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Assessment #11

Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies

August 2020

Alexandria, Virginia

Eleventh in a Series of Eleven Briefs Addressing—Beyond Beds: Crisis Services

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

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Recommended Citation: Balfour, M.E., Hahn Stephenson, A., Winsky, J., & Goldman, M.L. (2020). *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.* Alexandria, VA: National Association of State Mental Health Program Directors.

Abstract

How a community responds to Behavioral Health (BH) emergencies is both a public health issue and social justice issue. Individuals in BH crisis often receive inadequate care in emergency departments (EDs), boarding for hours or days waiting for treatment. These individuals account for a quarter of police shootings and over 2 million jail bookings per year. Explicit and implicit bias magnify these problems for people of color. Growing bipartisan support for reform provides an unprecedented opportunity for meaningful change, but solutions to this complex issue will require comprehensive systemic approaches. As communities grapple with BH emergencies, the question isn't *whether* law enforcement (LE) should respond to BH emergencies, but rather *when*, *how*, and *with what support*. This policy paper reviews best practices for law enforcement (LE) crisis response, outlines the components of a comprehensive continuum of crisis care that provides alternatives to LE involvement and ED utilization, and provides strategies for collaboration and alignment towards common goals. Finally, policy considerations regarding legal statutes, financing, data management, and stakeholder engagement are presented in order to assist communities interested in taking steps to build these needed solutions.

Defining the Issue

Healthcare and criminal justice systems are facing increasing challenges from the growing numbers of individuals experiencing behavioral health (BH) crises (defined here as a crisis related to mental illness or a substance use disorder).[1, 2] Unfortunately, there are few options available for a person in crisis. Law enforcement (LE) agencies, emergency departments (EDs), jails, and prisons have become the safety nets, yet they are not equipped to provide the care that these individuals desperately need.

Unlike medical emergencies, BH emergencies often result in a LE response. BH emergencies constitute between five to fifteen percent of all calls to 9-1-1 systems.[3] Adverse and sometimes tragic outcomes are all too frequent. It is estimated that a quarter of police-involved shooting deaths are linked to mental illness, half of which occur in the person's own home.[4] Over 2 million people with serious mental illness are booked into jail each year, often for non-violent "nuisance" or "quality of life" crimes such as loitering or vagrancy. Not surprisingly, the prevalence of mental illness and substance use disorders in jails and prisons are three to four times that of the general population.[5, 6] Once in jail, people with mental illness are incarcerated twice as long, and few receive needed treatment.[7, 8, 9] Upon release, with Medicaid benefits interrupted and a criminal record, they are more likely to be unemployed, homeless, and rearrested.[10, 11, 12, 13] Then the cycle continues.

Explicit and implicit bias magnify these problems for people of color. African Americans are 2.6 times more likely to be killed by police than non-Hispanic Whites; when combined with mental illness, this difference is nearly ten-fold.[14] For those struggling with substance use disorders, disparate sentencing penalties (e.g., harsher sentences for crack vs. powder cocaine) result in excessive imprisonment of Black Americans.[15] These long-standing inequities have been underscored by the continued high-profile killings of unarmed people of color by LE. Reducing racial inequities in crisis response and in access to BH care must be a central focus of any reform efforts.

The status quo negatively impacts LE as well. State civil commitment laws often prevent more appropriate responses to persons in crisis by requiring LE officers to conduct involuntary mental health transports. The lack of easily accessible treatment makes these transports time consuming and frustrating for officers.[16] A recent survey of LE agencies in the U.S. estimated the nationwide cost of transporting people with severe mental illness is $918 million annually. Law enforcement leaders also expressed dismay at the inhumanity of criminalization as a result of their role and concerns that the time spent on this function may restrict their ability to uphold public safety.[17] Police violence takes a toll on the officers too, with high rates of trauma and more suicides per year than line-of-duty deaths.[18]

As social movements for racial equality gain prominence, calls for fundamental policing reforms have gained traction and become more politically viable. This presents an unprecedented opportunity to rethink current approaches to people in BH crisis. While some call for "defunding" of the police in lieu of clinician first-responders, this will not eliminate the need for LE completely. Some BH emergencies may not become apparent until after officers are on scene for another issue. Other situations may pose an unacceptable amount of safety risk to civilian clinicians. Solutions will require broad systemic approaches with collaboration between LE and the healthcare system to create the optimum response for different types of cases, some of which may involve an LE response, a clinician response, or a co-response with shared responsibility.

