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Arnold Ventures

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.[1] As outcomes for those experiencing mental illness, substance use disorders and/or homelessness continue to deteriorate,[2,3,4] the costs of addressing these issues have risen.[5,6]

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.[7] Meanwhile, more than 20 million adults in the United States met the criteria for substance use disorder in 2014,[8] and nearly 553,000 experienced homelessness on a single night in January 2018.[9]

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.[10, 11, 12]

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.[13]

Simultaneously, the number of individuals entering the criminal justice system has also increased, particularly populations with behavioral health conditions.[14] 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.[15] Such realties have led to higher rates of mental illness[16,17], and substance use disorder[18,19], in the criminal justice system.

Unfortunately, many of these individuals, both within[20] 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.[21] 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).[22] 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.[23]

In terms of human costs, deaths attributable to substance use disorders increased by more than 600 percent between 1980 and 2014.[24] Chronic conditions, as well as environmental exposure, can reduce the life expectancy of an individual experiencing homelessness by 17.5 years.[25]

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),*[26] 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.[27] 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.[28]

SEATTLE, WASHINGTON

Officers in Seattle's Crisis Response Unit (CRU) receive special CIT training and work with mental health professionals to triage cases. Police officers take the lead on cases involving traditional law enforcement activities, such as arrests. Mental health professionals are tasked with cases where there is no evidence of a crime, or cases involving repeat contacts. Evaluation of Seattle's program found a reduction in time to case resolution, reduction in cases involving repeat contacts, an increase in referral to non-law enforcement agencies, and reduced burden on local hospitals.[29]

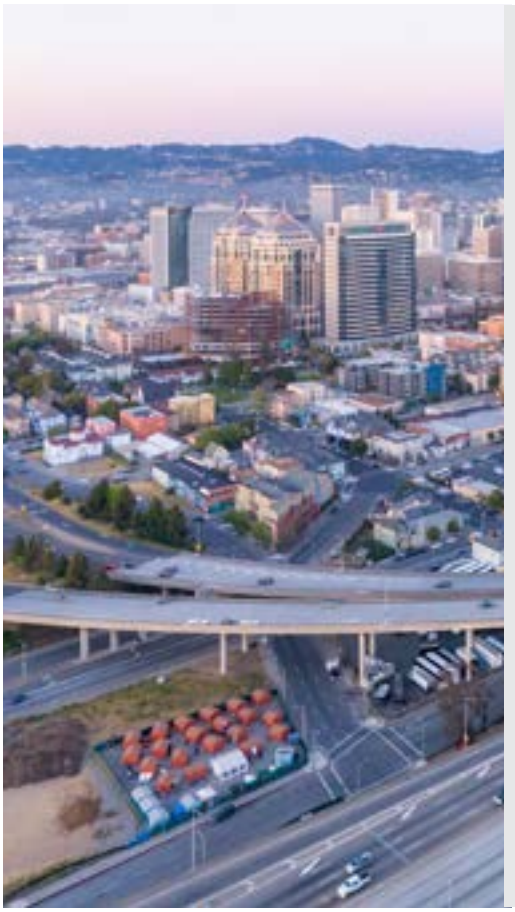
- *Co-responder initiatives*[30] that dispatch multi-disciplinary teams composed of a law enforcement officer and behavioral health specialist to intervene in mental health and substance use-related police calls. These teams can de-escalate situations that have historically resulted in arrest and assess 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.[31]

- **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.

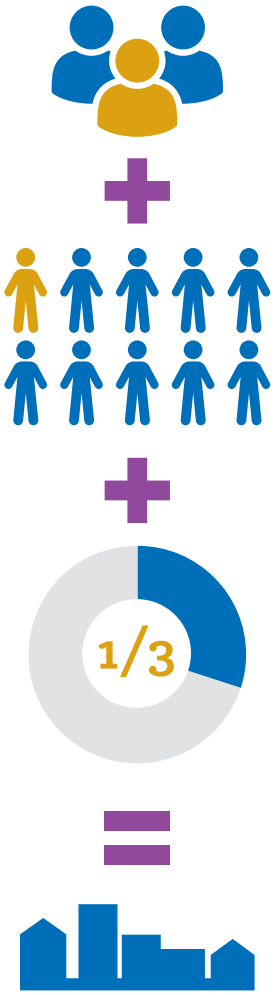
This initial list of local approaches is by no means exhaustive. Cities are innovating, learning from other cities, and tailoring crisis response strategies to their unique needs.

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]

ENDNOTES

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