The National Guidelines for Crisis Care – A Best Practice Toolkit advances national guidelines in crisis care within a toolkit that supports program design, development, implementation and continuous quality improvement efforts. It is intended to help mental health authorities, agency administrators, service providers, state and local leaders think through and develop the structure of crisis systems that meet community needs. This toolkit includes distinct sections for:

- Defining national guidelines in crisis care;
- Tips for implementing care that aligns with national guidelines; *and*
- Tools to evaluate alignment of systems to national guidelines.

In preparing this information, we could think of no one better to advise you than people who have worked successfully with crisis systems of care. Therefore, we based the information in this toolkit on the experience of veteran crisis system leaders and administrators

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These elements are discussed in more detail later in this toolkit. Effective crisis care that saves

Core Services and Best Practices

In this section, we define essential elements of effective, modern, and comprehensive crisis care along with the actions needed to bring those services to communities across the United States. The following represent the *National Guidelines for Crisis Care* essential elements within a no-wrong-door integrated crisis system.

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- 14% (59,269 of 431,690)

Regional crisis call services offer real-time access to a live person every moment of every day for individuals in crisis. Regional, 24/7, clinically staffed call hub/crisis call centers provide telephonic crisis intervention services to all callers, meet National Suicide Prevention Lifeline (NSPL) operational guidelines regarding suicide risk assessment and engagement and offer air traffic control (ATC) quality coordination of crisis care in real-time. Ideally, these programs will also offer text and chat options to better engage entire communities in care. Analogous to a 911 call for most emergencies, mental health, substance use and suicide prevention lines must be equipped to take all calls with expertise in delivering telephonic intervention services, triaging the call to assess for additional needs and coordinating connections to additional support based on the assessment of the team and the preferences of the caller.

At the time of this publication, Congress is considering a national 988 behavioral health crisis number to serve as a dedicated crisis call center line in a manner that generates better access to care through a more broadly recognized and remembered number than the local options that exist at this time.

Regional, 24/7, clinically staffed call hub/crisis call centers must:

efficiently connect individuals to care during their times of greatest need. Air traffic control (ATC) systems provide a primary example of how access to real-time data and consistent standards lead to remarkable efficiency in complex systems. Adopting an ATC model for crisis services can significantly reduce the incidence of tragic and unacceptable outcomes for individuals in crisis.

Air Traffic Control (ATC) works to ensure the safety of nearly 30,000 U.S. commercial flights per day. In the United States, this occurs with a very high success rate; making air travel remarkably safe today. Unfortunately, we have been less successful at supporting individuals who are navigating a mental health crisis.

The advancements in ATC that have helped transform aviation safety are two vitally important objectives and, without them, it is nearly impossible to avoid tragedy:

- Objective #1: Always know where the aircraft is (in time and space) and never lose contact; *and*
- Objective #2: Verify the hand-off has occurred and the airplane is safely in the hands of another controller.

These objectives easily translate to behavioral health and our evolving crisis systems of care. Always knowing where an individual in crisis is and verifying that the hand-off has occurred to the next service provider seem like relatively easy objectives to fulfill. However, they are missing from most U.S. behavioral health and crisis systems despite the existence of technology that is working in some regions. Individuals and families attempting to navigate the behavioral health system, typically in the midst of a mental health or addiction crisis, should have the same diligent standard of care that ATC provides.

Air traffic control (ATC)-type technology is being applied by some crisis call center hubs in the country; offering real-time connection to GPS-enabled mobile teams, true system-wide access to available beds and outpatient appointment scheduling through the integrated crisis call center. These exceptional practice centers serve as a true hub for whole, integrated crisis system of care.

Status Disposition for Intensive Referrals

In an effective ATC-based model for crisis services, there must be shared tracking of the status and disposition of linkage/referrals for individuals needing intensive service levels; including requirements for service approval and transport, shared protocols for medical clearance algorithms and data on speed of accessibility (average minutes until disposition). An effective program should take advantage of sophisticated software to help crisis professionals assess and engage those at risk and track individuals throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage. For example, some systems display names on a pending linkage status board that highlight names in green, white, yellow, or red to reflect how long an individual has been waiting for connection to care.

