City of Rochester, NY
Lovely A. Warren, Mayor
Rochester City Council

CRISIS RESPONSE PILOT PLAN

FY 2020-2021

Department of Recreation and Human Services
Dr. Daniele Lyman-Torres, Commissioner
www.cityofrochester.gov/crisisintervention

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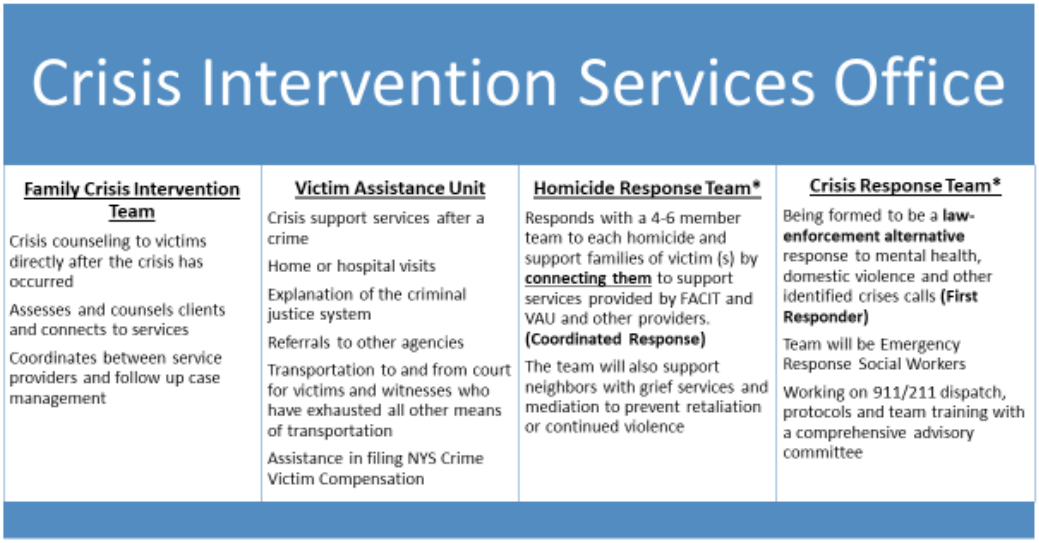
BACKGROUND

In September 2020, The City of Rochester announced the creation of a new Crisis Intervention Services Office. This office is comprised of 4 service units. The Family and Crisis Intervention Team (FACIT) and Victim Assistance Unit were both long-running community support programs within the Rochester Police Department (RPD). These two units were moved as a part of legislation passed by Rochester City Council into the new office. In addition, two new response teams were commissioned to be a part of this office. The Homicide Response Team has the purpose of providing a community wide coordinated response to families and neighbors impacted by homicides. Finally, the Crisis Response Team (or PIC Team) was commissioned to create a 24/7, law enforcement alternative response of trained professionals to address behavioral health and related crises occurring in the City of Rochester. **This pilot plan exclusively focuses on the crisis response team development and pilot launch.**



*New Teams

A SHIFT TO HUMAN SERVICES

The creation of the Crisis Intervention Services Office prompted the City of Rochester to return to providing human services as a formal function. This function and office was assigned to the Department of Recreation and Youth Services, thereby, changing the name to the Department of Recreation and Human Services (DRHS). This shift recognizes the need for increased efforts to ensure equitable access to supports and services for residents of the City of all ages and confronting many challenges.

EXECUTIVE SUMMARY

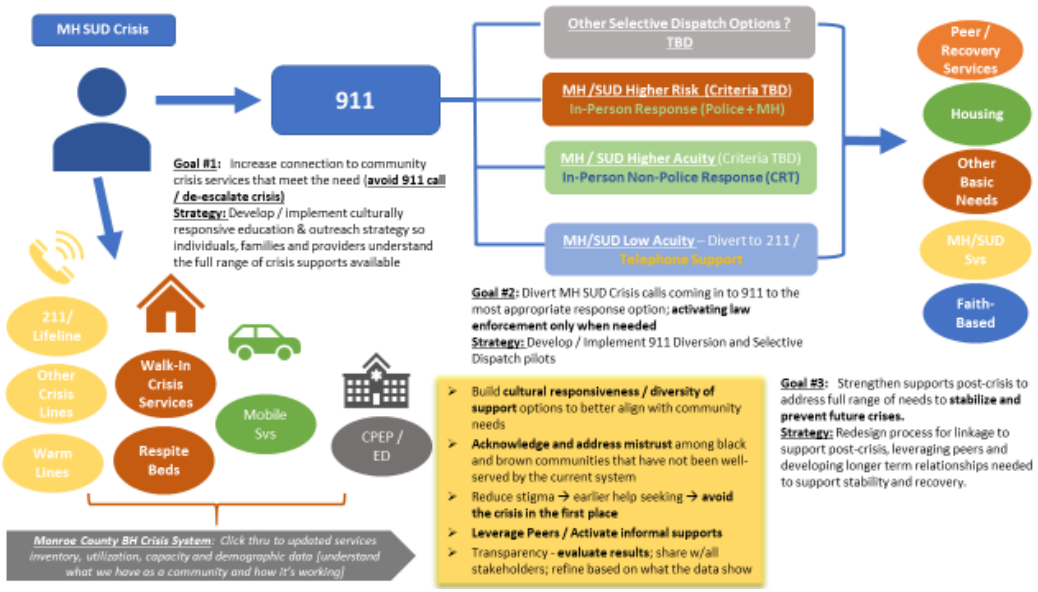
PILOT PLAN

The FACIT and Victim Assistance Units had been long standing programs which were transitioned to DRHS from RPD in their current state for further evaluation. The Homicide Response Team had been in the planning stages for two years as a part of the Roc Against Gun Violence Coalition spearheaded by City Council Vice President Willie Lightfoot. The Homicide Response Team was formally launched in November 2020. The **formation of a first responder team of behavioral health professionals for the crisis response** required a coordinated and comprehensive planning process to develop a pilot plan. **An advisory committee was formed and began meeting on October 1, 2020 with a goal of completing a pilot plan by 12/31/2020 for a January 2021 launch.** This plan represents the work of the advisory committee and the support of many national examples and models for law enforcement alternative responses. **The pilot will run through June 30, 2021.**

LOOKING AHEAD

Following a six month pilot of a crisis response team, the Homicide Response Team and the transition of the FACIT and Victim Assistance teams, there will be a thorough evaluation of the services. This assessment will inform the recommendations and formal structure to be introduced in the FY 22 budget process.

This plan is in full alignment with the Monroe County Task Force plan (*Appendix 1.1*), the community wide Systems Integration Initiative, and represents a portion of the work that needs to be done as a part of the community transformation of service delivery. **The implementation of additional phases will be assessed and considered at outlined milestones and may require additional resources.**



Adapted from Monroe County Task Force Report (2020)

Crisis Response- Person (s) In Crisis Team

PURPOSE

Increase efficiency for identifying and connecting individuals with the appropriate level of care during crisis situations. Engage individuals with solutions that influence behaviors by providing information needed to make informed decisions, better understand their mental health status, and know when to seek which level of care. Provide guidance and support for family members and friends of the person experiencing the crisis, work to reduce dependence on law enforcement and emergency medical services, for non-violent/non-legal type issues, and strive for diversion from the emergency department.

TEAM COMPOSITION AND COVERAGE

The PIC Team be comprised of **Emergency Response Social Workers**. The detailed qualifications and job description can be found in *Appendix 1.2*. These behavioral health professionals will be assigned to work in teams of two (2) at all times. There may be peak times in which there will be 2 PIC Teams on duty. Coverage will include a 24/7 call response to all of the City of Rochester. The jurisdiction of this team is limited to the City of Rochester as it is an initiative funded by City constituents and under the administration of the Mayor of the City of Rochester.

