ9[4], GAD-7[5], CANS[6], and ANSA[7]. These are used to assist in providing information relevant to achieving the prevention and support goals of programs accessed or delivered through CCR.	The assessment tools currently in use appear to have an empirical basis and are evidence based for screening purposes. The degree to which these published assessment materials meet the requirements for cultural responsiveness is still to be determined. Further study is needed regarding the validity and cultural responsiveness of the interview protocols and practices in use.
14. Enhance required implicit bias training and periodic follow up for all Crisis Intervention and Delegate Services personnel.	Training should include components related to diversity and cultural competence. Training should acknowledge the need for different norms that can correct for under diagnosis or under recognition of problems or disability among certain individuals, such as people of color.	The assessment systems also need to incorporate recognition of background information or insights from those who know the individual well, helping to explain deviation from normal or typical coping behavior.
Law Enforcement ***Enhancement Through Coordination of Care and Training***		
15. Enhance the newly implemented jail diversion program and services, including supporting the creation of a mental health court in Centre County.	The goal of the Behavioral and Mental Health Diversionary program is to identify persons with serious mental illnesses who are involved with the criminal justice system and redirect them from traditional criminal justice pathways to mental health treatment systems; thereby, reducing police contact and recidivism. By successfully completing the program, individuals avoid the	Centre County Behavioral and Mental Health Diversionary Program (BMHD). 2020 Developed by the Centre County District Attorney's Office through feedback and input by the Centre County Court, Centre County Probation and Parole, and Centre County Defense Bar. Twenty-three counties have mental health courts in PA that

[1] Columbia Suicide Severity Rating Scale (C-SSRS)

[2] National Suicide Prevention Lifeline (NSPL) Suicide Risk Assessment

[3] Adverse Childhood Experiences (ACEs) screening tool for children and adolescents

[4] Patient Health Questionnaire (PHQ-9) to assess depression

[5] Generalized Anxiety Disorder Scale (GAD-7)

[6] Child and Adolescent Needs and Strengths Assessment (CANS)

[7] The Adult Needs and Strengths Assessment (ANSA)

Recommendation	Explanation	Supporting Information
	negative consequences that criminal records can have when they reenter society and the workplace. Mental health courts provide a team of court staff and mental health professionals to screen/assess defendants, develop treatment plans, and supervise offenders. Tracking results will assess its effectiveness over time.	partner key justice system officials with mental health system leaders to divert offenders with severe mental illness into a judicially supervised program that includes community-based treatment. https://www.pacourts.us
16. Enhance law enforcement training in mental health.	a. Continuing Crisis Intervention Team (CIT) training b. Mental health law (302s) c. Cultural competency d. Implicit bias e. Response to special populations f. Available mental health resources g. De-escalation and crisis intervention	97% of Centre County police are trained in CIT. This is the largest percentage of any county in PA. (Consultant's report) It provides 40 hours of training in crisis techniques, de-escalation, and special populations. CIT includes an annual reinforcement component. Trainings in the mentioned areas are included in current programs; the recommendation is to continue and to build upon this strong base.
17. Support the full adoption of the Mental Health Crisis Best Practices Guide for Law Enforcement developed through the District Attorney's Office in July 2020.	The guideline aids Centre County law enforcement and mental health services in recognition and response to persons undergoing and dealing with mental illness and/or an emotional or behavioral crisis. In these situations, individuals are often in a fearful state and have difficulty processing information during contacts with police officers.	Developed by the Centre County District Attorney's Office through cooperation with Centre County Mental Health Services, Centre County Law Enforcement and First Responder Agencies. National Guidelines for Behavioral Health Crisis Care Response Best Practice Toolkit, SAMHSA, 2020.
18. Work with 911/Emergency Communications to develop policies and a procedure, including specific criteria to aid	Crisis responses often begin with a call to 911. Having the right service response to the right location with the right resources and information is a goal of the dispatch center.	There are programs that have specially trained their dispatchers to determine if a call is a safety issue or a support issue, e.g., Binghamton, NY,

Recommendation	Explanation	Supporting Information
911 dispatchers to divert appropriate calls from police to mental health services for first response.	When dispatching services, it is the policy to dispatch police along with any other service.	Broome County, NY Emergency Dispatch/911 Center.
MNMC Emergency Department ***Enhancements Through Coordination of Care***		
19. Enhance Mount Nittany Medical Center Emergency Department and other hospital services care, management and processes for mental health crisis patient response and overall care by creating the Behavioral Health Interdisciplinary Committee. The internal committee will consist minimally of the ED physician, psychiatrist, ED case manager, Manager, Emergency Department, and Manager, Behavioral Health. An internal or external consulting liaison member will provide resources on inclusivity and cultural responsiveness.	a. Identifying and adopting inclusive and evidence-based practices to enhance positive patient outcomes. b. Enhancing two-way communication with families. c. Conducting internal clinical case reviews and data collection, relative to diagnosis and determination, to seek opportunities to improve practice. d. Exploring evidence-based processes, technologies (i.e. telemedicine), and protocols e. Identifying and reviewing data to assess the effectiveness of the ED's mental health crisis response system. f. Assessing ongoing education and professional development needs to include, but not limited to, mental health crisis diagnosis and response, crisis intervention and de-escalation, cultural sensitivity, implicit bias, inclusivity, special populations, substance abuse, serious mental illness (SMI), HIPAA applications, 302 regulations/decisions. g. Reviewing policies and procedures, e.g. develop a consistent intake process and HIPAA compliant feedback loop for police bringing a person in crisis to the ED, as well as family/others. h. Reviewing and implementing applicable	Joint State Government Commission, PA General Assembly, July, 2020 "Report Summary in Response to House Resolution 268 of 2019 Behavioral Health Care System Capacity in Pennsylvania and Its Impact on Hospital Emergency Departments and Patient Health." http://jsg.legis.state.pa.us/ This committee will bring together in a formalized process those responsible for interactions with patients and families entering the mental health crisis system through the Emergency Department and will focus on further development, coordination, and consultation in those areas identified. In addition, outreach to law enforcement for standardizing protocols for Emergency Department visits with mental health related situations.

Recommendation	Explanation	Supporting Information
	recommendations in the PA General Assembly's Joint State Government Commission Report, released in July 2020.	

C. Implementation Plan

Recommendation	Explanation	Supporting Information
20. Create an implementation plan by operationalizing the Task Force recommendations.	a. Identifying and assigning responsibility for action b. Meeting with partners to hand off recommendations c. Developing action plans and timelines for implementation. d. Estimating resources needed (staff, equipment, space) and possible sources. e. Monitoring progress through data and metrics. f. Establishing a strategy for reporting progress and effective results of implementation.	To expedite the beginning of examination and action on the Task Force recommendations, the Centre County Commissioners, and the State College Borough Council, upon reception of the report can design plans around the organizing steps.
21. Form a core subgroup of the Mental Health Crisis System Task Force that will meet quarterly, beginning in January 2021, to review progress made and data on the recommendations provided by the various responsible entities.	a. Define membership b. Develop charge c. Review reporting mechanisms from responsible entities d. Provide background to implementation teams as needed.	The Task Force can provide another voice of support for the implementation of the enhancements to the Centre County Mental Health Crisis System.

CONCLUSION

"**Ask what's possible. Not what's wrong. Keep asking**." Margaret Wheatley

If implementation is successful, the Task Force believes the recommendations submitted in this document will serve to enhance and expand services provided through the mental health crisis delivery system in Centre County. It is our belief that these key recommendations build on the strong, basic foundation of the many services provided to Centre County residents and will provide the next urgent steps in enhancing the prevention, intervention, recovery continuum of the overall mental health system.

The urgency lies in the current state of mental health needs, which is outpacing the availability and accessibility of those services that we do have. Recruiting and retaining workers at all levels of the system is challenging. Funding for programming is limited, leading to closing or loss of outpatient service providers. Local inpatient beds are limited. Wait times for appointments for psychiatrists and psychologists can be weeks. Training must keep pace with emerging understanding of the many facets of serious mental illness, implicit bias, and racial inequity as they differentially impact effective treatment and interactions with law enforcement and the court system. Laws governing aspects of treatment (MHPA and HIPAA) must be re-examined and updated to address unintended consequences.

If we truly desire more positive outcomes for those receiving crisis services, we will continue asking the assigned responsible parties, agencies and committees to answer the following questions as part of their continuous quality improvements; what are we doing for all those who seek assistance through our systemwide crisis intervention resources during their most vulnerable times? How are we assisting their families and supporting those who love, care, and entrust them to our crisis service providers? In what ways are our services inclusive and representative of the diversity of individuals accessing our services? How are we proactively and creatively adapting to the diversity of needs on behalf of those who cannot effectively advocate for themselves? What are we doing through training and education to support those providing direct crisis service care to meet their responsibilities?

Together, we believe our community and our service providers can work effectively to both advocate and deliver excellent care during a myriad of challenges in the upcoming year. It will be one important step at a time.

“**Real change. Enduring change happens one step at a time**.” Ruth Bader Ginsburg

“With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care. Extremely valuable psychiatric inpatient assets are over-burdened with referrals that might be best supported with less intrusive, less expensive services and supports. In too many communities, the “crisis system” has been unofficially handed over to law enforcement, sometimes with devastating outcomes. The current approach to crisis care is patchwork and delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks: resulting in multiple hospitals readmissions, life in the criminal justice system, homelessness, early death and even suicide.”

National Guidelines for Crisis Care, SAMHSA, US DHH, 2020

DEFINITIONS

302 Warrant – Legal means by which an individual may be involuntarily committed to a psychiatric institution for evaluation and treatment. Issued by designated mental health professionals upon submission of a petition attesting to the behavior or crisis that the individual is undergoing.

302(b) – provision allowing law enforcement officers or physicians to take an individual into custody for transportation to a psychiatric facility for evaluation and treatment. Must be based upon personal observations by the officer or physician of the individual's behavior and mental health crisis.

Center for Community Resources (CCR) – organization offering Centre County Crisis Intervention Services, including crisis assessment services and diversion from emergency rooms for individual experiencing a crisis, yet not requiring medical treatment or security. Provides counseling, referrals, and specialists for mental health and behavioral health needs through a Walk-In Center, a telephone Helpline, and a Mobile Team to come to a home, schools, or other site. Services are available 24/7/365 at no charge.

Crisis Intervention Team (CIT) – qualified first responders, law enforcement officers, and mental health professionals who have been trained in CIT crisis resolution, de-escalation training, and knowledge of community-based resources.

Emergency Department (ED) – department of medical facility to which an individual experiencing mental health crisis may be taken for evaluation and services. In Centre County, the Mount Nittany Medical Center (MNMC) Emergency Department is most frequently utilized.

Delegate Services – responds to calls for mental health emergency or crises and has the ability to coordinate an individual's mental health needs. Used for petitions regarding involuntary hospitalization (302 warrants); contracted through **SAM Inc**. in Centre County.

Mental Health Professionals/Mental Health Workers – licensed and/or certified providers of mental health and behavioral health services, such as Centre County MH/ID/EI, Center for Community Resources, hospitals, and staff.

Mental Health Care Providers – include those persons designated as an individual's mental health decision maker or caretaker, such as family, nursing staff, support persons.

Serious Mental Illness – SMI is a diagnosable mental, behavioral, or emotional disorder than an adult has experienced in the past year that causes serious functional impairment that substantially interferes with or limits at least one major like

activity. Examples include schizophrenia, bipolar disorder, and major depression, as well as the disorders that cause serious functional impairment.

Mental Health Procedures Act (MHPA) – Pennsylvania statute providing for mental health procedures and provisions within the Commonwealth (codified at 50 P. S. §

§ 7101 - 7503). Most recently amended (updated) in October 2018 through Act 106.

MH/ID/EA Base Services Unit – Centre County Mental Health's early intervention program/unit responsible for coordinating mental health crises and services for law enforcement and mental health professionals dealing with early intervention or emergency crisis situation.

Mobile Crisis Worker – provides crisis intervention, assessments, and support for emergency mental health screenings.

Service Access & Management, Inc. (SAM) – service provider offering case management and human services. Provides coordination services for veterans and those experiencing a mental health crisis, also provides emergency services.

Intersectionality – exposing [one's] multiple identities can help clarify the ways in which a person can simultaneously experience privilege and oppression, e.g., race, gender, age, mental illness intersections produce distinct life experiences in various combinations.

Implicit Bias – also known as unconscious or hidden bias, implicit biases are negative associations that people unknowingly hold.

Marginalized Groups – also known as vulnerable populations, oppressed populations, underrepresented populations, or undercounted populations in community indicators and recommendations.

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APPENDICES A-D

APPENDIX A: FSS Consultant Report – James Fouts, LSW

Part 1. Centre County Crisis System Reformation Recommendations

Part 2. Mental Health Task Force Descriptive Report on the Centre County Crisis Intervention System

Centre County Crisis System Reformation Recommendations

In 2019 Centre County created a Task Force on Mental Health Crisis Services to: "conduct a comprehensive review of mental health crisis services across the County and to produce a detailed description of this crisis system along with recommendations to enhance and strengthen crisis services in Centre County for individuals with mental illness."

Centre County contracted with Forensic System Solutions (FSS) to work with the Task Force to develop a System Process Mapping. That report was submitted in April of 2020. Due to the COVID-19 further meetings were hampered. As part of that Report FSS staff has created the following list of recommendations to be explored by the Task Force. These recommendations are based on several factors including the rural nature of Centre County, the presence of Pennsylvania State University, already existing services and resources, and the unique Crisis Intervention Team model.

In February of 2020 the Substance Abuse and Mental Health Services Administration (SAMHSA) released the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. We've attempted to follow the Toolkit recommendations as much as possible given the unique setup of the Commonwealth of Pennsylvania's process of requiring only minimal standards of services and counties deciding individually to add additional services.

Essential Principles

A. The effectiveness of a comprehensive crisis system is dependent on the outpatient system of treatment. An easily accessible, all-inclusive system that meets the needs of those in recovery affects the inflow and the outflow from the crisis system. A strong outpatient system of care will assist in preventing crises, provide a source of diversion from more restrictive settings and be a reliable source of aftercare treatment. Without a strong system of case management and treatment services you can expect to have a higher level of need for crisis services, higher contact with law enforcement and the criminal justice system, and longer inpatient stays.

