Human Development

2020 Congressional City Conference
Marriott Wardman Park Hotel
Washington Room 3
Sunday, March 8, 2020
1:30 p.m.
## Agenda: Human Development

Marriot Wardman Park Hotel  
Room: Washington 3  
Washington, DC

**Sunday, March 8**

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<tr>
<th>Time</th>
<th>Session</th>
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<tr>
<td>1:30 p.m.</td>
<td><strong>WELCOME, INTRODUCTIONS AND MEETING OVERVIEW</strong></td>
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<td><strong>The Honorable Lindsey Horvath, Chair</strong></td>
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<td><em>Mayor Pro Tem, West Hollywood, CA</em></td>
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<td>Introductions and explanation of expected outcomes for the meeting. Report from NLC Board meeting and review of the 2020 HD legislative priorities.</td>
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<td>1:45 p.m.</td>
<td><strong>SUBSTANCE USE AND ADDICTION</strong></td>
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<td><strong>Johnnetta Davis-Joyce</strong></td>
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<td><em>Director of Center for Substance Abuse Prevention (CSAP)</em></td>
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<td><em>Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services</em></td>
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<td>Committee members will hear an update on the work that the Substance Abuse and Mental Health Services Administration has been conducting through the Center for Substance Abuse Prevention to develop policies, programs, and services to prevent the onset of illegal drug use, prescription drug misuse and abuse, alcohol misuse and abuse, and underage alcohol and tobacco use; and promote effective substance abuse prevention practices that enable states, communities, and other organizations to apply prevention knowledge effectively.</td>
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<td>2:05 p.m.</td>
<td><strong>NLC OFFICER GREETING</strong></td>
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<td>• <strong>The Honorable Joe Buscaino, President, National League of Cities</strong></td>
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<td><em>Councilmember, Los Angeles, California</em></td>
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<td>2:45 p.m.</td>
<td><strong>OVERVIEW NLC FEDERAL ADVOCACY PRIORITIES</strong></td>
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<td><strong>Stephanie Martinez-Ruckman</strong></td>
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<td><em>Legislative Director, Human Development, Federal Advocacy National League of Cities</em></td>
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<td>Committee members will hear an update on NLC’s Leading Together 2020 Cities Agenda, as well as other NLC federal advocacy priorities and issues before Congress, the Administration and the courts.</td>
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| 3:00 p.m. | AGING IN PLACE               | Nancy LeaMond  
EVP and Chief Advocacy and Engagement Officer, AARP  
The Honorable Andy Berke  
Mayor, Chattanooga, TN  
The Honorable Cyndy Andrus  
Mayor, Bozeman, MT |

Committee members will be engaged in conversation about the policies and practices across the country that are working to create more accessible and age-friendly communities. The conversation will touch on national trends and congressional action, as well as highlight the innovative programs on the ground in Chattanooga and Bozeman.

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<th>Time</th>
<th>FUTURE OF WORK</th>
<th>Speaker(s)</th>
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| 4:00 p.m. | FUTURE OF WORK               | Brooks Rainwater  
Senior Executive & Director, Center for City Solutions  
National League of Cities  
Jennifer Steinfeld  
Director of Entrepreneurship and Economic Development, Center for City Solutions  
National League of Cities |

The future of work, and the dignity and economic security of workers, are under threat, and this year NLC is launching a new opportunity around the future of work and workers, and we invite your city to join us. We are asking city leaders to commit to creating the right policies, programs, and practices to ensure their communities can thrive in the global, innovation-driven economy -- NLC helps participating cities reach their goals by partnering with national experts, and jointly providing technical assistance, seed funding, and peer learning. Brooks and Jennifer will share this opportunity with the Committee and answer any questions.

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<th>Time</th>
<th>WRAP UP AND ADJOURNMENT</th>
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**Attachments:**
- Committee Roster
- Hill Talking Points
- COVID-19 Blog
- Homelessness, Mental Health and Substance Use Briefs

**Next HD Committee Meeting:**
NLC Summer Board and Leadership Forum  
Los Angeles, California  
June 17-19, 2020
NLC POLICY DEVELOPMENT AND ADVOCACY PROCESS

As a resource and advocate for more than 19,000 cities, towns and villages, the National League of Cities (NLC) brings municipal officials together to influence federal policy affecting local governments. NLC adopts positions on federal actions, programs and proposals that directly impact municipalities and formalizes those positions in the National Municipal Policy (NMP), which guides NLC’s federal advocacy efforts.

NLC divides its advocacy efforts into seven subject areas:
- Community and Economic Development
- Energy, Environment and Natural Resources
- Finance, Administration and Intergovernmental Relations
- Human Development
- Information Technology and Communications
- Public Safety and Crime Prevention
- Transportation and Infrastructure Services

For each of the seven issue areas, a Federal Advocacy Committee advocates in support of NLC’s federal policy positions. Members of each Committee serve for one calendar year and are appointed by the NLC President.

Federal Advocacy Committees
Federal Advocacy Committee members are responsible for advocating on legislative priorities, providing input on legislative priorities, and reviewing and approving policy proposals and resolutions. Additionally, Committee members engage in networking and sharing of best practices.

Federal Advocacy Committees are comprised of local elected and appointed city and town officials from NLC member cities. NLC members must apply annually for membership to a Federal Advocacy Committee. The NLC President makes appointments for chair, vice chairs, and general membership. In addition to leading the Federal Advocacy Committees, those appointed as Committee chairs will also serve on NLC’s Board of Directors during their leadership year.

At the Congressional City Conference, Federal Advocacy Committee members are called upon to advocate for NLC’s legislative priorities on Capitol Hill, as well as develop the committee’s agenda and work plan for the year. Committee members meet throughout the year to further the plan, hear from guest presenters, discuss advocacy strategies and develop specific policy amendments and resolutions. At the City Summit, Committee members review and approve policy proposals and resolutions. These action items are then forwarded to NLC’s Resolutions Committee and are considered at the Annual Business Meeting, also held during the City Summit.

