Road Runners

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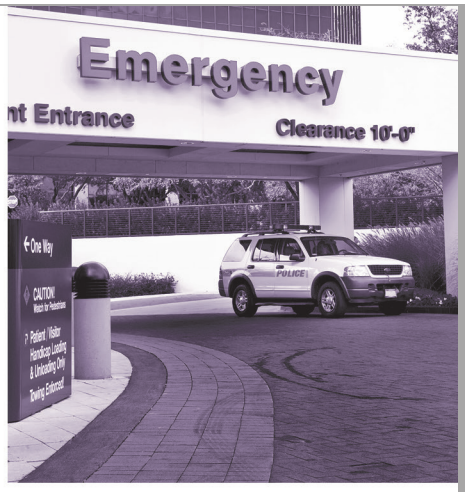

The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey

May 2019

TREATMENT ADVOCACY CENTER

TreatmentAdvocacyCenter.org/Road-Runners

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BACKGROUND

Approximately 8.3 million Americans have a severe mental illness such as schizophrenia, severe bipolar disorder or major depression with psychotic features.[1] Almost half of these people are untreated on any given day.[2] Without proper treatment, people with severe mental illness are at risk of experiencing negative outcomes that seriously impact them and the people around them.

Psychiatric Crisis:

In this report, we define a psychiatric crisis as a situation in which a person's psychiatric symptoms are so severe as to create a risk of physical harm to self or others or render the person unable to exercise self-care and live safely in the community.

Faced with limited community treatment options and a dire shortage of psychiatric inpatient beds, those in need of mental health treatment may not receive it until a crisis occurs and law enforcement intervenes. Approximately one-third of individuals with severe mental illness have their first contact with mental health treatment through a law enforcement encounter.[3]

Law enforcement officers are thus often on the front lines of psychiatric care, charged with responding to, handling and even preventing mental illness crisis situations.

The predictable results have been criminalization of severe mental illness and extreme overrepresentation of people with mental illness in jails and prisons.[4] Research indicates that persons with serious mental illness are most often arrested for misdemeanor crimes.[5] They are also four times more likely to be incarcerated for low-level charges than individuals without psychiatric disease.[6]

People with mental illness are more likely to be arrested if they live in communities with limited treatment options.[7] Officers sometimes even resort to "mercy bookings" (using low-level misdemeanor charges) to get individuals in psychiatric crisis off the street and into treatment.[8] Studies have found that in some parts of the country psychiatric treatment is more accessible in jail than in the community.[9]

Police officers and sheriffs' deputies with little or no medical or mental health training are now regularly required to recognize conduct as symptomatic of psychiatric illness while in the midst of a chaotic encounter and to strike a balance between upholding public safety and serving the needs of the person in crisis.

Once an individual is taken into custody, it is law enforcement's responsibility to transport him or her to the appropriate service. Law enforcement agencies throughout the country are feeling the strain of this responsibility on their budgets. Even when statistically controlling for type of response, law enforcement encounters with people with mental illness have been shown to use at least 90% more resources than encounters not involving mental illness.[10]

Diverting people in psychiatric crisis away from the criminal justice system and into treatment may be undermined by delegating the transportation function to law enforcement. Officers frequently find treatment-focused response options difficult to access or non-existent;[11] unsurprisingly, they adhere to the arrest procedures they have been trained to carry out.

In addition to serving as street-corner psychiatrists, law enforcement officers have become road runners, responding to mental health emergencies and traveling long distances to shuttle people with mental illness from one facility to another.

Members of law enforcement do not serve as treatment providers for any other illness. It is difficult to imagine subjecting someone having a heart attack to arrest, or someone with cancer being transferred to a specialty center, in handcuffs, in the back of a police cruiser.

But regardless of the fact that severe mental illnesses are brain diseases, we persist in treating their behavioral manifestations as criminal acts.

The Treatment Advocacy Center set out to develop a national picture of the outsized role law enforcement plays in psychiatric crisis response and transportation. *Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey* represents the first-ever national survey of sheriffs' offices and police departments on these issues. It provides a glimpse into the burdens being shouldered by law enforcement, and the fiscal and societal implications of that reality.

WHAT ARE LAW ENFORCEMENT TRANSPORTS?

As each community is unique, each law enforcement agency handles transportation of people with mental illness differently. Different types of transports may be precipitated by a variety of circumstances. Destinations may also vary significantly based on a host of factors such as the availability of services in a given community. Finally, policies, procedures and state laws all govern how transports of people with mental illness are conducted, by whom and to what destination.

While it is important to recognize national variability, we provide the following overview and categorization of law enforcement transport based on a common structure used throughout the United States.

Transportation of individuals with mental illness by law enforcement encompasses two general categories: "emergency" and "nonemergency" transport.

EMERGENCY TRANSPORT	Initiated by
Transportation in response to an individual in psychiatric crisis in the community	**Mental health service call:** A call to 911 or other crisis service line that results in a service response dispatched to the community **Law enforcement encounter:** An encounter between a law enforcement officer and an individual in psychiatric crisis while the officer is on patrol
	Destinations
	General hospital emergency department, psychiatric emergency room, inpatient facility, or jail

NONEMERGENCY TRANSPORT	Initiated by
Transportation in response to an individual with a severe psychiatric illness needing an intervention or service who is not in immediate risk of harm to self or others	**Planned event:** A court order or other planned event resulting in transport between facilities such as an emergency department to an inpatient bed
	Destinations
	Emergency department, inpatient facility, courtroom, or jail

Every act of transport is informed by state laws and regulations on involuntary treatment, including emergency evaluation, inpatient civil commitment and outpatient civil commitment. Civil commitment laws establish the criteria under which the state can involve itself in a person's mental health treatment, and the associated regulations dictate procedures by which it is permitted to do so.

- **Emergency psychiatric evaluation:** allows for temporary custody of individuals experiencing psychiatric crisis to determine the need (if any) for longer-term custodial care.
  - Law enforcement officers in every state are empowered by law to detain and transport to an evaluation facility any individual encountered in the community who the officer reasonably suspects is in psychiatric crisis and in need of a clinical assessment. If a clinician at the receiving facility agrees that evaluation is called for, the person will be admitted and held for a short period (in most states, no more than 72 hours) for a determination to be made on whether to seek a court order authorizing longer-term custodial care (known as "civil commitment").
  - State laws also typically outline criteria and procedures for a civil court judge, facility director or psychiatrist (sometimes two psychiatrists) to order or direct law enforcement officers to locate, detain and transport an individual in the community believed to be in acute psychiatric crisis. Depending on the procedures and availability of beds, this may result in a transport to a psychiatric unit in a general hospital, a crisis stabilization unit, a freestanding psychiatric hospital or a state psychiatric hospital for evaluation and assessment. Once delivered to the receiving facility, the person is subject to the same short-term hold for evaluation described above.
- **Inpatient commitment:** allows for longer-term involuntary hospitalization under court order for mental health treatment. Patients are subject to inpatient commitment until they are deemed stable, that is, no longer a danger to self or others.
  - Most often this is a nonemergency planned transport from the location of the individual's emergency evaluation to an inpatient facility such as a state psychiatric hospital.
- **Outpatient commitment:** allows for treatment in the community under civil court supervision for people with serious mental illness who have difficulty adhering to their treatment plan and have experienced negative outcomes as a result.
  - This process most often involves nonemergency transports, typically to civil court hearings.

WHY FOCUS ON LAW ENFORCEMENT TRANSPORTS?

The systemic shift to address mental illness as a law enforcement concern rather than a medical one has had profound consequences. Serious mental illness has become so prevalent in the U.S. corrections system that jails and prisons are now commonly referred to as "the new asylums."[12] The Los Angeles County Jail, Chicago's Cook County Jail and New York's Rikers Island jail each hold more mentally ill inmates than any remaining psychiatric hospital in the country.[13] Based on the total inmate population, approximately 383,000 individuals with severe psychiatric disease are currently behind bars — nearly 10 times the number of patients remaining in the nation's state hospitals.[14]

To halt this trend, we must address the problem at its inception.

Although it is impossible to fully quantify the loss of dignity, unmet potential and community unrest resulting from the failure to respond appropriately to people with mental illness in need of care, we can document the time and resources communities lose by forcing law enforcement onto the front lines of mental health care.

In that way, law enforcement transport can serve as both the "canary in the coal mine," alerting us to the crisis, and an avenue to begin to address the crisis itself.

METHODOLOGY

Quantitative methods

Questions were developed using prior knowledge of quantitative public health survey methods, an academic literature review of similar law enforcement and mental health surveys, and interviews with law enforcement and survey methodology experts. The draft survey questions were tested on law enforcement officers with the assistance of the New York State Association of Chiefs of Police and the National Sheriffs' Association, and further refined for accuracy and reliability.