   There must be a meaningful effort to promote these services in the community, especially to Consumers, Families, Police, other Criminal Justice Agencies, Crisis Intervention, and Emergency Rooms.

B. Peer and family member input is essential. The model of “Nothing About Us Without Us” is an effective force in creating an all-inclusive recovery-oriented system. It can lead to a powerful force in the fight against stigma and advocacy for adequate funding and resources. The recovery model has 2 primary premises.

   a. Recovery from a Mental illness is possible.

   b. That recovery becomes most effective when directed by the person in recovery.

C. Trauma is a huge factor in the lives of those in recovery. A system that understands and takes into account the effects of trauma in the lives of those it serves will see much better outcomes.

D. Crisis services must be more than an assessment for hospitalization. The S.A.L.T.S. model has been very helpful in strengthening that recovery model in Crisis Services. Stabilizing and deescalating the heightened emotions of the situation allows for more a deliberate and strategic approach to dealing with the crisis. Assessing the strengths and needs of the person in crisis then allows for the development of a plan for the resolution. Linking the person up with an appropriate level of service to assist them in their recovery is the next step. Teaching the person in crisis coping skills, resource procurement and self-advocacy skills allows them to maintain their progress towards recovery. Leaving individuals with a Safety plan helps prepare them for dealing with the next crisis.

Centre County should develop a Crisis Services Coordinating Committee that can periodically assess and make recommendations to the Crisis system. The Committee would focus on identifying and implementing best known strategies for crisis care while reducing avoidable visits to emergency departments and involvement with the criminal justice system. This includes:

- Recommending and establishing community partnerships to strengthen the continuum of care for mental health and substance abuse services.
- Promoting education and awareness of alternative community resources to the use of emergency departments.
- Making recommendations related to data sharing to help identify who, when and where people in crisis are served, and what the results of those services are.
- Creating a repository of evidence-based practices and providing technical assistance to Local Management Entities-Managed Care Organizations (LME/MCOs), law enforcement and providers on how to respond to crisis scenarios.
- Recommending legislative, policy and funding changes to help break down barriers associated with accessing care.
- Membership on this Crisis Service Coordinating Committee must be sufficiently inclusive to assure Consumers and Family Members are represented in meaningful numbers so as not to be overwhelmed by those

"professionals" who might have pre-ordained ideas of how the system should be organized and managed.

- Meetings should be frequent at the outset to build trust and mutual understanding of the issues at hand, with the potential of reducing frequency as the group gels and the initial needs are reasonably addressed.

Service Components of a best or promising model of Crisis Intervention

911 Emergency Dispatch - Most crisis responses begin with a call to either 911 or the Crisis Hotline. Having the right service respond to the right location with the right resources is a goal of the 911 Dispatch Center. When dispatching services, it's the policy of the 911 center to dispatch Police along with any other service. For most calls related to a mental health crisis Police are not really required.

In most cases a telephone conversation with a crisis worker can resolve or at least stabilize the crisis until other resources can get there. If the dispatcher believes the call is more appropriate for a referral to crisis, they give the caller the crisis number, tell them to call and end the call.

There are programs around the country that have specially trained their Dispatchers to determine if a call is a safety issue or a support issue. They have the ability to directly transfer a call to Crisis and hold on to the call until Crisis triages and determines the situation as not needing Police dispatch.

> "When a call goes into the Emergency Communication Center—911 dispatch—operators can be trained to triage those calls and identify whether the person in crisis is a danger to her or himself or an immediate threat to someone else. If not, then the person can be passed along to appropriate care in the mental health crisis system through a warm handoff to the crisis line. At that point, says Bruno, the crisis line can also do a secondary triage and determine whether it's still a safe situation. If they decide that it's unsafe, Bruno says they can do a warm handoff back to law enforcement, and law enforcement can send out Crisis Intervention Team (CIT) trained officers to go out and respond to those situations. " (CIT P. 114)

(Broome County, New York Emergency Dispatch/911 Center, 153 Lt Vanwinkle Dr, Binghamton, NY 13905, Phone: (607) 778-2170)

Warmline – Warmlines are a telephone line that People can call to talk to someone with lived experience with behavioral health issues. They are support lines operated by trained Peer specialists that are volunteers or paid staff. The Warmline is strength based, recovery oriented and trauma informed. Warmlines assist people in achieving their recovery goals. They are not suicide hotlines but can be part of the Crisis Hotline structure. The Warmline should be able to provide and receive warm handoffs to and from the crisis hotline and can collaborate with crisis hotline staff. Typically, they have limited hours.

Warmlines can assist the crisis system in dealing with those callers needing basic support and to talk through things rather than be in a major crisis. Some consumers are afraid to call Crisis due to the fear of being 302'd or are looking for support and

not assessment for hospitalization.   See So You Want to Start a Peer-Run Warmline? In the resource list.

Mobile – Mobile Crisis Intervention Teams describe a variety of services that provide crisis services wherever they are needed. There are several variants differing in team makeup or focus. Typically, there are two members on the team. One is a member trained in mental health and crisis intervention. Additionally, there can be a peer specialist, an emergency medical service professional, law enforcement officer or registered nurse with the backup of a virtually connected psychiatrist as a member of the team.

Team Variations –

CIT - Centre County has a very active and large mandatory attendance CIT trained Police Force. Although this is a positive in most cases, especially since the 911 dispatch system automatically sends Police to all calls for service, not all CIT trained officers have the prerequisite compassion, empathy, communication skills, and patience required for crisis intervention.

Most consumers and citizens are anxious around Police Officers. This can escalate the anxiety and crisis situation the person is in. I believe everyone in the crisis situation would like to limit Police involvement as much as possible.

Police involvement is required to serve a legally valid 302 warrant, to deal with situations that are potentially violent or have other safety risks involved. Other than these situations most crisis situations can be dealt with by a supportive telephone call or crisis team visit. Specialty training is needed for both 911 Dispatch operators equipped with warm handoff capabilities as described above Crisis Hotline workers. This training will allow both to assess for safety risks and can allow for referrals to the Mobile Teams to deal with the Crises more effectively without the aid of Police. Due to the rural nature of Centre County and the potential longer response times for Mobile Crisis Services, hotline workers must be able to provide telephone de-escalation and support services. If it's felt that the additional wait time will escalate the situation a CIT officer can be called to respond.

24/7 Mobile Team hybrids to explore:

Virtual Mobile Crisis Intervention: This is a Police response used when mobile crisis units are not readily available or after a crisis is de-escalated. Police are equipped with iPads that can connect the person in crisis to a trained crisis intervention worker located at the hotline. The crisis worker can communicate with the Police Officer and the person in crisis providing de-escalation, assessment, and disposition plans.

(New Perspectives Crisis Services, Snydersville, Pa. (570) 992-0879.)
https://www.rhd.org/program/new-perspectives-crisis-residence/
(Jim Thorpe, Pa Police Department (570) 325-9111)

CAHOOTS (Crisis Assistance Helping Out On The Streets): A Crisis Intervention program out of Eugene, Oregon. (911) "Dispatchers are trained to recognize non-violent situations with a behavioral health component and route those calls to CAHOOTS. A (mobile crisis) team will respond, assess the situation and provide

immediate stabilization in case of urgent medical need or psychological crisis, assessment, information, referral, advocacy, and, when warranted, transportation to the next step in treatment.” https://whitebirdclinic.org/what-is-cahoots/

Medical Mobile Crisis- This team utilizes the services of a registered nurse and a masters prepared crisis worker with the ability for immediate consultation with a psychiatrist. The psychiatrist can interview the person in crisis, make recommendations and give verbal orders for prescribing medications. The team can transport the person to the pharmacy to pick up their medications. The RN could also discuss side effects or other minor medical issues with the person rather than transporting them to the ER.

(See PA Crisis Intervention Regulations 5240.104 Subchapter E for Medical Mobile Program Description)

Acute Case Management – Short term wrap around type services provided to a person in crisis and their family post crisis incident. The service further assesses the needs, links with needed services, and provides for support and assistance in accessing basic needs. This service can be accessed through an Assertive Community Treatment Team (ACT) or a follow up crisis service. (Philadelphia Children’s Crisis Response Center https://www.philachildrenscrc.com/)

Stabilization and Assessment Centers (SAC)- The SAC are facilities whose general purpose is to stabilize and assess a person in crisis when their needs are of a more acute nature than hotline or mobile interventions can provide. Some are collocated with other Crisis Intervention Services and some are collocated with a hospital emergency room.

23 Hour bed - 23-hour crisis stabilization provides ongoing assessment (beyond the initial emergency psychiatric evaluation), intervention, and clinical determination for level of care. 23-hour crisis stabilization is appropriate for individuals requiring further intervention before a level of care determination can be made, particularly those who present as suicidal or psychotic secondary to substance use, as well as those whose initial clinical presentation suggests that medical necessity for another level of care will emerge via brief treatment. 23-hour crisis stabilization aims to provide one or more of the following:

- Amelioration of condition
- Resolution of acute intoxication
- Further diagnostic testing such as a urine drug screen, lab tests, and monitoring for the emergence of withdrawal symptoms
- Collateral information gathering to clarify history, assess level of support, determine access to safe housing, corroborate the individual’s report regarding precipitating events and to help engage in treatment
- Provision of medication or other clinical intervention and monitoring of response
- Level of care determination

CBH 23 hour Program Description (https://dbhids.org/wp-content/uploads/2017/12/23-Hour-Crisis-Stabilization-_23-Hour-Bed_.pdf)

Crisis Residence - The crisis residential service provides residential accommodations and continuous supervision for individuals in crisis. It is a bundled service that includes crisis stabilization and intervention, assessment, psychiatric evaluation and medication, short term treatment, linkage to needed services, safety planning and acute case management service. The service provides a temporary place to stay for consumers who need to be removed from a stressful environment. (See PA Crisis Intervention Regulations 5240.104 Subchapter F for Crisis Residential Program Description)

Fusion Model – Crisis Retreat/Living Room. Programs that welcome anyone from 2 to 23 hours at a time. These programs are highly Recovery oriented. They use a high number of Peer Specialists (from 25 to 35% of staff) and act as a welcoming center for those in crisis. People are fed, clothed, and left to sleep in a safe place. Then they are assessed and linked up with services. Often the person is followed up for 30 to 45 days. The only exclusion for services are safety issues such as need for detox or violence. Police and Mobile Teams are trained to assess for appropriateness of referral.

(Recovery Response Center 659 E. Chestnut Hill Road, Newark, DE 19713 Tel: (302) 318-6070) Recovery Innovations https://riinternational.com/crisis-services/

Emergency Department Telepsychiatry Consultation Service: The telepsychiatry consultation service provides availability to psychiatric consultation from 18 to 24 hours a day. This provides video consult between ED doctors and psychiatrists and psychiatric evaluations and assessments. Doctors would review patient records prior to video interview. This type of service has consistently lowered inpatient admissions, resulted in shorter ED stays and higher rates of follow up to aftercare services. The program allows for ED doctors more time to work on ED physical medicine issues.

Resources:

Substance Abuse and Mental Health Services Administration (SAMHSA): NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE: Best Practice Toolkit, 2020

SAMHSA: PRACTICE GUIDELINES: Core Elements for Responding to Mental Health Crises, 2009

Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS): CRISIS INTERVENTION WORKGROUP: Crisis Intervention Services Transformation Recommendations, 2011

CIT, International: CRISIS INTERVENTION TEAM (CIT) PROGRAMS: A Best Practice Guide for Transforming Community Responses to Mental Health Crises, 2019

The Nationa1 Empowerment Center and The Nationa1 Menta1 Hea1th Consumers' Se1f-He1p C1earinghouse:

SO YOU WANT TO START A PEER-RUN WARMLINE?: A Guide to Developing and Maintaining a Sustainable Warmlinehttps://power2u.org/wp-content/uploads/2018/03/Warmline-Guide.pdf

Submitted 7/23/2020

James Fouts, LSW

The Mission of the Centre County, Pennsylvania Task Force on Mental Health Crisis Services is to: “conduct a comprehensive review of mental health crisis services across the County and to produce a detailed description of this crisis system along with recommendations to enhance and strengthen crisis services in Centre County for individuals with mental illness.”

Mental Health Task Force Descriptive Report on the Centre County Crisis Intervention System

FSS **Forensic Systems Solutions**

A Core Program of Family Training and Advocacy Center

520 Christopher Columbus Blvd.

Centre County, Pennsylvania Mental Health Task Force Descriptive Report on the Crisis Intervention System

In 2019 Centre County created a Task Force on Mental Health Crisis Services to: "conduct a comprehensive review of mental health crisis services across the County and to produce a detailed description of this crisis system along with recommendations to enhance and strengthen crisis services in Centre County for individuals with mental illness."

Centre County contracted with Forensic System Solutions (FSS) to work with the Task Force to develop a System Process Mapping. A visual flow chart was completed showing each of the steps a person in crisis could go through. The flow chart outlined five stages:

1. First contact with Crisis/Police/Emergency Department (ED) to the resolution of the crisis or the decision for voluntary assessment at ED or 302 petitions,
2. ED evaluation to decision of discharge from ED, voluntary inpatient admission, or 302 commitment and hospitalization,
3. Hospital admission to discharge, voluntary admission, or decision for 303 petitions,
4. 303 petitions to Mental Health Review Officer (MHRO) decision, and
5. Discharge, voluntary admission, outpatient commitment or continued hospitalization to hospital discharge.

Initially the plan was to map all 5 stages of the process. Due to time constraints, the nature of Centre County activity mirroring the Penn State University Calendar, and the untimely death of Billie Willits, the original Chairperson of the Task Force, a decision was made to limit the scope of the mapping to the first two stages. Emphasis was to be placed on first contact with Crisis/Police/Emergency Department (ED) to the resolution of the crisis or voluntary inpatient admission or 302 commitment and hospitalization.

The Process Mapping creates a picture of the existing system. The mapping is not be a critique nor a satisfaction survey, but instead describes how the system is seen and experienced by members of the community and those working within the system.

