

POLICY BRIEF

Embedding

Equity

into

988:

Imagining a New Normal for Crisis Response

EXECUTIVE SUMMARY

The current emergency response system was not designed to meet the needs of those in behavioral health crisis. First responders are not equipped with training necessary to expertly intervene. Inadequate interventions occur too frequently for people in distress, and the consequences of this are increased trauma and inequity. Specific communities have experienced the most inequity and trauma: people who identify as LGBTQIA+; black, indigenous and people of color (BIPOC); rural communities; immigrants, refugees, and non-English speaking people; people living with disabilities; older adults; people experiencing homelessness or housing instability; formerly incarcerated or justice-involved populations; survivors of trauma; and neurodiverse people. Evidence shows these populations hesitate to call 911 in times of need because they fear the response will result in more harm than good (Sasson, et.al, 2015). This July, the United States will launch the first ever national emergency line devoted to psychiatric response and preparedness: 988. A historic time in healthcare, it is an opportunity for local and federal leaders to employ necessary tools that ensure previous experiences and failures are rectified and its implementation is equitable.

To address this, the Kennedy-Satcher Center for Mental Health Equity (KSCMHE), an entity of the Satcher Health Leadership Institute at Morehouse School of Medicine has partnered with Beacon Health Options, to establish concrete recommendations towards equitable and effective administration of 988. This has been done through a comprehensive literature review to understand the context of inequity in psychiatric response, and complemented with a leadership experience survey that was anonymously responded to by dozens of leaders in the behavioral health field across the country. Each recommendation also has opportunities for exploration and measurement of success into the future. Efforts to embed equity into 988 must be continuous and comprehensive.



In the *Leadership Experience Survey*, **92.6%** of respondents found the current U.S. psychiatric emergency response system is **not** equitable, while the remaining **7.4%** were **unsure**.

How can equity be embedded into 988?

Recommendation 1: Advance equity by prioritizing visibility of groups that are historically excluded or inadequately reached by our psychiatric emergency systems

Recommendation 2: Deployment of law enforcement in psychiatric emergency response should only be as needed

Recommendation 3: An effective crisis response team for psychiatric emergencies includes licensed mental health professionals and peer recovery specialists as essential personnel. Psychiatrists, nursing professionals, and medical interpreters should be available on call for streamlined response

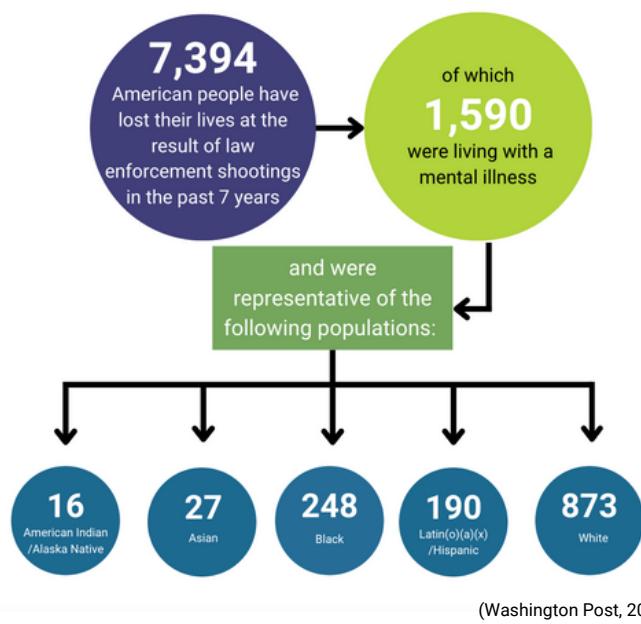
Recommendation 4: Mobile crisis units should be placed at local medical and mental health clinics. An equitable crisis response should be inclusive of individuals and environments that are reflective of the cultural and linguistic needs of the community

Recommendation 5: Targeted comprehensive training for key personnel should prioritize enhancing specific skills that can contribute to more equitable outcomes

Recommendation 6: Provide callers the option to opt-in and consent to use of geolocation or remain confidential and anonymous when they dial 988

SCOPE OF INEQUITY IN CRISIS RESPONSE

In the United States, although civilian casualties at the hands of law enforcement occur, these incidents are poorly documented. Here is what is known:



The unfortunate reality is, these numbers only tell the story of those who were fatally shot and not the story of countless others who have lost their lives to all other uses of force by officers.

