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Indianapolis, Indiana:

ENHANCING EMERGENCY RESPONSE THROUGH A MOBILE CRISIS ASSISTANCE TEAM

OVERVIEW

Indianapolis, Indiana is a large, metropolitan city in the midwestern United States and home to approximately 13 percent of the state's population.[1,2] Twenty percent of individuals in Indianapolis live below the federal poverty level.[3] Meanwhile, statewide, the overdose death rate is 29.4 per 100,000 population, among the higher rates in the nation (13th).[4]

In May 2016, the Criminal Justice Reform Task Force was formed as part of a city initiative to reduce incarceration of individuals with mental health issues and/or substance use disorder (SUD), many of whom were also homeless, between 2015 and 2016. According to 2015 estimates from the Marion County Sheriff's Department, approximately 40 percent of offenders in the county's jails were identified as having some mental illness.[5] Additionally, close to 85 percent of offenders with a mental illness were co-diagnosed with SUD.[6]

In December 2016, the Task Force issued a comprehensive plan for criminal justice reform that included, among other initiatives, diverting individuals away from the criminal justice system and into evidence-based mental health and substance use treatment and services, when appropriate. This resulted in the establishment of a Mobile Crisis Assistance Team (MCAT) pilot program in August 2017, serving the Indianapolis Metropolitan Police Department (IMPD)'s East district system. Spearheaded by the city of Indianapolis, MCAT is a multi-agency partnership program between IMPD, Indianapolis Emergency Medical Services (IEMS), and Sandra Eskenazi Mental Health Center (SEMHC, formerly known as Midtown), that aims to redirect time-intensive, complicated, pre-arrest situations to dedicated, specially trained teams.

Since its launch, MCAT has undergone several modifications and now works in conjunction with Behavioral Health Units (BHUs) across several adjoining districts. MCAT-BHUs assess,

triage, and link individuals to mental health and community-based support resources—alternatives to immediate detention or emergency department utilization.

Indianapolis has developed a number of innovative programs that target the challenges of SUD, homelessness, and mental health issues. This case study will focus on MCAT-BHU and present key takeaways for other cities considering similar cross-systems approaches.

PROGRAM DESCRIPTION

Mobile Crisis Assistance Team

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 IMPD officer, an IEMS paramedic, and a crisis specialist from SEMHC. 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.[7]

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, and legal implications of interagency collaboration. Working in 12-hour shifts, the four units provide 24/7 availability and respond to the scene of a crisis either through self-dispatch upon hearing of a relevant crisis via IMPD or IEMS dispatch radio, or at the request of other first responders. Generally, the MCAT officer ensures security at the scene of the crisis, the crisis specialist facilitates mental health assessments and treatment linkage, and the paramedic performs assessments related to substance use, checks vital signs, and addresses various medical issues.

While much of the current program has remained the same since 2017, the MCAT has undergone several modifications to increase efficiency and prevent redundancies. As a result of usage data, the program has reformed how the units respond to crises, tailored the types of calls the units respond to, and modified service hours to better meet the needs of the community. Data also suggested that the skills of the IEMS paramedics were underutilized. As a result, IEMS downscaled its partnership with IMPD and SEMHC; while IEMS paramedics are no longer included as part of the MCAT, IEMS continues to respond to MCAT calls when necessary.

Currently, there are MCAT units working in conjunction with BHUs across five out of the six police districts: North and Downtown, East and Southeast, and Northwest. Uniformed patrol officers maintain their role as first responders, but both BHU and MCAT are available to respond to calls as second responders, when needed. The responding BHU/MCAT team can release uniformed officers from the scene and take over to determine the best option for the citizens involved including service referrals and follow-ups. Individuals in crisis have access to a wide-reaching network of criminal justice and community service providers in Indianapolis, including the Reuben Engagement Center, a 30-bed facility providing services for Indianapolis' chronically homeless population.

RESULTS

By the end of the pilot program in December 9, 2017, MCAT responded to a total of 566 calls occurring among 488 individuals and conducted approximately 4.4 runs per day—with a range of 1 to 11 responses per day.[8] While a large majority of these individuals received only one MCAT response, 11 percent were categorized as "super-utilizers," meaning that they received two or more MCAT responses for unrelated crises.[9]

MCAT units self-dispatched in about 63 percent of runs, while the rest were primarily in response to specific requests from IMPD.[10] Mental health concerns were the most common primary reason for response at 59 percent, and was the only crisis type in 37 percent of responses.[11] The second and third most common emergencies to which MCAT responded were overdose or SUD- related crises and self-harm-related crises (35 percent and 34 percent, respectively).[12]

Further, data suggests that 56 percent of all responses resulted in transporting individuals to a hospital following an MCAT encounter, with 33 percent transported to SEMHC.[13] Seven percent of responses resulted in an arrest, of which 74 percent were initiated by an IMPD office already on the scene, rather than an MCAT officer.[14] Throughout the duration of the pilot program, less than two percent of arrests (nine encounters) were directly initiated by MCAT officers.[15]

In February 2019, city officials announced a year-long study to evaluate the effectiveness of MCAT-BHUs in meeting its goals.[16] The study will come from the Indiana University Center for Health and Justice Research (CHJF). Researchers will evaluate a number of metrics, including MCAT-BHU's effect on the use of emergency medical services, arrest rates, treatment engagement, response times, and hospitalization to better modify the program's approach.

