FY17-MH #01. Strengthen a Community-Based Crisis Response

Recommendation FY17-MH #01
Position the Colorado Crisis Services System as the comprehensive response to behavioral health emergencies in all Colorado communities by making the following reforms: a) Strengthen and enhance existing crisis services and resources; b) Amend §27-60-103 to clarify the intent of the crisis system; c) Undertake conforming regulatory changes to crisis system contracting; and d) Commit resources to incentivize the development and expansion of the crisis services provider network.

- Strengthen and enhance existing crisis services and provide resources to expand the system to ensure an appropriate health care response to behavioral health crises across Colorado.
- Amend statute (§27-60-103, C.R.S, enacted by SB13-266) to clarify the intent of the crisis system and formally introduce the responsibilities of being the preferred response to behavioral health crises across the state, and for engaging in community partnerships that facilitate such a response.
- Crisis System contracting and regulatory reform should specify the operational components necessary to achieve these responsibilities. View APPENDIX A
- The general assembly should commit resources to incentivize the development and expansion of an adequate crisis services provider network. View APPENDIX B

Proposed Statutory Language
Clarify the intent of the crisis system in legislation (§27-60-103, C.R.S; see SB13-266) to add:

- First line of response to individuals in need of an M-1 hold
- Eliminate the criminalized experience and restricted access to treatment that can occur in jails for those with mental illness by leading the development of a partnership-supported network of crisis services.

A proposed bill draft is appended below as APPENDIX C.

Discussion
Colorado’s Crisis System was developed to create an appropriate response to behavioral health crises and thereby reduce utilization of the criminal justice system and emergency departments to house or treat individuals with mental illness. To ensure that this system is effective in achieving its intended purpose, resources must be dedicated to cross-system collaboration as well as independent expansion. By taking steps to strengthen and enhance the Crisis System, Colorado will ensure that peace officers and other first responders are equipped with a variety of options when encountering behavioral health crises in the community. Enhancing this system will ensure that Colorado citizens who experience mental health crises are cared for by healthcare professionals, in turn relieving the criminal justice system.
APPENDIX A:
To ensure operational functionality of the crisis system in this proposed role, the following should be pursued in contracting and regulation.

Decriminalization of Mental Illness in all Crisis Regions:
- Minimum of 1.0 FTE Justice Liaison/Community Coordinator per contractor (4.0 FTE total in the state) to oversee the contractors’ engagement initiatives with key community partners, (criminal justice agencies, emergency departments (ED)s, hospitals, primary care facilities, etc.)
  - To be fully effective, a community resource team should be considered, to include the following positions:
    - Director/Program Oversight
    - Marketing/Community Relations
    - Training Director
    - Peer Specialist Program Director
- Formalize relationships with all law-enforcement departments in region and continue pursuit of collaborative community programming.
- Ability to intervene in behavioral health crises in the community as soon as they are identified to prevent a criminalized experience and/or the potential for a criminalization trajectory.
  - Build close relationships with first responders/dispatch centers to facilitate this.

Management of M1 Holds in all Colorado Communities:
- Specify that all Walk-in-Centers are prepared to take individuals on M1 holds and are 27-65 designated. Formalize partnerships to prioritize caring for high-acuity individuals in the least restrictive environment and without the use of law enforcement.
- Ensure all crisis services facilities, regardless of facility licensure, are able to adequately care for individuals on an M1 hold. Initiatives should focus on appropriate staff ratios, training of staff, and adequate reform to increase security.
  - Introduce a CSU facility licensure category and standardize expectations/involvement.
- Introduce regulations that formalize the expectation that rural crisis facilities engage with 24/7 facilities in their region (including but not limited to rural hospitals, EMS, medical labs, emergency clinics, primary care facilities, etc.) to form facility placement agreements and other local arrangements.
  - Regulations must be bi-directional to ensure engagement by both entities who are entering into agreements.
- Create a state-wide 27-65 web-based portal for data submission to support designated facilities by decreasing administrative workload and increasing capacity.
- Seek guidance from the 27-65 Board that allows providers to utilize telehealth for crisis services including emergency assessment & evaluation for treatment.
APPENDIX B:

To ensure an adequate crisis response network in all Colorado communities, the following should be prioritized for additional funding.