Members of the Task Force participated in the work of creating templates to be used in interviewing those involved in the crisis system. Sub committees were created based on subject matter knowledge, experience with the specific stages or interest in working with that group. Boiler plate templates were supplied by FSS and the sub committees enhanced them by making them more specific to the Centre County System.

The sub committees were then tasked with identifying the agencies or individuals to be interviewed within their assigned stages. Subcommittee members were assigned the responsibility of completing interviews using the questionnaires. Due to the complications listed above subcommittee members were not able to start the interviews and a decision by the Task Force leadership was for FSS personnel to complete the interviews. Interviews were held between mid-December 2019 and mid-February 2020.

All interviews were considered confidential and individual identifying information was not gathered. A total of 62 interviews were completed. Family members and consumers were self-identified and voluntary. Staff

from involved agencies were assigned by their administration. Interview times ranged from 20 minutes to 1 hour.

Interviewees Makeup:

SURVEY RESPONDENTS

Category	Interview Participants	Additional Information
Family Members	14	These families had 37 separate crisis contacts
Consumers	6	These consumers had 26 separate crisis contacts
Provider Agency Representatives	4	These provider agencies had 14 crisis contacts
CanHelp staff	5	
CCR Administration	3	
Service Access Management (SAM)		
Nittany Health Psychiatric Emergency Department	5	Interviews involved Physicians, Nurses, Case Managers
Police Departments	14	PSP, Patton, Ferguson, and State College Departments
Centre County 911	4	
Centre County MH/ID/EI and Substance Abuse	2	
Centre County Correctional Facility	3	Interviews involved Warden, Psychiatrist and Registered Nurse

See Appendix 1. Flow Chart – Stages 0ne and Two

A preliminary report on the findings of the interviews was presented to the Task Force at the February 20, 2020 meeting. The following information is a summary of the findings.

See Appendix 2. Flow Chart – Person in Crisis to Social Support Resolution

Social Support Resolution

Involvement in a mental health "Crisis Intervention System" begins with the recognition by a person, or by those around that person, that they are experiencing "an immediate stress producing situation which causes acute problems of disturbed thought, behavior, mood or social relationships requiring immediate intervention." (PA Title 55, Chapter 5240).

In Centre County the person experiencing a crisis has several options for working towards resolution of that crisis. Those individuals who recognize the need for assistance can call upon their own social support systems (Family, Friends, and Peers) for assistance. Gaining the support and objective viewpoints of others can be

helpful in dealing with a crisis. These supports can also point the way to professional therapeutic supports including outpatient or inpatient treatment services.

See Appendix 3. Flow Chart – Person in Crisis through Outpatient Services

Mental Health Services

There are a range of services available to assist in resolving a mental health situation. A Manual developed by the Centre County MH/ID/EI and Drug and Alcohol Services lists the services available in Centre County (https://centrecountypa.gov/DocumentCenter/View/2100/Resource-Book-2019-revised?bidId=). The Manual includes services paid for by the individual, by private insurance, and by public insurance such as Medicaid.

In Centre County, the Medicaid behavioral health managed care entity is Community Care Behavioral Health Organization (CCBH). CCBH is responsible for managing the behavioral health needs of individuals who are eligible for Medicaid Services. For individuals that have no insurance or are underinsured MH/ID/EI and Drug and Alcohol Services can manage services through contracted agencies.

Outpatient

The primary service to address behavioral health challenges is Outpatient Treatment Services which includes individual and group counseling as well as medication management. It was reported that new referrals to the Outpatient system in Centre County can expect to wait about 2 weeks to see an outpatient therapist and between 2 and 6 weeks to see a psychiatrist.

There is a **Mobile Medication Management Team**, which serves adults "who experience difficulties progressing toward wellness due to the inconsistent adherence to a prescribed medication regimen." It is a recovery focused service that enables individuals to be educated about their medications and trained to develop skills to manage their medication effectively in order to control symptoms and increase community tenure."

Another service is **Psychiatric Rehabilitation** which helps individuals to "develop, enhance or retain psychiatric stability, social competencies, personal adjustment, and/or independent living competencies." This service is primarily for those adults with Serious Mental Illnesses.

Case Management Services are also provided to individuals with behavioral health problems in Centre County. Case Managers "work directly with individuals to ensure people receive services and are linked with community resources that facilitate their path to wellness." Administrative Case Management, which provides "initial access to services requested and on an as needed basis," is available to those individuals age 3 and up. Blended Case Management is a more intensive service where staff "meets with individuals anywhere from once a week to once a month depending on assessed need" and is also available to those 3 or older.

"**Peer Support Services** (PSS) are specialized therapeutic interactions provided by a Certified Peer Specialist (CPS) who is a self-identified individual who is or has accessed mental and/or behavioral health services. CPS's are trained and certified to offer support and assistance to individuals who are working on their overall wellness. The service is designed to "…promote empowerment, self-determination, understanding, coping skills, and resiliency through mentoring and service coordination supports that allow individuals age 14 years and older to achieve their goals."

There are two specialty **Children's Services**:

Behavioral Health Rehabilitative Services (BHRS) are treatment and therapeutic interventions prescribed by a psychologist or psychiatrist provided on an individual basis in the home, school, and community. These services include Behavioral Specialist Consultants (BSC), Mobile Therapy (MT), and Therapeutic Support Staff (TSS). A BSC or MT can help develop crisis and safety plans. It was reported that there is a long waiting list for BHRS.

Family Based Mental Health Services (FBMHS) is an evidence-based service provided in the home by a team with at least one master's level professional. Goals are established by the family and treatment team. To receive FBMHS individuals must be diagnosed with serious emotional and/or behavioral disorder; be at-risk of needing treatment in a psychiatric hospital, Residential Treatment Facility (RTF), or other out-of-home placement.

See Appendix 4. Flow Chart – Person in Crisis through Crisis Services

Crisis Intervention Services

CCMH contracts with service provider agencies for Crisis Intervention Services. Until January of 2020 CCMH contracted with CanHelp, a part of Universal Community Behavioral Health Corporation. CanHelp provided Telephone Crisis, Mobile Crisis and Delegate Services. * Delegate Services are an administrative review of the petitions for psychiatric evaluation

Starting on January 2, 2020 Crisis Services have been provided by Center for Community Resources and Service Access Management, Inc. (SAM) has been contracted to provide the Delegate Services.

Crisis Intervention Services in PA follow the Proposed Crisis Intervention Regulations. Proposed 55 PA Code, Section 5240 **[Appendix 8]** (proposed in 1993, but never formally approved) and the Mental Health Procedures Act (Act of Jul. 9, 1976, P.L. 817, No. 143) **[Appendix9].** There have been very few changes in the Regulations since they were written in 1993 and in the MHPA since 1976. There is a current initiative in the Office of Mental Health and Substance Abuse Services to update the Regulations.

CanHelp Crisis Services included 24/7/365 Phone Crisis Intervention, Mobile Crisis Intervention and Delegate Service. Since CanHelp is no longer part of the County Services this report will report their history of service over the past 3 years.

Services Provided by CanHelp:

- 4,786 phone calls per year (last 3 years)
- 923 mobiles per year (mobiles steadily decreasing last 3 years)
- 436 Delegate visits
- Average time on phone 7.26 minutes.
- Average Mobile Response time (41 minutes)
- Average mobile visits - 1 hour 6 minutes
- Approximately 30% of Mobiles resulted in 302
- Average time for insurance pre-certification and bed search – 4.5 hours
- Most common calls were for depression, isolation, and support with children

The primary mission of the CanHelp telephone, mobile and delegate service was to resolve crises using the least restrictive resource available. Comments made during the interview process by crisis workers, family members, consumers, and police officers indicated that there occurred a major shift over the last several years of an increasing focus by CanHelp on the use of assessment tools and demographic reports. This focus on paperwork was listed as a major barrier for families and consumers. The universal impression that it gave was that the crisis worker was more interested in the paperwork than in resolving the crisis.

In January of 2020 CCMH contracted with the Center for Community Resources (CCR) for crisis intervention services. The services include Telephone Services, A Walk-in Crisis Assessment Center and Mental Health Library and Mobile Crisis Intervention Team. CCR will be governed by the same Pa State Regulations as CanHelp and will be inspected on a regular basis by OMHSAS and CCMH.

Since the Service is new, statistics are not yet available. It is assumed that some basic data such as Response Time and number of calls will remain relatively the same as what occurred with CanHelp.

Changes projected by the CCR Administration include a philosophy of Resolving the Crisis. They plan to break the cycle of "call crisis, go to hospital." Diversion from hospitalization will be a high priority. CCR would like to leave everyone with something tangible (such as written information) and a plan on what to do next. Collaboration with providers in serving consumers will be another high priority. Plans include several "meet and greets" and traveling to providers to educate them on the new crisis service.

Walk-in Crisis Assessment Center In addition to a different service delivery philosophy, Centre County has also established a new service, Walk-in Crisis Assessment Center (CAC), located at 2100 E. College Avenue in State College. The CAC is an open, inviting, and welcoming environment that has resource materials, and staff to assist the person in crisis. Staff will help create a crisis plan, seek out resources and resolve the crisis and avoid the need to contact Police, ED, or Mobile Crisis. The CAC is serviced by a bus route. Mobile Crisis and Police will be transporting people to the CAC as well. Walk in services also include frequent and as needed follow up phone calls until the crisis is resolved, the person no longer wants crisis services, or the person becomes active with treatment services. Follow up will assess the status and effectiveness of referred services

Centre County will be encouraging individuals with behavioral health crises to use the least restrictive services first. Services, in order of encouraged use include – Telephone, Walk-In, Mobile, ED Evaluation, and Inpatient hospitalization.

Mobile is an option if the individual is unable to get to the Walk-in Center or if the situation is more agitated. There will be a recommendation to go directly to the ED if a person calls the phone crisis service and requests hospitalization. There will no longer be a requirement that they be assessed by Mobile if they are seeking voluntary hospitalization. Delegate service is now split off into Service Access Management, a separate agency.

The CCR **Telephone services** will be focused on crisis stabilization before having a conversation regarding demographics and assessments. They will have a mixed priority of provided referral and crisis stabilization services. The major duties of the telephone service will be to give contact information for referral resources,

provide support, crisis resolution, and stabilization. They will dispatch mobile or delegate as needed for further crisis resolution or 302 assessments. Telephone Crisis workers will contact 911 if Police Services are requested. A new focus will be on providing Police with needed information when their services are called on by Crisis.

The focus of **Mobile** Crisis services is to provide de-escalation and crisis resolution services to individual experiencing a crisis in their own home or in the community. The Mobile Crisis staff will assess for safety and appropriateness for hospitalization and perform level of care assessments if needed, compile demographics and complete other documentation. In the past Mobile would not respond without Police presence if there is any sense of violence, agitation, etc. Mobile would also not be part of facilitating involuntary commitments. The Mobile staff would not accompany the Police as it was believed that an officer with training in Crisis Intervention being dispatched (which in Centre County is a basic expectation) would be enough to deal with the situation.

See Appendix 5. Flow Chart – Involuntary Commitments through the Delegate Service

Delegate Service

CCMH has contracted with Service Access Management, Inc. (SAM) for the involuntary commitment Delegate Service. Since they are a new provider as of January 2020 statistics are not available. The purpose for the Delegate is to assess the legality of 302 petitions, arrange serving of the 302 Warrant to the consumer, arrange transport to ED, find appropriate inpatient hospitalization for the consumer if 302 was upheld. The Mental Health Procedures Act (**Act of Jul. 9, 1976, P.L. 817, No. 143)** is the law that governs the 302 procedure. A "302" has several parts. The first is a "petition" that is signed by a "responsible citizen" that if approved by the County Mental Health Administrator or his/her "delegate", would become a warrant that would require a person to be evaluated by a licensed physician. If that physician believes that the person is "mentally disabled" and in need of inpatient hospitalization the person would then be hospitalized up to 120 hours (5 days). If the hospital determines more than 5 days are needed to assess or to treat and stabilize the person, a 303 hearing would be scheduled. If the court approves, the person could remain in the hospital up to 20 additional days.

To be considered legal a 302 petition must meet 5 criteria:

1. A person is "dangerous to self or others"
2. The danger is due to a mental illness and not due to an organic issue (i.e., developmental delay, substance abuse or dementia) or due to behavioral issues (i.e., domestic issue, personality conflict).
3. There is a "furtherance" of the threat. The person would have had to do something that showed they were following through with the threat.
4. The consumer had to show that they were not willing to be evaluated voluntarily.
5. The 302 must be signed on Block A by a "responsible citizen" or on Block B by a licensed physician or sworn "Peace Officer".

The SAM Delegates will fully assist in helping people complete 302 petitions. Many of the family members and providers interviewed indicated that in the past this assistance was minimal, and they would have liked more instruction on what is needed to be written by the petitioner.

If the petition is denied, the delegates will refer the petitioner to Mobile Crisis for additional services. They will also inform the petitioner of what grounds to look for in the future if involuntary commitment is potentially needed.

If the 302 is approved and the consumer was not in the ED already the Delegate would arrange for the local Police Department to serve the 302. If the Police were already on-site with the individual, they would get the original 302, explain the process to the consumer, and arrange transport to the ED. If they were not present the 302 would be faxed to the Police Department. In the past a phone call would be made to the Police department informing them of the 302 being faxed. The process of sharing information with the Police regarding the consumer was inconsistent and usually insufficient. Information might be given to the 911 Dispatcher, the Officer in Charge at larger Departments or the Dispatcher at PSP. Police indicate that, in the vast majority of calls, they would only have the information that was on the 302 or their own previous knowledge of the consumer prior to serving the 302. CCR and SAM have indicated that they will address these shortcomings.

When a 302 is enacted, the Delegate will go to the ED to give the original 302 to ED personnel as well as any information needed to complete the evaluation and the bed search. In about 60% of the cases the petitioner or family member would accompany the consumer to the ED and provide information to ED personnel.