For any response to be successful, the responders—whether LE or clinicians—require a functioning BH crisis system that can quickly accept individuals in crisis and provide the care they need. The solution is not simply to build more inpatient psychiatric beds any more than building more dialysis centers is the solution for gaps in diabetes care. Rather, communities must commit to investing in a coordinated system of care in which people get the help they need as early as possible, in the safest and least-restrictive setting as possible. This is underscored in The National Association of State Mental Health Program Directors' (NASMHPD) recent report entitled, *"Beyond Beds: The Vital Role of a Continuum of Psychiatric Care."* [19, 20] Other initiatives such as *Crisis Now* describe systemic approaches to community-based crisis services that are often less costly than more restrictive alternatives.[21]

This policy paper is intended as a guide for those who seek better ways to respond to individuals experiencing a BH crisis, beginning with the moment a request for help is made and ending with the successful transition to an appropriate level of care. We describe best practices for LE crisis response and outline the components of a comprehensive continuum of crisis care that provides alternatives to LE involvement, ED utilization, and hospital admission. We discuss the importance of addressing this complex issue from a systems approach rather than relying on standalone programs for an easy fix. Finally, we present policy considerations to assist communities to take concrete steps towards building an advanced crisis response system.

Law Enforcement Responses

The LE response to BH crisis has been under increasing scrutiny by the courts for several decades. In particular, the 9th Circuit Court of Appeals 2011 ruling in Glenn vs. Washington was a critical decision in the movement to improve outcomes for individuals experiencing behavioral emergencies. In this case, which involved the death of a young man in crisis holding a knife, the Court upheld an earlier ruling (Deorle v Rutherford, 2001)[22] stating that "we have made it clear that the desire to quickly resolve a potentially dangerous situation is not the type of governmental interest…that justifies the use of force that may cause serious injury." Furthermore, they underscored that the use of less forceful tactics is expected when responding to calls involving a person in emotional distress who is causing a disturbance or resisting arrest. Instead, LE officers should be expected to proceed slowly and figure out how to de-escalate the situation. This decision became the basis for many LE agencies to implement or expand Crisis Intervention Team (CIT) programs.

CIT and Training

The CIT model is the most widely known approach to providing LE with the tools needed to recognize individuals experiencing a BH crisis, deescalate them, and divert them to treatment instead of jail. CIT began in the late 1980s in Memphis, Tennessee, in response to a police shooting involving a person with mental illness. The centerpiece of CIT is a 40-hour training that involves scenario-based exercises and participation of community stakeholders including BH clinicians, treatment agencies, people with lived experience of mental illness, families, and advocacy groups.

CIT training is associated with higher likelihood of referral to treatment and lower likelihood of arrest, and CIT trained officers are more likely to use verbal redirection as the highest intensity level of force in the field.[23] CIT training is most effective when undertaken voluntarily by experienced officers. Compared to officers mandated to receive CIT training, voluntarily trained officers demonstrate better self-efficacy, de-escalation skills, and referral

decisions. Even when physical force was documented, voluntarily trained CIT officers were more likely to refer to treatment services and less likely to make an arrest.[24] It is estimated that 3,000 jurisdictions across 47 states have implemented CIT programs.[25]

The National Council for Behavioral Health and CIT International recommend that 100% of a department's uniformed patrol officers receive a required 8-hour Mental Health First Aid for Public Safety training while 20-25% voluntarily receive the 40-hour CIT training. 9-1-1 personnel should also receive training to help them recognize calls with a mental health nexus so that they can dispatch CIT trained officers when needed. This approach ensures both a basic level of competency among all officers and 24/7 availability of a specialized CIT response.

While CIT is often thought of as a police training program, its creators continue to underscore that training is only one part of a more comprehensive community approach.[26] Once officers are trained to identify a person in crisis and divert them to treatment, their first question is often "divert to what?" For this reason, the full CIT model recommends a crisis system that is ready to receive individuals from LE with quick and easy access and 24/7 availability. In practice, services are often not available and patients instead board in EDs waiting for inpatient beds. Oftentimes the officer must wait with them, sometimes for hours, making jail the path of least resistance for busy officers juggling multiple calls for service.

Beyond CIT: Dedicated Specialty Teams

Some LE agencies have created BH specialty teams composed of dedicated—not designated—personnel. This is a crucial distinction in LE. CIT trained officers are often *designated* to handle BH calls in addition to their regular duties, whereas *dedicated* teams focus exclusively on BH concerns. Team members may respond to mental health calls like regular CIT officers, but their specialization provides time and flexibility to problem-solve complex cases and collaborate with mental health partners on system improvement efforts. Examples include substance use teams that connect people to treatment in lieu of arrest, mental health case management teams that follow up with individuals after a crisis, investigative teams that seek to connect individuals to treatment before they reach the point of crisis, and homeless outreach teams. This level of resource commitment indicated leadership buy-in, and many of the agencies recognized as Police-Mental Health Collaboration Learning Sites (described below) have some form of dedicated team, in addition to CIT training, as part of their comprehensive approach to BH.

