Monroe County

Mental Health & Substance Use Disorder

90-Day Task Force

Priorities and Action Plan

January 4, 2021

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COUNTY EXECUTIVE

Acknowledgements

In September of 2020, the Monroe County Executive convened this Task Force. Over the past three months, a cross-sector, multidisciplinary workgroup including nearly 60 individuals has spent considerable time and effort working together to develop the strategies outlined in this report, with a specific focus on working as an integrated system of services and supports. The Monroe County Office of Mental Health would like to acknowledge the expertise, creativity and dedication all individuals participating in this effort brought to the work completed so far – and for the commitment individuals have expressed to continue this work. We are also grateful for the input and participation from community members who contributed their time, shared their experiences, and outlined their ideas about what systems change needs to look and feel like. This input was invaluable in shaping this initial work and we look forward to continuing to engage community voices as we shift from planning into implementation. We begin 2021 with a sobering appreciation for the magnitude of the work that lies ahead but also with the deep and sustaining hope that we can move toward the longer-term transformation of our community's behavioral health system needed to ensure that the right type of help is delivered when, where, and how it is needed, eliminating disparities and achieving equitable outcomes for all members of our community.

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EXECUTIVE SUMMARY

Background: This Mental Health and Substance Use Disorder Task Force was convened by the Monroe County Executive in September of 2020, shortly after our community learned about the death of Daniel Prude. We were given a 90-day timeframe and charged with "***Developing and implementing short-term strategies to address immediate gaps in the County's behavioral health emergency and crisis response systems within the context of longer-term, cross-systems redesign and transformation efforts and with the specific aim of improving our ability to meet the needs of Black, Brown and Indigenous communities."*** Since that time, a cross-sector, multidisciplinary workgroup comprised of nearly 60 individuals has worked together to develop strategies to address the most pressing issues facing our community's behavioral health crisis response services, with a specific focus on eliminating disparities in service access and outcomes. This ***Executive Summary*** highlights key aspects of this work.

Community Input: The priorities and strategies developed by the Task Force were shaped by input from community members about their experiences, what is most important to them when seeking care for themselves and those they love, and what help needs to look and feel like. It is important to note that when we use the term "behavioral health" it includes issues related to both mental health and substance use disorders. The input we received through the forums held by the Commission on Racial and Structural Equity's (RASE) Mental Health and Addictions subcommittee and through listening sessions with other community groups described later in this report was incredibly important. Although this was an important first step, it is also just the start of what must be an ongoing process of continued connection and input as we implement new approaches, assess progress, respond to new needs and continue to transform the system based on data and through the eyes of those who are utilizing the services and supports.

Priority Areas of Focus and Strategies: Driven by our charge and guided by community input, the Task Force focused its work on three priority goals:

Goal 1: Increase Connection to Behavioral Health Services that Meet Community Need: Services can only be helpful if they are culturally responsive and appropriate, well communicated, understood, and if the pathway to access is clear, welcoming, and unimpeded. Accordingly, work in this goal area will focus on:

- ✓ Developing and delivering education and training across behavioral health, healthcare, and human services providers to increase understanding and awareness of behavioral health emergency and crisis services and culturally informed assessment and responses to crisis;
- ✓ Outreaching to key influencers (including trusted organizations and individuals in the community) to bridge the connection to culturally responsive behavioral health emergency and crisis services and build trust, which will be essential to any strategy to improve access to and engagement in care; and
- ✓ Providing education/outreach to individuals, family members, and community members to increase understanding and awareness of all behavioral health emergency and crisis services and what may be the most helpful services based on the situation and cultural beliefs.

Goal 2: Respond to Behavioral Health Crisis Calls with the Most Appropriate Option, Activating Law Enforcement Only When Needed: The community's call for an expanded range of crisis response options to better address the needs of Black, Brown and Indigenous communities has been clear.

Toward this end, steps to be taken in the immediate term to expand capacity in this critical area will focus on:

- ✓ Diverting behavioral health crisis calls received by 911 but that don't require an immediate, in-person response to 211/Lifeline for assessment, de-escalation, and connection to support services; and
- ✓ Expanding selective dispatch options for crisis calls that require a timely in-person response. While this is clearly a longer-term undertaking, this goal will be advanced in the immediate term through three interconnected strategies:
  - o Expanding the Forensic Intervention Team (FIT) to fill immediate gaps. The County will leverage grant funding from the U.S. Department of Justice to expand the FIT coverage (which pairs law enforcement with a mental health clinician) when responding to behavioral health crisis calls, creating a 24 x 7 response capability;
  - o Creating capacity for other in-person (non-law enforcement) response options through continued collaboration with mobile behavioral health crisis services available through the University of Rochester Medical Center's Mobile Crisis Team and the mobile team linked to Rochester Regional Health System's Behavioral Health Access and Crisis Center (BHACC); and
  - o Partnering with the City of Rochester in launching its new Crisis Response Team, including the development of protocols for back-up support.

Goal 3: Strengthen Post-Crisis Supports to Address the Full Range of Individual Needs, Stabilizing and Linking to Prevent Future Crises: The time immediately following a behavioral health crisis is critical, and connecting individuals to the supports they need is key to preventing future crises and creating a pathway toward recovery and stability – shifting from episodic interactions to an ongoing therapeutic relationship. Accordingly, priorities over the next several months will focus on:

- ✓ Ensuring awareness, availability and coordination of follow up resources across locations and platforms (including telephone, mobile and walk-in services);
- ✓ Developing community standards for crisis follow-up to be used across all crisis support services that is based on the needs and priorities of each individual but also includes a structure for gathering information about basic needs to ensure linkage to appropriate resources. To be effective, we know this must be done in a way that is trauma-informed and in the context of the individual's culture.
- ✓ Activating access to care management services following a crisis, including offering referrals at every stage of crisis response, effective communication among providers, timely follow-up by care management staff, and ongoing training/education for care managers to ensure that their engagement takes the cultural nuance of the individuals into consideration; and
- ✓ Maximizing and expanding the use of peer support at all stages of a crisis with opportunities for ongoing connections to people with lived experience during the follow up process, including the active recruitment and professional development of peers from Black, Brown and Indigenous communities.

Implementation and Accountability: Given the immediate nature of this Task Force, some of this work has already begun, but success <u>will require ongoing management, coordination, and the ability to use data to assess progress and adapt as needed to achieve our goals.</u> To that end, this report includes a detailed implementation plan and timeline with a January start date. This will include building and

sustaining linkages to other workgroups and "community tables" where related work is already taking place. It also includes the development of a data collection and analysis strategy for each Task Force Goal, including Key Performance Indicators (KPIs), developing clear, actionable monitoring reports broken down by race/ethnicity wherever possible, and routine review among members of the MH SUD Task Force Oversight Team and community groups to assess progress and continue to build our understanding of community experiences, priorities, and needs and to eliminate disparities in access to care and outcomes. This will include the ongoing analysis of existing datasets, and the development of new data resources to support this work.

Next Steps: It is important to note that this is just the beginning of a much needed, broader, longer-term effort to transform the way services are provided to members of our community whose needs have not been met, especially individuals from our Black, Brown and Indigenous communities. But it is a beginning, and if we are laser focused on these initial building blocks, we expand the likelihood of our success as we work toward longer-term transformation of our community's behavioral health and healthcare systems, eliminating disparities and achieving equitable outcomes for all.

Background

The Monroe County Executive convened the Mental Health and Substance Use Disorder Task Force (the Task Force) in September of 2020, shortly after our community learned about the death of Daniel Prude. The Task Force was given a 90-day timeframe and charged with "***Developing and implementing short-term strategies to address immediate gaps in the County's behavioral health emergency and crisis response systems within the context of longer-term, cross-systems redesign and transformation efforts and with the specific aim of improving our ability to meet the needs of Black, Brown and Indigenous communities."***

This last point warrants specific emphasis as it extends beyond the disparities in access to, engagement in, and outcomes associated with health and behavioral health services that the COVID-19 public health crisis and the death of Daniel Prude have highlighted. In order for the work of this Task Force to begin to lay a foundation for more fundamental transformation, we must acknowledge, understand, and be committed to working to address the longer standing issues experienced by members of our Black, Brown, and Indigenous communities including: systemic racism, mistrust, day-to-day injustices, feeling talked down to, not valued and judged, and the additional stress that comes from seeking help in a time of crisis from a system in which care is often not readily available in your preferred language or in the context of your culture.

Guided by this charge, a larger, cross-sector, multidisciplinary workgroup comprised of nearly 60 individuals, including representation from Monroe County *(911, EMS, the Office of Mental Health, the Department of Human Services, and the Department of Public Health*), the City of Rochester (*Department of Recreation and Human Services*), law enforcement, area Mental Health and Substance Use provider agencies, peer service provider agencies, and community advocacy/policy groups has worked together for the past 90 days to establish priorities and to develop the strategies to address the most pressing issues facing our community's behavioral health crisis response services. A full list of participants involved in this work is included as Appendix 4.

Incorporating the community needs voiced in several input sessions held by the Racial and Structural Equity (RASE) Commission and other forums, the workgroup broke into three smaller teams focused on the following goals:

1. **Increase Connection to Behavioral Health Crisis Services** that Meet Community Need;
2. **Safely Divert 911 Calls** for Mental Health/Substance User Disorder Crises to the Most Appropriate Response Option, Activating Law Enforcement Only When Needed; and
3. **Strengthen Post-Crisis Supports** to Address the Full Range of Individual Needs, Stabilizing and Linking to Prevent Future Crises

Each of the work teams defined their own process to conduct the work, including using data as available to further refine their focus, exploring models and practices used in other communities for providing crisis and diversion services, sharing knowledge, information, literature and resources related to historical and systemic racism and disparities, barriers to care and best practice approaches and brainstorming strategies within the context of the focus on addressing disparities and improving outcomes for Black, Brown and Indigenous communities. Several of the data resources used to support this work are included in Appendix 3. While our work in this past 90 days has focused on addressing immediate priorities related to behavioral

health crisis services, the important work being done by RASE will both help to advance these priorities as well as continue to move us forward collectively address the deeper issues across service sectors.

In the sections that follow, we:

- Review the needs and priorities gathered through several listening sessions with community members who shared their experiences with the behavioral health crisis system and their ideas about the changes that are needed;
- Summarize the priorities and the specific actions to be taken to make progress in the goal areas described above;
- Outline an implementation and accountability plan, including structures to ensure progress, accountability and transparency as we work to make progress in these initial priority areas; and
- Identify areas where additional funding and investment will be needed to fully accomplish the work ahead of us.

Understanding Community Need and Incorporating Community Input

As outlined in the previous section, the COVID-19 public health crisis and the death of Daniel Prude have highlighted not only the disparities in access to, engagement in, and outcomes associated with health and behavioral health services but the longer standing implicit and explicit systemic injustice issues experienced by members of our Black, Brown, and Indigenous communities. In order to begin to address these issues and the resulting disparities, it is essential to connect with communities to not only gain a better understanding of their experiences, what is most important when seeking help, but also to involve them in meaningful ways to shape and drive the strategies and solutions to address these longer standing issues.

Much work has been done to seek the input of those in the community, particularly consumers/ recipients of behavioral health services and family members to help identify behavioral health service needs, gaps and opportunities for improvement. More recent activity has focused on seeking input from those in the community who have historically not been connected to the "formal" behavioral health system. These efforts have sought broader-based perspectives from those who may have accessed some support but are not connected to services, those who identified the need for support but have not yet sought services and trusted entities outside of the formal behavioral health system to who people in crisis may turn to. As we worked to develop our strategies and implementation plan to address crisis/emergency behavioral health services, we have gleaned relevant insights from community input gathering conducted by other groups such as the RASE Commission, the Rochester Monroe County Anti-Poverty Initiative (RMAPI), the Systems Integration Project, Monroe County, and the City of Rochester (i.e., focus groups, listening sessions, surveys, empathy interviews, discussion groups). Members of our work teams have conducted focused discussions with several groups to solicit feedback on the proposed strategies to address priorities and their further thoughts on behavioral health crisis services. A summary of these sessions may be found in Appendix 3. Of note in gathering these perspectives is the interdependency of many factors that emerge as one speaks of crisis – implicit bias of systems, poverty, immediacy of the situation, crisis as culturally defined, cultural norms and help-seeking behaviors /preferences. Each of these factors tie into the strategies used to support individuals in addressing a crisis situation.

Key themes have been gleaned from the collective work in seeking community input regarding behavioral health crisis services (and overall behavioral health services). These themes have shaped the goals established for the work of the Task Force, its work teams, and the proposed implementation plan:

- There is a lack of awareness and/or understanding of the range services available in our community to help with behavioral health crisis situations; it is not clear where to go for reliable, up-to-date information;
- There is reluctance among Black, Brown and Indigenous populations to utilize formal behavioral health services due to mistrust or lack of confidence that the service will be respectful/responsive to their cultural identity;
- There is no single response to crisis situations that will work for everyone – there needs to be alternatives or choices and a process to connect individuals to the best fit culturally responsive option to address the immediate situation;
- People in crisis are seeking immediate help/support to address the crisis; once that immediate need is met, there needs to be follow-up and support to help the person avoid recurring crisis situations;

- There needs to be accountability across the board – accountability among service providers to provide culturally responsive, equitable and quality services and accountability to the community by those charged with implementing change with:
    - Established metrics to measure progress and course correct as needed.
    - Established mechanisms for continuous involvement of the community in further shaping system change as it evolves.

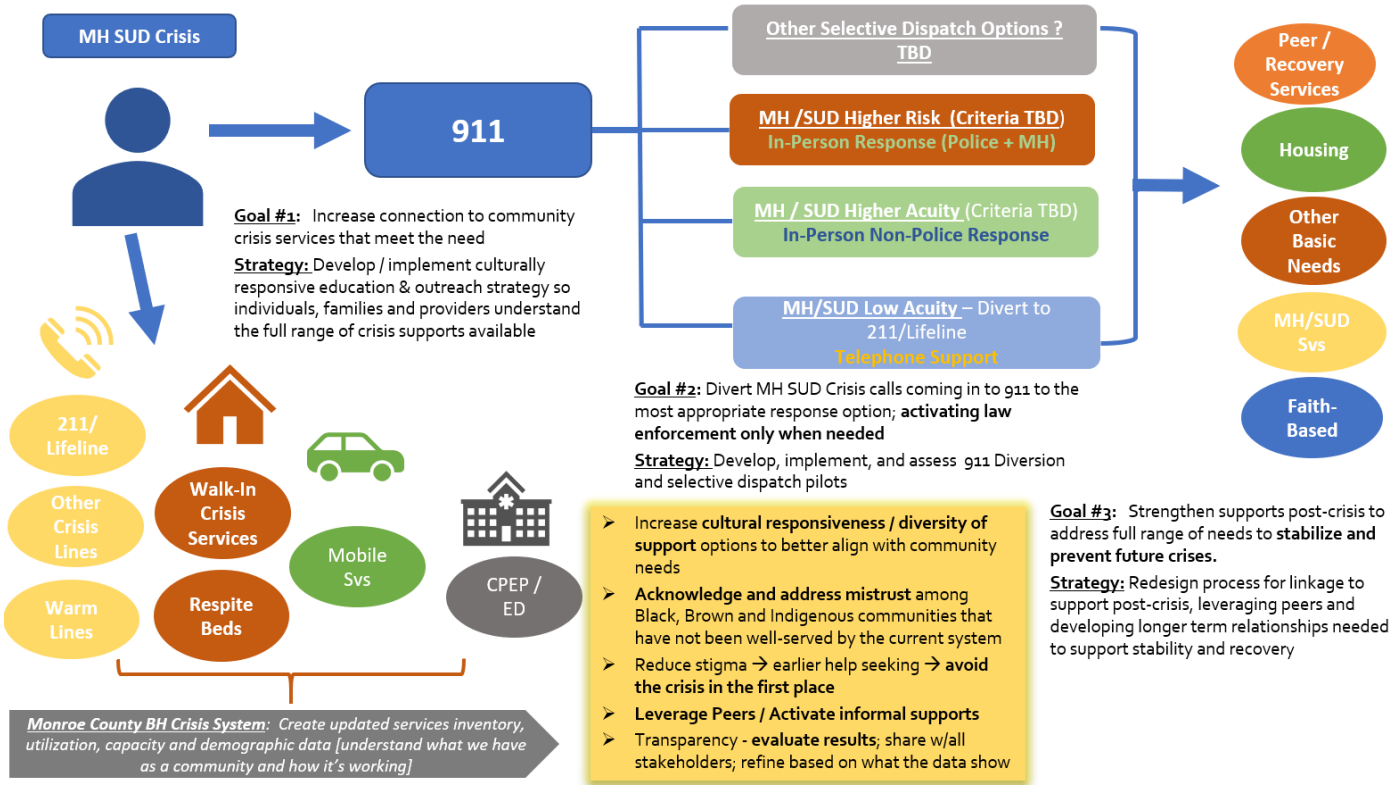
Goals and Priority Ares of Focus

Given the charge, the work of the Monroe County Mental Health and Substance Use Disorder Task Force focused on three core goals:

1. **Increase Connection to Behavioral Health Crisis Services** that Meet Community Need;
2. **Safely Divert 911 Calls** for Mental Health / Substance Use Disorder Crises to the Most Appropriate Response Option, Activating Law Enforcement Only When Needed; and
3. **Strengthen Post-Crisis Supports** to Address the Full Range of Individual Needs, Stabilizing and Linking to Prevent Future Crises

For each goal area, a multi-disciplinary work team was created and charged with the responsibility of generating priorities and strategies to advance each goal area, with an eye toward addressing immediate gaps while building toward the longer-term system transformation required for sustained impact and true change. While the work of each team was focused on their goal area, there are clear and important linkages and dependencies across these areas, as depicted in ***Figure One***, below:

Figure One – Overview of Task Force Goals and Strategies



As depicted above, the work and priorities emerging from each individual work team was guided by the following aims:

- ✓ Acknowledge and address the mistrust among Black, Brown and Indigenous communities who have not been well-served by the current system;
- ✓ Build the cultural responsiveness and diversity of behavioral health crisis support options to better align with community needs;
- ✓ Reduce stigma to enable earlier help seeking so that crises can be avoided where possible;
- ✓ Leverage peers and activate the informal, natural support within communities; and
- ✓ Do this work with transparency - using data to shape strategies and evaluate results; sharing this information routinely and broadly with key stakeholders and recalibrating approaches as needed based on data and ongoing community input.

The sections that follow summarize the specific priorities and proposed action plans for each goal area. The priorities of the work teams have been adopted by the Task Force and are presented here. Important additional detail regarding the work of each team, including the full report from each team, data that informed the work and other inputs is provided in Appendix 1 and Appendix 3. A detailed implementation plan and timeline follows, sequencing this work to begin in January 2021, with full implementation to occur in the first half of 2021.

Goal 1: Increase Connection to Behavioral Health Services that Meet Community Need

In developing strategies to address this goal, the primary area of focus for the Education/Outreach Workgroup was on education and outreach strategies aimed at community stakeholders to better connect Black, Brown and Indigenous communities with culturally responsive behavioral health emergency and crisis services. The workgroup identified multiple audiences that require focused education/training to increase their awareness and understanding of behavioral health crisis services available as well as how to identify the best option that is culturally responsive to address the immediate crisis situation. The primary audiences identified were:

- Key Influencers/touch points in Black, Brown and Indigenous communities (organizations/entities people trust and turn to and will likely listen to what they say);
- Behavioral Health providers;
- Providers across other health and human services sectors.

There are multiple sub-audiences within each of these audience categories (i.e., adults, youth, older adults, clinical staff, non-clinical staff, etc.) as well as intersectionality among these audiences.

The workgroup identified strategies for education/outreach for each of these audiences. Based on this work, the priorities over the next several months will focus on: (1) Education and training on topics including cultural humility and cultural response crisis services for behavioral health providers, including 211; (2) Outreach/identification and education for key influencers (beginning with Clergy and extending to others (e.g., CBOs, known places where people gather such as barbershops or salons); and (3) Community education, using strategies to directly reach Black, Brown and Indigenous communities with culturally appropriate messaging and materials and distribution through trusted sources to increase awareness of crisis services and how to access such services. An overview of current behavioral health crisis services may be found in Appendix 2. Additional detail regarding the priorities below is provided in Appendix 1 to this report.

<u>Priority #1</u>: Develop and deliver education and training across behavioral health and other health and human services providers to increase understanding and awareness of all behavioral health emergency/crisis services and how to identify the best fit that is culturally responsive to address the immediate crisis.

Currently, there is an array of support available for behavioral health crisis situations. There is a general lack of full understanding and awareness across providers of all service options as well as how different cultures experience and define crisis. The key steps to developing and delivering training are briefly outlined below.

- Develop core training curriculum and resource materials to support education and training, with modifications as necessary for provider and/or staff audience.
- Deliver curriculum to providers using multiple methods for group training per audience. The delivery of such training will leverage existing NYS Cultural Competence training, Health Home Care Manager training and other established training opportunities, building upon and/or supplementing such training with a focus on “Implicit Bias”, “Culture and Crisis”. Delivery of training will be phased in, with Behavioral Health providers, including 211, in Phase 1.