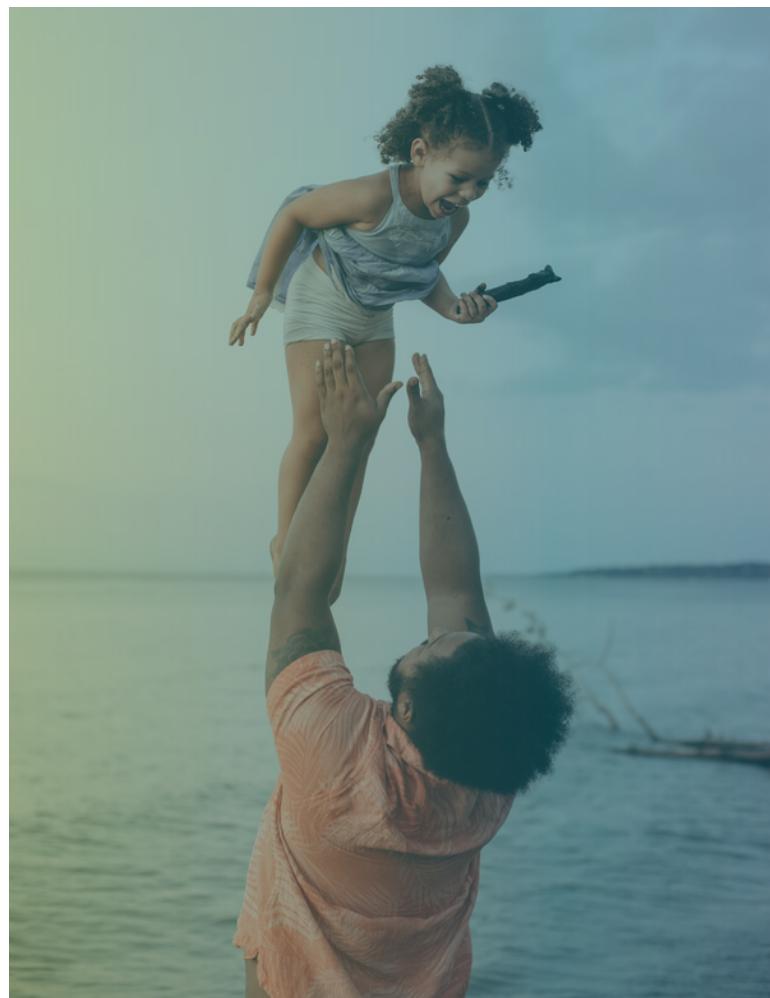
Like Linden Cameron, a 13-year old boy, and Antonio Martinez, a 25 year old Puerto Rican - American, just two names of neurodiverse individuals who were victims of unnecessary use of force by law enforcement (Ruderman Family Foundation, 2016; NPR, 2020).

Like Ricardo Muñoz, aged 27, living with unstable paranoid schizophrenia, killed by police in 2020 in Lancaster, PA. Six weeks earlier, **Walter Wallace, Jr. a black man** having a psychotic episode, killed by police in Philadelphia. In 2017, **Paul Castaway, a member of the Sicangu Lakota tribe**, living with mental illness and addiction, killed by police in Colorado.

The Ruderman Family Foundation found in 2016 that half of all use of force incidents involve people living with disabilities, which includes physical and mental disabilities, those who were diagnosed with a mental illness and substance use disorder (Ruderman Family Foundation, 2016).

With 75% of US Counties being designated as mental health shortage sites, police become the first and often most-used resource for those facing mental health crises (SAMSHA, 2016; Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009; Yang et al., 2015).

Overall, the most affected communities are communities of color.



RATIONALE & FRAMING

The current crisis response system in the United States of America is not equitable.

LITERATURE REVIEW

The literature review included 327 materials reviewed and coded for the historical, operational, and community context analysis including peer-reviewed articles, statistics from federal and state level data bases, as well as well-cited newspaper articles and podcasts. 148 citations have contributed to the findings in this report.

The literature review input key words into scholarly search hubs such as:



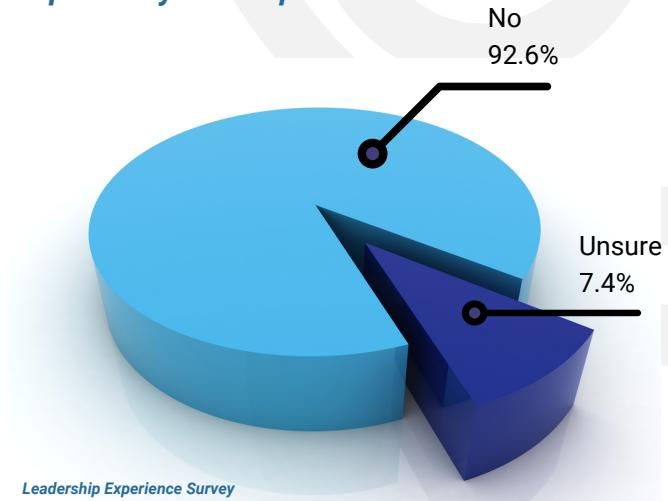
- **equity AND**
- **crisis response OR**
- **psychiatric OR**
- **law enforcement OR**
- **mental health OR**
- **co-response**

LEADERSHIP EXPERIENCE SURVEY

This comprehensive literature review informed the development of an IRB-approved 7-question survey (see [Appendix A](#)). Invitations to participate were sent to over 100 leaders in the behavioral health and crisis response fields, identified via social and professional networks and word of mouth. Results were collected anonymously over a 15 day period. The types of representatives that participated in the survey included:

- Behavioral health agency directors
- Psychiatric emergency personnel
- Law enforcement leadership
- Federal leadership
- Focused outreach to organizations serving historically invisible populations
- Legislative officials (members of Congressional Caucuses, Mental Health Caucus, etc)
- Leaders of lived experience

Is the current psychiatric emergency response system equitable?



POWERING EQUITABLE DATA IN 988

It is evident that existing data collection measures create barriers to understanding the intersection of equity and behavioral health. 988 will require detailed and thoughtful collection and disaggregation of data to fully capture the burden of mental health inequity in psychiatric response, and quickly develop tangible solutions that achieve equity.