Advocacy
Throughout the year, Committee members participate in advocacy efforts to influence the federal decision-making process, focusing on actions concerning local governments and communities. During the Congressional City Conference, Committee members have an opportunity, and are encouraged, to meet with their congressional representatives on Capitol Hill. When NLC members are involved in the legislative
process and share their expertise and experiences with Congress, municipalities have a stronger national voice, affecting the outcomes of federal policy debates that impact cities and towns.
2020 Human Development (HD) Committee Roster

Chair
Lindsey Horvath
Mayor Pro Tem
West Hollywood, CA

Vice Chair
Elizabeth Carr-Hurst
Mayor
Fairburn, GA

Vice Chair
Kristin Stephens
Mayor Pro Tem
Fort Collins, CO

Fabian Bedne, Planner, Neighborhood Development, Infrastructure, City of Nashville-Davidson, TN
Gale Brewer, Manhattan Borough President, City of New York City, NY
Sadie Britt, Council Member Ward 1, City of Lincoln, AL
Chris Callender, Council Member Ward 1, Village of Oakwood (Cuyahoga County), OH
Elizabeth Carr-Hurst, Mayor, City of Fairburn, GA
Yvette Colbourne, Commissioner, City of Miramar, FL
Sona Cooper, Alderwoman, Town of Spring Lake, NC
Amber Corrieri, Council Member, At Large, City of Ames, IA
Luke Feeney, Mayor, City of Chillicothe, OH
Nicole Frank, Mayor Pro Tem, City of Commerce City, CO
Rose Glover, Mayor Pro Tem District 2, City of Greenville, NC
Blaine Griffin, Council Member, City of Cleveland, OH
Laney Harris, Board Member, City of Texarkana, AR
Francisco Heredia, Councilmember District 3, City of Mesa, AZ
Lindsey Horvath, Mayor Pro Tempore, City of West Hollywood, CA
Nathan Johnson, Mayor, City of Yankton, SD
Lioneld Jordan, Mayor, City of Fayetteville, AR
Teresa Keng, Councilmember, City of Fremont, CA
Mario King, Mayor, City of Moss Point, MS
Kacy Kostiuk, Councilmember, Ward 3, City of Takoma Park, MD
Mike Lockhart, Council Member, City of Muscle Shoals, AL
Leta Mach, Council Member, City of Greenbelt, MD
Shireka McCarthy, Councilmember At-Large, City of Seat Pleasant, MD
Teresa Mosqueda, Council Member, Position 8, City of Seattle, WA
Todd Nock, Mayor Pro Tem, City of Pocomoke City, MD
Manuel Pelaez, Council Member District 8, City of San Antonio, TX
Dick Pelley, Council Member, City of Athens, TN
Jaime Resendez, Council Member, City of Dallas, TX
Cristal Retana, Council Member, City of Farmers Branch, TX
Cheryl Richardson, Councilmember, City of Marietta, GA
Sonya Sanders, Council President, Borough of Norristown, PA
Rosa Santana, Alderman, Ward 13-D, City of New Haven, CT
Sharmin Shahjahan, Trustee, Village of Hanover Park, IL
Willie Shaw, Commissioner, City of Sarasota, FL
Karl Skala, Mayor Pro Tem & Ward 3 Councilmember, City of Columbia, MO
Kristin Stephens, Mayor Pro Tem, City of Fort Collins, CO
Casey Thomas, Council Member, City of Dallas, TX
Yolanda Trout-Manuel, Councilmember, City of Auburn, WA
Laura Weinberg, Mayor-elect, City of Golden, CO
Beverly Williams, Commissioner, City of Lauderdale Lakes, FL
2020 Legislative Priorities for Cities, Towns and Villages

We NEED to Build Sustainable Infrastructure and a Skilled Workforce

Investing in infrastructure and the American workforce to rebuild transportation, water and broadband networks is essential to moving America forward.

In just two years, 4.6 million additional trained workers are projected to be needed to keep pace with the current hiring demands in the infrastructure sector alone.

Using municipal bonds, local governments and states have raised $3.8 trillion over the last decade to address the most pressing needs, but federal support to close the nation’s remaining $2 trillion infrastructure funding gap remains critical to our economy.

Tell Your Story: Which infrastructure projects and local workforce programs have been successful in your community and why? Will federal support help you scale your efforts?

Our legislative ask: Support a comprehensive infrastructure package with dedicated, equitable funding. We support the House majority’s Moving Forward Framework, which should include the following:

1. **Renew the Federal Transportation programs by the September 30, 2020 deadline** when the current FAST Act expires. Make cities full partners in the nation’s transportation goals by:
   - Restoring the **Surface Transportation Block Grant (STBG) Program** share for locals back to at least 62.5% and increase the use of this sub-allocation model for accountable, efficient reinvestment.
   - Increasing **local input** and decision-making for federal funds intended for them, especially for mid-size communities.
   - Supporting cities’ **Vision Zero safety** initiatives within NHTSA and FHWA directed programs in response to the highest pedestrian fatality rates in the U.S. in over 30 years.
   - Investing $145 billion over six years in **innovative transit and mobility choices** for small, medium, and large communities, especially for seniors.
   - Growing **connectivity among regions** with regional rail and key asset investments, especially to improve rail safety and on-time performance.
2. **Cosponsor the Investing in Our Communities Act (H.R. 2772)**, which restores the tax exemption on single use advance refunding bonds.
   - Allows state and local governments to take advantage of **advance refunding bonds** to refinance outstanding bond debt prior to the bond’s call date.
   - Allows municipal government to achieve **lower interest rates** and substantial savings, which could be reinvested in additional infrastructure or used to lower local tax rates.

3. **Support Water Infrastructure** legislation
   - In the Senate, the Environment and Public Works Committee is drafting a **water resources bill** that would authorize navigation, flood control, and ecosystem restoration projects under the U.S. Army Corps of Engineers. It will also include reauthorization of the **Clean Water State Revolving Fund**, and possible drinking water provisions. The committee expects to pass the legislation the spring and advance to the Senate floor by early summer.
   - In the House, **Clean Water Act** legislation is moving separately from the expected water resources bill, with **H.R. 1497** having already passed the Transportation and Infrastructure Committee.

4. **Reauthorize the National Flood Insurance Program (H.R. 3167 and H.R. 3872/S.2187)** which would provide additional funding for advanced mapping of flood zones and provide **additional funding** to help local communities mitigate risk of flooding.

5. **Cosponsor the BUILDS Act (H.R. 2831/S. 1517)**, the Building U.S. Infrastructure by Leveraging Demands for Skills Act which invests in **work-based learning programs** and support services within the infrastructure sector.

