# Crisis Response for Rural Communities: Using Technology and Peer Support to Meet People in Crisis, Where They Are

## Presented September 16, 2021

## Webinar Description

Rural communities can face many challenges in the development and delivery of crisis response programs for people with behavioral health conditions and intellectual and developmental disabilities, including wide geographic areas to serve, limitations in options for local treatment and social services, and resource constraints related to funding and staffing. Across the United States, rural communities have adapted best practices in crisis response to overcome these challenges and address the need for services in their jurisdiction by having mental health providers meet people in crisis where they are, either in-person or through telehealth services. These programs have shown that they can prevent the need for additional resources such as police and emergency medical services to respond to individuals in crisis and may enhance short- and long-term outcomes for these individuals.

Presented by the Department of Justice, Bureau of Justice Assistance's Academic Training to Inform Police Responses Initiative, this webinar will feature two programs that have adapted crisis response for use in rural communities. Panelists will present the innovative approaches in crisis response implemented by their programs and discuss the challenges of ensuring the needs of individuals in crisis who live in rural communities are met.

**For the webinar recording and slides, please visit the *Academic Training to Inform Police Responses website*.**

## Presentations

**(1) Crisis Response for Rural Communities: "The GLMHC App"**

***Larry Smith, CPRSS; Chief Executive Officer***
Grand Lake Mental Health Center
***Josh Cantwell, LCSW; Chief Operating Officer***
Grand Lake Mental Health Center

**(2) A Unique Partnership of People with Lived Experience, Law Enforcement, and Community Partners**

***Kasey Moyer, Executive Director***
Mental Health Association of Nebraska
***Captain Mike Woolman***
Lincoln (NE) Police Department

# Webinar Transcript

**Michael Hatch:** Today's webinar Crisis Response for Rural Communities: Using Technology and Peer Support to Meet People in Crisis, Where They Are. It's my honor to bring to the mic Dr. Robin Engel, the principal investigator for the Academic Training to Inform Police Responses from the University of Cincinnati for our welcome and introduction, Dr. Engel.

**Dr. Robin Engel:** Thanks Mike, and thank you all for joining us today for our webinar on Crisis Response for Rural Communities. My name is Robin Engel and in addition to serving as the principal investigator for this project, I'm a professor of criminal justice at the University of Cincinnati, and in partnership with the International Association of Chiefs of Police, I serve as the director for their Center for Police Research and Policy. This webinar has been made possible through the support of the Bureau of Justice Assistance as part of our larger Academic Training Initiative to Inform Police Responses. This initiative was born out of a recognition that as communities across the country are examining the methods used to respond to individuals with behavioral health conditions and intellectual and developmental disabilities that it's critical that we learn from both the practitioners about best practices in the field, and also from the researchers as we build the evidence base about the effectiveness of these practices. I'm so proud to be joined in this work by my colleagues from the University of Cincinnati, and subject matter experts from the Policy Research Associates, The Arc of the United States, and the International Association of Chiefs of Police. Together our team are building and developing training, technical assistance, and companion resources around the best practices in crisis response that are supported by research. Our goal is to assist law enforcement agencies in their communities as they respond to people with behavioral health conditions and intellectual and developmental disabilities and to ensure that these encounters are more effective and equitable, but also safer for both citizens and law enforcement officers. Often overlooked, the development and enhancement of crisis response programs in rural communities is actually critical to this work. Now, as someone who grew up in a small town, I know firsthand that rural communities can face many challenges in the development and delivery of crisis response programs, including the wide geographic areas they have to serve, limited options for local treatment and services, and resource constraints and funding and staffing. Growing up both of my parents worked as staff at the Willard Psychiatric Center. This was a large residential mental health facility in upstate New York. Now this facility was closed in the mid-1990s as part of the larger deinstitutionalization movement, and this placed much of the burden of crisis response squarely on the shoulders of local law enforcement. Over the years, many rural communities like the one that I grew up in, have been able to adapt best practices in crisis response to overcome these barriers and challenges, to better address the needs for service in their areas. And I believe it's so important to share their stories. So today you will hear about two such programs that are successfully implementing crisis response practices in their rural communities. Our panelists will also describe the challenges they have experienced and overcame in an effort to ensure they are meeting the needs of individuals in crisis who live in rural communities. And so, thank you again so much for joining us today, I'm gonna pass the button back here to Mike Hatch from PRA as he introduces our panelists.

**Michael Hatch:** Thank you for that, Dr. Engel. As Dr. Engel said my name is Mike Hatch, I'm a senior project associate with the Policy Research Associates, and I'm a very proud member to participate. I'm very thankful to be participating as a member of the Academic Training to Inform Police Responses. This is a fantastic program and opportunity, and you know, we're really at an unprecedented time full of opportunities and funding around transforming the crisis response system. So, I'm very excited to be here and be your moderator for today. Just a couple of housekeeping things before we get started, the preparation of this webinar was supported by grant number 2020NTBXK001, awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime and the Smart Office. Points of view or opinions in this document are those of the authors and do not necessarily reflect the official positions or policies of the US Department of Justice. As a reminder, we will, we'll have a Q & A session at the end, but if you look at the bottom right-hand corner of your WebEx screen, now you should see a place where you can submit your questions to the presenters in the Q & A pod. The presenters will have questions, will answer as many questions as time presents towards the end of our webinar today. If you do have a specific question for a specific presenter, go ahead and put the name that you're directing the question to and that will help us sort out specifically who that question will be for. We have ASL interpretation during this webinar. For best visibility of the interpreters, we recommend the following changes to your WebEx layout. In the upper right-hand corner of the window there will be a tab that says layout. First hide non-video participants, and then change your view to full screen and you should be able to see them pretty clearly. Live captioning is available for today's webinar. To view live captioning, select the accept button in the multimedia pod, located in the lower right-hand corner of your WebEx screen. The color contrast of the five-caption pod can be changed as needed. The high contrast style is recommended for best visibility.

So, I'm gonna go ahead and introduce all four of our just incredible presenters for today, and then we'll go ahead and get started with their presentations. First introduction is Larry Smith. Larry is the CEO of Grand Lake Mental Health Center. He's been with Grand Lake Mental Health for over 25 years. Currently, Larry has closed the health care communication gap between hospitals, emergency rooms, and police departments by helping to develop a first responder application that allows immediate access to a licensed mental health provider to give clients better care by providing services for them in the least restrictive environment. He has taken the infrastructure of first responder application and developed it into a client application and clinician application that will fulfill his goal of allowing the client to receive the services when and where they are needed. All this has put Grand Lakes Mental Health Center's model as one of the companies to watch as the CCBH gains momentum. Accompanying Larry is Josh Cantwell. Josh serves as the COO of Grand Lakes Mental Health Center. During his 15 years of service he has held many clinical and administrative roles. He's been instrumental in the development and oversight of multiple innovative programs including Grand Lake Mental Health Center's 24/7 treatment program. The model focuses on treating individuals in the least restrictive environment and has produced significant outcomes related to the reduction of psychiatric hospitalizations for those living in Northeastern and Northcentral Oklahoma. Josh is a firm believer in the philosophy that the impossible is just the possible that is yet to be tamed. Josh has created and published over 20 therapeutic games, focusing on mental health and substance use conditions. Josh holds a master's degree in social work from the University of Oklahoma, he's a licensed clinical social worker, and a certified peer recovery support specialist.