The survey questionnaire was created and disseminated via the software SurveyMonkey and distributed to law enforcement agencies throughout the United States. The National Sheriffs' Association sent the survey description and link via e-mail to more than 3,000 sheriffs. Michael Lefancheck, chief of the Baldwinsville, New York, Police Department and president of the New York State Association of Chiefs of Police, disseminated the survey to the state association of chiefs of police e-mail list and asked the president of each respective state association of chiefs of police to send it to their members. The survey responses were monitored as they were received, and e-mail and phone follow-ups were conducted with state chiefs of police and sheriffs' offices as needed to increase the response rate.

After data collection was finished, the dataset was extensively cleaned to improve data quality. Unknown responses were eliminated, and results were standardized for analysis. The data were coded and then sample sums or means were calculated. Weighted averages were calculated when applicable.

Qualitative methods

The survey questionnaire included qualitative questions where respondents could write in answers and provide more information. Pairing qualitative with quantitative responses provides further insight into the issues at hand and informs the conclusions that can be drawn from the data.

Deductive coding was used to develop a codebook, and all qualitative survey responses were coded. Codes were then categorized by topic area. Key themes emerged based on the categorization, and the top seven themes are presented based on the frequency of responses.

Case studies

Case studies were conducted to accompany the *Road Runners* survey results to provide an in-depth look at potential solutions for transportation of persons with severe mental illness in the United States. The locations were selected to highlight different aspects of the problem a program might be trying to solve and to give a variety of possible solutions. Jurisdictions may look to individual case studies to determine model solutions that best fit the needs of their unique communities. Case studies were completed by gathering source material and conducting in-depth interviews with key leaders.

RESULTS

Quantitative results

We received 355 unduplicated responses from law enforcement agencies throughout the country. Of those responses:

> "Transporting persons in crisis is very expensive for small agencies."
>
> — Wisconsin respondent

- Sixty-one percent were from police departments, 34% from sheriffs' offices, and 5% from other, including campus police, public safety, and state police.[i]
- All states were represented except Alaska, Connecticut and Hawaii. The highest number of responses came from Georgia, Wisconsin and New York; however, the response rate was highest in Nevada and Arizona.[ii]
- Thirty-two percent of responding agencies have 10 or less full-time equivalent (FTE) officers or deputies, 41% have 11 to 50 FTEs, 17% have 51 to 150 FTEs, and 9% have more than 150 FTE officers or deputies.[iii]

The responses represent **454,438** service calls or encounters with individuals with serious mental illness in the United States in 2017.

Key findings

Our survey sought to determine the burden created by law enforcement transportation of individuals with severe mental illness. Survey responses represent preliminary findings on the issue and illustrate an extensive resource drain on law enforcement agencies in the following ways:

Costs

Law enforcement agencies spent a considerable amount of money transporting people with mental illness. Our survey results indicate that **10% of law enforcement agencies' total budgets was spent responding to and transporting persons with mental illness in 2017.**

The role of police officers and sheriffs' deputies in mental illness transport has created a significant financial burden on law enforcement agencies throughout the United States. Based on the 304 survey responses that provided cost data, **more than $17.7 million was spent in 2017 transporting people with severe mental illness**. If extrapolated out to all law enforcement agencies in the country, the results indicate that **approximately $918 million was spent by law enforcement nationwide transporting people with severe mental illness in 2017.**[15]

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[i] The survey results represent an over-representation of sheriffs' offices. See the limitations section on page 18 for more details.

[ii] For a detailed look at the number of responses and response rate by state, see Appendix C on page 32.

[iii] The survey results represent an over-representation of larger agencies. See the limitations section on page 18 for more details.

Average distance to state hospital varies by state

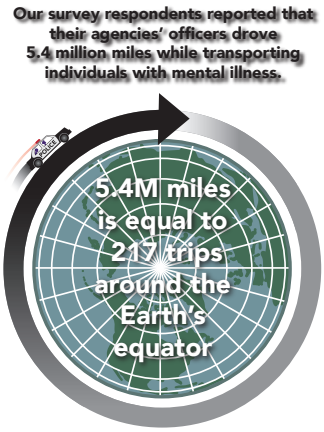
Providence, Rhode Island to Eleanor Slater Hospital, Cranston — 8.7 miles

Newark, New Jersey to Greystone Park Psychiatric Hospital – 24.5 miles

Milwaukee, Wisconsin to Winnebago Mental Health Institute – 94.7 miles

Billings, Montana to Montana State Hospital – 249 miles

Distance



Law enforcement officers put many miles on their squad vehicles transporting individuals with severe psychiatric diseases. Based on 336 surveys with distance data, law enforcement survey respondents drove a total of **5,424,212 miles** transporting individuals with serious mental illness in 2017 — **the equivalent of driving around the Earth's equator more than 217 times.**[iv]

The long distances to travel, especially in rural or frontier areas, provide law enforcement little incentive to transport an individual in psychiatric crisis to a medical facility instead of to jail, a practice that further criminalizes the illness. According to our analysis of survey responses, the average distance to transport an individual in mental illness crisis to a medical facility was five times farther than the distance to transport him or her to jail.

Time spent transporting varies significantly by department

"It is an 8 hour round trip drive to the state facility."
– Wisconsin respondent

"The transports we do to local facilities are very minimal and just outside our jurisdiction."
– Michigan respondent

"Our agency takes a lot of service calls for suicidal individuals. We have to transport those individuals to Shreveport which is about a 30-minute drive one way. We are a small agency that has limited resources."
– Louisiana respondent

Time

DURING TRANSPORT

Law enforcement agencies report spending a substantial amount of time responding to and transporting people with mental illness, much of which is considered outside regular law enforcement duties. Based on 325 survey responses with time data, **the amount of time spent**

[iv] The number of miles driven by law enforcement officers vary depending on average distances to the destination, including psychiatric facilities such as state hospitals, as well as overall numbers of psychiatric transports per agency.

transporting people with mental illness by law enforcement agency survey respondents in 2017 sums to 165,295 hours, or more than 18 years.

According to the survey results, **21% of total law enforcement staff time was used to respond to and transport individuals with mental illness in 2017**. This time spent by officers has significant implications for public safety. For example, due to the unpredictability of psychiatric crises, it is almost impossible to allocate staff time appropriately to cover these events for small agencies. Without the ability to predict when a psychiatric crisis transport will be needed, the necessary response may leave a community without adequate law enforcement coverage.

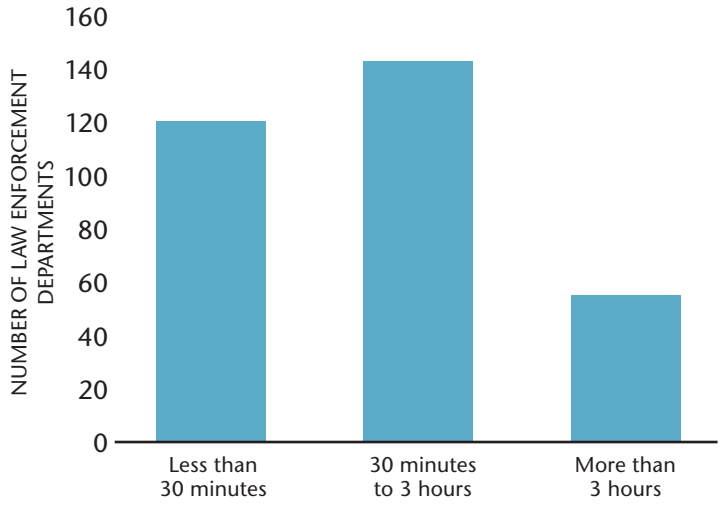
AFTER TRANSPORT OCCURS, WAITING FOR TRANSFER OF CUSTODY

Often, the biggest issue facing law enforcement is not the time or distance needed to travel for a mental illness transport, but the time spent waiting at hospital emergency departments for transfer of custody to occur. Results from the survey indicate that officers waited significantly longer **— almost 2.5 hours longer —** when dropping a person off at a medical facility than if transporting to a jail.

The average wait when transporting to a hospital was *three hours*, versus 37 minutes when transporting to jail.

As the graph below shows, there was significant variation among average officer waiting times when engaging in drop-offs to hospital emergency departments. Many variables affect officer waiting times, including time of day or week, such as whether the transport is occurring during business hours or on weekends. Some officers responded that waiting time is reduced substantially if the officer gives notice to the hospital; others said that they will not transport to a particular hospital at all if it does not provide a quick transfer. Bed availability at inpatient facilities also affects officer wait time. **Some officers reported having to wait with the individual for 72 hours or more until a bed becomes available.**

Officer Waiting Time in Emergency Departments



Research has shown that having central drop-off locations for law enforcement with a quick intake process results in reduced police officer frustration and decreased reliance on arresting and jailing people with mental illness.[16] In addition, the presence of a drop-off center has been shown to contribute to perceived efficacy of specialized police response programs.[17] For an example of how cross-sector collaboration between

law enforcement and mental health systems can improve outcomes for people with serious mental illness, see the case study "A comprehensive treatment system in southern Arizona," on page 11.