- Develop a "Resource Library" for posting of recorded trainings and materials.
- Monitor status of participation in scheduled training and viewing of recordings; develop plan to increase training availability and/or promote library as needed.

<u>Priority #2</u>: Outreach to key influencers/trusted organizations and individuals in the community (e.g., community-based organizations, faith community, identified community leaders, natural networks) to bridge the connection to culturally responsive behavioral health emergency/crisis services.

Building trust with the community is identified as an essential element in efforts to improve access to and utilization of behavioral health services. The strategies below focus on establishing relationships with those who are trusted in Black, Brown and Indigenous communities and providing them with education to increase their awareness and understanding of the array of crisis support services to bridge the connection to the community. Work that is currently underway to identify and outreach to key influencers/trusted organizations and individuals in the community will continue with the actions that follow.

- Identify opportunities for outreach to existing community networks to establish relationships with people who best connect with the community, building upon work done by MCOMH to address mental health needs resulting from the COVID-19 pandemic.
- Work with identified networks to understand concerns, education needs and best modes for delivery of education and develop a plan for delivery; modify elements of core training curriculum based upon needs (i.e., Faith community networks have formal training opportunities; community leaders may participate in education sessions).
- Support education with culturally appropriate, easy to understand, clear and consistent messages and materials to increase understanding and awareness of services and supports for culturally responsive behavioral health crisis situations.
- Partner with and resource community-based organizations to assist with linkages to diverse communities.
- Seek funding opportunities to support CBOs to provide such linkage.
- Monitor status of network outreach and linkage, participation in scheduled education sessions and use of Resource Library; develop plan to increase outreach and availability of education and/or promote library as needed.

<u>Priority #3</u>: Provide education/outreach to individuals in the community who may experience a behavioral health crisis, their families, and community members to increase understanding and awareness of all behavioral health emergency/crisis services and how to identify the best fit to address the immediate crisis.

Strategies will be employed to directly outreach to Black, Brown and Indigenous communities to increase awareness and understanding of the options available should they experience a behavioral health crisis. Rather than a general public education campaign, the actions outlined below provide the framework for focused approaches aimed at reaching the population, recognizing that although the message will be consistent, the mode of delivery and presentation of materials may differ by audience (i.e., youth, older adults, ethnicity, etc.).

- Develop culturally appropriate, easy to understand, clear and consistent messages and materials to increase understanding and awareness of services and supports for culturally responsive behavioral health crisis situations.
- Identify trusted natural helpers in communities and provide them with education and materials to support their interactions with individuals who may be experiencing and/or approaching a behavioral health crisis.
- Identify trusted social media and media platforms for messaging; work with platform administrators/users to design and promote messages on their venues.
- Monitor status of outreach and delivery of messages; identify gaps in audiences reached and develop plans to address gaps.

These are the first steps in what we envision will be an ongoing process of providing education and awareness of behavioral health crisis response options, increasing the cultural responsiveness of crisis supports and building trust in Black, Brown and Indigenous communities to access behavioral health services earlier to avert crisis situations.

Goal 2: Respond to Behavioral Health Crisis Calls with the Most Helpful Option, Activating Law Enforcement Only When Needed

In developing strategies to address this area of focus, the 911/Diversion Workgroup reviewed models that have been deployed successfully in other communities and utilized data describing local crisis calls for behavioral health concerns. Additional detail is provided in Appendix 1 to this report. Based on this work, priorities over the next several months will focus in two key areas: (1) Diverting behavioral health crisis calls received by 911 but that don't require an immediate, in-person response to 211/Lifeline for assessment, de-escalation and connection to services; and (2) Expanding selective dispatch options for crisis calls that require a timely in-person response.

Priority #1: Develop/implement process to divert low acuity behavioral health crisis calls from 911 to 211/Lifeline, avoiding the need to engage law enforcement where possible.

Based on data from the County's 911 system, a cohort of low acuity callers has been identified for this new process. To connect these types of callers to the resources they need while ensuring their safety, starting in January the following new process will be deployed. Key steps are recapped briefly below, and a more detailed workflow is provided in Appendix 1.

Identify Calls That Can be Diverted: The cohort of calls identified for this initial diversion pilot will include calls coming in to 911 for behavioral health concerns that are determined to be low acuity based on a screening protocol completed at 911. For this initial pilot, these calls will be limited to 1st party callers (that is, calls coming from the individual themselves so that they are able to respond directly to the screening questions). Calls coming from "911 only" phones (i.e., phones for which other call services have been disabled) will be excluded from this initial pilot to minimize the chance of any safety issues related to call disruption/reconnection.

- Assess Needs/Connect to Services: 211/Lifeline telephone counselors will assess the caller's needs, and if a safety plan can be developed, will link the caller to the service(s) that best meet their needs. 211/Lifeline has recently expanded their counselor capacity to be able to accommodate this additional call volume. Additional training and information about the full range of community behavioral health crisis services will be provided to the expanded 211/Lifeline counseling staff to ensure that callers are offered the options that best meet their needs. If 211/Lifeline counselor determines a safety plan for the caller is not possible, the caller will be linked back to 911 so an immediate, in-person response can be activated.
- Review, Update and Standardize Referral Process for Crisis Services: The Monroe County Office of Mental Health will facilitate the development of a common intake process and supporting Memoranda of Understanding (MOUs) between 211/Lifeline and behavioral health crisis providers, with a specific focus on mobile crisis services and after hours crisis options. This will include common data collection requirements and establishing expectations and standards for response times. The County will also work with providers and other community partners to develop strategies to address any transportation challenges that present barriers for callers who want to access walk-in crisis services.
- Assess Progress/Adapt as Needed: The Monroe County OMH Data Analysis unit will receive and aggregate data from 211/Lifeline, behavioral health providers, 911 and other sources to support

timely review and reporting of outcomes, including breakdown by demographic variables as available. A subset of work team members will continue to convene on a regular basis as part of an implementation/oversight team to assess progress, adjust as needed and continue to support other system transformation recommendations.

Priority #2: Expand selective dispatch options for crisis calls that require a timely in-person response.

Progress in this priority area will be addressed through three concurrent strategies that can be implemented early in 2021: (1) Expanding the Forensic Intervention Team (FIT) to address gaps, (2), Expanding local capacity to provide an in-person crisis response that does not require law enforcement; and (3) Collaborating with the City of Rochester as they launch their new in-person crisis response team.

Expand the Forensic Intervention Team (FIT) to Address Gaps: The current FIT model pairs law enforcement with a mental health clinician for calls from individuals struggling with significant mental health issues. Calls are typically dispatched by law enforcement. The County recently secured additional funding through a grant from the U.S. Department of Justice to expand the FIT coverage to address some critical gaps in the availability of this service. As such, one part of this multi-pronged strategy will include:

- Adding 2 full-time clinicians to the current 5-member FIT team to pair with law enforcement officers responding to calls between the hours of 7:00 pm and 3:00 am. Based on historic call volume data and identified needs, these new resources will be prioritized to calls from the Rochester Police Department. Recruitment is already underway and is focused on candidates who reflect the diversity of and have connections with the communities served by this expanded team.
- FIT staff will participate in training being offered to behavioral health providers, including training that focuses on delivering culturally appropriate and responsive services with an emphasis on implicit/unconscious bias.
- In parallel to this process, Monroe County OMH will be redirecting resources to add an additional full-time staff person and per diem coverage to FIT as needed to support a 24 x 7 response to address needs across the County.
- As FIT expansion efforts unfold, Monroe County OMH will revisit program goals and performance metrics and develop a data analysis and reporting strategy to assess progress in critical outcome areas and continue to adapt as needed.

Expand Capacity for Other (Non-Law Enforcement) In-person Response Options: Mobile behavioral health crisis services are also available through the University of Rochester Medical Center's Mobile Crisis Team and through a mobile team linked to Rochester Regional Health System's Behavioral Health Access and Crisis Center (BHACC). The Monroe County Office of Mental Health will continue to partner with these providers to identify, develop and implement strategies to expand capacity within these services to respond to community need.

Partner with the City of Rochester in Launching its new Crisis Response Team (CRT): Staff from the Monroe County Office of Mental Health have been working closely with the City of Rochester (and other partners, including 911 and 211/Lifeline) as it develops and pilots a new in-person Crisis

Response Team. This collaboration will continue, including working to develop strategies and protocols to provide back-up support in cases where the Crisis Response Team is not available to respond.

Assess Progress/Adapt as Needed: The Monroe County OMH Data Analysis unit will receive and aggregate data from law enforcement, behavioral health providers and other sources to assess progress using performance indicators/metrics to be developed in January, including metrics to measure progress in addressing disparities for Black, Brown and Indigenous people. Representatives from the County, City and providers will continue to convene on a regular basis to support implementation, assess progress, and adapt as needed.

These are the first steps in what we envision will be an ongoing process of expanding the array of crisis response options in our community, with the aim of matching the response to the needs and preferences of the individuals and families in need of support in their time of crisis. Based on the impact of these 3 initial strategies, other diversion and selective dispatch options will be considered for development.

Goal 3: Strengthen Post-Crisis Supports to Address the Full Range of Individual Needs, Stabilizing and Linking to Prevent Future Crises

In developing strategies to address this goal, the Post Crisis Connections Workgroup explored two regional approaches to behavioral health crisis response, Suffolk County's DASH program and Pittsburgh's Resolve program. The workgroup synthesized information learned from these approaches with experience from local practices and identified four priority components of follow-up services for further assessment and discussion: phone-based resources, mobile teams, walk-in services and the vital role of peer supports across all stages of crisis response. Each of these components was analyzed in terms of current status/availability in Monroe County and what the ideal state of these resources could be. Based on this work, the priorities over the next several months will focus on: (1) Availability/awareness of follow up resources; (2) Community standards for crisis follow up; (3) Involvement of care management services and (4) The role of peer supports across levels of crisis response.

Priority #1: Ensure awareness, availability and coordination of follow up resources across various locations and platforms (phone, mobile, walk-in).

A key aspect of the crisis response approaches explored was coordination of follow-up resources. This requires awareness and understanding of the supports available. Currently, there is an array of follow-up support options available post-behavioral health crisis situations. The key steps to ensuring awareness are briefly outlined below.

- Integrate post-crisis support information into education/training curriculum being developed that includes a focus on implicit bias and cultural responsiveness.
- Integrate post-crisis support information into multimedia creation/distribution (e.g., print and digital), with a priority placed on outreach to culturally diverse communities and natural resource networks.
- Participate in broader community efforts to ensure descriptive information about services and resources is accurate and up to date (e.g., 211 Community Resources repository).
- Monitor status of follow-up resources and develop plan to increase capacity as needed.

Priority #2: Develop community standards for crisis follow-up that will be used across all crisis support services that is based on the needs and desires of each individual but also includes a structure for essential follow-up actions to ensure linkage to appropriate resources.

Linkage to appropriate post-crisis support is an important aspect of helping individuals avert future crisis situations. The actions below will help to ensure that the follow-up offered is responsive to the individual's needs, desires and cultural preferences. Having an MOU among providers will additionally help to ensure that services are available/accessible in a timely manner post-crisis. Work in this priority area will also link to efforts underway through the Systems Integration Project to establish a shared language and common practices for assessment and service navigation.

- Develop list of follow-up actions that should be part of all crisis follow up processes.

- Develop community standards for training requirements for staff doing crisis follow-up and determine resources necessary for ongoing availability of training resources.
- Engage stakeholder groups to achieve commitment to community standards; develop MOUs.
- Implement community standards for follow-up actions.
- Monitor status of MOUs, adherence to standards, and needs for further training.
- Identify resources to support training standards and implement ongoing training plan.

Priority #3: Ensure access to and availability of care management services following a crisis. This should include offering referrals at every stage of crisis response, effective communication between providers, timely follow-up by care management staff, and ongoing training/education for care managers.

Strategies will be employed to improve the processes for linkage to care management services immediately post-crisis, including re-engaging individuals with their current care management provider or initiating referral for those who are not enrolled. The action steps below will be implemented in collaboration with the Health Homes operating in Monroe County.

- All crisis providers will inquire about or check status of care management services and submit referrals as needed.
- Crisis and follow-up services will implement process for notifying care managers of current or recent crisis; crisis services providers will be provided with a list of Care Management programs, supervisors, and after hours contact information.
- Care management programs will commit to contact within 24 hours for people experiencing a behavioral health crisis.
- Work with Health Home Care Management entities and providers to monitor expectations and standards, training and ongoing coaching needs for care management crisis follow-up and enhance as needed.

Priority #4: Enhance and maximize peer support options at all stages of a crisis, with opportunities for ongoing connections to people with lived experience during the follow-up process. Workforce development and program funding will be key parts of this process.

Peer support is considered a best practice for both mental health and substance use disorders. Strategies will be employed to increase the awareness of peer support services as well as to increase the availability of peer support through targeted workforce development. Key action steps are summarized below.

- Increase awareness of existing peer resources through incorporating peer services into education/training and outreach among community members, clinicians, and people seeking services.
- Participate in broader community efforts to ensure descriptive information about services and resources is accurate and up to date (e.g., 211 Community Resources repository).

- Convene community collaborative to develop plan for peer workforce development, including recruitment, training, scope of practice/position descriptions, competitive wage bands, and credentialing /supervision resources.
- Promote recruitment of peer professionals, with a focus on peers from Black, Brown and Indigenous communities, via community outreach and advertising by existing peer programs.
- Monitor capacity, utilization of and demand for existing peer services/programs.
- Explore sustainable funding options for expanding range and capacity of peer supports available in community while ensuring fidelity of these services.

These are the first steps in what we envision will be an ongoing process of improving linkage to culturally responsive post-crisis, support services that will help individuals establish and/or maintain linkage with behavioral services and supports and avert future crisis situations.

Longer Term Goal: Ensure the Provision of Culturally Responsive and Effective Behavioral Health Services and Support

The goals, priorities and action steps outlined above require that action occurs to advance health equity, improve quality, and address and eliminate racial and ethnic health care disparities by ensuring the provision of culturally responsive and appropriate services and care. Providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs will facilitate the elimination of healthcare inequities experienced by racial and ethnic minorities and other underserved populations.

This goal can only be realized with the sustained commitment of all community stakeholders, as a well-coordinated, collaborative process among those charged with implementation of the RASE Commission recommendations, the County's Diversion, Equity and Inclusion Department, Systems Integration Project Equity Board and other community-wide Diversity, Equity and Inclusion initiatives.

The below action steps represent the first steps to operationalize longer term actions to address this priority. These action steps outline an approach for moving this goal forward in 2021 with Monroe County contracted behavioral health provider agencies. This work will be on-going, with 2021 as the baseline. More detailed action steps and progress markers for this goal are articulated in the Education/Outreach Work Team Report recommendations.

- Assessment of Agency Diversity, Equity and Inclusion (DEI) Practices
    - Conduct focused, agency DEI self-assessment to (a) create an individual baseline and (b) to provide Monroe County with a solid, system-wide picture of where agencies stand relative to key DEI expectations.
    - Analyze and use the results; Review with County and with provider agency leadership. Identify and prioritize needs, gaps, and barriers.
    - Use data to prioritize, set goals for 2022, and to identify needs for technical assistance – both agency-specific and system-wide.
- Learning and Insight: Implementation Support for Lasting DEI Change
    - Provide meaningful opportunities for agency leaders to come together to improve their understanding (i.e., do the individual work) and provide the technical assistance/implementation support needed to apply these insights and learnings to agency policies and practices.
    - MCOMH staff will incorporate the review of performance data (agency-specific and system-wide), stratified by race/ethnicity, into routine provider meetings as well as individual contract performance reviews (e.g., provider engagement visits).
- Accountability
    - Establish individual and system-wide targets based on self-assessment; Reassess beginning in 2022 to track progress.
    - Create linkages between performance targets (both process and outcome) and contract funding.

- Support County's newly created DEI Department to ensure that the County procurement process and evaluation criteria incorporate evidence of an understanding of and a commitment to DEI as part of the scoring rubric.

The above goals and priorities summarize the work of the teams established to carry out the charge given to the 90-Day Task Force. With the implementation of these priorities, the following outcomes will be realized:

- Community members and stakeholders will be more aware of behavioral health crisis response options and will be better positioned to inform/support individuals seeking help;
- The system will provide an expanded range of behavioral health crisis response options that ensure safety AND better fit the needs of our community;
- There will be a decreased reliance on addressing behavioral health crisis situations through 911 and law enforcement responses;
- Individuals accessing crisis services will consistently be connected to culturally responsive post-crisis care that understands and responds to their needs and creates the support and connection needed to help prevent future crises;
- We will have strengthened cross-sector collaboration and created the structures and data-informed practices to allow us to continue to assess progress, address gaps and evolve the behavioral healthcare system to meet the needs of our community;
- The behavioral health system will move forward in addressing long-standing inequities and show improvement in providing culturally responsive services and supports.

From Strategy into Action - Create Structures for Implementation and Accountability

The work outlined in the previous section has already begun, but to be successful, it will take ongoing management, coordination, and the ability to use data to assess progress and adapt as needed to achieve our goals. To that end, the sections that follow lay out an implementation plan, timeline, and data analysis strategy with a January start date. Coordination and data analytic support will be provided by the Monroe County Office of Mental Health. Key elements include:

- ✓ We will form a multi-disciplinary, cross-systems ***MH SUD Task Force Implementation Oversight Team (the team)***, including community members, to continue the work and guide implementation over the next 12 months. The team will have diverse racial and ethnic representation. Participation agreements will be secured to ensure consistent, cross-sector involvement as the work unfolds. In addition, it will be important to ensure that the team includes community members with direct experience with the behavioral health system and that there is a mechanism to stipend them for providing their expertise and insights as the work unfolds. Members will receive orientation and education to better understand and be aware of cultural nuances, implicit bias and cultural responsiveness as they guide the implementation.
- ✓ The team will report to the ***Monroe County OMH Community Services Board,*** which will be charged with overseeing progress. (*Each county in New York State is required under NYS Mental Hygiene Law to have a Community Services Board, which acts in an advisory capacity to the Director of Mental Health in areas including: needs of persons with mental health and substance use disorders, system-wide priorities, and longer-range goals. Rather than duplicating, we propose leveraging this existing structure to oversee this important work)*

Build Linkages to Other Community Tables

While the ***MH SUD Task Force Implementation Oversight Team*** will be responsible for advancing the goals that have been established through this Task Force, it will be important to create consistent, efficient linkages to other community "tables," creating synergy, sharing information routinely and working across systems and structures to transform the ways services are provided. There are a number of workgroups or community "tables" that are already bringing providers and other stakeholders together. Rather than duplicate, it will be important to:

- Identify existing workgroups and tables (such as the Emergency Services Committee, Systems Integration Project, RPC Chief's meeting, Substance Use Providers, etc.) working to address crisis, behavioral health, and related community needs; and
- Build processes to ensure connection, information-sharing and collaboration across these workgroups.

Measure and Share Progress; Adjust as Needed to Achieve Results

The Monroe County Office of Mental Health's Data Analysis Unit has a number of existing data sources that have been used to shape the strategies outlined in this report and that will continue to be used and expanded on as needed to monitor the impact of this work. These include:

- The Behavioral Health Community Database (BHCD) – a community database maintained by the Monroe County Office of Mental Health that provides client-level demographic and service utilization for individuals receiving services within the public mental health system.
- The Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) – a web-based data system developed by the NYS Office of Mental Health (OMH) and available to local offices of mental health and behavioral health providers. PSYCKES includes Medicaid claims and encounter data and other administrative data to support quality improvement, clinical decision-making and care coordination.
- Specialized Datasets: The Monroe County Office of Mental Health has developed a number of specialized datasets to support the work of FIT, monitor law enforcement transports for individuals with behavioral health issues, and facilitate linkage of clients in jail to services needed to support re-entry.

Following requirements related to data sharing, reports from these data sources are routinely shared with providers and other system partners to better understand issues, identify gaps, and assess performance.

In addition to leveraging these existing resources, the Monroe County OMH team is working with the Rochester RHIO (Regional Health Information Organization) and other collaborators to bring additional data to bear as we assess the impact of these changes and plan for the ongoing evolution of the current system.

As we move into implementation, priorities will include:

- Developing a data collection/analysis strategy for each Task Force Goal, including Key Performance Indicators (KPIs);
- Ensuring that data collection/analysis strategy includes a focus on key variables required to understand and reduce disparities in access and outcomes;
- Developing clear, actionable, monitoring reports to assess progress toward these KPIs;
- Creating the opportunity for routine data/process review among members of the MH SUD Task Force Oversight Team; and
- Ensuring regular opportunities for input/information sharing with community groups to review progress, problem-solve issues, and continue to build understanding of community experiences, priorities and needs.

The section that follows includes a work plan outlining the key activities and milestones for 2021.