BH Crisis Response

Currently there are no national standards for crisis services like that of Emergency Medical Services (EMS) systems. However, several emerging frameworks have started to define crisis services and how they should interact with LE:

> *The Sequential Intercept Model* describes the typical pathway through criminal justice system for a person with BH needs and identifies opportunities for the healthcare system to intervene.[27] Intercept 0 (community-based crisis services) and Intercept 1 (9-1-1 and first responders) describe opportunities for crisis and LE to collaborate to prevent LE contact or arrest.[28]

Crisis Now: Transforming Services is Within Our Reach, is a 2016 report that lays out essential services for a crisis continuum of care: call centers, mobile crisis teams, and stabilization centers.[29]

National Guidelines for Crisis Care: A Best Practice Toolkit was released in 2020 by the Substance Use and Mental Health Services Administration (SAMHSA) as an update to Crisis Now.[30]

21st Century Behavioral Health Crisis Care is a report by the Group for the Advancement of Psychiatry, in collaboration with the National Council for Behavioral Health, scheduled to be released in 2021 that describes the services, competencies, and governance needed to create a coordinated crisis system with measurable outcomes.[31]

Crisis Call Centers and "Care Traffic Control"

Crisis call centers are often the first entry point to crisis services and, in some instances, can take the place of 9-1-1 calls that might otherwise have resulted in police dispatch. Crisis lines offer support to people in crisis 24 hours a day, 7 days a week via a range of modalities such as suicide hotlines, warm lines, and text functions. The National Suicide Prevention Lifeline (NSPL), launched in 2005, is a network of more than 170 crisis call centers located in communities across the U.S. that are supported by SAMHSA and local funding. The Veterans Administration Crisis Line (VCL) is linked to the NSPL, has since its inception in 2007 responded to more than 3.9 million calls, 467,000 online chats, and 123,000 texts.[32] In some communities crisis calls are accessed through nonemergency and information lines such as 2-1-1 and 3-1-1 or other local crisis lines. Studies of NSPL call centers have found that callers have significantly decreased suicidality during the course of the call,[33] a third are successfully connected with mental health referrals,[34] and less than a quarter result in LE or EMS being sent without the caller's collaboration.[35] As awareness of the utility of crisis lines increases, there has been growing momentum to create a nationwide, easy to remember three-digit number for NPSL and other crisis lines. The Federal Communications Commission (FCC) recently approved a new 9-8-8 number for implementation in July 2022.[36]

In addition to crisis counseling, crisis call centers are well situated to serve as a centralized hub for relaying information and coordinating the appropriate response. Such "care traffic control" functions include dispatching the nearest mobile crisis team, making outpatient appointments, and finding placement in crisis facilities or inpatient units. Some systems even have clinicians embedded in 9-1-1 communications centers so that BH calls can be diverted to the crisis line in lieu of a police response. Local and regional mental health system leaders must engage with relevant emergency management agencies to develop clear protocols and clinical criteria for when to dispatch a clinical team, LE, or both. Such policies and procedures can also help reduce the potential for implicit bias to affect decision-making.

Mobile Crisis Teams

Mobile crisis teams (MCTs) play a critical role in providing access to care for people in crisis. The first MCTs are believed to have been established as early as the 1930s in Amsterdam.[37] As of June 2020, at least 34 states in the U.S. have MCTs, although few operate statewide.[38] MCTs are typically composed of one or two providers including masters-level clinicians and psychiatric technicians[39] and frequently interact with EMS, LE, and CIT-trained officers.[40, 41] MCTs meet the patient where they are—at home, in the ED, on the street—obviating the need to transport them to a more restrictive environment.[42, 43, 44] MCTs should have

clear clinical criteria for when to request assistance from LE. Standardized protocols reduce the potential for implicit bias to affect clinical decision-making that may unnecessarily expose people of color to higher rates of LE involvement.

Some localities have established centralized dispatch for MCTs, often within crisis call centers. To improve response times, MCTs may be stationed throughout larger geographical areas (e.g., in police departments or outpatient clinics). Rural areas in particular benefit from dispersed models that are centrally coordinated. A more advanced approach is illustrated by the crisis line in Tucson, Arizona, which uses mobile phone software with GPS technology. Dispatchers can see each MCTs' location and status, allowing them to identify teams that are nearby or close to finishing up an encounter, similar to popular app-based ride hailing companies. The app also facilitates transmission of clinical information from the crisis line dispatcher to the MCT to assist with continuity of care.