Consider the following statistics on the experiences of communities characterized by historically adverse outcomes, that were derived from the literature review:

- Communities of color have lower rates of retention in treatment (Acevedo et al., 2020)
- Stigma and cultural beliefs about mental wellness are barriers to access for many populations (Misra, et. al, 2021)
- Communities of color have historically been misdiagnosed, as exhibited by rates of diagnosis of ADHD and schizophrenia (Gara et. al, 2019)
- Individuals with limited English proficiency (LEP) have greater difficulty accessing care and preventative services (Masland, Lou, & Snowden, 2010)
- More than 120 hospitals in rural areas have closed in the last decade (Rural Hospital Closures, 2022)

It is crucial to create a system that ensures trained, compassionate, and equitable mental health crisis response, especially for historically invisible populations within resource-restrained settings. As one survey respondent shared that, "Systemic change will help ensure more equitable service delivery and effectiveness of said services."

An overarching recommendation is that 988 must account for the collection and disaggregation of robust data and evaluation standards to capture equitable outcomes.

"There are many gaps in the existing service network that despite best efforts in outreach are lacking in terms of inequities in system access, infrastructure, staffing, hours of services, availability of specialty providers for referrals, and many more limitations."

Survey respondent

RECOMMENDATIONS TO EMBED EQUITY INTO 988



Findings from the literature review and leadership experience survey resulted in the development of **six key recommendations** to ensure 988 provides more equitable response to psychiatric emergencies.

- 1: Uplift groups who are historically invisible
2. Law enforcement participation in psychiatric emergency response should be as needed
- 3: Use of trained mental health professionals and peer recovery specialists is essential
- 4: Leverage local clinics as crisis response hubs for 988 calls
- 5: Implement comprehensive trainings to have more equitable response
- 6: Give the caller a choice to use geolocation services

1 UPLIFT GROUPS WHO ARE HISTORICALLY INVISIBLE

Advance equity by prioritizing visibility of groups that are historically excluded or inadequately reached by our psychiatric emergency system.

The literature review and leadership experience survey suggest the current system for psychiatric emergencies is not equitable for many communities, and some populations in particular are even more at risk for harmful results.

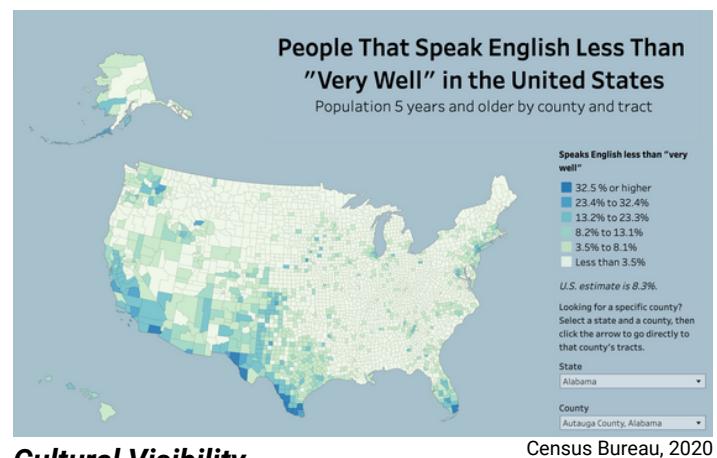
These communities include, and are not limited to

- People who identify as LGBTQIA+
- Black, Indigenous and people of color (BIPOC)
- Rural communities
- Immigrants, refugees, and non-English speaking people
- People living with disabilities
- Older adults
- People experiencing homelessness or housing instability
- Formerly incarcerated or justice-involved populations
- Survivors of trauma
- Neurodiverse people

Language Access

The literature review and survey demonstrated many populations have disparate needs; however, many groups are invisible in national efforts to address and advocate for these needs. Limited to no access to these resources can result in poor interpretation of contextual crisis and unnecessary hospitalization. If language access is better streamlined, many of these concerns can be de-escalated safely in the community. Marshall (2019) cited, when non-English speakers call 911, dispatch must conference call an interpreter causing significant delays in emergency situations.

Upon calling the 988 crisis line, people in crisis should have the opportunity to select a language option. This option should be available via text AND voice for as many languages representative of the diversity within the United States. With this in mind, 988 mobile crisis teams must consider the employment of language interpreters, as needed. Cultural humility training and engagement with community leaders can also ensure needs are met in a tailored and responsive manner.



Cultural Visibility

For certain racial and ethnic populations, there is historic evidence that shows that there is a lack of knowledge base in how to access support. In 2017, the American Psychiatric Association found that only 33% of African Americans who need mental health services receive it. A leadership survey participant stated, “AAPI (Asian American/Pacific Islander) communities access behavioral health services the least and present to emergency departments with more severe psychopathology.” Thousands of American Indian/Alaska Native (AI/AN) people experience discrimination, lack of opportunity, and the long-term effects of multi-generational trauma. The result of this trauma includes unique needs attached to mental illness, substance use disorders and suicide (Indigenous | NAMI: National Alliance on Mental Illness, n.d.).

Suicide is the second leading cause of death in indigenous youth aged 10-24 and teen suicide rates amongst indigenous youth are nearly 3.5 times higher than the national average (Werk, 2020).