CRISIS LINE

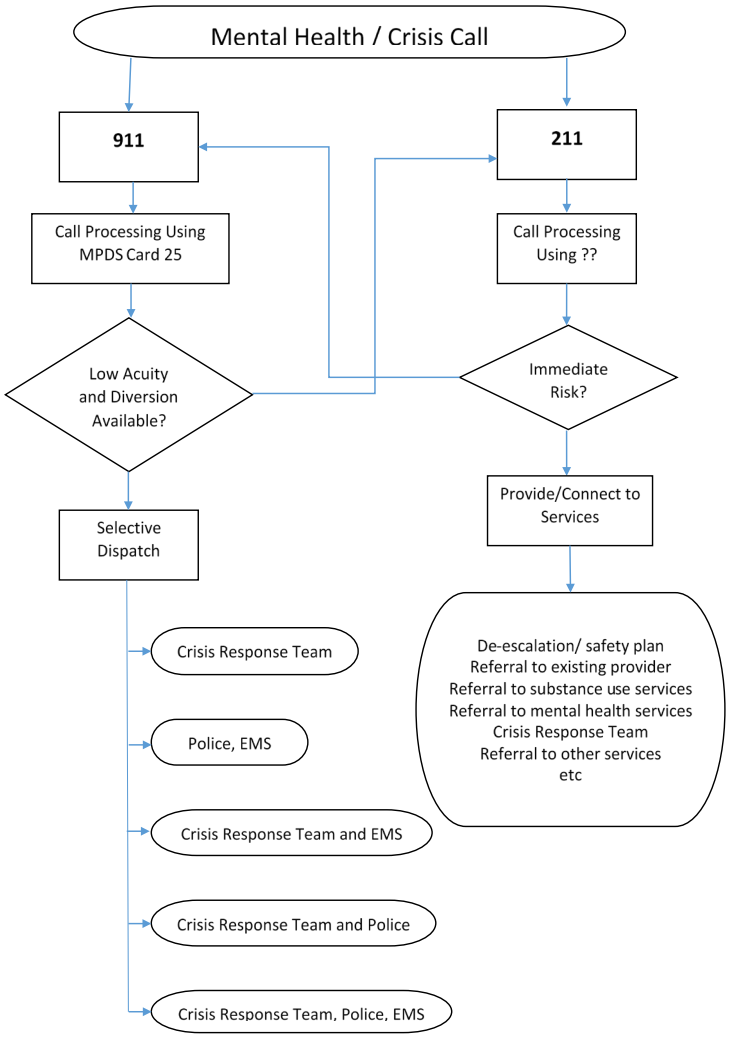
There is a strong desire to provide an alternative to 911 for the community to call for behavioral health crises and to reach the PIC Team without requiring 911 answering resources. 211/Lifeline is a 24/7 human services and crisis hotline serving the Finger Lakes region and operated by Goodwill, Inc. 211 has become a number that Rochester residents rely on for access to referrals and connections to local services. By partnering with 211, the City of Rochester can ensure that the telephonic counselors answering calls for behavioral health crises can get people connected to services directly, or be served by the PIC Team if an in person response is indicated.

Call taking and dispatching are two distinct functions. The publicized number for the Crisis Intervention Services Office and specifically for the PIC Team will be 211. It was decided that given the nature of the PIC Team work in the field that **911 will provide the dispatching services** so that two-way communications between the PIC Team and other emergency services such as EMS and law enforcement stay easily accessible should those resources be required. In addition, the calls planned to be diverted to the PIC Team in this pilot and in subsequent phases are calls that are currently being given to EMS or law enforcement for response and come in through 911. The flow chart below includes information from the Monroe County Task Force Report as well as outlines the call flow for the implementation of the PIC Team. Both work flows rely on 211/Lifeline. **Calls coming in to 211 which are appropriate for the PIC Team will be sent to 911 for the PIC Team to be dispatched.**

CRISIS RESPONSE- PERSON (S) IN CRISIS TEAM

SELECTIVE DISPATCH

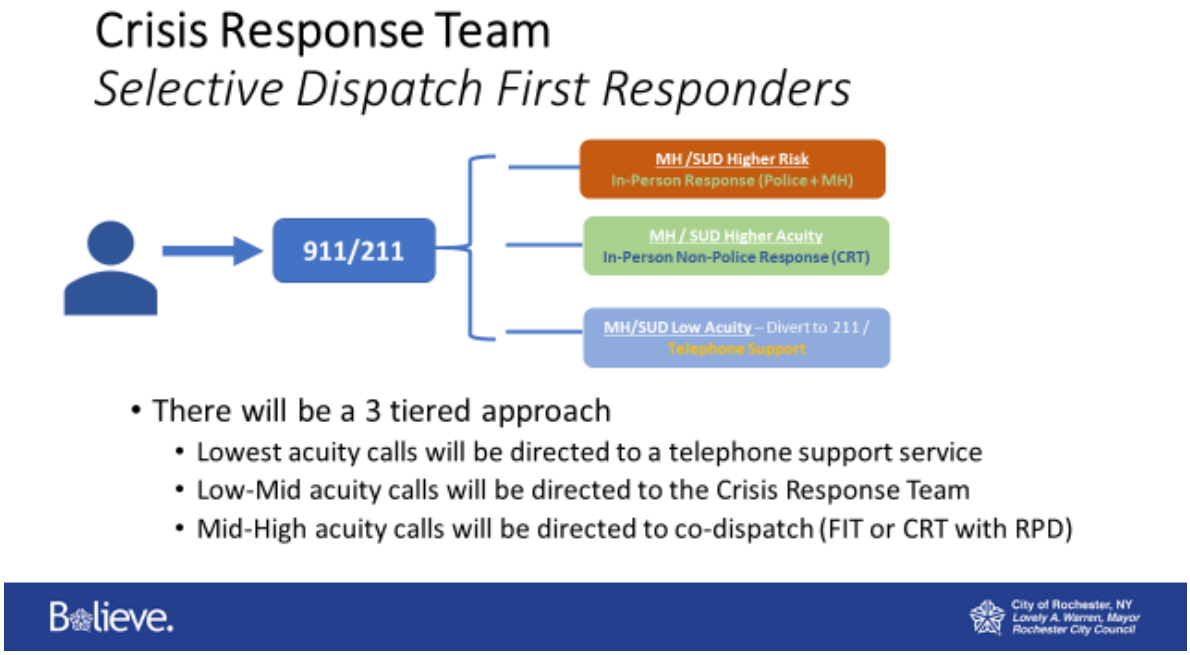
Using a flow chart, the ability to assess and assign calls coming in through 911 and 211 were analyzed by call type and a variety of factors which assigns an acuity level or level of complexity/severity to a call. The model below outlines how calls coming in categorized as "mental health" can be routed using this risk analysis process. Another flowchart in *Appendix 1.3* provides a horizontal overlay of the two call flows.



Jeremy T. Cushman, MD, MS, EMT-P, FACEP, FAEMS
Crisis Diversion and Selective Dispatch Concept Map – 10/22/2020

CRISIS RESPONSE- PERSON (S) IN CRISIS TEAM

The selective dispatch work group settled on creating three (3) tiers of levels which can be addressed in the new system which includes telephonic support (diversion) and the PIC Team (selective dispatch). The third or highest level of risk or acuity will be considered a co-dispatch situation in which law enforcement, EMS and the PIC Team could be dispatched together. **The initial pilot phase will focus only on Tiers 1 and 2 which include telephone support and PIC Team response**. Tier 3 would be addressed in future phases of implementation.



CALL TYPES SELECTED FOR PILOT

The "25 Card" consists of EMD call codes used by 911 Emergency Communications and Public Safety providers (Fire, Police, EMS) as a common language to assign calls to categories for service delivery and tracking. There are a number of codes on this list and variants include weapons, violence, severe bleeding, etc. In *Appendix 1.4* the full City Response Team Matrix can be found. The codes selected for the pilot are: "25A1", "25A2" and "25B3". This represents 2,671 City calls based on data from (2019) 911 records. That is out of a total of 6,159 calls in the categories reviewed. **Therefore, this pilot is estimated to divert 43.4% of these call types away from law enforcement or EMS and to the PIC Team.**

Additional call types have been identified for future phases of implementation from the "25" card, but also can come from other categories to be explored such as "wellness checks".

CRISIS RESPONSE- PERSON (S) IN CRISIS TEAM

ON-SCENE PROTOCOLS

A significant amount of analysis developed the work flow for this pilot at every level. There are detailed on-scene protocols based on assessing the scene for safety, completing an analysis of the situation or crisis, providing immediate support and de-escalation, and making real time connections and enrollments when appropriate.

Some of the risk level assessment for the pilot level cases is outlined below:

LEVEL 1: LOW RISK

CLIENT PROFILE:

The individual is in need of intervention due to subjective distress and/or mild level of dysfunction or difficulty in coping with current stressors. The individual would not seem to require hospitalization but may benefit from consideration for additional short term formal services.

LEVEL 2: MODERATE RISK

CLIENT PROFILE:

The individual is in need of timely intervention due to the inability to cope with current stressors. Risk of harm to self or others is not pressing at time of contact due to the presence of other reliable supports or due to lack of plan or intent. Person is considering harming themselves, but doesn't have plan or means – could be given alternatives.

CARE NETWORK

In order for the intervention to be successful, the network of available supports and services must be in place and ready to partner with the Crisis Intervention Services Office. A detailed resource list was compiled by the Advisory Committee is included in *Appendix 1.5*. Some of the key points include:

Chemical Dependency:

Service Partners: Delphi Rise, Evelyn Brandon, Huther Doyle.

Service Gap: Evelyn Brandon and Huther Doyle do not offer services during nights and weekends. The 24 hour service Delphi offers is the detox open access.

Mental Health:

Preferred Partners: Liberty Resources, Spiritus Christi Mental Health Center, Catholic Family Services, U of R Emergency Mental Health services, and Rochester Regional Crisis Center.

Service Gap: Only U of R and Rochester Regional offer services during weekend and evening hours.