Key Activity / Milestone	4-Jan	11-Jan	18-Jan	25-Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
From Recommendations into Action --> Build Structures for Implementation and Accountability															
Create multi-disciplinary, cross-systems ***MH SUD Task Force Implementation Oversight Team*** , including community members, to guide implementation. Secure participation commitments for 2021 and provide stipends to community members providing expertise to the workgroup. Facilitation and coordination to be provided by Monroe County OMH.															
Create Linkage to ***Monroe County OMH Community Services Board*** for ongoing oversight, consistent with this body's statutory responsibilities															
Set work team calendar for 2021															
Build Linkages to other "Community Tables" and Initiatives; Creating Synergy, Sharing Information, and Working Across Systems and Structures to Transform Services															
Identify existing workgroups and tables (e.g., Emergency Services Committee, Systems Integration Project (SIP), substance use providers workgroups, etc.)															
Create and operationalize structure for ensuring connection, information-sharing and collaboration across workgroups.															
Measure and Share Progress; Adjust as Needed to Achieve Results															
Develop data collection / analysis strategy for each Task Force Goal; including defining Key Performance Indicators (KPIs) for each area															
Develop clear, actionable, monitoring reports															
Incorporate routine data / process review into the work of the MH SUD Task Force Implementation and Oversight Team															
Ensure regular opportunities for input / information sharing with community groups to review progress, problem-solve, and continue to build understanding of community experiences, priorities and needs.															
Goal Area 1: Increase Connection to Behavioral Health Crisis Services that Meet Community Need															
Priority 1: Develop and deliver education and training across behavioral health and other health and human services providers to increase understanding and awareness of all behavioral health emergency/crisis services and how															
Develop core training curriculum															
Develop resource materials to support education and training; establish mechanism for posting of materials and recorded training in a Resource Library.															
Deliver education/training for behavioral health and other providers															
Priority 2: Outreach to key influencers/trusted organizations and individuals in the community (i.e., community-based organizations, faith community, identified community leaders, natural networks, etc.) to bridge the															
Initiate networking/outreach for trusted community organizations, entities and leaders (i.e., faith-based, CBOs, salons/barbershops, neighborhood associations, etc.), including natural helpers.															
Provide education/training opportunities to identified networks, using multiple approaches/modes.															
Partner with and resource community-based organizations to assist with linkages to diverse communities.															
Priority 3: Provide education/outreach to individuals in the community who may experience a behavioral health crisis, their families, and community members to increase understanding and awareness of all behavioral health															
Develop culturally relevant, easy to understand information resources (print, media, etc.) about behavioral health emergency/crisis supports															
Provide community education and outreach about behavioral health emergency/crisis supports															
Identify trusted natural helpers in communities and provide them with education and materials to support their interactions with individuals who may be experiencing and/or approaching a behavioral health crisis.															
Identify and reach out to trusted social media and media sources; develop plan(s) with media to promote messages on their venues															
Longer Term Priority: Long term action to ensure the provision of culturally responsive and effective behavioral health services and support															
Begin more focused work toward the longer term actions needed to provide culturally responsive and effective behavioral health services, including expectations and accountability across behavioral health providers.															
Goal Area 2: Respond to Behavioral Health Crisis Calls with the Most Appropriate Option, Activating Law Enforcement Only When Needed															
Priority #1: Develop / implement process to divert low acuity behavioral health crisis calls from 911 to 211/Lifeline, avoiding the need to engage law enforcement where possible															
911 calls determined to be (a) low acuity (following current screening protocols); (b) 1st party callers; and (c) not coming from a "911 only" phone will be triaged to 211/Lifeline *[Note: Start date to be coordinated with City's Crisis Team to optimize implementation with 911 teams)*															
Develop a common Intake Process / supporting MOUs)between 211/Lifeline and behavioral health crisis providers, w/specific focus on mobile crisis services and afterhours crisis options															
Viable, short-term solution to address transportation needs that create barriers to accessing walk-in crisis services will be developed as needed.															
The Monroe County OMH Data Analysis unit will receive and aggregate data from 211/Lifeline, behavioral health providers and other sources to support timely review and reporting of outcomes.															

Key Activity / Milestone	4-Jan	11-Jan	18-Jan	25-Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Priority #2: Expand selective dispatch options for crisis calls that require a timely in-person response															
Expand the FIT Team to Address Gaps : Add 2 full time clinicians to the current FIT team to support calls from RPD between 7:00 pm and 3:00 am.															
Recruitment / onboard new positions with clinicians who reflect the diversity of the communities served. (Recruitment underway; Target early February)															
Fund and recruit additional clinical FTE and per diem coverage as needed to support a 24x7 response option to address needs across the County.															
Expand Capacity for Other In-person Crisis Response Options (Non-Law Enforcement) : MC OMH will work with the University of Rochester and Rochester Regional Health System to expand the capacity of exiting in-person mobile crisis supports to respond to community need.															
Monroe County OMH and the City of Rochester will continue to collaborate to coordinate response from the City's new Crisis Team and FIT to maximize coverage to calls placed from with the City of Rochester.															
Partner with the City of Rochester in Launching its new Crisis Response Team (CRT): Continue to coordinate with the City of Rochester (and other partners, including 911 and 211/Lifeline) as it develops and pilots a new in-person Crisis Team, including developing strategies and protocols to provide back-up support in cases where the Crisis Team is not available to respond.															
Assess Progress / Adapt as Needed: The MC OMH Data Analysis unit will receive and aggregate data from law enforcement, behavioral health providers and other sources to assess progress using performance indicators / metrics to be developed in January.															
Goal Area 3: Strengthen Post-Crisis Supports to Address the Full Range of Individual Needs, Stabilizing and Linking to Prevent Future Crises															
Priority #1: Ensure awareness, availability & coordination of follow up resources across locations and platforms (i.e., phone, mobile, walk in);															
Integrate into curriculum being developed by Education/Outreach work team, with a priority placed on outreach to culturally diverse communities and natural resource networks.															
Multimedia creation/distribution (e.g. print and digital) to promote follow up resources among community members, clinicians, and people seeking services.															
Review of current resource guides to ensure accuracy (DePaul NCADD, MHA Finding Your Way, MCOMH/City website, etc.)															
Monitor status of follow up resources and develop plan to increase capacity as needed.															
Priority #2: Develop and implement community standard for crisis follow up that will be used across all crisis support services that is based on the needs and desires of each individual but also includes a structure for essential															
Develop list of core follow up questions that should be part of all crisis follow up processes															
Develop community standards for training requirements for staff doing crisis follow up (potentially including Motivational Interviewing, Person Centered Practices, Trauma Informed Practices, Cultural Competence/Responsiveness, and awareness of community resources.)															
Indicate resources necessary for ongoing availability of training resources.															
Engage stakeholder groups to achieve commitment to community standards; develop MOU.															
Implement community standards for follow up questions															
Identify resources to support training standards (including possible support from MCOs and other funding sources) and implement ongoing training plan.															
Priority #3: Ensure access to and availability of care management services following a crisis, including offering referrals at every stage of crisis response, effective communication between providers, timely follow up by care															
All crisis providers will inquire about or check status of care management services (EMedNY, PSYCKES, etc.) and submit referrals as needed. (Note: Providers will be encouraged to provide as much information regarding cultural/language needs to ensure best match to appropriate CM program.)															
Crisis and follow up services will implement process for notifying care managers of current or recent crisis.															
Provide crisis services with list of CM programs, supervisors, and after hours contact info.															
Care management programs commit to contact within 24 hours for people experiencing a crisis.															
Work w/Health Homes to confirm training standards and ongoing coaching for care management re: crisis follow up and enhance as needed. Potential topics should include Motivational Interviewing, Person Centered Practices, Trauma Informed Practices, Cultural Responsiveness, and awareness of community and cultural resources.															
Priority #4: Maximize and enhance peer support options at all stages of a crisis, with opportunities for ongoing connections to people with lived experience during the follow up process.															
Increase awareness of existing peer resources via multimedia creation/distribution (e.g. print and digital) among community members, clinicians, and people seeking services.															
Review current resource guides to ensure accuracy (DePaul NCADD, MHA Finding Your Way, MCOMH/City website, etc.)															
Convene community collaborative to develop plan for peer workforce development, including recruitment, training, scope of practice/position descriptions, competitive wage bands, and credentialing/supervision resources. Existing peer stakeholder groups could be leveraged to facilitate this collaborative effort.															
Promote recruitment of peer professionals via community outreach and advertising by existing peer programs															
Monitor capacity, utilization of and demand for existing peer services/programs.															
Explore sustainable funding options for expanding range and capacity of peer supports available in community while ensuring fidelity of these services.															

Next Steps - Supporting the Work

Much can be accomplished through continued cross-systems collaboration and by leveraging and re-directing existing Monroe County OMH resources. However, achieving the goals we have established in this report will also require continued collaboration and linkage to other systems initiatives to create synergy, avoid duplication, and maximize resources, including the significant and important work underway under the auspice of the Systems Integration Project (SIP) and the Racial and Structural Equity (RASE) Commission and its subcommittees. Importantly, the channels currently being developed to promote education about and access to the COVID-19 vaccine may also create inroads for education and connection to this community's behavioral health crisis services. We must and will continue to work to align the community's efforts.

Moreover, while some of this work can be jumpstarted through the re-direction of existing resources, the ability to secure supplemental resources to support key activities, particularly those tied to communication, education, outreach and training will be critical.

Finally, as noted at the start of this report, it is important to note that this is just the beginning of a much needed, broader, longer-term effort to transform the way services are provided to members of our community whose needs have not been met. But it is a beginning, and if we can be laser focused on these initial building blocks, we expand the likelihood of success as we work toward longer-term transformation across our community's behavioral health and healthcare systems, with the aim of improving outcomes and elimination of disparities.

APPENDIX 1

WORK TEAM REPORTS

Appendix 1

MONROE COUNTY MENTAL HEALTH & SUBSTANCE USE DISORDER 90-DAY TASK FORCE

EDUCATION/OUTREACH WORK TEAM SUMMARY REPORT

December 2020

EDUCATION/OUTREACH WORK TEAM SUMMARY REPORT

WORK TEAM CHARGE

The Education/Outreach Work Team was convened on October 2020 and given the charge "To develop a culturally responsive education and outreach strategy to help individuals, families and providers understand the full range of crisis supports available (outside of 911) – as well as efforts to make changes to better respond to community needs". The Work Team is comprised of 9 participants representing an array of stakeholder groups, including community organizations, 211/LIFELINE, behavioral health providers, peers, and individuals with close ties to Black, Brown and Indigenous communities. The Team met for 90 minutes on a weekly basis starting on 10/19/20, with additional work conducted between meetings. All work was conducted using a racial equity lens. The following tasks were identified to be accomplished within a 90-day period:

1. *Identify key audiences for whom education and outreach is needed:*

Outcome: The Work Team identified several key audiences for whom education and outreach is needed:

- Individuals who may use services or are close to those who may be experiencing a crisis;
- Key Influencers/touch points in Black, Brown and Indigenous communities (organizations/entities people trust and turn to and will likely listen to what they say);
- Behavioral Health providers;
- Providers across other health and human services sectors.

There are multiple sub-audiences within each of these audience categories (i.e., adults, youth, older adults, clinical staff, non-clinical staff, etc.) as well as intersectionality among these audiences. This will require the use of multiple methods for delivering the message, as well as for the development of materials.

2. *Develop strategies for reaching the audiences – getting the message/information/education into each audience's hands.*

Outcome: The Work Team reviewed each of the audiences and sub-audiences to develop strategies that may be effectively employed to reach the audience. Certain elements were identified that are integral to any strategy used:

- Stigma reduction
- Cultural responsiveness /understanding cultural nuances
- Attention to Bias, both implicit and explicit bias in messages and delivery
- Anti-racism models
- Addressing fear, mistrust, historical racial trauma & inequity – acknowledge/validate
- Within the above context, identifying the best fit option that is culturally responsive to address the immediate crisis.

To be most effective, education/outreach must occur for multiple key audiences simultaneously. Behavioral health and other health and human services providers will need education and training

regarding new/modified (as well as existing) emergency/crisis services options, along with better understanding of cultural nuances as related to crisis situations. The delivery of messages through trusted/credible community sources is considered critical as community outreach is conducted to increase awareness of the options available for addressing behavioral health emergency/crisis situations. These trusted sources may include natural helpers, cultural brokers, organizations embedded in communities (i.e., places of worship, neighborhood businesses or gathering spots, etc.).

3. *Create clear, relatable, culturally responsive, educational / communications messages and materials:*

Outcome: The Work Team focused on the strategies for delivering the message(s) to key audiences, with the overall message being where to turn to in a behavioral health crisis/emergency situation. This includes: What is available? How to identify the best option for the situation? How to access which option? What to expect from the response? What to expect for support after the immediate crisis is addressed? The specifics in each of these areas will be informed by the work currently underway in the related Work Teams (911/Diversion; Post Crisis Connections). As related to education/training for behavioral health and other health and human services providers, the Work Team identified the core elements for a training curriculum to help providers better understand crisis and culture as the foundation for any crisis response.

4. *Develop immediate and longer-term recommendations for enhancing the cultural responsiveness of behavioral services.*

Outcome: The Work Team conducted its work through a racial equity lens, with a focus on improving services and outcomes for Black, Brown and Indigenous populations in our community. Although the Team's charge was related to the behavioral health emergency/crisis system, it was recognized early that this work touched on equity and cultural responsiveness across the entire system – particularly how access to culturally responsive services and supports earlier may avert escalation to crisis. The Work Team has developed a recommendation for actions to ensure the provision of culturally responsive and effective behavioral health services and support, including expectations and accountability across behavioral health providers.

RECOMMENDATIONS

The Education/Outreach Work Team has developed a series of recommendations for implementing a culturally responsive education and outreach strategy to increase understanding and awareness of behavioral health emergency/crisis services among multiple audiences in the Monroe County community, with a focus on Black, Brown and Indigenous communities. These recommendations are supported by strategies and action steps that are linked with efforts underway to improve the response to behavioral health emergency/crisis situations in our community and the outcomes experienced by individuals who utilize such services. Detailed notes and work accomplished to support the action steps delineated in these recommendations will provided to the implementation teams established.

The primary recommendations fall into the following key areas:

- Education/training for behavioral health and other providers

- Networking/outreach and education for trusted community organizations, entities and leaders (i.e., faith-based, CBOs, salons/barbershops, neighborhood associations, etc.), including natural helpers in the community.
- Community education and outreach supported with the development of culturally relevant, easy to understand information resources (print, media, etc.) regarding behavioral health emergency/crisis supports available.
- Long term action to ensure the provision of culturally responsive and effective behavioral health services and support, including expectations and accountability across behavioral health providers.

Recommendation #1:
Provide education and training across behavioral health and other health and human services providers to increase understanding and awareness of all behavioral health emergency/crisis services and how to identify the best fit that is culturally responsive to address the immediate crisis.

Action steps	Metric	Timeline
1. Develop core training curriculum, with modifications as necessary for provider and/or staff audience; leverage existing NYS Cultural Competence training opportunities.	Curriculum developed, incorporating key elements	TBD
2. Develop resource materials to support education and training; establish mechanism for posting of materials and recorded training in a Resource Library.	Print and digital versions of materials available for distribution; Resource Library established	Q1 2021
3. Deliver Curriculum to Providers – Group Training per audience delivered and recorded a. Behavioral Health Providers b. Other Related Providers	Provider training scheduled and delivered; recordings posted in library	Q1 2021 – BH Providers Q2 – Other Providers
4. Monitor status of participation in scheduled training and viewing of recordings; develop plan to increase training availability and/or promote library as needed.	Define performance measures and monitor no less than quarterly.	Start Q1 2021, then ongoing

Recommendation #2:
Outreach to key influencers/trusted organizations and individuals in the community (i.e., community-based organizations, faith community, identified community leaders, natural networks, etc.) to bridge the connection to culturally responsive behavioral health emergency/crisis services.

Action steps	Metric	Timeline
1. Identify opportunities for outreach to existing community networks to establish relationships.	Networks identified and relationships developed	Underway
2. Partner with and resource community-based organizations to assist with linkages to diverse communities. Understand the limitations of the	CBO's are identified and resources secured	Q1/Q2 2021

system and work with the people who know how to work with the community.		
3. Work with identified networks to understand concerns, education needs and best modes for delivery of education and develop plan for delivery. Phase-in as network/audiences are identified, beginning with Faith-based/Clergy	Plans for delivery of education are developed for Faith-Based/Clergy network(s);	Q1 2021
4. Modify core training curriculum developed as necessary per network need and delivery method, use essential elements of curriculum for education sessions	Elements of core curriculum are modified	Q1 2021
5. Develop resource materials to support education and training; establish mechanism for posting of materials and recorded training in a Resource Library.	Print and digital versions of materials available for distribution; Resource Library established.	Q1 2021
6. Provide education/training opportunities to identified networks, using multiple approaches/modes.	Faith-based/clergy education/ training scheduled and delivered	Q1 2021
7. Monitor status of network outreach and linkage, participation in scheduled training and viewing of recordings; develop plan to increase outreach and availability of education and/or promote library as needed.	Define performance measures and monitor no less than quarterly.	Start Q1 2021, then ongoing

Recommendation #3:
Provide education/outreach to individuals in the community who may experience a behavioral health crisis, their families, and community members to increase understanding and awareness of all behavioral health emergency/crisis services and how to identify the best fit to address the immediate crisis.

Action steps	**Metric**	**Timeline**
1. Develop culturally appropriate, easy to understand, clear and consistent messages to increase understanding and awareness of services and supports for culturally responsive behavioral health crisis situations.	Messages developed that may be used across multiple platforms	Q1 2021
2. Identify trusted natural helpers in communities and provide them with education and materials to support their interactions with individuals who may be experiencing and/or approaching a behavioral health crisis.	A cadre of natural helpers is identified and provided with education and materials	Begin Q1 2021; on-going
3. Identify trusted social media platforms for messaging; work with platform administrators/users to design delivery	Platforms are identified; messaging	Q1 2021

	tailored to reach platform audience	
4. Identify and reach out to trusted media sources; develop plan(s) with media to promote messages on their venues	Media identified; plan developed to support messaging on venues	Q1 2021
5. Distribute print materials through key influencers, behavioral health providers and other health and human services sectors.	Materials distributed	Q1 2021
6. Monitor status of outreach and delivery of messages; identify gaps in audiences reached	Define performance measures and monitor no less than quarterly	Start Q1 2021, then ongoing

Recommendation #4:
Longer Term Goal: Ensure the provision of culturally responsive and effective behavioral health services and support.

This recommendation is intended to advance health equity, improve quality, and address and eliminate racial and ethnic health care disparities by ensuring the provision of culturally responsive and appropriate services and care. Through the implementation of the recommendations listed below, a new benchmark can be established for culturally responsive and appropriate services to improve the health of all individuals especially racial and ethnic minorities and other marginalized populations.

Providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs will facilitate the elimination of healthcare inequities experienced by racial and ethnic minorities and other underserved populations.

Organizations should be required to create a strategic plan that lays out a framework and timeline for operationalizing the recommendations. Some of the elements of the recommendations will be included in the curriculum. Additionally, organizations must have a common understanding in the interpretation of the recommendations.

The below Action Steps represent the first steps to operationalize longer term actions to address this priority. These action steps outline an approach for moving this goal forward in 2021 with Monroe County contracted behavioral health provider agencies.

Action Steps	**Tasks**	**Timeframe**
Assessment of Agency Practices	• Conduct focused, agency DEI self-assessment to (a) create an individual baseline and (b) to provide Monroe County with a solid, system-wide picture of where agencies stand relative to key DEI expectations.	Q1/Q2 2021
	• Analyze and use the results; Review with County and with provider agency leadership. Identify and prioritize needs, gaps, and barriers.	Q2 2021

	• Use data to prioritize, to set progress goals for 2022, and to identify needs for technical assistance – both agency-specific system-wide.	Q3/Q4 2021
Learning / Insights: Implementation Support for Lasting Change	• Provide meaningful opportunities for agency leaders to come together to improve their understanding (do the individual work) and provide the technical assistance / implementation support needed to apply these insights and learnings to agency policies and practices • MCOMH staff will incorporate the review of performance data (agency-specific and system-wide), stratified by race/ ethnicity, into routine provider meetings as well as individual contract performance reviews (e.g., provider engagement visits).	Q2 2021 Q2/3 2021
Accountability	• Establish individual and system-wide targets based on self-assessment; Reassess beginning in 2022 to track progress • Create linkages between performance targets (both process and outcome) and contract funding • Support County's newly created DEI Department to ensure that the County procurement process and evaluation criteria incorporate evidence of an understanding of and a commitment to DEI as part of the scoring rubric	Q4 2021 Q3/4 2022 Q1 2021

The process identified above will provide the information for organizations to develop a strategic plan to operationalize the recommendations for cultural competence based upon their assessment. The key elements for such a plan are summarized below, along with the indicators demonstrating the presence of these elements in the organization's plan.

Elements of Organizational Cultural Competence and Indicators

Element	Indicator
Advance and sustain organizational governance and leadership that promotes health equity through policy, practices, allocated resources and a diverse workforce.	1. Dedicated budget for DEI and cultural competence activities and training 2. Recruit, promote, and support a culturally diverse governance, leadership, and workforce that are responsive to the population in the service area. 3. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. 4. Complete and sustain the *Ethnicity at a Glance,* a matrix of race/ethnicity characteristics of staff (by category), Governing Board and service recipients.