6. **Cosponsor the Digital Equity Act (H.R. 4486/S. 1167)** which would establish new grant programs for states and communities to expand **broadband access** and **digital literacy** for residents, as well as federal program evaluation to identify the most promising practices for digital equity projects.
2020 Legislative Priorities for Cities, Towns and Villages

We NEED to Restore Local Authority to Empower Local Solutions

City leaders are working to improve the health and welfare of their communities and the people who live there. City leaders are problem solvers and innovators and eager to partner with other levels of government to support and compliment their efforts.

But instead of partnership and support, many cities have confronted interference.

When federal-state-local relationships break down, and when the federal government unduly limits local authority, city leaders are left with fewer tools and reduced power to solve problems.

Tell Your Story: Share a challenge that your municipality identified and successfully addressed through local-state or local-state-federal efforts. Which efforts have been limited due to overreach?

Our legislative asks:

1. **Cosponsor the Accelerating Broadband Development by Empowering Local Communities Act (H.R. 530) and Restoring Local Control Over Public Infrastructure Act of 2019 (S. 2012),** which would repeal recent harmful Federal Communications Commission (FCC) regulations that limit the ability of local governments to responsibly manage the deployment of 5G wireless infrastructure.

2. **Cosponsor the Restore the Partnership Act (H.R. 3883/S. 2967),** which would reconstitute and reform the U.S. Advisory Commission on Intergovernmental Relations (ACIR). The commission would champion a forum to discuss and address concerns over federal overreach.

3. **Cosponsor the Protecting Community Television Act (H.R. 5659 and S. 3218) which would reverse an FCC order that finalized rules to upend decades of cable franchises practices.** The FCC order provides a handout to cable companies by allowing them to dramatically reduce negotiated franchise payments by deducting the value of non-cash franchise elements, such as institutional networks or discount programs for seniors.
2020 Legislative Priorities for Cities, Towns and Villages

We NEED to End Housing Instability and Homelessness

Cities, towns and villages across the United States are facing a crisis in housing and homelessness.

Housing instability is increasingly recognized as one of the biggest barriers to economic prosperity for American families. The housing crisis is driving homelessness to levels that are overwhelming local governments and service providers working at the intersection of mental health, substance abuse disorder and homelessness.

Tell Your Story: How many constituents in your community are affected by housing instability? How does that affect your local economy and what programs could use federal support to empower local programs offering wraparound support? Share a constituent concern to provide a specific example.

Our legislative asks:

1. Cosponsor the Eviction Crisis Act (S. 3030), which would create new tools to help end the nation’s rising rate of home evictions.

2. Cosponsor the Family Stability and Opportunity Vouchers Act (S. 3083), which would create an additional 500,000 housing vouchers specifically designed for low-income families with young children to expand their access to neighborhoods of opportunity with high-performing schools, strong job prospects, and other resources.
Managing Through the Coronavirus: What Local Leaders Need to Know

By NLC Staff on March 3, 2020

As more cases of COVID-19, the Coronavirus, are identified in the United States, local leaders must answer the question about their own role in responding to the outbreak. The good news is that cities, towns and villages have longstanding emergency protocols for public health emergencies such as this and now is the time to show leadership.
Here are three things to prioritize with your local response:

1. Keep Calm and Clearly Communicate Information to Residents

Historically, the United States public health system is adept at responding to global outbreaks and has done so successfully in the past with SARS, Zika, H1N1 and Ebola, just to name a few. There is no reason to think that Coronavirus will be any different. A key message to your communities must be: prepare but don’t panic.

Local leaders must ensure that accurate, timely information is communicated to your residents about your emergency response plans, how residents should be preparing at home and how/when they should seek medical care. Included in that coordination is ensuring that schools are relaying accurate information to parents and families, including messaging that might be helpful for children to understand.

Relying on official sources to guide your efforts, such as the World Health Organization and the Centers for Disease Control and Prevention is critical. Utilize social media, community organizations and official government channels to share health and hygiene recommendations with your residents as well as other pertinent local information.

2. Ensure Coordination Between Local/State Health Departments

While local leaders are on the front lines of the response efforts, effective coordination with state and federal health departments is critical. Ensure that your local health department is in regular communication with the state health department and the Centers for Disease Control and Prevention (CDC). Be sure to identify where more federal funds will be needed to support the local response and communicate that information clearly to all partners, including your federal elected representatives.

3. Take Care of Your Team
As employers, cities, towns and villages must also be examining their own sick leave and telework policies so city employees can stay home when they are sick and remain there until they are fever free for 24 hours. City offices and agencies should utilize CDC workplace posters and fact sheets to help share proper prevention protocol, including handwashing with soap and water for at least 20 seconds or using a hand sanitizer that contains at least 60% alcohol (if soap and water are not available).

Cities should be prepared with staffing contingency plans for absenteeism due to the virus. And, don’t forget about your first responders – ensure that they have the latest information and protection to remain on the front lines!

Information on COVID-19 changes rapidly and staying on top of information can be daunting. NLC will be hosting a conference call with representatives from the Administration after Congressional City Conference (March 8-11) to provide updated information to local leaders. Stay tuned for more information on that call. In the meantime, we hope to see you in DC next week, where we will hear firsthand from the Administration.

About the authors: Stephanie Martinez-Ruckman is the Legislative Director for Human Development at the National League of Cities. Follow Stephanie on Twitter @martinezruckman.
EMERGENCY RESPONSE AND CRISIS STABILIZATION: CITIES LEADING THE WAY

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

October 2019

Key Takeaways

1. Cities are implementing innovative, cross-systems approaches to emergency response and/or crisis stabilization for those experiencing substance use disorder (SUD), homelessness and/or mental illness. However, they face a number of challenges including data collection and analysis; data integration and sharing; facility and workforce development; flexible, sustainable funding; and cultural attitudes, among others.

2. Opportunities for cities to collaborate with and utilize resources from federal, state and county governments can support and spread the innovative, cross-systems approaches being developed at the municipal level.


**Background**

This is the third in a series of issue briefs that will discuss innovative city-level approaches and practices that incorporate cross-systems approaches to care. The first issue brief in this series, “**Mental Illness, Substance Use, and Homelessness: Advancing Coordinated Solutions through Local Leadership**,”1 explores the scope of problems posed by mental illness, SUD and homelessness, and introduces innovative approaches that cities are using to maximize linkage to treatment and services. The second, “**Working Across Systems for Better Results: City Efforts to Address Mental Health, Substance Use, and Homelessness Through Emergency Response and Crisis Stabilization**,”2 explores the cross-systems nature of these and other approaches in greater detail. This third issue brief explores the challenges faced when implementing these approaches and how city leaders have overcome barriers related to the development and implementation of emergency response and/or crisis stabilization efforts. This brief also explores ways for state and federal partners to help overcome these challenges. The cities interviewed for this project include:

- Fort Collins, Colorado
- Huntington, West Virginia
- Indianapolis, Indiana
- Manchester, New Hampshire
- Philadelphia, Pennsylvania
- Rapid City, South Dakota
- San Antonio, Texas
- Wake County, North Carolina
- Wichita, Kansas

Case studies describing each city’s programs can be found at the [Mental Health, Substance Use and Homelessness page](#).

