Criminal Legal System Diversion

CREATING AN EFFECTIVE BEHAVIORAL HEALTH RESPONSE SYSTEM

THE PROBLEM

Too many people are involuntarily hospitalized, arrested, injured, or killed by police due to mental health or substance use conditions (together, behavioral health (BH) conditions) and related unmet social service needs. As a result of under-investment in BH treatment and social supports like housing, individuals and their families increasingly find themselves in crisis with nowhere to turn but 911. We have been trained to use our emergency response system for health emergencies, fires, and criminal activity. But BH and social service emergencies are not well handled by an ambulance, a fire truck, or a police officer. Too often, the response to a BH emergency results in a decidedly un-therapeutic result. How can BH crises be prevented in the first place, and how can your first 911 call become your last BH crisis?

How do people end up in a crisis?

Long-standing under-investment in housing, income support, food security, and BH services, as well as associated stigma, have created significant barriers to mental wellbeing and increased risk for onset of mental health and substance use conditions. It is unreasonable to expect a person who lacks a house or regular nutrition to maintain mental wellbeing or treatment participation, and in fact, lack of such basic needs can cause significant trauma and can exacerbate BH symptoms. In fact, 21% of people who are unhoused have a serious mental illness (SMI[1]).[i] Without early treatment and consistent access to treatment when wanted, individuals with BH conditions may experience increasingly challenging symptoms, and their symptoms can interfere with other parts of life like their ability to work or maintain housing. They may end up in a BH crisis – a psychotic episode, suicide attempt, or significant substance use that imminently threatens their health or safety. Many families don't recognize the signs and symptoms of mental health conditions early due to lack of health literacy information and education. Even when they do, it can be very hard to find support in a timely manner. In Massachusetts, the wait for psychiatry intakes can be months even if one can find a practice accepting new patients, and many psychiatrists only accept out-of-pocket payment.

What happens in a crisis?

During a BH crisis, the individual, a family member or loved one, or even a bystander might seek immediate help. The first instincts are usually to call 911 or, if possible, transport the person to a hospital emergency department (ED). But there are other options. Indeed, Massachusetts has a more robust crisis response system than most states, with a state-wide network of Emergency Service Providers (ESPs) available for mobile crisis response and site-based crisis care in sub-acute beds. Most people aren't aware that ESPs exist. Even when an ESP is called, it may not sufficiently meet the immediate needs. Experience

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[1] Serious Mental Illness (SMI) refers to mental health conditions that are considered to be seriously disabling and/or chronic. Many individuals with mental health conditions do not identify with the term "illness" or specific medical diagnoses. MAMH believes that each individual should define their own experience in a way that is meaningful to them, and this brief avoids using the term "illness" unless required by definitions in data sources.

shows that ESP mobile crisis intervention may take too long to respond or fail to come at all; does not accept all types of insurance; and too often re-direct callers to an ED for an intake assessment anyway.[ii,iii]
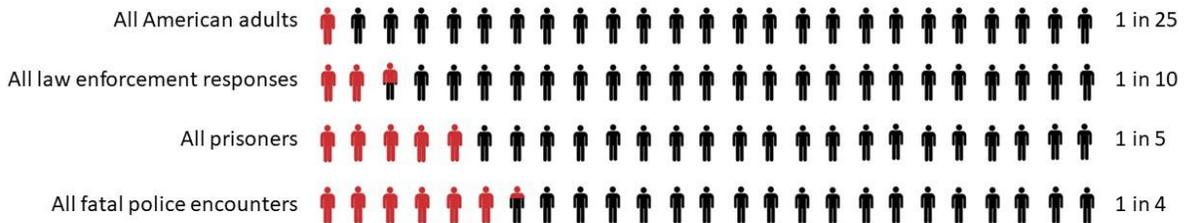
Many people call 911 because it is the most familiar and universal way to respond to an emergency. However, many other people in a BH crisis refuse to use 911 either because of a generalized distrust of the way that police respond based on the racial or ethnic identity of the person or based on an expectation (perhaps based on past negative and traumatic experiences) that police will not be skillful in handling a BH emergency.