Co-Responder Teams

In co-responder models, a BH clinician co-responds to crisis calls with LE. This model is popular in the United Kingdom and Canada (where it is sometimes called "street triage") and was pioneered in the U.S. by the Los Angeles Police Department in the early 1990s. There is wide variability in how co-responder programs are operationalized.[45] Models include teams that ride and respond together, teams that arrive separately, and teams where only the officer responds to the scene with clinician support via phone or video. Some programs have plainclothes officers in unmarked cars, while others are uniformed. There is no consensus on which model is most effective, and programs should be adapted to the local context. For example, an officer and clinician riding together may work well in a dense urban area with a high volume of mental health calls, while a more sparsely populated area may be better served by one of the other models. EMS co-response models have also been implemented. Developed in 1989 in Eugene, Oregon, the CAHOOTS (Crisis Assistance Helping Out On The Streets) program pairs a clinician with EMS to respond to crisis calls.[46] The RIGHT (Rapid Integrated Group Healthcare Team) Care model, operating in Dallas, Texas, deploys a three-member team of a clinician, LE officer, and paramedic.[47]

While community members report they prefer the co-responder model to a police-only response, studies of other outcomes have been mixed.[48] A review of police and mental health co-responder programs concluded that these programs decreased arrests and the amount of time officers spent handling mental health calls, but there was limited evidence on other impacts.[49] Furthermore, many programs are limited in scope in terms of hours or operation or geographical area served. In particular, programs experience difficulty when there is a lack of community mental health resources. While co-responder models have recently received much attention, they are not a panacea but rather one component of a larger crisis response system.

Specialized Crisis Facilities

Crisis facilities vary widely in scope and capability. Some are designed for low acuity patients who primarily need peer support and a safe place to spend the night, while others treat the highest acuity patients presenting as danger to self or others, acute agitation, and substance intoxication. When coupled with the lack of standardized nomenclature, this variation can create confusion for community stakeholders and policymakers unless expectations are clearly articulated and understood.

From its inception, the CIT model outlined requirements for a "receiving center" where officers can bring individuals for treatment.[50] These include 24/7 availability, faster drop-off times than jail, and a policy of never turning officers away. Ideally, the center should be able to accept any patient regardless of behavioral acuity, including those who may be suicidal, violent, or intoxicated. Such a "no wrong door" policy ensures that highest acuity patients receive care in a specialized setting designed to meet their needs.

Receiving centers are known by a variety of names— crisis stabilization units, 23-hour observation units, psychiatric emergency services units, emPATH (emergency Psychiatric Assessment, Treatment & Healing) units—and may be free-standing or adjacent to a hospital or ED. Many also receive patients via LE, MCTs, transfers from EDs, and walk-ins.[51] Crisis facilities provide a safe and therapeutic environment for assessment and stabilization, with interdisciplinary treatment teams that include psychiatric providers, social services staff, nurses, BH technicians, or peer supports. With rapid assessment, early intervention, and proactive discharge planning, most patients are able to return to community-based care. Studies show these units are associated with reduced rates of hospitalization, boarding of psychiatric patients in EDs and arrests.[52, 53, 54]

Living Rooms, detoxification centers, and sobering centers provide 24/7 alternatives for less acute needs and often accept police drop-offs for patients who meet their admission criteria. They are typically unlocked and serve patients who are voluntary, non-violent, and motivated for help.[55] Living Rooms offer a home-like environment with couches and artwork and are staffed predominantly by peer specialists, with limited coverage by a psychiatrist or other provider. They are especially helpful if psychosocial stressors are the main precipitants of the crisis. Detoxification centers provide medically supervised detoxification services, while sobering centers employ primarily psychosocial and peer support.

Crisis clinics or mental health urgent care centers offer same-day or walk-in access for outpatient assessment, crisis counseling, medication management, and coordination of care, including enrollment in benefits. These clinics can be part of a crisis center, ED, outpatient specialty mental health clinic, or standalone, and provide bridge services until the person is connected to appropriate outpatient care.

Crisis residential, crisis respite, and peer respite facilities offer longer term (days to weeks) residential care. They are often used as step-down from inpatient care. Some programs may accept low acuity patients from LE.

Post-Crisis Care

Post-crisis wraparound services are increasingly recognized as essential to ensure that patients are successfully linked to long-term treatment and avoid reutilization of crisis and other acute services.[56, 57, 58] These services can be provided by BH programs (e.g., peer navigators), LE-based case management, or a combination of both. In addition, community paramedicine approaches deploy paramedics to check on frequent 9-1-1 callers, some of whom have BH needs.[59] In each model, the goal is for crisis services to connect people to treatment and address the social determinants of health (e.g., housing, transportation, food) with the goal of preventing future encounters with LE.