Do No Harm

The experience of feeling systemically invisible, is in itself a barrier to understanding systemic inequity. Many are at risk for being traumatized, re-traumatized, or met with punitive measures by the system due to their identity. It is important they are prioritized to receive access to culturally attuned wellness. Specific sensitivity must be given to groups where disclosure of status can carry heavier consequences in our legal system. The experience of facing legal repercussions due to homelessness, identifying as LGBTQIA+, or being undocumented should not be a deterrent to accessing care. 3,225 of 6,450 transgender and non-binary persons reported to the National Center for Transgender Equality and National Gay and Lesbian Task Force that they had to inform their physician how to care for people who carry those identities (Grant et al., 2011).

Survey respondents were allowed to select all categories related to who they believe needed to be reached more effectively to make the system equitable. As many respondents were leaders of lived experience, one survey respondent shared:

"My choice is the group I experience as neglected by our current psychiatric emergency response system, not who I believe is neglected. What I believe and what I experience are two different things. I would select more if I based my answer on who I believe is neglected."



2 LAW ENFORCEMENT PARTICIPATION IN PSYCHIATRIC EMERGENCY

RESPONSE SHOULD BE AS NEEDED

Though law enforcement is currently a part of all emergency response systems, there is an unnecessary utilization of the use of force, arrest, involuntary hospitalization and/or death of persons in crisis responses.

Understanding the History

Law enforcement, specifically police departments, have historically partnered with a range of mental health programs within their state and regionally. An essential element of these Police-Mental Health Collaboration Programs (PMHC) includes specialized and comprehensive training for officers to respond to psychiatric emergencies (Bureau of Justice Assistance – U.S. D.O.J, 2022). A detailed table of these types of programs can be found in [Appendix B](#). Co-responder teams are particularly noteworthy to demonstrate how reducing police participation can begin to increase access to care versus incarceration. A co-response team includes a specially trained law enforcement officer, as well as a mental health crisis worker.

A study conducted in Indianapolis compared the effects of co-response teams versus traditional police response and found that co-response teams were 52% less likely to arrest individuals going through a crisis immediately after a 911 incident, but there were no changes in arrests long term (Bailey et al., 2021). Furthermore, while there are cases such as Colorado's co-response team that decreased involuntary hospitalization by 5.1% and diverted 2.6% of persons in crisis from jail, the racial makeup of Colorado is more homogenous than other US cities representative of diversity.

Why Use of Law Enforcement Isn't Equitable

Due to a lack of community mental health services, law enforcement in rural communities are often the first and only resource available for individuals experiencing mental health concerns (Yang et al., 2015). Without adequate training or resources, law enforcement is "problematically stretched thin" to provide services they are not equipped to provide (El-Sabawi et. al, 2021, pg. 6). This is evident by lack of training, rates of arrests, hospitalization and deaths of those living with mental illness that have resulted from placing law enforcement as the main source for psychiatric emergency response. The arrest rate for recipients of public mental health services is estimated to be 4.5 times that of the general public (Fisher et al., 2011), and these rates are much higher in BIPOC populations.



52%
of respondents feel law enforcement presence should be used as needed in the 988 system

The leadership experience survey found that 52% of respondents believed that police involvement in psychiatric emergency response should be as needed, instead of ever-present. A respondent stated,

"There is too much unintentional harm that happens when law enforcement gets involved". Another said, "Involvement of law enforcement often results in explicit or implicit coercion of people to accept treatment, which is both unethical and ineffective (or worse, resulting in escalation)."

3 USE OF TRAINED MENTAL HEALTH PROFESSIONALS AND PEER RECOVERY SPECIALISTS IS ESSENTIAL

An effective crisis response team for psychiatric emergencies includes licensed mental health professionals and peer recovery specialists as essential personnel. Psychiatrists, nursing professionals, and medical interpreters should be available on call for streamlined response.

89% of survey respondents deemed a licensed mental health professional as essential job functions on a crisis response team. 85% of respondents also deemed a peer recovery specialist to be essential. The literature review and survey note that as available, a psychiatric nurse or licensed prescriber should be consulted to avoid misdiagnosis and inappropriate treatment response. One respondent stated, *"Ideally there would be a psychiatric medical specialist such as a psychiatric mental health nurse practitioner who could be consulted during the crisis who could prescribe if needed. Because medical conditions can mimic psychiatric conditions it is important that someone who can diagnose and consider differential diagnoses be available."*

Tailoring Communications

Effective crisis response also includes ensuring the individual is able to communicate, understand, and be provided the appropriate care. A survey respondent highlighted the need for medical translators/interpreters as a part of the effective crisis response team in heavily populated non-English speaking areas.

Another recommended, *"A medical translator is important but given the variation in languages in different geographies, having mobile access to speakerphone / tablet interpretation (including sign language) could be needed because a single translator will be unlikely to speak all needed languages."*

Historically invisible populations are more likely to have mistrust in the healthcare system due to a demonstrated history of experiences of discrimination when accessing care (Bazzargan, Cobb and Assari, 2021). Effective communication measures also include the use of peer recovery specialists, an evidence based model that shows that leaders and experts of lived experience build trust and identify with people in crisis in a uniquely different way than trained professionals. Survey respondents placed specific attention on youth peer specialists, community leaders, and faith-based leaders as important resources to better engage with people.

Mental Health Clinician Shortage and Expanding Telehealth Delivery

The literature review uncovered that the United States is currently experiencing one of the most dramatic shortages of mental health professionals, especially in rural communities.

More than 75% of all U.S. counties are mental health shortage areas, and half of all U.S. counties have no mental health professionals at all (SAMSHA, 2016; Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009).

