Frontline Reports

The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Materials submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred) and no references, acknowledgments, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@cumc.columbia.edu) or to Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (smgoldfingermd@aol.com).

The Tucson Mental Health Investigative Support Team (MHIST) Model: A Preventive Approach to Crisis and Public Safety

Effective collaboration between law enforcement and crisis systems can improve outcomes for people with mental illness and for public safety. For example, the Memphis Model of crisis intervention training (CIT) enhances police officers' skills for safely deescalating crises. However, such programs focus on emergency response. After the 2011 shooting of U.S. Representative Gabrielle Giffords, the Tucson law enforcement community sought to develop a more upstream, proactive approach.

The Tucson Police Department (TPD) and Pima County Sheriff's Office (PCSO) enhanced their CIT programs by introducing the Mental Health Investigative Support Team (MHIST), which links individuals to services before a situation escalates to a crisis.

Core Components

MHIST plays an important role in the civil commitment system. Arizona statute requires law enforcement to transport individuals to a treatment facility when assisted outpatient treatment is revoked (such as for missed appointments) or an application for evaluation is filed with the court. These transport orders are assigned to a dedicated team of MHIST officers and deputies. Centralized tracking allows the most acutely ill individuals to be prioritized for location and transport. Having a dedicated team facilitates development of rapport with frequently served individuals. Team members wear plain clothes and drive unmarked cars to avoid the stigma and potential for behavioral escalation that can result from the sight of uniformed officers.

The investigation component focuses on connecting individuals to behavioral health services before the situation escalates into a crisis or criminal court involvement. Cases are flagged for review with specific "mental health circumstance" codes or individual officer referral. MHIST detectives focus on two types of cases: noncriminal, "nuisance" cases that would not normally be investigated but may, if analyzed for patterns, indicate a mental health need and cases with a potential criminal component or threat to public safety. If mental health needs are identified, MHIST detectives work with community support, mental health, and criminal justice systems to facilitate an outcome that meets the needs of the individual and addresses public safety concerns. Justice-system diversion is pursued whenever possible.

Behavioral Health System Partnerships

As a non–HIPAA-covered entity, MHIST focuses on sharing information with health providers rather than receiving it, conveying information such as living conditions, neighborhood issues, firearm access, 911 calls, and so on. Initial barriers resulting from privacy concerns and mistrust were overcome as MHIST convinced providers of the team's intent to facilitate connection to treatment and prevent arrest. Some patients have developed strong rapport with MHIST team members and have signed consent to participate in treatment team meetings.

In addition, behavioral health crisis services have been designed to facilitate working partnerships with law enforcement. The Crisis Response Center (CRC) serves as the central receiving facility for law enforcement to bring individuals to treatment rather than jail. Half of the 12,000 individuals receiving care at the CRC each year arrive via law enforcement referral. Officers are never turned away, and their median turnaround time is under ten minutes.

Eleven crisis mobile teams (CMTs) are available to collaborate with MHIST in assessment, stabilization, connection to services, and welfare and follow-up checks. A dedicated law enforcement line ensures rapid access and connects directly to a supervisor. The behavioral health authority requires that CMTs arrive on scene within 30 minutes for law enforcement–initiated dispatches.

Outcomes

In 2015, TPD served 308 civil commitment transport orders, and PCSO served 176, all without a single use of force. TPD SWAT deployments for "suicidal barricaded subject" decreased from 14 per year 2012–2013 to three per year 2014–2015, at a cost savings of $10,000 per incident. Both teams have case examples of threats to public safety (such as planned mass casualty events at a church or place of employment) that were averted without use of force or criminal court involvement.

The Tucson MHIST model adds to the continuum of solutions available for law enforcement to address the behavioral health needs of the community it serves and suggests that earlier intervention mitigates adverse outcomes of behavioral health crises, including use of force, criminal justice involvement, and threats to public safety.