Our next presenter is Kasey Parker. Kasey was the second employee hired in 2006 as the Associate Director of the Mental Health Association of Nebraska. 10 years later, she was promoted to Executive Director. Kasey has assisted in the development implementation of the state's first peer-directed and nationally accredited programs in Nebraska and is currently the largest peer-run organization in the Midwest, employing approximately 45 peer specialists. These programs include the H.O.P.E. Supported Employment Program, implemented in 2008, the peer respite Keya House, implemented in 2009, and the law enforcement referral program, which we'll hear about today, developed and implemented in 2011. Mental Health Association of Nebraska serves over 1,000 unduplicated individuals a year who live with mental health, substance use trauma, and/or have been previously incarcerated.

And last, but not least, is Captain Mike Woolman. Captain Woolman has been a member of the Lincoln Nebraska Police Department since September of 1987 and is currently assigned as the commanding officer of the Southeast Team. During his career at the LPD he has worked as a field training officer coordinator, internal resource officer, planning and research sergeant, Southwest Team captain, and duty commander. Captain Woolman is also a former commander of the Canine Unit and Field Force. Captain Woolman earned his bachelor's degree from Concordia University in organizational management and graduated from the FBI National Academy in 2012. So, at this time I'll turn it over to Larry and Josh who will tell us about crisis response in rural communities, the GLMH app. Go ahead and take it away guys.

**Josh Cantwell, LCSW:** Thanks Mike. First off, I wanna say that we're very excited to share some of the innovative practices that we have been utilizing in rural Northeastern and Northcentral Oklahoma, specific to crisis response. So, currently we are a certified community, a certified community behavioral health center operating in 12 rural Northeastern and Northcentral counties. And I'm gonna talk a little bit about some of the philosophical shifts that have occurred when working in this unique area and towards this unique goal. So, I'm gonna talk to you a little bit about what it was like before we started doing business the way we do business now. This is gonna sound very familiar to many people on this call. In 2015 around 1,000 of the people that we were responsible for serving in those 12 counties had to access the highest level of mental health care, that highest level of mental health care being inpatient hospitalization. So, they were taken out of their home, and how this would come about is that really the first line of someone noticing that there was a mental health crisis brewing was when a law enforcement officer would come upon someone in the field and determine that they were having a possible mental health crisis. So, what would happen is that law enforcement officer would then drive to the nearest emergency room where they would then check that person in and they would retain custody of that individual. So that law enforcement officer would then sit with that individual at the emergency room where someone would possibly call a mental health professional that was likely sleeping, that was on call, they would have to wake up and drive to the hospital, and then the hospital would determine whether the person was medically stable, and this process lasted really a minimum two to three hours. So that means that that law enforcement officer was off the street at that point, sitting with this individual during that time, and then once the determination was made of what was gonna happen, which most times was an inpatient hospitalization was gonna occur, then that law enforcement officer was responsible for taking that person to the inpatient facility where the treatment was going to occur. Most of the time, this was outside of the service area. Again, so we're talking another hour, two hours, maybe three hours. This process, we used to hear stories of it being, you know, four or five hours, sometimes encapsulating multiple shifts. So that officer would

have to trade off with another officer that would then come on shift and begin that custody of that individual, and so law enforcement officers would sit at the hospital and wait and wait and wait. And you can imagine that that created a pretty tumultuous relationship between the mental health system and the law enforcement system. Larry, do you have anything to add about the background of the problem that we were trying to solve?

**Larry Smith, CPRSS:** I think you did a great job in explaining that Josh, let's move on to the next slide if we could. So, what Josh talked about was the way that it used to be, and I can't imagine being a police officer anywhere and having to deal with the issues that they had to deal with, or the waiting time. It took the police officers out of the community. What we knew is that we needed to fix that problem. It had to be fixed, and so we started looking at ways to fix it. The real, the way that we fixed it was to look at a way for a police officer to have immediate access to an LMHP, a recovery support specialist, a nurse practitioner, or a psychiatrist. And what we knew is we couldn't have those four people riding around in a police car in 800, because we have 835 police cars on the street in our 12 counties that we serve, and we knew it was impossible to put those people in the police car with those people. So, we created an app and we put it on iPad, that iPad is in the single app mode. And when that police officer touches a button on that iPad, it rings at and goes to another iPad, or it goes to several iPads, that's in our crisis center. So, we had to build urgent care facilities and crisis centers that would answer these iPads, which would also give the police officer an option to take that person to a mental health facility versus to the local emergency room. So, we put in three of these types of units located strategically in our 12 counties, then when the police officer touched the iPad it would be answered at one of the local crisis centers closest to the police officer, and by an LMHP, and then we could actually do the assessment, we could recommend to the police officer what he would do with that person. And what we found was that suddenly we had police officers that were able to deliver the person to one of our crisis service centers and get back on the street in a very short period of time, which made our community safer.

So, the real thing here was that we were able to tell that police officer maybe that person needs to go back home. Maybe that person needs this type of service or we're willing to do this or our that, but the main thing was that we saw the arrest go down. We, where a police officer would come up on somebody that may be in a psychiatric episode, instead of them having to put their hands on them they could simply look at them and say would you like to talk to a therapist? And they would hand this iPad to the client and the client would then talk to the therapist and we would figure out what's going on, what is the best treatment, what is the best approach to this person to keep them in a safe environment and in the community and in the least restrictive environment possible. So, we bypass the emergency room which also basically bypasses the inpatient because what would happen at the emergency room is they would just the would say that they're thinking about suicidal, having suicidal thoughts or whatever. The ER doctor, needing to get them out of the emergency room, would recommend that the person be placed in inpatient. So, we reduced our number of people going to inpatient by around 90% and some, it depends on the numbers you look at, anywhere from 85 to 95%, in this period of time by using technology. So basically, when I first, when a police officer comes up on somebody he touches a button, the therapist shows up, we can, he can have access to that. So, it's almost like virtually having these four people in the front seat of the police officer's car. And then when the police officer is done with them, they can touch a button and those people go back into, goes back into his iPad, and they're accessible to him when and where he needs them. So, do you have anything to add to that Josh?