CRISIS RESPONSE- PERSON (S) IN CRISIS TEAM

Domestic Violence:

Preferred Partners: Willow Domestic Violence Center, RESTORE and Resolve.

Service Gap: Only Willow has weekend and overnight service hours available.

Housing:

Preferred Partners: DHS after-hours, YWCA, Demitri House, Catholic Family Services including shelters- Francis Center Men's Shelter, Sanctuary House, and Place of Hope.

Service Gap: Bed capacity at shelters is at times an issue. Different shelters are geared toward different demographics i.e. gender, age, mothers/families.

Older Adult Services:

Preferred Partners: Life Span Elder Abuse Center, Adult Protective Services

Service Gap: Adult Protective services is the only evening and weekend service provider, and that is in the event there is a life-threatening situation.

Individuals with Differing Abilities:

Preferred Partners: Center for Disability Rights

Service Gap: Provider does not offer services after 5pm or on weekends.

Youth Resources:

Preferred Partner: Center for Youth

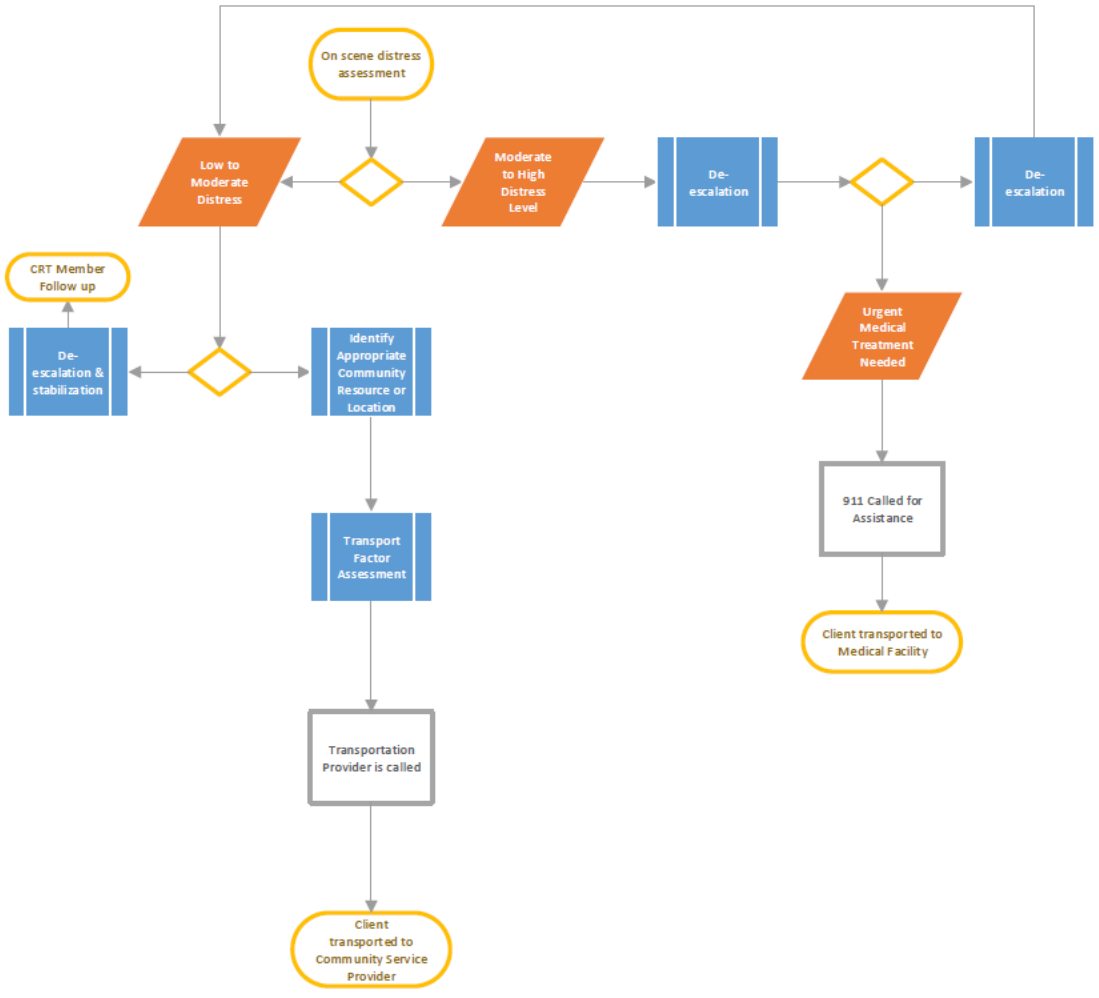
Service Gap: Capacity for shelter beds and other programs can be a challenge.

PEER INTERGRATION

The use of people in recovery from mental health and substance abuse disorders has been recognized as a critical component of successful health outcomes for individuals in crisis (Philadelphia Dept. of Behavioral Health and Intellectual Disabilities Services and Achara Consulting, Inc., 2017). The Advisory Committee has made a commitment to continuing to review how to best integrate peer navigators into the Crisis Intervention Services Office and with the work of the PIC Team in particular. It is anticipated that **the pilot will inform where and how to best activate peer navigators and allow for the identification of funding needed to recruit, train and staff peer support personnel in the model**.

CLIENT TRANSPORTATION

A significant finding in the development of the pilot plan is the limited availability of transportation during overnight hours outside of emergency medical or law enforcement responses. There are a number of factors which were considered regarding decisions for providing transportation. A transportation matrix and checklist has been created, and transportation will be ensured as a cost of operating the pilot. For transportation not requiring an ambulance, and not limited by accessibility needs, **use of ride share services allows for the best "on-demand" service platform.** A wide range of options including public transportation may be applicable depending on the individual circumstances of each encounter.

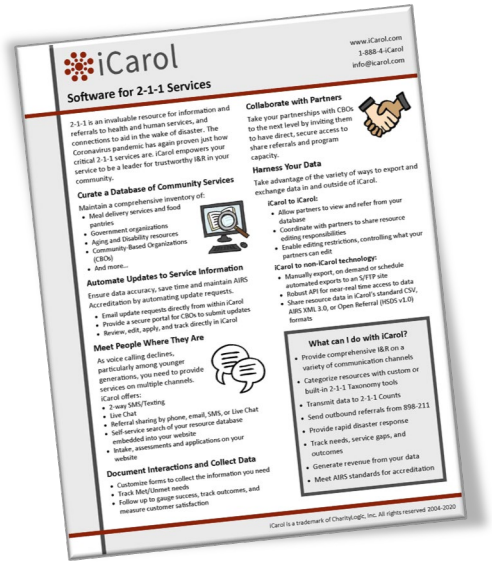


Transportation Options Model (Crystal Benjamin-Bafford, 2020)

CRISIS RESPONSE- PERSON (S) IN CRISIS TEAM

DOCUMENTATION AND SHORT TERM CASE MANAGEMENT

Documenting the encounters with residents in crisis as well as the connections to service will be completed using iCarol software as provided in partnership with 211/Lifeline. The system will allow for the secure and compliant capturing of resident information, consent to provide support, access to updated referral information, and the ability to follow up on responses to close the loop. The partnerships with organizations and agencies in the Care Network is critical in providing a meaningful connection that leads to improved outcomes for people in crisis.



Each encounter with an individual or family will be tracked and followed up on for 90 days. This short term case management will ensure enough time to connect individuals with the care or service coordination which is widely available and provided by a number of community based organizations and medical service providers. Information on the encounter and support provided will be maintained for future reference or to support reoccurring needs.

CLINICAL SUPERVISION AND TRAINING

The Emergency Response Social Workers require clinical supervision to ensure that they are able to provide effective, ethical, and responsible services to clients. In addition, the supervision should also assist with the technical development of skills for the social worker or mental health professionals. The outline of training provided initially and potentially ongoing is listed in *Appendix 1.6*.

Funding and Expenses

PILOT START UP AND OPERATIONS

- Staffing: The pilot for the CRT will include:
  - 1 FTE Coordinator
  - 2 FTE Emergency Response Social Workers
  - 1 PTE Emergency Response Social Worker
  - 10 Per Diem Emergency Response Social Workers
- Contracted Services
  - White Bird Clinic (CAHOOTS)- Technical assistance and training
  - 211/Lifeline-Call center services, telephone triage, iCarol System, care network coordination
  - Coordinated Care Services- Clinical supervision and training
  - Transportation Planning-Client transportation plan development

IMPACT ON FY 22

The pilot is being supported with $650,000[1] transferred from contingency by City Council. These funds were set aside during the completion of the FY 21 budget and allocated to racial equity initiatives. The remaining funding is coming from the existing FY 21 DRHS Budget. The funding for a full year of operations will be evaluated and considered in the development of the FY 22 budget.

CAPITAL CONSIDERATIONS

In addition to office configuration and set up, capital expenditures for vehicles and small equipment has been considered in the pilot funding and will be reflected in the CIP requests for DRHS in future years.

