carelon Behavioral Health

Point of partnership

Clinical intervention at the scene

First responder, clinician collaboration de-escalate behavioral health crises

Introduction

The demand for comprehensive and well-coordinated crisis systems is taking center stage nationally. Driving factors include the opioid epidemic, increasing suicide rates, stigma associated with seeking behavioral health services, and challenges to accessing care. Further, a pandemic of proportions not seen in 100 years and evidence of racial disparities in accessing healthcare fuel concerns for the wellbeing of our family, friends, and neighbors. Stakeholders are re-evaluating their emergency response systems, and law enforcement agencies are seeking behavioral health support and education. In turn, individuals experiencing behavioral health crises simply want to get the care they need in the most effective and compassionate manner possible.

Accessing crisis care for those experiencing a mental health- or substance use-related emergency is complicated. The most common response is a call to 911. However, unlike the predictable response to a medical emergency, emergency response for behavioral health concerns varies greatly depending on local resources and the coordination between them.

Few well-defined crisis response systems exist for behavioral health emergencies. Often, services are not well-coordinated, and the relationships between agencies are informal. As a result, many in crisis may fall through the cracks.

Too often the response to behavioral health emergencies relies on the system designed for medical emergencies. Frequently, the result is a 911 call to law enforcement, which can have two likely outcomes: a trip to the hospital emergency department, which can lead to unnecessary, costly inpatient care, or worse, arrest and incarceration.

The behavioral health system has the opportunity to evolve. The absence of a standard coordinated system leads to barriers to care, high costs, and poor health outcomes. Individuals with behavioral health disorders often experience a fragmented and confusing set of services while law enforcement officers must deal with complex situations without adequate behavioral health support. The end result can be the unintended criminalization of mental illness and other treatable behavioral health conditions.

> "Like a physical health crisis, a mental health crisis can be devastating for individuals, families and communities. While an individual crisis cannot be fully predicted, we can plan how we structure services and organize approaches to best meet the needs of those individuals who experience a mental health crisis. Too often that experience is met with delay, detainment and even denial of service in a manner that creates undue burden on the person, law enforcement, emergency departments and justice systems."

SAMHSA - National Guidelines for Behavioral Health Crisis Care - A Best Practice Toolkit - 2020

Today's news frequently includes stories of police officers responding to behavioral health crises. This document reflects on the intersection of the behavioral health crisis system and law enforcement. It offers solutions to build a comprehensive system of care for people with mental health and substance use disorder conditions; to promote the collaboration between law enforcement and behavioral health professionals; and ultimately, to improve the health and wellbeing of our communities.

First responder challenge: Behavioral health crises

The argument for a formal crisis system

Criminal justice often acts as the back-up behavioral health system where such a system does not formally exist. Consider the following data as it reflects on typical police officer activities related to behavioral health crises, according to the Treatment Advocacy Center's 2019 Road Runners Report:

- The average distance to a medical facility is five times further than the closest jail.
- An officer's average wait time at a medical facility is approximately 2.5 hours longer than at a jail.
- Approximately 10 percent of law enforcement agency budgets go towards transporting.

Crisis costs

5.4M
miles driven transporting individuals in crisis to medical facilities

$918M
or approximately 10% of law enforcement agency budgets go towards transport costs (projected nationwide)

$10K
annual cost per person for community mental health services

165,295 hrs
spent waiting at medical facilities

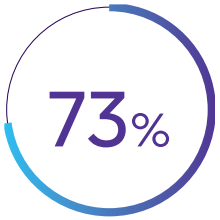
$31K
annual cost per person of housing an inmate with mental illness

Individuals experiencing behavioral health emergencies are not best served by makeshift systems in place today. If for no other reason, their condition becomes criminalized. Each year, approximately 2 million people with mental illness are admitted to US jails. The current system often prevents individuals from getting the care they need, leading to poor quality outcomes. For example, nearly half of people involved in law enforcement transports do not receive treatment: 8 percent are immediately released, and an additional 37 percent are evaluated and released.

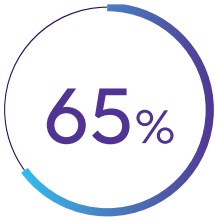
First responder conundrum

Without a well-coordinated system to address behavioral health crises, it's not surprising that the law enforcement and criminal justice systems become involved. There are at least three issues with this scenario. First, for individuals contemplating a suicide or experiencing psychosis, a law enforcement encounter may result in an escalation instead of bringing the calming relief an individual in crisis needs.