If the 302 was signed on Block A (responsible citizen) and upheld by the physician, a search for a bed in a psychiatric hospital begins. The first choice is for the local Mount Nittany Health Behavioral Health Unit. If admission is approved, the delegate would complete an insurance company pre-certification to assure payment was available. If the local inpatient unit is unable to serve the individual, a “bed search” is conducted to find a behavioral health unit that would accept the consumer. The bed search would begin locally and the go in an ever-widening circle of hospitals. There is a shortage of local inpatient psychiatric beds which affects consumers and their significant others in that some must drive to Pittsburgh or Philadelphia to visit the consumer or take part in discharge planning or treatment meetings. It is also difficult since out of the area facilities may not know the local resources to make adequate aftercare plans.

If the 302 was signed on Block B (physician or police officer) the ED will complete the pre-certification and the bed search.

Documentation from the Delegates also includes completing the Act 77 paperwork which sends notice to the Pennsylvania State Police Pennsylvania Instant Check System (PICS). This Notification of Mental Health Commitment results in the committed individual being placed on a list that prohibits them from purchasing a firearm and possessing firearms.

Changes in the MHPA have been discussed in the PA Legislature but action has been taken to change the involuntary hospitalization criteria. One Law, (H.B. 1233) took effect on October 24, 2018 addresses non-hospital care. The Law amends the MHPA and establishes a new standard for court-ordered assisted *outpatient* treatment in the community with a standard based on a medical determination of whether a seriously mentally ill individual needs and can benefit from assisted outpatient treatment to survive safely in the community. It leaves intact the “clear and present danger” criteria needed for involuntary inpatient hospitalization. Part of the law allows for Counties to “opt out” of implementing the new standard, and, in

fact, every County in PA has chosen to opt out of implementing the new standard. Nonetheless, Centre County is currently reviewing the law and assessing its' potential impact on the community.

See Appendix 6. Flow Chart – 911 Dispatch to Police Department

Centre County 911 Dispatch

The vast majority of Police calls are dispatched via the 911 Center. Some calls are received directly at the police station and an Officer in Charge receives the information and passes it on to the responding officer. The 911 Center is governed by Pa Code Title 35 Chapter 53.

Centre County 911 Dispatch Staffing

Positions	Number of Staff
Full-time Dispatcher Positions	18
On-call Dispatcher Positions	5
Shift Supervisors	4
QA Supervisor	1
Training Supervisor	1

In 2019 the Centre County 911 Dispatch Center received:

911 Phone Calls	41,460
Non-emergency Phone Calls	101,068
Total Calls	142,528
Incidents Dispatched (Police, Fire, EMS)	79,755

Training includes classroom time, Act 120C Training, Active listening skills, Learning a basic script, APCO (Association of Public Safety Communications Officials) – 40 hours, Emergency Medical, Dispatch – 32 hours, 4-6 months shadowing, Continuing education classes. in addition to training, there is always a supervisor to provide guidance and teaching. There is a 24-hour supervisor available.
The 911 Call process with mental health emergencies involves having the dispatcher ask for the callers call back number and address in case they are cut off. Then they request a short description of the issue to send to the Police. They also try to get the following information:

- What's happening right now to make you call
- Prior or current violent behavior
- Weapons or access to weapons
- Animals in the home
- Name of your family member in crisis
- Age of family member in crisis
- Height and weight of family member in crises
- Clothing description of family member in crises
- Current location of family member in crises
- Diagnosis (Mental Health and/or Medical)

- Current medications (On or Off?)
- Drug use (current or past)
- Triggers (what upsets them?)
- Describe what has helped in previous police contacts
- Identify other persons in the residence or at the location
- Does consumer know the Police are on the way?
- Past relationship with Police
- Have you called the crisis intervention service?

The Dispatchers pass as much of this information on to the Police as they can, but they are not always able to get good information. This can be frustrating to the callers in that they have to answer the same questions repeatedly to 911, Police, Crisis, ED staff. (911 recommends that families that know they may be calling 911 have this information written down before hand to help in the midst of a crisis. The 911 dispatcher would stay on the line until the Police arrived and provide support during the wait time.

Police

Centre County Police Departments range in size from 6 officers to 62 officers. They include the Pennsylvania State Police (Rockview), Penn State University Police, State College Borough Police, Ferguson Township Police, Patton Township Police, Bellefonte Borough Police, Spring Township Police, and the Centre County Sheriffs' Office. All Police Departments are made up of sworn Peace Officers and can sign 302 warrants without going through the Delegate System.

Municipal Police Officers' Education and Training Commission (MPOETC) certifies training and certifies a cadet as a Police Officer. Training and certification are mandated by the PA Act 120.

Requirements to become a Police Officer include a background check, psychological evaluation, physical fitness examination, polygraph, Police Academy Training ~ 20 – 25 weeks for municipal departments and Pennsylvania State Police Academy – 27-28 weeks. PSP and many departments require an additional 60 college credit hours.

The Academy's include courses in Law, Vehicle Code, Criminal Procedures, Firearms and Weapons, Human Relations, Driving, Use of Force, Handling Prisoners, Dealing with Special Needs. There is a minimal amount of instruction specific to Mental Illness but dealing with people in crisis is a topic spread throughout other courses. 14 hours of continued education certifications are required. (mix of required curriculum and electives) every year. In Centre County this includes yearly Crisis Intervention Team (CIT) training refresher and/or new topic material.

97% of Centre County Municipal Police are trained in CIT (which is the highest County percentage in the State). CIT training is a 40-hour training and includes mental illness, suicide assessment and intervention, dual diagnosis (co-occurring substance abuse and mental illness), autism, local resources, de-escalation, veterans' issues, family and peer perspectives, suicide by cop, juveniles in crisis, and self-care. The rate of CIT training for the Pennsylvania State Police is lower than the Centre County Municipal Police Departments, but they have additional training yearly.

CIT also includes a workgroup that deals with specific issues related to mental health and police. It is a problem-solving group that works through both systemic issues and issues specific to certain individuals served by both Police and Mental Health.

In addition, Police complete a CIT report for each call that is considered a crisis call. That form is sent to the CIT coordinator for either further system follow up and/or data collection. Some calls may be missed as they may not initially be considered a crisis call or may turn in to a criminal call.

Data from the CIT reports for the past three years show approximately 650 CIT calls per year with approximately 250 calls resulting in hospital evaluations.

Police Officers in Centre County report an average of 3-4 Crisis calls a week and 2 to 3 calls involving a 302 warrant a month. This number changes between the smaller departments and larger departments.

Police are notified of a crisis call by the Centre County 911 Dispatcher. Police report that they typically receive basic information regarding the call including address, name of the person calling and sometimes the name of the individual, and the nature of the call (usually in 1 to 2 sentences). Police rarely get a call from Mobile Crisis or Delegates directly as the call typically comes through the 911 dispatcher. Police response time is usually less than Mobile due to location of local Police Departments and their knowledge of the area.

When the situation is a crisis call and the involuntary commitment process is not needed, the Police will provide de-escalation and support and refer the family to Crisis Intervention. Their first priority is for safety and stabilizing the person in crisis.

There were mixed responses from families as to how helpful the Police were. Some indicated that the Police were supportive and knew their family member from frequent visits and some felt that the Police were not helpful and would send too many officers to deal with the situation. This would be intimidating and agitate the consumer. Police protocol dictates that when responding to a situation that was described as being violent or dangerous, they will respond with high numbers of officers to inhibit violence from an agitated person and provide for officer and others' safety.

Police typically do not stay on the scene for long, especially if the situation becomes settled quickly and is deemed safe. Another factor is whether there is a need in the community for Police. There is generally not much interaction between Crisis and the Police. However, if the situation is tense or there is the possibility of the need for a 302, the Police will wait for either the Mobile Team or the Delegate to arrive.

Serving 302's – When the Police are on scene, they wait for the Delegate to complete the 302 unless they see the behaviors and can petition themselves. Sometimes verbal authorization is given by the Delegate which allows the Police two (2) hours to transport without the 302 paperwork in hand. Police have mixed feelings about this since they are taking the Delegate's word that they are approved to transport the person against their will with no legal backup. Police have requested that the Delegate complete page 4 and fax it to the Department would suffice to give them the legal backup they need to transport without the 302 in hand.

If the person was calm and/or willing to go voluntarily the Police will arrange for the person to be transported by ambulance to the Emergency Department. If necessary, for safety reasons, the Police will do the transfer.

Depending on the individual situation, handcuffs may be used when transporting, especially if the person was agitated, Police will exercise caution and use cuffs.

Police are often asked to implement an approved 302 petition for involuntary evaluation, unless the individual was already at the ED. Police will receive a call from Dispatch that a 302 was faxed to their Department. Typically, the information on the 302 is the only information provided to the Police. Police have stated that they need critical information to properly respond to and serve the 302. They recommend that the Delegate or Crisis call them directly with the following information:

- Prior or current violent behavior
- Weapons or access to weapons
- Animals in the home
- Name of consumer
- Age of consumer
- Height and weight of consumer
- Clothing description of consumer
- Current location of consumer
- Diagnosis (Mental Health and/or Medical)
- Current medications (On or Off?)
- Drug use (current or past)
- Triggers (what upsets them?)
- What has helped in previous police contacts?
- Identify other persons in the residence or at the location
- Past relationship with Police
- Does consumer know the Police are on the way?

There were mixed reports on whether Crisis was present or if Crisis should be present when Police are implementing a 302 petition. Some officers stated that Crisis was present only if the 302 was not done yet. If they were just serving the 302, Crisis rarely goes. Some officers were worried that having inexperienced crisis workers or delegates present would put an extra burden on the Police to keep them safe. However, there are many models in Pennsylvania where Crisis co-responds with Police and waits till the Police certify that it is safe and appropriate for the Crisis staff to become involved. If a decision is made to have Crisis co respond, training with Police and Crisis would have to be completed.

There was some inconsistency as to whether the Police had to accompany consumer to wait in ED Waiting Room for triage. Some officers reported that their responsibility was simply to call the Nurse in the ED to have the person taken back to the Psychiatric Emergency Department Quiet Rooms.

Police typically give a verbal report to Mount Nittany Health Security and nursing staff in the ED with what (limited) information they had acquired. It was reported that the usual wait in ED is approximately ½ hour unless there is a need to triage first.

See Appendix 7. Flow Chart – Mount Nittany Medical Center Emergency Department through Decision to Uphold/Deny 302 or Convert to Voluntary

Mount Nittany Medical Center Emergency Department

In 2013 MNMCED completed renovations to its Emergency Department (ED) which includes a 4-bed private room unit specially designed for patients with behavioral health needs. This unit features safety rooms equipped with metal retractable garage doors that can close over equipment and windows. The rooms are all video monitored specially trained nursing staff.

Staffing at the ED includes support personnel, Licensed Physicians, Registered Nurses, and Emergency Behavioral Health Case Managers. The BHEDU also has access to all hospital staff and equipment as part of the Emergency Department. The staff completes medical, psycho-social, and psychiatric evaluations, 302 evaluations and inpatient admission assessments based on level of care needed. Crisis intervention, medication management, referral services and needed lab work is also provided.

Staffing – Staffing is available 24 hours/365days a year. Physicians are licensed in the State of Pennsylvania. They have specialized training in Emergency Medicine. Their initial psychiatry training was through a psychiatric rotation during residency. The doctors are trained in Emergency Medicine but have little on-going training in psychiatry. They receive additional on the job training in the MHPA and 302 evaluations. All staff receive Crisis Prevention Intervention Training, and all have Required Continuing Education Training, some of which is in psychiatry.

Registered Nurses – Licensed as a registered nurse in PA, Crisis Prevention Intervention Training, Specialty Mental Health Training, on-the-job training, and Continuing Education requirements.

Emergency Behavioral Health Case Manager – Meets the requirements for crisis worker under the proposed 55 PA Code, Section 5240 (proposed in 1993, never approved) and MHPA (Act of Jul. 9, 1976, P.L. 817, No. 143). Additional training includes crisis intervention training, delegate training, crisis assessment and intervention. The case manager also has knowledge of local resources and hospital inpatient admission criteria. Ongoing training is generally on the job with various available external trainings.

Upon admission to ED the consumer is placed in Behavioral Health rooms, their belongings are secured, and they change into a paper gown. If they have not been triaged, they will then be triaged by an RN. Voluntary and less agitated patients are usually triaged outside the unit first unless prior arrangements are made, even if accompanied by Police Officers. Agitated patients are immediately brought into the BHED Unit. Hospital Security is available if needed.

Patients are then Medically Cleared -Medical clearance has the aim of identifying potential medical issues causing the symptoms (such as infection, encephalopathy, and substance abuse intoxication or withdrawal) and medical comorbidities requiring care but not directly related to the current psychiatric complaint (such as diabetes or chronic obstructive pulmonary disease). If they are medically cleared the 302 evaluation can begin.

If they are not medically cleared (the most common reason for not being medically cleared is intoxication) they will receive treatment for the medical condition and the 302 evaluation will wait until the person is medically cleared.

The case manager will check the 302 grounds, 302 paperwork or need for delegate to complete a 302. Case Manager will then begin with collecting information on the patient including history and history of current

crisis. They will speak with the petitioner and crisis worker/delegate/police if available for background. This information is passed on to the doctor.

The doctor will perform the 302 evaluation, starting with an evaluation of the organic nature of crisis (i.e., is there evidence of a mental illness?) Then they will go on to assessing the level of dangerousness and whether a "furtherance of the threat" is present. If the patient is at the level of need that they need hospitalization, they will be offered a voluntary admission instead of being committed against their will. If they do not meet the level of care that requires inpatient hospitalization the Case Manager will explore outpatient resources with the patient and family.

When signing a voluntary admission (a 201) the patient agrees that they consent to inpatient hospitalization and sign that they will give 72 hours' notice before discharging from the hospital.

If hospitalization is agreed upon a bed search is completed. If the 302 was signed in Block A and is upheld by the Doctor the Delegate will complete the Insurance Pre-certification and Bed Search. If the 302 was converted into a 201or the 302 was signed in Block B the ED Behavioral Health Case manager will complete the bed search and pre-certification. The average length of time in it takes to complete a bed search varies as to bed availability, medical clearance, and disposition plan. It typically takes between 4 – 5 hours.