**Josh Cantwell, LCSW:** I don't think so. That was a very good characterization. What Larry's talking about is a very simple philosophy that encompasses what we're trying to do. So, the first part of this is that we want people to be served when and where they need it. The only barrier that we want to exist is the barrier of desire, desire to receive treatment. And so, with this model, when we look at the other philosophy of providing treatment in the least restrictive environment, it was great that we provided access to law enforcement officers because, like Larry said, that provided 24/7 instant access to experts. So really a law enforcement officer didn't have to be making those judgment calls anymore. All they had to think was, "I could use some assistance in making a decision here," and that's as far as they had to go because once they hit that button, they could consult, they could get an assessment, or the person could begin to actually get treatment while they were driving to the location where continued treatment was going to occur.

The problem was that access didn't create more levels of care. So, we still initially only had a couple levels of care to choose from, right? Traditionally you have the option of outpatient treatment, or the highest level of care which was inpatient treatment. So, we had to add those multiple layers of care that Larry was talking about, and that's what we did. We opened some of our clinics 24 hours a day. We began to provide options throughout those 12 counties. We sprinkled three facilities that we kind of invented at that point in time. Now we we've had some policy that's caught up to us in the state of Oklahoma since then, where they have legitimized some of the ability for us to run these under, you know, under actual certifications. But when we started this, we just, we opened these intensive outpatient centers that

were treating people 24 hours a day, and so the great part about that is the same staff that were answering the calls 24 hours a day, were the same staff manning those facilities. So that seamless transition of care would look something like this. Officer would call on an iPad and do a face-to-face session with the person they had that they were gonna bring to a facility. We would say yes, they definitely need to receive treatment, we'll see you in about 20 minutes. Law enforcement officer would get on the road, we could be talking to that person on the iPad as they're en route, and then when they arrive the same person they've been talking to for the last 20 minutes is the person that greets them at the door. They already have some familiarity, and that warm handoff is about as warm as you can get. I'd call that a pretty hot handoff at that point. So those licensed staff, dedicated to handling those crisis connections, they weren't just waking up from a sleep, they weren't on call, they were actually providing services to individuals during that time and taking those calls. So, what we know, Larry is big on the idea that the least expensive environment and the least restrictive environment are synonymous. So that means that through this process, not only have we been able to save time and allow law enforcement officers to be doing the job that they're trying to do, which is public safety, and we're providing better treatment, but we're also saving the state millions of dollars in the process. So, when we talk about these restrictive environments, now we've created multiple levels of care and people only have to go to the highest level of care if it is the only place where they can receive the help that they need. And we are gonna speak on this a little bit further in other slides. So, Larry, would you like me to go to the next slide or you have anything to add on this one?

**Larry Smith, CPRSS:** Yeah, Josh, you can go to the next slide, but I wanna comment a little bit on the fact that we opened up our outpatient clinics 24/7, and put our urgent care chairs, our urgent care facilities and added those to our, three of our outpatient clinic suites. And by doing that we staffed it 24/7, and we all know that mental health doesn't happen from eight to five, Monday through Friday. And we just needed to be responsible and open up those centers 24/7 and recognizing that mental health can happen at any time, and we are available to those police officers, to the community, and to the consumers, because it doesn't have to be brought by a police officer. Now they can be brought by a loved one, or they can drive themselves to the clinic if they choose to and receive their 24/7 services.

So that's our clinics that we opened. We have 22 clinics in 12 rural counties, but three of those were open 24/7, strategically located, and we're in the process of opening up three more of those clinics 24/7 too. So police officers will be within a 30-mile range of anywhere in our 12 counties to be able to get services and be able to get services for the client. So, using technology in helping that. We use technology in our clinics, we use that technology, and the law enforcement cars, 835 iPads in police cars. We have iPads in all of our schools. So, if there's an incident with an adolescent, we can also then help the school with an LMHP by pushing that same button that you would push for a crisis. We also use, have those iPads in all of our emergency rooms, and we're putting those iPads in jails in order to be able to assist the, our sheriff's departments, and if we have somebody that's in a jail that needs an evaluation or they may need some mental health services we can also provide it in jails.

I think most important though is once we come up on someone and we discover that they are a high need person that may be going in and out of mental health crisis, well we don't want them to do is just repeat and repeat and repeat. So, when they come into our crisis center or when they come into our system now we give them an iPad to take home. So now a consumer is in their home and they have immediate access to a therapist that's a crisis worker if they need it. They also can push their button for their personal therapist and that therapist then would receive a message that that a client wants to talk to them, and so whenever that therapist is available, they can call that therapist, they can call that client back. And we calling, we're calling that services anytime anywhere and I think it's important because people will pretty well know when they're getting triggered, or when they have an incident, or when something happens, and if we can catch that crisis in the very beginning of it, then many times when people can stay in their home without having to come to the crisis unit, without needing any other type of services except communicating with RSS, their therapist, or a crisis worker that's in one of our units. And we have around 5,000 to 6,000 iPads out right now in clients' homes, another 835 out in police officer's car, then another 30 or so out with the, in the reservations of the Native American population of the, their marshals, their federal marshals, also are carrying our iPads.

So, the goal of the objective is to treat people in the least restrictive environment and make sure that we're backing up any of our police officers with consultation, with LMHPs. We've added a second button to those iPads and now a police officer that may have a traumatic incident happen to them, whether that's a shooting or whether that's coming up on a car accident and someone is injured in it seriously, or anything that the police officer may choose to talk, they've got a button that they can push on that that will connect them to a therapist that they can talk to and calm down, get calmed down, help them with any situations that they may be addressing. So, this is another way that we have helped with crisis in our communities and with our police officers. Josh, do you have anything to add to that?

**Josh Cantwell, LCSW:** You may have mentioned it, but I just wanted to point out that we have special requests coming in all the time now so when other entities notice that they're experiencing people coming in that may be in mental health crisis, they'll request these iPads. So, interestingly enough, we partnered with libraries and museum boards. So, all the, all of the museums in our areas and all of the libraries in our areas also have iPads now to link people that come in for, that may be experiencing a mental health crisis.

So, we're gonna share a couple of the outcomes. There's multiple outcomes, you've heard us reference some. These are some of the more interesting outcomes. What's cool, this slide usually has a police car driving around the globe by the way and so if you can picture that it adds a little more flare to this slide. But we, law enforcement officers in the last few years, we have been able to save them 297 days of nonstop driving, so this is time that they can be doing what their primary role is. We've saved 409,000 miles, which is the equivalent to 16 trips around the world. So just mileage cost is around $221,000, and officer time savings is around $146,000. So again, when these machines are in the public, those thousands of machines that Larry was talking about, each one of those is one less call every time that that button is pushed, that a law enforcement officer is not responding to and allowing us to just directly begin handling that situation. Larry are you ready to talk about-

**Larry Smith, CPRSS:** Yeah, yeah sounds good, Josh. The other outcome that we are measuring, and we measure several outcomes by the way, we waste no data. There, Great Lake Mental Health takes all data and we look at it, we, and we make sure that if there's an outcome there that we can tell where it is. However, in 2015 when we started this project, we had 4,325 open clients. And of those 4,325 open clients, 835 of them ended up in inpatient. As you can see our client population exploded over from 2015 to 2019. But if you look at the number of people going to inpatient, it went the other direction and that's where we know that we had a good outcome and a good, and we're, and we are saving inpatient days and we're saving millions of dollars because everybody that was going to that, by the way, everybody that went to inpatient in 2015 went to the emergency room before they went to inpatient. So, there's several million dollars being saved by the iPads. And sometimes people say, “how can you afford to put these iPads and all these clients' homes, and all these police cars, and the museums, and the libraries?” And my answer has always been how can you afford not to- look at the outcomes, look at the millions of dollars being saved by people not going to inpatient. So, anything else, Josh, on that slide that you'd like to add?