Second, most of the interactions between law enforcement and individuals in crisis are non-criminal. However, the interaction with law enforcement can suggest some degree of criminality to others. The unintended consequence can contribute to the stigmatization of behavioral health conditions.



mental health calls that result in a law enforcement transport are of a non-criminal nature



of all such transports, the officer did not perceive the individual to be at risk of hurting others

Source: 2019 Road Runners Report.

Third, many officers have not been trained to recognize and effectively address behavioral health crises. However, when police officers do get involved, they usually transport individuals to emergency departments where nearly half of people are discharged without treatment. The cycle of behavioral health crises and all of their possible ramifications continues.

Most officers don't have the training to recognize and handle behavioral health crises.

Florida Mental Health Institute Case Study

The institute analyzed the arrest, incarceration, and acute care utilization rates of 97 individuals identified as recidivists with the acute care system.

Over a five-year period, these individuals accounted for:

2,220
arrests

27,000
days in jail

13,000
days in crisis units, hospitals and emergency rooms

conservatively estimated the cost to the community at $13 million with no return on investment in terms of reducing re-entry into the system or promoting recovery.

The cost of recidivism

Without a formalized behavioral health crisis system, individuals experiencing behavioral health crises may find themselves cycling in and out of the criminal justice and emergency healthcare systems. Consider a case study conducted by the Florida Mental Health Institute to determine recidivism's cost to the community, shown at left.

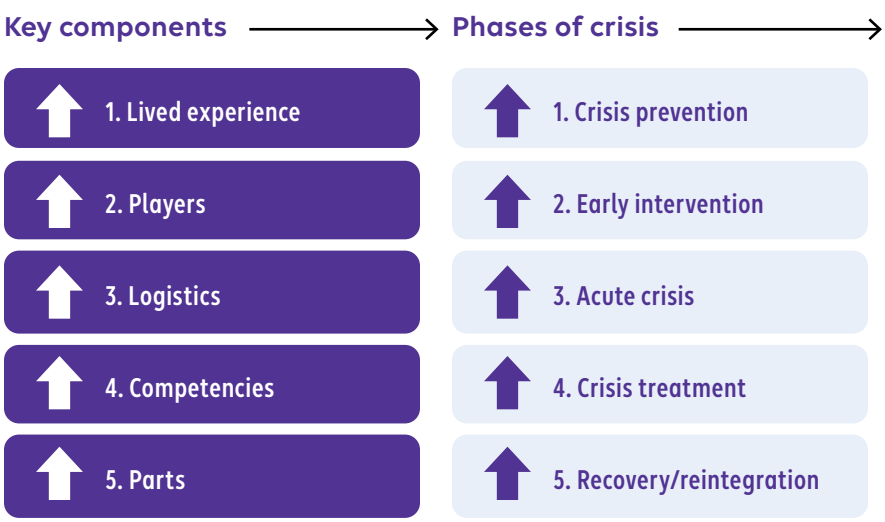
The quality of life for individuals with behavioral health conditions and law enforcement involvement diminishes in several important ways. For example, frequent touches with law enforcement decrease their chances of gainful employment. Further, possible incarceration—instead of treatment—often perpetuates the negative cycle of continued law enforcement involvement and unemployment. However, there can also be physiological ramifications to delayed—or worse, no—treatment. Research indicates that untreated multiple episodes of psychosis can damage the brain, specifically the "gray matter" that controls memory storage and the retrieval of memory.

End silos with a comprehensive behavioral health crisis system

Just as hospitals are structured to handle physical health emergencies, a behavioral health crisis system should exist to address behavioral health emergencies. Typically, as noted earlier, communities rely on existing services, such as 911, law enforcement, emergency departments (ED), inpatient psychiatric units, involuntary treatment processes, and jails/detention to address behavioral health crises.

Approximately, one in eight emergency department visits involve a behavioral health issue, according to the Agency for Healthcare Research and Quality, but the ED often is not the best place for someone in crisis to experience relief. Indeed, those seen in the ED with a behavioral health crisis are more likely to be placed in an inpatient setting instead of receiving community-based care, which is more effective, less costly and provides the comfort and familiarity of one's community.