24/7 Outpatient Scheduling

Crisis staff s

Mobile crisis team services offering community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. For safety and optimal engagement, two person teams should be put in place to support emergency department and justice system diversion. Emergency medical

- Peer support;
- Coordination with medical and behavioral health services; *and*
- Crisis planning and follow-up.

As most mobile crisis responses are initiated via phone call to a hotline or provider, the initial step in providing community-based mobile crisis services is to determine the level of risk faced by the individual in crisis and assess the most appropriate response to meet the need. In discussing the situation with the caller, the mobile crisis staff must decide if other first responders, such as police or emergency medical services, should be involved while understanding that this is not the preferred approach and one that should only be used when alternative behavioral health responders are not available or the nature of the crisis indicates that EMS or police are most appropriate.

For example, if the person describes a serious medical condition or indicates that he or she poses an imminent threat of harm, the mobile crisis team should coordinate with emergency responders. The mobile crisis team can meet emergency responders at the site of the crisis and work together to resolve the situation000911tep

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Crisis receiving and stabilization services offer the community a no-wrong-door access to mental health and substance use care; operating much like a hospital emergency department that accepts all walk-ins, ambulance, fire and police drop-offs. The need to say yes to mental health crisis referrals, including working with persons of varying ages (as allowed within the facility license) and clinical conditions (such as serious emotional disturbances, serious mental illness, intellectual and developmental disabilities), regardless of acuity, informs program staffing, physical space, structure and use of chairs or recliners in lieu of beds that offer far less capacity or flexibility within a given space. As we will discuss later in this toolkit, it is important to fund these facility-based programs so they can deliver on the commitment of never rejecting a first responder or walk-in referral in order to realize actual emergency department and justice system diversion. If an individual idua

8. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated; *and*
9. Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.

National

referrals accepted and time to make decisions on referral acceptance; offer valuable data on how each participate in the system of care is supporting the needs of the community.

Peer

Addressing Recovery Needs

Crisis providers must address the recovery needs of individuals and families to move beyond their mental health and substance use challenges to lead happy, productive and connected lives each and every day. At the 2019 International Initiative for Mental Health Leadership (IIMHL) Crisis Now Summit, consumer Misha Kessler ended his description of his direct experiences with crisis services, “Mental illness is [just]

Work to convert those with an involuntary commitment to voluntary so they are invested in their own recovery.

Significant Role for Peers

One specific, transformative element of recovery-oriented care is to fully engage the experience, capabilities and compassion of people who have experienced mental health crises. Including individuals with lived mental health and substance use disorder experience (peers) as core members of a crisis team supports engagement efforts through the unique power of bonding

commitment to dramatic reductions in suicide among people under care. These changes were adopted and advanced in the revised *National Strategy for Suicide Prevention* (2012), specifically via a new Goal 8: “Promote suicidi

Implementation Guidance

1. *Incorporate suicide risk screening, assessment and planning into the new employee orientation for all team members.*
2. *Mandate completion of Applied Suicide Intervention Services Training (ASIST) or similar training by all team members serving individuals who receive crisis services.*
3. *Incorporate suicide risk screening, assessment* v ‰ o v v] v P] v š } š Z Œ] •] • % *practices.*
4. *Automate the suicide risk screening, assessment and planning process, and associated escalation processes, within the electronic medical record of the crisis provider.*
5. *Commit to a goal of Zero Suicide as a state and as a crisis system of care.*

Safety for both individuals served and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality and possibly thoughts or aggressive behaviors, issues with life and dea792 r5F1 12 Tf[(w)7(i)-258.2319( )(s)16(etti)-18(n)-16(

Assistance Collaborative, 2005). Nationally recognized best practices in crisis intervention such as CPI (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and Therapeutic Options (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and clients in the crisis setting.