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 experiencing mental illness, SUD and/or homelessness. City leaders may adapt the strategies included here to address their city’s specific challenges in these areas.

**Overcoming Challenges**

Cities face a number of challenges in developing and implementing city-level programs in emergency response and/or crisis stabilization for those experiencing mental illness, SUD and/or homelessness. Because these issues extend across systems, creating multi-sector collaboration and establishing shared values and vision among diverse stakeholders pose a central challenge.

Cities that participated in this project shared their experiences in overcoming challenges and achieving better emergency response and/or crisis stabilization for their vulnerable populations. The challenges – and the strategies used to address these challenges – are diverse, and include:

- Obtaining sustainable, flexible funding;
- Addressing the social determinants of health;
- Overcoming stigma;
- Conducting primary data collection and analysis; and
- Developing facilities and workforce
Obtaining Sustainable, Flexible Funding

Without sustainable, flexible financing, cities will struggle to implement programming that will meaningfully impact individuals with SUD, mental illness, or those experiencing homelessness in their communities.

Financing may derive from a reallocation of existing resources or an injection of new funding. In Wichita, the local police department opted to reallocate existing department resources to fund its Homeless Outreach Team. Wake County and Philadelphia fund their crisis response initiatives through Medicaid behavioral health managed care organizations (MCOs) that are able to reinvest health care savings to fund innovative programs. To develop new sustainable funding streams, Fort Collins and San Antonio used local ballot initiatives to institute a marginal municipal tax increase devoted to funding crisis response initiatives.

Often, cities cannot rely on just one source of funding to sustainably support programming for their vulnerable populations. For example, time-restricted grants and pilot programs can be attractive options for cities seeking to experiment with innovative approaches to emergency response and/or crisis stabilization. However, if grant funding is not renewed or pilot programs are not extended, cities may be forced to dissolve effective programs. To address such issues, cities may “braid and blend” funding from different sources.

Braiding refers to coordinating funding and financing from several sources to support a single initiative or portfolio of interventions (usually at the community level). Braided funding/financing streams maintain their distinguishable strands. This allows each funder to track resources.

Blending refers to combining different streams of funding into one pool under a single set of reporting and other requirements. This makes streams indistinguishable from one another but also allows funds to meet city needs that are unexpected or unmet by other sources.

Many city interviewees believe that federal funding should allow cities and counties to braid local funding, including funding from the Substance Abuse and Mental Health Administration (SAMHSA) block grant funds, State Opioid Response (SOR) grants, Community Development Block Grant (CDBG) funding and grants from the Department of Justice (DOJ), in order to implement or sustain emergency response/crisis stabilization activities for individuals struggling with SUD, mental illness and/or homelessness.

In addition, cities noted the importance of receiving funding from state governments quickly or, alternatively, receiving federal funding directly. Often, block grants and other federal funding flows to state governments. Some states may be slow to send this money to cities and often take a portion of the money for administrative or other purposes. Providing money directly to cities for crisis intervention services for vulnerable populations could help cities respond faster and more efficiently.
Philadelphia's response to homelessness prevention, behavioral health and SUD treatment is unique in that its programs are primarily financed through Community Behavioral Health (CBH), one of the country’s few city-run Medicaid MCOs. Since 1997, this centralized system has enabled the city to coordinate care and directly reinvest savings generated from more efficient, appropriate care delivery. CBH is a division of the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and accounts for $1.3 billion of the department’s $1.6 billion budget. The MCO has produced extremely cost-effective results: it spends 92 cents of every dollar on purchasing treatment for city residents. Nationally, MCOs spend between 7.6 to 14.3 percent of funds on administrative costs making CBH one of the most cost-effective MCOs in the country.

CBH is funded through HealthChoices, Pennsylvania’s Medicaid MCO program, allowing the city to meet the behavioral health needs of approximately 700,000 Medicaid recipients through value-based payment that incentivizes high-quality outcomes. By having the CBH function as a single-payer for behavioral and substance use treatment in the city, an efficient system is created in which the city incentivizes the provider network to produce high-quality health outcomes in a cost-efficient manner. Philadelphia’s centralized approach has enabled the city to design programs and payment mechanisms that comprehensively address homelessness, SUD and mental illness. Most importantly, the city’s unique funding mechanism allows for savings and reinvestment directly back into the community.

Addressing the Social Determinants of Health

Addressing the underlying causes - or social determinants of health (SDOH) - that contribute to homelessness, SUD and mental illness will make crisis response more effective and less costly. Social determinants, such as housing insecurity, unemployment and transportation access impact homelessness rates and resulting health outcomes. City governments can address these issues by improving the physical and social aspects of their communities that underlie health problems, better responding to and supporting vulnerable individuals, and connecting individuals to a wide array of social supports. Addressing SDOH is not only about connecting people to additional services. It is also about supporting communities to prevent problems from developing in the first place and empowering communities to better respond when issues arise.

In Wake County and San Antonio, city and county leaders convened diverse local stakeholders to address the socioeconomic factors that affect behavioral health outcomes and homelessness. The causes of these issues are multifactorial and necessitate comprehensive responses. Involving diverse groups of stakeholders to develop emergency response and crisis stabilization strategies for individuals experiencing mental illness, SUD and/or homelessness enables cities to develop more effective response efforts.
For example, SDOH are increasingly coming under the purview of health care providers and issuers. These entities may invest directly in SDOH, such as non-emergency medical transportation and housing, which could help mitigate the health effects associated with non-pathological issues, such as a lack of access to treatment and unstable housing. However, because coordination with and oversight of these entities remain limited, having dedicated governmental oversight of these efforts to measure and improve SDOH can provide greater vertical (i.e. federal, state and local) and horizontal (i.e. cross-departmental) collaboration and coordination to more effectively address SDOH.