PILOT EXPENSES FY 21

DESCRIPTION	EXPENSES
Personnel	$479,200
Supplies and Materials	$9,600
Training and Contracted Services	$143,500
Other Operating Expenses	$30,500
Total	**$662,800**

[1] $300,000 authorized by Rochester City Council on September 15, 2020. $350,000 is pending City Council approval on January 19, 2021.

Key Metrics

Given the stated purpose for the alternative response pilot, below are a set of metrics to be refined and monitored throughout the pilot as well as subsequent phases. Goals (KPIs) should be established in each metric area by the end of the pilot phase, and can serve as a means for determining future implementation and funding sources.

% OF CALLS TRANSITIONED

Reduce the number of behavioral health and lower acuity calls traditionally responded to by law enforcement or EMS (The Justice Collaborative Policing Task Force, 2020).

IMPACT ON ED/HOSPITAL UTILIZATION

Reduce the number of individuals transported to the emergency department that could be instead addressed in a non-hospital setting (The Justice Collaborative Policing Task Force, 2020).

OUTCOMES FOR INDIVIDUALS

Along with documenting meaningful connections to services, i.e. enrollment in ongoing case management, other KPIs can be established and tracked regarding the reduction in the number of non-warrant arrests that result during a 911 response (The Justice Collaborative Policing Task Force, 2020).

COST-BENEFIT ANALYSIS

One critical metric will be to monitor and analyze comparing the investment into the PIC Team and related Crisis Intervention Services Office programming with the costs of sending law enforcement or EMS for the same interventions.

Evaluation and Scalability

EVALUATION

The Advisory Committee established to draft and build the pilot plan will continue to provide oversight of the pilot, the establishment of key metrics, and a timeline with resource needs for future phases.

- Launch-January 21, 2020
- 30 Day evaluation-troubleshoot initial issues
- 60 Day evaluation-establish reporting on key metrics
- 90 Day evaluation-review short term case management services
- 120 Day evaluation-make recommendations for adjustments and next phase
- 180 Day evaluation-complete pilot evaluation and plan for next phase

FUTURE PHASES

Future phases will be dependent on the outcomes of the pilot, the availability of community services, and the access to required resources to cover expenses. Incremental expenses include: staffing, technology, peer integration, transportation expenses, contracted services, and administrative expenses.

CONTACT INFORMATION AND ADVISORY COMMITTEE

Contact Information and Advisory Committee

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Meghan de Chateauvieux, Willow Domestic Violence Center

Pastor Theresa Crocker, Faith Hope and Charity Worship Center

Dr. Jeremy Cushman, University of Rochester, Monroe County, City of Rochester

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Kelly Wilmot, Monroe County Office of Mental Health

ACKNOWLEDGMENTS

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The inception, development, funding and launch of the crisis response PIC Team pilot would not be possible without the vision, support, and hard work of the following:

- Mayor Lovely A. Warren
- Rochester City Council
- The Crisis Response Team Advisory Committee
- Senior Management Team
- Department of Recreation and Human Services Team
- Contracted Service Providers
- Community Input

Appendices

1.1 Monroe County Task Force Report
1.2 Job Description for Emergency Response Social Worker
1.3 12.7.2020 Draft Call/Dispatch Workflow
1.4 City Response Team Matrix
1.5 Care Network Resource List
1.6 Training and Clinical Supervision

References

1.1 A Sample Process for Developing a Community Based Emergency First Responders (EFR) Program, The Justice Collaborative Policing Task Force (September 2020)
1.2 Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide, SAMHSA (2018)
1.3 Philadelphia Dept. of Behavioral Health and Intellectual Disabilities Services and Achara Consulting Inc. (2017). *Peer Support Toolkit.*

Appendix 1.1

Monroe County Mental Health & Substance Use Disorder 90-Day Task Force

Priorities and Action Plan

December, 2020

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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 addiction 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 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/ training across behavioral health, healthcare, and human services providers to increase understanding and awareness of behavioral health emergency and crisis services;
- 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 how to identify and access the best response to an immediate crisis**.**

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 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:

- Expanding the Forensic Intervention Team (FIT) to fill immediate gaps. The County will leverage grant funding from the US Department of Justice to expand the FIT model (which pairs law enforcement with a mental health clinician) when responding to behavioral health crisis calls, creating a 24 x 7 response capability;
- 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
- 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; 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

Implementation and Accountability: Given the immediate nature of this Task Force, some of this work has already begun, but success will require ongoing management, coordination, and the ability to use data to assess progress and adapt as needed to achieve our goals. 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 to assess progress, and routine review among members of the MH SUD Task Force Oversight Team and community groups to assess progress and continue to build understanding of community experiences, priorities and needs.

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. 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.

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 <u>and</u> 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: mistrust, day-to-day injustices, feeling talked down to 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 _.

Incorporating the community needs voiced in several input sessions held by the RASE Commission and other forums, the workgroup broke into 3 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

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 / 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 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 behavioral health consumers/service recipients 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, 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. Of note in gathering these perspectives is the interdependency of many factors that emerge as one speaks of crisis – 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.

Certain key themes have been gleaned from the collective work in seeking community input regarding behavioral health crisis services (and overall behavioral health services). These key themes have shaped the goals established for the work of the Task Force and 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 options 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.

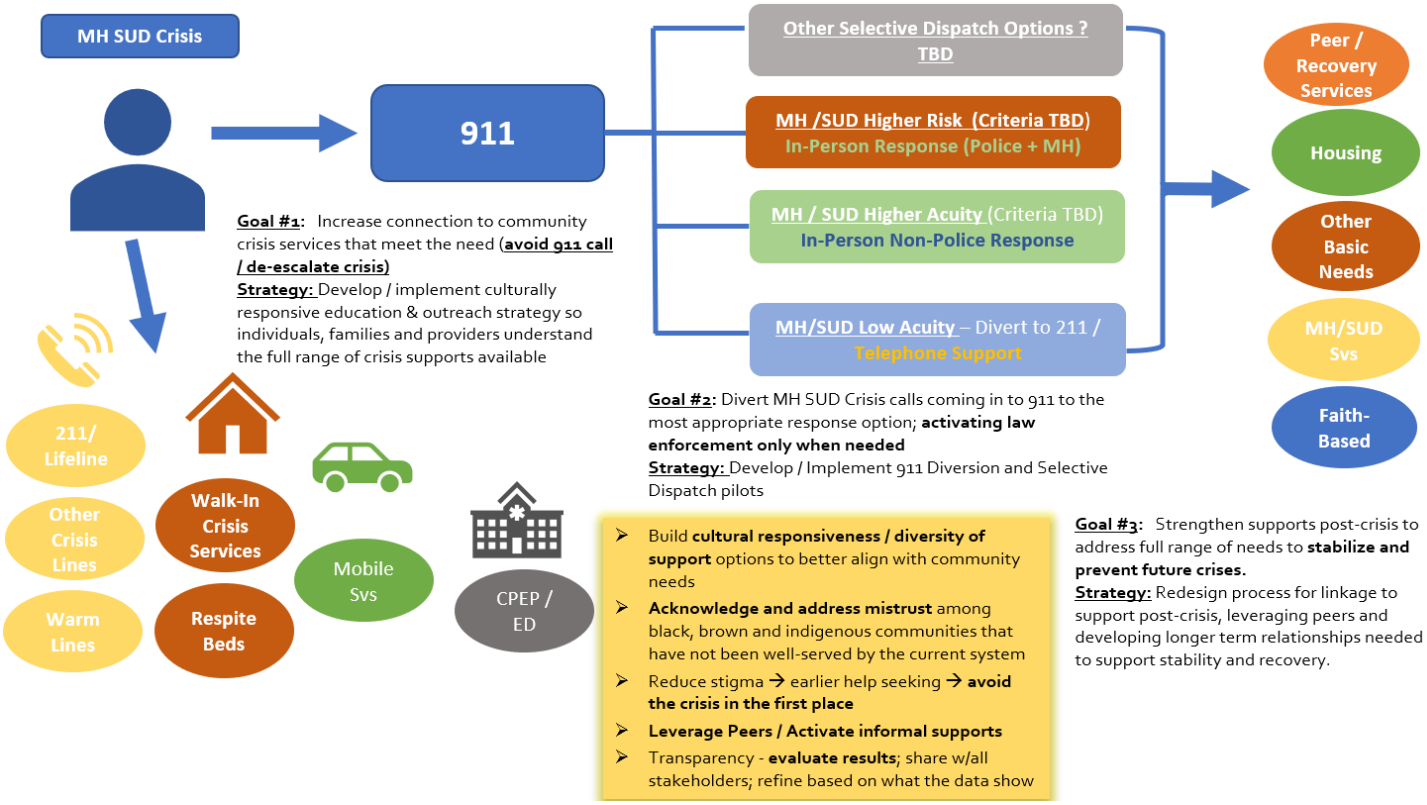
Goals and Priority Ares of Focus

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 – Taskforce Goal Overview



As summarized in *Figure 1,* 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 __. 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 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 required 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 for behavioral health providers; (2) Outreach/identification and education for key influencers (phase 1 identified as Clergy); 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. Additional detail is provided in Appendix ___ to this report.