Adequate staffing for the number and clinical needs of individuals under care is foundational to safety. Access to a sufficient number of qualified staff (clinicians, nurses, providers and peer support professionals) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to themselves or others (DHHS, 2006).

In some crisis facilities licensed or certified to provide intensive services, seclusion and/or restraint may be permitted. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both clients and staff and may re-traumatize individuals who have experienced physical trauma. Therefore, restraint and seclusion are now considered safety measures of last resort, not to be used as punishment, an alternative to appropriate staffing of crisis programs, a technique for behavior management, or a substitute for active treatment (Technical Assistance Collaborative, 2005).

Crisis providers must engage in person-centered planning and treatment while assessing risk for violence to collaboratively develop de-escalation and safety plans for individuals served by the program. Staff and individuals involved in those interventions should be debriefed after a seclusion/restraint event to inform policies, procedures, and practices; reducing the probability the crisisriefed

Implementation Guidance

1. *Commit to a no-force-first approach to care.*
2. *Monitor, report and review all incidents of seclusion and restraint with the goal of minimizing the use of these interventions.*
3. *Remember that barriers do not equal safety. The key to safety is engagement and empowerment of the individual served while in crisis.*
4. *Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all.*
5. *Incorporate quiet spaces into your crisis facility for those who would benefit from time away from the milieu of the main stabilization area.*
6. *Engage your team members and those you serve in discussions regarding how to enhance safety within the crisis program.*

V

Law enforcement agencies have reported a significant increase in police contacts with people with mental illness in recent years. Some involvement with mental health crises is inevitable for police. As first responders, they are often the principal point of entry into emergency mental health services for individuals experiencing a mental health or substance use crisis.

Police officers are critical to mobile crisis services as well; either (1) providing support in potentially dangerous situations (Geller, Fisher, & McDermeit, 1995) when the need is assessed or (2) as a referral source delivering warm hand-offs to crisis mobile teams. Research investigating law enforcement response to individuals with mental illness (Reuland, Schwarzfeld, & Draper, 2009) found police officers frequently:

- Encounter persons with mental illness at risk of harming themselves;
- Often spend a greater amount of time attempting to resolve situations involving people exhibiting mental health concerns;
- Address many incidents informally by talking to the individuals with mental illness;
- Encounter a small subset of "repeat players"; *and*
- Often transport individuals to an emergency medical facility where they may wait for extended periods of time for medical clearance or admission.

In many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the *de facto* mental health mobile crisis system. This is unacceptable and unsafe. The role of local law enforcement in addressing emergent public safety risk is essential and important. With good mental health crisis care in place, the care team can collaborate with law enforcement in a fashion that will improve both public safety and mental health outcomes. Unfortunately, well-intentioned law enforcement responders to a crisis call often escalate the situation solely based on the presence of police vehicles and armed officers that generate anxiety for far too many individuals in a crisis.

We now know a good deal about crisis care/law enforcement collaboration. Deane et al. (1999), reporting on partnerships between mental health and law enforcement, found the alliance

between first responders and mental health professionals helped to reduce unnecessary hospitalization or incarceration. Specialized responses to mental health crisis included police-based specialized police response, police-based specialized mental health response, and mental health-based specialized mental health response. These forms of collaboration share the common goal of diverting people with mental health crises from criminal justice settings into mental health treatment settings and were rated as "moderately effective" or "very effective" in addressing the needs of persons in crisis.

Specialized police responses involve police training by mental health professionals in order to provide crisis intervention and act as liaisons to the mental health system. The Memphis Crisis Intervention Team (CIT) model pioneered this approach. In CIT, training for law enforcement includes educating officers about mental illness, substance use and abuse, psychiatric medications, and strategies for identifying and responding to a crisis (Tucker *et al*., 2008). Lord *et al*. (2011) found most off

The approach

Crisis Service Coding

Establishing a common definition for "crisis services" is essential to this coding process given the ever-expanding use of the term "crisis" by entities describing offerings that do not truly function as no-wrong-door safety net services accepting all referrals. Crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for anyone, anywhere and anytime. This crisis service coding discussion focuses solely and exclusively on the three essential crisis services. Any other service may offer value within the continuum of care but should not use "crisis service" coding.