Offer language assistance to individuals who have Limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	1. Develop and maintain a process for identifying the cultural nuances of the client (to include language and reading skills of clients, family members and advocates for the client.) 2. Facilitate access to language services 3. Recruiting bi-lingual, bi-cultural staff. Ensure competency of such staff. 4. Establish contracts with interpreter services for in person, over the phone, and video remote interpreting. Ensure competency in language assistance (e.g., interpreting skills for health/behavioral care settings). 5. Use cultural brokers when an individual's cultural beliefs impact care communication
Engagement, continuous improvement and accountability	1. Establish culturally appropriate goals policies, and management accountability, and infuse them throughout the organization's planning and operations. 2. Conduct ongoing assessments of the organizations related activities and integrate cultural competence measures into measurement and continuous quality improvement activities. 3. Conduct regular assessments of the community health assets and needs and use the results to design, plan and implement services that are culturally responsive and appropriate for the populations in our community. 4. Collect and maintain accurate and reliable demographic data to monitor and evaluate and inform service delivery – quality of care, equitable health outcomes, disparities etc. 5. Partner with the community to solicit their input and feedback in designing, implementing, evaluating policies, practices, and services to ensure that they are culturally responsive and appropriate. 6. Communicate the progress of the organization in provision of culturally responsive services and addressing disparities using approved metrics that is monitored by funders, stakeholders, constituents and the general public

END NOTES

The Work Team has compiled extensive notes of the discussions that are summarized in the above recommendations. These notes will be passed along to the Team(s) charged with implementation of these recommendations. The brief summary below provides some detail related to the audiences identified and recommendations for education/training strategies for behavioral health providers and clergy. Discussion additionally included initial identification of media and social media platforms to be further explored.

Audiences:

Key audiences for education/outreach/training were categorized into the following areas:

- **Individuals who May Use the Services**
  - Community – Individuals and Families; Friends – Primary Focus Black and Brown Populations – First and Foremost / Defining Factor
  - Broadly defined
  - Who are the communities?
    - Any focused populations – communication strategies different for different groups
    - Black/African American // Historical Trauma
    - Latinx
    - Speakers of other languages – Spanish, Deaf/Heard of Hearing, immigrants, etc.
    - "vulnerable" groups (FLPPS Report; Older Adults, reentry, children/adolescents; poverty, homeless, LGBTQ)
    - Intersectionality (Black & Brown populations – w/in the above "groups")
    - Need to fully understand each group within the community for strategies to be most effective

- **"Key Influencers" / Touch Points in the Community–**
  (organizations/entities people trust and turn to and will likely listen to what they say);
  - Individuals – Friends, families, trusted person(s) in neighborhood; "credible messengers", natural supports
  - Peers / former recipients of services; those that others can relate to (i.e., youth)
  - Organizations –
    - social or cultural groups (i.e., Rochester Jamaican Organization, Native American Cultural Center)
    - Faith-Based – clergy, interfaith ministry groups, religious organizations
    - CBOs (i.e., community centers; recreation centers, food pantry, smaller neighborhood or population focused organizations)
    - Focus = Key Influencers in Black & Brown communities
  - Those in community who others listen to -- likely to listen to what they say
    - Barber shops, salons, etc.
    - Indigenous shops; neighborhood shops or restaurants
  - Transporters (i.e., bus drivers, including school bus drivers)
  - Coaches/people like dance teachers

- **Behavioral Health Providers**
  - Organizational and direct care/those who are providing the services
  - Clinicians –more focused; their role/impact in engaging consumers
  - Peers
  - All levels of BH services / all programs
  - Child/Youth/Adolescent Providers

- **Other Providers – (May not be trusted)**
  - Medical / drs/pediatricians/FQHCs
  - Schools/teachers /parent liaisons
  - Fire department; EMS
  - Law enforcement
  - Veteran's Organizations
  - Social services – Child & Family Services; benefits people
  - Other payors – insurers; foundations, etc.
  - Certain youth serving agencies (i.e., CFY, Teen empowerment, PASS, Healthy Baby Network, Metro Justice for Teen Potential, Healthy Kids)
  - FACT

<u>Strategies</u>

Training: Behavioral Health and Other Providers (modified as Appropriate)
Draft outline for components of a training curriculum

- Some training elements may differ for different staff types (i.e., clinicians; care managers)
- Topic areas:
  - Implicit Bias /Explicit Bias – Understanding, recognizing
  - Crisis and culture – understanding how defined, viewed, etc.
  - Understanding the full array of behavioral health emergency/crisis response options
    - What is available? Full understanding of all the options
    - What to access when – what is the best fit option for the immediate need?
    - My internal crisis response services and when outside options may best fit
  - 911 – understanding diversion pilot; new options
  - 211
  - Post crisis support
    - Providing on-going support – immediate post crisis and beyond
- Delivery Methods
  - Tap into existing in-service at agencies
  - BH system-wide sessions
  - Series of training
  - Supported with resource materials

Training/Education Strategy / Brainstormed for Clergy
Depending on the groups/audience, may be more educational that "formal" training
- Faith Communities: open and embracing learning by clergy group
  - Many people go to spiritual leaders first

- Stigma reduction, helping to frame, ties in with faith
- Basics to understand and tying into faith traditions
    - Stories from tradition to understand MH/BH
    - Engaging leaders to help shape what it would look like
    - Baseline education to leaders
    - Structuring education for their faith community
- Leaders of health ministries at churches (lay people)– discuss with faith leaders' group, discuss with other touchpoints (ministers, etc.), conduct baseline training for them
- IHMC – Interdenominational Health Ministry Coalition
- ROM – Renewing of the Mind (MH) training (in an "off" year, but build up people who want to do more)
- Mental Health Clergy Consultation – MH and stigma and advance understanding of MH in faith community, monthly meeting, open to training for faith leaders

Appendix 1.1

MONROE COUNTY MENTAL HEALTH & SUBSTANCE USE DISORDER 90-DAY TASK FORCE

911 DIVERSION AND SELECTIVE DISPATCH WORK TEAM SUMMARY REPORT

December 2020

911 Diversion and Selective Dispatch Work Team

Participation and Structure: This work team was comprised of 16 representatives, including: Monroe County EMS, 911, 211/Lifeline, the City of Rochester Department of Recreation and Human Services, law enforcement, providers of crisis response services, other community providers and advocacy / policy making groups (including the Mental Health Association and the National Alliance on Mental Illness), the Finger Lakes Performing Provider System and representation from Rochester City Council. Staffing and coordination support were provided by the Monroe County Office of Mental Health and Coordinated Care Services, Inc.

The workgroup met, both as a full group and in smaller work teams, for several hours each week from October through mid-December. The first sessions were focused on developing a clear understanding of the services currently available in the community to support individuals experiencing behavioral health crises. The group also reviewed diversion programs in place in other communities, including Broome County, New York and Houston, Texas.

Areas of Focus, Priorities and Next Steps: From there, the workgroup focused on three core areas, which are outlined in the sections that follow.

Develop Workflows to Guide New Practices: For each area, the workgroup began to outline the more detailed workflows needed to guide the implementation of these new processes, starting first with the steps to be taken to divert low acuity calls coming in to 911 to 211 / Lifeline. While still under development, these emerging process flows are incorporated as an attachment to this Appendix to help depict the work completed to date. Details will continue to be fleshed out as we move toward implementation later this month, as outlined in the implementation plan shown earlier in this report.

1. <u>Develop / implement process to divert low acuity behavioral health crisis calls from 911 to 211/Lifeline, avoiding the need to engage law enforcement where possible</u>

- The initial cohort for this expanded diversion pathway will focus on crisis calls coming in to 911 meeting the following criteria:
    - Low acuity (following existing screening protocols in place at 911 using the EMD "cards"25A and 25B)
    - Coming from 1st party callers (so that the nature of the issue is being shared directly by the individual, allowing for an assessment); and
    - Not coming from a "911 only" phones (those that have been disabled for all but 911 services) to avoid the risk of losing the call during transfer.
- 211/Lifeline telephone counselors will assess the caller's needs, and if a safety plan can be developed, link caller to the service(s) that best meet their needs. 211/Lifeline has added capacity that will allow them to accommodate this new workflow. However, capacity will need to continue to be monitored as other initiatives / communication efforts will likely increase call volumes.
- If the 211/Lifeline counselor determines a safety plan is not possible, the caller will be linked back to 911 (person to person) so an immediate, in-person response can be activated

- The MC OMH will work with 211/Lifeline to ensure that counselors have current and complete information about the full complement of community behavioral health crisis services to ensure they refer callers to the optimum service option.
- Steps will also be taken to develop a common intake process and supporting MOUs between 211/Lifeline and behavioral health crisis providers, with a specific focus on mobile crisis services and afterhours crisis options. The MC OMH will help to facilitate this process.
- The workgroup also anticipates the need to develop solutions to respond to transportation challenges that might prevent callers who are willing to access walk-in crisis services.
- The Monroe County OMH Data Analysis Division will receive and aggregate data from 211/Lifeline, behavioral health providers and other sources to support timely review and reporting of outcomes as this new process is implemented.
- The start date for this new diversion pathway will be coordinated with 911, 211/Lifeline and the launch of the City of Rochester's new in-person Crisis Team (described below).

2. <u>Expand selective dispatch options for crisis calls that require a timely in-person response</u>

In parallel with the diversion efforts outlined above, workgroup focused on other strategies to be developed and implemented in the near term to expand the array of options available to respond to individuals experiencing a behavioral health crisis – and to add capacity to existing options to fill identified gaps. While outlined separately in the sections that follow, successful implementation will require ongoing coordination and collaboration as we build toward a more responsive and integrated system. As such, a subgroup will continue to work closely together as we move to implementation in January.

Expand the Forensic Intervention Team (FIT) to Address Gaps: The County recently secured additional funding through a grant from the US Department of Justice to expand FIT (which was developed as a co-response model, pairing a mental health clinician with law enforcement on response calls to individuals experiencing a significant behavioral health concern). These new funds will be used to:

- Add 2 full time clinicians to provide coverage for calls between 7:00 pm and 3:00 am. Based on historic call volume data and identified needs, these new resources will be prioritized to calls from the Rochester Police Department.
- Recruitment is underway and is focused on candidates who reflect the diversity of and have connections with the communities served by this expanded team.
- Monroe County OMH is also redirecting resources to add one additional staff person and per diem coverage as needed to support 24x7 response capacity for needs across the County.

Expand Capacity for Other (Non-Law Enforcement) In-person Response Options:

- Mobile, in-person behavioral health crisis services are also available through the University of Rochester Medical Center's Mobile Crisis Team as well as through a mobile team linked to Rochester Regional Health System's Behavioral Health Access and Crisis Center (BHACC).

The Monroe County Office of Mental Health will continue to partner with these providers identify, develop and implement strategies to expand these services to respond to community need.

Partner with the City of Rochester in Launching its new Crisis Response Team (CRT):

- Staff from the Monroe County Office of Mental Health will continue to work closely with the City of Rochester (and other partners, including 911 and 211/Lifeline) as it develops and pilots a new in-person Crisis Response Team. This will include developing strategies and protocols to provide back-up support in cases where the Crisis Response Team is not available to respond.

Figure One - Crisis Response- 911 Diversion Workflow
Working Draft

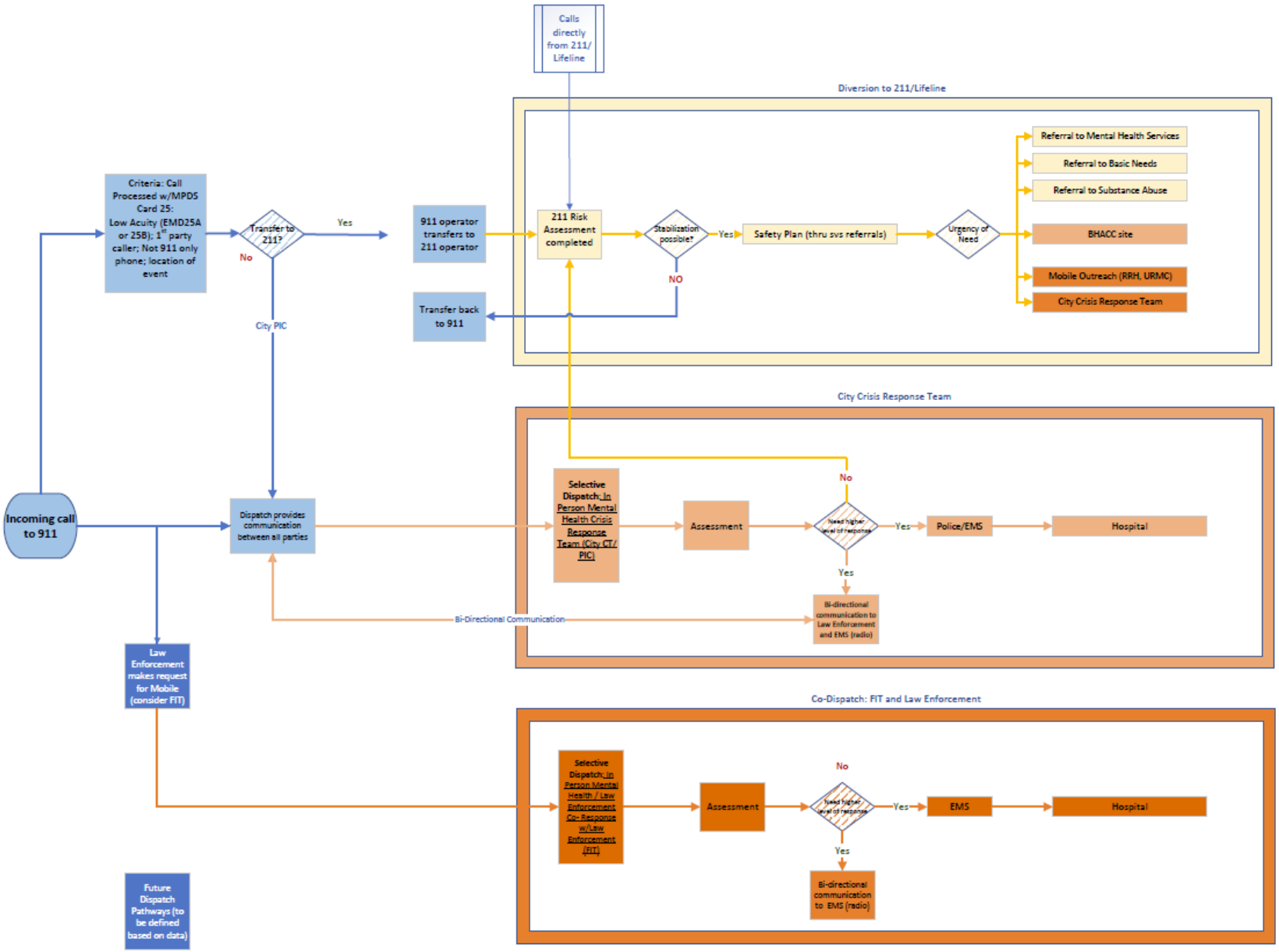
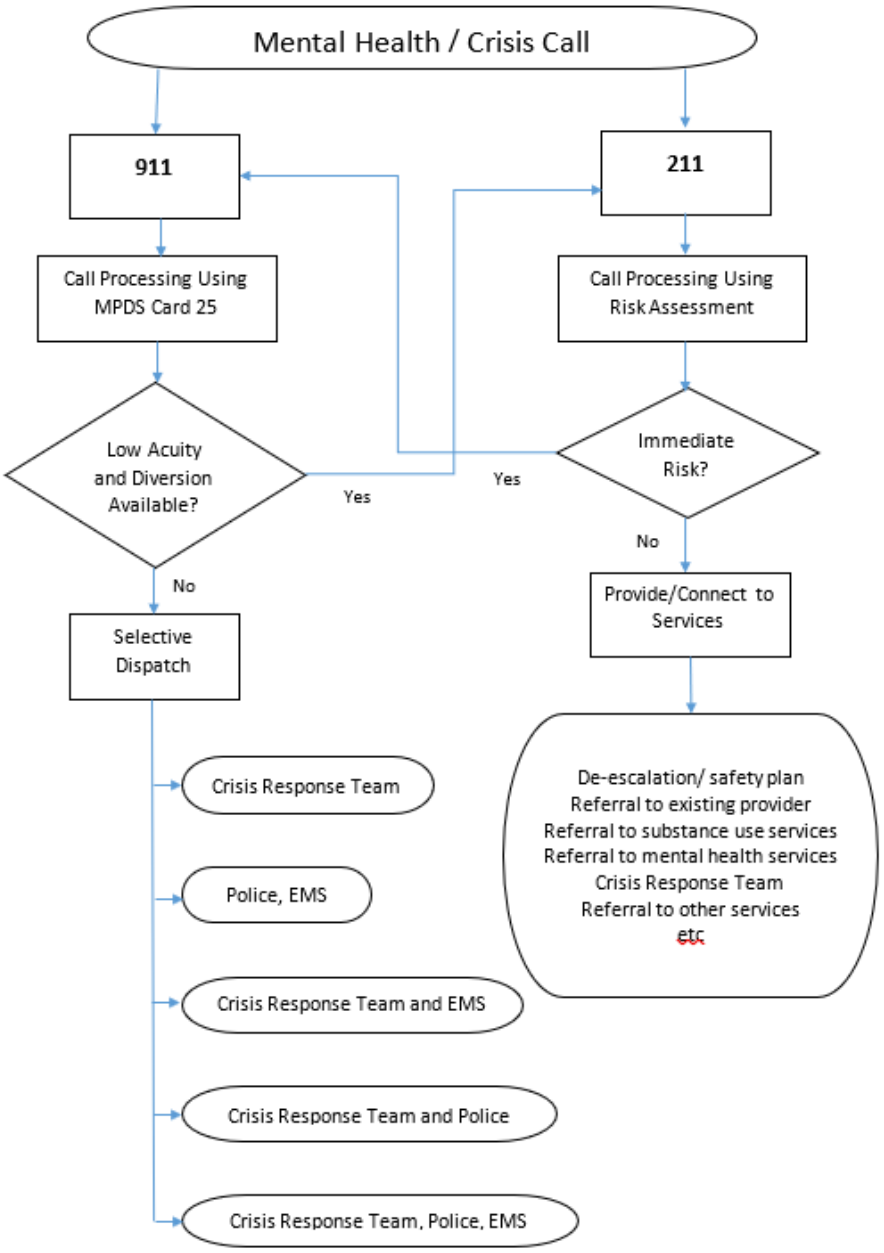


Figure 2: Initial Model



Appendix 1.2

MONROE COUNTY MENTAL HEALTH & SUBSTANCE USE DISORDER 90-DAY TASK FORCE

POST CRISIS CONNECTION WORK TEAM SUMMARY REPORT

December 2020

POST CRISIS CONNECTION WORK TEAM SUMMARY REPORT

Work Team Charge:
The Post Crisis Connection team was convened to develop strategies aimed at strengthening supports after a crisis occurs by addressing a full range of needs to provide stability and minimize future crises. The work group is comprised of 7-8 core members representing an array of stakeholder groups, including peer professionals, service program leaders, private practice clinicians, hospital systems, and community organizations. The group met for 90 minutes on a weekly basis starting on 10/19/20 and identified the following goals to be accomplished within a 90-day period:

1. Explore models of crisis response and follow up being used in other geographic areas

Outcome: The work group identified two regional approaches to behavioral health crisis (Suffolk County's DASH program and Pittsburgh's Resolve program) that both utilize a hub-based approach to crisis resources (i.e. centralized access to a range of crisis supports). Leaders from each program attended a work group session to provide overviews of program history, services, and lessons learned.

2. Determine priority components of the follow up process

Outcome: The work group synthesized information learned from other regional approaches with experience from local practices and identified four priority components of follow up services for further assessment and discussion: phone based resources, mobile teams, walk in services and the vital role of peer supports across all stages of crisis response.

3. Assess the current and ideal states of follow up resources in Monroe County

Outcome: Group members assessed the priority components identified above through a brainstorming session that analyzed each component in terms of current status/availability in Monroe County, what the ideal state of these resources could be, and the current/potential role of peers in the delivery of each component. This included a consideration of diversity and equity in the access to a utilization of these services. Details of this analysis can be found in the appendices of this report.

4. Develop immediate and longer-term recommendations for enhancing local resources

Outcome: The group synthesized the information discussed to date and developed a list of short and longer term recommendations relating to four priority areas: availability/awareness of follow up resources, community standards for crisis follow up, involvement of care management services, and the role of peer supports across levels of crisis response. Detailed recommendations with associated timelines and metrics/indicators can be found below.

Work Team Recommendations

1. **Ensure awareness, availability and coordination of follow up resources across various locations and platforms (phone, mobile, walk in)**

Action steps	Metric	Timeline
1. Integrate into curriculum being developed by Education/Outreach work team, with a priority	Follow up info integrated into	TBD

placed on outreach to culturally diverse communities and natural resource networks.	community training curriculum	
2. Multimedia creation/distribution (e.g. print and digital) to promote follow up resources among community members, clinicians, and people seeking services.	Print and digital versions available for distribution.	Q1 2021
3. Review of current resource guides to ensure accuracy (DePaul NCADD, MHA Finding Your Way, MCOMH/City website, etc.)	Reviews and revision completed.	Q1 2021
4. Monitor status of follow up resources and develop plan to increase capacity as needed.	Define performance measures and monitor no less than quarterly.	Start Q2 2021, then ongoing

2. Develop a community standard for crisis follow up that will be used across all crisis support services that is based on the needs and desires of each individual but also includes a structure for essential follow up questions to ensure linkage to appropriate resources.