Centre County Correctional Facility (CCCF)

Many people with mental health issues end up going into jail rather than into treatment. Whether due to the social consequences of having a mental illness or there being no treatment facilities available, the rates of people with mental illness in jail is much higher than the rates in the general public. The average number of inmates with mental illness is 4 to 8 times the amount of people in the general population with a mental illness. With that in mind, we consider the Centre County Correctional Facility a part of the Crisis Intervention System.

The Centre County Correctional Facility was completed in 2005. It has a capacity of approximately 350 with 2/3 of inmates from Centre County and additional inmates from other counties making up the rest. These other inmates are here due to overcrowding in other county jails that contract with Centre County.

Once an inmate is booked through Central Booking, they undergo several medical, physical, and psychiatric screenings. There are 3 different Gender Specific Mental Health and Suicide Screening Assessments completed at Booking and at Intake. All new admissions are also reassessed by mental health staff within 24 hours of admission. There is also a psychiatrist on call 24 hours via telepsych for consultation and medication management. Hospitalization upon intake is an option if an emergency arises. It is very difficult to arrange so most emergencies are handled at the jail. If an inmate goes to the hospital, a Corrections Officer will accompany the patient.

If the inmate is assessed as having suicidal thoughts, they are placed within a 4-level suicide watch system. The highest level gets a suicide smock (rigid cloth that does not give flexibility for use in choking oneself) and they are placed in a padded suicide cell which is video monitored with 15-minute checks. Once placed on a suicide watch the inmate must stay on that level of watch at least 24 hours before being brought to the next lower level.

If the inmate shows signs of, has stated that they have, or it is known that they have a history of mental illness or they are in detox from a substance, they see psychiatrist via telepsych immediately.

If an inmate is on a medication upon admission it must be verified. Once verified they are started within 4 hours of verification. All inmates reassessed at least every 90 days. The medication formulary is compatible with common medication usage and available unless it is a medication commonly abused.

If it is determined that an inmate needs medication for their own or others safety a Medications over Objection hearing can be done with a court order.

If the person is already on Medication Assisted Treatment for Substance Abuse Issues, they will follow through with Medication Assisted Treatment if coming from Department Of Corrections (not often, usually only for court) or if community treatment already in place. Pregnant inmates will be transported to Methadone Clinic for treatment. Additional Substance Abuse Treatment is contracted through Crossroads.

In House Treatment Programming includes:

Substance Abuse Treatment including 12 Step, Talk Therapies and Medication Assisted Treatment (MAT)

Mental Health including: Medication Management, Individual and Group Therapies

GED, Work and Job Skills

Building Hope Mentoring Program

Various additional programs run by volunteers including advocacy and parenting

Spiritual Programs

Torrance Regional Forensic Psychiatric Center is used for Competency Assessments and Restoration as well as long term forensic hospitalization.

Reentry services are provided by a Centre County Mental Health Forensic Case Manager. The Case Manager is ½ time at CCCF and ½ time in Community through MH/ID/EI. Upon discharge community services are set up to get benefits, housing, and treatment resources. CCCF is taking part in a pilot program that ties in State Department of Human Services to jail OMS to have Medical Assistance benefits started immediately upon release

Typically, there are 3 days' worth of medications given upon release with services set up to get new prescriptions in the community. For those with Serious Mental Illnesses up to 2 weeks can be given (in script form).

Barriers

There were 2 final questions given to all interviewees.

1. What were the barriers in (for recipients of services) you receiving the best services or (providers) providing the best services possible?
2. What recommendations would you give to the Mental Health Task Force to improve the Crisis Intervention Services of Centre County.

The following is a compilation of those barriers and those recommendations. The barriers were grouped into 5 categories:

1. Lack of Resources – Inpatient, Outpatient and Diversionary.
   There was a general consensus among all parties that there was a lack of resources.

   A. Several families discussed the difficulties they had to deal with when their family member was placed in an inpatient facility that was hours away. This made for fewer family visits and less effective discharge and aftercare planning. The lack of local hospital access is a cost issue with increased time that the Delegate or Behavioral Health Case Manager has to take in procuring a bed and arranging transportation. ED doctors also indicate that several hospitals require unneeded lab work which also increases the time spent in the ED. The issue of a lack of inpatient psychiatric beds is an issue throughout the Commonwealth.
   B. There are insufficient diversionary resources that can be used instead of inpatient hospitalization or jail. The new Center for Community Resources CAC is an example of an innovative approach, but it is new, and has already experienced challenges related to access for consumers who lack transportation. Mount Nittany Health ED, Crisis and Police all indicate that limited diversionary options lead to more people being 302'd and hospitalized.
   C. Outpatient services are an essential part of preventing crises, diverting from more restrictive placement, and generally helping consumers in their recovery goals. The consensus of all those interviewed was that there are not enough outpatient treatment and support services. Independent supported living to assist those with mental illness to live independently in the community may be at the top of the list. Needed housing options include Community Residential Rehabilitation (CRR) type of placements and some section 8 vouchers with little housing supports? Long waiting lists for Children's BHRS were also discussed by many family members. Although the Mental Health Manual lists many outpatient services available there was a belief between most interviewees that the waiting list to see a psychiatrist was much longer than stated by Mental Health officials. One common theme is that reimbursement rates for outpatient services and supports are so low that services need to be limited in order for provider agencies to survive.

2. Lack of Information/Training
   A. Interviewees gave many different descriptions of the same service suggesting that the knowledge of available services is not widespread. Understanding the available services is essential in referral services, crisis intervention and diversion from more restrictive resources. More outreach to providers and family members is needed to "get the word out" about available services.
   B. There were several concerns that the level of priority given to crisis stabilization needed to increase. Some believe that this is a training issue, and some believe that this may be an issue of shifting philosophies of crisis services. Several Police Officers indicated that

they had better training in CIT than crisis personnel. 911 dispatchers also believe that family members and providers need to learn additional skills in crisis stabilization and "not lean on the Police for services." This may be changing with the CCR Crisis Service change in philosophy.

C. Providers representatives indicated that they do not have sufficient knowledge to adequately manage the involuntary commitment process. Although most agreed that they had enough training in suicide assessment and intervention, they want more training in crisis stabilization and de-escalation.

D. Family members who used the crisis services indicated that they had few resources to stabilize their family member and were often in a state of crisis themselves which made for communication with 911, Police and Crisis difficult. Many requested training in dealing with a crisis and getting the proper information to Police.

3. Police Response

A. Many consumers and family members were afraid of Police intervention. Fears ranged from too many Police showing up, Police presence upsetting the person in crisis, fear of being arrested, and previous Police interventions turned bad, and general mistrust of Police. Although Police are trained in de-escalation techniques it is difficult to de-escalate when a trusting relationship cannot be developed. There is a belief among family members and Police themselves that Mental Health is not the primary job of the Police. However, there are Commonwealth mandates that the Police serve 302's in the community and Police are dispatched to any call that is seen as being potentially dangerous.

B. Another problem with Police intervention is the use of handcuffs. Interviewees expressed concern with the inconsistent practice with the use of handcuffs when transporting a person to the ED.

C. Police Officers consistently indicated that they did not get enough information from 911 or from Crisis when directed to serve a 302 or to respond to a crisis situation. Unless they are at the scene prior to a 302 being completed they are usually only sent the copy of the 302. Additional information regarding weapons, safety issues, etc. is typically not relayed to them.

D. Other Police related issues relate to the inconsistent use of Verbal Authorizations by the Delegates to transport individuals without the 302 paperwork in hand. While the use of Verbal Authorization can expedite the process to the benefit of the individual in crisis, Police are in need documentation of the legal reason to take someone to the hospital against their will.

E. An additional barrier is that Police protocols for dealing with crisis situations varies between departments and especially between municipal departments and the State Police.

4. ED Response

A. There were several issues raised as barriers, primarily by Police. Although most Police felt they had a good relationship with the ED staff there was a sense of not understanding the criteria used to reject a 302. There was a sense that the decisions were inconsistent, and they do not receive a good explanation of why a person was released.

B. Police also indicated that they are not notified if a person was being released from the ED. Officers signed 302's believing that dangerous behavior was potentially committed due to a mental illness. If the person was released stating that they were not mentally disabled, then the Police need to know the person was being released to the community to determine whether to investigate the issue as a potential crime.

C. There is inconsistency in the expectation of Police staying in the ED Waiting Room with patients brought for evaluations. Some officers always brought the person back to the BHEDU and some were told to wait in the waiting room. Interviewees pointed out that being in the waiting room with a police officer can be embarrassing and upsetting to the patient as well as to others waiting in the Waiting Room.

5. Crisis/Delegate Response

    A. There is concern that the response times from the Mobile Crisis Team and the delegates can take up to several hours. Although people understood the nature of a large rural county and the possibility of the teams being busy elsewhere in the county, they were concerned about the wait.

    B. Often the wait would be with a slightly agitated or very depressed person with little or no support. The Police would be called which sometimes can be agitating to the person in crisis. It could also be an unnecessary use of the resources of smaller community with limited Police coverage.

    C. Interviewees indicated that the telephone crisis response was sometimes supportive and sometimes not. There is a universal belief that the telephone crisis workers held completing paperwork a higher priority than crisis stabilization and giving support to family members.

    D. Interviewees also indicated that Delegates are not considered helpful in completing the 302 petition. Some petitioners felt they were being judged on how they completed the 302 rather given assistance in completing the form.

Recommendations:

These recommendations have been listed for your review and will be discussed at a later date in a separate report after discussion with the Mental Health Task Force. Recommendations come in 3 forms.

1. **Corrections** to the current system. Changes that need to be made in order to repair faulty protocols or policies or changes that bring the system in compliance with the law or mission of the agency.
    a. For Crisis Services - Staff training and supervision should be more clinically based.
    b. For Crisis Services - Supervisors should be trained to do more clinical supervision.
    c. For Crisis Services - More time should be spent on stabilizing crisis (various respondents suggested this).
    d. For Crisis Services - More focus on gathering safety issues rather than a hospital analysis.

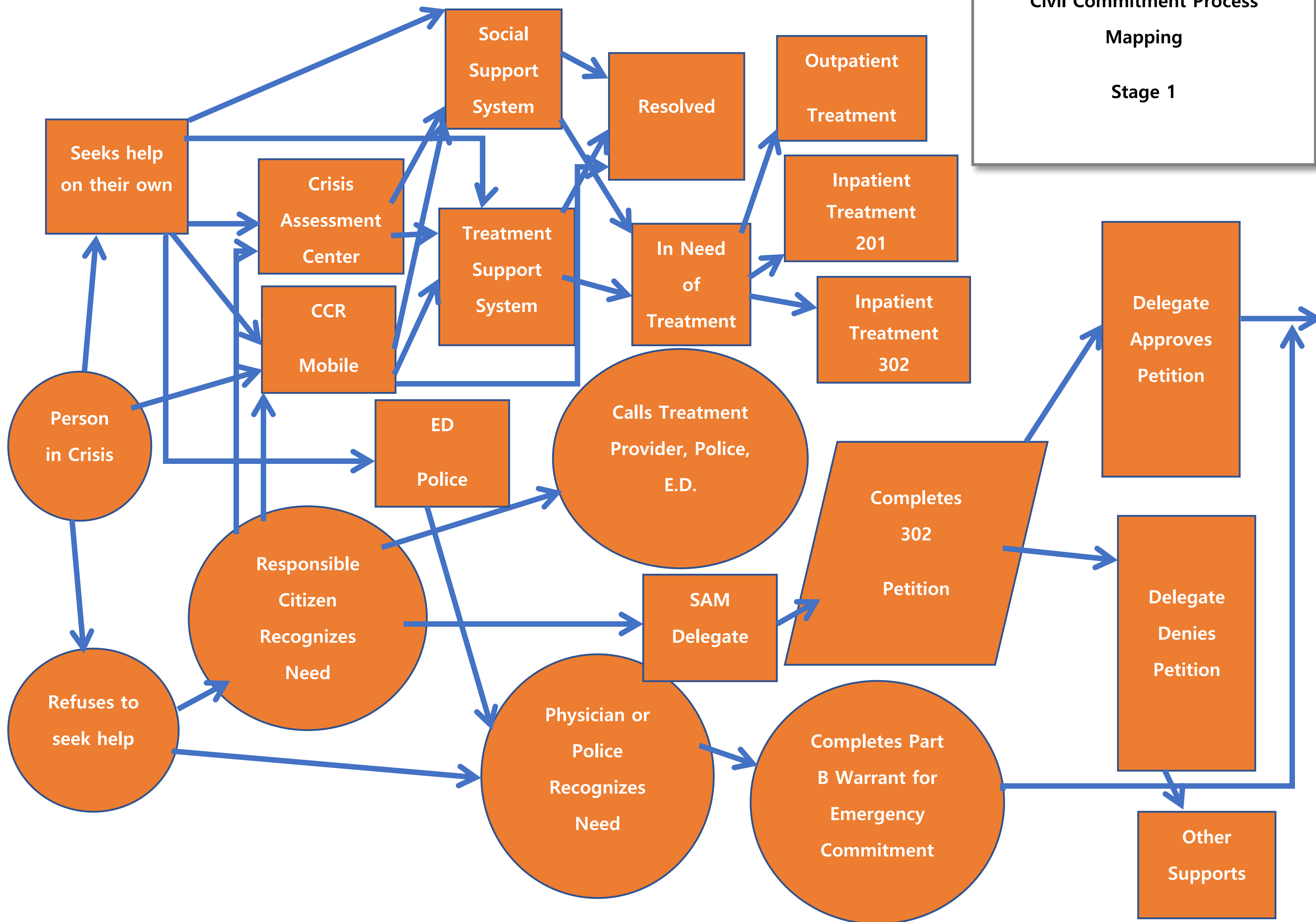
2. **Improvements** to the system. Improvements make the system better without adding new resources. Improvements can include changes to the current system such as increasing access to services, furthering training, skill building or information sharing, etc.
    a. For Providers - More training should be given to providers on crisis intervention and MHPA.