WHEN TRANSPORTING TO A MEDICAL FACILITY

According to anecdotal evidence and media reports on the subject, law enforcement officers often voice frustration that when they do transport an individual to a hospital, the officer may see the same individual denied admission or prematurely discharged — effectively walking out the front door as the officer is driving away. In an attempt to capture and quantify this concern, the survey included a question regarding admission after transport to a medical facility.

> "It seems that most subjects we transport to a medical facility for a mental evaluation are not evaluated or treated for very long."
>
> — Louisiana respondent

The survey results indicate that of those persons with a severe mental illness who were transported to a medical facility, on average, **55% of persons transported were admitted for evaluation, 37% were evaluated and then released, and 8% were immediately released**. The results confirm officers' frustrations: only a little more than half of the time were individuals who were transported to treatment by law enforcement actually admitted for an evaluation.

See Appendix B on page 28 for more survey results, including breakdowns of emergency versus nonemergency transport, distributions of transport destinations and the utilization of mental health training or support services by law enforcement agencies.

21%
Staff time spent responding to or transporting individuals with mental illness.

3 hours is the average time an officer waits at a medical facility until transfer of custody occurs.

37 minutes is the average time an officer waits when transporting an individual to jail.

10%
Overall budget spent responding to or transporting individuals with mental illness.

$17.7 million
Spent in responding to and transporting individuals with mental illness from survey respondents.

$918 million
Estimate of dollars spent each year on mental illness transport by law enforcement.

5 times
longer is the average distance driven by law enforcement to transport an individual to a medical facility than to jail.

5.4 million
miles driven by officers transporting individuals with mental illness by survey respondents.

A Comprehensive Treatment System in Southern Arizona

In southern Arizona, a collaboration between law enforcement and mental health providers has fostered one of the most innovative prevention and crisis response models for persons with mental illness in the United States.

The model, based in Tucson, Arizona, draws from a number of crisis intervention standards while incorporating additional specialized personnel and a crisis center offering comprehensive psychiatric support services. Tucson's system addresses not only people in the midst of a crisis or within the civil commitment process, but also those susceptible to falling through the cracks, by preventing crisis situations from occurring.

Through a more thoughtful approach to serious mental illness that focuses on the full continuum of psychiatric care — from prevention to crisis response — Tucson has been able to decrease the number of psychiatric events in which law enforcement officers may need to intervene. As a result, officers spend less time responding to crises and transporting individuals to care or legal proceedings. However, when law enforcement does need to transport people with mental illness, procedures that ensure quick drop-offs at treatment facilities and an adequate supply of treatment beds help reduce the time officers spend and distances they travel while fulfilling their responsibilities. The participating officers are also trained to conduct transports in a nonstigmatizing manner — one that balances the safety of the individual and the public while limiting the use of restraints and treating everyone involved with respect.

The Tucson model comprises three key characteristics:

Law Enforcement Mental Health Support Teams

Since 2014, the Tucson Police Department has operated a specialized team of officers who respond solely to situations involving individuals with mental illness, known as the Mental Health Support Team (MHST). Although the Tucson Police MHST has become the larger, more well-known face of the Arizona model, the original MSHT was created by the Pima County Sheriffs' Office in 2013. Both are operational today, but all data referenced in this section is specific to the Tucson Police MHST. MHST personnel volunteer to participate in this capacity and are not appointed to do so by superiors, earning their self-imposed motto of "dedicated, not designated."[18] Team members have an understanding of mental illness and how it relates to public safety as well as service skills and attributes that make them well suited for the role.[19] Research suggests participating on a voluntary basis improves the success of mental health–related specialty law enforcement programs.[20]

MHST personnel undergo specialized training that teaches them to identify and build rapport with persons living with psychiatric conditions and facilitate needed care *before* crises occur. Their duties primarily lie in prevention rather than crisis response, differentiating them from other law enforcement–mental health frameworks such as the Crisis Intervention Team (CIT) model. The MHST curriculum is not mutually exclusive to that of CIT — more than 70% of Tucson first responders and 911 dispatchers are CIT trained[21] — but provides an additional level of instruction from a different perspective with slightly different goals.

The MHST serves two important functions: support/transport and investigative. Both functions have the goal of providing linkage to treatment before a situation escalates to a crisis.

First, support/transport personnel assist people already involved in the civil commitment process. When a court generates an application for psychiatric evaluation or another type of commitment order, the MHST is responsible for locating and serving the order to the individual. Dedication to ful-

filling as many orders as possible ensures that those in need of treatment are properly brought into the mental health system. Serving orders peaceably and inconspicuously, using unmarked vehicles and plainclothes uniforms, and reducing the need for use of force are also core elements of MHST operation. And in 2016, MHST increased the success rate of orders served to nearly 100% — compared with a previous rate of 30% — and did so peaceably without officers needing to use force.

The MHST also has positive impacts on other law enforcement officers. By taking on responsibilities related to commitment orders and shifting ownership away from general law enforcement, the MHST saved patrol officers more than 300 hours of time during the first half of 2017 alone.[22]

The second function of the MHST is investigative, conducted by detectives who inspect thousands of service calls each year that are flagged by dispatchers as potentially mental health related.[23] For example, if someone reports loss of contact with a family member who has a severe mental illness, MHST detectives will seek more information about the individual and his or her situation. If detectives determine that assistance is needed, they may try to connect the person with previous treatment providers or facilitate new connections to providers in the community. Detectives also collaborate with treatment providers by sharing relevant information about the individual's living conditions. For example, detectives may note whether the person has access to firearms, was the subject of previous 911 calls or has been involved with the criminal justice system.

Initially apprehensive about working with law enforcement, providers have since helped build a solid relationship centered on the shared goals of decreasing unnecessary arrests and improving individual treatment.

Crisis Mobile Teams

For situations that can be resolved without the need for civil commitment, law enforcement or MHST personnel may enlist the support of a crisis mobile team. Such teams are made up of medical professionals who help with assessment and stabilization of a person experiencing a psychiatric crisis, as well as with post-treatment follow-up. Law enforcement agencies have a direct line to crisis team supervisors. In the event a team needs to be dispatched, it must arrive on the scene within 30 minutes. Crisis mobile teams may also be dispatched as co-responders with MHST personnel.

The Crisis Response Center

Another essential element of the Tucson mental health system is its centralized Crisis Response Center (CRC). Unlike many crisis care facilities and inpatient psychiatric hospitals in other parts of the country, Tucson's crisis response facility pledges to "address any behavioral health need at any time," and rarely refuses admission to a person who might exhibit disruptive behaviors or have a complex medical history.[24] Individuals transported by law enforcement are guaranteed admission as a matter of policy. The center serves about 1,000 individuals per month, almost half of whom are referred by law enforcement (45%). Walk-ins (35%) and individuals referred by emergency departments (10%) or crisis mobile teams (10%) make up the remainder of clients.[25]

The facility's location near public transportation options and major roadways makes incoming and outgoing travel easy for both clients and law enforcement. It is also adjacent to other resources, including a mental health court, an inpatient psychiatric hospital and a general hospital emergency department.

The CRC goes to great lengths to provide a space that allows it to accomplish its treatment goals while remaining comfortable. It offers recliners and couches for client use, as well as showers and laundry facilities. There is also *no visible security presence*, although staff is trained to handle

safety concerns. If an agitated patient needs a quiet place to calm down, the CRC has a single seclusion and restraint room to protect the individual and others in the vicinity until tensions have settled. However, on the whole, the facility's rate of restraint use is 75% below the national average for inpatient psychiatric hospitals, or less than 0.15 hours per 1,000 patient hours.[26]

The CRC also contains a 23-hour observation unit for people in immediate need of crisis resolution because they present a danger to themselves or others. The unit is staffed 24 hours a day, seven days a week, and uses mental health providers and peers living with mental illness to resolve crises and discharge individuals with detailed treatment plans. The median wait between admission and speaking with a clinician is just 90 minutes. Most patients (60% to 70%) seen in the 23-hour observation unit are discharged the next day, avoiding inpatient psychiatric hospitalization altogether.[27]

As our transportation survey results indicate, when officers transport people with severe mental illness to a treatment facility, they are often met with a lengthy intake process, confusion as the facility is not ready to accept the individual, or refusal to admit the individual entirely. If a person in law enforcement custody is admitted, the transporting officer(s) must maintain custody and remain on the premises until an official transfer occurs. Tucson's CRC was designed to mitigate or eliminate these barriers.

A special gated entry for law enforcement and an alert system notifying staff of incoming patients allow for a quick and smooth client transfer. Drop-offs typically take officers less than 10 minutes, which is half the time required for a jail booking.[28] This timing is important to ensure that transporting individuals to the CRC is a viable alternative to jail.

As a testament to its success, more than 85% of patients would recommend the CRC's services to friends or family members.[29]

Qualitative results

Qualitative information has distinct benefits for gaining further insights into data-driven results, providing answers to key questions around what the data mean and what conclusions can be drawn. Because qualitative data are based on human observations and experiences, the results illustrate people's thoughts, motivations and beliefs in ways not captured by numbers and statistics.