**Josh Cantwell, LCSW:** I wanna, I just wanna kind of head off some questions that I would have if I was looking at this and hearing what we're saying. A natural assumption is that we had an increase in crisis utilization during this time. So, I would say if I was in the audience listening, well, that makes sense cause you just are seeing those people in the crisis centers. You're just trading one level of care for another. But that is absolutely not what happened. So, there's another slide that we can show that we don't have on this deck, but it shows the exact same phenomenon occurring with our crisis episodes. They're decreasing at about the same rate as the inpatient hospitalization episodes are because people are having instant access to 24 care, 24-hour care in their homes.

So, I'm assuming that that may save a couple of questions for us. So, I'm just gonna talk about the next steps briefly, I know we're running out of time here. So really if you hear the philosophy that we're talking about, it's really about filling in the gaps to access all around the areas that we serve. So every time that we find another gap, it's kind of like putting rocks in a bucket and then putting sand in with the rocks and then filling the rest of the gaps up with water, that's where we're at. So, we're in the process of giving people in our communities any time they think, man, I really may need some mental health assistance. That means not just necessarily them but someone they love or just information, that they are just seconds away from being able to access that, because we wanna put these machines in gas stations, we wanna put these machines in box stores, anywhere where people frequent and may experience mental health issues, we want them to be able to access us. So we're filling in the gaps and really we're using this philosophy of trying to be outcome-based and fix problems at any means necessary to other conditions.

So right now, the next step that we're undertaking is through this Brief Stay Therapeutic Home concept. And this is a concept that takes two existing evidence-based practices, it takes the wraparound treatment model and it takes, let me think of the other model that I'm trying, PCIT, Parent-Child Interaction Therapy. Those two models, and what that, what, wraparound services is you utilize everyone's natural support systems, churches, schools, family members and friends, to help in the process of recovery. And Parent-Child Interaction Therapy is where we put people in a room and observe their interactions with their children and we put a microphone on them and we put an earpiece in their ear and we listen, we teach, we model, and we give them suggestions for changing the way that they're interacting in real-time, okay? We've taken those two concepts. And what we're gonna try to do now, the outcome we're looking for is we're gonna try to decrease the number of kids that are being removed from their homes. We're gonna try to decrease number of kids going into foster care, we're gonna try to decrease the number of kids going into residential treatment. Cause remember when kids go to residential treatment, they're not going for

five days or 10 days, they're going for 30 days or three months or nine months. And we are going to apply these philosophies and we are not going to do it in a clinic setting, we're gonna build a house. And so, we break ground next week on this house and what we're trying to do, that's a very, Larry maybe you just heard that for the first time we're breaking ground next week. But what we're trying to do is wire a house where we can provide these situations with those individuals, where we're going to bring them in for 72 hours or longer, let the whole family stay there, and we are going to observe, teach, train during those times of high conflict, and we're gonna bring them in prior to going to inpatient, prior to being removed from their home, and we're gonna bring them back in for soft landings upon returning from foster care or from residential treatment. So that is just another example of how we're gonna apply these principles to other high needs. And that concludes our presentation for today, thank you.

**Larry Smith, CPRSS:** Remembering that our goal and objectives is to treat people in the least restrictive environment possible, thank you.

**Michael Hatch:** Thanks guys for that awesome presentation. As a reminder to our participants, if you do have a question for Josh or Larry, please put them in the Q & A in the bottom right-hand of your screen and we will get to those as time allows us at the end. Moving on to Kasey Parker and Captain Mike Woolman in Nebraska, go ahead and take it away, folks.

**Kasey Moyer:** Hello everyone, it's really good to be here. I'm gonna start out a little bit by talking about the Mental Health Association of Nebraska. Again, my name is Kasey Moyer. I'm the Executive Director, I'm also a person with lived experience living with mental health and substance use issues, and I'll go ahead and let Captain Woolman introduce himself.

**Captain Mike Woolman:** I'm Mike Woolman, I'm a captain with Lincoln Police Department, and I have the pleasure to work with Mental Health Association and just wanted to pass on Larry and Josh, that sounds like a great program you guys have going so congratulations.

**Kasey Moyer:** So I wanna start out with looking at this partnership and talk about how we were initially funded because it was really hard to have people buy into the idea many years ago that peers had, could have an impact in the criminally, criminal justice system. So, and do this, there we go, MHA was founded in 2001. At the time we only had two staff. Currently we average between 45 and 48 staff. It's important to know that all of us live with mental health and substance use issues. Our board is also required to be 51% or more with people living, with lived experience.

**Captain Mike Woolman:** Lincoln Police Department, just a quick background on us, we're about 283,000, we're the capital city in Nebraska, home of the University of Nebraska Cornhuskers. Not a very good football team this year, but we'll get better. We have about 518 personnel, of that 350 is the authorized strength. We take about 120,000 calls for service and our mental health investigations are about 3,200, but I think everybody knows that our mental health calls are way higher than that when you talk about domestics and check welfares, and in child cases that relate to mental health, majority of our calls have some sort of a mental health connection to that. Investigations without us, an EPC is Emergency Protective Custody, that is us physically taking someone into custody and having to have them put in the crisis center, and we really wanna reduce that, and you can see in this slide the bottom color there is the one that it shows our EPCs declining over the years, while our mental health calls continue to climb. And our goal is to get to somebody before they're in a mental health crisis and get them hands, within the hands of a peer. Someone that has lived experience, to someone that knows what someone's going through and try to help them navigate themselves into getting healthy.

So, the three traditional responses for law enforcement has always been we get to a call, we find out what's going on, we do informal counseling with somebody, if we have to arrest somebody there was a crime committed we do that, or we take them into emergency protective custody, but then what always happens when the officers go home or we leave the call, that's always the unknown and we wanna give someone a support and give them some help when we're not there. So, the new not so new unique approach, also Luke Bonkiewicz, who does a lot of our research, the quote from him is, "the true ability to assist consumers in crisis requires not only educating and training officers about mental health, but also collaborating with mental health organizations. LPD has partnered with the Mental Health Association of Nebraska to create a post-crisis assistance program for consumers called the R.E.A.L Program," it's Respond, Empower, Advocate, and Listen, and the peers came up with that name. The initiative strives to make consumers aware of available mental health services following a mental health crisis, and in turn and the key here is to avert future crises requiring law enforcement involvement. And this is key not even in city of Lincoln's size, but it's even way more pertinent in the rural community where they don't have the resources that we have, and when you pull several deputies to a call then the rest of the county has no deputies to respond so it's even more important there, but notably it's the police officers who initiate the consumer's voluntary participation in the program.