Programs are more effective when they are structured to address core issues. Cohesive community-based crisis systems do not exist without purposeful, effective planning and strategy and diligent oversight to ensure the proper development and allocation of resources. Carelon Behavioral Health uses the following crisis system of care framework to guide our community crisis planning. The framework offers 10 points of opportunity for building depth and breadth into a crisis system.



When these 10 components work synergistically, as shown in the graphic, communities will have an optimal performing behavioral health crisis system.

Source: Kappy Madenwald, Madenwald Consulting; Steve Day, Technical Assistance Collaborative

The "parts" of an effective crisis system help individuals tap into appropriate services. The requisite parts are as follows:

1. **1-800 "front door".** A front entry into the crisis system, this is a 24/7 hotline that provides phone-based de-escalation and resolution: screening, initial assessment, triage, information and referral services.
2. **Mobile crisis units.** These units, inclusive of peers, facilitate crisis resolution, administer pre-screening assessments and use de-escalation techniques. They also coordinate crisis follow-up care, including education and support to families.
3. **Community-based locations.** These locations provide crisis walk-in capability, including EMT or law enforcement drop-off, and help stabilize and connect individuals to services.
4. **Integrated SUD/medication-assisted treatment solutions.** Processes need to be integrated to ensure that access to SUD treatment is available within the crisis response system, including follow-up, and must be comprehensive and provide referrals.
5. **23-hour receiving centers or peer living rooms.** These locations provide options that offer a less restrictive, more recovery-focused approach for people in acute crisis but who do not require hospital care.
6. **Providers for all levels of care available for urgent access.** Providers are needed at all levels of care to address an individual's needs, depending on their acuity level, support system and immediate needs.
7. **Crisis collaboratives.** Law enforcement, community organizations, faith-based organizations, and other stakeholders work together to develop and provide integrated, community- based intervention, care plans and services.
8. **System management and oversight.** A unifying organization serves several critical functions: technology infrastructure that facilitates access to services tracking availability; high-risk member management; coordination throughout treatment episodes; network oversight; and promotion of system-wide data-sharing and outcomes measurement.

A robust behavioral health crisis response system can reduce the overutilization of psychiatric beds or ED boarding as well as the overreliance on emergency responders. The end result is improved health outcomes at reduced cost.

In the following sections, we explore in detail two components of the crisis continuum that can help law enforcement and other first responders.

Behavioral health intervention at the scene

Mobile crisis intervention

Mobile crisis intervention (MCI) is the deployment of trained behavioral health professionals who respond to people experiencing a behavioral health crisis in the community. While mobile crisis units' specific activities can vary from community to community, they generally perform the following activities:

- Facilitate crisis resolution by using de-escalation techniques
- Administer pre-screening assessments
- Triage and coordinate crisis diversionary services
- Provide follow-up services and referrals

A mobile crisis response ensures a clinical intervention as opposed to an interaction with law enforcement. Trained to handle behavioral health crises, mobile crisis units' de-escalation techniques can prevent crises from reaching the stage that requires more intensive services, such as inpatient psychiatric care. They connect people to the care they need and act as the glue to the larger behavioral health crisis system, mitigating unnecessary trips to emergency departments and law enforcement involvement. Equally important, mobile crisis response reduces the potential stigma associated with seeking help.

The state of Connecticut has seen success as well with its youth MCI services in reducing rates of subsequent emergency department (ED) utilization. The Child Health and Development Institute of Connecticut, Inc. reported in 2018 that MCI utilization had risen dramatically in the prior 10 years, with most referrals originating from schools, parents and caregivers, and EDs. Specifically, Connecticut Medicaid data indicated a 20 percent increase in youth visits to the ED for behavioral health reasons.

A study, funded by the Children's Fund of Connecticut and conducted by the University of Connecticut School of Social Work with additional support from Carelon Behavioral Health, found that over an 18-month follow-up period, youth who used MCI services showed a 25 percent reduction in risk of subsequent ED use compared to youth who had not used the services.

Emergency Services Program/Mobile Crisis Intervention in Massachusetts

Carelon Behavioral Health's Massachusetts Behavioral Health Partnership administers the state's Emergency Services Program (ESP) whose network provides behavioral health and substance use disorder crisis services for anyone who is covered by MassHealth or Medicare or is uninsured. The program's intervention and stabilization services can occur anywhere in the community, helping to prevent unnecessary emergency department (ED) use.