Our analysis of the qualitative responses from the survey indicates key themes concerning law enforcement agencies throughout the United States. These themes emerge from beliefs among members of law enforcement about what contributes to the criminalization of mental illness, the issues law enforcement faces when its members participate in transportation and "care" of persons with mental illness and potential solutions to address these issues.

The following represent the key themes, in order of frequency.

Inadequate treatment capacity

The most prominent theme emerging from the survey is that the psychiatric bed supply for people with severe mental illness is extremely limited. Respondents felt that many of the time and resource issues surrounding psychiatric transports are due to an inadequate supply of beds in the community for individuals to receive treatment.

As with any other illness, severe psychiatric diseases have a variable illness course, with waxing and waning symptomology and resulting needs for the individual suffering. Therefore, a full continuum of psychiatric care, including outpatient, crisis, and acute care, as well as longer-term and residential-type beds, are needed for a functioning psychiatric system.

> "Far too often, crisis services do not represent a systemic approach to addressing community needs but rather a collection of disconnected, overlapping and non-coordinated services offered by well-intended providers; often missing essential pieces needed to align the service delivered with the needs of the individual."
>
> — *A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness*, National Association of State Mental Health Program Directors, August 2018

Few communities in the United States have such a robust crisis care system in place.[30] The limited availability of crisis care, both in specialty psychiatric emergency centers and emergency departments in general hospitals accepting psychiatric patients, means law enforcement officers must travel long distances with individuals in psychiatric crisis in the back of their squad cars. As the survey results indicate, personnel drove, on average, five times farther when transporting a person in psychiatric crisis to a medical facility than if they were to transport him or her to the local jail.

In addition, the number of state hospital beds in the United States has hit an all-time low.[31] Because state hospital beds remain the most commonly used, and in some communities are the only available beds for civil and forensic commitments,[32] the limited bed supply results in officers driving long distances or even across the state for an emergency evaluation or inpatient commitment.

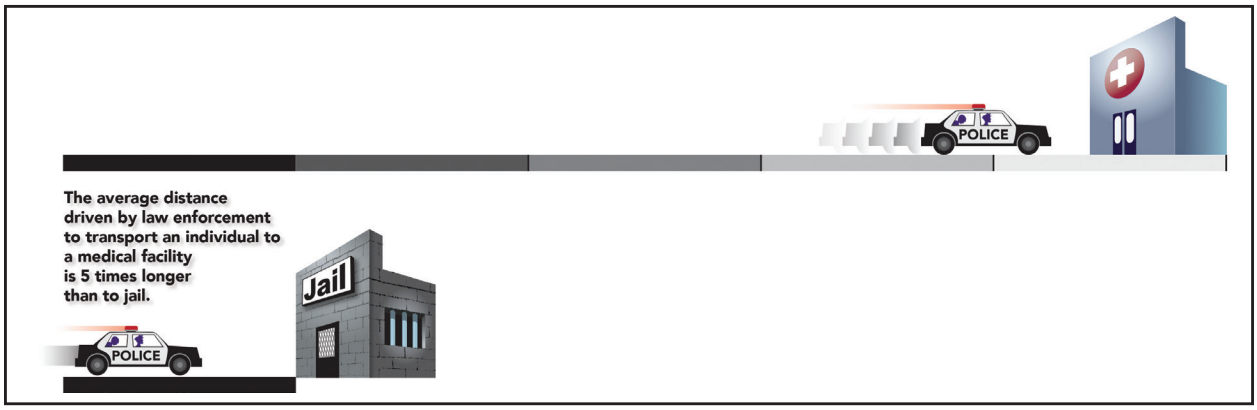
The limited supply of inpatient beds also creates a bottleneck in emergency departments. People presenting to the emergency department who may need a higher level of psychiatric care have nowhere else to go. As a result, psychiatric patients commonly board in emergency departments for days,[33] and the transporting law enforcement officer may have to wait with the person until he or she is admitted to a bed or a transfer of custody occurs. Alternatively, an individual may be "streeted," or released from the emergency department back to the street where the law enforcement officer picked the person up in the first place. This practice has implications for the safety of the individual as well as the public, both of whom law enforcement are employed to protect.

> "We should not be in the mental health transport business. … We are a police department, not doctors."
>
> — Illinois respondent

Even if a treatment facility has open and available beds, barriers may prevent it from accepting certain patients under certain conditions. For example, psychiatric facilities may not admit an individual who is under the influence of drugs or alcohol.[34] Or, specialty crisis centers may not admit an individual who has physical health challenges that could require intensive medical attention. Because law enforcement officers have a significant role in psychiatric crisis response and transport, they are ultimately required to make what amount to clinical decisions based on patient status and the complex structure of treatment options to determine the destination to which an individual should be transported.

The inhumanity of criminalization

The second major theme that emerged from the survey responses is that members of law enforcement believe they should not have such a prominent role in caring for and transporting individuals with serious mental illness because it leads to criminalization of the illness.



Just as the back of a squad car is not an appropriate place for someone in cardiac arrest, law enforcement respondents suggest that their vehicles are not an appropriate place for someone suffering from a psychiatric crisis. In addition, some respondents express concern regarding requirements to use handcuffs for psychiatric transports.

> "Since when did we consider the idea, even with the best intentions, that placing someone in need of psychiatric care in the back of a squad car is a good thing?"
>
> — Illinois respondent

Law enforcement respondents also voice trepidation about their increasing role and responsibility in psychiatric care and frustration with the mental health and medical system for lacking accountability for its failures. Some respondents acknowledge their role in criminalizing mental illness and expressed strong dissatisfaction with systems of care that incentivize criminal justice involvement instead of healthcare. As an illustration, our survey indicates that, on average, law enforcement respondents waited **five times longer** when transporting an individual to a hospital versus a jail.

Resource concerns

Law enforcement respondents indicate that their role in psychiatric crisis response and transport has a significant impact on their budget and staff time. This is reinforced by our survey results, which show that 21% of officers' time and 10% of law enforcement agency budgets were spent responding to and transporting individuals with serious mental illness.

Agency staffing is typically very streamlined, with schedules created based on community coverage and ensuring public safety. Because of the nature of a psychiatric crisis, these events are unpredictable and response is difficult to plan for ahead of time. The long distances to drive, time officers must stay with the individual for transfer of custody, and requirement that officers respond to calls in pairs all create considerable resource challenges. In particular, for smaller agencies with less staff and more efficient schedules, the unpredictable nature of psychiatric crisis calls puts a disproportionate strain on operations and takes officers away from regular duties.

Another resource concern for law enforcement in handling psychiatric transports is the lack of appropriate staff training due to inadequate agency budgets. CIT and other forms of law enforcement training may not be feasible for small agencies for a number of reasons, including large up-front and ongoing expenses, lack of available staffing and competing priorities.

Law enforcement training

Training to respond to mental health calls for service and de-escalation techniques, irrespective of cost, was the next most frequent emerging theme. Responses show a need for more training in psychiatric illnesses and best practices for how to respond to calls involving people experiencing symptoms of such illnesses. Survey respondents also express an understanding of the positive effect adequate mental health training has on an officer's ability to interact with individuals with mental illness and keep them out of the criminal justice system.

> "I feel as all law enforcement should be required to have mental health CIT training."
>
> — South Carolina respondent

Survey respondents differed in their opinions about the appropriate proportion of agency patrol officers who need CIT training. Some believe mandating CIT training for all officers is necessary, while others feel strongly that agencies should adhere to the core elements of CIT and promote the CIT specialist role.

Research has shown officers respond better to CIT training when they volunteer to participate.[35] However, states and jurisdictions are moving toward mandating CIT-like training due to the belief that all officers will likely encounter people with mental illness at some point while on patrol and should be adequately prepared.

The survey results indicate there is an understanding that some basic level of mental health training is needed for all officers. In addition, the results suggest that officers recognize that training is effective in improving law enforcement encounters with persons with mental illness.

Public safety concerns

Law enforcement's responsibility is to enforce the law and ensure public safety. A major survey theme indicates that law enforcement officers feel their role in transporting individuals with serious mental illness severely restricts their ability to uphold public safety. The long-distance driving that is required, sometimes with two officers, is debilitating to small agencies, leaving parts of the community without the protection of law enforcement for long periods of time. Lengthy turnaround periods when engaging in hospital drop-offs also keep officers off patrol.

> "The current system can and does paralyze efficient police operations to protect the general public."
>
> — Michigan respondent

Cross-sector collaboration

Law enforcement respondents suggest that coordination and collaboration between the criminal justice, health care and social service systems are needed for a meaningful shift in the treatment of individuals with mental illness to take place. The sixth major theme based on our analysis emphasized the willingness of law enforcement to work with other agencies to improve outcomes for individuals with serious mental illness.