Action steps	**Metric**	**Timeline**
1. Develop list of core follow up questions that should be part of all crisis follow up processes	Core follow up questions completed	Q1 2021
2. Develop community standards for training requirements for staff doing crisis follow up (potentially including Motivational Interviewing, Person Centered Practices, Trauma Informed Practices, Cultural Competence/Responsiveness, and awareness of community resources.)	Training standards developed	Q1 2021
3. Indicate resources necessary for ongoing availability of training resources.	Resource list completed	Q1 2021
4. Engage stakeholder groups to achieve commitment to community standards; develop MOU.	Signed MOUs from all relevant stakeholders	Q1-Q2 2021
5. Implement community standards for follow up questions	Core questions implemented across all follow up resources	Q2 2021
6. Identify resources to support training standards (including possible support from MCOs and other funding sources) and implement ongoing training plan.	Training begins	Q3 2021

3. Ensure access to and availability of care management services following a crisis. This should include offering referrals at every stage of crisis response, effective communication between providers, timely follow up by care management staff, and ongoing training/education for care managers.

Action steps	**Metric**	**Timeline**

1. All crisis providers will inquire about or check status of care management services (EMedNY, PSYCKES, etc.) and submit referrals as needed. (Note: Providers will be encouraged to provide as much information regarding cultural/language needs to ensure best match to appropriate CM program.)	Process implemented across all crisis and follow up programs	Q1 2021
2. Crisis and follow up services will implement process for notifying care managers of current or recent crisis.	Notification policy implemented	Q2 2021
3. Provide crisis services with list of CM programs, supervisors, and after hours contact info.	Info provided with plan for regular updates	Q2 2021
4. Care management programs commit to contact within 24 hours for people experiencing a crisis.	24 hour response policy implemented	Q2 2021
5. Work with Health Homes to confirm training standards and ongoing coaching for care management re: crisis follow up and enhance as needed. Potential topics should include Motivational Interviewing, Person Centered Practices, Trauma Informed Practices, Cultural Responsiveness, and awareness of community and cultural resources.	Practice and training standards developed	Q3-Q4 2021

4. **Peer support options should be enhanced and maximized at all stages of a crisis, with opportunities for ongoing connections to people with lived experience during the follow up process. Workforce development and program funding will be key parts of this process.**

Action steps	**Metric**	**Timeline**
Increase awareness of existing peer resources via multimedia creation/distribution (e.g. print and digital) among community members, clinicians, and people seeking services.	Print and digital versions available for distribution.	Q1 2021
Review current resource guides to ensure accuracy (DePaul NCADD, MHA Finding Your Way, MCOMH/City website, etc.)	Reviews and revisions completed.	Q1 2021
Convene community collaborative to develop plan for peer workforce development, including recruitment, training, scope of practice/position descriptions, competitive wage bands, and credentialing/supervision resources. Existing peer stakeholder groups could be leveraged to facilitate this collaborative effort.	Convene community collaborative	Q2 2021
Promote recruitment of peer professionals via community outreach and advertising by existing peer programs	Recruitment plan implementation	Q2 2021

Monitor capacity, utilization of and demand for existing peer services/programs.	Ongoing monitoring plan implemented	Q3 2021
Explore sustainable funding options for expanding range and capacity of peer supports available in community while ensuring fidelity of these services.	Assessment of current and potential funding options	Q4 2021

POST CRISIS CONNECTION WORK GROUP – NOVEMBER 2020

ANALYSIS OF CURRENT AND IDEAL STATES OF CORE CRISIS FOLLOW UP ELEMENTS

Core components	Current State Programming for Core Component	Current State Role of Peers in Core Component	Future State Recommended Considerations for Core Component
Phone Resources	• Many different program specific procedures • HOPE has phone based follow processes • Affinity Place warm line • RRH BHACC incoming/outgoing calls 8a-11p • Open Access 24/7 peers accessible via phone & walk in • SMH 24/7 crisis call line for people accessing SMH services • FIT does phone follow up • 211 • Clifton Spring CPEP has phone/follow up process in other counties. • MCT follow up to check on status of linkages. • 211 is a resource but some concerns about capacity. 211 handles issues well beyond behavioral health. They also serve multiple counties.	• Affinity Place – contracts with MHA for ongoing peer support (60 day f/u) • Need to get more info about role of new positions in Public Health dept. • Peer supports only available by contacting specific programs – no process for triaging through 211, etc. • Limited child and family peer resources available.	• We have a lot of resources already – need centralized follow up. Could this be 211? • 211 staff needs connection to each resource so hand off can be 'warmer.' Also – wait times thru 211 can be concerning. • Need quick connection to peer support. • Emphasis on warm hand off instead of just a referral, then options for continuous support instead of "hand off." • Relates to Outreach/ education work team; community needs to be aware of any new processes (centralized, etc.) • Are we too used to having so many options to navigate? How do we simplify? How do we balance this with "no wrong door?" • Historical conversations about a community wide centralized call center with MOUs among providers, access to scheduling, etc.
Mobile Outreach	• Mobile Crisis Team - constantly evaluating to adapt and meet community needs. Providing clinical follow up, ensuring linkages, trying to reduce additional ED visits. Primary evaluation by specialist, info from collaterals, etc. New regs may impact "clinical	• Close relationship with FIT • Liberty peer team does community outreach around addition services; also takes MH into account. Ride-alongs with LE. • Potential role of Public	• Need to explore how intentional racial/cultural equity of staff is in these programs? This is an issue across programs. Need diversity/cultural comp training. Need to acknowledge cultural issues that impact willingness to access resources. • Need more immediate resources for follow up response. • Need standardized core elements for follow up across

	eval" vs general crisis assessment. • C&Y component to MCT; Strong also has crisis therapists available • Open Access program – peers + other staff doing outreach multiple times per week to homeless/soup kitchens, doing SUD evals. Can also bring individuals back to OA program if needed. Some follow up possible. • FIT – 5 clinicians working with law enforcement depts, 2 more being added for overnight. All referrals directly from law enforcement. Follow up as appropriate – case by case basis. Linkage to other services, some ongoing involvement. Close relationship with Liberty peer services. • BHACC – 2 person team initiated by self, family, providers. 10-6pm. Telephonic follow up. Intention is to go 24/7 eventually. Typically same day response. • HealthReach for the Homeless – BH + Primary care outreach for homeless. Referrals + outreach. • PCHO homeless street outreach, try to connect individuals with supports/assistance. • SAMHSA grant team doing community	health outreach workers? • Some peers embedded in ED. • Peers embedded in BHACC, SAMHSA team.	community/programs, including structure, timing, expectations, etc. • Follow up approach needs to be based on individual assessment/person driven. Needs to be a flexible, recovery-oriented process which includes the ability to be creative. • Need to connect with communities to build trust, etc. • Training & education for staff doing this work: recovery oriented; person centered; MI; what should follow up look like. • Need a better understanding of what resources are available among existing clinicians/programs/resources. • Hard to separate crisis from post-crisis; any changes to crisis services will drive needs post-crisis. • Also need to consider individual vs family support.

	work re: BH/homeless needs.		
Walk In/ Facility Based (Including hours of operation; also community based, not site based)	• BHACC, incl. LE drop off except for RPD • HOPE Place • Affinity Place • Open Access • MHA Drop in center/Creative Wellness Opportunities • St. Joseph's Neighborhood Center • ROC Fitness • CORE Center	• Some programs are peer run (Affinity Place) other have peer supports available. • MHA programs have peer supports integrated.	• Need something 24/7 in addition to ED/CPEP. • Open Access has 24/7 walk in for SU evals.

APPENDIX 2

CRISIS SERVICES OVERVIEW

Monroe County Mental Health and Substance Use Disorder Crisis Services Overview (January 2021)

	Age Group	Service Type	Provider Name	Service Name	When is this service available?	How can this service be accessed?	Service Description Summary (what kind of help can I expect to get?)
1	Adult & Youth	24 x 7 Telephone Support	Goodwill of the Finger Lakes	211/Lifeline	24/7	• Dial 2-1-1 or 1-877-356-9211 • Access through their website: https://211lifeline.org/index.php • Access the text line by texting your zip code to 898-211	• Community members can talk with experienced tele-counselors for free and confidential assistance connecting to vital services within the community. • Includes help for crisis stabilization as well as locating basic resources (like food, clothing, shelter).
2	Adult	24 x 7 Telephone Support (Peer Warm Line)	East House / Mental Health Association	Warm Line	24/7	• Service can be accessed 24x7 by calling (585) 563-7470	• This peer run warm line is staffed 24 hours a day, 7 days per week in collaboration with the Mental Health Association of Rochester. • Staffed by Peer Support Specialists who understand that at times, it can be easier to talk to individuals who have had similar experiences, it is a no-fee, recovery-oriented alternative to emergency room evaluations.
3	Adult & Youth	24X7 Telephone Support (for URMC patients)	University of Rochester Medical Center (URMC)	UR Medicine - Strong Behavioral Health 24/7 Crisis Call Line	24/7	• Call (585) 275-8686	• This telephone support service is available to URMC patients who may be coping with issues related to a mental illness, for example, a panic or anxiety attack, but who do not feel the need to visit the Psychiatric Emergency Department
4	Adult	Telephone Support (Peer Run)	Liberty Resources	Peer and Family Support Programs	9am-4:30pm with afterhours support available	• Peer Support #: 1-855-778-1300 • Family Support #: 1-855-778-1200 • After-hours line #: 1-855-778-1200	• A Recovery Support Navigator Team provides family-focused (or other loved one–focused) services designed to guide, educate, and support families through the substance-use-disorder treatment and recovery process through peer and family support.
5	Adult	Short-term Crisis Drop-in Center (Peer Run)	Villa of Hope	Hope Place	3pm-11pm, 7 days per week	Walk in or call: • Water Tower Park, 1099 Jay St, Bldg. P, Rochester, NY 14611 • (585) 325-3599	• Peer-run "Living Room Program[i]" staffed by Certified Peer Support Specialists who have first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges. • Support Specialists use their lived experience to assist in supporting adults experiencing difficulties with their resiliency, recovery and wellness.
6	Adult	Short-term Crisis Drop-in Center (Peer Run)	Mental Health Association	Self-Help Drop-In Support Services	5pm-9pm; 7 days per week	Walk in or call: • 344 N. Goodman St., Rochester, NY 14607 • (585) 325-3145 x300	• The Drop-in Center is available to support individuals who need immediate, after hours support. • No referral or appointment is necessary, individuals can just call or walk-in.
7	Adult	Short-term Crisis Beds (Peer Run)	East House / Mental Health Association	Affinity Place	24/7	Call or Walk-in • (585) 563-7083 • 69 Alexander Street, Rochester, 14607 *Note: While it is best to call ahead to determine availability of beds and eligibility; Space is typically available*	• 8-bed respite program for individuals experiencing psychiatric crisis and who live in Genesee, Livingston, Monroe, Orleans, Wayne and Wyoming counties • The program is staffed 24 x7 with individuals who identify as living with a mental illness and provide guidance, mentoring, as well as support to other who are experiencing crisis. Stays are typically between 3 – 5 days. • Guests can come and go as they please (so are able to work or attend meetings, appointments, etc.). There is no fee for this service.

	Age Group	Service Type	Provider Name	Service Name	When is this service available?	How can this service be accessed?	Service Description Summary (what kind of help can I expect to get?)
8	Youth	Short-term Crisis Beds	Elmira Psychiatric Center	Child & Adolescent Crisis Respite Center	24/7 based on bed availability; admissions 7 days a week	• To make referrals: Admissions Office (607) 737-4990	• Provides short-term crisis beds (stays of up to two weeks). • Services include crisis stabilization, behavior support, medication education and training, family and peer support and parenting education. • Family must be present at admission and transportation is needed to facility, which is a 2-hour drive from Rochester.
9	Adult	Walk-in Crisis Services	Rochester Regional Health System	Behavioral Health Access & Crisis Center	M-F 8am-midnight - walk in 8am-10pm	No appointment needed - call or walk in: • (585) 368-3950 • 89 Genesee Street, Rochester NY, 14611	• Provides urgent care for mental health and substance use disorder crises. • Individuals receive an assessment, determination of the level of care needed, and are linked to behavioral health services
10	Adult & Youth	24 x 7 Walk-in Evaluation & Referral	Delphi Rise	Open Access	24/7	No appointment needed - call or walk in: • (585) 467-2230 • 835 West Main Street, Rochester, NY 14611	• 24/7 Substance Use Disorder evaluation center • Peer run telephone support line for family or individual support and information; • Evaluation followed by placement (transportation is available) • Living Room model provides access to case management • Available for individuals 12 yrs. and older
11	Adult	24 x 7 Walk-in Evaluation / Medically Supervised Withdrawal / Stabilization	Helio Health	Rochester Evaluation Center	24/7	No appointment needed - call or walk in: • (585) 287-5622 • 1350 University Avenue, Rochester, NY 14607 Admission based on NYS LOCADTR criteria (mild to moderate withdrawal)	• The Rochester Evaluation Center has 40 beds offering medically monitored and medically supervised withdrawal and stabilization services • Offer medication for withdrawal management including medication assisted treatment and inpatient or outpatient program or residential program referrals
12	Adult	Mobile Crisis Services	RRHS	RRHS Crisis Outreach Team	M – F 10 am - 6 pm	Call (585) 368-3950	• Provides an in-person visit in the home or other community location by staff from the RRHS Behavioral Health Access and Crisis Center (BHACC).
13	Adult & Youth	Mobile Crisis Services	URMC	URMC Mobile Crisis Team	M-F 8 am-10 pm Sat/Sun 8 am-4:30 pm	• Call (585) 529-3721 or access via 211/Lifeline	• The MCT works with individuals and families within Monroe County who are experiencing a mental health crisis. Services are designed to divert individuals who are not at risk of harming themselves, as well as their families, from the county's psychiatric emergency departments. • A team of mental health professionals go to the individual or family in their home, place of employment, school, etc. There are no age restrictions. Services provided include assessment and referral. • There is a child/youth-specific team
14	Adult & Youth	Emergency Department	RRHS	Emergency Department	24/7	Walk in: • 1425 Portland Ave., Rochester, NY 14621	• Physicians and specially trained nursing staff and technicians provide evaluation, stabilization and intervention for mental health and addiction.

	Age Group	Service Type	Provider Name	Service Name	When is this service available?	How can this service be accessed?	Service Description Summary (what kind of help can I expect to get?)
15	Adult & Youth	Emergency Department	URMC	Comprehensive Psychiatric Emergency Program (CPEP)	24/7	Walk in: • 601 Elmwood Ave, Rochester, NY 14642	• The CPEP provides psychiatric evaluation to see if inpatient hospitalization is needed and if so, to facilitate admission to an inpatient psychiatric unit. • All people seen in the CPEP Emergency Unit are evaluated by a psychiatrist, in addition to psychiatric nursing and clinical social work staff members.

[i] A "Living Room" model is an alternative to hospitalization for people experiencing a mental health crisis. People in mental health crises have reported needing a safe space where they can talk to someone who understands what they are going through. The Living Room Model is a potential solution to this need. Some studies show that people who visit Living Rooms have better outcomes than those who visit emergency departments and it can be a cost-effective alternative to emergency department visits for mental health crises.

APPENDIX 3

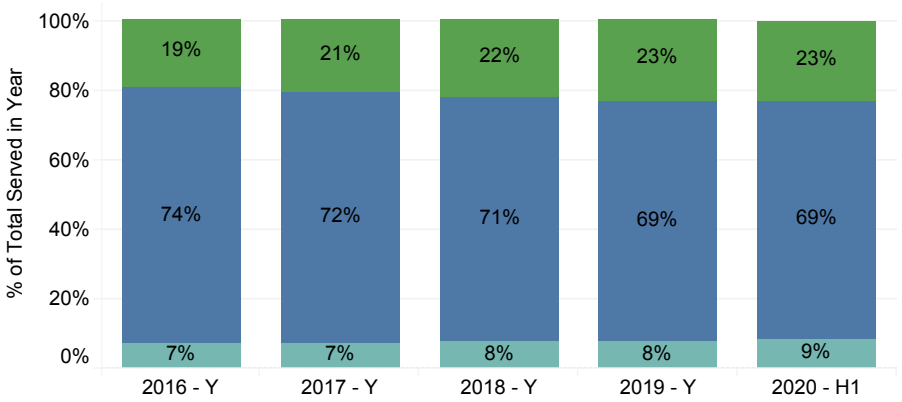
DATA SOURCES

Monroe County Public Mental Health System Individuals Served

Filter Dashboard for Age Group
All

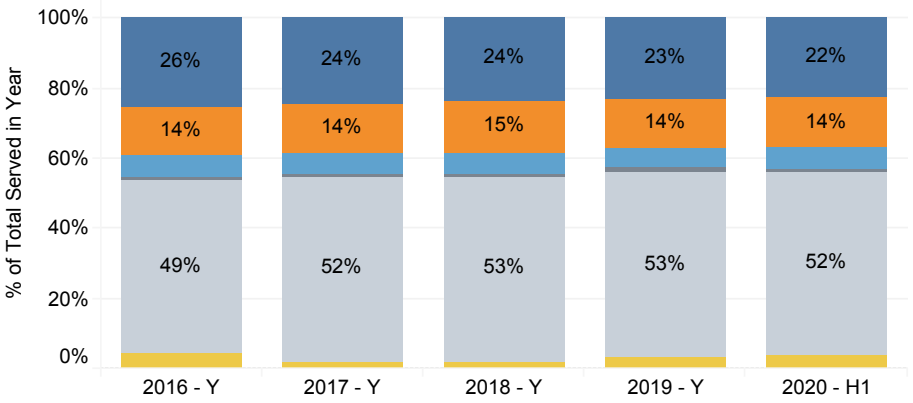
By Age Group

	2016 - Y	2017 - Y	2018 - Y	2019 - Y	2020 - H1
Grand Total	**39,564**	**40,211**	**41,455**	**42,092**	**30,394**
Children & Youth (<18)	7,593	8,294	9,143	9,718	6,969
Adults (18 to 64)	29,264	29,105	29,237	29,246	20,872
Older Adults (65 and Over)	2,809	2,910	3,171	3,236	2,588



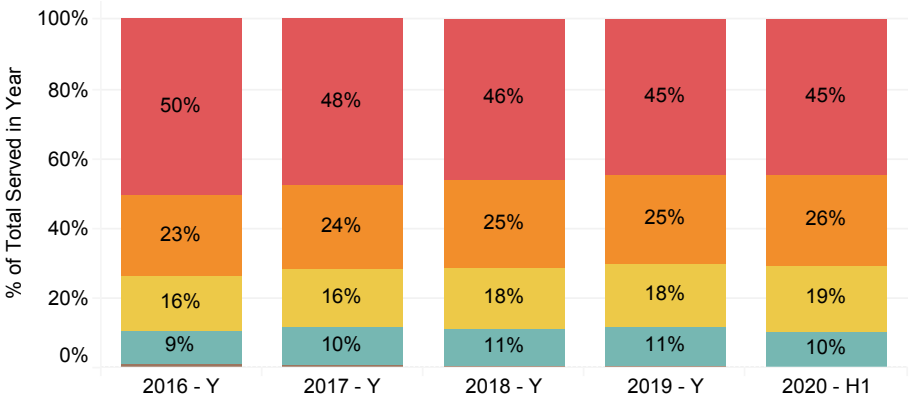
By Race-Ethnicity for All

	2016 - Y	2017 - Y	2018 - Y	2019 - Y	2020 - H1
Black Not Hispanic	10,142	9,847	9,796	9,750	6,797
Hispanic-Latino	5,382	5,673	6,182	5,850	4,342
Other (includes Multi-Racial)	2,445	2,323	2,386	2,345	1,919
Asian / Pacific Islander	430	468	480	476	344
White Not Hispanic	19,475	21,082	21,900	22,336	15,868
Unknown	1,701	818	711	1,335	1,124



