

WORKING ACROSS SYSTEMS FOR BETTER RESULTS:

CITY EFFORTS TO ADDRESS MENTAL HEALTH, SUBSTANCE USE AND HOMELESSNESS THROUGH EMERGENCY RESPONSE AND CRISIS STABILIZATION

The second in a series of issue briefs examining city-level approaches to emergency response and crisis stabilization.

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Key Takeaways

- 1. Cross-system approaches can produce better outcomes for vulnerable populations during emergency and crisis stabilization responses.** Instead of organizations working in silos, cross-system collaboration can enable stakeholders in a community to leverage their skills, expertise, and resources to more effectively assist vulnerable populations.
- 2. First responders play a unique role in emergency response and crisis stabilization initiatives by serving as an entry point to broader systems of care.** By diverting vulnerable individuals to vital services and supports, first responders can help individuals receive the care and services they need while avoiding incarceration.
- 3. Several cities across the country attribute the success of their emergency response and crisis stabilization efforts, in part, to cross-system collaboration.** These cities serve as exemplars to other cities as they work towards developing more effective emergency crisis and stabilization responses to help support individuals with mental illness, substance use disorder and/or experiencing homelessness.

Mental illness, substance use disorder, and homelessness affect millions of Americans each year.^{1,2,3} Cities are on the front line of addressing these complex health and social conditions. These issues pose significant, interconnected challenges that are best met through a coordinated response that includes first responders (e.g. police, fire and EMS), hospitals/emergency departments, jails/prisons, courts, housing authorities and key community partners.

Definitions

Emergency response means targeted programs that strengthen the capacity of police, fire, paramedics and/or EMS/EMTs to recognize and respond to individuals experiencing mental illness, substance use disorder and/or homelessness and to safely de-escalate emergency situations.

Crisis stabilization means targeted programs to maximize diversion to long-term preventative treatment and services instead of arrest, which could potentially lead to people cycling through jails and hospital emergency rooms. Crisis stabilization responses include the initial encounter as well as up to 72 hours of stabilization or linkage to services.

Background

The scope and impact of these issues are immense. The first issue brief in this series, "[Mental Illness, Substance Use, and Homelessness: Advancing Coordinated Solutions through Local Leadership](#),"⁴ explores the scope of the problem and introduces innovative approaches that cities are using to maximize diversion to preventive treatment and services. While it is important that all levels of government are engaged in addressing these conditions, cities play a unique and important role as they are on the front lines in communities and act as providers of emergency response and crisis stabilization services. Increasing awareness regarding the complexity and interconnectedness of mental illness, substance use disorder and homelessness are prompting cities across the country to reexamine their approaches and to develop and adapt new, better coordinated systems of response. Effective approaches, like the ones described in this issue brief, acknowledge the broad impact of cross-system collaboration for individuals and cities affected by mental illness, substance use disorder and homelessness.

Cross-System Collaboration

Researchers define cross-system collaboration as "the linking or sharing of information, resources, activities, and capabilities by organizations in two or more sectors to achieve jointly an outcome that could not be achieved by organizations in one sector separately."⁵ Providers of services for vulnerable populations recognize cross-systems approaches are an integral part of caring for those with trauma,⁶ which is a "near universal" experience for those with behavioral health conditions like mental illness and substance use disorder.⁷ Cross-system collaboration offers a variety of benefits, including more efficient allocation of resources, creation of a continuum of support so that individuals are aided in all facets of their lives, and shared performance measures that can assess the efficacy of all systems involved.⁸

Cross-system collaboration is crucial in addressing mental health and substance use crises as well as homelessness because of the range of needs that people in crisis experience and the number of systems they affect. In this context, collaboration brings together agencies and individuals from multiple sectors, including first responders (police, fire, EMS), hospitals and emergency rooms, housing authorities, transportation, courts, religious organizations and other community stakeholders to provide critical supports to individuals in crisis. Working in concert, cross-systems approaches help vulnerable populations access more appropriate treatment and support services. Many cities across the United States have been adopting and embracing a cross-system collaboration approach and are experiencing positive impacts.

Crisis Stabilization in Huntington, West Virginia⁹



In its 2017 strategic plan to address the opioid crisis in Huntington, in collaboration with Cabell and Wayne counties, the Huntington Mayor's Office of Drug Control Policy revealed some important statistics: Area recovery centers could treat and house individuals with behavioral health issues for under \$30 per day compared to the \$48.25 per day cost of incarcerating individuals with low-level drug and alcohol offenses.¹⁰ These potential cost savings, and the potential of better overall outcomes for individuals, encouraged the city to create their Quick Response Team (QRT).