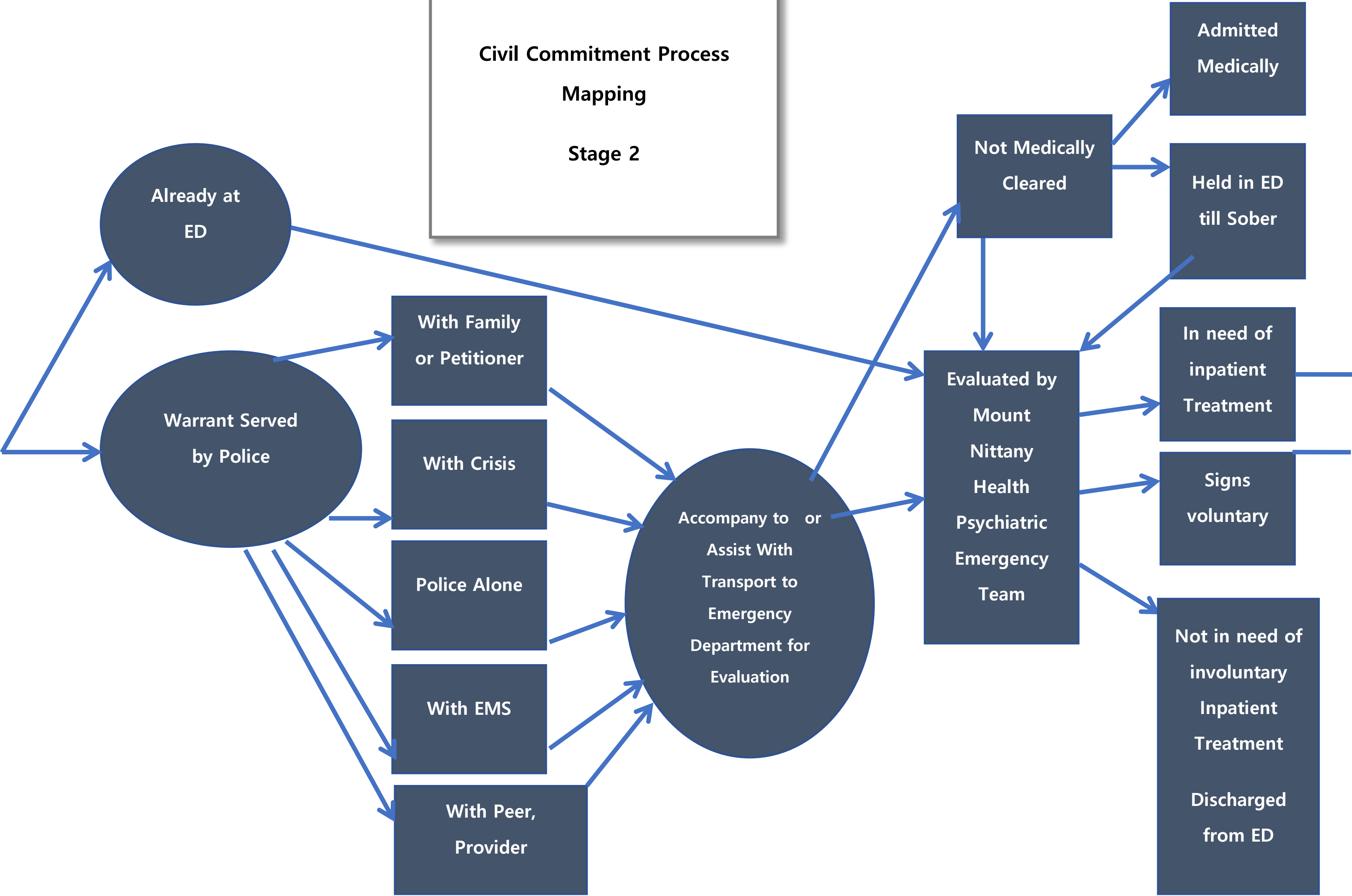
b. For Emergency Department - There is a need for more consistent psychiatric evaluations in the ED.
c. For Emergency Department - ED Doctors should receive additional training in recovery principles, communication skills, and MHPA (various respondents suggested this).
d. For Police = Training for <u>all</u> police should include MHPA and verbal authorizations.
e. For Family Members and Consumers - Callers to 911, Police or Crisis should be prepared with needed information.
f. For Police and Delegates – there should be more consistent and liberal use of verbal authorizations with legal backup.
g. For Emergency Department - Disposition notice should be given to Police if the person is leaving the ED.
h. For Police - List of psychiatric medications and uses would be helpful
i. For Emergency Department – Consistent policies should be developed for working with Police.
j. For Crisis Services - Consistent policies should be developed for working with Police.
k. For 911, Crisis and Delegates - More information on the consumer and the situation should be provided to Police prior to going to serve 302
l. For Crisis Services - Provide officers with more justifiable reasons when requested to check the welfare of a person.
m. For Emergency Department - Do not have Police and accompanied patients wait in waiting area.
n. For Crisis Services – Provide more phone support rather than sending Mobile or while awaiting Mobile
o. For all Services – There should be more direct communication with families and significant others.
p. For All Involved– Set up Meet and Greets between Police, Providers, Consumers and Family Members, especially when folks are healthy and working their recovery.
q. For Crisis and Emergency Department - Keep records of previous contacts or share current documentation between services and just inquire as to changes.
r. For Delegates and Emergency Department – There should be more offers of and allowances for voluntary admissions.
s. For Providers and Emergency Department - Lower the cost for services and inpatient treatment.

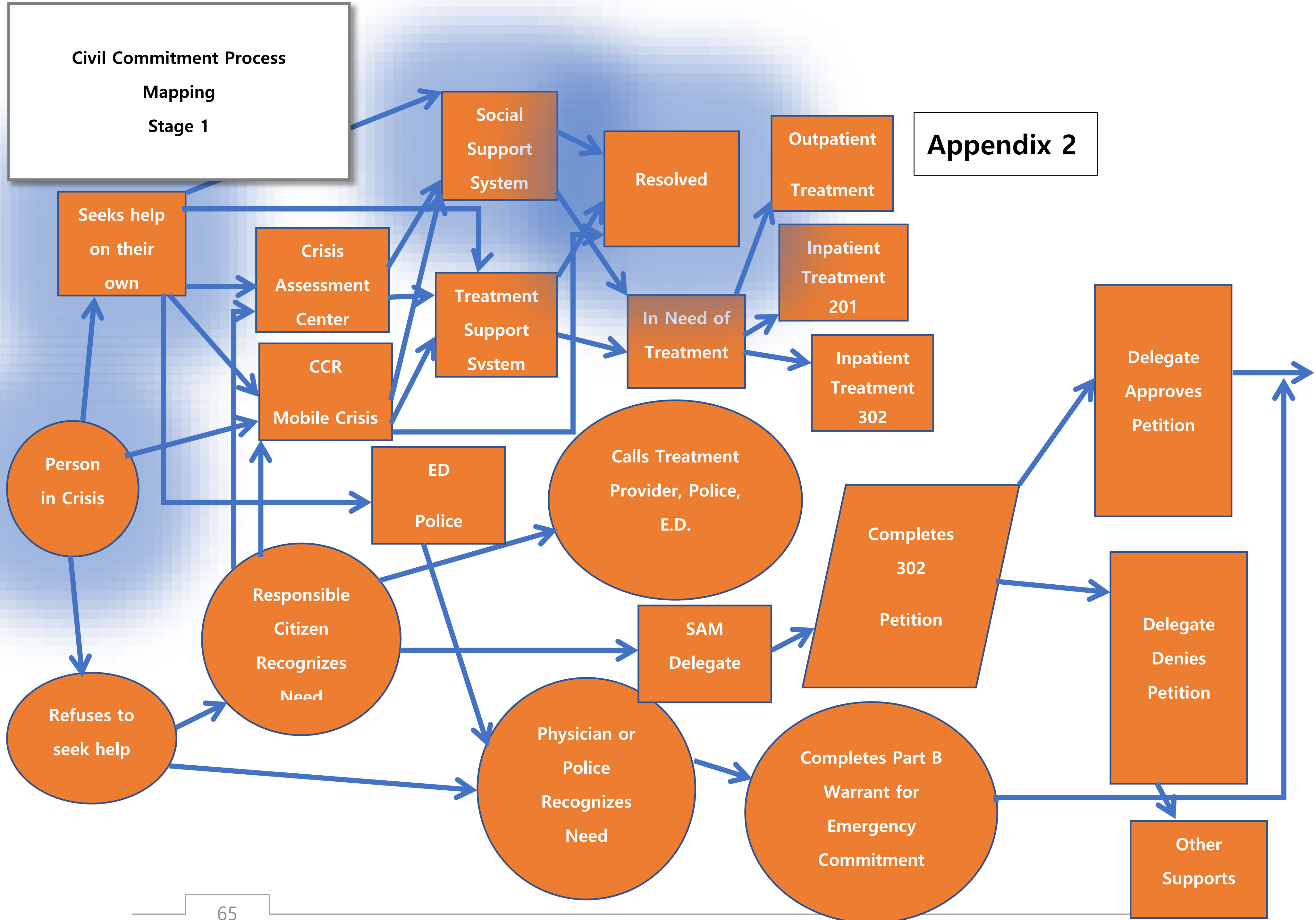
3. **<u>System Enhancements</u>** are additions to the system including new services or expanding current services.
    a. For CC MH/ID.EI and D&A – Create additional forensic reentry service coordination, especially housing and quicker entry into ongoing services.
    b. For CC MH/ID.EI and D&A – Create a forensic peer specialist program.
    c. For all Providers - Improve salaries.
    d. For CC MH/ID.EI and D&A – Create more follow up services, especially independent living supports.
    e. For County Commissioners - Increase veterans' services and jail diversion services.
    f. For CC MH/ID.EI and D&A, NAMI, or Peer Specialists – Create a Warmline.
    g. For the Commonwealth - Increase State Hospital bed availability.
    h. For Crisis Services and Police - Train Crisis to respond with Police.
    i. For Crisis Services and Police – Create a Police Co-Responder position.
    j. For CCR and CC MH/ID/EI and D&A – Create additional hospital diversion programs (Crisis Residence, ACT team, Intensive Outpatient Treatment, Acute Case management Programs).
    k. For Emergency Department – Provide psychiatrist consults in ED for difficult cases.

l. For all Involved – Create a Database Switchboard that provides access to treatment history CCBH and CC MH/ID.EI and D&A.
m. For Emergency Department – Make bed search availability 24 hours
n. For CC MH/ID.EI and D&A - Create more local outpatient support resources.
o. For CC MH/ID.EI and D&A - Create more local outpatient treatment resources.
p. For CC MH/ID.EI and D&A – Create more Proactive and Preventative services.
q. For CC MH/ID.EI and D&A – Provide more children's services, more training in children's issues.
r. For CC MH/ID.EI and D&A – Create additional supportive housing and independent living support services.
s. For Mount Nittany Health Center – Increase the beds in the inpatient hospital unit.
t. For Crisis Services – There should be a Quicker response from Crisis.