State and federal governments can play a role in addressing SDOH. Expanding coverage in state and federal public insurance (e.g. Medicare and Medicaid) to reimburse costs related to SDOH, such as non-emergency medical transportation and housing, could help mitigate the health effects associated with non-pathological issues, such as a lack of access to treatment and unstable housing. State and federal governments may also directly fund affordable housing, job creation, public transit, early childhood education, and public schools. Without investment in these activities, the burden for providing these services falls exclusively on cities.

**WAKE COUNTY, NORTH CAROLINA**

Wake County’s Enhanced Mobile Crisis Pilot Program utilizes a team of mobile crisis clinicians to connect individuals in crisis with the services and providers best suited to their needs, in an effort to decrease overutilization of emergency departments (EDs). This initiative came out of the 2017 Wake County Behavioral Health Summit, which convened more than two hundred professionals, government officials, activists and other community members to proactively address gaps in local behavioral health services. In addition to addressing clinical supports and crisis intervention services, participants were asked to discuss social factors such as criminal justice involvement and housing insecurity.  

Feedback from the summit ultimately led to a comprehensive behavioral health plan that addresses social determinants of health and considers multiple approaches to addressing a wide range of social and medical needs. In addition to the Enhanced Mobile Crisis Pilot Program, Wake County aims to conduct a feasibility study for implementing a housing rental subsidy program paired with support services for vulnerable populations, make recommendations for improving access and service delivery to individuals leaving detention and expand permanent supportive housing for high-need individuals, as part of a holistic approach to behavioral health.
Overcoming Stigma

People experiencing homelessness, SUD and/or mental illness regularly encounter stigma from community members, friends, family and professionals when they seek help. Cities that have employed punitive approaches to these issues may find that individuals have low levels of trust in law enforcement, health care professionals and city-backed initiatives.

Nationally, African Americans and Native Americans experience the highest burdens of homelessness, mental illness and SUD. Cities should utilize available data to identify the characteristics of their highest-need individuals and most vulnerable populations. Cities can then engage members of these communities in designing culturally inclusive and responsive programs and training program leaders in cultural competency. In addition, cities can address these issues by treating people experiencing homelessness, mental illness and/or SUD with dignity and respect, advocating for their basic rights and needs and normalizing conversations about addiction, homelessness and mental illness.

State and federal governments should work closely with cities to design interventions that account for a diverse range of experiences, backgrounds and preferences. In Rapid City, city leaders are working to provide cultural education for the first responders who administer their emergency response and/or crisis stabilization initiatives as well as the local politicians who are responsible for funding them.

RAPID CITY, SOUTH DAKOTA

The Rapid City Policy Department (RCPD) reports that of the city’s 74,000 residents, it regularly interacts with approximately 300 individuals. Upwards of 90 percent of these individuals are Native American, and many are coping with chronic homelessness and SUD. To help provide sustainable solutions for the city and to appropriately respond to high-need individuals, the RCPD invested in a special unit to connect high-need individuals with a number of helpful resources and supports, remove barriers to care and services, and reduce police calls and related costs.

To work effectively with Rapid City’s relatively large population of Native American residents, many of whom grew up on one of the seven reservations in South Dakota, law enforcement and service providers needed to understand Native American history, culture and perspectives. To promote cultural competency, the RCPD has implemented a department in-service class that addresses its history with Native and non-Native relations, helping officers understand why alcohol and substance use is prevalent among this community as well as why many Native Americans are distrustful of law enforcement. The RCPD consults with and brings in members of the tribal community to inform and present some of these lessons. This class and other similar training give officers, especially those that are new to the state, some working knowledge about the cultures and cultural interactions that define Rapid City.
Emergency Response and Crisis Stabilization: Cities Leading the Way

Conducting Primary Data Collection and Analysis

City leaders stressed the importance of primary data collection and analysis as an essential tool in demonstrating the need for program development and implementation as well as describing program successes to stakeholders and funders.\textsuperscript{26} Data-driven approaches\textsuperscript{27} can be used to assess programs, modify them strategically to improve participant outcomes and tailor them for different target populations.\textsuperscript{28,29} Primary data collection and analysis can range in complexity, cost and effort and may include:

- Tallies/counts of program activities (e.g. number of calls responded to, number of repeat calls, number of meetings attended, etc.)
- Time tracking (e.g. staff time in training, average call length, time needed for interview/investigations, response time to emergency call, time to connect to care, time to follow-up, etc.)
- Demographic information (e.g. age, race, gender, primary language spoken, etc.)
- Dollars spent/saved (e.g. cost of traditional response vs. cost of new response; salary information for uniformed officers, social workers and support staff; cost of special equipment or infrastructure, etc.)

Because SUD, homelessness and mental illness are complex and intersecting issues, primary data collection and analysis may require additional time, specialized equipment and trained staff to accurately capture program results. Such cross-cutting challenges may also necessitate more robust data integration. This is especially true for cross-systems approaches in which the agency that initially responds to an individual in crisis may not be the same agency that provides treatment.

Cities can leverage the expertise of existing public or private agencies, including city public health departments, universities and nonprofit organizations, to assist with data collection, analysis and integration. For example, Manchester has worked with Dartmouth University, the local public health department and an EMS provider to collect and analyze data on its Safe Station program.\textsuperscript{30,31} Indianapolis is partnering with the Indiana University Center for Health and Justice Research (CHJR) to evaluate data from the city’s Mobile Crisis Assistance Teams. Officers with the San Antonio Police Department Mental Health Detail have become increasingly involved in data collection following up with individuals who have experienced a mental health emergency and their case managers once they have been referred to treatment in order to incorporate outcome data into program analyses. In Huntington, Quick Response Teams are able to follow-up with individuals who have experienced an overdose using data collected by Cabell County EMS. In Fort Collins, the Fort Collins Police Services, Larimer County Sheriff’s Office and nearby Loveland, Colorado Police Department have begun collecting and coding emergency calls related to mental illness in the same way so that data can be better integrated and shared across jurisdictions.