Advanced Systems

Crisis Services vs. Crisis Systems

While each of the various programs described thus far is likely to improve outcomes in isolation, the impact is multiplied when an array of programs and services work together as a coordinated system to achieve common goals. This approach is illustrated in Figure 1, which is based on the crisis system in Tucson, Arizona. In this model system, healthcare and LE stakeholders agree on a common goal of preventing avoidable jail, ED, and hospital use by providing care in the least restrictive setting that can safely meet the needs of an individual experiencing a BH crisis. Because less restrictive settings tend to be less costly, clinical and financial goals are aligned. In Arizona, a Regional Behavioral Health Authority (RBHA) contracts with multiple BH agencies to create an array of services organized along a continuum of intensity, restrictiveness, and cost. At all points along the continuum, which in this case includes co-location of crisis call center staff within 9-1-1, co-responder teams, and crisis facilities, easily accessible handoffs by LE facilitates connection to treatment instead of arrest. To further incentivize coordination, some contracts confer a "preferred customer" status to LE, so that, for example, response time targets for MCTs are faster for calls that involve LE.

Governance and accountability are key to ensuring that crisis services operate as an organized and coordinated system. In the Arizona model, the RBHA serves this function via its role as the single payer and regulator for the crisis system. Other systems may be governed by counties, cities, or formalized stakeholder groups. Regardless of the convener, advanced crisis systems should have governance and accountability structures that align the various services towards common goals, foster collaboration between a broad array of community stakeholders (e.g., LE, health systems, schools, etc.), operate with a "no wrong door" approach where components collaborate to deliver services without restrictive entry or exclusion criteria, and use data to measure outcomes, make decisions, and improve performance.

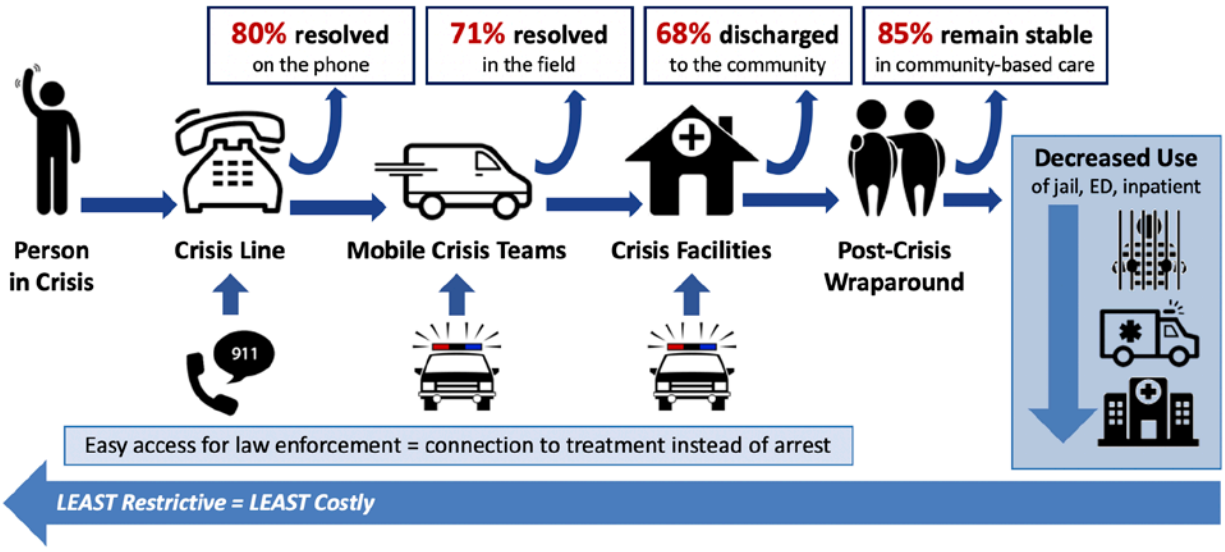

Figure 1. Alignment of crisis services towards a common goal. In a high functioning system, the individual services in the continuum work together to achieve a common goal, in this case, stabilization in

the least restrictive (which is also the least costly) level of care. Data is provided by Arizona Complete Health and applies to the southern Arizona geographical service area for FY2019. Crisis line resolved calls is the percentage of calls resolved without dispatching CMT, LE, or EMS. MCT resolved cases is the percentage of face-to-face encounters resolved without the need for transport to a higher level of care. Crisis facilities community disposition is the percentage of discharges to levels of care other than hospital, ED, or jail. Continued stabilization is the percentage of individuals with an MCT or crisis facility encounter who did not have a subsequent ED visit or hospitalization within 45 days.

"One Mind" Law Enforcement Organizations

Social movements such as Black Lives Matter have motivated communities to examine the role of LE in supporting the safety and welfare of their citizens, and there is growing momentum for policing reforms such as community-oriented policing and procedural justice that seek to improve trust and legitimacy between LE and the communities they serve. The treatment of a community's most vulnerable members plays an important role in building that trust, and thus improved responses to BH crisis are critical to reform efforts.

