


PTACC GUIDING PRINCIPLES FOR BEHAVIORAL HEALTH PRACTICE

Principles to Guide Behavioral Health Practice in Pre-Arrest Diversion Programs

The Police, Treatment, and Community Collaborative (PTACC) aims to strategically enhance the quantity and quality of community behavioral health and social service options through engagement in pre-arrest diversion. The purpose of PTACC is to provide vision, leadership, advocacy, and education to facilitate the practice of pre-arrest diversion across the United States.



AUDIENCE: This document is intended for not-for-profit and for-profit behavioral health service providers as well as law enforcement, community, and other pre-arrest diversion program partners to guide inception, development, and execution of treatment and recovery support for substance use disorders (SUD) and/or mental illnesses with regard to pre-arrest diversion.

The Center for Health and Justice at TASC has identified five pathways to maximize diversion opportunities and connection to treatment, recovery support, and community services (learn more about the pathways on page 4). PTACC endorses all of these pathways and encourages communities to explore the approaches that best meet their needs. PTACC encourages availability of all pathways to maximize diversion opportunities and connection to treatment, recovery support, and community services.



GUIDING PRINCIPLES FOR THE FIELD: TREATMENT AND/OR SOCIAL SERVICE PROVIDERS

Police, Treatment, and Community Collaborative (PTACC) Guiding Principles of Recovery believes that recovery is a holistic, person-driven process rooted in compassion and respect. PTACC also acknowledges that there is no one-size-fits-all plan as recovery is highly personalized and individualized.¹ The following guiding principles must inform treatment and/or social service providers, and promote meaningful and impactful service delivery. These principles also recognize the need to identify options that are non-traditional from both treatment and recovery perspectives. This is not a prescriptive or exhaustive list, but rather a guide.

1. PROMOTE HOPE, HEALTH, AND DIGNITY:

PTACC embodies the principles of hope, health, and dignity throughout the engagement, treatment, and recovery continuum. Exercising great patience without judgment, PTACC prioritizes the needs and preferences of individuals and their families. PTACC strives to ensure that the behavioral health provider partners engaged in pre-arrest diversion programs are committed to providing a welcoming process and environment and are capable of meeting the complex needs of the substance use disorder (SUD)/Mental Health pre-arrest diversion population(s). Building bridges helps provide access to pre-arrest diversion services and assist in transitioning individuals seamlessly from homelessness, poverty, incarceration, and degradation to a place of hope, health, and dignity.



2. EMBRACE DIVERSITY:

The ability to provide equal treatment and access to services from law enforcement, service providers, and the community to a diverse clientele is vital to ensuring reductions in disparities. Fair, impartial, and culturally competent treatment and services need to be available for all types of individuals, no matter their nation of origin, gender identity, sexual orientation, race, religion, or culture. Furthermore, populations we work with may include individuals who were formerly incarcerated or are currently under supervision, are homeless, have co-occurring disorders, or may need integrated health and behavioral health treatment and/or other services. Assessment efforts should avoid labeling and stereotyping individuals and creating cultural barriers, which stigmatize or alienate treatment efforts.

3. SYSTEMS, PROVIDERS, AND STAFF MUST RECOGNIZE THAT RECOVERY IS AN INDIVIDUALIZED PROCESS:

It is imperative that PTACC and our partners understand the cycles of change as individuals move through the stages of recovery. To be effective, helping responses and resources must align with the individual's change process (e.g., need for habilitation vs. rehabilitation, treatment or recovery with or without medication, etc.). For many systems, providers, and staff, this alignment will require increased recognition of the legitimacy of multiple pathways of long-term recovery and an associated transformation of service culture, delivery, and supports. SUD are chronic conditions that can involve periods of remission and relapse, and thus require an individualized personal program of sustained recovery management, which may include a variety of treatment approaches and recovery support options.

4. RESPECT THAT RECOVERY IS A JOURNEY, NOT AN EVENT:

Treatment and service providers, as well as other pre-arrest diversion partners, must recognize that the terms "engagement," "treatment," and "recovery" should be considered in the broader sense. Accomplishment of such validates the differing stages of readiness for SUD treatment programs and the recovery process, as well as an individual's understanding of their recovery. We must utilize efforts that reduce harm to the individual and offer multiple paths to wellness. Individuals should not be penalized for their inability to maintain abstinence or commit to traditional treatment pathways. An individual's treatment plan should be both person-centered and based on self-assessment techniques.

5. COORDINATE CARE ALONG THE SERVICES CONTINUUM:

It is vital that providers work as part of a system that extends beyond behavioral health to encompass physical, mental, spiritual, and social health. PTACC systems of care engage with treatment and service providers in their community to create a network of services and supports across the continuum. Individuals will need access to an array of community-based treatment and service options from initial engagement through long term recovery supports. An effective system of behavioral health services will foster greater engagement and retention. Providers and individuals working together greatly enhances service efficacy. We encourage each community to assess its treatment and service capacity, identify areas for enhancement, as well as effective practices that could be shared with other communities and systems.