The QRT is an innovative partnership among city agencies, medical providers, mental health specialists, law enforcement, university researchers and the faith community aimed at providing crisis stabilization and support for people who recently experienced an overdose. The QRT attempts to visit every overdose patient in Huntington to assess individual needs, develop a personalized plan for intervention and connect them to local resources.

The process begins when a person calls 911 and an EMS team is dispatched to respond to the call. The QRT then screens records to identify eligible QRT participants. QRT eligible participants are individuals who live within Cabell County and who are identified as needing an intervention based on their substance use. The QRT includes a team consisting of an EMS practitioner, a mental health provider or a certified peer recovery coach, a law enforcement officer in plain clothes and a faith leader who follow up with the individual who has experienced an overdose within 72 hours. Every QRT member has been trained in Screening, Brief Intervention, Referral to Treatment (SBIRT) and motivational interviewing through Marshall University, the local college in Huntington.

During their visits, QRT speaks with each individual to assess their needs and works to connect them to the region's numerous addiction service providers and other supports. These resources include PROACT, a "one-stop shop" for outpatient addiction treatment and support center; Project Hope, a residential treatment facility that enables mothers with substance use disorder to live with their children; and the Presteria Center, an inpatient and outpatient treatment center. Marshall University Public Health department provides evaluation and assessment of QRT practices.¹¹

While the program is in its infancy, it has realized some success. Between December 2017 and July 2018, there were 650 overdoses in Huntington.¹² The QRT was able to contact over half of the individuals who experienced these overdoses and more than one quarter agreed to enter treatment.¹³

The Expanded Role of First Responders

The closure of many long-term psychiatric hospitals in the United States (a historical trend also known as deinstitutionalization) and a lack of mental health services to replace them has left a gap in nearly every community. That's why there's an increasing demand for first responders, including police, fire and EMS, to engage with individuals experiencing crisis due to mental illness, substance use disorder and homelessness. In response to this increasing need, the Crisis Intervention Team (CIT) model,¹⁴ described in the [first issue brief](#), was created to better equip police in their expanded role as "mental health interventionists."¹⁵

Traditional approaches to addressing these challenges have often involved funneling vulnerable individuals into emergency rooms or jails and prisons and later discharging them back into the community without establishing connections to further treatment or support services. Many cities are recognizing the shortcomings of these tactics and are adopting new approaches that intentionally establish and foster collaboration among first responders and other behavioral health and social service system providers, with the goal of connecting people experiencing behavioral health issues and/or homelessness to preventive treatment to improve their lives and reduce or eliminate their contact with the justice system.

Emergency Response in San Antonio, Texas¹⁶



The San Antonio Police Department (SAPD), like many police departments in the country, has received an increasing number of emergency behavioral health calls over the last several years.¹⁷ SAPD's Mental Health Detail (MHD), established in 2008, is the primary unit tasked with addressing these calls. The SAPD Mental Health Detail began with a team of two officers trained in CIT to effectively respond to calls from people in mental health crisis, deescalate mental health emergencies and coordinate treatment with local behavioral health providers. It has subsequently expanded to include ten officers, two detectives and several social service and healthcare providers, including a Licensed Professional Counselor (LPC), a Licensed Master Social Worker (LMSW) and a Qualified Mental Health Professional (QMHP) contracted to the city from Baptist Healthcare System to meet demand. Local community behavioral health providers also provide expert training to the detail in serious mental illnesses.

The MHD's work typically begins when 911 dispatchers send patrol officers to respond to calls. If a situation is confirmed to involve an individual experiencing a mental health crisis, the responding officer will hand off the case to the MHD. Specially trained officers assigned to the MHD respond to calls in plain clothes and arrive in unmarked cars. The team assesses the individual and transports them to the appropriate facility. The MHD responded to 1,825 calls in 2017 of which 758 were taken to a behavioral health facility and placed under an emergency detention including 38 where emergency detention occurred in lieu of arrest.¹⁸ There were two uses of force in response to MHD calls in 2017, a 50 percent reduction in use of force from 2016.¹⁹ The SAPD places an emphasis on steering individuals experiencing behavioral health crises toward treatment instead of arrest and incarceration whenever possible.

Another unique and effective partnership is the SAPD's Integrated Mobile Partners Action Care Team (IMPACT). IMPACT unifies the SAPD Mental Health Detail, the San Antonio Fire Department EMS Mobile Integrated Healthcare Team and local behavioral health and social service providers to assist individuals

experiencing chronic homelessness. This cross-systems approach removes barriers to treatment by ensuring that case management is available from emergency response to crisis stabilization to treatment. Upon coming into contact with the team, individuals experiencing homelessness who are willing to accept help are transported and connected to social services and healthcare treatment.²⁰ Of the 3,030 contacts the IMPACT program made from October 2015 through February 2018, over half were referred to behavioral health or social providers.