Federal and state governments may assist cities with collecting and sharing data. Social service providers are often reluctant to share data with first responders due to concerns about violating data privacy protections under the Health Insurance Portability and Accountability Act (HIPAA)\textsuperscript{32} and the Family Educational Rights and Privacy Act (FERPA). This can lead to difficulty completing referrals and tracking the effectiveness of initiatives via follow-up. The Department of Health and Human Services (HHS) could address these concerns by educating individuals and organizations about HIPAA so that all participants in crisis response, stabilization and treatment initiatives can responsibly share data in a manner no more or less restrictive than what federal law requires. State laws can also be a barrier (either real or perceived) to data sharing, depending on the city. The state agencies responsible for administering these laws could also provide cities with instruction on how to establish robust and flexible data sharing systems while still maintaining compliance with state laws. Both federal and state agencies could work with cities to determine which data they should collect during emergency calls related to mental illness, substance use disorder and homelessness so that these data can be more consistent across cities for comparison. For cities that lack resources to collect these data, federal, state and potentially even county agencies could provide technical assistance and grant funding.
In response to an increase in 911 calls related to community members with mental health conditions, Fort Collins Police Services (FCPS) partnered with SummitStone Mental Health and Addiction Treatment Center and the University of Colorado Health (UCHealth) Memorial Hospital to fund and hire a mental health co-responder. The mental health co-responder is a licensed professional counselor and addiction specialist with experience working with justice-involved individuals in a variety of settings. As part of FCPS’ Mental Disorders Response Program, the mental health co-responder facilitates a more coordinated approach to mental health-related police calls, helping to divert individuals away from the criminal justice system and into appropriate treatment services.

Although SummitStone has maintained a substantial database of mental health services provided to community members, it did not necessarily capture information that could help FCPS evaluate the impact of the Mental Disorders Response Program. Moreover, police officers, mental health centers and hospitals collected and coded information using different protocols. To improve data collection and analysis, FCPS has developed a mental health response coding system and educated its officers about how to use this system to track mental health-related calls. Since initiation, FCPS has worked with data analysts from SummitStone and UCHealth Memorial Hospital to identify what information is needed and to set up the systems to allow for efficient data-sharing among the city’s providers.

### Developing Facilities and Workforce

Crisis stabilization efforts often require specialized training and equipment, as well as knowledge of treatment options. Many communities are burdened by limited or overburdened referral options for treatment or assistance. Accordingly, cities may be challenged to employ, train and equip a workforce sufficient to meet its demands for mental health, homelessness, and SUD services.

To demonstrate their city’s specific needs surrounding training, equipment and/or facilities, city leaders can use data captured through crisis response initiatives. In Huntington, Quick Response Team responders found that even if they reached a person who was willing to seek help, local hospitals and SUD treatment providers were often overwhelmed and unable to admit new patients. City leaders were able to use this information to advocate for new SUD treatment facilities with specialized services for specific populations, such as pregnant women and women with young children.
To more effectively leverage its existing workforce for crisis response initiatives, the city provided Crisis Intervention Team (CIT) and other relevant training to all first responders and implemented the Mobile Crisis Assistance Team (MCAT) pilot program.

The MCAT pilot program was developed in response to the high prevalence of incarcerated individuals with mental illness and SUD in the city, which resulted in overcrowding in jails. Four MCAT units were formed for the pilot program, each consisting of a specially-trained Indianapolis Metropolitan Police Department (IMPD) officer, an Indianapolis Emergency Medical Services paramedic and a crisis specialist from Eskenazi Health Midtown. The East district, which spans roughly 50 miles, was selected for the pilot program due to its high Social Disorder Index ranking and the high rates of 911 calls associated with mental illness and ambulance runs for medical emergencies.34

Prior to the launch of the program, MCAT units completed approximately 320 hours of training, reviewing topics such as mental health, use of force and de-escalation techniques and legal implications of interagency collaboration. This training enabled unit members to build relationships, adopt useful skills from one another and become familiar with the language, philosophies and procedures of the other agencies.35 Arnold Ventures has provided funding for a forthcoming review of the pilot program so that its results may be better understood.
**Recommendations**

Cities play a critical role in emergency response and/or crisis stabilization, particularly for vulnerable populations including those with SUD, mental illness and those experiencing homelessness. The cities highlighted in this research identified a number of strategies and policy changes that would help address the challenges they face and enhance their work. Of particular importance are positive working relationships with state and federal partners. A number of specific recommendations flow from this research, including:

**Financing**

- Cities should receive flexible financing that enables braiding and blending of funding to address shifting community needs.

- Funding from the Substance Abuse and Mental Health Administration (SAMHSA), including block grant funds and State Opioid Response (SOR) funding, should be used to implement or sustain emergency response/crisis stabilization funding for individuals struggling with SUD, mental health challenges and/or homelessness.
  - Cities should receive this funding quickly and have maximum flexibility to braid these funds with local and other sources of funding

- Center for Medicare and Medicaid Innovation (CMMI) should develop a special initiative with cities to test innovative approaches to crisis stabilization for vulnerable populations.

**Addressing Social Determinants of Health**

- Center for Medicare and Medicaid Services (CMS) should structure public insurance programs such as Medicaid to allow for reimbursement of costs related to SDOH. For example, Medicaid dollars should be used for non-emergency medical transportation costs and housing supports.

- Federal agencies like the Department of Housing and Urban Development (HUD), Department of Transportation (DOT) and the Department of Education (DOE) should adequately fund affordable housing, job creation, public transit, early childhood education and public schools.
  - State government counterparts in these areas should also provide funding to improve and address these issues.

- A special office at HHS (perhaps at the Centers for Disease Control and Prevention (CDC) should be created to provide funding and assistance to local health departments to better address SDOH and coordinate and integrate these efforts into a comprehensive response to crisis intervention for vulnerable populations.

**Reducing Barriers to Treatment**

- Barriers to providing mental and behavioral health services via telehealth can be reduced.
  - Under federal law, state Medicaid programs must cover medication-assisted treatment (MAT) and may choose to cover MAT via telehealth. Several states have introduced legislation to expand telehealth prescribing for MAT. Other states should follow suit.
  - Meanwhile, CMS removed geographic limitations for telehealth services for individuals with SUD to treat SUD or co-occurring mental health disorders. CMS has recently proposed to include opioid use disorder counseling among the list of covered telehealth services in Medicare. In continuing its trend toward expanding coverage of telehealth services, CMS should finalize this rule.
• Mental and behavioral health services should be reimbursed at rates comparable to physical health services and that access to care is not restricted by narrow provider networks.

• SAMHSA, CMS, Health Resources and Services Administration (HRSA), Department of Justice (DOJ), the US Interagency Council on Homelessness (USICH) and other federal agencies should collaborate directly with cities to identify the characteristics of high-need individuals and vulnerable populations and to help design interventions that account for a diverse range of experiences, backgrounds and preferences.

