MISSOULA BEHAVIORAL HEALTH UPDATE

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May 3, 2023

Good Day Sunshine,

I have served as Missoula County's Mental Health Coordinator for 14 months now and I'd like to share some of what I've learned and discerned about behavioral health crisis response systems broadly and behavioral health crisis response systems in Missoula specifically. I invite you to take a beat, take a breath, and settle in for some story and perspective.

I arrived to Mental Health Coordination with a strong background in Community Health. "Community Health" is a 'working *with* community', not a 'to' or 'at' or 'for' community. Community Health recognizes that health is culturally derived, socially mediated, and individually defined. People are experts in their own lives and we practice meeting people where they are and working with individuals and communities toward their vision of their best health. Community Health is relational, time-intensive, and iterative: it is both a Team Sport and a Marathon.

Last summer, I increased and enhanced my knowledge and understanding of behavioral health services and behavioral health systems. I needed to orient to the behavioral health landscape before I could visualize how distinct systems intersect, overlay, and impact behavioral health, while also appreciating what that might look and feel like for individuals moving through these systems.

I dipped and dived into resources and reports like the National Council's Roadmap to the Ideal Crisis System and SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. I reviewed current and comprehensive assessments of Missoula's Behavioral Health Crisis Care and Substance Use Disorder Continuums. These local-level assessments review current community needs, system capacities, and the gaps between needs and capacities that are limiting our community's ability to consistently meet people where they are with what they need in real-time.

SAMHSA, the National Council, Crisis Intervention Team International, the Vera Institute of Justice and other reputable organizations proffer that an ideal crisis system begins with the aspirational vision that every person gets the right response, in the right place, every time. **A no-wrong-door crisis care continuum is the dream and we work towards that magic by acknowledging the inherent worth and dignity of each individual, welcoming them with humility, respect, and safety, and helping clients and patients identify, prioritize, and coordinate services and care across the continuum of care with the warmest of hand-offs.**

All frameworks, including evidence-based and best practice, are rooted in community health and center the primary customer and their collaterals. Primary customers or consumers are persons or patients seeking crisis services; collaterals are anyone or any organization connected to an individual's crisis care response. Once centered, customers and collaterals identify and describe values and principles of an ideal crisis response, including what it looks and feels like to engage with a single point of care or service, or across multiple care or service points, which is not uncommon during a behavioral health emergency.

By data alone, we know that more often, more people are experiencing emergent mental health events and/or are managing mental health conditions for longer periods of time. Currently, 1 in 5 US adults experience mental illness and 1 in 20 experience a serious mental illness each year. We also know that while there is a need for services, many people go without for a variety of understandable reasons, often directly related to the social determinants of health. More than half of all US adults living with mental illness did not receive treatment in 2022, and 51% of Montanans living with mental illness did not receive treatment in the same year. Treatment engagement for Substance Use Disorder is even starker. In 2022, a staggering 93.5% of all US adults living with Substance Use Disorder did not receive treatment. **Unchecked or unmanaged illness—physical or mental—catches up to us, and there is a high likelihood that many folx not currently engaged with services or treatment will experience a behavioral health crisis and we as a community are working toward responding to them with the right service, at the right time, every time.**

Given the complexity of the social determinants of health, including the social determinants of mental health, adding more services to our existing continuum of care will not in itself course correct US mental healthcare, nor will it improve mental health outcomes or mental health recoveries. In order to remedy our historically fractured mental health system, **we need to adjust our approach to health and healing upstream through innovation, collaboration, coordination, and cultural change**. Prioritizing the inherent dignity of every human, fostering empathy and understanding for individual experience, and leaning into each other's strengths while taking big deep breaths will go a long way toward promoting public safety, enhancing patient outcomes, and reducing system costs. While this is a herculean undertaking, we have tried and tested models and frameworks to break through those barriers to care, while also ensuring that any new crisis service is formally integrated into the existing continuum of crisis care.

The Crisis Intervention Team Program, or CIT Program, is one of several crisis response models that continues showing promise for people experiencing mental health crises and for the people and organizations working with them. CIT Programming originally launched in 1988 as the Memphis Model and has been in Missoula since 2015. CIT is a best-practice crisis intervention framework that prioritizes partnerships, community, training, policies, protocols, and research and evaluation to promote safety, improve outcomes, and enhance quality of life for community members and first responders alike. **Strategic partnerships create the Crisis Intervention Team**

structure, **while training, policies, and procedures operationalize our coordinated response effort**, and **evaluation helps integrate new services into the existing continuum of care while continually refining our shared program response across Missoula.**

With significant research, relationship, and time, I came to recognize that CIT is a community health improvement framework for effective, coordinated crisis response. CIT works with its primary consumers toward their vision of their best health, which includes working with them toward their vision of an ideal crisis response network. In Missoula, that vision is a coordinated and integrated community-wide behavioral health response that improves consumer and responder safety, and appropriately connects individuals to the type and level of care commensurate with their need, every time it's needed.

For too long, in too many communities, behavioral health crisis response has been unofficially handed over to law enforcement. At its core, **the Crisis Intervention Framework can help us re-establish the true intent of various professional roles and organizational services, so that we are meeting people in crisis with what they need, when they need it**. In an effective Crisis Intervention Team-Based System, a law enforcement officer tends to public safety, while a mobile crisis response clinician stays with a person experiencing a mental health crisis for as long as it takes. An emergency room is for urgent physical health needs, and a crisis receiving center is for emergent behavioral health crises. In this way, **people in mental health crisis receive the right service at the right time, every time, while crisis response professionals remain centered in their primary role or purpose.**

Course correcting decades of deficient behavioral health funding and short-sighted policies that perpetuate injustice and various *–isms* will take significant time and all of the grace as we unlearn and rebuild a more effective, compassionate, person-centered response across Missoula. Even SAMHSA recognizes that the most potent element of an effective crisis system is relationships, and partnerships are the primary building block of Crisis Intervention Teams. **It turns out, being human and practicing compassionate connection can cultivate hope and hope can save lives. <3** In the coming months, I look forward to sharing how crisis response best practices are currently being operationalized in Missoula County through strategic partnerships, strong coalitions, shared training, and program evaluation squarely centered on the consumer and collateral experience, knowing that hope is healing and mental health recovery is possible.

In Good Community and Good Community Health,

Mary

A Deeper Dive, a Closer Look

- What is 'community health'? Examining the meaning of an evolving field in public health. (2014)
- National Council's Roadmap to the Ideal Crisis System (landing page and 2021 PDF Toolkit)
- SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit (2020 PDF Toolkit)
- Crisis Intervention Team International: What is CIT?
- Vera Institute of Justice (2019, Crisis Response Services for Mental Health, Literature Review, PDF)
- NAMI Mental Health by the Numbers 2020
- Mental Health America Adult Data 2022 with options to download printable reports from 2022, 2021, and 2020.
- Mental Health America, the State of Mental Health in America 2023
- Healthy People 2030, the Social Determinants of Health
- Social Determinants of Mental Health, front-and-back, University of Minnesota School of Public Health
- The Truth About Deinstitutionalization, The Atlantic, May 2021
- What is Mental Health Recovery? Two-minute video from an international healthcare organization. (2020)
- Crisis Intervention Team 10 Core Elements. Brief primer on CIT programming including ongoing, operational, and sustaining program elements.
- Crisis Intervention Team Missoula, City of Missoula.