Law enforcement respondents expressed frustration with the health system for its lack of accountability in taking care of people with severe mental illness. The survey results indicate that respondents recognize multiple service sectors and stakeholder groups are involved, and they are all needed to effectively solve the problems facing individuals with mental illness.

Individuals with mental illness who are frequently encountered by law enforcement made up one-fourth of all transports of people with mental illness, according to our survey results. Previous research has shown that people with serious mental illness who are high utilizers of one system are often also high utilizers of other systems, including emergency departments, hospitals and social services.[36] Emerging scholarship points to the importance of cross-sector collaboration to improve outcomes for such people.[37]

Super-utilizers

"Making up barely 3% of US adults, individuals with schizophrenia or severe bipolar disorder make up a disproportionately large share of the people presenting in hospital emergency departments, being admitted to hospitals, generating calls to city police departments, being booked into county jails, living in homeless shelters or on the streets and otherwise falling victim to the dismantling of the US mental health system over the last half century.

"As a result, people with treatable psychiatric diseases generate patterns and costs found nowhere else in Western democracies."

— Doris A. Fuller et al., *A Crisis in Search of Data: The Revolving Door of Serious Mental Illness in Super Utilization*, April 2017

Lack of data

The final major theme illustrated by survey responses concerns the availability of data and the need for more information to generate thoughtful solutions. Respondents note the difficulty in completing the survey due to a lack of agency data collection but also highlight the importance of gaining an understanding of the issues faced by law enforcement to better inform decision making.

Respondents also express a need for better documentation of encounters with people with mental illness to improve future encounters. For example, officers felt that if they had better ways to document service calls that involve people with mental illness, they would have increased opportunities to divert people into treatment instead of arrest.

"I apologize for saying 'unknown' so often. We deal with mentally ill people all day, every day, but many times we don't know whether or not it is formally documented. We also do not track many of the stats you were looking for. I hope what little I provided is of some assistance to you."

— Minnesota respondent

However, officers also mention resistance to increasing the burden of data reporting for law enforcement, as current reporting requirements are already time intensive and difficult to resource. Some officers feel that mandating data reporting limits their ability to maintain order and provide safety for their community.

See Appendix A on page 24 for case studies highlighting how communities are addressing some of the concerns raised by law enforcement survey respondents.

LIMITATIONS

The findings presented here are based on survey responses by law enforcement agencies throughout the country and therefore are subject to limitations associated with survey research. Although data cleaning and quality check precautions were taken to ensure accuracy of data, the consistency and completeness of the data provided is not entirely verifiable. Much of the data requested in the survey questions were not tracked or collected by all law enforcement agencies. Questions were worded as to provide best estimates to gain a better picture of the role of law enforcement in mental illness crisis response and transportation across the United States.

Efforts were made to increase response rates through follow-up emails and phone calls to ensure states were represented within the survey results. However, a limitation of the study is the low response rate by law enforcement agencies. There were 355 unduplicated responses to the survey, but there are approximately 15,761 local and county police departments and sheriffs' offices throughout the country,[38] resulting in a response rate of 2.3%. Although low response rates are not uncommon among surveys of law enforcement due to unique factors such as access to officers, distrust of researchers, and concerns of respondent anonymity,[39] the low rates are a limitation of our findings. However, research has shown that a sample with a low response rate but which includes multiple agencies in multiple locations may be preferable to a more homogenous survey population with a larger response rate.[40] Additionally, response rate alone is not necessarily indicative of the representativeness of a sample population.[41,42]

Selection bias may have been introduced due to limitations of the survey sample and its representativeness of the general population of law enforcement agencies in the United States. Voluntary response bias may have occurred due to the nature of the survey and its distribution, resulting in more responses by agencies where the issue of severe mental illness transportation is especially acute.

The total survey responses have other measurable selection biases that suggest the results are not fully representative of the general distribution of law enforcement agencies in the United States.[43] First, sheriffs' offices comprise approximately 20% of the law enforcement agencies, whereas the survey sample included 32% of responses from sheriffs. Second, the number of responses and response rates varied by state. Although states with the highest number of responses did not necessarily have comparable high response rates due to differences in numbers of total law enforcement agencies in each state, variations in both the number of responses and response rates by state may skew the results.[v] Third, survey responses are not representative of the size distribution of law enforcement agencies in the country. According to an analysis of 2016 Law Enforcement Agency Roster data, 47% of law enforcement agencies have less than 10 FTE sworn officers, compared to 32% of the survey results.[44] These limitations make an accurate comparison of the results by state impossible.

Beyond these limitations to data analysis, the scarcity and quality of much of the literature examining transportation of individuals with mental illness by law enforcement deprives the topic of a solid evidence base within which to consider the findings of this analysis.

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[v] See Appendix C on page 32 for the number of responses, by state.

DISCUSSION

The system of care for people with severe mental illness is complex and far from perfect, and this is in no small part due to law enforcement's outsized role in emergency and nonemergency transport for this vulnerable population. Throughout the United States — in communities large and small — law enforcement has become the de facto facilitators of treatment for individuals with serious mental illness and those in the midst of a psychiatric crisis.

Law enforcement is often the first contact for someone experiencing a psychiatric crisis in the community.[45] Officers spend significant amounts of time and resources serving in a role for which they neither planned nor trained. They are forced to make decisions about where to take someone in crisis, wrestle with how long it will take to get there and worry about the opportunity cost of leaving their regular duties, all the while knowing the person in crisis may not even receive the treatment he or she needs.

There are a host of reasons why law enforcement officers have become responsible for transporting individuals with severe mental illness. Hospitals do not have enough psychiatric treatment beds, and community care or preventive services are variable or nonexistent. People are too often left without the resources and care management they need to avoid reaching the point of crisis.

As evidenced by the responses to this survey, police departments and sheriffs' offices across the country understand and recognize the need for solutions. While each jurisdiction is unique, this is a nationwide concern with consequences for every community, regardless of size, demographic makeup or political leaning.

Impact of law enforcement transport of individuals in severe mental illness crisis

Criminalization of mental illness — Law enforcement's outsized role in transportation of individuals with biological brain diseases has resulted in further criminalization of severe mental illness.

Whether a result of outdated policies, a lack of training or simply a police force overwhelmed with community demands, people experiencing a psychiatric crisis are frequently transported in the same manner as individuals who have committed a crime. Such an experience, complete with uniformed officers, a squad car with flashing lights and a backseat cage, is a public commotion fit for the suspect of an armed robbery. It is not surprising that such an experience results in trauma and stigma for the individual that endure far past the resolution of the incident.[46]

Adverse consequences for help-seeking — A psychiatric crisis is a difficult time for individuals and their families. It can be made even more challenging by the involvement of law enforcement. On top of the debilitating manifestations of illness — psychosis, suicidality or a combination of other harrowing symptoms — when law enforcement gets involved, families may see their loved ones treated like criminals, often by law enforcement officials with no medical background. Such negative experiences can have a drastic effect on whether individuals or families choose to seek help during a subsequent crisis.[47]

Delays in access to timely treatment — Even the best-trained law enforcement officer is not a mental health professional. It is unfair to expect him or her to have the knowledge or skills to accurately assess someone in the midst of a psychiatric crisis. In such a difficult and

stressful situation, well-meaning efforts may not yield the appropriate results. This problem is compounded in communities where officers lack even basic mental health training.

Officers often act in a "gray area" during encounters with people with mental illness,[48] not guided by clear paths of action. Law enforcement operates under a different paradigm than healthcare professionals, and their decision making is "based less on the degree of psychiatric symptomology than on the sociopsychological and structural factors pertinent to each situation."[49] It is neither fair nor conducive to suitable health outcomes to task officers with making choices that affect the treatment of individuals with severe mental illness.

Escalation of crises — Individuals with severe mental illness tend to feel vulnerable and fearful of law enforcement and are particularly concerned about experiencing abuse or the use of force.[50] Due to symptoms of their psychiatric illness, they may have trouble following directions given by law enforcement during the interaction and may respond to commands in unpredictable ways.[51] This combination of factors increases the chance of an unnecessary escalation of the crisis and the potential for a tragic outcome.

Officers' own concerns such as perceived unpredictability or dangerousness of the situation can also lead to unnecessary escalation.[52] Crises can very quickly become elevated in volume, tone or physicality, simply because officers are either unaware of the person's illness or untrained in how to handle it. One in four deaths that occur as a result of a police shooting are people with mental illness.[53] But proper training using alternative crisis response and transportation models can mitigate these avoidable consequences. In just one example, annual fatal encounters of people with mental illness by police in Miami-Dade, Florida, decreased by 90% following implementation of a police mental health training program.[54]

Limitations of law enforcement time spent on public safety responsibilities — When law enforcement officers transport people with severe mental illness to treatment facilities, the survey results indicate their trips may take hours or even days. Between travel time and wait time while transferring custody of an individual to the receiving location,[55] officers responding to our survey reported spending upwards of one full week for *a single mental illness transport*. All of the time spent on mental health calls is time *not* spent protecting the community at large.[56]

This concern is particularly salient in rural communities or small jurisdictions where law enforcement agencies are already stretched thin and areas to patrol may be large. Survey respondents reported that when multiple officers on a small force are "lost" to a mental illness transport, the officers' typical beat is understaffed and vulnerable to safety concerns. Using alternative methods of crisis response and transportation for people with severe mental illness allows law enforcement to remain at, or quickly return to, their regular duties and commitment to public safety.