The potential benefits of cross-system collaborations in emergency response and crisis stabilization can be significant for both providers and those receiving services. For providers, cross-system approaches can reduce workload on already overburdened systems like jails and emergency departments. They can also reduce the use of force, as has been the case in San Antonio. For those served, a collaborative cross-system approach may play a role in improving their well-being.

Emergency Response in Wichita, Kansas²¹



Wichita is the largest city in Kansas and home to the largest homeless shelter in the state. Consequently, individuals who experience homelessness in Kansas often find themselves in Wichita. Between 2009 and 2011, the prevalence of chronic homelessness in the city doubled, and officers found themselves responding to an increasing number of emergency calls related to homelessness. In response, the Wichita Police Department (WPD) began a pilot program establishing a Homeless Outreach Team (HOT) in February 2013.

The program's team consists of three specially trained police officers who partner with community stakeholder organizations across the city to connect individuals experiencing homelessness to support and services in lieu of ticketing and arrest. HOT officers receive 10 hours of classroom training and then one to two months of on-the-job training to perform their duties. HOT officers must also be certified in CIT and seek annual homelessness-related trainings as part of their continuing education in homelessness intervention.

The HOT's intake process typically begins when there is a call for service (CFS) for a welfare check, panhandling or other homelessness-related situations to which the HOT is dispatched directly. This may occur through traditional emergency dispatch, but there is also a HOT hotline and email address that citizens, including the business community in Wichita, can utilize to initiate the team's dispatch. If the HOT is unavailable, patrol officers responding to the scene have a number of ways to connect to HOT including warm hand-offs when the HOT becomes available, flagging scenes for HOT follow-up or giving individuals experiencing homelessness the phone number to contact HOT directly.

Once a HOT officer arrives at the scene, the officer completes an intake interview and HOT form used to understand the individual's circumstances; determines if they have any income, disabilities or other factors that may assist in connecting with specific programs; and obtains permission to share details with referral agencies. Individuals with disabilities may be eligible for referral to federal²² or private rapid rehousing,²³ where they can be provided with temporary rental and deposit assistance to help them avoid or quickly transition out of homelessness. Individuals experiencing homelessness with co-occurring mental illness may be referred to COMCARE, a local behavioral health service provider with a Crisis Stabilization Unit.²⁴

The HOT also operates as part of the city's Continuum of Care (CoC) which receives funding from the U.S. Department of Housing and Urban Development (HUD) to comprehensively address homelessness. HOT officers attend all CoC and other homelessness-related stakeholder meetings throughout Wichita, alongside housing, behavioral healthcare and other service providers, to coordinate Wichita's more comprehensive response to homelessness. The HOT team also engages the community by conducting training for business owners on how to communicate with individuals experiencing homelessness and educates community groups on how to support the existing homelessness programs and service providers.

Wichita's HOT is now a permanent program with three full-time officers and has received national recognition as an exemplar for other cities.^{25,26} Since its inception in 2013, the HOT and its cross-systems partners have placed over 1000 people into permanent or transitional housing and have managed to reduce the city's chronic homeless population by 77 percent. Research suggests chronic homelessness can cost taxpayers \$30,000 to \$50,000 per year per individual experiencing homelessness²⁷ which could suggest significant cost savings associated with the work of the HOT and its partners.

Next Up: Overcoming Barriers to Development and Implementation

Challenges exist when developing and implementing city-level approaches in emergency response and crisis stabilization for those experiencing mental illness, substance use disorder and/or homelessness. The next issue brief will explore barriers to establishing and implementing these programs and will share how cities manage to overcome these barriers to achieve better emergency response and crisis stabilization for their vulnerable populations.

About this Issue Brief Series

This issue brief is the second in a series of issue briefs that discusses city-level approaches and practices for emergency response and crisis stabilization for individuals experiencing mental illness, substance use disorder and/or homelessness. The first issue brief in this series, "[Mental Illness, Substance Use, and Homelessness: Advancing Coordinated Solutions through Local Leadership](#),"²⁸ explores the scope of the problems posed by mental illness, substance use disorder and homelessness and introduces innovative approaches that cities are using to maximize diversion to treatment and services. This second issue brief explores these and other approaches in greater detail with a focus on the cross-system nature of these approaches.

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About this Project

With support from Arnold Ventures, the National League of Cities (NLC) is exploring city-level approaches and practices surrounding emergency response and crisis stabilization for individuals suffering from mental illness, substance use disorder and/or homelessness. The broad goal of this project is to provide a resource to help city leaders implement effective strategies for emergency response and crisis stabilization for individuals with mental illness, substance use disorder and/or experiencing homelessness. City leaders may adapt the strategies included here to address their city's specific challenges with mental illness, substance use disorder and homelessness.



ENDNOTES

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