Available 24/7/365, the program includes mobile crisis intervention for both youth and adult along with other community crisis stabilization services. Due to their crisis expertise, MCI clinicians know the many treatment options for more appropriate referrals and better linkage to community-based services. The approach works. Using mobile crisis services has resulted in significantly lower hospitalizations:

83% of youth and 61% of adults receiving mobile interventions were referred to community-based outpatient and diversionary services instead of inpatient care.

Law enforcement mental health training

As first responders, police officers encounter all types of emergencies. Even in the most effective behavioral health crisis system, law enforcement may have a role in handling these crises. The ideal is for as reduced a role as possible, but for those times when it's unavoidable, police officers benefit from training that helps them to recognize and handle a behavioral health crisis.

That training is a diversion program called Crisis Intervention Training (CIT). Recommended for 911 dispatchers, police officers and other responders, it includes an initial 40-hour training and two-day annual refresher courses. CIT is an example of "problem-oriented policing," which helps to reduce unnecessary force.

The goals of CIT vary. It is a pre-arrest jail diversion for individuals experiencing a behavioral health crisis. It also provides community partnership among law enforcement, individuals in crisis and their families. The National Alliance on Mental Illness (NAMI) extends that definition further by saying that "CIT programs create connections between law enforcement, mental health providers, hospital emergency services, and individuals with mental illness and their families." In addition to improving responses to people in crisis, NAMI states that CIT also promotes officer safety, citing that, in Memphis, CIT resulted in an 80 percent reduction of officer injuries. Additionally, CIT has reduced the time they spend on a mental health call, putting them back into the community more quickly.

Research shows that CIT has positive effects. Police officers who received the training report improved attitudes and reduced stigma around mental illness. They also report that they perceive themselves less likely to use force in a potential mental health crisis encounter. Secondly, evidence suggests that CIT promotes prebooking jail diversion. One study demonstrates that CIT led to increased verbal negotiation, with referral to treatment more likely and arrest less likely. In spite of its efficacy, there are only 2,700 CIT programs in the country, representing approximately 15 percent of total police departments.

Another prebooking jail diversion program is LEAD—Law Enforcement Assisted Diversion. LEAD "is a community-based diversion approach with the goals of improving public safety and public order, and reducing unnecessary justice system involvement of people who participate in the program," according to the LEAD National Support Bureau. Intended for low-level offenders, trained officers may screen and divert individuals to case management for treatment and other resources instead of arresting them.

Finally, there are hybrid models of crisis response. Co-responder teams involve trained officers or even paramedics pairing up with specially trained behavioral health clinicians to respond to these crises. In the case of community outreach teams, police officers and other crisis responders work with behavioral health partners to identify at-risk individuals and engage them in treatment.

More on CIT

The CIT model started in Memphis, Tennessee, in 1987 when police officers shot a young man who, in a mental health crisis and unable to respond to verbal requests, lunged at them.

The Memphis model CIT program promotes an integrated model through a three-pronged approach:

- 40-hour instruction for selected police officers from community health workers, officers familiar with CIT, and from people with mental illness
- Training and special coding for dispatch operators so they can recognize a high probability of a mental health crisis, which research shows is a strong indicator of the probability of future use of force
- A centralized drop-off mental health facility that automatically accepts people experiencing a mental health crisis to minimize police officer transfer time

Seattle LEAD Program

The first prebooking diversion program started in Seattle in 2011, and the program's outcomes tell a positive story. Compared to a control group, LEAD participants were:

58%
less likely to be arrested

33%
more likely to have income/benefits

46%
more likely to be "on the employment continuum"

2x
more likely to be sheltered

Additionally, LEAD participants showed cost reductions of $2,100 compared to $5,961 cost increases from the control group participants.

Conclusion

We can improve response to behavioral health emergencies. Together, we can build comprehensive crisis systems that deliver the right care at the right time. While the challenge is real, work is underway to build comprehensive crisis systems of care designed specifically for individuals facing behavioral health emergencies. These systems aim to ensure individuals receive effective crisis response services instead of criminal justice system involvement. Bolstered by collaboration, they work to ensure that law enforcement agencies have adequate support and education for those times when they are called upon to assist in behavioral health emergencies.