Crisis services are designed to connect individuals to care as quickly as possible through a systemic approach that is comparable to that of the physical healthcare system. The table below provides a look at similarities between crisis services and their physical health counterparts; offering a framework that can be used to model reimbursement for these similar services in a manner consistent with public expectations of parity.

Table 2 tEmergency and Crisis Service Analogies

Services for Responding to a Health Crisis		
	Physical Health	Mental Health & Substance Use
Emergency Call Center	911	Crisis Line
Community-Based Response	Ambulance / Fire	Mobile Crisis Line

option. The most straight-forward option is

Assessing Adequacy of System Capacity

Crisis services are meant to address the acute mental health, substance use and suicide prevention needs of a community. This can only be achieved by designing services that meet the unique needs of all members of that community. Therefore, crisis services must offer the capacity to address the needs of rural and

Tips for System Implementation

Communities across the nation are challenged by t

professionals are expected to strengthen their skills and knowledge through ongoing CEU and CME professional advancement opportunities focused on improving team members' ability to deliver crisis care.

Providers also incorporate non-licensed individuals within the service delivery team; creating the need for additional training and supervision to ensure services are delivered in a manner that advances positive outcomes for those engaged in care. Verification of skills and knowledge of non-professional staff is essential to maintaining service delivery standards within a crisis

also an opportunity to use this approach to establish greater efficiencies when offering 24/7

System Evaluation Tools

As communities work to implement true crisis systems of care that meet the needs of their residents, SAMHSA wants to ensure resources to support advancement of best practice care be made accessible to all. Innovative community and staffing analytic calculators and videos around program structure have been made available on the National Association of State Mental Health Program Director's (NASMHPD's) www.crisisnow.com website and are also published as part of this evidence-based practice resource page. Additionally, we have created a *Crisis Service Best Practice Review Tool* with a listing of evaluated elements included in this section of the toolkit. You will see that the tool is designed to evaluate the degree of implementation of essential element implementation tips that have been defined throughout this *Toolkit*. The elements are summarized here:

1. Regional or statewide crisis call centers coordinating in real time:
    a. Operate every moment of every day (24/7/365);
    b. Staff with clinicians overseeing clinical triage and other trained team members to respond to all calls received;
    c. Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center expectations defined in this toolkit;
    d. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call;
    e. Coordinate connections to crisis mobile team services in the region;
    f. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed;
    g. Incorporate Caller ID functioning;
    h. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need;
    i. Implement real-time regional bed registry technology to support efficient connection to needed resources; *and*
    j. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.
2. Centrally deployed, 24/7 mobile crisis systems:
    a. Include a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation;
    b. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or to particular days/times;
    c. Connect individuals to facility-based care through warm hand-offs and coordinating transportation as needed;
    d. Incorporate peers within the mobile crisis team;
    e. Respond without law enforcement accompaniment unless special circumstances warrant inclusion; supporting true justice system diversion;
    f. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; *and*

Conclusion

Crisis services must be designed to serve anyone, anywhere and anytime. Communities that commit to this approach and dedicate resources to address the community need decrease psychiatric boarding in emergency departments and reduce the demands on the justice system. These two benefits translate into better care, better health outcomes and lower costs to the community. The *National Guidelines for Crisis Care* t *A Best Practice Toolkit* delivers a roadmap that can be used to truly make a positive impact to communities across the country.

For crisis services to work effectively, the handoff from law enforcement must be quick, with assessment occurring after—and not before—the handoff takes place. There must be a full partnership with the community and an understanding by community partners, particularly law enforcement, of how crisis services can most effectively work 12 792 rs1elyst1b-BT/F1 12 Tf1 0 0 1 135.6

Continuous Quality Improvement & Innovation

In 2014, Connections Health Solutions began operating the crisis stabilization programs inside the Crisis Response Center in Tucson, Arizona. It seems self-evident that crisis services should offer timely, high quality care to people experiencing a psychiatric emergency. The response must match the need. Remember the opening theme to the long running NBC hit ER: everyone is running because lives depend on it.