So, the R.E.A.L Program like I said is Respond, Power, Advocate and Listen. Officers refer people with mental health illnesses for voluntary health provided by trained peers, specialists who have lived experiences with mental health illness or substance abuse. We've had over 4,000 referrals since 2011, currently five to six referrals a week. Those continue to grow. We've also done trainings for physicians, bus drivers, landlord, elected officials, families, others that can do referrals and you're probably saying, why would you train a landlord? Well, maybe they have a, one of their clients who lives at their apartment complex they've known for years, they're gonna see their decline in their mental health before we will, and the goal is to get them into contact someone before police gets involved in it, so that's why we've trained some of those different ones. Physicians, also, they see a lot of it. More than 320 of our officers have made the referral. My detective said it's so easy that a captain can do it, so I've even made a couple referrals. And Kasey, I'll let you talk about the recovery model and the diversion from higher levels of care.

**Kasey Moyer:** Yeah, I think it's just really important that people, that the peers, need to stay in the recovery model. So we are not clinicians, however we do help individuals navigate that system. Navigating the behavioral health system on a good day is difficult, not only when you're probably having your worst moment. So that's kind of our goal is to be able to just walk alongside people, again, it's always voluntary so sometimes LPD will refer a person, and they may decline at first, but then they will keep referring and we will keep trying to make that connection with them. So, we try really hard not to give up on people. Again, the idea we don't, as people who live with mental health issues, don't like to have our rights taken away and we don't like ending up in those higher levels of care such as jail and hospitals and those types of things. So we introduce them to peers with the idea of hopefully averting the crisis rather than ending up in crisis. And again, it's a win-win as the presenters talked about before, not only is it less traumatizing for us, but it is also less costly to the system.

**Captain Mike Woolman:** So how does this all work the R.E.A.L Program? Officers determines that a R.E.A.L Program referral is appropriate, the responding officer emails, we have an email to the Mental Health Association, briefly describes the contact, explains relevant mental health issues, and provides contact information. These are a couple of examples with some information redacted. The one on the left talks about Cathy, is at a residence, she had suicidal comments, she's been stressed out, the officer suggested a referral, she's getting tested for Alzheimer's and suffers from PTSD and sexual abuse as a child, Cathy has been crying in the past two days and would like to talk to someone. The officer also added in there that she has a cat named Ollie that's a way for the peer to connect to Cathy. And it gives a little bit more personal information there. So, the officer will email that to the Mental Health Association, and the nice thing is the Mental Health Association peer then responds to that officer and let them know, hey, we were able to contact Cathy, here's the plan, if you go out with her, or on her again, let us know, these are some things that maybe will help you with that contact. And the other, there's another one on the other side basically, same type of referral and that officer, David Wunderlich, did and so these are really key. Our officers in the past, when I was hired in '87, we wanted to help people, but we had no resources. So, I would leave calls where I knew someone wasn't in a mental health crisis but I knew they were in need of help, and we'd give them a business card and tell them to call someone Monday through Friday eight to four, and that just doesn't work. If they're already in a crisis it's hard for them to remember that happened. They already having anxiety when they have two police officers, three police officers in uniforms there, and were causing stress and anxiety to them so this program has been very beneficial to us and we've seen individuals that we used to go out on, they have contacts with the peers and they're definitely on their way to recovery. And we put them in a situation where they can succeed. The officers feel better about it when they leave the call, that they know that they're going to turn them over to someone who can get with them within usually 12 hours, 24 hours, and try to make a difference in that person's life.

**Kasey Moyer:** I wanted to point out in this slide too that you can see in that second email that individual ended up in jail because he did commit a crime. So, they still go ahead and make the referral, and then the peers have access to the county jail, so we can go in and hopefully create a re-entry plan with them, kinda find out what their needs are. If they need a provider, if they need medication assistance, whatever that might be, and hopefully connect them. I also wanted to talk a little bit about responses to the rural. Lancaster County is a much smaller department, the Sheriff's department, they, but they too, we've trained all of them in the program and they too can send us an email, similar to this, and we will respond. I had a deputy out on a county road, very rural, and he came in contact with an individual who was having car trouble. She clearly was also dealing with mental health issues. He called us, we were able to get peers out there and he was so thankful that somebody could come out and meet with her rather than having to leave her there.

So, the other one more thing I wanna point out is that how the officers' attitude and culture has changed. When we first started this, these emails we'd get a name and a phone number, and that was about it. But as the officers started to see people improve and they started understanding, they were seeing people at their worst and now they get to see people and hear back from people about how, when they're

doing well. And they started believing in recovery, and how they looked at mental health really changed the culture. So, pretty much what we do is, again, we show up. We will, once that referral comes in, we try even as soon as it comes in to go right out, and we share our experience. We talk about not wanting law enforcement to show up at our door, and how it was uncomfortable for us. And we can help them with a number of things, again, including getting connected to providers. We also do have people who can do crisis response as far as a licensed therapist and med provider, we have access to them so that we can address those issues as well.

**Captain Mike Woolman:** So, a little bit of breakdown on the individuals that we've referred. It's roughly 50-50 male and female. Kasey, you wanna advance on this?

**Kasey Moyer:** Yup, sorry about that.

**Captain Mike Woolman:** I'm sorry, age groups you'll see between 20 and 60 is the majority of individuals that we're referring. White about 86%, 14% non-white. And then this is a nice breakdown of the self-reported mental health conditions that we're seeing on these calls and it just kinda shows that it's, you know, depression, bipolar, you know, schizophrenia, hearing voices, anxiety, PTSD, and it kinda gives you a little bit of information on some of the calls that were going out on that person's not in immediate crisis, but these are the individuals at the Mental Health Association R.E.A.L Program are responding to. Kasey, I think you missed those successful, there you go, you wanna go over those?

**Kasey Moyer:** Yup, so LPD will make a referral and it can be anyone. And sometimes, you know, we get referrals that are, the individual is living in their car and they typically park on this street at this time and maybe you can try and catch them there. So sometimes it's difficult to find people, but the peers are out there, they're under bridges, they're on the street, and about 62% of the time we're able to find them. I mean, to be honest, some people just don't want to be found. And we lose track of them, but they can be referred again and hopefully we can connect with them. When we do meet up with them about 85% of those don't close the door on us and are wanting to talk and are wanting to get connected to services.