Like crisis systems, public safety agencies benefit from a broad organizational approach that goes beyond the implementation of a single program or training. The International Association of Chiefs of Police (IACP) created its "One Mind" campaign to encourage this type of systems thinking, challenging LE leaders to begin by committing to three core elements: partnership with community mental health agencies, model policies to guide interactions with individuals experiencing a BH crisis, and training programs built on Mental Health First Aid and CIT.[60]

Figure 2 illustrates how these elements fit together to create a systematic approach across the Tucson Police Department. Leadership provides the foundation by creating the culture and operational procedures needed to support safe and compassionate interactions with people in crisis. Mental Health First Aid training provides a basic level of competency to all officers, while those with the aptitude and interest are encouraged and incentivized to pursue more advanced CIT training. Specialized teams receive further training such as Motivational Interviewing and Trauma-Informed Care and work to develop partnerships with BH agencies and other community partners As they continue to gain knowledge and experience, these specialized teams also serve as subject matter experts to the rest of the organization.

A growing number of LE agencies have developed similarly sophisticated strategies for addressing BH emergencies. The U.S. Department of Justice Bureau of Justice Assistance has identified ten such agencies departments as model programs called Police-Mental Health Collaboration Learning Sites. These agencies serve a wide range of jurisdictions in terms of population size and geographical distribution. Most employ a number of the programs described in this paper, tailored to work for their individual communities. What makes these departments exceptional is that these programs fit within comprehensive, agency-wide approaches in partnership with BH and other social service agencies. Details about each program can be found on the Learning Sites website,[61] and funding is available for site visits and other technical assistance. In addition, the Council of State Governments, which supports the Learning Sites program, has created an online *Police-Mental Health Collaboration Toolkit* to help LE executives to develop or advance approaches to addressing BH crisis.[62]

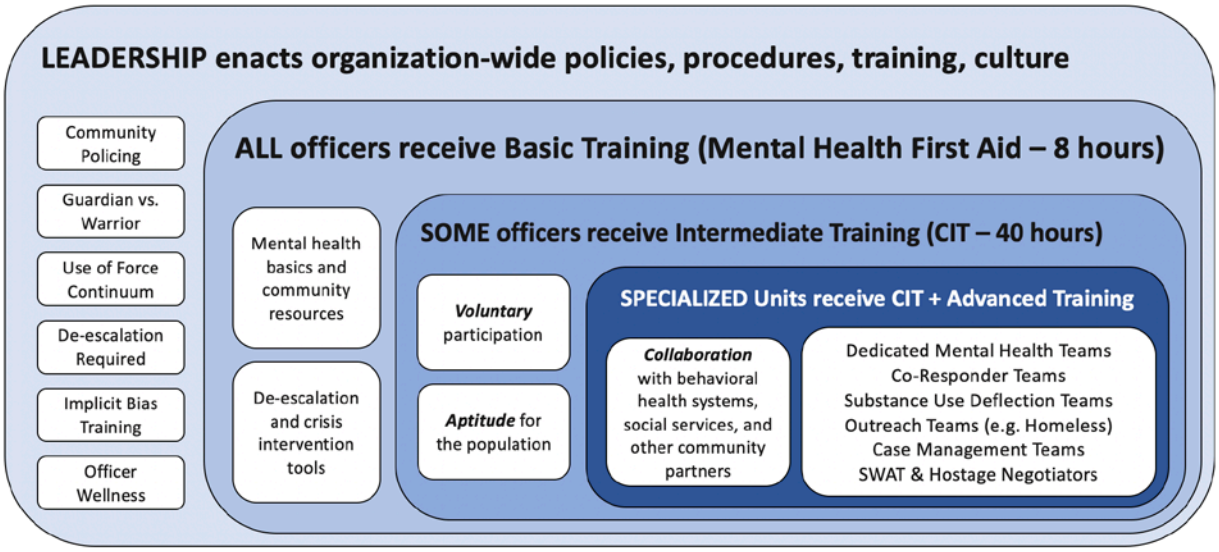

Figure 2: Organizational approach to serving community members with BH needs.

Cost Savings Across Systems

Numerous studies have demonstrated that crisis services reduce spending on ED visits and inpatient hospitalizations. For example, in one study, a mobile crisis intervention decreased spending on inpatient admissions by 79%,[63] and in another, the addition of a clinician co-responder reduced costs by 23% compared to regular policing due to fewer inpatient admissions.[64] A claims analysis of crisis stabilization services estimated a $2.16 return on investment due to savings in inpatient, outpatient, and ED utilization.[65] The Health Care Financial Management Association estimates that eliminating unnecessary ED use for BH emergencies in the U.S. could save as much as $4.6 billion annually.[66]

Better crisis response benefit LE and the justice system as well. CIT training in the Denver Police Department resulted in follow-up care for more than 44% of individuals rather than arrest and incarcerations, saving the state more than $3 million in jail expenses.[67] By changing the response to suicidal patients "barricaded" in their homes, the Tucson Police Department reduced the number of SWAT deployments from 14 per year to 2, at a cost savings of $15,000 each.[68]

The true power of a collaborative approach is illustrated by studies of savings across healthcare and justice systems. Maricopa County, Arizona, has a robust crisis system composed of call centers, mobile teams, and crisis stabilization centers. In 2016, the system served approximately 22,000 individuals and generating savings of $260 million in hospital spending, $37 million in ED spending, 45 years of ED psychiatric boarding hours, and 37 full-time equivalents (FTEs) of police officer time and salary.[69]

IV. Policy Implications

To create high-functioning systems, a range of policies across multiple stakeholders must be put in place.