COVID-19 has increased attention to the use of telehealth services as a means to improve access. Compared to urban areas at 87%, however, 75% of rural households have broadband internet (Center for Health Care Strategy, 2020). While observing telemedicine usage among Medicare recipients, it was found that rural, non-urban adjacent recipients used telemedicine more than 5 times that of urban users.

In rural areas, telemedicine is most frequently used for the service of psychotropic medication management (60.9%), bridging the gap of a historic challenge for those living with diagnoses that require medication adherence as a baseline to remain stable. To combat the usage of emergency services as primary care, telemedicine has improved access for tribal reservations, rural areas, and urban areas, especially during expanded emergency provisions during the COVID-19 epidemic.

A 988 Solution

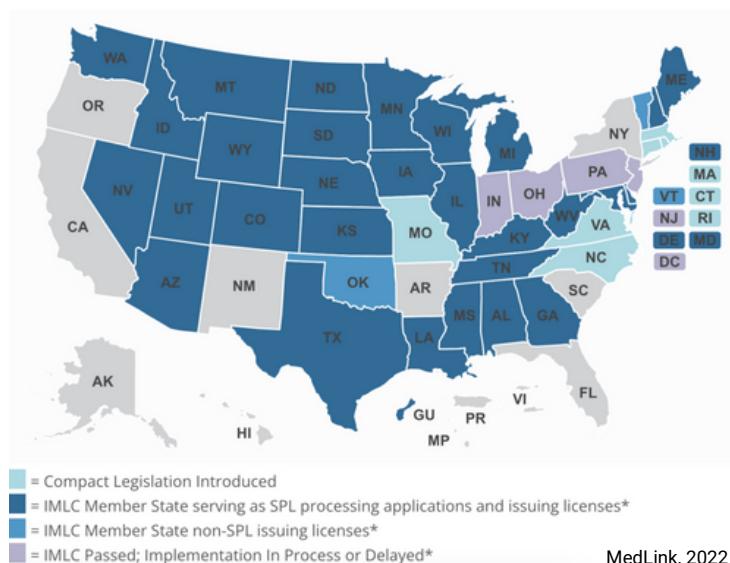
45 states and the District of Columbia currently have signed interstate telehealth licensing compacts (between two or more states), as a response to the disproportionate increase in demand for services during the COVID-19 pandemic, and an on-going clinician shortage across all health disciplines (National Center for Interstate Compacts Database, 2019). These compacts enable providers to practice across state lines, simplifying access to cross-state telehealth. This is especially critical for specialists in participating states where specialty care is not readily available. (HHS, 2022).

If approached federally, under congressional mandate, regional and national telehealth licensure compacts could immediately increase access to care to those communities most affected by access disparities across the country.

988 creates a new federal frontier of opportunity in how mobile crisis response can be tailored and contextualized to meet the needs of those parts of the country that have the poorest and most disparate outcomes. With that, efforts should be made to incentivize and recruit graduating clinicians to work in these areas to provide the culturally responsive and attentive care that is so needed.

The National Health Service Corps has historically been a meaningful resource to meet this need by placing qualified health professionals at federally certified clinical sites, in return for student loan repayment options. 988 allows for more aggressive recruitment of these qualified professionals to be placed on rural, tribal, and resource-deprived community-based mobile crisis teams for a two-year commitment as NHSC members.

Funding under 988 can effectively meet this need and work closely with training institutions to create a direct pathway to employment for those graduates willing to commit years of public service in these areas.



4 LEVERAGE LOCAL CLINICS AS CRISIS RESPONSE HUBS FOR 988 CALLS

Mobile crisis units should be placed at local medical and mental health clinics. An equitable crisis response should be inclusive of individuals and environments that are reflective of the cultural and linguistic needs of the community.

85% of survey respondents identified local clinics as effective host sites for 988 to ensure equitable services are provided. 63% also saw LGBTQIA+ organizations and homeless housing agencies as additional appropriate spaces to host 988 crisis teams.

The survey showed that investing in local clinics and culturally-responsive organizations as host response centers affords more community centered response systems that not only know the community but also ensure responses are effective based on the resources available.

"I think the team should, first of all, be comprised of individuals who culturally and linguistically match the community...every community will be different and each location needs to be based on community needs and proximity to help." - Survey respondent

People living in rural locations experience mental illnesses at similar or higher rates than those in urban areas (SAMSHA, 2016). Rurality also is met with a unique intersectionality when coupled with other identities that experience disparities. Despite having a greater need for services, rural communities have less access to the "behavioral health continuum of care" (SAMSHA, 2016; Petterson, Williams, Hauenstein, Rovnyak, & Merwin, 2009; Borders & Booth, 2007). Funding cuts, workforce shortages, and other systemic concerns are further confounded by a lack of adequate internet infrastructures, traveling long distances to see specialty providers, and challenges seeking care confidentially (SAMSHA, 2016; Bryant, Greer-Williams, Willis, & Hartwig, 2013).

To increase resource deprivation, one respondent suggested,

"I have also seen mobile responders responding remotely from their homes so they can get to locations more quickly- especially rural ones."