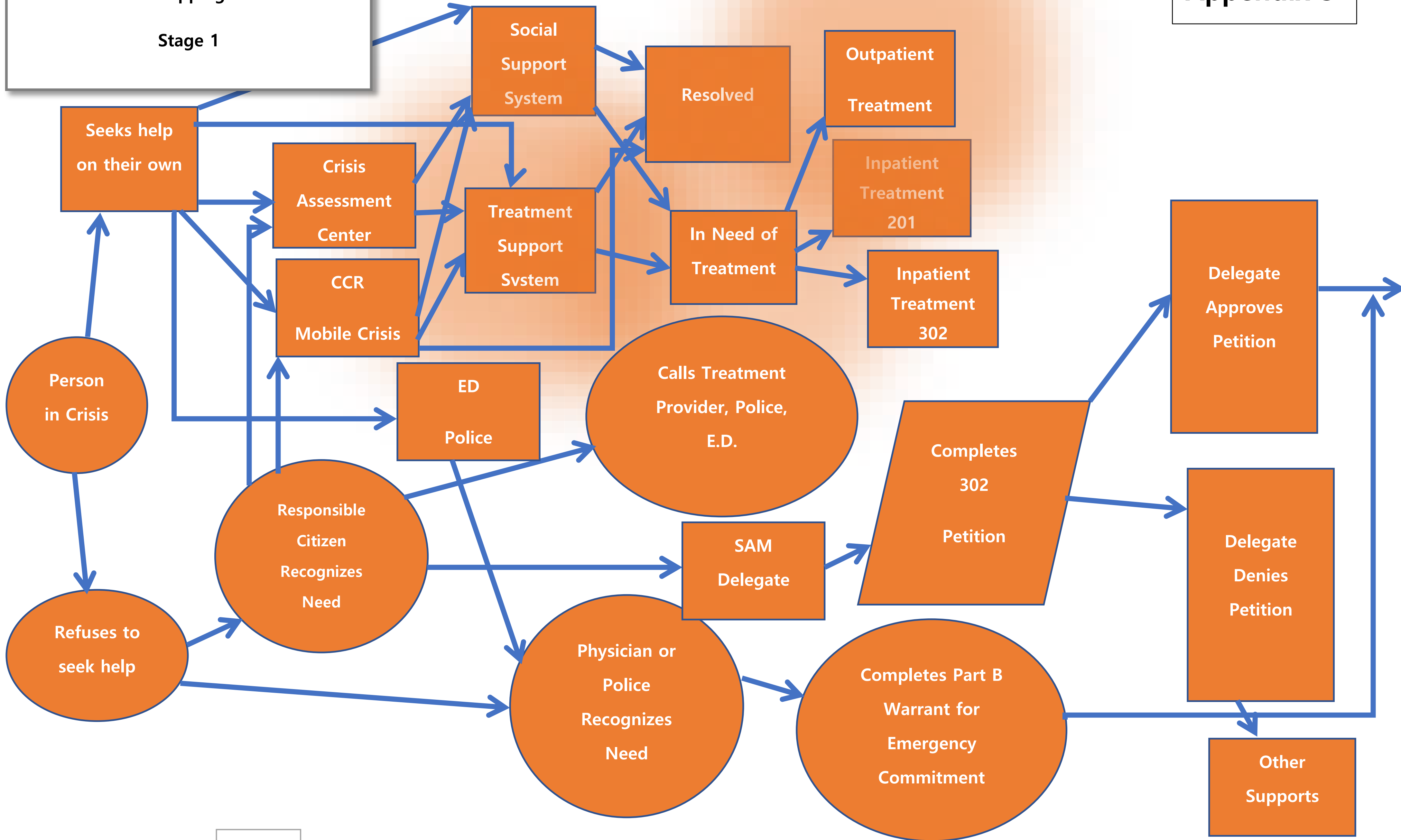
Appendix 1

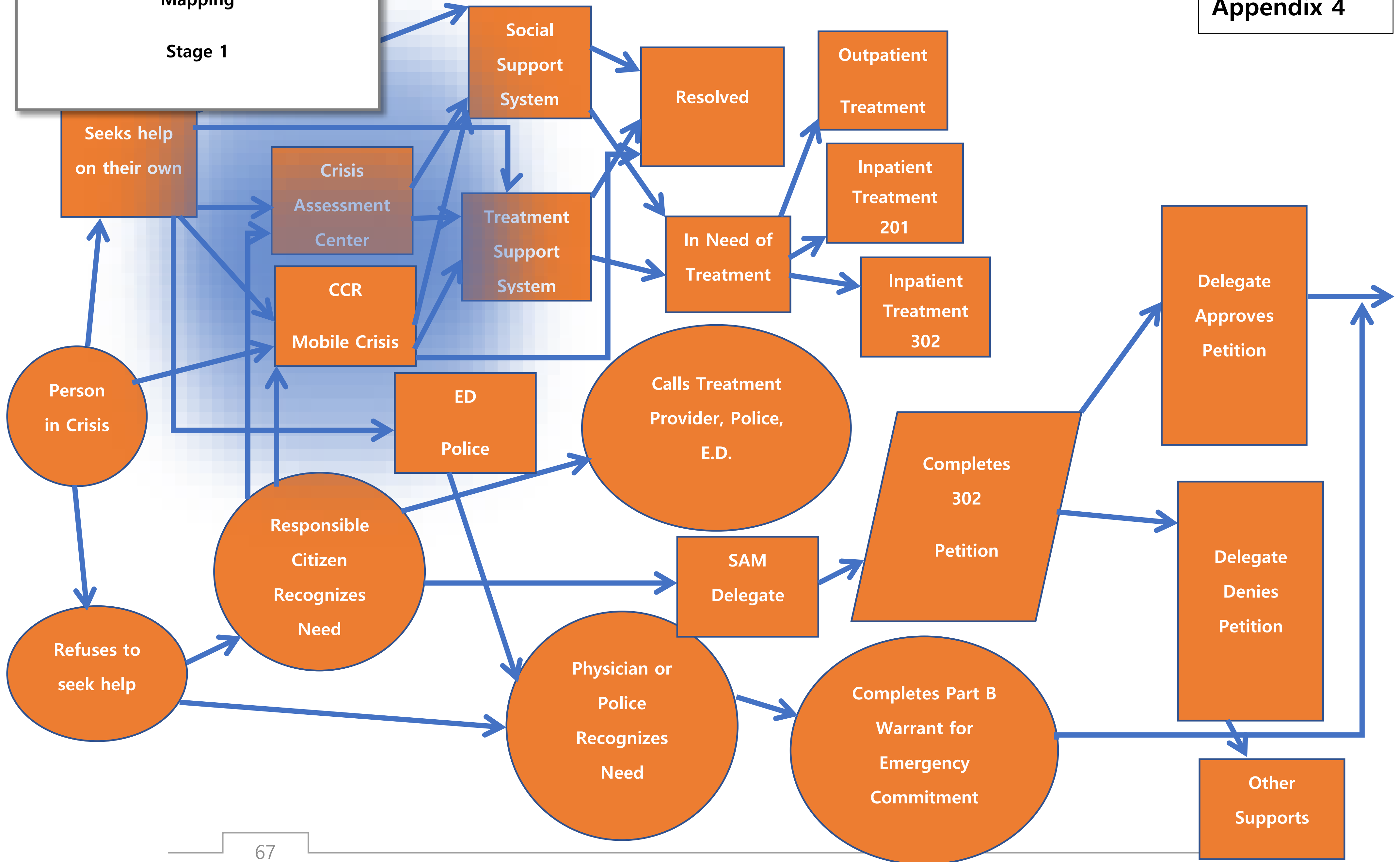



Civil Commitment Process
Mapping
Stage 2
Already at
ED
Warrant Served
by Police
With Family
or Petitioner
With Crisis
Police Alone
With EMS
With Peer,
Provider
Accompany to or
Assist With
Transport to
Emergency
Department for
Evaluation
Not Medically
Cleared
Admitted
Medically
Held in ED
till Sober
Evaluated by
Mount
Nittany
Health
Psychiatric
Emergency
Team
In need of
inpatient
Treatment
Signs
voluntary
Not in need of
involuntary
Inpatient
Treatment
Discharged
from ED

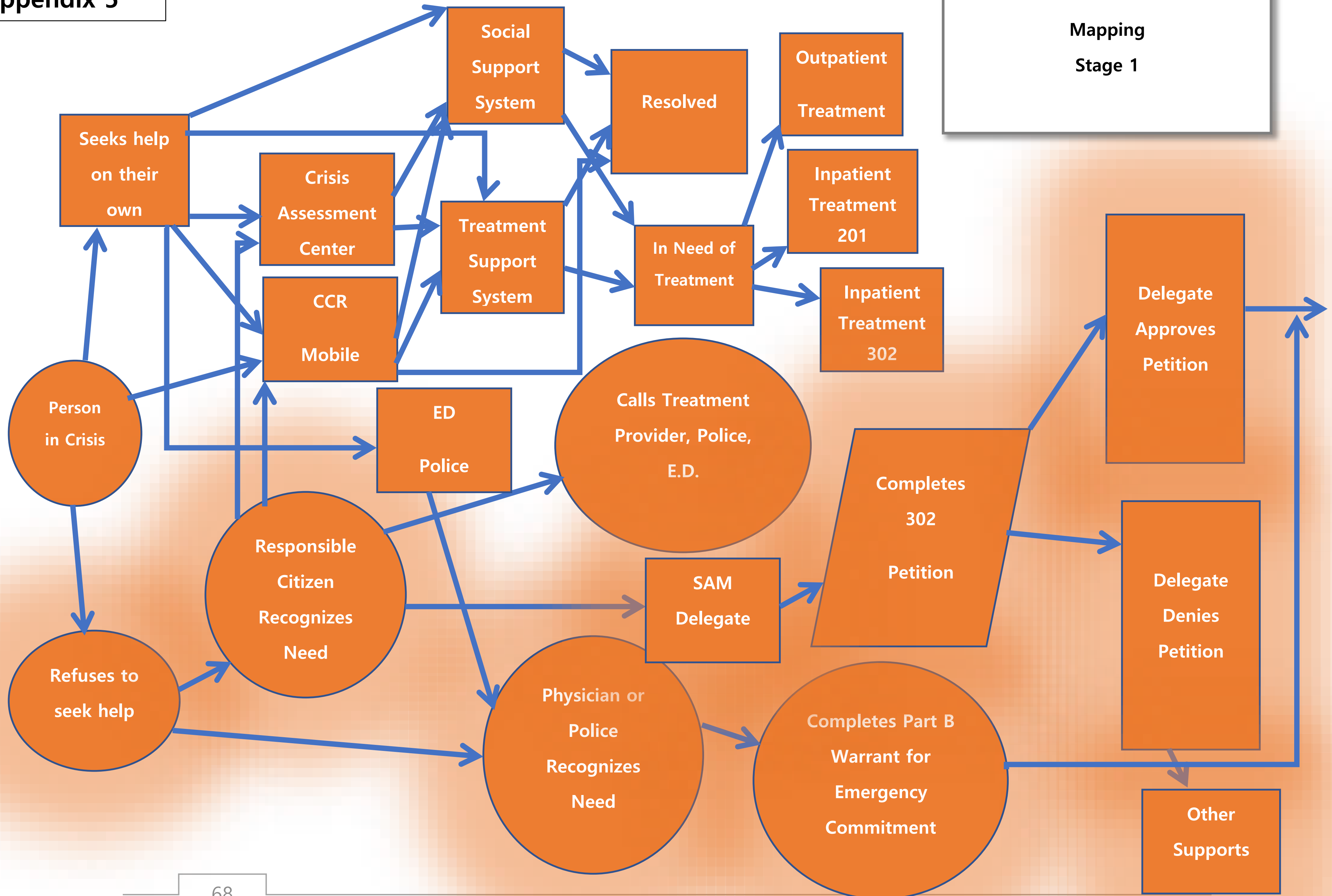


Civil Commitment Process
Mapping
Stage 1
Appendix 2
Social Support System
Resolved
Outpatient Treatment
Seeks help on their own
Crisis Assessment Center
Treatment Support System
Inpatient Treatment 201
In Need of Treatment
CCR Mobile Crisis
Inpatient Treatment 302
Delegate Approves Petition
Person in Crisis
ED Police
Calls Treatment Provider, Police, E.D.
Completes 302 Petition
Responsible Citizen Recognizes Need
SAM Delegate
Delegate Denies Petition
Refuses to seek help
Physician or Police Recognizes Need
Completes Part B Warrant for Emergency Commitment
Other Supports


Civil Commitment Process
Mapping
Stage 1
Appendix 3
Social
Support
System
Resolved
Outpatient
Treatment
Seeks help
on their own
Crisis
Assessment
Center
Treatment
Support
System
Inpatient
Treatment
201
In Need of
Treatment
CCR
Mobile Crisis
Inpatient
Treatment
302
Delegate
Approves
Petition
Person
in Crisis
ED
Police
Calls Treatment
Provider, Police,
E.D.
Completes
302
Petition
Responsible
Citizen
Recognizes
Need
SAM
Delegate
Delegate
Denies
Petition
Refuses to
seek help
Physician or
Police
Recognizes
Need
Completes Part B
Warrant for
Emergency
Commitment
Other
Supports

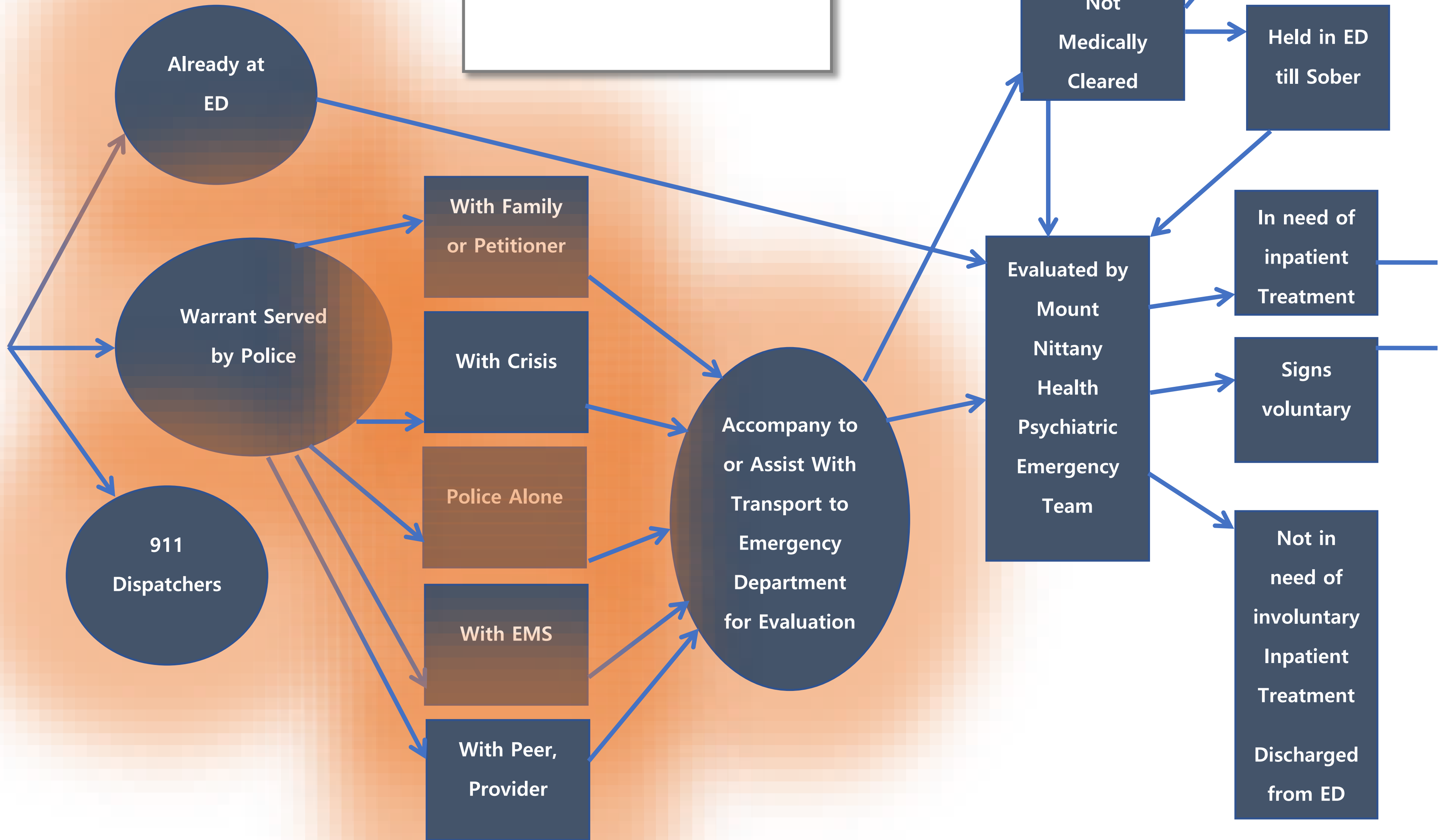

Civil Commitment Process
Mapping
Stage 1
Appendix 4
Social Support System
Resolved
Outpatient Treatment
Seeks help on their own
Crisis Assessment Center
Treatment Support System
Inpatient Treatment 201
In Need of Treatment
CCR Mobile Crisis
Inpatient Treatment 302
Delegate Approves Petition
Person in Crisis
ED Police
Calls Treatment Provider, Police, E.D.
Completes 302 Petition
Responsible Citizen Recognizes Need
SAM Delegate
Delegate Denies Petition
Refuses to seek help
Physician or Police Recognizes Need
Completes Part B Warrant for Emergency Commitment
Other Supports

