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.

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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.[3]

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, PENNSYLVANIA

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.[4] 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.[5] 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.[6]

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.[7] 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.[8,9,10] 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.[11,12] 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.[13,14]

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.[15] 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.[16]

💬 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.[17,18,19,20,21,22,23,24] 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.[25]

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.

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.[26] Data-driven approaches[27] can be used to assess programs, modify them strategically to improve participant outcomes and tailor them for different target populations.[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.[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)[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.

FORT COLLINS, COLORADO

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.[33] 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.

INDIANAPOLIS, INDIANA

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)[36] 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.[37] CMS has recently proposed to include opioid use disorder counseling among the list of covered telehealth services in Medicare.[38] 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.

Acknowledgments

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