The HARRIS CENTER for Mental Health and IDD
Transforming Lives

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Memorandum

To: Wayne Young, Executive Director
From: Scott Hickey, Ph.D. Director of Health Analytics, The Harris Center
Re: Models of Non-law Enforcement Responses to Mental Health Crisis Calls
Date: August 30, 2021

In August 2020, The Mayor's Task Force on Policing Reform Subcommittee on Best Practices and Training solicited input through a community survey. More than 12% of 7,300 total survey responses referenced mental health solutions to policing reform. Of mental health related suggestions, 21% offered ideas for reform including the use of non-law enforcement mental health teams, psychologically based screening for employment of officers, ongoing psychological support and counseling for officers, and use of CIRT Teams pairing social workers with law enforcement officers.

The need for alternative programs has received national attention and support from communities as well. Analyses of 911 calls from five US cities indicates that most calls are low to medium priority. The Center for American Progress (retrieved 8/30/21 from) noted:

> "Sending police to low-priority calls carries significant societal costs. First, stretched thin by low-acuity 911 calls, police officers have less time to devote to serious crimes. And when police spend their days racing between 911 calls, officers have few opportunities to proactively build relationships with community members. Crucially, sending law enforcement is not the best response to resolve certain types of calls for service. The police, for instance, are regularly expected to respond to people with mental health or substance use disorders. Yet officers are not hired for their skill in managing complex behavioral health needs, nor do they have the necessary training or resources to do so effectively or safely. Because the police are not set up to provide the necessary quality of service, police response can create negative outcomes for people with disabilities and those with chronic or acute behavioral health conditions. Often, these individuals are arrested and booked into jail, which can exacerbate their medical needs."

A survey of best practices in the use of non-law enforcement mental health teams as well as hybrid teams pairing social workers with law enforcement officers has focused attention on nationally recognized programs. The Albany Law Review has surveyed established alternative policing programs and has summarized four exemplary models. Included are programs from Eugene Oregon, Austin Texas, Olympia Washington and Edmonton Alberta. These programs have estimated the cost of a police response as Annual Police Budget/ # of Responses. This method yields estimates of cost per response for programs ranging from $363 (Olympia) to $2,573 (Edmonton). In contrast, alternative policing costs were dramatically lower. The Cahoots Program from Eugene reported $88/response while Austin reported a cost of $402 per alternative policing response. Estimated savings were calculated as exceeding $3 Million in Austin and above $22 Million in Eugene.

Programs based on the CAHOOTS model are being launched in numerous cities, including Denver, Oakland, Olympia, Portland, and others

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The Harris Center has moved to implement its own, augmented version of these models, relying on the guidance and experience garnered from published experience, but with local improvements as described below.

The Harris Center's Mobile Crisis Outreach Team Rapid Response (MCOT RR)

Rapid Response expands the reach of the traditional Mobile Crisis Outreach Team with the addition of 18 licensed master level and bachelor level clinicians partnered to provide 24/7 rapid response to city residents referred by the Crisis Call Diversion program. Several characteristics distinguish this newly implemented model. The traditional model provided extensive screening by Crisis Call Diversion program and additional phone screening by the MCOT team (to assess the nature of the mental health crisis) prior to dispatch and on-site response.

While benefits of having medical team member may justify the cost for some alternative programs, The Harris Center's Rapid Response MCOT Team has been constructed to focus on mental health crises. Rather than relying exclusively on bachelor's degreed staff and persons with lived experience, The Harris Center has opted to build teams which include licensed mental health professionals. The training and expertise these licensed professionals bring to their work has proven invaluable in our work with more traditional mobile crisis response teams. The addition of these licensed clinicians is expected to enhance the quality of care offered in this locally modified and augmented model.

In contrast to traditional MCOT, in the MCOT RR pilot, Crisis Call Diversion sends calls directly to MCOT Rapid Response within 5-10 minutes of receiving 911 calls that have been screened for safety and determined to be mental health related.

These call codes include suicide attempt with no weapon, suicide attempt weapon unknown, suicide threat, urgent mental health welfare check, mental health disturbance, trespasser/prowler with mental health concerns, suspicious person with mental health concerns, truancy calls, and routine mental health welfare checks.

MCOT Rapid Response team meets individual on the scene and assesses the client. MCOT RR team can either resolve the crisis on scene, transport individual to a psychiatric hospital or refer to MCOT for continued crisis stabilization. If individual is involuntary, MCOT RR can call 911 for police to meet MCOT RR on scene. Community-based crisis response alleviates the Houston Police Department, Houston Fire Department, and Emergency Medical Services from responding, freeing them to provide emergency medical, fire and police response to Houston area residents.

Initial outcomes for the program are promising. Since March 2021, Crisis Call Diversion has answered 2,582 calls for service. Crisis Call Diversion has diverted and deescalated 1,158 of the calls over the phone and 165 calls were sent to MCOT Rapid Response. MCOT Rapid Response was able to resolve 64 of the calls on scene, 44 were transported to a hospital, 2 were transported to Jail Diversion Program, 37 of the calls HPD/HFD were needed to help on the scene, and for 18 of the calls the individual was unable to be located upon arrival.

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Conclusions

It is expected that alternative policing models have been sufficiently described and tested to allow for successful implementation. Further local refinement of this model may enhance outcomes. It is expected that implantation will yield benefits in quality of care, in reduced demand on law enforcement, and in cost savings to the community. Evidence from the CAHOOTS experience provides assurance that the model can be implemented safely and effectively.