6. IDENTIFY AND REDUCE BARRIERS FOR ACCESS TO SERVICES AND SERVICE DELIVERY:

Make services easily accessible to the community, law enforcement partners, and consumers. When establishing or organizing your community's service network, review prohibitions/exclusions that are dated and reduce barriers for access to services and recovery supports. For example, expand accessibility of Medication Assisted Treatment (MAT), which includes the use of methadone, buprenorphine, and injectable naltrexone medications to stabilize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings and normalize body functions, along with counseling and behavioral therapies. Also expand access to Medication Assisted Recovery (MAR) programs, such as those that combine opioid medications with peer support, housing, and other needed resources. By removing abstinence-only programs, arbitrary medication timeframe limits, and other service restrictions to enable people in MAT and/or MAR to access critical treatment, other services, and recovery supports, devastating consequences such as relapse, overdose, recidivism, and increased risk of communicable disease can be reduced or prevented. Incorporating a no 'wrong door' is another strategy to expanded access to assessment, treatment, MAT, and MAR.

7. APPLY HOLISTIC, INTEGRATED CARE:

Individuals have a variety of needs, each of which requires attention to support ongoing recovery. As a network of behavioral health providers, address and prioritize safety and other basic, real-life problems such as homelessness, domestic violence, chronic medical conditions, income supports, and employment supports when dealing with a person's presenting conditions, and consider other community-based services that will bolster an individual's treatment and recovery efforts. For example: Employ a Housing First, Consumer Choice, Harm Reduction, or other Basic Needs Model.

8. INCORPORATE PROMISING AND/OR "EVIDENCE-BASED" PRACTICES:

Recovery and support services should include best practices or promising practices supported by research. Ongoing education and training should occur, not only for the consumers, as a mechanism to enable them to pursue goals interrupted due to symptoms of behavioral and health conditions, but also for professionals, to keep them current on available best and promising practices. Examples include: Trauma-Informed Care, Cognitive Behavioral Approaches, and Motivational Interviewing.

9. EVALUATE PROCESS MEASURES AND OUTCOMES:

Evaluate outcomes of pre-arrest diversion and linkage to care programs, as well as services including recovery supports by assessing individual and aggregate outcomes of those entering treatment and other services via various pathways. By developing research pathways to support care, we can build a strong foundation for providing services. Use systems that incorporate, with real-time capability, methods for collecting, evaluating, and distributing clinical and financial outcomes. These methods should be based upon uniform criteria and standards. Develop a separate set of outcomes and client satisfaction measures for each stakeholder group – law enforcement, behavioral health, community, and consumer. In addition, outcomes research should include the entire care continuum from early engagement to long term recovery, and should be ongoing focusing on systems, individuals and communities. A feedback loop that may inform treatment in real time would be preferred.



10. UTILIZE OUTCOMES AND RESEARCH TO EVOLVE CARE:

PTACC encourages development and continual evolution of collaborative data strategies that work to inform policy; measure the impact of interventions, services, and supports; and improve the quality and outcomes for consumers, their families, and communities. Outcomes should include a feedback component that informs practice. Outcome-driven systems with real-time capability and methods for collecting, evaluating, and distributing clinical and financial outcomes optimize use of finite resources in developing best practices. These methods should be based upon uniform criteria and standards to obtain comparable data. Outcomes and client satisfaction measures for each stakeholder group – law enforcement, behavioral health, medical community, and consumer – inform the full continuum of care. Attention should be paid to process measures and proximal and distal outcomes. - Research should also focus on the recovery process utilizing a wide lens to include physical, social and psychological measures of recovery to inform an evolving system.

11. UNWAVERING COMMITMENT TO ETHICAL CONDUCT AND PRACTICE:

Professional ethics are at the core of PTACC. PTACC, not-for-profit, and for-profit behavioral health service providers; law enforcement; community; and other pre-arrest diversion program partners have an obligation to articulate basic values, ethical principles, and ethical standards. The values, principles, and standards that guide professional conduct are defined by a commitment to integrity, honesty, accountability and a moral obligation to all those served. These principles are relevant to all entities, regardless of their professional functions, the settings in which they work, or the varying populations served.



PRE-ARREST DIVERSION: PATHWAYS TO TREATMENT AND/OR COMMUNITY SUPPORT

Self-Referral	Active Outreach	Naloxone Plus	Officer Prevention	Officer Intervention*
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Self-Referral • Individual initiates contact with law enforcement for a treatment referral (without fear of arrest), preferably a warm handoff to treatment. Example: Police Assisted Addiction and Recovery Initiative (PAARI) Angel Program

Active Outreach • Law enforcement initially IDs or seeks individuals; a warm handoff is made to treatment provider, who engages them in treatment. Examples: Police Assisted Addiction and Recovery Initiative (PAARI) Arlington; Quick Response Team (QRT)

Naloxone Plus • Engagement with treatment as part of an overdose response or a severe SUD at acute risk for opioid overdose. Examples: Drug Abuse Response Team (DART); Stop, Triage, Engage, Educate and Rehabilitate (STEER); Quick Response Team (QRT)

Officer Prevention • Law enforcement initiates treatment engagement; no charges are filed. Examples: Crisis Intervention Team (CIT); Law Enforcement Assisted Diversion (LEAD) Social Contact; Stop, Triage, Engage, Educate and Rehabilitate (STEER); Mobile Crisis; Co-Responders; Crisis/Triage/Assessment Centers; Veterans Diversion

***Officer Intervention** • Law enforcement initiates treatment engagement; **charges are held in abeyance or citations issued**, with requirement for completion of treatment and/or social service plan. Examples: Civil Citation Network (CCN); Crisis Intervention Team (CIT); Law Enforcement Assisted Diversion (LEAD) Assessment; Stop, Triage, Engage, Educate and Rehabilitate (STEER); Veterans Diversion

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