Virginia: The Difficulty of Garnering Legislative Support for Alternative Transportation Models

The experiences of Virginia illustrate the complexities and difficulties states face when seeking to enact mental health transport reform. For more than a decade, Virginia advocates and law enforcement officials sought to reduce the use of law enforcement officers to transport individuals in a mental health crisis to limited degrees of success.

Surveys conducted by the Virginia Sheriffs' Association and the Virginia Association of Chiefs of Police amply illustrated the need for reform.[57] In 87.5% of all jurisdictions, law enforcement provided the sole form of civil commitment–related transportation,[58] while sheriffs' offices required 26.3 additional full-time staff members for related transportation duties.[59] Officers also often traveled further than 50 miles outside their jurisdiction, increasing time spent away from regular patrols and service calls.[60]

Following the Virginia Tech tragedy in 2007, Virginia policymakers launched and expanded a series of task forces and commissions focused on mental health system reforms, including transport issues. In 2009, the General Assembly took its first steps, allowing state magistrates to authorize alternative transportation in some cases. However, the General Assembly soon limited the scope, restricting alternative transportation to persons who did not present an immediate danger to themselves or others.

The issue remained largely dormant until the 2014 and 2015 sessions, when the legislature was moved to enact reforms in response to the tragedies experienced by Senator Creigh Deeds and his son. In 2015, the General Assembly voted to remove the restrictions it had previously put in place, broadening the law to allow alternative transportation regardless of legal status or perceived dangerousness and removing liability for "civil damages for ordinary negligence" from transportation providers. Such liability was broadly viewed as a barrier to the viability of statewide alternative transport.[61]

In 2017 — a full decade after the Virginia Tech tragedy — the General Assembly finally passed legislation to develop a feasible model for statewide alternative transportation,[62] with a $7 million appropriation passed the following year. The model is not expected to be fully statewide until 2021.[63]

Solutions

The survey included questions to solicit potential solutions to reduce the burden of transportation of people with severe mental illness by law enforcement. Potential solution topics included increasing the Crisis Intervention Team (CIT)-trained proportion of law enforcement agencies, increasing the availability of mobile crisis teams to assist law enforcement in an encounter and the use of ambulances to conduct transport.

It is important to note that there are a variety of different solutions being successfully implemented by communities and this is by no means an exhaustive list. In addition, given the complexities of systems and the differing needs of communities, a one-size-fits-all approach is not necessarily preferable. However, regardless of each model's basic foundation, collaboration between the criminal justice and mental health sectors has fostered successes and improved outcomes in multiple communities. See the case studies in the appendix for examples of this success.

Law enforcement-based specialized response[64]

One of the most well-known and frequently used models for mental illness crisis response is the law enforcement-based specialized response, such as the CIT program. In the CIT model, specially trained law enforcement officers are designated to respond to mental health service calls and other situations involving people with mental illness. An important aspect of the program and one often cited as a major reason for its success is that the officers have volunteered to participate in the selection and training process.[65] This practice ensures that only officers who are dedicated and genuinely interested in working with individuals in psychiatric crisis are trained and dispatched to the field. The 40-hour training required of CIT officers focuses on clinical knowledge related to mental illness as well as de-escalation techniques to use during a crisis.[66] CIT is more than just law enforcement training; it is a model program with an intentional design that includes an emphasis on law enforcement partnerships with community members and a central receiving facility for law enforcement drop-offs.[67]

Law enforcement-based specialized mental health response[68]

In another form of crisis response, law enforcement partners with mental health professionals to attend to crisis situations, commonly referred to as co-responder teams or the co-response model. By bringing both law enforcement and mental health staff to the scene, response personnel are able to address public safety concerns as well as clinical needs such as assessment and stabilization. Mental health professionals also provide guidance regarding next steps for treatment so that the person in crisis can be transported to the most appropriate medical facility. It is suggested that co-response models may lead to increased linkages to treatment options as well as a quicker return to regular duties for law enforcement officers.[69] In some partnerships, mental health professionals provide assistance via phone or video rather than traveling with law enforcement to the crisis location.[70]

Mental health-based specialized mental illness response[71]

Response models may also rely entirely on mental health professionals, such as a mobile crisis or assertive community treatment team. In such models, psychologists, psychiatrists, social workers and other mental health providers work together to stabilize individuals in crisis and provide follow-up assistance.[72] Mental health response teams may coordinate with law enforcement when necessary.[73]

Centralized crisis centers

Centralized crisis centers may be used in any of the response models above, although they are specifically recognized as a "core element" of CIT programs and are an essential part of the crisis care continuum.[74] Noted heavily in the literature of psychiatric crisis response, crisis centers significantly improve outcomes of law enforcement encounters with individuals experiencing a psychiatric crisis.[75] Crisis centers offer an alternative to jail or crowded emergency departments by being accessible, providing quick intake and drop-off procedures for law enforcement, and specializing in care for people with mental illness and/or substance abuse.[76] These facilities also are bound by much less strict requirements than most inpatient psychiatric facilities and generally accept individuals regardless of agitated behavioral, intoxication or medical concerns.[77]

Protected transport for nonemergency situations

Some jurisdictions have examined alternatives to nonemergency medical transportation for persons with psychiatric illnesses. For example, in Minnesota, trained drivers use protected vehicles certified by the department of transportation, but which are not ambulances or unmarked law enforcement vehicles, to transport psychiatric patients. In 2015, the state authorized Medicaid funding for such services, dramatically decreasing the barriers for using this form of transportation alternative.[78]

Data solutions

Some localities use integrated data systems among health and criminal justice sectors to identify repeat users of community resources and intervene before crises occur.[79] After learning that an individual is consistently being held in emergency departments and/or being arrested for minor offenses, law enforcement can work with medical professionals to provide more intensive, wraparound treatment plans and make referrals to other types of social supports.

Telepsychiatry

Jurisdictions are capitalizing on technological advancements by offering telepsychiatry services. With telepsychiatry technology, mental health providers offer assessment and treatment planning via video chat.[80] Telepsychiatry is especially beneficial for "rural, remote and isolated populations."[81] This digital engagement allows for crisis de-escalation before a law enforcement officer even has to be dispatched, providing a quicker response to the person in crisis and saving time for officers. The psychiatrist may even determine that immediate transport to a treatment facility is not necessary. The technology may also be used in a preventative manner, with providers offering treatment advice and follow-up[82] virtually when regular in-person appointments are not feasible.

APPENDIX A: CASE STUDIES

Targeted Adult Service Coordination,
16 Southeastern Counties, Nebraska

Summary

The Targeted Adult Service Coordination (TASC) program presents a commonsense approach to providing alternative transportation options for persons with mental illness. It uses mental health crisis response teams dispatched at the request of law enforcement to provide a medical alternative to the traditional Nebraska emergency evaluation model — one that relies heavily on law enforcement involvement.

Originally organized to assist solely with crisis intervention and mental health assessments, the TASC program has been adapted to meet additional needs of its community. Now, rather than law enforcement officers, TASC crisis care clinicians transport individuals requiring crisis stabilization or hospitalization to their appropriate destinations. Since clinicians typically return to treatment facilities following a crisis response, transporting an individual there creates no additional burden and frees officers to continue with regular duties.

Program specifics

TASC is a non-fee service program offered to individuals in 16 counties in southeastern Nebraska, including the state's two largest cities, Lincoln and Omaha. It employs crisis response teams operating 24 hours a day composed of licensed mental health practitioners who provide crisis intervention services and mental health assessments.

Traditionally, law enforcement personnel were required to pick up and transport people in psychiatric crisis. With the TASC program, when an officer recognizes that someone is experiencing symptoms of mental illness, he or she can contact TASC instead of taking the individual into custody. TASC then dispatches a trained crisis specialist to conduct an on-scene mental health assessment and determine the best course of action. If necessary, people in crisis are transported in unmarked TASC-program vehicles, rather than in handcuffs in the back of a police car.

TASC may take up to two hours to respond to a crisis due to the large geographical area covered by the program. To improve response times in rural harder-to-serve areas, TASC personnel are currently employing telehealth techniques, such as the use of secure tablet computers that allow a mental health clinician to remotely assess an individual's situation and work with officers at the scene.

Results

Approximately one-fourth of all TASC crisis calls resulted in alternative transportation via the TASC model.[83] As there are limited mental health services in rural hospitals, most such transports are directed to Lincoln's largest public hospital, Lincoln Regional Center. TASC also provided approximately $1,700 in transportation funds for individuals to access follow-up mental health treatment, including bus fares and cab rides.