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The Domestic Violence Initiative: A Private-Public Partnership Providing Psychiatric Care in a Nontraditional Setting

The Domestic Violence Initiative was formed in 2014 as a collaboration between the Women's Program in the Department of Psychiatry at Columbia University Medical Center and the New York City Mayor's Office to Combat Domestic Violence. This collaboration, which receives support from the Chapman Perelman Foundation, piloted the provision of clinical psychiatric services on site at the Bronx Family Justice Center (BxFJC), one of a growing number of family justice centers (FJCs) nationwide that provide colocated social and legal services for survivors of intimate partner violence (IPV) and sex trafficking. The BxFJC offers case management, counseling, advocacy, and educational opportunities, as well as civil and criminal legal assistance. To our knowledge, no other FJC has colocated psychiatric care.

Our clinical team consists of a psychiatrist on site two days per week and an L.C.S.W. psychotherapist on site one day per week, along with clinical trainees under their supervision. Patients referred to our program by other service providers are survivors of IPV, sex trafficking, or both. They present at screening or follow-up at the BxFJC with requests for mental health care, behavioral disturbances, or difficulty with self-regulation. Each patient is evaluated for 90 minutes (or 120 minutes if in translation) by our psychiatrist, who is bilingual in Spanish and English. Treatment includes psychopharmacologic management and group and individual psychotherapy. The clinicians collaborate closely with other on-site service providers, including case managers, counselors, and legal staff. All services at the New York City FJCs are free of charge.

We surveyed staff and partner agencies at the four NYC FJCs at the outset of this collaboration about knowledge of mental health sequelae of IPV and attitudes toward integration of psychiatric services. Over 80% (N=195) of staff responded to the survey and identified among patients a high degree of untreated psychiatric symptoms and poor access to care. Among self-identified case managers and counselors, 75% (N=86) indicated that their clients would have better outcomes with additional psychiatric care but cited barriers to accessing care, such as geographic distance, lack of language fluency, lack of insurance, undocumented status, stigma, and mental health providers' lack of training regarding IPV. In the survey and related focus groups, attitudes toward including on-site psychiatric services were generally very positive, although mixed with concern about stigmatizing survivors and impact on child custody cases.

From April 4, 2014, to March 1, 2016, our team received 168 referrals, and 106 were evaluated by our bilingual psychiatrist. We conducted a chart review to determine demographic characteristics of patients, initial psychiatric diagnoses, safety risk factors, and treatment history.

Of the 106 patients who were evaluated, 104 (98%) identified as female. Patients ranged in age from 18 to 65, with a mean age of 37. Of the 168 patients referred, 54% (N=90) spoke primarily English and 33% (N=55) spoke only Spanish; other languages included French, Fulani, Bengali, Ewe, German, Haitian Creole, Hungarian, Mandarin, Somali, Tagalog, and Twi.

The most frequent axis I diagnoses at evaluation were posttraumatic stress disorder (44%, N=47), major depression (46%, N=46), mood disorder not otherwise specified (NOS) (37%, N=39), anxiety disorder NOS (31%, N=33), and substance use disorder (10%, N=11). High rates of comorbidity were observed, with a median of two diagnoses and a range of zero to four diagnoses per patient. A total of 42 patients (40%) reported a prior suicide attempt, and of these, 15 (36%) never received mental health care, five (7%) reported abbreviated care (discontinuation of treatment after one or two visits), and two (5%) received psychiatric care only after multiple suicide attempts.

With the success of this privately funded pilot program, New York City is expanding the model to all five FJCs, with funding from the THRIVE NYC initiative (https://thrivenyc.cityofnewyork.us). We continue to collaborate with the city on the expansion and impact assessment of these colocated services.

This collaboration demonstrates the feasibility and acceptability of providing psychiatric services to IPV survivors in nonmedical, community-based settings, where, compared with traditional health care settings, these survivors are more likely to present for services. Our finding of a very-high-risk patient population with inadequate prior treatment highlights the need to improve access to care for survivors of IPV, as well as to educate mental health care providers and policy makers about the impact of IPV on psychiatric illness and risk of suicide.

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