Dr. Margie Balfour found the reality of crisis services was often the exact opposite. It can take hours or even days in an emergency department to be "medically cleared" before entrance is granted to many of the nation's "crisis stabilization" programs. Law enforcement and first responders are expected to take the person in crisis to the hospital first, not the crisis unit. It should be noted that these programs do not represent crisis receiving and stabilization facilities as defined in this *Crisis Service Best Practice Toolkit*.

The experience of the more than 13,000 individuals that utilized the services of the Crisis Response Center each year had been uneven. There were often long delays in the clinical triage area while the patient awaited a decision on whether he or she would be admitted or discharged. Frustration abounded. The result was a decrease in safety that manifested as increases in injuries and assaults. Individuals in crisis were sometimes left unattended for long periods of time and staff were spread areas amongst multiple program areas. Security was frequently involved.

Lean Six Sigma in Action

There was a significant need to improve and speed the triage process but there was a lack of agreement on the mission of the facility. Dr. Balfour and the Connections Health Solutions team met with the leadership and front-line staff in a series of tow.05 429.28 Tm0 g0 G[(a)-20(r)16(ea)-22( )59(w)7(h

tracking tools. Next, they analyzed wasted time and function. What were the tasks that added value? What were the tasks that added little value but were nevertheless required (by licensure, contract, etc.)? And finally, what were the tasks that were unnecessary and simply represented waste?

The value analysis found that the old process required almost 11 hours to connect to needed care and that nearly 40% of this process was simply unnecessary and non-value added. Wasted time for individuals and family members dealing with a behavioral health crisis. Idly sitting in the waiting room comprised

In 1996, Recovery Innovations, Inc. (dba RI International) created its first Crisis Recovery Center just outside Phoenix, Arizona in the west valley city of Peoria. Like many similar Crisis Stabilization Programs across the country, it offered an alternative to acute inpatient, jail and emergency departments (EDs), a place where a mental health crisis could be handled by professionals as immediately as possible.

This program was an improvement, but it still had some of the issues that plague crisis care in EDs. It focused too much on procedures and diagnoses and too little on engagement and collaboration, which are vitally important for the individual in a mental health crisis. The hospital model was designed to treat disease and injury and RI set out to develop a new and unique approach that would handle the needs of those in debilitating emotional pain.

In 2002, RI began its evolution of the Crisis Recovery Center with the development of the Living Room model. It featured a strong focus on good contact with the person in distress and introduced new staff types as well. Certified Peer Specialists brought their own experience in mental health crisis and recovery and empathic and trauma-informed care into the interdisciplinary team.

The facility transformed from a colder, more sterile, traditional medical setting to have a warm inviting feel. Individuals were referred to as guests and not consumers. The teams began quality improvement efforts to reduce the prevalence of seclusion and restraint. And, overall, the Living Room felt more like home than an institution.

Still, there was the potential to make real community impact, since most acute cases were being diverted to traditional crisis facilities, i.e., hospitals and jails. In 2014, the leadership at Mercy Care, the health plan tasked by the Arizona Healthcare Cost Containment System (AHCCCS, the Arizona Medicaid authority), challenged RI to adopt the never-reject approach to law enforcement drop-offs.

At that time, RI was receiving 100 to 150 law enforcement drop-offs per month, but they w/F1 12 T8.o3e0 1 7

The graphic on the previous page demonstrates the increase in the total number of individuals in a crisis served by the program and law enforcement referral activity over the time period that this model was adopted. With 32 licensed chairs in the 23-hour observation and treatment program and 16 beds in the sub-acute crisis program, the law enforcement drop-off number doubled over the time-frame. Always accepting law enforcement referrals increases officer trust that making a drive to the facility is preferable to other traditional options, i.e., jail, hospital, relocation, etc.