911 May Dispatch Police
The concern is well-founded; 911 was not designed to handle BH emergencies. Our emergency response system is designed around fire, medical, and criminal emergencies. When the 911 operator dispatches law enforcement officers, the individual in crisis might feel threatened and/or traumatized. The interactions too often result in arrests and incarceration, and even death. Police often do not have the de-escalation tools they need for this situation, and instead use the tool they have and are trained to use: force. The person in crisis can end up injured, arrested, or killed. People with BH conditions are 16 times more likely to be killed by police than the general public.[iv] In a survey of police chiefs in Middlesex County Massachusetts, the Middlesex County Restoration Center Commission found that up to 75% of officer time may be spent on BH calls for service, though only about 6% of those calls for service are catalogued as such in 911 call logs and dispatch codes.[v]

People with untreated Serious Mental Illness (SMI) are:

All American adults	1 in 25
All law enforcement responses	1 in 10
All prisoners	1 in 5
All fatal police encounters	1 in 4

This mismatch between the type of need and the type of dispatched responder is a contributing factor in the high level of disparity in the arrest of individuals with BH conditions. Nearly 50% of prisoners at the Middlesex Jail & House of Corrections have a mental health condition – 80% of whom have a co-occurring substance use condition – and 75% of prisoners have a substance use condition.[ii] Among longer-term prisoners in Massachusetts, 36% of male and 81% of female prisoners have a mental health condition, while 28% and 75% respectively have a serious mental health condition.[vi] Nationally, seventy percent of youth in the juvenile justice system have a diagnosable mental health condition.[i] Similarly, between 60 and 70% of Massachusetts youth in the custody of the Department of Youth Services (the juvenile justice carceral entity) have been found to have at least one mental health condition.[vii]

Jails and prisons are intentionally places of significant liberty restrictions and, often, of trauma, which is widely understood to be highly correlated with mental health symptoms.[viii] People with BH conditions are disproportionately punished in jail and prison; an estimated 4,000 people with SMI are held in solitary

confinement inside of US prisons. Suicide is the leading cause of death for people held in local jails.[i] BH symptoms can thereby be exacerbated by institutional settings, increasing the likelihood of potential future encounters with emergency services and repetition of this cycle. The disparity among individuals with BH conditions being over-represented in the criminal legal system is highly related to the racial and ethnic disparities in that system: among incarcerated people with a mental health condition, non-white individuals are more likely to be held in solitary confinement, be injured, and stay longer in jail.[i]

911 May Dispatch Emergency Medical Services (EMS)
A traditional medical response that can be dispatched in response to a 911 call also is not ideal: the individual in crisis might be transported to an ED with the goal of evaluation and hospitalization. One in eight visits to the ED nationwide are related to BH conditions.[i] However, for a number of reasons, including a lack of community crisis stabilization options and a shortage of available BH hospital beds, the person may spend days or even weeks in the ED with no psychiatric treatment waiting for that hospitalization.[ix] This time spent untreated, waiting for a hospital bed is referred to as "ED boarding," and in addition to being traumatic for the individual, it is expensive and resource-consuming for the healthcare system. The Health Policy Commission found that though individuals with a BH diagnosis only accounted for 14% of ED visits in 2015, they accounted for 71% of all ED visits that boarded. The percentage of all individuals boarding in ED's increased from 17% in 2011 to 23% in 2015.[x] In addition to the trauma experienced by a patient while boarding in an ED, involuntary hospitalization is a particularly traumatizing experience due to the removal of rights to personal choice and the medicalized hospital environment. Further, hospitalization itself is often not necessary to treat a mental health emergency; some hospitalizations could be avoided entirely or diverted to alternative levels of care if those care alternatives included crisis stabilization, intensive outpatient, in home services, and respite capacity, with appropriate levels of social supports and staffing levels.