- Expand existing facilities and operations to reach 24/7 capacity in all counties
  - Mobile Response Units – 24/7 capacity.
    - Fiscal supports & incentives (both to the crisis contractor and community partners) to purchase, install, and use of tele-health for mobile crisis evaluations in partnership settings (e.g. hospitals, health clinics, law enforcement facilities, and other crisis service locations.)
  - Walk-in-Centers – 24/7 ability to manage high-acuity encounters.
    - Fiscal supports & incentives (both to the crisis contractor and community partners) to purchase, install, and use of tele-health for walk-in crisis evaluations in partnership settings.
    - Expand crisis services network in each crisis region by incentivizing the partnering with or designating of 24/7 and tele-health capable walk-in-centers at existing facilities in rural communities:
      - Allow crisis contractors to subcontract with rural providers.
        - Target areas: Western Slope, NE region, SE region
      - Potential subcontracted providers may include:
        - Existing Crisis Contractor facilities that are not currently crisis services (i.e. ATU, outpatient offices)
        - Other CMHC outpatient facilities/clinics
        - SUD treatment facilities
        - Law enforcement substation with CMHC or crisis staff conducting services via tele-health
        - Other primary care facilities

- Incentivize local partnerships between law enforcement, behavioral health, and other first responders.
  - Fund new and existing joint programs that match community need and density using the Bureau of Justice Assistance’s Police Mental Health Coordination Toolkit (PMHC toolkit), state (e.g., EDGE, CRT) and national models.
    - Embed crisis clinicians/consultants in first response systems (law enforcement ride-along, dispatch centers, etc.)
  - Provide resources to support crisis contractors’ employee (minimum 1 FTE) community coordinator to facilitate relationship building and program oversight.
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- Develop and install additional tele-suites (equipment, training, other supports) to ensure 24/7 crisis tele-assessment capacity in every county. Funding to promote joint-utilization between systems (criminal justice agencies, hospitals, etc.)
  - Provide the crisis system with the capacity to install, market, and provide technical assistance for this capacity.
  - Create a state-level coordinator position (e.g., Office of IT – State Telehealth Coordinator) to oversee piloting, utilization, and outcomes.

- Support crisis contractors to expand mobile capacity in rural areas as appropriate.
  - Allow for crisis clinicians to respond to more incidents independently or jointly with first responders.
  - These teams should have a primary role in outreach, dispatch, community-coordination, etc. to match the rural communities’ needs.

- Develop, as needed, data collection and outcome evaluation systems.
  - Analysis to focus on clinical outcomes, cross-systemic cost-avoidance, best-practice development, contract compliance, etc.

- Explore development of new crisis facilities and services to ensure adequate capacity in all regions of Colorado.
  - Increase ATU, CSU, WIC, respite capacity where need is determined.
  - Expand resources for peer services and explore increasing the scope of work for peers.

Appendix C:
Tentative bill draft begins on the following page.
A BILL FOR AN ACT

CONCERNING .

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://www.leg.state.co.us/billsummaries.)

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly
finds and declares that:

(a) Behavioral health and behavioral health crises are healthcare issues;

(b) As such, Colorado should immediately end the use of facilities within the criminal justice system as placement options for individuals who have been placed on an emergency seventy-two-hour mental health hold but who have not been charged with nor convicted of a crime;

(c) The behavioral health coordinated crisis response system was created in 2013 to address behavioral health crises and should be utilized throughout the state as the preferred response to such crises; and

(d) The behavioral health coordinated crisis response system should be responsible for engaging in community partnerships that facilitate a coordinated healthcare response for individuals in a behavioral health crisis.

(2) Therefore, the general assembly finds that steps should be taken to strengthen the ability of the behavioral health coordinated crisis response system to respond to behavioral health crises in all Colorado communities. These steps include ending the use of jails and other correctional facilities for placement of emergency seventy-two-hour mental health holds; ensuring the adequacy of community-based options for persons on an emergency seventy-two-hour mental health hold; and dedicating resources to incentivize collaboration and formal partnerships between appropriate local healthcare providers.

SECTION 2. In Colorado Revised Statutes, 27-60-101, amend (1)(b) and add (1)(c) as follows:

27-60-101. Behavioral health coordinated crisis response system - legislative declaration - report by department. (1) (b) The
general assembly therefore finds that a behavioral health coordinated crisis response system:

(I) A coordinated crisis response system provides for early intervention and effective treatment of persons in mental health or substance abuse crisis;

(II) A coordinated crisis response system should involve first responders and include information technology systems to integrate available crisis responses;

(III) A coordinated crisis response system should be available in all communities statewide; and

(IV) A coordinated crisis response system may include community-based crisis centers where persons in mental health or substance abuse crisis may be stabilized and receive short-term treatment.