Appendix 5

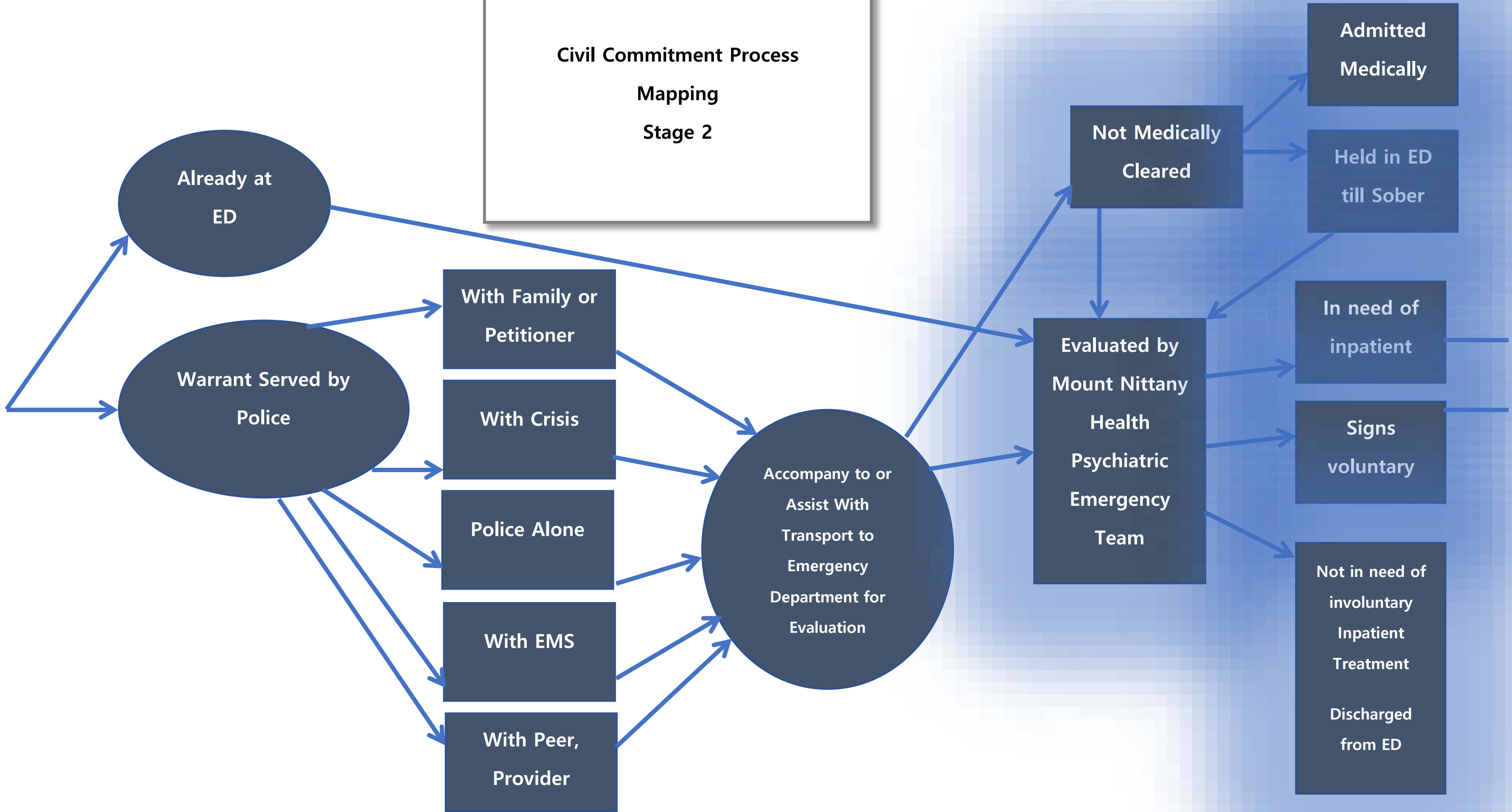


Appendix 6

Civil Commitment Process Mapping Stage 2



Appendix 7



APPENDIX B: Considerations for Future Reference

Here is a list of items from the Task Force discussions that were not included in the Key Recommendations; they are listed here as points of information from the work of the Task Force. Some of these may emerge from the work carried out in the various Key Recommendations. We kept them as part of the record of discussions for possible future reference.

1. Build a network of mental health professionals.
2. Create a warmline (early intervention hotline or drop-in service with emotional support free, confidential peer-support services).
3. Identify a list of local forensic peer specialists and their programs.
4. Promote community trainings to increase understanding of issues and existing resources.
5. Additional funding for mental health crisis services that could allow for improved salaries for staff.
6. Expect delegates to meet personally with each client, not rely on second-hand report.
7. Create additional hospital diversion programs (Crisis Residence, ACT team, Intensive Outpatient Treatment, Acute Case Management Programs), and create more follow up outpatient services, especially independent living supports.
8. Find alternatives to reliance on Emergency Department sites for evaluations.
9. More training should be given to Crisis Intervention and Delegate providers on crisis intervention and MHPA.
10. Provide more structured supervision and support, preparation, and training for delegates beyond initial group training; more clinical staff supervision for Crisis Intervention staff.
11. Develop an interactive, user-friendly map of services for consumers.

APPENDIX C: Public Meeting Summary (Not listed in any specific order)

These summary comments from the two Public Meetings are provided both for reflections on the Key Recommendations presented and comments pertaining to related mental health concerns. They will be useful for the future considerations of those governmental bodies, departments, agencies, entities, and community groups engaged in implementation of the Task Force Key Recommendations and other related social service needs.

- Consistent positive comments about the draft Task Force recommendations being a very good first step to enhancing the mental health crisis system in Centre County
- Executive Director of American Mental Wellness Association offered any assistance the MHWA can provide to the work of the Task Force
- Interest in divesting guns from the service of involuntary commitment (302) warrants
- Advocacy should be broadened to include housing, food insecurity, medical care, and employment
- Cultural bias exists about persons suffering from serious mental illness
- Support for a co-responder or civilian crisis response team with CAHOOTS and STAR being two examples mentioned
- Need for more beds locally
- Importance of de-escalation as a focus in mental health crisis responses
- Additional training is necessary including in the following areas: Treating physician and psychiatrist, de-escalation, implicit bias, power and control dynamics, intersectionality, critical race theory, cultural capacity training,
- Need to address the outdated Pennsylvania law, including HIPAA restrictions
- Lack of access or inability for family members to be involved if the individual does not approve
- Need for more persons of color as part of the mental health services provided
- Importance of securing funding to implement the Task Force recommendations
- Concern that jails have become mass incarceration housing units for those suffering from mental illness
- Pleased the Task Force included a focus on the impact of race in the mental health crisis system
- Importance of investing in psychiatric rehabilitation programs, transitional and permanent housing programs, a general "housing-first" approach in our community, and intensive assisted outpatient programs
- Other ideas suggested included: different types of peer support for individuals weighing in on all new programs in mental health services, accountability for providers, educating community and caseworkers on history of ableism, in general, but especially within mental health communities

APPENDIX D: Work Sheets for Gaps and Opportunities

	Gaps	Opportunities
Crisis Interventions (CCR)	• Lack of evidence-based modeling - MCO's (Managed Care Organizations) have minimal standards for crisis intervention that do not require evidence-based services. • Tracking Concerns - CCR reports it limits track first visit/contact and subsequent visits/contacts (No limitations in the numbers of times a person can utilize crisis intervention services) • Reduced walk-ins after COVID Waiver for telehealth allowed for service at walk in center to become limited. - Due to COVID concerns, it created shorter encounters. Probably less than 1 hour (from 1-1.5 hours) • Longer waiting time as service is expanded - Waiting longer to receive care because of the increased number of people accessing crisis intervention. • Treating children under age 18 - Adolescents who visit the center for a telehealth appointment require adult guidance and supervision to assure that they are using the session effectively • Inpatient Assistance Limitations - During assessment, if in-patient is considered for individual, transferred to ED but occur as CCR does not do pre-certs or bed searches out of area.	• Certified Peer Specialists Incorporate peer services during a crisis service to allow for support and education. • Role of Follow Up - Opportunity to assume the role of a case manager for individuals who are released from the ER and who have been found to fail to meet the criteria for involuntary admission, and/or who refuse voluntary treatment. Connecting with those individuals with follow up services from crisis provider. • Data Tracking - CCR has the capacity for development of a digital data management and tracking system, including a repository for client records and tracking contact information, that can store and provide information for the Delegate to access and later share with the ER staff and others.
Delegate (SAM Inc.)	• Information sharing on the client - While SAM describes a handoff of information from CCR to SAM when a case is opened it is unclear what kind of information is shared and	• Increasing training and supervision - Training and ongoing supervision in their role through support by SAM leadership

	whether that information makes it to the ER • GAPS to using the 302 criteria - Personal care/medical care: the ongoing harm of active psychosis to the brain may be permanent. - Shelter: the inability to maintain housing due to the threat to others in the home. - Risk of harm related to involuntary hospitalization and treatment? • Staff Retention - High stress level that may lead to a quick turnover or burnout • Additional training and supervision needs - Individuals they are hiring as delegates don't have a lot of background/academic training - Defined ongoing support and oversight - Implicit Bias Training: Both at the beginning and ongoing to assist with decision making - Defined supervision for the preparation and ongoing clinical support for individuals who serve as delegates • Outdated MHPA from 1976 - Still requires only a licensed MD to do emergency exam part of it. - Psychiatrists don't do these evaluations rather than just ED doctors. • No assessment tool to determine 302 criteria for physicians and delegates • Delegates are not required to meet with individual perceives that they are relying on reports/hearsay from other people. • Transportation issues	- Educating on the appropriate use of 302 criteria - Making recommendations for physician on the ED on the application of an involuntary commitment. • Communication - Explore procedures for CCR or other agencies (such as CAPS) to obtain client permission and share clinically relevant information about the person during involuntary commitment process. • Licensing - What opportunities are available that can bring us beyond minimum requirements for staffing and service of delegate? • Continued for expansions – alternatives - Example peer components to EDs - Alternatives to ED sites for evaluations - Allow for physician extenders because retention and recruitment are challenging.

	- Law enforcement provides transport, not a mental health provider. - Limited Ambulance services for people with mental health crisis • Standardization issues - Prior provider had limited intake forms and electronic records. Current provider working for further documentation and electronic records. - Interview format: While delegates are introduced to the interview process to follow with individuals during their training, there is no evidence that they are provided with a structured interview format or other tool to apply and follow during their field work. • When the person does not meet "criteria;" - Follow up care for individual - Follow up supports for family and friends	
Law Enforcement	• Limited CIT training for Pennsylvania State Police (PSP) troopers • Unless trained in CIT, PSP troopers not recognizing the value of and completing the CIT Referral form. • Limited available transportation services • Limited services and resources for police when the person in crisis does not meet the 302 criteria. • Limitations or barriers to law enforcement serving as the 302 petitioner	• Use of the new programs coming from District Attorney's office • Resources for the Mental health well-being of the first responders • Additional collaboration on the overall mental health guidelines and protocols with all stakeholders • Mental health workers accompanying police for warrant process? • Emphasis or focus on mental health for crisis calls • Use of plainclothes and soft uniform attired police officers • Increased training for law enforcement and all stakeholders, including community trainings • Expanding documentation including expanded data collection • Assisted Outpatient Treatment (AOT) • Build support from outside groups to work with/assist law enforcement
Emergency Department	• Variation in the process of patient admission accompanied by LE • Inpatient access to beds can be	• Enhancing communication with within the system, i.e. MH/ID/EI/D&A, mobile and delegate services, LE and ED

	delayed due to availability • Training for physicians and ED staff beyond minimum training, e.g. add best practices, in-depth mental health, implicit bias, 302 regulations decisions • Follow up for discharged patients if not a 302 for them, family, police if involved • Transportation locally, within county, distance in state • Systematic standardized process of communication with other agencies in crisis services • Standardizing 302 process for consistency across all involved in 302 decisions	• Enhancing education for all staff as it relates to mental health crisis diagnosis and response, intervention, de-escalation, cultural sensitivity • Establish a community agency collaborative forum connecting crisis, inpatient, outpatient, social service, and non-profit support organizations • Create and communicate a standard process for patients arriving by LE to ED • Enhance data gathering of patients served • Review recommendations in the State Government Joint Commission Report 2020 • Increase use of evidence-based assessments for risk of harm and of psychiatric consultations in ED
Issues within the System	• Disconnect/lack of coordination and sharing between police, 911 operator, mobile, and delegate personnel • Need for additional cultural competency/implicit bias training and understanding • Cultural considerations and understanding of implicit bias, racial equity • Adequate efficient sharing of pertinent patient information among involved responders within the system • Bridging the gap between mental health treatment inpatient/outpatient and incarceration as an outcome when police are involved • Uneven existence of electronic records for efficient sharing of data • Cut-off and no recovery of available funding - 2012 took at 10% cut and haven't recovered. Need to advocate funding for mental health just as much as for updates to MHPA.	• Organizing a Crisis Team • Standardizing the process for the 302 • Need for greater Data-Collection and creation of a Data-Sharing system • Evidence-based assessment approach or tools (e.g., CAHOOTS, Co-responder Model) • Promote and enhance accessibility of mental health resources to the community • Organize a total team approach related to domestic, wellness checks, and mental health warrants • Increase training for cultural considerations • Explore standardizing the application of the 302 decision making process applying the MHPA regulations • Create a data-sharing system to track the system's effectiveness across populations and services using electronic records • Evidence-based assessments for risk of harm analysis/decisions