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 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 "Culture and Crisis". Delivery of training will be phased in, with Behavioral Health providers 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 improving access to/ 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 connected 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 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.
- Seeking 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 Appropriate Option, Activating Law Enforcement Only When Needed

In developing strategies to address this area of focus, the 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 ___ 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 ___.

- Define Calls Appropriate for Diversion: The cohort of calls identified for this initial diversion pilot will include calls coming in to 911 for behavioral health concerns determined to be low acuity based on a screening protocol. These calls will be limited to 1st party callers (that is, calls coming from the individual 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, link 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 / 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 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: 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 afterhours 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 to 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 and other sources to support timely review and reporting of outcomes. 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, (2), Expanding local capacity to provide an in-person response that does not require law enforcement; and (3) Collaborating with the City of Rochester as they launch their new in-person 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 funding additional funding through a grant from the US Department of Justice to expand the FIT model to address some critical gaps. As such, one part of this multi-pronged strategy will include:

- Adding 2 full time clinicians to the current FIT team to pair with law enforcement officers responding to 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.
- In parallel to this process, Monroe County OMH will be redirecting resources to add an additional staff person and per diem coverage as needed to support a 24x7 response option to address needs across the County.

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 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.

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. 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 workgroup explored two regional approaches to behavioral health crisis response, Suffolk County's DASH program and Pittsburg'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.
- 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
- Review of current resource guides to ensure accuracy (DePaul NCADD, MHA Finding Your Way, MCOMH and City websites, etc.)
- 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 MOU.
- Implement community standards for follow up actions.
- Identify resources to support training standards and implement ongoing training plan.

<u>Priority #3</u>: 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 commit to contact within 24 hours people experiencing a crisis.
- Work with Health Home Care Management providers to confirm training standards and ongoing coaching for care management crisis follow up and enhance as needed.

<u>Priority #4</u>: 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.
- Review current resource guides to ensure accuracy (DePaul NCADD, MHA Finding Your Way, MCOMH and City websites, 211, 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.
- 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.

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. More detailed Action Steps and Progress Markers for this Goal are articulated in the Education/Outreach Work Team Report recommendations.

- Assessment of Agency 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 as outlined in Monroe County's MH / SUD Taskforce - including service delivery and outcomes
    - Analyze and use the results; Review with County and with provider agency leadership. Identify and prioritize needs, gaps, and barriers.
    - Use data to prioritize, to set progress goals for 2022, and to identify needs for technical assistance – both agency-specific and system-wide.
- 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
    - MC OMH 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. 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.
- ✓ 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 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 MC OMH has created 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 MC OMH resources, the MC 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);
- ✓ 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.

Appendices (to be provided with final report)

a. **Work Team Reports and Supporting Documents**
b. **Behavioral Health Crisis Service Overview: Snapshot of Current Services**
c. **Data Sources**
    ii. **Behavioral Health Crisis Services - Utilization and Trends**
    iii. **Community Input – Summary of Input**
d. **Acknowledgements**
    iv. **Taskforce and Work Team Participants**

Appendix 1.2

JOB DESCRIPTION

POSITION: Emergency Response Social Worker

BUREAU: Commissioner's Office/Crisis Intervention Services Office

ESSENTIAL FUNCTIONS:

Serves as a vital member of the Crisis Intervention Services team as the primary responder to emergency calls which include, but are not limited to: mental health (crisis, suicide), substance abuse, and domestic violence and family disputes. The Crisis Intervention Services team can be dispatched at any point 24 hours a day, 7 days per week. This position will be a part of an on call rotation for responses.

Crisis Response

- Leads all emergency crisis responses
- Mobilizes response team members and assigns tasks and duties
- Represents the City and response team at the scene
- Conducts the formal assessment of needs for the affected person(s) and/or family
- De-escalates crisis situations
- Ensures the safety of affected person (s) in the management of the crisis
- Manages and oversees an immediate support plan for each affected person(s) and/or family
- Provides first aid, CPR, controlling bleeding, or administers Narcan as needed
- Immediately connects affected person (s) with appropriate services and follows through until a hand off to a fixed support system can be confirmed

Service Coordination

- Organizes and coordinates all information on applicable and available services and partner agencies to respond to needs for affected person(s)
- Hosts meetings and forums with participating partners and collects/shares data
- Manages the information on responses, personal information of affected person (s) and relevant data for reporting

Training

- Designs and coordinates staff, volunteer, and partner trainings to include: orientation, mandatory trainings, program in-services and professional development
- Ensures the appropriate staffing and training for quality program and service delivery
- Provides on-site professional coaching and training for responders as needed

Qualifications

- Master's degree in Social Work (MSW), Counseling, Psychology, Mental Health Counseling or closely related field that includes substantial course work in

counseling; AND 3 years of paid experience in crisis intervention and direct service to vulnerable populations.

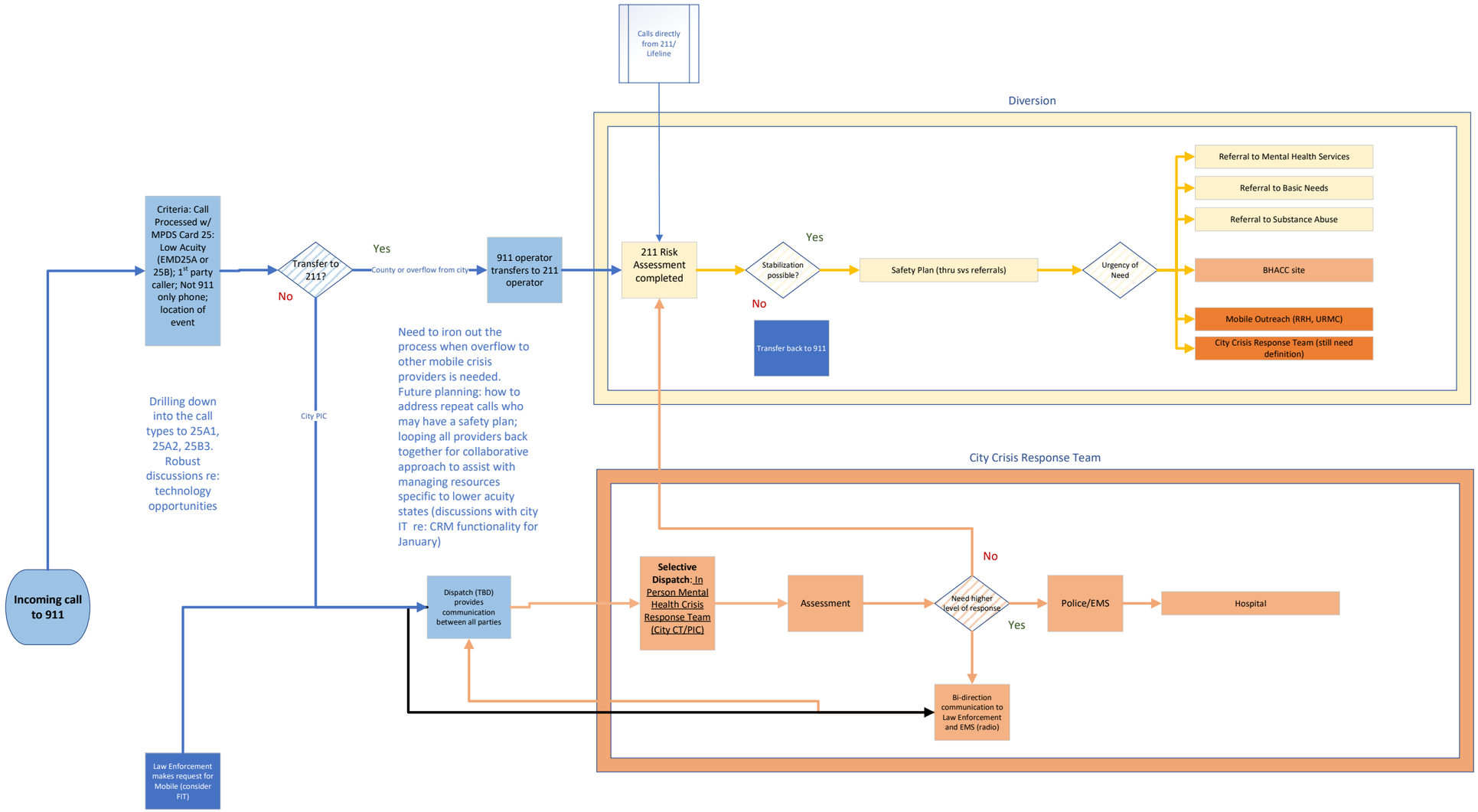
OR a Bachelor's degree in Social Work (BSW) or closely related field that includes substantial course work in counseling; AND with 10 years of direct service to vulnerable populations.