Upon release from prison or jail, a person's life may be upended. While confined, they may have lost a job or their housing. Those most basic human needs – which can be referred to as "social determinants of health" – are essential to a person's ability to engage in any kind of follow-up treatment needed to maintain their wellness and prevent future crises. Without a stable home, when struggling to meet basic needs, how can a person be expected to manage daily routines, medical necessities, and scheduled obligations like personal hygiene, taking medication or going to regular doctor's appointments? This is why 68% of people released from prison and jail ultimately are arrested again[xi] – because the experience interrupts basic life necessities so deeply that it is hard to put the pieces back together, and many are discharged from those settings to homelessness and insecure housing situations.

Similarly, transition from a hospital can be a critical and fragile time for an individual with a BH condition. Like persons released from jails and prisons, a hospitalized person may also have lost a job or their housing. One out of seven people who died by suicide had contact with inpatient mental health services in the year before their death. In fact, in the month after a patient leaves inpatient psychiatric care, the suicide death rate is 200 times higher than that of the general population.[xii] Massachusetts readmission rates for state psychiatric hospitals were 8.7% of all admissions within 30 days of release and 11.1% of all admissions within 180 days of release; Massachusetts ranks 18th highest in the nation on the former metric.[xiii] Among all inpatient psychiatric hospitals nationwide, unplanned re-admissions within 30 days of discharge are about 21%.[xiv]

CREATING A BEHAVIORAL HEALTH EMERGENCY RESPONSE SYSTEM

An ideal BH system would preserve dignity and respect personal choice while preventing cycles of continued negative engagement with the health and criminal justice systems, and would include:

Accessible Early Intervention and Treatment and Investment in Social Determinants of Health
First, we need accessible early intervention and outpatient treatment programs that people want to use. The use of involuntary interventions should be minimized and discouraged. Requiring parity of BH care to physical health care would help to achieve this by ensuring that health insurance covers fundamental health needs and that primary care practitioners or licensed BH providers and the individuals themselves, not insurance administrators, get to decide what care a person wants and needs. The public must be educated and provided adequate information on recognizing BH crises, how to seek help early, and what warrants a crisis response phone call. We need to recruit and retain a more diverse BH workforce to ensure that people from all backgrounds can receive linguistically and culturally responsive services. The workforce should include "peer supporters" – that is, persons with lived experience with the mental health system. Social determinants of health must be met to ensure that all people can maintain their wellness unhindered by concerns about where they will sleep or how they will eat. These are the necessary components of a system that prevents BH crises in the first place.

988: A New Behavioral Health Emergency One-Stop Shop
Even with the best systems in place, some individuals will still have a BH crisis. We must be prepared to respond to a crisis without causing further trauma to the individual and setting up the individual to succeed after the crisis. To do this, we must create a specific BH emergency response system. First, a separate BH emergency phone number – 988 – would provide an alternative to the 911 emergency system, which is forced to handle situations it was not designed for.

988 would open the door to a suite of services that could be deployed as needed to meet the specific needs of individuals and families, and would be designed to favor the least restrictive possible setting to reduce the trauma experience. These services could include:

Case Study: Tucson[xv]
Pima County, Arizona has developed many of the elements we present here:
- A crisis call center co-located with 911 with crisis chat and text;
- Mobile crisis intervention that can be dispatched by the crisis call center;
- A Crisis Center location where individuals can be transported by mobile crisis clinicians, police, or themselves or a loved one; and
- After-care planning and supports that prevent future crises.