The program has achieved significant cost savings for cash-strapped local government budgets. For example, the county's share of emergency protection custody hospitalization costs, which run $500 per day, is $191. With average lengths of stay ranging from two to six days, each hospitalization episode tallies hundreds, if not thousands, in costs.[84]

In fiscal year 2018 alone, the TASC program diverted almost 250 people from hospitalization, resulting in $249,000 to $747,000 in cost savings, depending on length of stay. Based on these calculations, the program effectively pays for its $251,000 annual budget with the reduction in hospitalization costs alone.

TASC provides invaluable ancillary benefits as well, such as allowing law enforcement to remain on patrol. As the Nebraska City police chief told the *Idaho Statesman*, before TASC, "if things went real smooth, maybe an officer would be back in 2-1/2 hours. ... [W]e were losing manpower on the street — and I guess that's not a big deal if we had 10 or 15 guys working a day. But we don't."[85]

Most important, the program ensures that people with mental illnesses receive necessary care and wraparound supports in a timely manner.

Data as Diversion, *Camden, New Jersey*

Summary

The Camden Coalition of Healthcare Providers in Camden, New Jersey, focuses on using data to improve outcomes for people with serious mental illness, and ultimately lessen the burden on law enforcement providing transportation to this vulnerable population.

According to our survey results, when a law enforcement officer responds to a mental illness–related emergency, 30% of the time the person in crisis is transported by the officer to the nearest hospital emergency department. By creating an integrated data system among hospitals, primary care practices, social services and correctional facilities, Camden providers are able to identify high-use patients and implement specialized care plans before such costly and time-consuming emergency department visits even occur.

Program specifics

Healthcare "hotspotting" uses data shared among a group of healthcare providers to identify high utilizers of hospitals, emergency departments and other healthcare resources. These patients have high levels of need, including multiple chronic medical conditions, mental illness, substance abuse disorders and other barriers to optimal health such as poverty and homelessness.

For this population, symptom maintenance after discharge often proves much more challenging than for the average hospital patient. Such challenges often lead to frequent repeat visits, especially for chronic medical concerns. This is both an unfavorable outcome for patients and an inefficient use of provider resources and of law enforcement officers typically tasked with providing transport.

Dr. Jeffrey Brenner has become widely known as the face of efforts to address hotspotting. He founded the Camden Coalition of Healthcare Providers — a group of hospitals, primary care facilities and community partners "committed to elevating the health of patients facing the most complex medical and social challenges" — in 2002. The Coalition has since incorporated criminal justice data into its data-sharing network and has been widely hailed for its work to address this difficult-to-serve population.

The shared network offers providers and Coalition staff the opportunity to engage in healthcare hotspotting. Patient information is updated in real time, giving providers as much information as possible regarding patients presenting at their facilities. This avoids unnecessary duplication of services and promotes more effective treatment. The system also helps Coalition staff identify people with complex medical needs for targeted intervention programs, which can lead to long-term symptom management that may not have been accessible otherwise.[86]

Results

The Camden Coalition's data networks found that a small share of complex-needs individuals accounts for a disproportionately large share of health and criminal justice resources — and sometimes, individuals are "dual utilizers" and use high amounts of both:

- In 2011, 10% of the city's patients (mostly Medicare and Medicaid recipients) accounted for nearly three-quarters (74%) of total healthcare costs.[87]
- From 2010 to 2014, just 5% of individuals arrested accounted for 25% of total arrests.[88]

- Of all individuals arrested from 2010 to 2014, 67% had at least one emergency department visit in the same time frame.
    - Within the group of individuals who had an emergency department visit and an arrest from 2010 to 2014, 226 had multiple emergency department visits *and* arrests and were in the top 5% of all study subjects.[89]

Notably, the 226 people who had extremely high rates of emergency department use and arrests were most often arrested for nonviolent offenses, and three-quarters (75%) had received a mental health diagnosis. Given the prevalence of mental illness within this population, preventative and maintenance care focused on patients' unique needs could drastically reduce interactions with the health system and law enforcement.

Initial research on the real-world impact of Camden's data and care management strategy has shown significant cost reductions.[90] A study of 800 complex-needs patients enrolled in a specific Camden care management program, Link2Care, is currently in progress.[91]

APPENDIX B: SUPPLEMENTAL DATA

Types of mental illness transport by law enforcement

Emergency transport vs. nonemergency transport

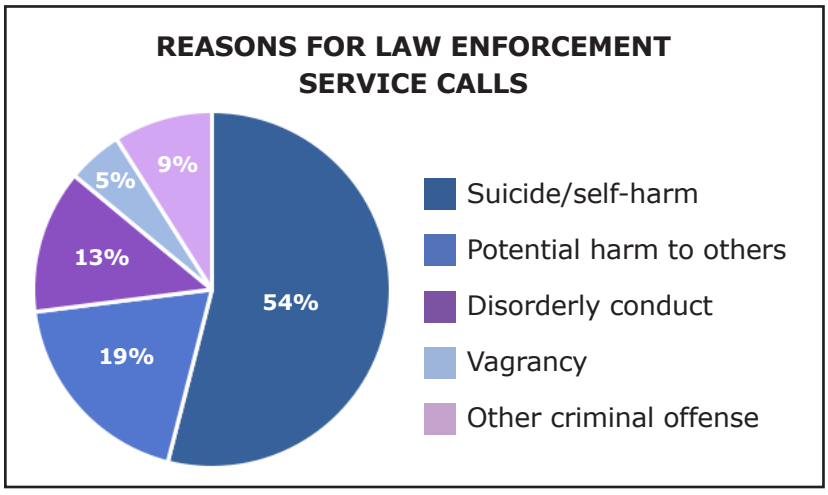
There are a variety of different types of transportation of individuals with severe mental illness, and each law enforcement agency handles each type differently. On average, 56% of all transports conducted by survey respondents were for emergency transports—law enforcement responding to psychiatric crises. The remainder of transports, according to respondents, fell into the category of nonemergency transports— to and from jail, courts, or medical facilities—which are often planned in advance.

There is significant variation among jurisdictions in how mental illness transports are conducted. In some localities, police departments, sheriffs' offices, emergency medical services, and fire departments may all share responsibilities for emergency and nonemergency transports. In other localities, these duties may be separated based on the type of transport or fall solely on one or two public service entities. State statutes and local policies and procedures define ownership of psychiatric transports, and guide how individuals with mental illness move from initial service call, encounter, or planned pickup, to their ultimate destination.

Emergency transports — service calls vs. law enforcement patrol encounters

Of reported emergency transports that were precipitated by a psychiatric crisis, on average, 70% were due to a mental health service call, whereas 30% were due to a law enforcement encounter while on patrol. The high proportion of transports from mental health service calls highlights the importance of training 911 dispatchers to recognize the signs of a psychiatric crisis. Dispatchers can then appropriately categorize calls and dispatch a specialty response unit, such as a Crisis Intervention Team (CIT) or mobile crisis team, if available. Previous research has shown that service calls dispatched as mental health calls were more likely to be transported to treatment rather than jail.[92]

Considering the average 30% of crisis transports resulting from a patrol encounter, the survey results also indicate the value of providing some form of mental health and crisis de-escalation training to all law enforcement personnel who have patrol duties. The unpredictable nature of a psychiatric crisis and the outsized role of law enforcement in the response requires at least a basic level of training for officers to handle the situation appropriately.



Reasons for mental illness transport by law enforcement

A striking reality of law enforcement transports of people with severe mental illness is that relatively few instances involved any sort of crime. In fact, according to survey respondents, the vast majority (73%) of reasons for reported mental health service calls or encounters that resulted in a transport by law enforcement were non-criminal. Even when calls or encounters were criminal in nature (27%), the majority were for low-level infractions, often referred to as quality-of-life crimes.

Transports due to civil commitment orders

The survey results raise questions about the necessity of law enforcement in transporting individuals with mental illness who are in custody, but do not otherwise pose a safety risk. Almost one out of every three (32%) transports of individuals with severe mental illness by law enforcement survey respondents were due to an involuntary treatment order, evaluation, or commitment—events that are planned and typically do not involve a high risk of safety concerns.[vi]

Officer or deputy perceptions of dangerousness of individual

For 65% of all law enforcement transports in 2017, reported by survey respondents, the officer did not perceive the individual to be a risk of harm to others. Therefore, in just 35% of reported transports was the individual perceived to be a public safety risk. If law enforcement is primarily tasked with transporting individuals with mental illness or in the midst of a psychiatric crisis due to considerations of public safety, the survey results suggest that nearly two-thirds (65%) of the time, transports could be conducted by an entity other than law enforcement.

The role of families in mental illness crisis response

Family involvement in psychiatric crisis episodes is imperative given that individuals with severe mental illness often do not recognize they are ill or in need of help.[93] Almost one in four (23%) mental health service calls were due to a family member request for assistance, according to the results from the law enforcement survey.