FINANCING AND SUSTAINABILITY

The Substance Abuse and Mental Health Services Administration (SAMHSA) allocated $10.9 million in funding, authorized by the 21st Century Cures Act, to support initiatives that address Indiana's opioid epidemic, including the MCAT pilot program.[17] In addition to funding from SAMHSA, Indiana designated funding from its existing Mental Health and Addiction Forensic Treatment Fund to help establish MCAT.[18] The majority of the program's existing funding comes from the budgets of IMPD and SEMHC. However, program leaders are continuously working to identify additional funding opportunities between the IMPD, SEMHC and additional criminal justice partners.

In May 2019, SEMHC received a $1.3 million grant to expand the scope of services available to MCAT-BHUs to resolve both crisis and ongoing mental health/SUD related needs in all six IMPD districts. This includes adding care coordinators to focus on treatment continuity and peer recovery coaches to improve outcomes for individuals with SUD.[19] The funding comes from the State of Indiana Division of Mental Health and Addiction and allows for an expansion of existing program hours.

ROLE OF CITY LEADERSHIP

Each of the agencies involved identified a coordinator within its leadership to design and implement the MCAT pilot program

in unison. In addition to designing and implementing training and identifying unit members in their respective agencies, the official coordinators were tasked with making procedural and logistic decisions with support from the Indianapolis Office of Public Health and Safety (OPHS). Additionally, in preparation for the launch of MCAT, a business associate agreement between the Health and Hospital Corporation of Marion County, of which IEMS and SEMHC are part, and IMPD was created to protect personal health information of those with whom the MCAT teams come into contact.[20]

LESSONS LEARNED

Responding to Challenges

An evaluation of the pilot program identified several challenges in the implementation of MCAT.

Inconsistent procedures. With a lack of clarification of on-the-scene procedures, unit members were often left frustrated and confused, resulting in variation in response efforts among the units.[21] Additionally, the evaluation of the MCAT pilot notes challenges in establishing both internal and external communication. MCAT leadership shared that there were difficulties not only in establishing communication protocols and coordinating resources among the agencies, but with relaying MCAT goals to external actors in the community, such as health care providers outside of MCAT and other first responders.[22]

Data collection. Data collection and sharing are often difficult in these emergency response scenarios. MCAT continues to evaluate the data it collects to develop better metrics to measure success. It is also working towards more effective data sharing procedures.

Community expectations. Balancing the expectations of community members, criminal justice agencies and the medical community can be challenging. MCAT works to keep an open line of communication among all involved partners and continuously evaluates and evolves its programing. This includes providing education to combat the stigma associated with homelessness, mental health and SUD. Interviewees report the community has been receptive to these educational efforts and supportive of the MCAT-BHU initiative.

Accessibility. There is a national shortage of behavioral healthcare workers as well as social supports for individuals with behavioral healthcare needs.[23] This shortage is expected to grow over the coming decade.[24] Indianapolis, like many of the other cities profiled in this project, faced behavioral healthcare resource shortages when implemented MCAT-BHU including limited availability and accessibility to local outpatient mental health and SUD treatment services for the populations served by MCAT.[25] In response, the city is currently investing in the construction of a healthcare center on its new criminal justice campus. The center will be a location to connect individuals to needed services and will provide a physical space where individuals may wait while being connected with services or alternatively, can be placed in temporary beds for more challenging placements. City leaders hope this will provide first responders with additional resources when assisting citizens experiencing mental illness, SUD, or homelessness.

Key Takeaways for Cities

For other cities considering similar cross-systems approaches to SUD, homelessness, and mental health issues, there are several key lessons that can be learned from Indianapolis' MCAT program:

Initiate cross-systems collaboration and engage city leaders early: MCAT benefited from the years of collaboration between IMPD, IEMS, and SEMHC leadership which provided a platform for resource negotiating and agency accountability in the program's infancy stage. In addition, strong support towards program implementation from city officials and key stakeholders, both public and private, helped to open avenues for future partnerships.

Share information between agencies to help create tailored responses: Access to the combination of patient information from the different agencies, within the bounds of regulations and legal mandates, helped BHUs better locate, serve, and follow-up with specific individuals in and after the moment of crisis. Additionally, this triangulation of information helped the units identify the patterns and needs of "super-utilizers" of local justice system and emergency services.

Invest in team building and training: Initial MCAT 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.[26] Another important element of the initial implementation of the program was the ability of the units to select their teams. Allowing units to select their teams gives them more control over who they will share office space with and ride together for many hours of the shift. MCAT is unlike other assignments in law enforcement and/or a clinical settings where the employees work closely together, but also have time apart from the team. The team effort can keep unit members together and dependent upon one another for significantly longer traditional assignment. Thus, it becomes even more important for partners to enjoy working together and, more importantly, communicate and trust one another.

Persistence. Developing an emergency response and crisis stabilization effort to better serve vulnerable populations is not something that happens overnight. Cities must continue to evaluate and adjust the programs to identify what provides the greatest value for each individual community based upon its needs and available resources.

Unless otherwise noted, all information is based on an interview with the Indianapolis Metropolitan Police Department.

ENDNOTES

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