Knowledge, Skills and Abilities

- Knowledge of geography of the City
- Knowledge of social and human services agencies
- Knowledge of community resources and referral agencies and their functions
- Skill in expressing oneself both orally and in writing
- Ability to plan and oversee the work of others
- Ability to deal effectively with community service agencies and with the public
- Ability to distinguish between legal and referral advice, tact, professional demeanor
- Ability to exercise discretion and judgment in dealing with sensitive issues
- Willingness to work in partnership with law enforcement
- Willingness to work evenings, weekends, overnights, and holidays out in the field
- Willingness to maintain confidentiality
- Proficiency in speaking and writing Spanish or ASL is a plus
- Must maintain First Aid, CPR, AED certification
- City residency is required

Appendix 1.3

DRAFT- Crisis Response- 911 Diversion Workflow
Version Date: 12.7.20



Appendix 1.4

Event Type	County Count	City Count	Divert to 211?	Response Tier	LE?	Crisis Response?	EMS?
25A1 - PSYCHIATRIC - NON-SUICIDAL AND ALERT	1512	1082	Some	2		Yes	
25A1B - PSYCHIATRIC - NON-SUICIDAL AND ALERT, VIOL	80	43		3	Yes	Future	
25A1V - PSYCHIATRIC - NON-SUICIDAL AND ALERT, VIOL	862	449		3	Yes	Future	
25A1W - PSYCHIATRIC - NON-SUICIDAL AND ALERT, WITH	20	9		3	Yes	Future	
25A2 - PSYCHIATRIC - SUICIDAL (NOT THREATENING) A	549	357	Some	2		Yes	
25A2B - PSYCHIATRIC - SUICIDAL (NOT THREATENING)	15	10		3	Yes	Future	
25A2V - PSYCHIATRIC - SUICIDAL (NOT THREATENING)	193	116		3	Yes	Future	
25A2W - PSYCHIATRIC - SUICIDAL (NOT THREATENING)	14	12		3	Yes	Future	
25B1 - PSYCHIATRIC - SERIOUS HEMMORHAGE	12	11		5	Yes	Future	Yes
25B1B - PSYCHIATRIC - SERIOUS HEMMORHAGE, VIOLENT	3	1		5	Yes	Future	Yes
25B1V - PSYCHIATRIC - SERIOUS HEMMORHAGE, VIOLENT	6	4		5	Yes	Future	Yes
25B1W - PSYCHIATRIC - SERIOUS HEMMORHAGE, WITH WEA	4	1		5	Yes	Future	Yes
25B2 - PSYCHIATRIC - NONE SERIOUS OR MINOR HEMMORH	43	20		5	Yes	Future	Yes
25B2B - PSYCHIATRIC - NON SERIOUS OR MINOR HEMMORH	9	5		5	Yes	Future	Yes
25B2V - PSYCHIATRIC - NON SERIOUS OR MINOR HEMMORH	12	4		5	Yes	Future	Yes
25B2W - PSYCHIATRIC -NON SERIOUS OR MINOR HEMMORHA	17	13		5	Yes	Future	Yes
25B3 - PSYCHIATRIC - THREATENING SUICIDE	2145	1232		3		Yes	
25B3B - PSYCHIATRIC - THREATENING SUICIDE, VIOLENT	263	158		4	Yes	Future	
25B3V - PSYCHIATRIC - THREATENING SUICIDE, VIOLENT	1099	636		4	Yes	Future	
25B3W - PSYCHIATRIC - THREATENING SUICIDE, WITH WE	150	95		4	Yes	Future	
25B4 - PSYCHIATRIC - JUMPER (THREATENING)	366	267		5	Yes	Future	
25B4B - PSYCHIATRIC - JUMPER (THREATENING), VIOLEN	3	1		5	Yes	Future	
25B4V - PSYCHIATRIC - JUMPER (THREATENING), VIOLEN	42	33		5	Yes	Future	
25B4W - PSYCHIATRIC - JUMPER (THREATENING), WITH W	2	2		5	Yes	Future	
25B5 - PSYCHIATRIC - NEAR HANGING, STRANGULATION,	6	1		5	Yes	Future	Yes
25B5B - PSYCHIATRIC - NEAR HANGING (ALERT), VIOLEN	1	1		5	Yes	Future	Yes
25B5V - PSYCHIATRIC - NEAR HANGING (ALERT), VIOLEN	6	5		5	Yes	Future	Yes
25B5W - PSYCHIATRIC - NEAR HANGING (ALERT), WITH WE	0	0		5	Yes	Future	Yes
25B6 - PSYCHIATRIC - UNKNOWN STATUS	975	646		5	Yes	Yes	Yes
25B6B - PSYCHIATRIC - UNKNOWN STATUS, VIOLENT WITH	76	50		5	Yes	Future	Yes
25B6V - PSYCHIATRIC - UNKNOWN STATUS, VIOLENT	639	420		5	Yes	Future	Yes
25B6W - PSYCHIATRIC - UNKNOWN STATUS, WITH WEAPONS	21	14		5	Yes	Future	Yes

City Model		
Total Dispatches (less MHAA)	6159	
Crisis Only (January)	2671	43.4%
Crisis + LE Only	1831	29.7%
Crisis + LE +EMS	1657	26.9%

25D1 - PSYCHIATRIC - NOT ALERT	355	242	5	Yes	Future	Yes
25D1B - PSYCHIATRIC - NOT ALERT, VIOLENT WITH WEAP	18	12	5	Yes	Future	Yes
25D1V - PSYCHIATRIC - NOT ALERT, VIOLENT	302	188	5	Yes	Future	Yes
25D1W - PSYCHIATRIC - NOT ALERT, WITH WEAPONS	8	7	5	Yes	Future	Yes
25D2 - PSYCHIATRIC - DANGEROUS HEMMORHAGE	3	1	5	Yes	Future	Yes
25D2B - PSYCHIATRIC - DANGEROUS HEMMORHAGE, VIOLEN	6	3	5	Yes	Future	Yes
25D2V - PSYCHIATRIC - DANGEROUS HEMMORHAGE, VIOLEN	4	7	5	Yes	Future	Yes
25D2W - PSYCHIATRIC - DANGEROUS HEMMORHAGE, WITH W	6	0	5	Yes	Future	Yes
25D3 - PSYCHIATRIC - NEAR HANGING, STRANGULATION	4	0	5	Yes	Future	Yes
25D3B - PSYCHIATRIC - NEAR HANGING, STRANGULATION	0	0	5	Yes	Future	Yes
25D3V - PSYCHIATRIC - NEAR HANGING, STRANGULATION	1	1	5	Yes	Future	Yes
25D3W - PSYCHIATRIC - NEAR HANGING, STRANGULATION	0	0	5	Yes	Future	Yes
Total	9852	6159				
MHAA - PSYCH/ POLICE ON SCENE	3571	1700	n/a	Yes	On Request	Variable