Today, 80% of all guests received by the program are referred by law enforcement, and none of them first visited a hospital ED for medical clearance. The program has literally not refused a single police referral in the past five years, despite over half being involuntary. But unlike entering a hospital or jail, these individuals in crisis are immediately greeted by a peer staff who orients them to the care they will receive. There is active engagement and collaboration throughout their stay, and they become active participants.

In the Fusion Model, crisis becomes an event to be resolved and stabilized, versus a diagnosis to be treated. And, since law enforcement engages in zero wall time by by-passing the ER completely and is back on the street in less than five minutes, the burden on police is eased and the experience for the person in crisis is improved.

Figure 5 - Crisis Recovery Centers implementing the Fusion Model Across Several States

Once LOCUS identifies the correct level of care in the continuum, providers can select from a menu of services tailored to a person's particular needs. Menu items include clinical services, supportive services or crisis resolution and prevention services and describe the conditions of the care environment. Dr. Sowers says that, on average, a person with a lower composite score wouldn't have the same need-intensity as a person with a higher one, but that isn't always the case. He says the first three dimensions—risk of harm, functional status, and comorbidity—include overriding concerns. If a person scores high in these critical areas, the algorithm will alter recommendations accordingly, pairing the person with an increased level of service. "There is a composite score and treatment grid that gives clinicians the correct placement. It's easy to use."

Dr. Sowers never anticipated it would work so well and has been pleasantly surprised at how widespread adoption has been; not just when it was developed it in the 1990s but in the decades since. Unlike most innovations, LOCUS is a tool that is as applicable today as when it began. Since their inception, LOCUS and CALOCUS (the Child and Adolescent counterpart) have gone through

drug, then the ED physician's call would be forwarded to the toxicologist. (Typically, only 1 out 100 calls escalate to the toxicologist.)

The SPI also does follow-up and tracks outcomes. For example, if the person who took Banamine had a seizure, the SPI would add that to the database. They would also call the patient and ask how the person is doing and see if he or she needs an appointment. If a child drank bleach, the SPI would speak with the parents, telling them that they are not bad parents, and talking them through how to prevent the incident from happening again. They can even address more obscure poisonings. If a person eats a rare mushroom, the center will get the caller in touch with a

The murder of Kitty Genovese in Queens, New York, in 1964 sparked outrage and was one of the driving forces behind the 911 emergency call system people know and depend on today. It wasn't the murder itself that left people incensed but that 38 people witnessed Winston Moseley kill Genovese and did nothing about it. The behavioral reaction was later called The Bystander Effect or Kitty Genovese Syndrome. It turns out that at least one man did call the police to report that Genovese was seriously injured. His call went unanswered.

Most people can't remember a time before a centralized number for people to call in an emergency; when people dialed 0 for an operator or directly called the nearest police or fire station. John Draper, Ph.D., project director of the SAMHSA-funded National Suicide Prevention Lifeline (800-237-TALK or chat), hopes that a three-digit-number for mental health and suicide crisis will one day be equally ubiquitous. "Right now people have to remember an 800-number, and even though calls go up 15-percent per year and 2.2 million calls were answered in 2018, we know that 13-million people seriously think about suicide each year, which means we are far from the universe of people who could be reached."

In December, former Senator Orrin Hatch (R-Utah) wrote a letter to Marlene H. Dortch, Secretary of the Federal Communications Commission (FCC), urging the agency to use the three-digit-number 611 for Lifeline. The senator wrote that the designation would connect Americans

A three-digit-number, says Dr. Draper, will likely increase the number of callers to the Lifeline and, as a result, has the power to change how people think about mental illness. More callers equate to more data the national hotline can collect and analyze. He says this is precisely what's happening in the United Kingdom with 111, a three-digit designation for all urgent health needs,

Even though Margiotta didn't use the CIT training as initially designed, it made him rethink how law enforcement was engaging with the community. Over the next few years, he built a diversion program and housing first initiatives during the day while patrolling downtown Phoenix at night.

National

National