(c) The general assembly further finds that the intent behind the development of a behavioral health coordinated crisis response system was to:

(I) Create an appropriate and preferred response to behavioral health crises that would eliminate the use of the criminal justice system and reduce the use of emergency departments as treatment or housing options for persons with mental illness or persons experiencing a behavioral health crisis;

(II) Provide an appropriate first line of response to individuals in need of an emergency seventy-two-hour mental health hold;

(III) Decriminalize mental illness by leading the development of a partnership-supported network of crisis
SERVICES; AND

(IV) CREATE A FRAMEWORK TO CREATE, STRENGTHEN, AND
ENHANCE COMMUNITY PARTNERSHIPS THAT FACILITATE THE PREFERRED
RESPONSE TO BEHAVIORAL HEALTH CRISIS, INCLUDING ENSURING THAT
PEACE OFFICERS AND OTHER FIRST RESPONDERS ARE EQUIPPED WITH A
VARIEY OF OPTIONS WHEN THEY ENCOUNTER A BEHAVIORAL HEALTH
CRISIS.

SECTION 3. In Colorado Revised Statutes, 27-65-102, add 11.3
as follows:

27-65-102. Definitions. As used in this article, unless the context
otherwise requires:

(11.3) "INTERVENING PROFESSIONAL" MEANS A PERSON DESCRIBED
IN SECTION 27-65-105 (1)(a)(II) WHO MAY EFFECT A SEVENTY-TWO-HOUR
HOLD UNDER THE PROVISIONS OUTLINED IN SECTION 27-65-105.

SECTION 4. In Colorado Revised Statutes, 27-65-105, amend
(1)(a), (2), and (3); and add (1)(c) as follows:

may be invoked under either any one of the following two conditions:

(a) (1) When any person appears to have a mental illness and, as
a result of such mental illness, appears to be an imminent danger to others
or to himself or herself or appears to be gravely disabled, then a person
specified in subparagraph (II) of this paragraph (a), each of whom is
referred to in this section as the "INTERVENING PROFESSIONAL" AN
INTERVENING PROFESSIONAL, AS SPECIFIED IN SUBSECTION (1)(a)(II) OF
THIS SECTION, upon probable cause and with such assistance as may be
required, may take the person into custody, or cause the person to be
taken into custody, and placed in a facility designated or approved by the
executive director for a seventy-two-hour treatment and evaluation.

(I.5) **When any person appears to have a mental illness and, as a result of such mental illness, is in need of immediate evaluation for treatment in order to prevent physical or psychiatric harm to others or to himself or herself, then an intervening professional, as specified in subsection (1)(a)(II) of this section, upon probable cause and with such assistance as may be required, may immediately transport the person to an outpatient mental health facility designated or approved by the executive director for a seventy-two-hour treatment and evaluation.**

(II) The following persons may effect a seventy-two-hour hold as provided in subparagraph (I) of this paragraph (a) subsections (1)(a)(1)

AND (1)(a)(I.5) OF THIS SECTION:

(A) A certified peace officer;

(B) A professional person;

(C) A registered professional nurse as defined in section 12-38-103 (11) C.R.S., who by reason of postgraduate education and additional nursing preparation has gained knowledge, judgment, and skill in psychiatric or mental health nursing;

(D) A licensed marriage and family therapist, licensed professional counselor, or addiction counselor licensed under part 5, 6, or 8 of article 43 of title 12 C.R.S., who by reason of postgraduate education and additional preparation has gained knowledge, judgment, and skill in psychiatric or clinical mental health therapy, forensic psychotherapy, or the evaluation of mental disorders; or

(E) A licensed clinical social worker licensed under the provisions
of part 4 of article 43 of title 12. C.R.S:

(b) Upon an affidavit sworn to or affirmed before a judge that relates sufficient facts to establish that a person appears to have a mental illness and, as a result of the mental illness, appears to be an imminent danger to others or to himself or herself or appears to be gravely disabled, the court may order the person described in the affidavit to be taken into custody and placed in a facility designated or approved by the executive director for a seventy-two-hour treatment and evaluation. Whenever in this article a facility is to be designated or approved by the executive director, hospitals, if available, shall be approved or designated in each county before other facilities are approved or designated. Whenever in this article a facility is to be designated or approved by the executive director as a facility for a stated purpose and the facility to be designated or approved is a private facility, the consent of the private facility to the enforcement of standards set by the executive director shall be a prerequisite to the designation or approval:

(c) UPON AN AFFIDAVIT SWORN TO OR AFFIRMED BEFORE A JUDGE THAT RELATES SUFFICIENT FACTS TO ESTABLISH THAT A PERSON APPEARS TO HAVE A MENTAL ILLNESS AND, AS A RESULT OF THE MENTAL ILLNESS, IS IN NEED OF IMMEDIATE EVALUATION FOR TREATMENT TO PREVENT PHYSICAL OR PSYCHIATRIC HARM TO OTHERS OR TO HIMSELF OR HERSELF, THE COURT MAY ORDER THE PERSON DESCRIBED IN THE AFFIDAVIT TO BE TRANSPORTED TO AN OUTPATIENT MENTAL HEALTH FACILITY DESIGNATED OR APPROVED BY THE EXECUTIVE DIRECTOR FOR A SEVENTY TWO HOUR TREATMENT AND EVALUATION.

(d) WHENEVER IN THIS ARTICLE A FACILITY IS TO BE DESIGNATED OR APPROVED BY THE EXECUTIVE DIRECTOR, HOSPITALS, IF
AVAILABLE, SHALL BE APPROVED OR DESIGNATED IN EACH COUNTY
BEFORE OTHER FACILITIES ARE APPROVED OR DESIGNATED. WHENEVER IN
THIS ARTICLE 65 A FACILITY IS TO BE DESIGNATED OR APPROVED BY THE
EXECUTIVE DIRECTOR AS A FACILITY FOR A STATED PURPOSE AND THE
FACILITY TO BE DESIGNATED OR APPROVED IS A PRIVATE FACILITY, THE
CONSENT OF THE PRIVATE FACILITY TO THE ENFORCEMENT OF STANDARDS
SET BY THE EXECUTIVE DIRECTOR IS A PREREQUISITE TO THE DESIGNATION
OR APPROVAL.

(2) (a) When a person is taken into custody pursuant to subsection
(1) of this section, such person shall not be detained in
a jail, lockup, or other place used for the confinement of persons charged
with or convicted of penal offenses. except that such place may be used
if no other suitable place of confinement for treatment and evaluation is
readily available. In such situation the person shall be detained separately
from those persons charged with or convicted of penal offenses and shall
be held for a period not to exceed twenty-four hours, excluding Saturdays,
Sundays, and holidays, after which time he or she shall be transferred to
a facility designated or approved by the executive director for a
seventy-two-hour treatment and evaluation. If the person being detained
is a juvenile, as defined in section 19-1-103 (68), C.R.S., the juvenile
shall be placed in a setting that is nonsecure and physically segregated by
sight and sound from the adult offenders. When a person is taken into
custody and confined pursuant to this subsection (2), such person shall be
examined at least every twelve hours by a certified peace officer, nurse,
or physician or by an appropriate staff professional of the nearest
designated or approved mental health treatment facility to determine if the
person is receiving appropriate care consistent with his or her mental

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(b) A sheriff or police chief who violates the provisions of paragraph (a) of this subsection (2), related to detaining juveniles may be subject to a civil fine of no more than one thousand dollars. The decision to fine shall be based on prior violations of the provisions of paragraph (a) of this subsection (2) by the sheriff or police chief and the willingness of the sheriff or police chief to address the violations in order to comply with paragraph (a) of this subsection (2).

(3) Such a facility shall require an application in writing, stating the circumstances under which the person's condition was called to the attention of the intervening professional and further stating sufficient facts, obtained from the personal observations of the intervening professional or obtained from others whom he or she reasonably believes to be reliable, to establish that the person has a mental illness and, as a result of the mental illness, is an imminent danger to others or to himself or herself, OR IS GRAVELY DISABLED, OR IN NEED OF IMMEDIATE EVALUATION FOR TREATMENT. The application must indicate when the person was taken into custody and who brought the person's condition to the attention of the intervening professional. A copy of the application shall be furnished to the person being evaluated, and the application must be retained in accordance with the provisions of section 27-65-121 (4).