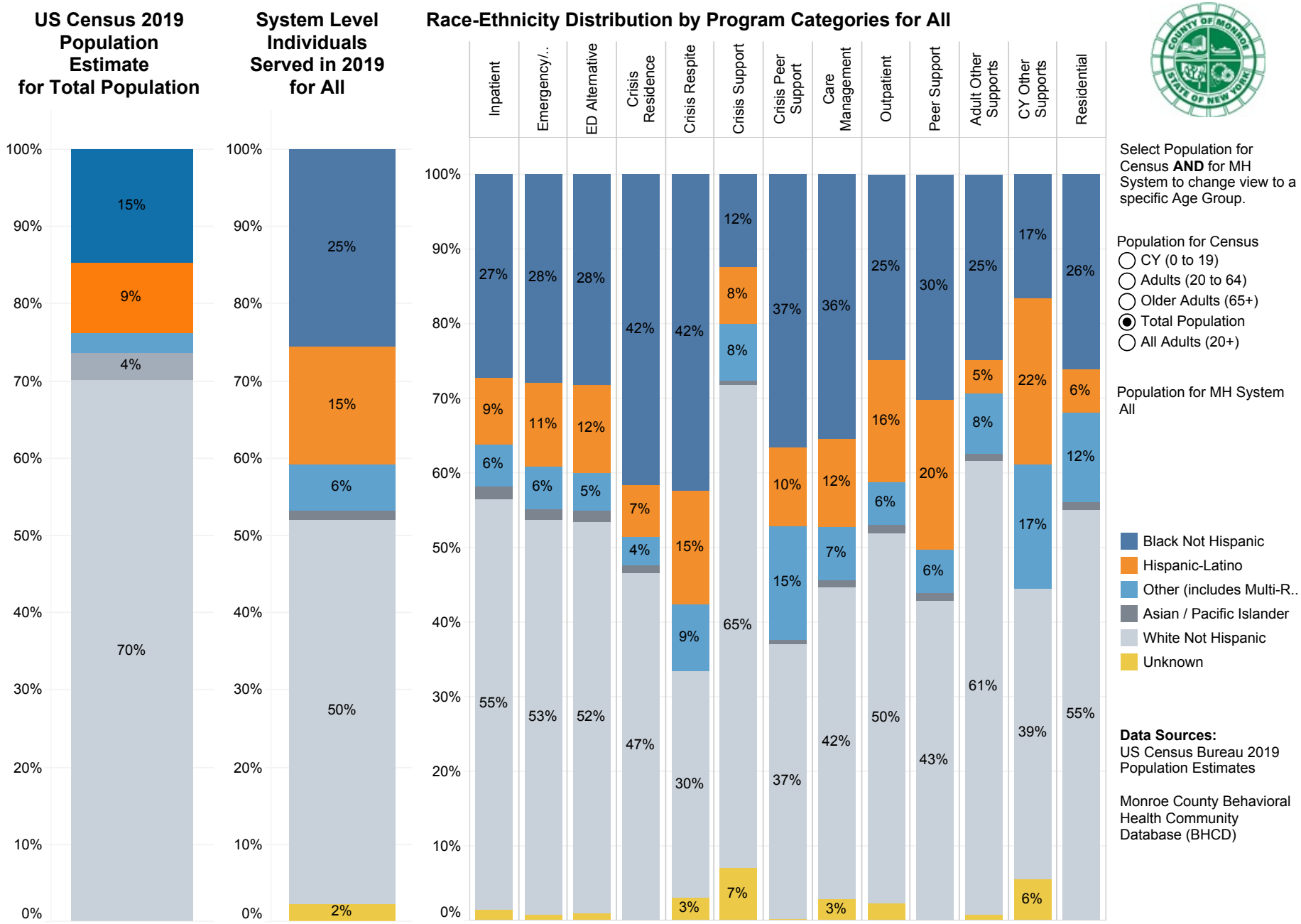
By Residence Location for All

	2016 - Y	2017 - Y	2018 - Y	2019 - Y	2020 - H1
Rochester City	19,952	19,130	19,123	18,801	13,612
Inner Suburbs	9,228	9,796	10,437	10,732	7,984
Outer Suburbs	6,193	6,629	7,267	7,647	5,642
Out of County	3,729	4,218	4,526	4,804	3,102
Unknown	481	438	102	108	54



Data Source: Monroe County Behavioral Health Community Database (BHCD)

Race-Ethnicity of Public Mental Health Service Consumers Residing in Monroe County Compared To US Census Bureau Population Estimates for 2019



Select Population for Census **AND** for MH System to change view to a specific Age Group.

Population for Census
- ◯ CY (0 to 19)
- ◯ Adults (20 to 64)
- ◯ Older Adults (65+)
- ◉ Total Population
- ◯ All Adults (20+)

Population for MH System
All

- Black Not Hispanic
- Hispanic-Latino
- Other (includes Multi-R..
- Asian / Pacific Islander
- White Not Hispanic
- Unknown

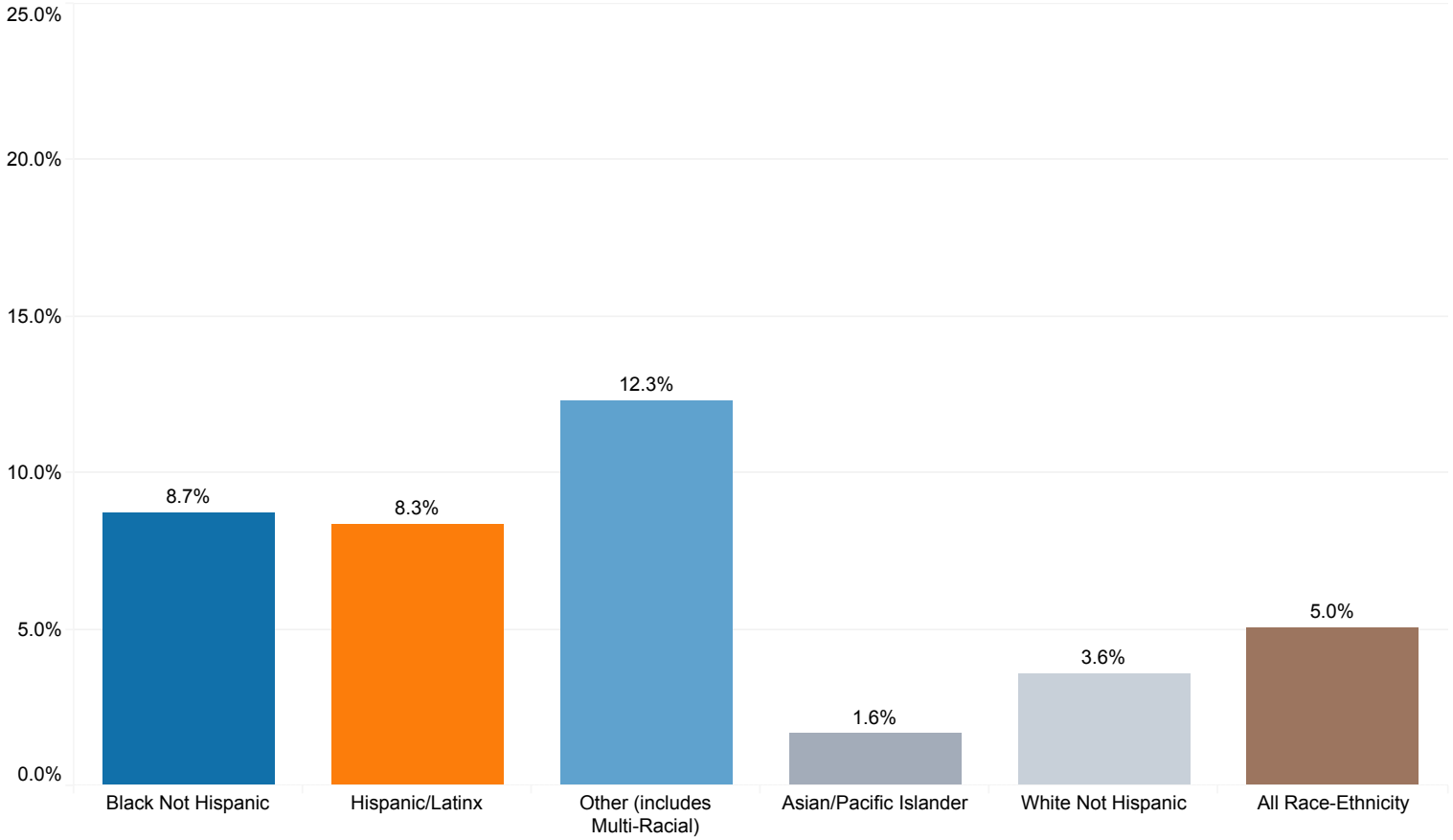
Data Sources:
US Census Bureau 2019 Population Estimates

Monroe County Behavioral Health Community Database (BHCD)

Percentage of Monroe County Residents Utilizing Public Mental Health Services in 2019

Race-Ethnicity	Indivs	MH Served	% Population Using MH Services
Black Not Hispanic	108,511	9,479	8.7%
Hispanic/Latinx	68,088	5,672	8.3%
Other (includes Multi-Racial)	18,011	2,215	12.3%
Asian/Pacific Islander	27,025	444	1.6%
White Not Hispanic	520,135	18,496	3.6%
All Race-Ethnicity	741,770	37,180	5.0%

Population
- ◯ CY (0 to 19)
- ◯ Adults (20 to 64)
- ◯ Older Adults (65+)
- ◉ Total Population
- ◯ All Adults (20+)



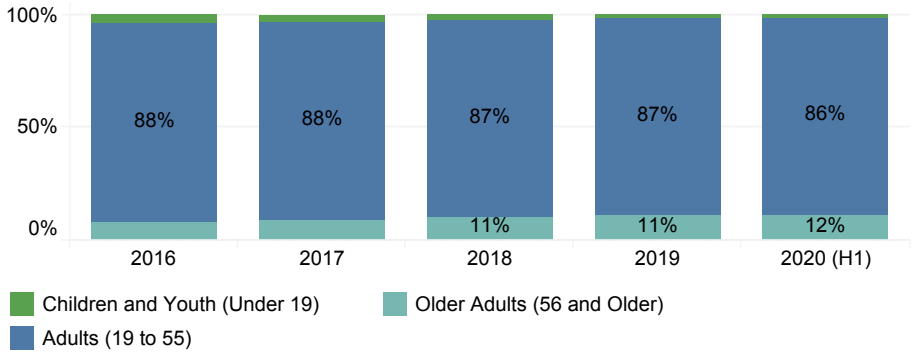
Data Sources:
US Census Bureau 2019 Population Estimates

Monroe County Behavioral Health Community Database (BHCD)

Total Episodes for Monroe County Licensed Substance Use Services by Demographics

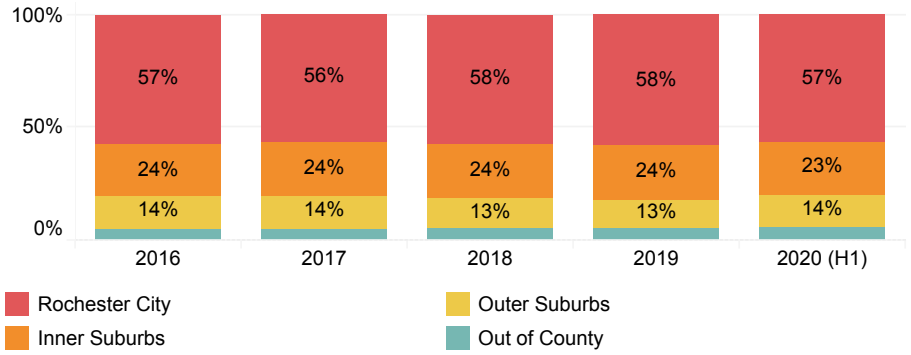
By Age Group

	2016	2017	2018	2019	2020 (H1)
Grand Total	**17,892**	**17,926**	**16,914**	**18,106**	**10,717**
Children and Youth (Under ..	651	586	375	347	208
Adults (19 to 55)	15,709	15,771	14,730	15,741	9,265
Older Adults (56 and Older)	1,532	1,569	1,809	2,018	1,244



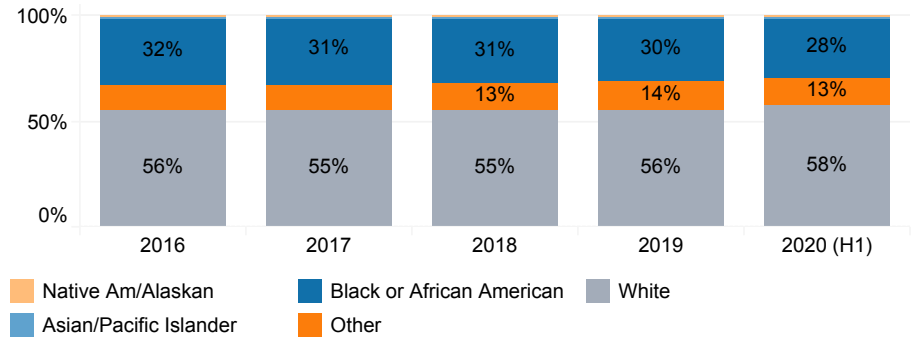
By Residence Location

	2016	2017	2018	2019	2020 (H1)
Rochester City	10,217	10,114	9,772	10,430	6,081
Inner Suburbs	4,246	4,398	4,070	4,227	2,492
Outer Suburbs	2,536	2,533	2,278	2,343	1,479
Out of County	891	942	846	891	653



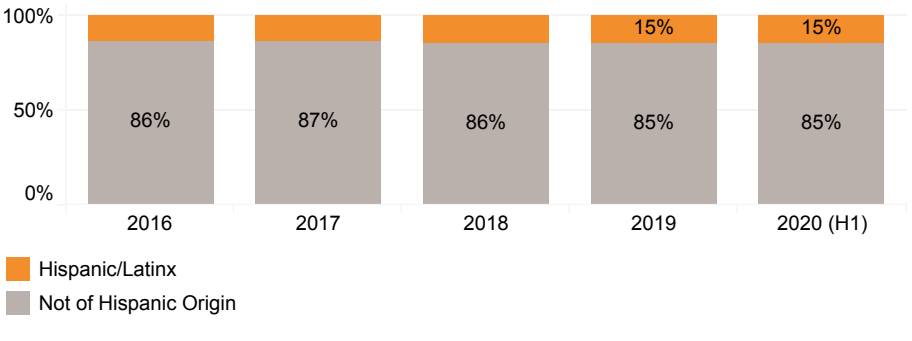
By Race

	2016	2017	2018	2019	2020 (H1)
Native Am/Alaskan	81	92	98	95	48
Asian/Pacific Islander	76	77	96	115	62
Black or African American	5,759	5,654	5,183	5,279	3,009
Other	2,031	2,242	2,272	2,464	1,424
White	9,943	9,922	9,317	9,938	6,162



By Hispanic Origin

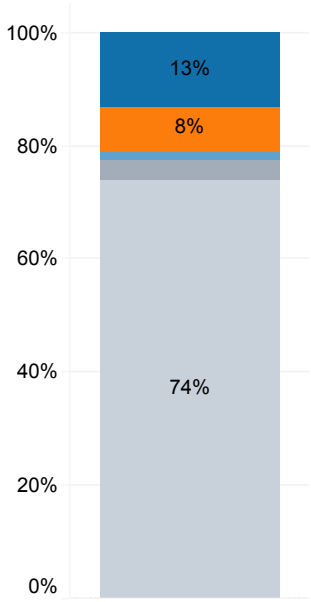
	2016	2017	2018	2019	2020 (H1)
Hispanic/Latinx	2,468	2,417	2,452	2,673	1,578
Not of Hispanic Origin	15,422	15,572	14,514	15,218	9,127



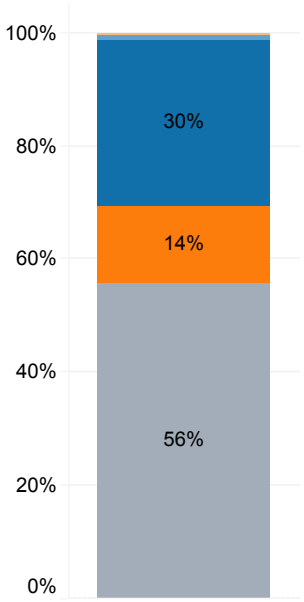
Data Source: New York State Office of Alcohol and Substance Abuse Services (OASAS) Client Data System

Race-Ethnicity Distribution of Licensed Substance Use Service Episodes Compared to 2019 Population Estimates

US Census 2019 Population Estimate for All Adults (20+)



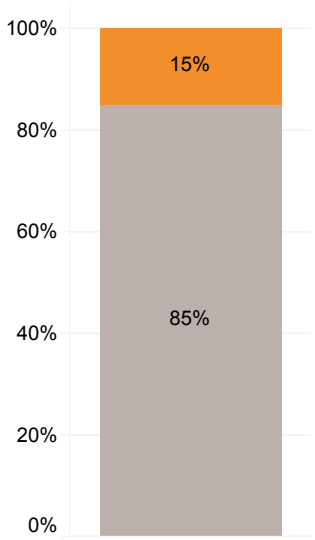
System Level Episodes of Care in 2019



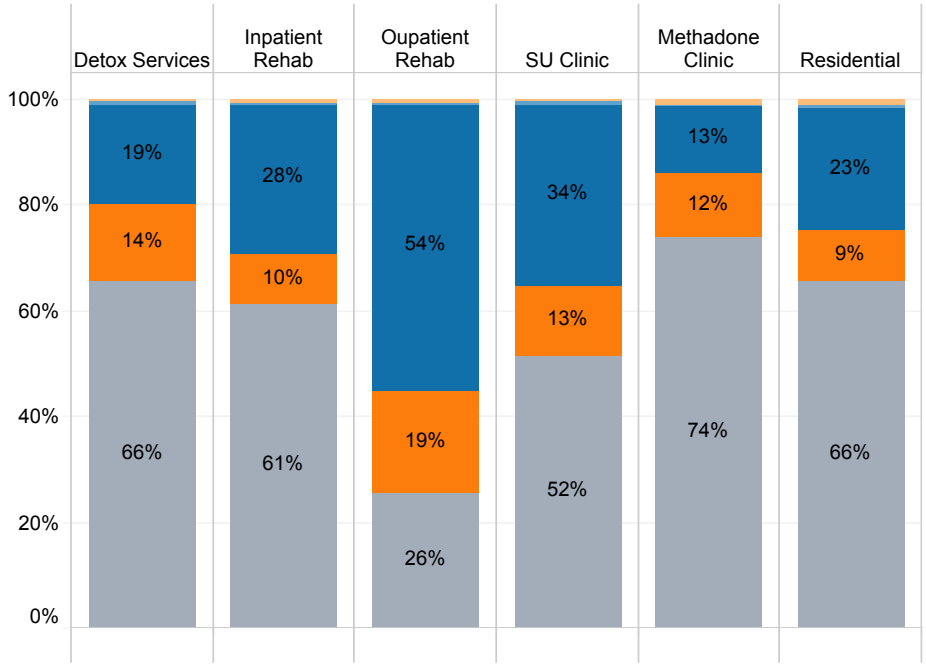
Census Race-Ethnicity

- Black Not Hispanic
- Hispanic/Latinx
- Other (includes Multi-Racial)
- Asian/Pacific Islander
- White Not Hispanic

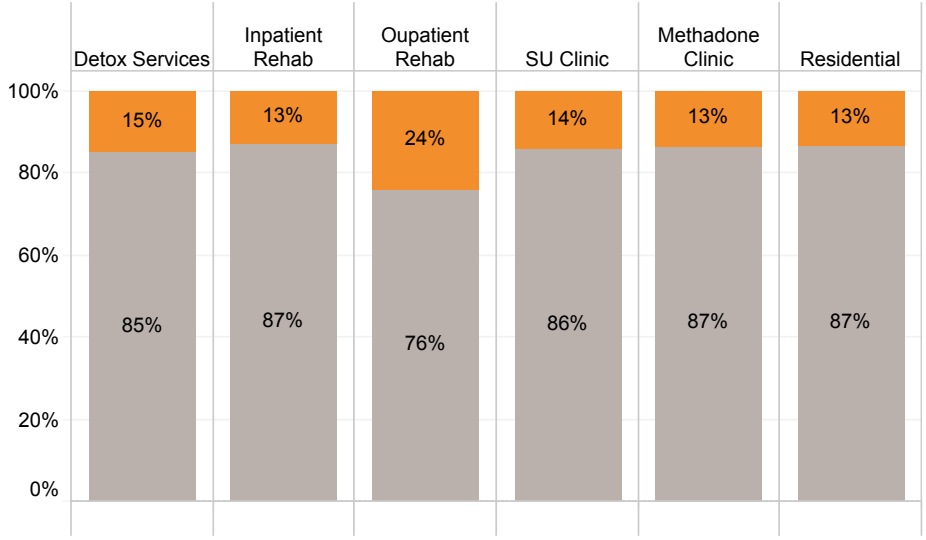
Hispanic Origin



Race-Ethnicity Distribution of Episodes by Program Category



By Hispanic Origin



Population for Census

- ○ Total Population
- ◉ All Adults (20+)

SU System Race

- Native Am/Alaskan
- Asian/Pacific Islander
- Black or African Ameri..
- Other
- White

SU System activity is not available by 2 dimensions.

Age Population breakout is not available - less than 5% of episodes are for Children & Youth.

Ability to pull Episodes for just Monroe County is also not possible - only 5% out of county in 2019.

Race and Hispanic Origin can only be reported as separate values.