Attention to Tribal Needs

A study done by the Department of Health and Human Services (2011) explored the extent to which American Indian/Alaska Natives (AI/AN) have access to mental health services through the Indian Health Service (IHS) and tribal facilities. Although 82 percent of the surveyed facilities reported that they provide mental health services, a variety of staffing issues and shortages affected access to these services. Most notable was the extreme shortage observed of psychiatrists and other licensed providers at these IHS and tribal facilities overall (Department of Health and Human Services, 2011). As AI/AN communities are experiencing a suicide crisis in youth ages 10-24, it is imperative that tribal clinic sites are equipped with funding and resources from 988 to ensure that needs can be met.

Attention to the People Experiencing Homelessness

Specific attention must also be given to people experiencing homelessness and housing instability, as there are many times when psychiatric crisis response for this population is met with arrest instead of access to care.

Los Angeles Fire Department (LAFD) calls were analyzed from January to December 2018. The City of Los Angeles is 480 square mile and has a population of 3,949,776 with a homeless population of 31,285. During 2018, there were 355,411 911 calls. Homeless patients were involved in 36,122 (10.2%) of calls. Calls for the homeless population occurred at a rate of 14 times the rate of housed residents. (Abramson et al., 2020).

5 IMPLEMENT COMPREHENSIVE TRAININGS TO HAVE MORE EQUITABLE RESPONSE

Implementation of comprehensive training to enhance the skills of key personnel can contribute to more equitable responses. The literature review and survey found it is essential that key personnel are trained in various areas relevant to psychiatric emergency response. It is important to note that key personnel includes all levels of support on the crisis care continuum. Culture plays a critical role in ensuring appropriate and equitable responses, specifically when supporting BIPOC communities. Responses from the leadership experience survey identified:



Understanding Cultural Needs

Studies have found that although rates of significant stress, anxiety, depression, and other mental health concerns are higher in communities of color, rates of accessing services are lower due to cultural stigma associated with mental health.

For example, a study by Lee and Tokmic (2019) showed that less-acculturated Latin(o)(a)(x) and Asian immigrants tend to seek help from primary care physicians or alternative medical practices, and rarely utilize traditional mental health services to address depression and anxiety. Training should be provided to strengthen cultural humility in these areas, and to ensure linkages are made with referral points that are more traditionally utilized by these populations, like primary care clinics and school-based mental health settings.

Building on Existing Community Strength

The shortage of mental health professionals has led to increased attention and popularity of Gatekeeper Training (GKT) to address the demand for mental health services.

Gatekeepers are individuals who have “face-to-face” contact with large numbers of community members as part of their usual routine” (Burnette et al., 2015, p. 2). Two common mental health trainings for gatekeepers and other community participants can include Mental Health First Aid and the Question, Persuade, Refer suicide prevention training. Survey respondents also highlighted examples of mental health training that can be tailored at both the gatekeeper and provider level, which include and are not limited to:

- Trauma-informed training
- Substance-use training (e.g Naloxone training)
- De-escalation training
- Counseling on Access to Lethal Means (CALM)

Peer to Peer Training Modules

988 is an opportunity for various parts of the country to learn from each others strengths to advance equity through meeting the needs of all people across communities. Specific opportunities should be given to organizations that can become best practice peer-to-peer trainers for organizations in parts of the country that demonstrate needs for improvement.

Common Ground, Oakland, CA

Common Ground is an example of organization excelling at working in crisis with neurodiverse populations. The organization has crisis workers who can be reached by call, text or in person 24 hours a day, 7 days a week. Suggestions from Common Ground for working with neurodiverse populations in crisis are to be direct using as few words as possible, allow extra time for processing responses, ask about interest, avoid using metaphors, slang, social nuances & allegories and speaking without the use of words that describe emotions (ex. Are you angry?) (Morgan, 2018).

6 GIVE CALLER THE CHOICE TO USE GEOLOCATION SERVICES

Provide callers the option to opt-in and consent to use of geolocation or remain confidential and anonymous when they dial 988. Currently, the National Suicide Prevention Lifeline does not use geolocation services. The benefits to this lie in protection of anonymity of the caller, who may feel safer accessing services if their location and identity is unknown. Without the use of geolocation, however, individuals may not be routed to local resources that can provide timely support where and when needed. Using tools such as geolocation can be beneficial if used in the right way.

Geolocation Requires Attention to Detail

Survey respondents had varying input which validated the mixed perspectives on the use of geolocation. Some highlighted the benefits of accessing local resources via geolocation during heightened crisis. Alternatively, respondents also highlighted that certain sensitivities must be accounted for in those states where identity disclosure leads to arrest or involvement from child protective services. This includes the LGBTQIA+ community and those who may be undocumented immigrants. There are moments however, where geolocation may also provide critical and needed safety points for people in or at risk for crisis. For LGBTQIA+ or undocumented callers in states that present legal ramifications for disclosure, use of geolocation could result in referral to local safe havens or sanctuary clinics that make critical services available.

Many respondents agreed that to maintain and promote safety, and ensure more good than harm, allowing callers to have the option to opt in or opt out of geolocation services can guarantee that the best response is truly caller-centered and caller-empowered.

"If there is evidence that geo-location may improve outcomes, then there should be a way for callers to consciously opt in or out of geolocation, either proactively via agreement with their phone provider or on a case-by-case basis at the time of each interaction. I am entirely on board with broad geolocation (such as a caller's location determined as precisely as a county or town/city), but the prospect of being able to pinpoint a location within a few feet as is possible with 911 raises privacy concerns that could be a barrier for some to access services." - Survey respondent

The Crisis of Response Times

An estimated 240 million calls are made to 9-1-1 in the U.S. each year. In many areas, 80% or more are from wireless devices (National Emergency Number Association [NENA], 2021). The National average response time for 911 is 15 minutes and 19 seconds (Snibbe, 2018). When COVID-19 was at its peak, this significantly worsened. When every second is so critical in an emergency response, using tools such as geolocation can help effectively find resources in closer proximity to the caller.