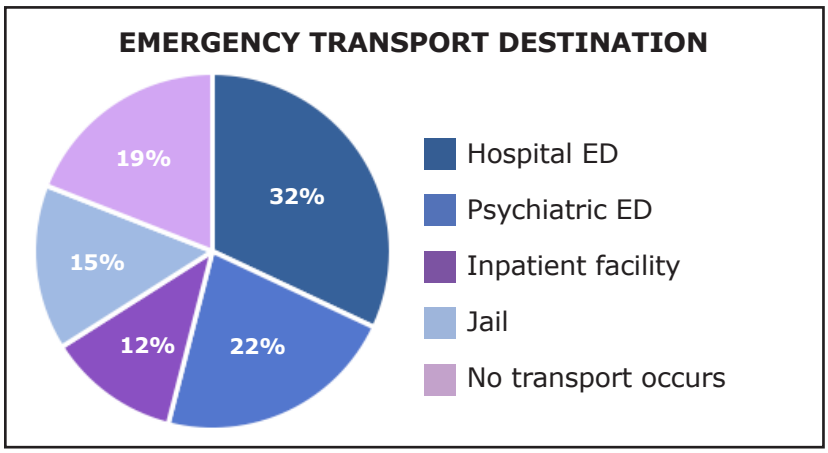
Yet, research shows that family members' expertise and concerns are not valued in the interaction between law enforcement and an individual in psychiatric crisis.[94] In addition, often ignored is the fact that family members may be involved in the crisis as victims.[95] Research shows that family members only call law enforcement when they can no longer manage the situation on their own and have conflicted feelings about calling law enforcement for assistance, worried that their loved one will view the action as a betrayal or that it will lead to a negative outcome.[96] Law enforcement and others must respect families' role in mental illness crisis response and provide avenues for information sharing and mutual understanding.

[vi] This is not mutually exclusive with other options. For example, a family member may call 911 and a law enforcement officer will respond and transport to a hospital emergency department for an involuntary evaluation.

Destinations of mental illness transport by law enforcement

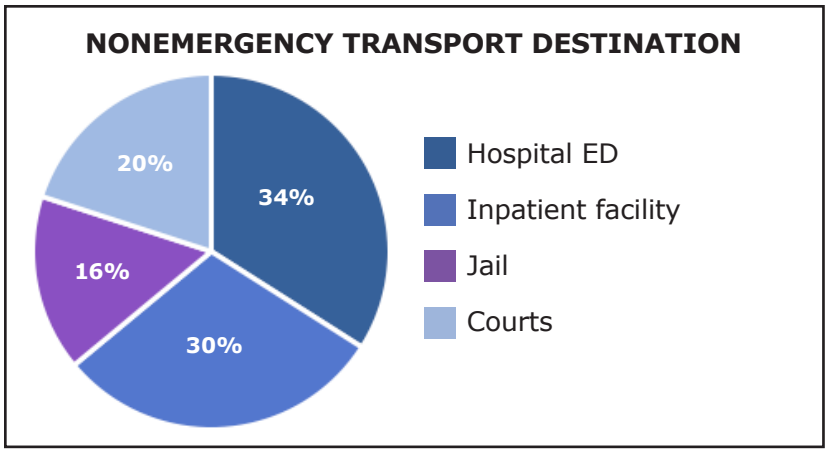
Destinations — Emergency transports

Once an individual in psychiatric crisis is picked up by a law enforcement officer, there are a variety of places to which he or she may be transported. The destination of emergency transports depends on a multitude of factors, including state statutes, law enforcement policies and procedures, and available community resources. The following graph indicates the average frequency of various destinations for emergency transports, as reported by survey respondents.



Destinations — Nonemergency transports

Law enforcement agencies also play a significant role in nonemergency transports to and from jails, courts and hospitals for individuals with serious mental illness. According to respondents, 44% of all transports conducted by law enforcement were nonemergency transports. The destinations for nonemergency transports are primarily controlled by the reason for the service call—and less by officer discretion—but still speak to the systematic utilization of law enforcement for the transport and care of individuals with serious mental illness. This type of transport may be particularly conducive to the use of non-law enforcement transportation providers, compared to emergency transports, due to its planned nature and predictable outcomes.



> As public officials increasingly invest in policies and programs designed to reduce costly high-utilization trends, recognizing and tracking the impact of SMI [severe mental illness] in the larger phenomenon is not only relevant, it is urgent.
>
> — Doris A. Fuller et al., *A Crisis in Search of Data: The Revolving Door of Serious Mental Illness in Super Utilization*, April 2017

Super-utilizers

Individuals with severe mental illness, although making up barely 3% of the overall population, are over-represented in the systems that are most affected by the failures of the U.S. mental health system, including criminal justice, homelessness services, and safety-net emergency services.[97] Many high utilizers of one system, such as those with frequent emergency department visits, are also high utilizers of other systems, such as inpatient facilities or homeless shelters, a term coined as super utilization.[98] According to survey respondents, on average more than one-quarter (26%) of transports of individuals with severe mental illness conducted by law enforcement were for high utilizers—individuals who had three or more service encounters with law enforcement in one month. The role of severe mental illness in super utilization is largely uncharted, however, due to lack of integrated data collection and collaboration across systems.[99]

Potential solutions

Included in the survey were questions about solutions for reducing the burden of transportation of individuals with severe mental illness by law enforcement. However, it is important to note that there are a variety of solutions being successfully implemented by communities in the United States and abroad, and the following is by no means an exhaustive list. In addition, due to the complexities of the systems involved and the unique needs of different communities, a one-size-fits-all approach is not necessarily preferable.

- **CIT training:** CIT is more than just specialized training; it is a model program with core elements that determine its success. However, the 40-hour CIT training for officers has been regarded as one of the best evidence-based training programs for law enforcement in interactions with individuals with a mental illness.[100] The survey results indicate that on average, 44.5% of officers from agency respondents have CIT training. While the CIT model suggests that about 20% of officers within a given agency receive CIT training who volunteer to participate, responses from surveyed agencies were distributed bi-modally—with many (43%) adhering to the 20% standard, and more than one-quarter reporting that 76-100% of their officers are trained in CIT. The notable proportion of agencies with more trained officers than recommended points to the growing movement within law enforcement agencies to require CIT training for all officers or include CIT training as part of the police academy.
- **Mobile crisis:** In nearly one in five (18%) transports reported by survey respondents, a mobile crisis team assists law enforcement. Half of the time these teams are requested but unavailable.
- **Ambulance assistance:** Ambulance services were requested by law enforcement in 30% of all transports, according to respondents. One in five (20%) of those times an ambulance was unavailable.

APPENDIX C: RESPONSES BY STATE

STATE	NUMBER OF RESPONSES	TOTAL LAW ENFORCEMENT AGENCIES	RESPONSE RATE
Alabama	3	386	0.8%
Alaska	0	42	0.0%
Arizona	14	93	15.1%
Arkansas	2	354	0.6%
California	13	395	3.3%
Colorado	4	224	1.8%
Connecticut	0	121	0.0%
Delaware	1	39	2.6%
Florida	13	325	4.0%
Georgia	34	531	6.4%
Hawaii	0	4	0.0%
Idaho	6	113	5.3%
Illinois	4	865	0.5%
Indiana	3	508	0.6%
Iowa	3	383	0.8%
Kansas	19	346	5.5%
Kentucky	9	355	2.5%
Louisiana	13	329	4.0%
Maine	3	131	2.3%
Maryland	1	108	0.9%
Massachusetts	7	353	2.0%
Michigan	12	505	2.4%
Minnesota	6	410	1.5%
Mississippi	2	328	0.6%
Missouri	2	588	0.3%
Montana	2	108	1.9%

STATE	NUMBER OF RESPONSES	TOTAL LAW ENFORCEMENT AGENCIES	RESPONSE RATE
Nebraska	3	212	1.4%
Nevada	5	31	16.1%
New Hampshire	7	207	3.4%
New Jersey	6	492	1.2%
New Mexico	1	109	0.9%
New York	22	472	4.7%
North Carolina	14	456	3.1%
North Dakota	1	105	1.0%
Ohio	13	803	1.6%
Oklahoma	1	409	0.2%
Oregon	12	155	7.7%
Pennsylvania	4	1,036	0.4%
Rhode Island	5	38	13.2%
South Carolina	3	238	1.3%
South Dakota	6	137	4.4%
Tennessee	16	355	4.5%
Texas	9	1,060	0.8%
Utah	2	124	1.6%
Vermont	3	71	4.2%
Virginia	8	292	2.7%
Washington	6	213	2.8%
West Virginia	2	225	0.9%
Wisconsin	26	498	5.2%
Wyoming	4	79	5.1%
Total:	**355**	**15,761**	**2.3%**

SOURCE: Law enforcement agency data from 2016 Law Enforcement Agency Roster, United States Department of Justice

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