**Captain Mike Woolman:** Okay, some of the findings that we've had with this program if you're kinda wondering how successful it is. We had to tell people this isn't a broken arm that you put a cast on and in six weeks you get it off, go through rehab and two, three months, you're good to go. No, this is something that someone's lived with for years and years and something that they're always gonna live with, so we know that we're not going to make an immediate impact, although anecdotally we do see that the impact has been made because we're not going to that individual's residence on a call for service they're dealing with peers and are getting the help they need. Significant impact of the R.E.A.L Program begins one to two years after referral for higher utilizers of the police services. The delayed effect is not surprising due to the complexity of mental health illness, waiting lists, medication changes, securing employment, establishing a support network, and other challenges, everybody on this webinar's aware of. There's specific significant reduction in the number of mental health calls at 12, 24 and 36 months, and by the time we get to 36 months the number of mental health calls was reduced by one third, and that that number just keeps getting better and better as we go through the program.

**Kasey Moyer:** So, we also learned during the pandemic that we needed, the increase was in mental health calls was really difficult to handle. I think our Warmline calls, which I didn't talk about here, went up about 34%. So, we had to connect with other providers on a more regular basis. So, we have crisis teams that can also go out immediately that do have a therapist and like I said a med provider, social worker, and then we have expanded our hours. MHA runs a Warmline in two different locations, it's, and we are averaging about 400 calls per month at each Warmline. Those again increase, there was one month in 2020 where we got 1400 calls on one line in a month. So, expanding that, and then adding the Living Room, which is exactly that- it's a Living Room where if somebody just needs to be removed from their environment and have a safe place to have a sandwich, get something to drink, talk to a peer, kinda regroup before going back out and again, before ending up in those higher levels of care.

**Captain Mike Woolman:** So, a little bit about law enforcement training. So back when I was hired in '87, they trained us more on how to take people in custody and take them into emergency committal and how to do that paperwork and state statutes than they ever did on training us about people with mental health. That has changed 180 degrees. All our new recruits have some extensive mental health training in the academy, and we have peers from the Mental Health Association as part of that training. At least two to three peers are in that training and help train the officers, the officers see somebody that has, that is living life with some of these mental conditions and is successful and out there and tells them about their contacts. The officers then understand that they can help these individuals and what a great asset the peers

are. Those peers also help train the new dispatchers, the sheriff deputies, our Lincoln Fire and Rescue, all their personnel have been trained and they, just recently, went through that this summer, three or 4-hour training for all of them dealing with and trying to help people get through mental health crises. We also have a 40-hour behavioral health and threat assessment training that's been going on for 10 years and that is what police officers, deputies, have. A lot of deputies from even smaller agencies outside of Lincoln, Lancaster County, that attend that. And about 65 go through that, that has spurred on a youth beta training and that's all of our school resource officers go to that training, but we find that that has been very, very beneficial. Our trainings that we tell our recruit officers is, you know, we didn't get that when I was in the academy, why? They don't take their meds. And here's the conditions that if they do take their meds, why they wouldn't do that. And so our officers are way more educated, have resources, and know that they can call that peer, because that peer is a living, breathing business card that we use to give somebody, it's nice to have that peer go out that has all those resources, and when that person asks that question they can walk them through that at the pace that person wants to be walked at and they meet them where they're at, and they're willing to do whatever to get that person, the help that they need, or the resources that they need to get through that crisis. And we all know that two or three police officers at your front door, if you're in crisis, isn't the answer to that question, but we will have the resources so someone can answer that question.

So, we've made huge strides on the department in the sheriff's office in rural area also. A quick note, this week we had a call with an individual in mental health crisis that discharged a firearm in her residence. It took a lot of our officers to go to that call and hours of negotiations. We wanna get to individuals before that happens, and that was a strain on our resources in the city so it's even more important in the rural area, where they don't have the resources we have, to try to prevent someone to get to that level, to get to them early on before there is a mental health crisis where it escalates into to a firearm being discharged. So this is something that when you don't have the personnel these calls take a lot of it and we wanna get to someone and get them help before they get to that part.

**Kasey Moyer:** And like the Captain said, it's, this has really grown. I mean, we are, we've trained primary care providers, like he said, landlords, and next week we're training city employees with libraries on how to connect with people living with mental health issues and what might be helpful and what's not. So, this again is our partnerships I think thanks to the success that we've had the other providers have come to understand that peers can be a valuable asset too, to the system as well. And so, we now partner with our hospitals, with our local ACT teams, which are a sort of community treatment teams. We have a great relationship with the detox center and how to get somebody there when they need that service. Connecting them with Intensive Case Management and the director of emergency services if there's a barrier that we're coming across, we have direct access to those folks so that we can get help with that. We are also unique in that the Lincoln Police Department, this was completely voluntary for the individual and of course as a peer I would want that, but if they are connected to providers and they may have a plan, we call it a wellness recovery action plan, they may have a plan that if they are in crisis, they've already told us who they wanna connect with, who they want to be, what do I wanna say? Then LPD can red flag them in their system and the contact information for who they would like us to call comes up on there. So, if they want a peer from the R.E.A.L Program to come in, law enforcement knows who to call.

**Captain Mike Woolman:** One quick note on some of this case I just wanna let everybody know that we do have crisis response team that do respond to immediate crisis, youth and adult. And one thing that we started, Kasey you talked about the Living Room, something where I think it's gonna continue to be a benefit force if you'd expand on that, Kasey.

**Kasey Moyer:** Yeah, like I said, the Living Room is exactly that and people, initially it was law enforcement referrals only cause we always start out smaller and then grow bigger. But now we have people who are walking in as well so. It's always important we're constantly trying to get folks to take control of their own mental health and get the services that they need when they need it so they have access to the Living Room and hopefully that will continue to grow. So, we wonder why this is, oh go ahead Mike.

**Captain Mike Woolman:** No go ahead, Kasey.

**Kasey Moyer:** We just wonder why this is a unique partnership. I think when we first started it was hard for us to believe, especially those that may have been in their cop cars at, in the back of their car at one time, and now we're working alongside of them and it's a win-win, like I said, for both of us and our services as peers, there's no stop to them. We will follow up with folks for as long as they want. And we have individuals that have made good connections with peers, so if some of them may have been referred two, three years ago and we're still having coffee with them on a regular basis. We love that this gives the opportunity for the individual to be the driver of their own program and get the services when they need them. And that's all I have, so thank you for your time today.

**Michael Hatch:** Thanks so much Kasey and Captain Woolman, we really appreciate that awesome presentation. And I do hope that it does become the norm as we continue to talk about this and it's not a unique situation anymore. So thank you for that. So as a reminder, again, at the bottom right-hand corner is the Q & A section. Please submit your questions to the presenters in the Q & A pod. We'll start going through some of those questions now, we do have quite a few here. So, I'm gonna start going through those questions and if our presenters could answer those if they're directed to you. So, the first one is from Gretchen, are the connect, are there any connectivity problems that clients experience because of lack of broadband Wi-Fi availability? If so, how was this barrier over overcome in Oklahoma? So, Josh or Larry?