Top 5 Longest 911 Response Times

Wyoming – 35:44

Vermont – 22:56

Montana – 22:34

North Dakota: 21:30

Kansas – 21:22

Top 5 shortest 911 Response Times

Illinois – 6:00

California – 6:51

Rhode Island – 7:03

Connecticut – 7:54

Massachusetts – 8:33

Snibbe, 2018

POTENTIAL IMPACT

Results from the literature review and leadership experience survey show that there is a demonstrated need to ensure that equity is embedded into 988. The pre-existing approach to psychiatric emergency response has had disparately negative and at times fatal outcomes for specific populations that have been grossly underrepresented and neglected by our health and behavioral health system. The aim is that these recommendations can serve as a foundational tool to create equitable evaluation measures and national advisory committees for 988's ultimate success. 988 is a critical moment to ensure that historic failures are rectified and done so in a culturally attuned and client-empowered manner. Each recommendation has also been met with gaps in the literature review and anecdotal responses in the surveys, which place emphasis on certain questions to be further examined once 988 is launched:

- 1**
- What solutions can be developed beyond punitive ones for people experiencing homelessness?
 - Will undocumented persons be safe to use psychiatric emergency services in all U.S states and territories?
 - What measures will be utilized to ensure the safety and confidentiality for callers in crisis who identify as LGBTQIA+?

- 2**
- How will policies under 988 repair trust within BIPOC communities that have been met with the most adverse law enforcement outcomes?
 - How can 988 bridge the gap between law enforcement and mobile crisis in resource deprived areas?

- 3**
- Telehealth use dramatically increased through COVID-19, can expansion of telehealth access be considered to account for clinician and prescriber shortages?
 - What measures can be developed to capture locality and expertise of services at a national scale, so collaboration between crisis sites across state lines can be more cohesive?

- 4**
- How will mobile crisis be dispatched on tribal land?
 - How are states being held accountable for use of funds for crisis sites?
 - How will technical assistance be provided to clinic sites receiving 988 responsibilities?

- 5**
- How can the efficacy, utility, and feasibility of existing training on mental health and cultural humility and implicit bias be measured and tailored to community needs?
 - What other training that is based in cultural foundations can be expanded?

- 6**
- Can using geolocation services reduce response time?
 - What safety protocols are being put into place to protect the privacy of populations that would benefit from remaining "anonymous"?
 - How does this impact lower socio-economic communities who may not have devices with geolocation capabilities?

AUTHORSHIP

About Kennedy-Satcher Center for Mental Health Equity

The Kennedy-Satcher Center for Mental Health Equity (KSCMHE), an entity of the Satcher Health Leadership Institute at Morehouse School of Medicine, was jointly envisioned by the 16th U.S. Surgeon General, Dr. David Satcher, and former U.S. Representative Patrick J. Kennedy (D-RI). Building on their longstanding relationship and shared commitment to promoting mental health parity and health equity for people living with mental health and substance use disorders, the Center was made possible through a generous endowment from the Kennedy Forum, and matched by MSM's endowment from the National Institute on Minority Health and Health Disparities.

<https://kennedysatcher.org/>

<https://satcherinstitute.org/>

About Morehouse School of Medicine

Morehouse School of Medicine (MSM), located in Atlanta, Ga., exists to improve the health and well-being of individuals and communities, increase the diversity of the health professional and scientific workforce and address primary health care through programs in education, research, and service, with emphasis on people of color and the underserved urban and rural populations in Georgia, the nation, and the world. MSM is among the nation's leading educators of primary care physicians and has twice been recognized as the top institution among U.S. medical schools for its dedication to the social mission of education. The faculty and alumni are noted in their fields for excellence in teaching, research, and public policy, and are known in the community for exceptional, culturally appropriate patient care. Morehouse School of Medicine is accredited by the Commission on Colleges of the Southern Association of Colleges and Schools to award doctorate and master's degrees.

About Beacon Health Options

Beacon Health Options is a leading behavioral health services company serving one out of six people across all 50 states. We work with employers, health plans and government agencies to support mental health and emotional wellbeing, crisis and foster care, substance use disorder recovery, and employee health programs that improve the health and wellness of people every day. Our multi-modal, insights driven approach allows us to integrate social, behavioral and physical health solutions to drive improved outcomes for everyone we serve. By collaborating with a network of providers in communities around the country, we help individuals live their lives to the fullest potential. For more information, visit www.beaconhealthoptions.com and connect with us on www.twitter.com/beaconhealthopt and www.linkedin.com/company/beacon-health-options.

