The Crisis Care Continuum: Resources for Judges During and After the COVID-19 Pandemic

A Pandemic Resource for Courts

Developed in collaboration with the National Judicial Task Force to Examine State Courts' Response to Mental Illness

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The purpose of this brief is to acquaint court leaders with the opportunities to influence change in their courts and communities during these difficult times and to implement practices that will result in better outcomes for those with serious mental illnesses. Links to research and resources are provided at each stage of the crisis care continuum. A system assessment tool is also included and is recommended as a first step for courts and system partners. The system disruptions caused by the COVID-19 pandemic provide an immediate and unique opportunity to engage in meaningful system change, at a time when that change is needed most. Courts can and should be a part of leading that change.

During the exigency of an individual experiencing a mental health crisis, a common response is to call 911. This invocation of the criminal justice system is often harmful to the person in crisis, particularly so during this pandemic, and it paves the way for courts to become ensnared in issues often better addressed by community behavioral health treatment systems.

While there is significant evidence that law enforcement is now more amenable to not taking individuals into custody because of infection-related concerns and jail restrictions, a significant number of these interactions still result in the individual experiencing a mental health crisis being transported to a hospital or a jail, and entanglement with the criminal justice system often follows.

Hospital emergency departments are designed for and exceptional at treating physical medical emergencies. They were not designed to treat mental health crises. As a result, a person in a mental health crisis often experiences a delay or disconnect from mental health treatment by being "psychiatric boarded" in an emergency department (experiencing an extended wait for a suitable psychiatric placement without receiving mental health treatment) or being discharged without any transition to mental health care.

People with serious mental illness also now often face potentially debilitating stays in jail waiting for an appropriate treatment placement. Many state psychiatric hospitals and other

residential treatment facilities have either closed their doors to new admissions or imposed quarantine periods before admission. Even in non-pandemic times, transitions to treatment facilities are often slow and traumatic.

An effective crisis care system avoids this frequently harmful criminal justice track, and diverts people experiencing a mental health crisis to a more effective, less expensive, and more humane response: treatment. Lifesaving treatments like crisis units, medications, therapies, and safety plans have been developed and are increasingly accessible across the country. A major challenge is how to connect people in a mental health crisis to these lifesaving treatments in their moment of crisis.

Courts and judges have a stake in making this connection happen, especially during the pandemic. Crisis systems and community supports have been disrupted and weakened, so the chances of a person needing mental health treatment being inappropriately tracked to the criminal justice system are higher now than ever before. Rebuilding (and enhancing) our crisis care continuum of services going forward will divert people who are inappropriate for the criminal justice system to treatment and will reduce the number of misdirected criminal cases – cases that frustrate families and judges alike. A robust crisis care continuum narrows the funnel of cases that come to the criminal justice system, and those that remain are more likely to be those that need the supervision and accountability that a judge brings to the table.

This brief outlines a framework for assessing gaps in a community's crisis care continuum, and points to the vast resources that have been developed to help jurisdictions fill those gaps by implementing evidence-based solutions. Jurisdictions across the country have done the hard work of trailblazing and experimenting, and examples of their successes are included. After these interventions and resources are described, a decision-making resource is included to help jurisdictions decide which new interventions should be prioritized given the needs and resources of that community.

While most of these interventions are designed to be implemented at the local level, one new initiative has the potential to provide a consistent resource across the country. The 988 "national suicide prevention and mental health crisis hotline" will be in effect by 2022, and will provide not only a single point of entry to the crisis system, but the authorizing statute also allows state and local governments to assess a surcharge on phone lines to support the operation of the crisis line *and* costs of "personnel and the provision of acute mental health, crisis outreach and stabilization services (incurred) by directly responding to the 9–8–8 national suicide prevention and mental health crisis hotline." Courts, judges, and their communities should begin now to design more robust crisis response systems that utilize this new resource.

Criminal justice systems are generally ill-equipped to appropriately handle people with mental illness. Courts can and should take a leadership role in diverting people with mental illness from the criminal justice process. Promoting an effective crisis care continuum allows for earlier access to treatment, more humane and effective interventions, safer communities, financial savings, and a more appropriate use of criminal justice resources.

ASSESSING GAPS

The Crisis Now Scoring Tool is an excellent way to assess a jurisdiction's current level of early response services. The assessment breaks out the continuum into three stages: call centers, mobile outreach, and sub-acute stabilization.

PROMISING PRACTICES

In 2018, The National Association of State Mental Health Program Directors published a brief entitled *A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness*. This paper identifies three broad essentials of a crisis system: regional or statewide call centers, centrally deployed 24/7 mobile crisis resources, and short-term residential stabilization facilities.

A fourth overarching principle is that at all stages, interventions must include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

In 2020, SAMHSA released *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit*. This comprehensive toolkit is similar to the NASMHPD product, with minimum requirements for each intervention and best practices that should also attend each step.