**Larry Smith, CPRSS:** We furnished the iPad and the data plan and so we make sure that the data plan that we're using is one that works in there in that consumer's specific area. And that data plan is of course limited to, since the iPad is put into a single app mode which is part of the application, it allows the, but there's always problems with broadband in rural America, but we do make sure that the iPad that is provided for the police officer for the client does have the best chance of working. And we are a part of the first responder AT&T plan, so we do take priority with our program. Josh, is there anything else you have to say about?

**Josh Cantwell, LCSW:** Yeah, I just wanna expand on that last part. So, what's super important is, regardless of what the barrier is, what cannot happen is that machine, the only thing worse than not having a mental health machine in the form of an iPad, is someone thinking that they have that safety net, rather it's a community partner, law enforcement officer, or a community member and hitting that button and nothing happened. So, it doesn't matter if it's connectivity, it doesn't matter if it's because there's not enough people on the other end of that line to answer it, if that happens once, the person who tried it if they survive the episode will never try it again. A law enforcement officer that tries it will never use it again. So, in order to maintain fidelity of a program like this, zero times can there be a situation where there's connectivity issues. When Larry was talking about that, so it was a long arduous process and us meeting with some pretty high-up individuals at AT&T, to get recognized as first responders. So, this is usually reserved for firemen and policemen, when it comes, I'm sorry, firearm and law enforcement individuals to get recognized as first responders, and it's usually for the event of a widespread, some sort of catastrophe, and so it's the FirstNet version of the AT&T network which allows it to jump to different networks. So, it really has assisted us to make it virtually impossible for someone not to have connectivity. We have certain areas in our state that we still have to kinda consider a one-off and use other companies. And so, as those as those little blackout areas arise we have to know who does have connectivity there. So great question.

**Michael Hatch:** Thanks, guys. Next question now has to do with language barrier. Do you have linguistic services available for this project?

**Josh Cantwell, LCSW:** Yeah, so we've gone through multiple iterations of how to best meet these needs. Currently we were utilizing some software. Here's the thing, this is not a cop-out, I don't have that information right in front of me, but we had settled on what we have determined to be the most reliable translation software to utilize.

**Michael Hatch:** Okay, we'll kick this next question over to Kasey and Mike and then maybe Josh and Larry you can follow up too cause I think this pertains to both of you. How does your staff work with individuals with mental health and intellectual disabilities?

**Kasey Moyer:** So, again, we work strongly with our community providers so when that is something that is, you know, the issue again we get those folks who have expertise in those areas to work alongside with us and get them involved.

**Captain Mike Woolman:** We try to make sure there is no wrong door. Co-occurring disorders are with drug and alcohol, a lot of other issues, so we're, we sort that out after the fact. Immediately, we're gonna deal with the crisis and then we'll sort where's the best place for that person to get their services at.

**Michael Hatch:** Okay, awesome. Next question is from Yolanda. How were the iPads funded? Through grants, or how did you fund that project?

**Captain Mike Woolman:** Josh, are you gonna do that or you want me to do it?

**Josh Cantwell, LCSW:** I got it. So, I'm gonna tell you that you don't have enough time to hear the whole story, but there's been a transition of the type of agency that we are. When we started this, we were not a CCBHC. And so, as a CCBHC, now we get paid on a cost reimbursement basis which kind of means that whatever we need to do to achieve an outcome, then we're able to get reimbursed for that. That meaning that we're focusing more on the outcome, we're getting paid on the outcome rather on a fee-for-service basis. I know that's a lot, there's a whole presentation you can do on that, but that's not how we were able to do this because we started on a fee-for-service basis. And when you put the pen to the paper, what it really boils down to is that if you are able to provide someone with an iPad, and they use it for one

intake and they use it for one appointment a month, you paid for that machine. Really once you've used it for one intake that machine has been paid for. It virtually eradicates a no-shows. So, the only no-show now is not based on access due to transportation, or sickness, or mobility, or mental health symptoms, it's really based on do they want to talk to us? So, it's really, if they want to talk to us then we can connect now so we're able to greatly decrease those no-shows again allowing us to pay for those machines. So now again, we, the success we've had it's very likely that when we utilize this model in applications, not now, not all funders will pay for, for iPads I'm just gonna tell you right now. But when it comes to the data plans associated with these and the licensing agreements with the software company, it's, we usually get the grant when we apply with this model because of the outcomes that we're seeing. So, all three of those fee-for-service, now as a cost reimbursement on being paid for the outcomes as a CCBHC and grants. I'll tell you what the nightmare is, is managing the assets. So, the asset management associated with all those different, you've got thousands of machines that we have to keep track of. So, I'm just gonna tell you, I would be asking that question too, how do you keep track of them? And I will tell you very carefully.

**Michael Hatch:** Thanks, Josh. Next question is for Kasey, do you have specific qualifications or certifications to be a peer specialist?

**Kasey Moyer:** Yes, so we are, we did, we do 40 hours of intentional peer support training, and we are all certified in that. We also do ASSIST, which is Applied Suicide Intervention Skills Training, and then Trauma-Informed Care, WRAP, Wellness Recovery Action Planning. Honestly, we try and get as much training that will support us in our positions as we can. We are CARF accredited, so we're also required by those standards to be trained in certain areas of diversity, first aid and CPR, and those types of things.

**Michael Hatch:** Okay, and going a little bit further on that, this is for Captain Woolman and Kasey, it's a two-part question. Do you bring people to peer respite houses as well? And if so, do you, how do you determine to take them there, and how many peer respite houses are there in Nebraska?

**Kasey Moyer:** So yes.

**Captain Mike Woolman:** Kasey, you wanna answer that? You wanna talk about Keya?

**Kasey Moyer:** Yup, I can do that. So, Keya House is a respite house, it's a four bedroom, a typically a five-day stay. And yes, law enforcement do, if people want to get there they do sometimes bring them there. We encourage people to get there on their own. And then we also have a 20-bed, peer-run transitional living for individuals who are recently incarcerated, with the priority of those living with mental health and substance use issues, and they can access those services, and that's a much longer stay. The idea is to not have people reenter the community living with mental health and substance use issues to homelessness. So, we have two houses.

**Captain Mike Woolman:** And, on a side note, our officers in the recruit academy on their tour day they go tour the Keya House so they're aware of it where it's at, talk to people that are there, and so they know that that's someplace that we can refer someone to. I happened to be the captain on the team when that first started, and we thought there'd be all sorts of issues. We have not had issues. The neighbors love them down there, same as a Honu House, with people coming directly out of the penitentiary. We thought we would have a lot more issues than we do. Kasey's staff does a great job, they live next to an assisted living facility that has kind of adopted them. And if we had more time we can talk about all the neighborhood things they do with them but we are aware that our officers take people there, we stop at the Honu House so people that have just recently got out of the penitentiary are used to seeing an officer in uniform, and that they get to know them as an individual. So, we try to break down that barrier also. So, we're connected with the Mental Health Association in a lot of other ways just besides the R.E.A.L Program.

**Michael Hatch:** Okay, and I know just a follow up question to that, Captain Woolman, do you have any sort of triage protocols for, used for dispatchers to help determine if it's a behavioral health crisis and what resources to send?