Appendix 1.5

Chemical Dependency	Address, Phone	Hours	Website	Population Served	Types of Services Provided	Strengths	Gaps or Drawbacks
Delphi Rise	835 W Main St, Rochester, NY 14611 (585)467-2230 8am-7pm M-F	M-TH 8:00AM-8:00PM. F 8:00AM-12:00PM.	https://www.delphirise.org/	Teens/Adults	Outpatient Treatment, Prevention Education and Counseling, Reentry Services, Mental Health, Rapid Re-Housing, Domestic Violence Education, and Care Management Delphi on-demand substance abuse evaluations and referrals.	24 hour acces for detox. Agency has the longest workday.	Only the detox is open 24 hours
Evelyn Brandon	81 Lake Ave, Rochester, NY 14608 (585)922-9900	M-Th 8am-5pm Fri 8am-5pm	https://www.rochesterregional.org/locations/rochester/evelyn-brandon-health-center-chemical-dependency-clinic	Children/Adults	Outpatient programs, inpatient rehabilitation, residential programs. Substance abuse professionals, Addiction psychiatrists, Mental health therapists, Physicians, Nurses, Social workers, Nutritionists, Vocational counselors & recreational therapists.	Affordable online Counseling available. One of the few substance abuse clinics still offering medical detox treatment.	Hours don't include weekends or times past 5
Huther Doyle	360 East Avenue Rochester, NY 14604	Hours of Operation: Monday-Thursday 8am-6pm | Friday 8am-5pm	https://www.huthedoyle.com/	Adults	Evaluation & referrals, outpatient treatment, relapse prevention, services for specialized patients ie dual diagnosis. A family wellness/engagement center.	The variety of Programming	Currently only available via telehealth due to pandemic. Regualry, hours don't go beyond 8 or weekends
Domestic Violence	Address, Phone	Hours	Website	Population Served	Types of Services Provided	Strength	Drawbacks or Gaps
RESOLVE	Fairport, New York 14450	M, W, F 9:00AM-5:00PM TU and TH 9:00AM-7:00PM	https://resolve-roc.org/	Adults 18 and older	Domestic abuse survior support including: transition planning,therapy and self-defense.	Free or low cost	Available hours
Restore Sexual Assault Services	Monroe County 585-546-2777 and 1-800-527-1757	24 hour hotline available	https://restoresas.org/	Family	Offer short term over the phone assistance. Work with victim assistance,	Collaborative community response to domestic violence	Currently is not responding to hospital calls
Willow Domestic Violence Center	693 East Avenue Rochester, Ny 14607	24 hour access	https://willowcenterny.org	Women and children	• Willow Domestic Violence Center have a 24 hour hotline. • They have a 24 hour access • Willow Center is the only New York State Office of Children and Family Services licensed provider of residential and non-residential domestic violence services in Monroe County. • Service Children and family • All services are free and confidential • Only Domestic Violence organization that offers Housing. If shelters are full you have the option to relocate to another county	Clients can stay as long as 3/4 weeks at a time, ***Ignite ASL program**	
Elderly	Address, Phone	Hours	Website	Population Served	Types of Services Provided	Strengths	Drawbacks or Gaps
Adult Protective Services	585-753-6532	Monday-Friday, 9 am – 5 pm	https://www.monroecounty.gov/hs-adult	18 or older and have a physical or mental impairm	Safety monitoring and advocacy.	Will respond to life-threatening issues within 24 hours via after-hours number	No evening or weekend hours for non-life threatening situations.
Lifespan- Elder Abuse Center	1900 S. Clinton Avenue, Rochester, NY 14618	Monday-Friday, 8:30 am to 4:30 pm. Extended hours to 7 pm each Wednesday	https://www.lifespan-roch.org/	Elderly	Investigation and intervention services in cases and suspected cases of elder abuse and mistreatment in ten Finger Lakes counties in upstate New York, Informational presentations about elder abuse and scams for organizations, caregivers and others throughout upstate New York., Education and training for professionals and those who work with/have frequent contact with older adults to recognize the signs and symptoms of abuse, Incubator for Enhanced Multidisciplinary Teams (EMDTs) in New York. Advocacy as manager of the NYS Coalition on Elder Abuse.	Our main office is open Monday-Friday, 8:30 am to 4:30 pm. Extended hours to 7 pm each Wednesday	Available hours
Housing	Address, Phone	Hours	Website	Population Served	Types of Services Provided	Strength	Gaps or Drawbacks
Catholic Family Center	87 N Clinton Ave, Rochester, NY 14604 (585) 753-2780	Depend on program	http://www.cfcrochester.org/	Family	Catholic Family have a variety of shelters Emergency Housing • DHS: • (585) 753-2780 • After Hours Placement: (585) 442-1742, Rochester, NY 14605 Francis Center Phone :(585) 423-9590 • Place of Hope Phone:(585) 436-5452 • Sanctuary House Phone:(585) 277-7550 Womens place 146 Hobart Street	Most offer 24/7 placement through DHS	Bed Capacity
Demitri House	102 North Union Street Rochester, New York 14607 (585) 325-1796 phone (585) 546-2678 fax	Monday through Thursday, 9 to 5Friday, 9 to 12Closed 12 to 1 for lunch. Shelter accepting till 9:30pm	ljpritzel@dimitri-house.org	Men	Men's Shelter, Food Pantry, Mental Health Support.	Offer a vareity of services ie shelter, food, mental health support. Offers a long-term housing program.	Shelter is only open until 9pm. Some programs only service specific zip codes.
Monroe County Department of Human Services	691 St Paul Street Rochester, NY 14605 585-753-6000	M-F 8:00AM-4:00PM. After hours emergency services available.	http://www.monroecounty.gov/hs-index.php	Adults	Emergency Shelter, Child Care Subsities, SNAP, Temporary Financial Assistance, Medical Insurance Enrollment, and Foster Care.	After hour shelter placement and variety of services.	Capacity to attend to residents.
YWCA Of Rochester & Monroe County	175 N Clinton Ave, Rochester, NY 14604 (585) 546-5820 Open 24hrs and will be placed by DHS. DHS shelter placement line 585-753-2780	24 hours	http://www.ywcarochester.org	Women/women with children	Offer long term housing (47 bed units),One on one case management,Emergency Housing for women and children.	Open 24hrs and will be placed by DHS. DHS shelter placement line 585-753-2780. They offer long term housing.	The agency only services women and women with children
Individuals with Disabilities	Address, Phone	Hours	Website	Population Served	Types of Services Provided	Strengths	Drawbacks or Gaps
Center for Disability Rights (CDR)	497 State Street, Monroe, Rochester, NY, 14608- (585)-546-7510	Monday-Friday 9am-5pm	www.nyconnects.ny.gov	Serves those with disabilities	Interpretation, Service Coordination, Indpendent Living, Recreation	Population served	Available hours
Mental Health	Address, Phone	Hours	Website	Population Served	Types of Services Provided	Strength	Gaps or Drawbacks
Catholic Family Center	87 N Clinton Ave, Rochester, NY 14604 (585)546-7220	M-F 8:30AM-5:00PM Evenings and SA by appointment	https://www.cfcrochester.org/our-services/building-community/	Children/Youth/Adults/Elderly	Shelter, mental health and substance abuse services, immigration services, employment skills, services for seniors, food and clothing.	In person services, phone services, and virtual services availible to the clients. New American Services, Long-term case management. Wide range of services	Primarily offer Monday-Friday day time hours. Evenings and SA by appointment
Liberty Resources	175 Humboldt St. Rochester, NY 14610 (585) 410-3370	M-TH 8:30AM-7:00PM F 8:30am-5PM	https://www.liberty-resources.org/	Youth/Adults	Coordinated services to offer mental health care, addiction recovery, physical health, employment, and housing support.	Substance abuse and mental health support offered for youth and adults.	Hours don't include weekends or times past 5
Rochester Regional Behavioral Health Access & Crisis Center	89 Genesee St. Rochester, NY 14611 (585)368-3950	24/7 access	https://www.rochesterregional.org/services/behavioral-health/emergency-psychiatric-services	Youth/Adults	Alternative to the Emergency Department for someone experiencing mental health or chemical dependency struggles. The center is designed to address individuals' concerns faster and in a more comfortable setting. Agency provides a link to other community resources for mental health, housing more.	24 Hour Access	
Spiritus Christi Mental Health Center	121 N. Fitzhugh Street Rochester, Ny 14614 585-325-1186	Tuesday through Thursday, 9 am to 5 pm	www.scmentalhealth.org/	Youth/Adults	Mental health care and support. Support groups for grieving and domestic abuse.	Client doesn't need insurance	Hours don't include weekends or evening or night
U of R Comprehensive Psychiatric Program (CPEP)	601 Elmwood Ave Rochester, NY 14642Phone: (585) 275-4501	24 hours	https://www.urmc.rochester.edu/mental-health-wellness/emergency-services/psych-ed.aspx	Adults	Is part of, the Medical Emergency Department. The primary purpose of this unit is to provide individuals with a psychiatric evaluation to determine if inpatient hospital intervention is needed, and if so, to facilitate admission to an inpatient psychiatric unit.	24 Hour Access	

Youth Resources	Address. Phone	Hours	Website	Population Served	Types of Services Provided		Drawback's or Gaps
Center For Youth	905 Monroe Ave. Rochester, NY 14620 585-473-2464	Depend on program	https://www.centerforyouth.net/shelter-housing-crisis-services/	12 to 18 year olds	Shelter, food, and basic medical attention.	Offer a variety of services including permanent and transitional housing	Beds & program capacity

Agency	Address, Phone, and Hours	Website	Population Served	Substance Abuse	Mental Health	Domestic Violence	Housing	Food Insecurity	Drawbacks	Services Provided
Action for a Better Community	33 Chestnut Street, Rochester, NY (585)325-5116	https://www.abcinfo.org/	Children/adults	X					No walk-ins, responsivness	Help with energy conservation for your home
Bivona Child Advocacy Center	1 Mount Hope Ave, Rochester, NY 14620 (585)935-7800 8:30am-5pm M-F	bivonacac.org	Children/Families		X				The hours of operation are from 8-5pm. A referral must come from a community partner to be apart of Bivonia. etc police, case worker etc.	They offer an interview medical examination, meet with a family advocate and connect with a therapist, all under one roof, in a warm, child-friendly environment.
Conifer Park	556 South Ave Rochester , Ny 14620 Open 6 days a week M-Th 9-7:30pm	https://www.coniferpark.com/	Adults	X					Inpatient only	Evaluation, counseling, medication, excepts walk ins and appts. Take all insurance and if clt does not have ins they will work with them.
Crisis Intervention Program	275-5599	**https://www.urmc.rochester.edu/childrens-hospital/developmental-disabilities/services/crisis.aspx**	children/adults		X				The client has to be apart of OPWDD in order to eligible for the program. Client must live with a family member who can participate in treatment and is willing to learn new ways to help with the behavior challenges/responsivenes s	We work with families for a short time to understand why a behavior is happening and teach caregivers ways to help. We do this by: • Learning about the person and family, observing challenging behaviors • Asking caregivers to track challenging behaviors • Developing a behavior plan, which may include: • Ways caregivers can prevent behaviors • Helping caregivers use new skills to increase desired behaviors • Helping the person develop ways to communicate other than challenging behavior • Teaching caregivers to use the behavior plan • Linking family to longer term services, if needed
Dept Social Services and Emergency Housing	111 Westfall Road Rochester , Ny 14620 585-753-6007 M-F 8am-4pm	dfa2a26.sm.TA.Customer.Service@dfa.state.ny.us	Families	X	X	X	X	X	Hours available they agency does have after hour services for some programs	Cash assistance, Supplemental Nutrition Assistance, shelter and medical
Family Access Connection Team	1099 Jay Street, Building J, 2nd Floor, Rochester, NY 14611 (585)753-2639 M-F 9am-5pm	https://www.monroecounty.gov/hs-fact-far	Youth							Review of Person in Need of Supervision (PINS) complaints from parents, school officials or police. Provides assessment and referrals to network of collaborating agencies. Facilitates single point of access to mental health services, case management or services deemed appropriate. Triage matters to Family Court, Probation Diversion or referral to other service. Provides diversion services.