Civil Commitment and Mental Health Transports

While many people in crisis voluntarily seek care, there remains a subset who lack the capacity to make rational decisions. In these situations, state civil commitment statutes define the role of LE in detaining and transporting individuals involuntarily for psychiatric evaluation.[70] In some states, only LE— not clinicians or family—can initiate the process to petition the court for emergency psychiatric evaluation. Even if civilians can initiate petitions, some states require that the individual's risk of harm to self or other be "imminent." Waiting for the situation to decompensate to the point of present dangerousness creates the conditions for a volatile and risky encounter with LE. Furthermore, existing laws often dictate that involuntary transports to crisis or other treatment facilities must be performed by LE. However, a recent survey of LE agencies estimated that 65% of transports did not pose a risk of harm to others and could be completed by another entity.[71] Many of these laws were written decades ago and should be updated to include earlier interventions and alternative crisis responses rather than relying so heavily on LE. LE should provide transport only when no other means is available to protect the safety of the individual or those providing the transport. The use of handcuffs or physical restraints should be a last resort and limited to those persons who have been identified as risks to themselves or others without the use of restraints.

Regulations and Accreditation Standards

Because most crisis services are funded and regulated at the state or local level, there is wide regional variation in terms of program definitions, licensure, accessibility, and quality. National standards are needed in order to ensure consistent quality across crisis services and systems. The upcoming *21st Century BH Crisis Care* report, created in response to the federal Interdepartmental Serious Mental Illness Coordinating Committee's call for national standards, will be the first attempt at defining measurable standards for a comprehensive crisis system, inclusive of service continuum, governance/finance, and clinical quality.[72] In the meantime, accreditation exists and should be incentivized for some individual crisis programs via organizations such as the American Academy of Suicidology, CARF International, and the Joint Commission.

Standardized practice across the nearly 18,000 LE agencies has been even more challenging. While best practice standards have been proposed through initiatives such as President Obama's 21st Century Policing Task Force[73] and IACP's One Mind Campaign, participation is voluntary. Too often, reform and accountability are only realized after a Department of Justice consent decree is enacted. However, there is growing support for policing reform legislation that include accreditation standards and incentives for LE agencies to adopt more progressive practices.

Financing

With organized governance and financing structures, communities can braid funding streams from federal, state, and local sources to create robust crisis systems that provide both good care and responsible stewardship of public funds. Medicaid in particular is a critical

component of crisis financing, and thus Medicaid expansion is one straightforward strategy for states to enhance crisis funding. All states use Medicaid to finance some degree of crisis services (e.g., reimbursement for billing code "H2011 – Crisis Intervention Service"), but those with managed Medicaid have increased flexibility to fund a wider variety of crisis services via 1115, 1915(b), or 1915(c) waivers. Managed care organizations provide a structure to combine multiple funding streams such as state and local funds earmarked for crisis or indigent care, SAMHSA Mental Health and Substance Abuse Block Grants (MHBG and SABG), and other federal grants such as Projects for Assistance in Transition from Homelessness (PATH) grants and Cross Area Service Program (CASP) grants. Such arrangements maximize efficiency and accessibility by pooling resources to create a common safety-net crisis infrastructure that can serve anyone in need, regardless of payer.[74] Emerging financing models such as value based payments provide additional mechanisms for Medicaid programs to invest in crisis and other social services, and future federal budgets may include a crisis "set aside" in the MHBG.[75, 76]

In contrast, Medicare and most private health plans provide little or no coverage for crisis services. When privately insured individuals receive crisis care, the cost is either uncompensated or borne by public safety-net funds. These payers must be held accountable to provide parity coverage for BH emergency care. The Centers for Medicare and Medicaid Services (CMS) Emergency Triage, Treat, and Transport (ET3) demonstration program provides parity Medicare reimbursement for EMS to transport to "alternative" destinations other than the ED, including crisis facilities.[77] Models like this are a step in the right direction

In communities with robust crisis systems, co-responder and other support personnel can be allocated to collaborate with and assist LE officers without additional cost to LE agencies. There are also federal grants such as the COPS (Community Oriented Policing Services) and Byrne Memorial Justice Assistance Grants that LE may use to create BH programs.