**Data Sharing**

• SAMHSA, CMS, HRSA, DOJ, USICH and other federal and state agencies should work with cities to identify data they should collect on emergency response and/or crisis stabilization initiatives and provide technical assistance and funding to help cities collect these data.

• HHS should coordinate a multi-agency workgroup to identify barriers and make recommendations to improve data sharing across systems (criminal justice, health and social services systems). The DOJ, HHS, the Department of Education and other federal agencies should issue guidance to better inform first responders, healthcare providers and social services providers about how and what types of data can be shared while maintaining compliance with HIPAA and FERPA.

**Spread and Scale**

• CMS should create a special, cross-agency affinity group to help cities share and scale best practices related to crisis intervention for vulnerable populations, including those experiencing SUD, mental illness and/or homelessness.

• Federal agencies and private entities should work to identify partnership opportunities that augment existing public dollars invested in enhanced emergency response and crisis stabilization efforts for individuals experiencing mental health, substance use and/or homelessness.

• Cities need partnerships and strategies that allow for more dynamic financing opportunities (e.g. local wellness trusts, braiding and blending approaches, etc.) and replicability of emerging best practices to better serve the needs of their communities. (See ‘Financing’ section above regarding the need for flexibility to braid and blend financing).

**Conclusion**

City and program leaders stressed that consistent, open communication; coordination and collaboration of diverse stakeholders; flexible funding options; development of data-driven solutions; and a willingness to accept risk were essential factors in overcoming challenges related to crisis intervention and emergency response for vulnerable populations. Cities need support from federal and state governments to successfully address the intersecting challenges of SUD, homelessness and mental illness. Further, federal and state governments can learn from the work being conducted at the city level to develop cross-systems approaches and apply best practices in the planning, implementation and evaluation of these programs geared towards more effective responses to vulnerable populations.
About this Project

With generous 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.

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ENDNOTES


16 Id.


Emergency Response and Crisis Stabilization: Cities Leading the Way


Emergency Response and Crisis Stabilization: Cities Leading the Way

37 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program-Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions From the Medicare Shared Savings Program-Accountable Care Organizations-Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder Under the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. Final Rule. 83 Fed. Reg. 59452-60303. (CMS-1693-F, CMS-1693-IFC, CMS-5522-F3, and CMS-1701-F)

38 Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations. Proposed Rule. 84 Fed. Reg. 40482-41289. (CMS-1715-P).
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.

September 2019

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. 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.

**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,” 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.” Providers of services for vulnerable populations recognize cross-systems approaches are an integral part of caring for those with trauma, which is a “near universal” experience for those with behavioral health conditions like mental illness and substance use disorder. 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.

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.
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. 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 Prestera Center, an inpatient and outpatient treatment center. Marshall University Public Health department provides evaluation and assessment of QRT practices.

While the program is in its infancy, it has realized some success. Between December 2017 and July 2018, there were 650 overdoses in Huntington. The QRT was able to contact over half of the individuals who experienced these overdoses and more than one quarter agreed to enter treatment.
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, described in the first issue brief, was created to better equip police in their expanded role as “mental health interventionists.”

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, Texas

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. 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. There were two uses of force in response to MHD calls in 2017, a 50 percent reduction in use of force from 2016. 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. 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, Kansas**

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 federal or private rapid rehousing, 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.
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. 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 homelessness 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,” 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.

A special thanks to Greg Dwyer, MPH and Katie Horton, RN, MPH, JD at the Milken Institute School of Public Health for their research and contributions to this issue brief.

**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

1 The National Institute of Mental Health defines serious mental illness as a mental illness that results in serious functional impairment, which substantially interferes with or limits one or more major life activities. National Institute of Mental Health. “Mental Illness” NIMH. (2019). https://www.nimh.nih.gov/health/statistics/mental-illness.shtml


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MENTAL ILLNESS, SUBSTANCE USE, AND HOMELESSNESS:
ADVANCING COORDINATED SOLUTIONS THROUGH LOCAL LEADERSHIP

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

July 2019

Key Takeaways

1. Mental illness, substance use disorder, and homelessness pose significant, interconnected challenges for cities as they affect millions of people nationally. City leaders play a key role in ensuring individuals receive the appropriate treatment and services at the right time.

2. Traditional approaches to addressing these challenges have proven less than effective. Many individuals with mental illness, substance use disorder, and/or homelessness lack access to important health and social services. Responses often have funneled vulnerable populations into emergency departments, jails, and prisons, imposing both human and financial costs. Innovative efforts like emergency response teams and crisis stabilization centers have the potential to serve as doorways into more appropriate services and treatments.

3. Cities across the country are implementing innovative approaches to improve outcomes. Newer approaches in emergency response and crisis stabilization prioritize programming that increases the capacity of first responders to safely deescalate emergency situations involving individuals with mental illness, substance use disorder, and/or experiencing homelessness. These approaches maximize diversion to treatment and services instead of arrest or unwarranted emergency department visits.
Communities have long grappled with the interconnected challenges of mental illness, substance use disorder, and homelessness. Over the past decade, the toll of these challenges has grown as the opioid epidemic further strains access to health care, housing, education and other critical services. As outcomes for those experiencing mental illness, substance use disorders and/or homelessness continue to deteriorate, the costs of addressing these issues have risen.

Fortunately, municipalities are developing and implementing innovative approaches to better serve vulnerable populations in the areas of emergency response and crisis stabilization. Instead of incarceration, many approaches work across systems, involving first responders (police, fire, EMS), hospitals and emergency rooms, housing, transportation, courts and other community stakeholders to provide critical services and supports to individuals in crisis.

This issue brief, the first in a series, examines the challenges posed by mental illness, substance use disorder and homelessness and introduces innovations from a diverse array of communities with a focus on emergency response and crisis stabilization. This brief and those to follow will provide local leaders with tools and strategies to better address emergency response and crisis stabilization systems for those experiencing mental illness, substance use disorder and/or homelessness.

**Addressing Complex Challenges**

In 2017, more than 46 million adults in the United States lived with a mental illness, including over 11 million with a serious mental illness. Meanwhile, more than 20 million adults in the United States met the criteria for substance use disorder in 2014, and nearly 553,000 experienced homelessness on a single night in January 2018.

The prevalence of mental illness, substance use disorders and homelessness necessitates new approaches that address the unique challenges each of these issues individually pose. The fact that these conditions are sometimes co-occurring can further complicate attempts to address them.