- *Crisis chat and text:* Experienced BH professionals would talk to the person in crisis, attempt to de-escalate over the phone, wherever the person is, and connect the person to BH and social supports, for example by scheduling a future outpatient psychiatry appointment right there on the phone. In Tucson, 80% of calls are resolved in this way (see case study);[xv]
- *Mobile crisis intervention:* If it is not possible to resolve the crisis remotely, a BH professional can go to wherever the person in crisis is located whether that is a home, a commercial setting, or elsewhere in the community. The BH professional would then attempt to de-escalate the crisis and provide similar follow-up supports to the individual to maintain their wellness in the future. In Tucson, 68% of crises that call for mobile crisis intervention are resolved this way; [xv]
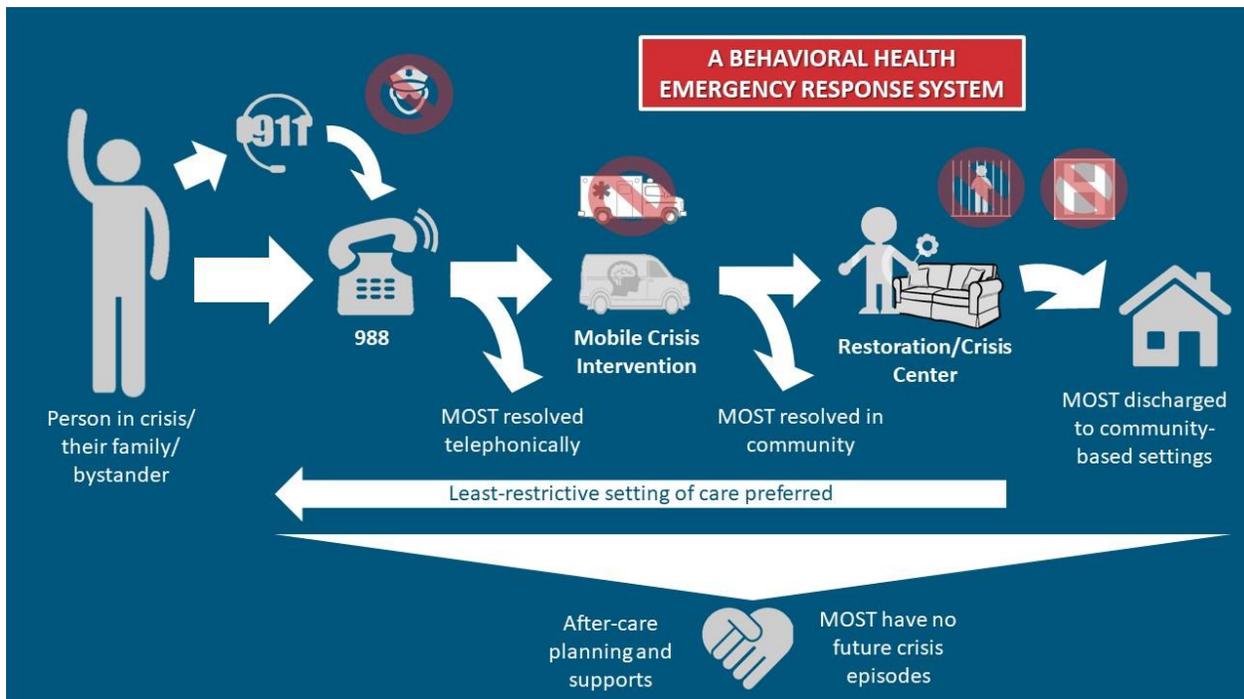
- *Restoration center or crisis center and Living Room or peer respite:* Some people might require more immediate care in a location with more resources than are available to crisis BH professionals in the field. That might mean the person is acting in ways that feel threatening to those around them, or the person might have drugs or alcohol in their system at a level that is unsafe. They might simply need a place to go away from the environment they were in at the time of crisis. In such cases, a crisis services center like those run by ESPs, Restoration Center[v], Living Room, or peer respite site (like Afiya in Western Massachusetts, run by the Widflower Alliance) could provide a more welcoming, less institutional, and therefore more therapeutic setting for care. Such a location might provide triage and assessment (at crisis centers and Restoration Centers); a place to sleep staffed by a clinical and social support team with access to medical care as needed; information and access to medications and medication adjustments (at crisis centers and Restoration Centers); urgent and crisis therapeutic interventions; peer support; and a multi-service center with social workers and peer supporters who can help navigate housing, food assistance, legal services, and other resources (in the case of a Restoration Center, Living Room, or peer respite). In Tucson, 60% of individuals who go to the crisis center are discharged to the community, and not to a hospital; 80% of those individuals remain stable in community-based care, without having another crisis episode; [xv] and
- *Aftercare planning and supports:* Each component of 988 should include real-time connections to medium- and long-term treatment and supports like outpatient treatment, detoxification, residential treatment, housing navigation, and other supports needed to prevent future crises.