Policy makers, state officials, and payers may express concerns about the costs associated with funding a crisis system. The cost savings described above must be presented in a compelling narrative to convince decision-makers that the costs of *not* doing so is neither good business sense nor good for community health and safety.

Data Sharing and Quality Improvement

Individual-level data sharing can help LE agencies and BH providers coordinate care for individuals involved in both systems. For example, knowing that someone is receiving BH services can help LE officers choose the most appropriate intervention when coming into contact with that individual. Conversely, LE officers often have information about past interactions and psychosocial factors that can aid clinicians in their assessment. When developing data sharing protocols, it is important to reach consensus regarding relevant state and federal laws and to include input from stakeholders with lived experience. The Health Insurance Portability and Accountability Act (HIPPA) is often seen as a barrier but does allow data sharing in emergencies. Data can also be shared via Business Associate Agreements (BAA) or by obtaining consent from the patient.

Data is a powerful tool for quality improvement across the entire system,[78] and performance data will also be increasingly tied to financing as alternative payment models evolve. Data can also be used to improve health equity by deliberately looking at disparities in outcomes among underserved populations. However, very few quality measurement standards exist for BH crisis services. Some standard measures are in use by crisis call centers[79] and a measure set for crisis facilities has been proposed.[80] Reporting through SAMHSA's Uniform

Reporting System, which is already required of states receiving MHBG funds, may be expanded to include crisis metrics if the MHBG crisis services set aside is approved in upcoming federal budgets.[81]

For now, communities will continue to be compelled to define metrics that reflect their values. Aligning metrics across multiple system components can guide the system towards common goals. For example, in Figure 1, the various system components—call center, mobile teams, crisis facilities—report the percentage of patients stabilized without the need for a higher level of care. Each of these measures is one facet of the overarching goal of crisis stabilization in the least restrictive setting possible, and can be organized into a dashboard that monitors performance relative to that goal. System partners can then use real-time outcomes to identify targets for improvement and organize improvement initiatives.

For communities just beginning to organize, data collection can be a good first step. Data helps to engage stakeholders and build the business case for investing in crisis services. Furthermore, data sharing with the public and key community stakeholders can garner trust and legitimacy for LE agencies attempting to improve their approach to BH emergencies.

Stakeholder Engagement and Collaboration

Strong partnerships are critical to generating the enthusiasm to design, fund, and implement crisis systems and ensure they function effectively on an ongoing basis. Potential stakeholders include state and local governmental agencies, payers, LE agencies, emergency management agencies responsible for 9-1-1 dispatch, BH providers, social service agencies, and consumer advocacy groups representing people with lived experience of a BH crisis. Strategic inclusion of elected officials or other influential community leaders can be an effective way to garner support.

How to begin largely depends on the dynamics of each local community. Momentum may come from a variety of stakeholders, including counties seeking to reduce their jail population, EDs overcrowded with psychiatric patients, LE agencies strained by mental health transports, or community leaders galvanized by a tragic outcome involving a person in BH crisis. Collaborative groups can be built upon existing organizational infrastructure (e.g., a county task force) or created *de novo* as an independent group. Most localities already have at least some component of a crisis system in place, and system mapping exercises such as Sequential Intercept Mapping serve as a process to both ensure understanding of the existing context and engage additional stakeholders. Successful collaborations are iterative and longitudinal and may begin with small, simple improvements that require no additional resources (e.g., setting up a process for LE and BH agencies to communicate with one another in certain situations). By building on the success of these "easy wins," partners can progress to more sophisticated solutions. Eventually, the collaborative is no longer building a crisis system but rather monitoring and improving the system they built.

Disparities, Inequity, and Explicit Bias

Solutions will need to take into account the many complexities at play and explicitly address any forces that perpetuate stigma, health inequities, and racism, including how they impact crisis response decisions, service structures, and service delivery. Whenever possible, minorities, people of color, and individuals with lived experience should be involved in system planning to provide their perspectives on what it means to be a truly recovery-oriented, trauma-informed, and culturally responsive system.

V. Conclusion

As communities grapple with BH emergencies, the question isn't *whether* LE should respond to BH emergencies, but rather *when*, *how*, and *with what support*. Both LE agencies and healthcare systems must adopt systems approaches to serving individuals in crisis that strive towards a common goal of connecting people to care in the least restrictive setting, minimizing LE involvement when possible, while ensuring the safety of the individual in crisis, care providers, and the public. Stakeholders will need to collaborate closely to ensure adequate planning, financing, accountability, data collection, and oversight. Successful solutions have the potential to improve health outcomes for individuals in crisis, improve public safety by lessening demand on police, and reduce costs across the healthcare and criminal justice systems. With growing bipartisan support for meaningful change in these complex systems, every effort should be made to seize the moment and improve the accessibility, quality, and equity of BH crisis care in our communities.

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

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