**Captain Mike Woolman:** So, we have, we, that is something that we've continually worked on and we have brought them into the training that the officers get in the academy, and that's something that Captain Ben Kopsa is looking at expanding even more. Before, to be honest, we probably left them out of the loop way too long, and that's on us. We've learned that and our dispatchers are actually employees of the police department, so we have trained them up and we'll continue to do that. And they're very interested when they talk to people on the phone, they know it's not maybe a response, but they can also make referrals also. So, we have improved that, unfortunately that lacked for years and we're making up with that. We've also improved that with our fire department too, because our fire and rescue goes out on calls that we don't go to, and we want them to be able to know about this program and if they want an officer to come to that house on their call to let dispatch know so we're trying to tighten those two areas up that had been neglected.

**Michael Hatch:** Awesome, and here I was hoping this question would come up for Josh and Larry. What are your plans for integrating the iPads with 988 system next year?

**Josh Cantwell, LCSW:** Yeah, so we're actively trying to figure out how that's gonna look. It's a consideration for not just our area cause remember we're serving about, oh, I didn't tell you this, you don't have to remember it it's about 17% of Oklahoma is all that we're covering right now, so our Oklahoma network is gonna have to, we're working with them to try to determine how these are gonna get routed. So, it's a great question, obviously, by my answer you can tell that I've just not quite sure what that's gonna look like yet. Hey, and while we have the opportunity though I wanted to say that Mike and Kasey's program, Larry and I have been kind of texting back and forth over listening to it, this is fantastic. I just wanted this, I just wanna put that out there so thanks.

**Captain Mike Woolman:** Thank you very much, we appreciate it.

**Kasey Moyer:** Yeah thank you and I think we can take some of what you're doing and look at how we might even improve ours, so.

**Michael Hatch:** We're gonna conclude the question-and-answer segment with one final question for both groups. And we'll start with Kasey and Mike, and then follow up with Josh and Larry for this question. So how do you go about getting law enforcement and emergency services to buy into your programs?

**Captain Mike Woolman:** Well, you know, it wasn't, that's a great question number one. We had to change our culture, to be real honest with you. We look at mental health totally different now than we did in '87 and '95 and as we got better, and it had to, you get leaders in your department that are passionate about something, that are change agents, and it's a slow process, but our newer officers and officers that have been on the department for the last 10, 11, 12, 13 years, they know no different. This is a normal police work that we do, is dealing with people with mental health, providing them resources, knowing who a peer is from day one in the academy, and we just had to change our culture and then our senior officers, we continued to train them, and some of our more passionate officers or some of those senior officers that did not have resources to help people in the past, that now have those resources, and I can tell you back when I was a street officer back in the late 80s, early 90s, I didn't have those resources, and I know individuals by name that I could have helped and maybe prevented some tragic events in their life by hooking them up with peers, so I'll just wrap it up and say it's a cultural change in your department and you need some change agents and leaders to do that, but it can be done and it can be very successful.

**Kasey Moyer:** I have to be honest too and tell you initially in 2011 when we started this and we started the email referral, we bribed officers. We told them that, we gave them, what do I wanna say? Tickets for eating, gift certificates for, and you know, whoever sent the most referrals. And to be honest when they started seeing the people that they were, who were generating you know, four or five, 10 calls a week, not calling as much anymore, and Captain will tell you, you know, some officers make the referral because they're annoyed and they wanna be done with this and others are really concerned and I think once they start seeing those, you know, those calls go down and people getting the help that they need then you get more officers buying into it. But bribery is an option.

**Michael Hatch:** That's awesome. Josh and Larry.

**Larry Smith, CPRSS:** From Great Lake Mental Health standpoint what we found is things started changing when we started helping police officers do their job, or do our job really. But get the job done, they could spend more time on the street doing what they are trained to do, and we really started seeing a change in their attitude when we were able to take that consumer off their hands in 15 minutes or 30 minutes, or, you know, there'll be at our facility for maybe five minutes, we'll give them a cup of coffee and they're out of there. So all of those things that made it easier for a police officer do their job they appreciated, and they started becoming much friendlier after that. We also, Josh could talk a little bit about this, but we also found us a retired police officer that was very friendly to mental health, and we hired him and he is now our liaison for all of our police departments, and when we have an issue because police officers talk to police officers much better than they talk to mental health professionals. So, when it comes to its understanding of what the issues are and what the problems are. So, we hired an ex-lieutenant that retired and his job is to make sure that he communicates with the police officers and all the sheriff departments in our 12 counties. Josh, you got anything to add to that?

**Josh Cantwell, LCSW:** That was it, we just gotta, we gotta do what we tell them we're gonna do, it's gotta work, it's gotta work all the time, and they can't have to talk to slick talkers like Larry and I. They've gotta talk to people speaking the same language.

**Michael Hatch:** That's a great point Larry, and you know, like you said, cops talked to cops and as a retired police lieutenant who transitioned

into this career myself, I like to call it side door access. And a lot of times those retired officers have that side door access that maybe our mental health partners may not be able to get into the chief's office as easily as that retired lieutenant with that side door of access. So that's a great point thanks for making that.

**Larry Smith, CPRSS:** Yeah, that was some of the best money that we spent, is to hire that officer that knows how to talk to officers.

**Michael Hatch:** Yeah awesome point, thanks for making that and sharing that point so. So that concludes the Q & A segment of this webinar. I can't thank our panelists enough for presenting on two amazing programs. And, you know, we chose these programs out of a lot of programs that are out there across the country, because we felt that these two really had utility in rural areas and felt that they could really shine a light on sometimes a forgotten area with rural communities.

So, we did want to just add a couple of federal resources on here for rural communities. The first one is the Health Resource and Services Administration, and we're going to put the links to these right in the chat. So, if you know, you can certainly Google these to get them, but we'll put the links in the chat as well. The next one is the Rural Health Hub Information. This one actually has a mental health rural communities toolkit on it that was a really cool resource and there's a lot of good information that you can find on there. And then finally is the Substance Abuse and Mental Health Services Administration, SAMHSA. They have a really good guide on the crisis services and there's components of rural response in that guide as well. We just wanted to add these as some federal resources that are out there and available for communities. You know, feel free to check these out and look them up. SAMHSA one that's in the link is actually a PDF version to that guide and has, like I said, it has a lot of really good resources in it. So, this does conclude today's webinar. On behalf of the Academic Training to Inform Police Responses, which again is made up of the University of Cincinnati, Policy Research Associates, The Arc of the United States and the International Association for Chiefs of Police, we can't thank you enough for being here today, we hope that you are able to take some information from this and, you know, we will look forward to hearing from you and look back for some feedback on this. So, thank you so much for your time, everybody, and have a great day. Bye-bye.

*This resource was created through support by Grant No. 2020-NT-BX-K001 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the authors and do not necessarily reflect the official positions or policies of the U.S. Department of Justice.*