This suite of services could reduce the number of people who are brought to a hospital setting or who interact with police. This might allow for those individuals who truly require hospitalization for their BH emergency to get treatment immediately, without boarding in EDs.

A BEHAVIORAL HEALTH EMERGENCY RESPONSE SYSTEM

988 — Person in crisis/ their family/ bystander — MOST resolved telephonically — Mobile Crisis Intervention — MOST resolved in community — Restoration/Crisis Center — MOST discharged to community-based settings

Least-restrictive setting of care preferred

After-care planning and supports — MOST have no future crisis episodes

Reduce Harm in the Current 911 System

It is likely that some people will continue to call 911 during a BH emergency instead of calling 988. In those cases, our existing emergency response system must do a better job of triaging calls and routing the ones that can be handled by the 988 system to that call center. This will require:

- *Reviewing 911 dispatch scripts:* Updating 911 dispatcher call scripts and dispatcher training to specifically seek out calls that can be diverted to therapeutic, BH crisis response;
- *Correctly documenting BH 911 calls:* Creating call codes in the computer-aided dispatch (CAD) systems for BH emergencies to adequately document those cases in which calls can be diverted;
- *Diverting more 911 calls to 988:* Establishing systems for warm hand-off of 911 calls to 988 operators, either by co-locating call centers or ensuring formal protocols live transfer of calls;
- *Investing in more co-responders:* Expanding the number of BH clinicians who go out on BH 911 calls alongside police officers (called co-responders). The primary program in Massachusetts that funds these professionals is the Jail Diversion Program at the Department of Mental Health; this program ought to be funded to a level supporting co-responders on all shifts for all police departments statewide. This and other co-responder programs funded directly by police departments or non-profits should also integrate peer supporters on such teams. The state should also create a program for social workers who can also respond to 911 calls to help address problems with housing, income and food security, and other social determinants of health; and
- *Reducing risk to the individual in crisis in those cases when law enforcement must respond:* Establishing protocols that reduce the likelihood of police harming an individual if a 911 call warrants officer involvement (for example, if a person in BH crisis has a weapon):
  - Improving CIT to meet the fidelity metrics of the Memphis Model, which has been shown to reduce arrest and harm to individuals by establishing a police management structure that solicits citizen input and specifically dispatches specially trained officers to such calls,
  - Dispatching co-responders as often as possible,
  - Ensuring that BH professionals are in the lead on scene, and
  - Training law enforcement officers in verbal de-escalation tactics and less lethal forms of physical intervention (called Crisis Intervention Training).

Prevent Future Crises Through More Therapeutic Institutional Environments

For those individuals who do end up in hospital, jail, or prison, reducing the trauma experienced there and providing therapeutic environments as well as focused aftercare planning with follow-up can reduce the high rate of follow-on crises that cause high rates of re-hospitalization and recidivism.

CONCLUSION

People with BH conditions experience significant disparities in a lack of preventative treatment leading to traumatic hospitalization and ED boarding; criminal legal system involvement; and harm caused by police. Many of these disparities intersect with discrimination experienced by people of color. Reversing these disparities will require investments in prevention, a range of treatment options, and a comprehensive and coordinated BH crisis and emergency response system. Such a system would create a suite of services under the auspices of a dedicated BH emergency line using 988, as well as changes to the way 911 dispatch and policing happens. Finally, reducing criminalization of BH conditions also requires better treatment inside jails and prisons, and better reentry transition services for individuals.

For more information or to get involved, contact President and CEO Danna Mauch, PhD, at dannamauch@mamh.org.

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