Finally, another recent 2020 publication, *Using Technology to Improve the Delivery of Behavioral Health Crisis Services in the U.S.*, produced by The National Association of State Mental Health Program Directors suggests ways to promote evidence-based crisis care solutions using social media and other technologies and also ways in which implementation of the various components of a crisis continuum can be more efficient and effective if they take advantage of technological innovations, particularly during in-person contact restrictions that accompany a pandemic.

The SAMHSA Toolkit and the NASMHPD paper are both collated with other new crisis resources in SAMHSA's new, almost 300 page compendium, Crisis Services: Meeting Needs, Saving Lives.

All of these resources describe agreed-on essential components of a crisis response continuum, and these components apply to some or all of the following crisis strategies.

- **Crisis Lines**
  Crisis lines provide direct support to individuals experiencing distress via telephone. The lines are typically confidential and can provide immediate support and problem-solving, as well as facilitate referrals to mental health and community support services. For example, Salt Lake County has a continuum of crisis lines.

  The Bureau of Justice Assistance estimates that 10% of police contacts are related to psychiatric emergencies; suggesting 24 million 911 calls per year could be appropriately served through 988 in the future.

- **Dispatch Collaborates with Mental Health Providers**
  Dispatchers are trained to identify mental health-related calls and, if appropriate, transfer them to helpline crisis counselors who are stationed in the dispatch center. These crisis counselors then determine whether the situation can be resolved over the phone, rather than by a patrol unit. In Houston, Texas mental health professionals are embedded in the emergency call center.

- **Train Dispatchers for Mental Health Related Calls**
  Dispatchers and call-takers are trained to identify and appropriately respond to calls that may have a mental health component. This can include mental health awareness, verbal de-escalation techniques, appropriate triage and dispatch protocols, and coding of mental health calls. Examples of materials and online resources.

- **Crisis Intervention Team**
  CIT officers are dispatched to mental health calls or to assist officers who are not CIT-qualified. These officers complete a 40-hour training course in mental health and de-escalation techniques and maintain partnerships with mental health providers. This SAMHSA publication outlines steps to implement a data driven CIT program.

- **Mobile Crisis Services**
  Mental health professionals are available to respond to calls, either on the scene or as a follow up, at the request of law enforcement officers. These professionals can then begin the assessment process, provide acute on-site crisis stabilization, and facilitate connections to needed care and services. Some teams may also respond to requests directly from community members. Examples and online resources.

- **Co-Responder Teams**
  Working as a co-responder team, a specially trained officer and a mental health crisis worker respond together to mental health calls for service. By drawing upon the combined expertise of the officer and mental health professional, the team is able to link people with mental illnesses to appropriate services or provide other effective and efficient responses. The most common approach is for the officer and

crisis worker to ride together in the same vehicle for an entire shift, while in other agencies the crisis worker meets officers at the scene, and they handle the call together. Co-responder teams can respond throughout the entire jurisdiction, or they work in areas with the greatest number of mental health calls. Examples and online resources.

- **Crisis Stabilization Centers**
  Crisis stabilization centers provide short-term access to emergency psychiatric services for individuals experiencing crisis. These centers often provide constant supervision throughout a person's stay. Some centers provide care for less than 24 hours, while others provide short-term residential stabilization services. Policies are established that enable law enforcement officers to efficiently transport people in need to the center in lieu of arrest or hospitalization. Examples and online materials.

  The ”Arizona Model” is often cited as the pinnacle of crisis stabilization models, and it refers in part to Maricopa County, Arizona, which includes the greater Phoenix area. There, the associated savings of a crisis system containing all three core aspects of a crisis system have included:

  - 37 full-time equivalent (FTE) police officers engaged in public safety instead of mental health transportation/security;
  - Reduction in psychiatric boarding of 45 years annually; and
  - Decrease in inpatient spending by $260 million.

These data, along with an entire library of related research and resources are available at http://crisisnow.com, and the Stepping Up Initiative’s Strategy Lab also has a plethora of useful resources. SAMHSA’s GAINS Center also published specific tip sheets for various criminal justice system players, sheriffs, public defenders, judges, prosecutors, and police chiefs, several of which relate to the crisis response continuum.

CHOOSING WHAT MODEL(S) TO IMPLEMENT

Every community is different – different available resources, different funding structures, different existing programs, relationships, attitudes, and cultures of innovation. A September 2020 Arnold Ventures and Abt Associates guidebook, *Reimagining America's Crisis Response Systems*, provides “a decision-making framework for responding to vulnerable populations in crisis.”

The framework was developed by systematically reviewing the range of approaches already in use around the country and identifying evidence-based principles embodied in those approaches. The guidebook then assesses and categorizes the program types by a variety of elements – which crisis response provider is involved, for which population is the intervention appropriate, what training would be required to implement the response, what local laws or policies might be barriers, and what data

would be useful to collect and to demonstrate success. Existing examples of each model are also highlighted.

Whether a jurisdiction has an extensive existing crisis continuum in place or no behavioral health crisis services, engaging in an assessment of those structures and then applying the logic models of the guidebook discussed above to those services will identify specific steps that can be taken to improve that jurisdiction's crisis response.