Local emergency response and crisis stabilization systems increasingly serve as the first point of contact for individuals experiencing mental illness, substance use disorders or homelessness. Between 2006 and 2013, emergency department (ED) visits for mental illness increased by more than 50 percent, while ED visits for substance use disorders increased by nearly 40 percent.

Simultaneously, the number of individuals entering the criminal justice system has also increased, particularly populations with behavioral health conditions. The Substance Abuse and Mental Health Services Administration (SAMHSA) attributes this increase, in part, due to lack of access to services for those with mental illness, substance use disorder, and/or experiencing homelessness, and drug laws which can lead to increased contact with law enforcement, arrests, and jail bookings. Such realities have led to higher rates of mental illness and substance use disorder, in the criminal justice system.

Unfortunately, many of these individuals, both within and outside of the criminal justice system, continue to enter into uncoordinated systems that do not connect individuals to appropriate care and support services.

**Impacts and Costs**

Mental illness was the most costly condition in the United States in 2013, with $201 billion in direct health care costs, eclipsing conditions such as heart disease, cancer and diabetes. Substance use accounts for $64 billion in annual health care costs and $340 billion in annual overall costs (including costs associated with crime and lost work productivity). Researchers have found that costs associated with homelessness, including emergency department visits, hospital in-patient stays, shelters, jails, prisons and other treatment centers, can reach between $30,000 and $50,000 per year per individual.

In terms of human costs, deaths attributable to substance use disorders increased by more than 600 percent between 1980 and 2014. Chronic conditions, as well as environmental exposure, can reduce the life expectancy of an individual experiencing homelessness by 17.5 years.
**Current City Responses**

While federal and state responses and resources are urgently needed, local city leaders are uniquely positioned to develop new and innovative strategies tailored to their own cities’ needs. Examples of these strategies include:

- **First Responder-Provider Partnerships:** Police and other first responders are collaborating closely with behavioral health providers to better serve individuals with mental illness, substance use disorders or those experiencing homelessness in emergency situations. Partnerships can take multiple forms, including:
  - **Crisis Intervention Teams (CITs)** in which mental health providers and other community stakeholders provide police officers with specialized training on mental illness. The model includes both a training component and response component. Training includes lessons on how to identify individuals with mental illness, where to access mental health treatment, legal issues surrounding mental illness, and how to safely deescalate situations involving individuals experiencing mental health emergencies. CIT programs also train emergency dispatchers to recognize the signs of mental illness during emergency calls and assign calls involving mental illness to CIT-trained police officers. CIT trained officers are better able to safely deescalate emergent behavioral health situations, connect individuals to treatment, and divert individuals from the criminal justice system when possible.

- **Co-responder initiatives** that dispatch multi-disciplinary teams composed of a law enforcement officer and behavioral health specialist to intervene in mental health and substance use-related police calls. These teams can de-escalate situations that have historically resulted in arrest and assess whether the person should be referred for an immediate behavioral health assessment. For example, in Boston, Massachusetts’ co-responder programs, Master’s-level clinicians ride with police officers to respond to emergency calls involving mental illness.
• **First Responder-Led Referral Programs**: These programs enable individuals who want treatment for substance use disorders to go to police\(^{32}\) or fire departments\(^{33}\) for connections to treatment, with the assurance that they will not face criminal liability for their substance use.

**GLOUCESTER, MASSACHUSETTS**
In 2015, the Gloucester Police Department (GPD) launched the Angel Program, a first responder-led referral program, in which trained police officers assist individuals with referrals to substance use disorder treatment. The program allows individuals seeking treatment to approach GPD staff for referrals to care. Individuals must meet the program’s inclusion criteria – no active arrest warrants and no acute medical or safety concerns – in order to participate. Trained police officers refer those who meet program criteria directly to treatment centers.\(^{34}\) An evaluation of the Angel Program revealed that nearly three-quarters of participants were engaged in care at follow up.\(^{35}\)

• **Regional Dedicated Emergency Psychiatric Facilities** are stand-alone psychiatric emergency departments to which multiple medical emergency departments within a specified geographic region send their psychiatric patients for care. In addition, first responders can bring individuals directly to a regional center in some cases, reducing the burden on local medical emergency departments.

**ALAMEDA COUNTY, CALIFORNIA**
If emergency responders in Alameda County determine that an individual undergoing a psychiatric emergency is stable enough to transport, they can transfer the person directly to John George Psychiatric Hospital, the regional dedicated emergency psychiatric facility. In some cases, the individual is sent to the nearest medical emergency department for stabilization and subsequent transport to John George once beds become available. Individuals experiencing a mental health emergency may also self-present at John George facility to seek treatment.

In one study of the Alameda Model, Emergency Department waiting times (waiting time in the ED once patients who have been admitted to the hospital) were reduced by over 80 percent. The designated psychiatric facility achieved a patient stabilization/discharge rate of greater than 75 percent, significantly reducing the need for hospitalization.

Since its inception, Alameda Health Systems has modified the Alameda Model to allocate limited resources more efficiently. In the newer Census Management Model operating in Alameda, patients arriving at emergency departments are triaged by acuity of their behavioral health emergencies. The most emergent patients are sent to John George and individuals with less acute emergencies remain in local emergency departments until John George has the capacity to treat them to prevent overcrowding.

This initial list of local approaches is by no means exhaustive. Cities are innovating, learning from other cities, and tailoring crisis response strategies to their unique needs.
Next Up: A Deeper Look at City Approaches

Future briefs will discuss in more detail the various, cross-system approaches that cities have implemented, offering additional examples of promising or effective strategies for other communities to consider.

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. A special thanks to Katie Horton and Greg Dwyer at the Milken Institute School of Public Health for their research and contributions to make this brief possible. The overarching goal of this project is to highlight best practices and effective strategies in emergency response and crisis stabilization for these populations so that other cities might replicate and scale them as needed.

One out of every three individuals with a serious mental illness receives no mental health treatment.\(^{36}\)

Nine in ten adults with a substance use disorder receive no treatment.\(^{37}\)

More than one-third of people experiencing homelessness are unsheltered.\(^{38}\)

Together, these unmet needs present a crisis for the people experiencing them and a major challenge for the communities in which they reside.

For instance, between 2014 and 2018, the number of people experiencing homelessness decreased (from 576,460 to 552,830) and yet there was an increase in the number of unsheltered homeless over the same time period (from 175,399 to 194,467).\(^{39}\) As of 2018, more than one in three people experiencing homelessness remained unsheltered.\(^{40}\)


Id.


Id.