Hispanic Origin

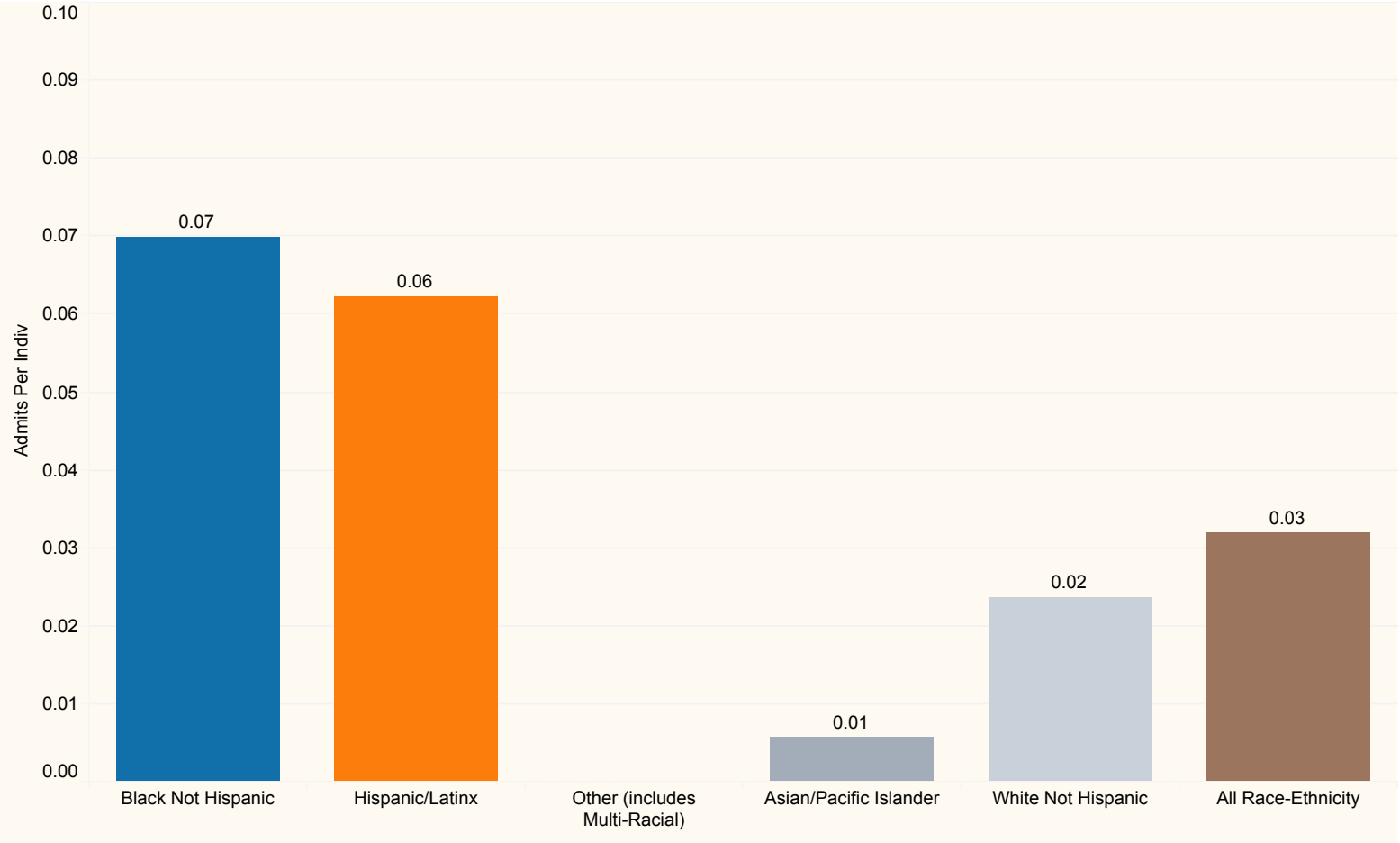
- Hispanic/Latinx
- Not of Hispanic Origin

Data Sources:
US Census Bureau 2019 Population Estimates

NYS OASAS Client Data System

Substance Use Episode Rates Per Individual Using Population Estimates 2019 - All Adults (20+)

Race-Ethnicity	Indivs	SU Admits	Admits Per Indiv
Black Not Hispanic	75,642	5,279	0.07
Hispanic/Latinx	42,990	2,673	0.06
Other (includes Multi-Racial)	8,988		
Asian/Pacific Islander	19,983	115	0.01
White Not Hispanic	418,621	9,938	0.02
All Race-Ethnicity	566,224	18,106	0.03



Population
- ○ Total Population
- ◉ All Adults (20+)

The calculation for SU Episode Rate per Individual uses the Total Licensed Substance Use Episodes divided by Total Population for the Race-Ethnicity Group. Note that this calculation was not completed for the "Other" category as historically, the majority of cases with this value had a Hipsanic Origin indicated.

The "Hispanic/Latinx" calculation was based on the Hispanic Origin value.

The default population setting for this dashboard is "All Adults (20+)" because of the limitation of not being able to report on 2 dimensions from the system and the low percentage of individuals < 20 years of age utilization Licensed Substance Use services in Monroe County.

Data Sources:
US Census Bureau 2019 Population Estimates

NYS OASAS Client Data System

Frequent Crisis Service Utilization for January to June 2020

Total Crisis Visit Frequency

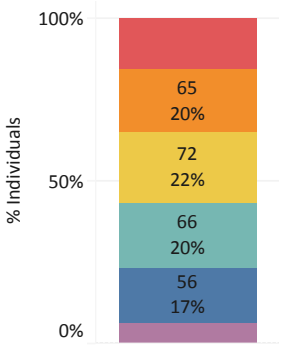
	Individuals	Total CRISIS Visits	CPEP or ED Visits	Mobile or BHACC Visits
82	1	82	80	2
39	1	39	6	33
35	1	35	0	35
28	3	84	61	23
22	3	66	59	7
21	1	21	21	0
19	2	38	38	0
17	1	17	0	17
14	3	42	30	12
13	3	39	29	10
12	1	12	11	1
11	3	33	32	1
10	3	30	30	0
9	15	135	126	9
8	17	136	116	20
7	12	84	71	13
6	29	174	145	29
5	35	175	128	47
4	84	336	237	99
3	114	342	245	97

By Age Group

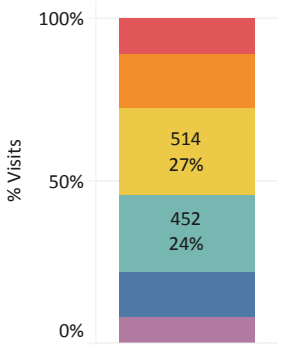
	Individuals	Total CRISIS Vi..
Under 18	52	213
18 to 25	65	317
26 to 35	72	514
36 to 45	66	452
46 to 60	56	265
Over 60	21	159

Under 18 · 18 to 25 · 26 to 35 · 36 to 45 · 46 to 60 · Over 60

By Individuals



By Crisis Visits



Total Selected Individuals

332

Total Selected Visits

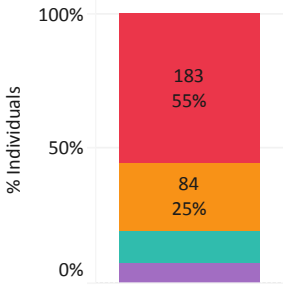
1,920

Client Residence Location

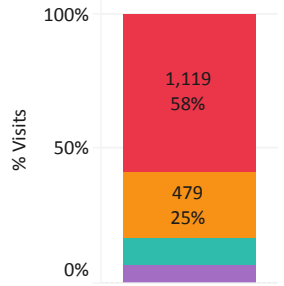
	Individuals	Total CRISIS Visits
City	183	1,119
Inner Suburbs	84	479
Outer Suburbs	39	193
Not Monroe	26	129

City · Outer Suburbs · Inner Suburbs · Not Monroe

By Individuals



By Crisis Visits



Visits Per Client

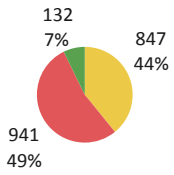
5.8

HHCM Status

- [x] ACT Enrolled
- [x] Enrolled During or Post
- [x] HH Eligible
- [x] HH Enrolled
- [x] Not HH Enrolled and Eligi..

Crisis Visit Types Used

	Individ..	Total CRISIS ..	CPEP or ED Visits	Mobile or BHA..
Both Visit Types Used	130	847	524	323
Only CPEP/ED Used	178	941	941	0
Only Moble/BHACC Used	24	132	0	132



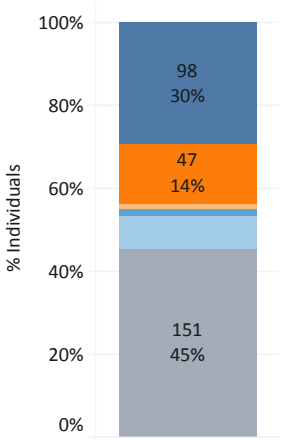
Both Visit Types Used · Only CPEP/ED Used · Only Moble/BHACC Used

Race-Ethnicity

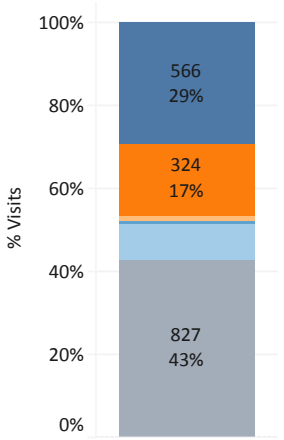
	Individuals	Total CRISIS Visits
Black	98	566
Hispanic	47	324
Multi-Racial	4	22
Asian	5	23
Other	27	158
White	151	827

Black · Hispanic · Multi-Racial · Asian · Other · White

By Individuals



By Crisis Visits



Click on graph segments to filter and/or use the HHCM categories above.

HHCM (Health Home Care Management) Status was derived from both the Monroe County Behavioral Health Community Database (BHCD) and NYS OMH PSYCKES information.

Data Sources: Monroe County Behavioral Health Community Database (BHCD), NYS Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)

Other Service Information for 2020 January to June Frequent Crisis Users

Year of First Public MH System Contact

	Individuals	Total CRISIS Visits
First Contact Prior to 2000	95	646
First Contact 2000 to 2004	31	179
First Contact 2005 to 2009	39	266
First Contact 2010 to 2014	39	257
First Contact 2015 to 2017	40	210
First Contact in 2018	18	95
First Contact in 2019	27	104
New in 2020	43	163

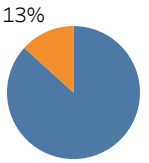
First Contact Prior to 2000 · First Contact 2000 to 2004 · First Contact 2005 to 2009 · First Contact 2010 to 2014 · First Contact 2015 to 2017 · First Contact in 2018 · First Contact in 2019 · New in 2020

Crisis Visits and Inpatient Admissions (for CPEP and ED)

Visit Types Used	Individuals	Total CRISIS Visits	Inpat Admits	% Inpat Admits
Both Visit Types Used	130	847	48	9%
Only CPEP/ED Used	178	941	63	7%
Only Moble/BHACC Used	24	132	0	

Overlap with Top 77

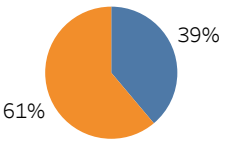
	MHT Top 77 Yes	MHT Top 77 No
Individuals	44	288
Total CRISIS Visits	361	1,559



Yes · No

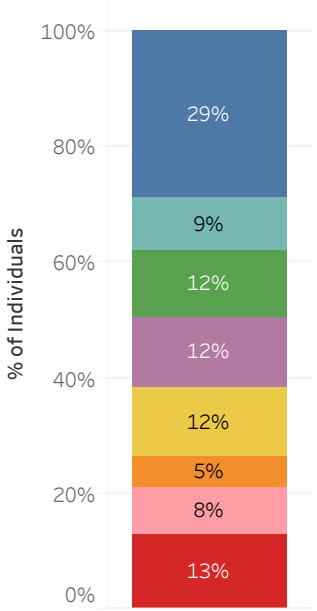
Individuals with Any MHTs

	Any MHTs Yes	Any MHTs No
Individuals	203	129
Total CRISIS Visits	1,210	710

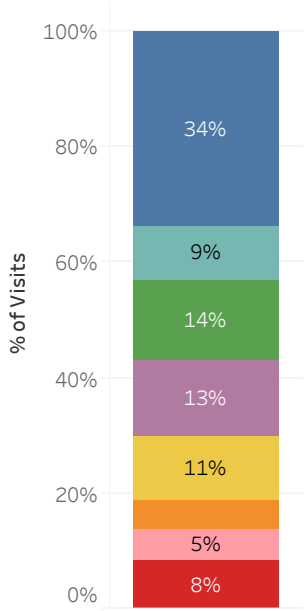


Yes · No

Individuals



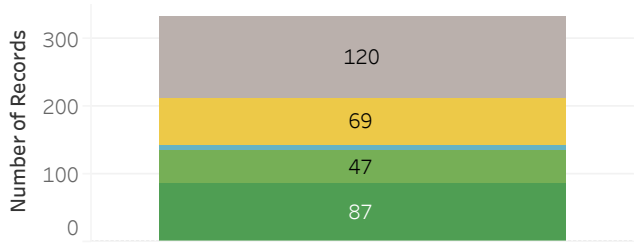
Total Crisis Visits



Health Home/Care Mgmt Status

	Both Visit Ty..	Only CPEP/E..	Only Moble/..	Grand Total
HH Enrolled	36	43	8	87
Enrolled During or Post	22	22	3	47
ACT Enrolled	1	8		9
HH Eligible	25	42	2	69
Not HH Enrolled and E..	46	63	11	120

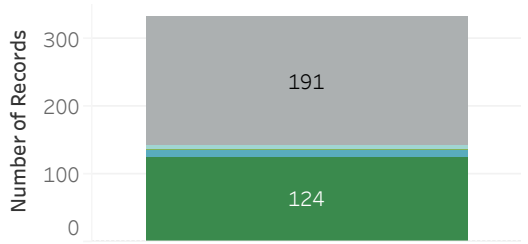
Not HH Enrolled.. · ACT Enrolled · HH Enrolled · HH Eligible · Enrolled During ..



Outpatient Involvement at Crisis

	Both Visit Ty..	Only CPEP/E..	Only Moble/..	Grand Total
Clinic	57	59	8	124
ACT	1	11		12
Day Tx	1			1
PROS	3	1		4
No	68	107	16	191

No · Day Tx · Clinic · PROS · ACT



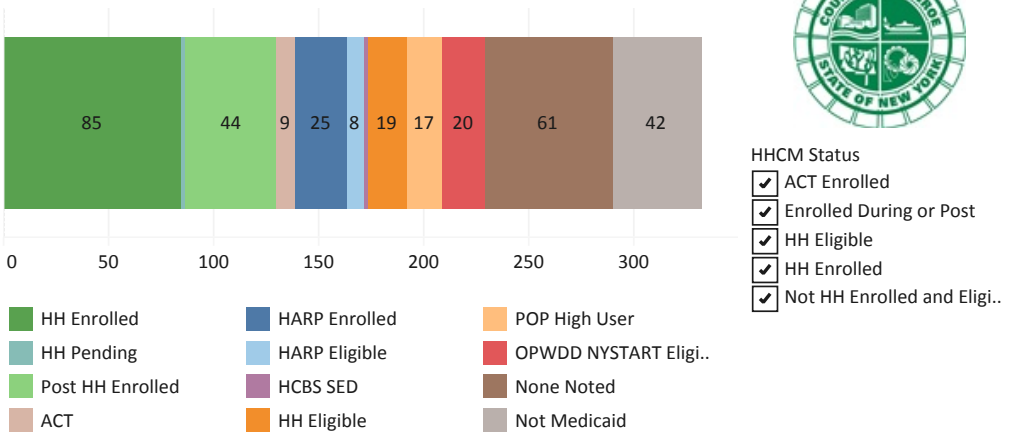
Data Sources: Monroe County Behavioral Health Community Database (BHCD), NYS Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)

Other Characteristics for Frequent Crisis Utilization Clients

PSYCKES Additional Connection Information

Data Source: NYS OMH PSYCKES Care Coordination Notes

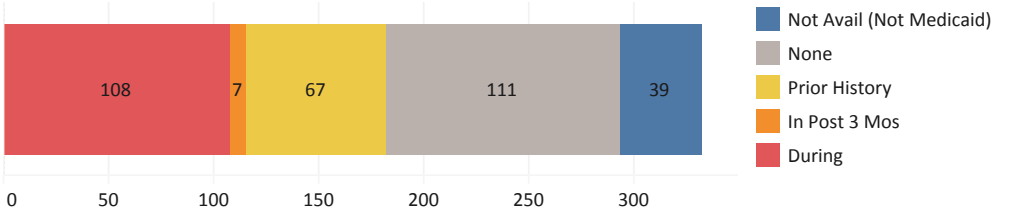
	HH Enrolled	HH Pending	Post HH Enrolled	ACT	HARP Enrolled	HARP Eligible	HCBS SED	HH Eligible	POP High User	OPWDD NYSTART Eligible	None Noted	Not Medicaid
Both Visit Types Used	36		20	1	7	4		7	7	7	21	20
Only CPEP/ED Used	42	1	21	8	17	4	1	10	10	13	34	17
Only Moble/BHACC Used	7		3		1			2			6	5
Grand Total	85	1	44	9	25	8	1	19	17	20	61	42



Latest Suicide Alert (Attempt, Ideation, Self-Injury)

Data Source: NYS OMH PSYCKES Alerts and Incidents

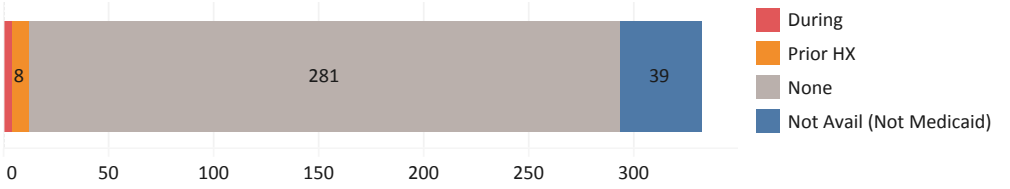
	During	In Post 3 Mos	Prior History	None	Not Avail (Not Medic..
Both Visit Types Used	40	3	25	43	19
Only CPEP/ED Used	67	4	37	55	15
Only Moble/BHACC Used	1		5	13	5
Grand Total	108	7	67	111	39



Latest Overdose Incident

Data Source: NYS OMH PSYCKES Alerts and Incidents

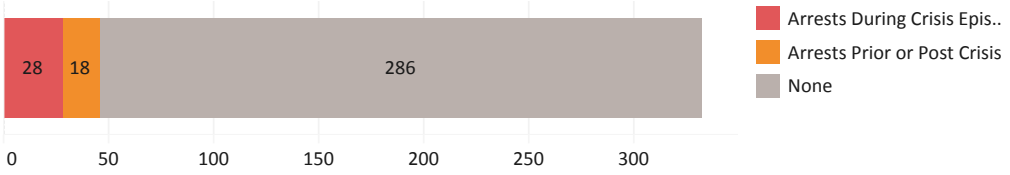
	During	Prior HX	None	Not Avail (Not Medicaid)
Only Moble/BHACC Used			19	5
Only CPEP/ED Used	3	5	155	15
Both Visit Types Used	1	3	107	19
Grand Total	4	8	281	39



History of Arrests in 2020

Data Source: Arrest reports provided by law enforcement departments to MCOMH

	Arrests During Crisis Episode	Arrests Prior or Post Crisis	None
Both Visit Types Used	4	6	120
Only CPEP/ED Used	24	12	142
Only Moble/BHACC Used			24
Grand Total	28	18	286



Characteristics of Top 77 Highest MHT Individuals for January to June 2020

Number of Individuals by Total MHTs

MHTs in Jan to June	Number of Individuals	9.41	22.09
Grand Total	77	320	119
17	1	17	0
11	5	43	12
10	3	19	11
9	1	9	0
8	5	25	15
7	3	6	15
6	7	34	8
5	17	71	14
4	35	96	44

Residence Location with MHT Incident Location

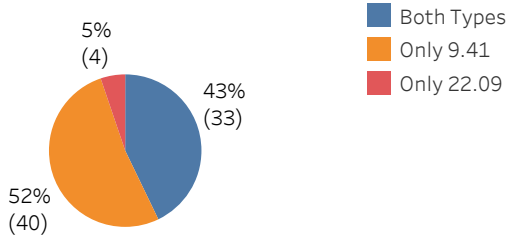
MHT Zip Codes

Res Geog	City	Inner Suburbs	Outer Suburbs	Grand Total
City	32	2		34
Inner Suburbs	4	26		30
Outer Suburbs	3		10	13
Grand Total	39	28	10	77

This chart shows where MHT Incident Occurred in the column and the Residence of Individual on the row. For example, 32 of the 34 individuals living in the city had MHTs in the city while 2 had them in the inner suburbs.