	Genesee Behavioral Health Center	224 Alexander St. Suite 100, Rochester, NY 14607 (585)922-7770 8:30am-	https://www.rochesterregional.org/locations/rochester/genesee-	Adult		X					The adult outpatient services at the Genesee Mental Health Center provide mental and behavioral health services for adults ages 18 and over and their families.
	Helio Health	1350 University Ave Rochester, NY 14607 (585)287-5622 24/7 access	https://www.helio.health	Adults	X	X				Limited services in Rochester area. During COVID all service are avaiable via telehealth	Offer Inpatient detoxification and inpatient rehabilitation Substance Use Disorders Mental Health Diagnosis Certified Community Behavioral Health Clinic (CCBHC) Child and Adolescent Services Center of Treatment Innovation (COTI) Problem Gambling Treatment Program Opioid Treatment Program 24-hour Regional Open Access Center for Addiction Home and Community Based Services On-Site Pharmacy Targeted Case Management
	Hillside	1183 Monroe Ave Rochester, NY 14620 (585)256-7500 24/7 accessible	https://www.hillside.com/about-us/family-agencies/	Youth/Families		X					Child welfare, mental and physical health, youth development, juvenile justice, special education and developmental disabilities.
	John Norris Addition Treatment Center	1732 South Avenue Rochester, NY 14620 OFFICE (585) 461-0410	https://oasas.ny.gov/	Men	X					Inpatient only	inpatient treatment program that provides chemical dependency and problem gambling services for adult men and women addicted to alcohol and other drugs.
	NAMI Rochester	320 N. Goodman St. Suite 102, Rochester, NY 14607 585-423-1593 9am-4pm M-F	namiroc.org	Adult/teen		X		X	X	There is no live person to speak to regarding services, you must leave a VM and wait for callback. The services are only available until 4pm	Provides mental health support. Provide court advocacy and education. Provide Support to families who live with mental health challenges
	Office of Mental Health	1099 Jay St. Bldg. J, Rochester, NY 14611 (585)753-6047	https://www.monroecounty.gov/mh		X	X				Emailed requesting call back or email response to connect about our programs.	
	OPEN DOOR MISSION	210 W Main St, Rochester, NY 14614, 585-423-1825	http://www.opendoormission.com/	Adults			X	X		Capacity	What we offer:Case management, group counseling, life skills, job readiness, medicals services, recovery support team , transitional living programs

	Parkridge Chemical Dependency	1565 Long Pond Road Rochester, NY 14626 585-723-7723 M-Th 7:30am-8pm, Friday 7:30am-5pm, Saturday 8am-2pm	https://www.inpatientdrugrehabcenters.com/park-ridge-chemical-dependency	Adults	X	X				Detox/Inpatient	Inpatient Rehab Programs with a primary focus on Substance abuse treatment and drug rehab
	Person Centered Housing (PCHO)	400 West Ave Ste 200 Rochester, Ny 14611 585-736-4663 M-F 8am-5pm	https://pcho.org	Adults	X	X		X		Responsiveness	PCHO provides homeless outreach, rapid rehousing, permanent supportive housing, housing stability coordination and care management using evidence based person-centered practices and housing first methods to Monroe County NY residents.
	RAIHN	142 Webster Avenue, Rochester, NY 14609, Office: 585-506-9050	https://www.raihn.org/	Adults and children			X	X		If clients have a criminal history they will not be allowed to stay at the facility.	RAIHN provides families with the support they need to secure safe, stable housing.
	Rochester Pathways Methadone Clinic	435 E. Henrietta Road Rochester, Ny 14620 585-424-6580 6AM-2PM M-Sat. Appt only	https://www.methadonecenters.com/methadone-centers/rochester-pathways	Adult	X					Service Hours	Primary focus on substance abuse treatment
	Salvation Army	585-987-9500 70 Liberty Pole Way	Use.salvationarmy.org	Adults	X	X	X	X	X	Capacity	Offer shelter they have available.
	Self-Help Drop-In Support Services	539 South Avenue Rochester NY 14620 585-454-3530 Everyday 5pm-9pm	http://www.mharochester.org/	Adult 18 and older	X	X				-Responsiveness (Google says they may be currently closed due to COVID)	Provides a self-help drop-in service to individuals experiencing a short-term situational crisis. Support is provided by individuals who have overcome mental health concerns and now offer support to others as they find their own path to mental wellness
	Sleep In Heavenly Peace	844-432-2337	https://www.shpbeds.org/	Children						Offer children beds for those in need	Offer Free bunk beds to Children in need
	Sojourner Home	30 Millbank St, Rochester, NY 14619. 585-+436-7100	https://www.sojournerhome.org/	Women				X		The agency is going through a transition for 4-6 months possibly longer. They are not taking any clients	housing for women and families whose lives have been impacted by homelessness, domestic violence, chronic poverty, family instability, mental health issues and substance use disorders
	SPCC	148 S Fitzhugh St, Rochester, NY 14608 (585)325-6101 8:30am-5pm M-F	https://www.spcc-roch.org/	Children/Family						Many of the referrals comes from DHS and Bivonia.	Family Trauma Intervention Program, Healthy Families Monroe Program, Teen Age Parent Support Services Program, the WIC Vendor Management Agency. We are committed to fostering strong relationships, reducing the risk of maltreatment and promoting healing by sharing our expertise in trauma, child abuse and neglect, and intimate partner violence.

	Substance Abuse Treatment Rochester	1092 Joseph Ave 284, Rochester, NY 1462. 1-866-731-7680	http://reynardclinic.com/substance-abuse-treatment/#rochester/	Adults	X					Responsiveness-unable to connect	Specialize in Detox, residential treatent and out patient treatment
	Villa of Hope	3300 Dewey Ave, Rochester, NY 14616 (585)865-1550 8am-5pm M-F	https://villaofhope.org/	Children/Adults	X	X		X		Due to COVID all behavior health appts are being done over telehealth. They are not taking any walk ins. M-F 8-4pm staff will be at the clinic.	Provide services for adolescents and adults utilizing individualized, trauma-responsive, evidence based, and holistic treatment models. Outpatient Chemical Dependency Clinic, Addiction Prevention Education Program and Mental Health Outpatient Clinic. We are certified by Office of Alcoholism and Substance Abuse (OASAS) and Office of Mental Health (OMH).

Appendix 1.6

Crisis Response Team
Training Program
11.28.2020

Prioritized Trainings

CPR & AED Certification for Health Care providers (inclusive of children/infants, choking and AED use)
Mental Health First Responders Training
Naloxone (Narcan: administration and triage of overdose situations)
Narcan Training
Domestic Violence Trauma Training
De Escalation Crisis Intervention Training
Suicide Assessment, Intervention and Prevention
Substance Abuse First Responder's Training
Trauma Informed Care Training
Crisis Intervention

Additional Trainings

- Mental first aid training, suicide awareness, youth and adolescents, safety of our people
- Listening Skills
- Self-Care
- Follow-up Care
- Mental Health First Aid (Adult & Youth)
- Emotionally Disturbed Persons
- Applied Suicide Intervention Skills/ 'Question, Persuade, Refer' by Gatekeeper
- Grief Recovery / Counseling
- HIPAA/PHI Confidentiality Training
- SAMHSA Training (Substance Abuse and Mental Health Services Administration)
- Trauma Informed Communication Techniques Training
- Mental Health Designee Certification, etc.
- Immersion simulation
- Role-playing
- De-escalation techniques
- Applying triage concepts
- Changing response modes (upgrade to EMS response, LE response, downgrade either, etc.)
- Stop the Bleed training for managing serious bleeding
- Equipment for each of the above and training in its use
- Understanding the EMS System and the benefits/limitations of:
    a. Basic Life Support response
    b. Advanced Life Support response
    c. When physical restraint may be necessary and understanding the process

d. Capabilities of chemical restrain and when it may be necessary