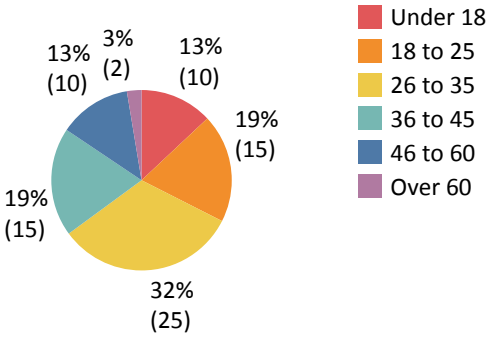
Individuals by MHT Combinations

Both Types	33
Only 9.41	40
Only 22.09	4



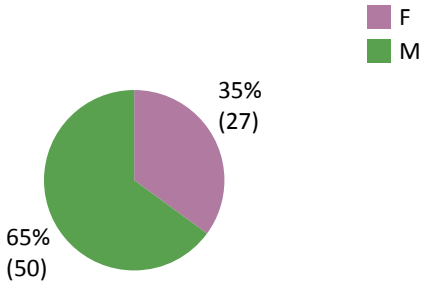
Individuals by Age Group

Under 18	10
18 to 25	15
26 to 35	25
36 to 45	15
46 to 60	10
Over 60	2



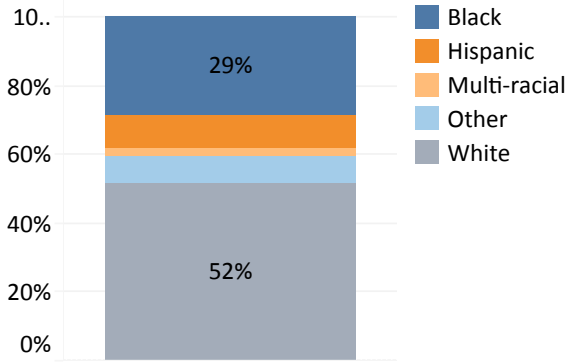
Individuals by Sex

F	27
M	50



Individuals by Race-Ethnicity

Black	22
Hispanic	7
Multi-racial	2
Other	6
White	40



Inpatient Admission and Other Psych ED Activity during January to June 2020

Inpatient Admits from MHTs and Additional Psych ED Visits

	Number of Individuals	Total MHTs	Inpatient Admit from MHT	Other Psych ED During
Both Types	33	194	1	42
Only 9.41	40	227	7	75
Only 22.09	4	18	0	0
Grand Total	77	439	8	117

Other Inpatient Admits

	Other Inpatient During	
	No	Yes
Both Types	31	2
Only 9.41	28	12
Only 22.09	4	
Grand Total	63	14

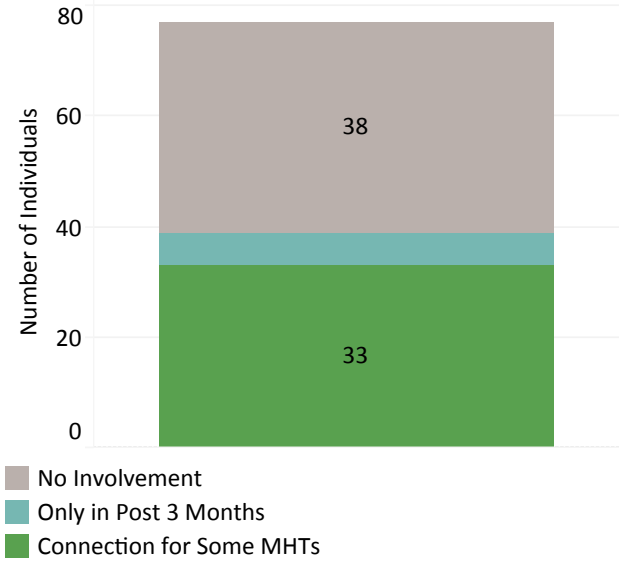
Total MHTs and Inpatient Admits for MHTs

	Total MHTs	Number of Admits
Both Types	194	1
Only 9.41	227	12
Only 22.09	18	0
Grand Total	439	13

Involvement at Time of MHTs

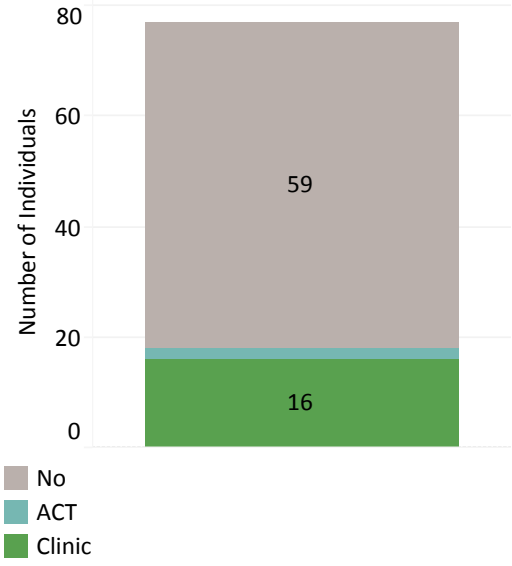
MCOMH Forensic Intervention Team

	Connection for Some MHTs	Only in Post 3 Months	No Involvement
Both Types	10	1	22
Only 9.41	23	4	13
Only 22.09		1	3
Grand Total	33	6	38



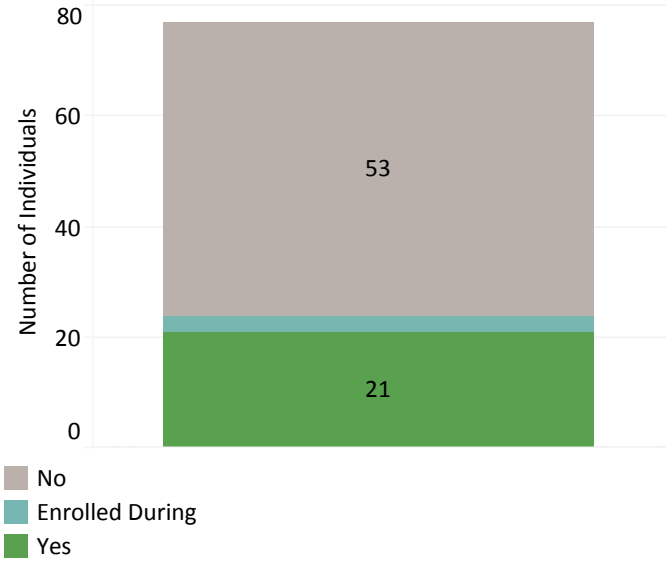
Outpatient As Reported in BHCD

	Outpatient Engaged		
	Clinic	ACT	No
Both Types	4		29
Only 9.41	11	2	27
Only 22.09	1		3
Grand Total	16	2	59



Care Management Enrolled (from BHCD and PSYCKES)

	Yes	Enrolled During	No
Both Types	7	2	24
Only 9.41	13	1	26
Only 22.09	1		3
Grand Total	21	3	53

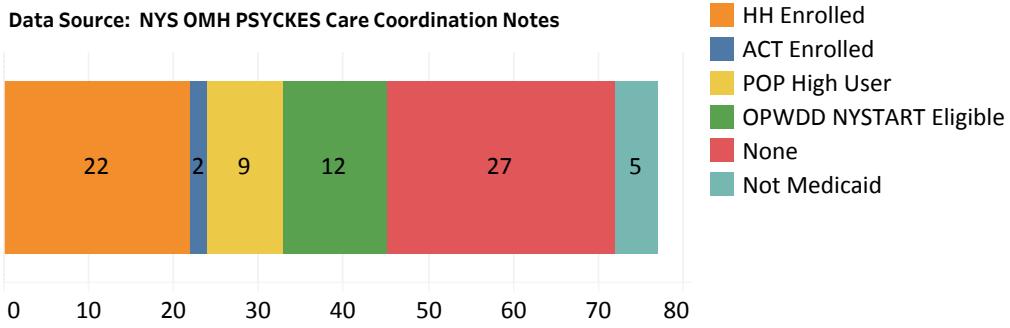


Other Characteristics for Individuals

PSYCKES Additional Connection Information

	HH Enrolled	ACT Enrolled	POP High User	OPWDD NYSTART Eligible	None	Not Medicaid
Both Types	8		5	1	19	
Only 9.41	13	2	4	11	6	4
Only 22.09	1				2	1
Grand Total	22	2	9	12	27	5

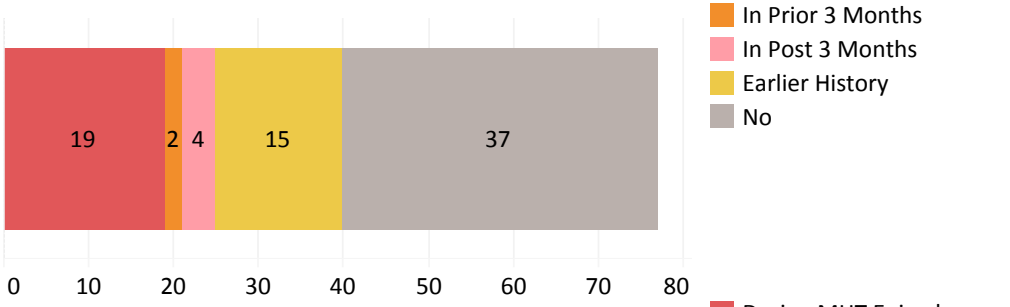
Data Source: NYS OMH PSYCKES Care Coordination Notes



Latest Suicide Alert (Attempt, Ideation, Self-Injury)

	During	In Post 3 Months	In Prior 3 Months	Earlier History	No
Only 9.41	12	3	2	7	16
Both Types	7	1		7	18
Only 22.09				1	3
Grand Total	19	4	2	15	37

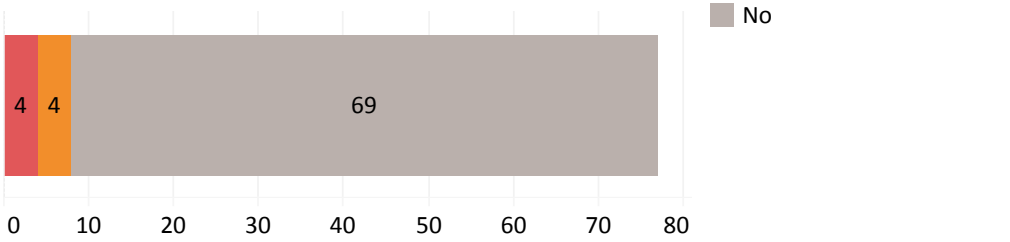
Data Source: NYS OMH PSYCKES Alerts and Incidents



Latest Overdose Incident

	During MHT Episode	Older History	No
Both Types	3	4	26
Only 9.41			40
Only 22.09	1		3
Grand Total	4	4	69

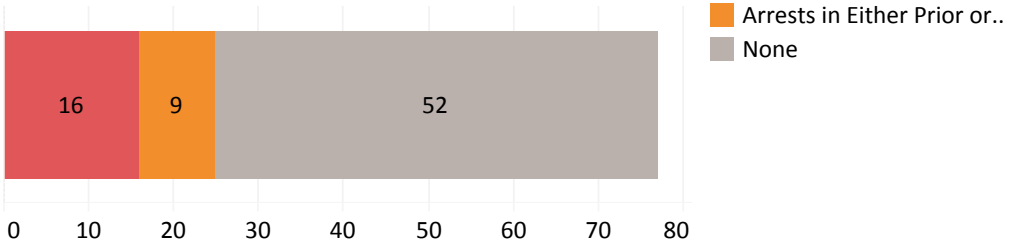
Data Source: NYS OMH PSYCKES Alerts and Incidents



History of Arrests

	Arrest During MHT Episode Period	Arrests in Either Prior or Post 3 Months	None
Only 9.41	7	2	31
Both Types	8	5	20
Only 22.09	1	2	1
Grand Total	16	9	52

Data Source: Arrest reports provided by law enforcement departments to MCOMH



COMMUNITY FEEDBACK SESSIONS SUMMARY

Our work teams have conducted focused discussions with community members to solicit feedback on the proposed strategies to address priorities and their further thoughts on behavioral health crisis services. During the month of December 2020, community discussion sessions were conducted with four (4) groups – family members and adult mentors who have participated in the Prevention, Access, Self-Empowerment and Support (PASS) program, members of Systems Integration Community Voices group, family members from NAMI Rochester and members of IMPACT, a collaboration between law enforcement and the faith community. The number of participants in each of these discussions ranged from 4 – 12 individuals. Staff from the Monroe County Office of Mental Health and Coordinated Care Services, Inc. facilitated the discussions, briefly reviewing the priorities and strategies identified by the 90 Day Task Force and its Work Teams and seeking feedback on the work conducted, areas for further consideration and the most important aspects of culturally responsive and effective services to address behavioral health crisis situations.

The key themes and consolidated feedback gleaned from these discussions is summarized below.

- There is a lack of awareness and/or understanding of the range of services available in our community to help with behavioral health crisis situations; it is not clear where to go for reliable, up-to-date information.
    - Simplify access – one place for people to call when experiencing a behavioral health crisis.
    - Acknowledge that sometimes people need both a referral and someone to "walk with them" to get the help they need (for both crisis and follow-up services).
    - There were suggestions about the need for communicating information about current crisis services to the community in multiple ways – PSA style, printed cards that individuals could have on their refrigerator, etc.
        - Need for an effective way to get the resources out to families/loved ones
            - Use simple message like "for mental health concerns, call 211"
    - It was noted that there are many natural helpers / informal supports in our community and education efforts should focus on identifying these individuals and ensuring that they have current information about what's available. These informal channels with trusted messengers will be important.
- There is reluctance among Black, Brown and Indigenous populations to utilize formal behavioral health services due to mistrust or lack of confidence that the service will be respectful / responsive to their cultural identity.
    - Important to have someone who looks like the people served, reflective of community: credible messaging, people who can be related to.
    - There are many natural helpers / informal supports in our community and education efforts should focus on identifying these individuals and ensuring that they have current information about what's available. Building trust with these channels is important – they are trusted messengers in communities.

  - For immigrant and refugee communities, importance of church, cultural brokers, refugee centers, and places where people gather and get their news and discuss amongst each other.
    - Give them the knowledge and information they need; have a way to supplement their work.

- There is no single response to crisis situations that will work for everyone – there needs to be alternatives or options and a process to connect individuals to the best fit culturally responsive option to address the immediate situation.
  - There were also questions about when crisis calls come in (whether 211 or 911) who and how are they evaluated to ensure that the best decision is made regarding response.
  - Immediacy of addressing the situation is important –
    - Experience with 211 - Some families did not get an immediate response; perception is that "211 is not set up to respond to a crisis in an immediate way.
  - There should not be a single point of access to services; people need to access crisis services in a way that is comfortable and welcoming to them; they need to feel respected and have trust and confidence in who they are reaching out to for crisis support or for information.

- Better assessment before someone is referred or sent somewhere.
  - Data informed decision – how to approach and how law enforcement can triage – getting right team in there to help if needed.
  - Better way to determine/assess if mental health or substance use crisis – may drive a different response.

- People in crisis are seeking immediate help/support to address the crisis; once that immediate need is met, there needs to be follow-up and support to help the person avoid recurring crisis situations.;
  - Ensuring that as people are referred from a crisis to a service that might help them that the service is actually available to them (i.e., they don't get there and find out they're not eligible or hit some other barrier).
  - People respect people who have been where they are at (peers).

- Considerations when developing the crisis response options –
  - Co-police response
    - "When a person is highly agitated, the tiniest thing can make them feel worse, so if someone were to call for help and the police show up, that could freak them out more"
    - Suggestion that 911 send the ambulance and not the police
  - Making sure that any team is safe – multi-disciplinary team.

- In developing any crisis response team, involving individuals and agencies in the community is important, collaborate with more agencies – immigrant organizations, smaller agencies, CBOs.
    - Organizations are spread thin in resources, so people who we need to come to table, do not have time to step away. Supplement resources at organizations so they can engage at planning work.
- Crisis Intervention Training for law enforcement.
- There needs to be accountability across the board – accountability among service providers to provide culturally responsive, equitable and quality services and accountability to the community by those charged with implementing change with:
    - Established metrics to measure progress and course correct as needed
        - How do we plan to evaluate the results/how will you know if you've met your goals?
    - Accountability checks – fair and equitable practices; recruiting so that people of color have access to positions.
    - Make sure current crisis resources are utilized appropriately.
    - Monitoring group needs to look at how to build capacity.
- Established mechanisms for continuous involvement of the community in further shaping system change as it evolves.
    - Making sure services are meeting needs in the community without competition among agencies vying for slice of the pie.

APPENDIX 4

TASK FORCE AND WORK TEAM PARTICPANTS

Our sincere thanks and appreciation for the work and commitment of the Task Force and Work Group participants over these past few months. The dedication all demonstrated to getting an enormous amount of work accomplished in a short period of time was impressive! It is our hope that many of you will continue on as the hard work of implementation of the priorities outlined in this report now begins. We look forward to implementation and accomplishing the Goals that will help the community move toward longer-term transformation of our community's behavioral health and healthcare systems, eliminating disparities and achieving equitable outcomes for all.

Monroe County Office of Mental Health 90-Day Task Force Participants

Aaron Anandarajah, Student, RASE Commission
Alia Henton-Williams, City of Rochester
Amy Mills, 911
Anne Wilder, Coordinated Care Services, Inc.
Bonnie Smith, Monroe County OMH
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Corinda Crossdale, Monroe County Executive's Office
Daniele Lyman-Torres, Ed.D., City of Rochester
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Don Kamin, Ph.D., Monroe County OMH
Eric Caine, M.D., URMC, RASE Commission
Heather Newton, NAMI
Jason Teller, Monroe County OMH
Jennifer Lake, Goodwill of the Finger Lakes; 211/Lifeline
James VanBrederode, Gates Police
Jessica Watington, Monroe County OMH
Karen Buss, 911
Kelly Wilmot, Monroe County OMH
Korey K Brown, Monroe County Sheriff's Dept.
Laura Gustin, Systems Integration Project
Lenora Reid-Rose, Coordinated Care Services, Inc.
Mandy Teeter, Rochester Regional Health
Mary Lupien, Rochester City Council
Melanie Funchess, Mental Health Association of Rochester
Michael Mendoza, M.D., Monroe County Public Health
Muhammad Shafiq, Ph.D., Nazareth College, RASE Commission
Neilia Kelly, Coordinated Care Services, Inc.
Patrick Phelan, Greece Police
Richard Tantalo, Monroe County Public Safety
Rodney Corry, Coordinated Care Services, Inc.

Thalia Wright, Monroe County DHS
Tisha Smith, Ed.D., Monroe County Public Health
Frank Keophetlasy, Monroe County Legislature

Monroe County OMH 90-Day Task Force Work Group Participants

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Anne Wilder, Coordinated Care Services, Inc. *(Diversion Work Team)*
April Aycock, Ed.D., URMC – Strong Recovery *(Education/Outreach Work Team)*
Becky Maynard, Monroe County OMH *(Post Crisis Connection, Diversion Work Teams)*
Bonnie Smith, Monroe County OMH *(Education/Outreach Work Team)*
Cameron Farash, Liberty Resources *(Post Crisis Connection Work Team)*
Candice Lucas, Ed.D., Monroe County DHS
Carole Farley-Toombs, URMC *(Post Crisis Connection Work Team)*
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David Catholdi, Brighton Police Dept.
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Deborah Turner, Goodwill of the Finger Lakes – 211/Lifeline *(Education/Outreach Work Team)*
Destiny Brown-Hernandez, Villa of Hope *(Post Crisis Connection Work Team)*
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Elijah McCloud, Mental Health Association of Rochester *(Education/Outreach Work Team)*
George Roets, Yates County Department of Community Services
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Heather Penrose, Mental Health Immediate Action Alliance *(Diversion Work Team)*
Jason Teller, Monroe County OMH *(Diversion Work Team)*
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Jeremy Cushman, M.D., Monroe County/EMS *(Diversion Work Team)*
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Karen Buss, 911 *(Diversion Work Team)*
Kelly Wilmot, Monroe County OMH *(Diversion Work Team)*
Khadijah Tillman, Sankofa Family Counseling *(Post Crisis Connection Work Team)*
Kiah Nyame, Ed.D., Community *(Post Crisis Connection Work Team)*
Korey Brown, Monroe County Sheriff's Dept.
Laura Commaroto, Coordinated Care Services, Inc. *(Education/Outreach Work Team)*
Lawana Jones, Autism Council; Monroe County Community Services Board
Lenora Reid-Rose, Coordinated Care Services, Inc. *(Education/Outreach Work Team)*
Lindsay Gozzi-Theobald, Villa of Hope
Lisa Mancini, Helio Health *(Post Crisis Connection Work Team)*

Mandy Teeter, Rochester Regional Health *(Post Crisis Connection Work Team)*
Mary Laduca, Delphi Rise *(Post Crisis Connection Work Team)*
Mary Lupien, Rochester City Council *(Diversion Work Team)*
Mary Russo, Mental Health Association of Rochester *(Education/Outreach Work Team)*
Moses Robinson, Rochester Police Department *(Diversion Work Team)*
Nathan Franus, Finger Lakes Performing Provider System *(Diversion Work Team)*
Neilia Kelly, Coordinated Care Services, Inc. *(Education/Outreach Work Team)*
Patrick Seche, URMC - Strong Recovery
Phyllis Jackson, Common Ground Health *(Education/Outreach Work Team)*
Rodney Corry, Coordinated Care Services, Inc. *(Post Crisis Connection Work Team)*
Sam Farina, Fairport Police Department
Sharon Bauer, Health Homes of Upstate NY *(Post Crisis Connection Work Team)*
Sue Sullivan, Delphi Rise
Val Way, East House
Yana Khashper, ROCovery Fitness *(Education/Outreach Work Team)*