APPENDICES

A. EMBEDDING EQUITY INTO 988: LEADERSHIP EXPERIENCE SURVEY

<p>1. Do you believe our current national psychiatric emergency response system (911) is equitable?</p>	<p>Yes No Unsure Prefer Not to Answer Comments_____</p>
<p>2. The literature review found that the following groups and communities experience the poorest outcomes in our current psychiatric emergency response system. Please select all the groups/communities you experience as neglected by our current psychiatric emergency response system (911) (check all that apply, and please feel free to expand in the comments).</p>	<p>BIPOCBIPOC YouthLGBTQIA+Tribal and rural populations Immigrant/Non-English-Speaking Communities Disability groups - people who are hearing, vision, or mobility impairedGeriatric groups - home-bound/isolated Homeless individualsFormerly incarcerated/Justice-Involved Neurodiverse IndividualsPrefer Not to AnswerComments_____</p>
<p>3. The literature review determined the following professional roles should be considered to make an effective crisis response team more culturally responsive. Please select the personnel categories you believe are essential for a 988 mobile crisis response team to ensure equitable and effective crisis response support. (check all that apply and please feel free to add any not seen here in comments)</p>	<p>Peer recovery specialist Medical translator Licensed mental health counselor or social worker Nurse (LPN or RN) Law EnforcementEMT Community gatekeeper (faith-based leaders, volunteer leaders, tribal leaders, etc.) Prefer Not to Answer Comments_____</p>
<p>4. Findings from the literature review provided examples of how law enforcement has historically been involved in psychiatric crisis response. Examples included but were not limited to concepts like: co-response treatment teams, diversion programs, and more expanded mental health first aid training for police officers. Based on your experience and expertise, please describe to what level you believe law enforcement should have in 988 response to ensure outcomes become more equitable. (Please feel free to expand on your answer in the comments).</p>	<p>No Involvement As Needed Always Unsure Prefer Not to Answer Comments_____</p>
<p>5. The literature review determined the following types of centers and/or facilities as potential hosts for 988 mobile crisis teams in order to increase equity in response outcomes. Please select the type of agency or setting where you feel 988 mobile crisis teams should most appropriately be based: (check all that apply)</p>	<p>HospitalsLocal clinics (medical and mental health) LGBTQIA + serving organizations Homeless shelters and housing agencies Re-Entry ProgramsPrefer Not to AnswerComments_____</p>
<p>6. In addition to the standard training provided to emergency dispatchers that will answer calls initially, the literature review highlighted the following skills that dispatchers should have to contribute to more equitable 988 response. Please select the additional competencies or training you believe should be required for a dispatcher on the 988 crisis line in order for it to become more equitable (please add any additional thoughts in the comments):</p>	<p>Assessing for primary spoken language choice De-escalation training Culturally contextual training (tribal education, differing cultures/beliefs) Mental Health First AidTraining to assess demographic background (race, ethnicity, age, gender identification, sexual identity) Prefer Not to Answer Comments_____</p>
<p>7. The literature review exhibited pros and cons for the use of geolocation but demonstrated a link between access to geolocation and culturally responsive care. Do you believe 988 should access geolocation tracking services to locate where the caller is at the time of the call?</p>	<p>Yes No Unsure Comments_____</p>

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B. POLICE-MENTAL HEALTH COLLABORATION PROGRAMS (PMHC)

Law enforcement, specifically Police departments have partnerships with a range of mental health programs within their state or even across states, and an essential element of these Police-Mental Health Collaboration Programs (PMHC) includes specialized and comprehensive training for officers to respond to psychiatric emergencies (Bureau of Justice Assistance – U.S. D.O.J, 2022). There are 5 types of PMHC programs and agencies from state to state employ different approaches based on community needs/resources. The 5 types of programs utilized by law enforcement for psychiatric/behavioral health emergencies are outlined below.

CIT's (Crisis Intervention Teams)	Co-Responder Team	Mobile Crisis Team	Case Management Team	Tailored Approach
<p>1. Known as CIT, this is the most commonly used approach by law enforcement.</p> <p>2. Originated in Memphis and often called the “Memphis Model.”</p> <p>3. The model includes pre-arrest jail diversion for those in a mental illness crisis (<u>CIT Center, 2022</u>)</p> <p>4. Involvement in CIT is voluntary – Officers volunteer to respond to psychiatric emergency calls.</p> <p>5. Involves a 40-hour training course and CIT officers are then dispatched to mental health calls or to assist officers who are not CIT qualified.</p>	<p>1. Co-responder teams include a specially trained law enforcement office as well as a mental health crisis worker.</p> <p>2. The team, with their combined expertise, assess and refer people with mental wellness concerns to appropriate services.</p> <p>3. The most common approach is for the officer and crisis worker to ride together in the same vehicle for a shift. In some agencies, the crisis worker meets the officer at the scene.</p> <p>4. Co-responder teams can respond through an entire jurisdiction, or they work in areas with the greatest number of mental health calls.</p>	<p>1. A group of mental health professionals who are available to respond to calls for service at the request of law enforcement officers.</p> <p>2. The aim of the mobile crisis unit is to divert individuals from unnecessary jail bookings and/or ER's</p> <p>3. The crisis workers are trained in de-escalation and help stabilize encounters. The workers also assume responsibility for securing mental health services for persons, including those in crisis who may need further evaluation and treatment.</p> <p>4. Mobile crisis teams are not necessarily dedicated to assisting only law enforcement officers but respond to requests directly from community members or their families and friends.</p>	<p>1. A proactive team approach in which behavioral health professionals and officers provide outreach and follow-up to repeat callers and those who typically utilize emergency services.</p> <p>2. Officers do not treat or diagnose the individuals but work with behavioral health professionals to develop specific solutions to reduce repeat interactions.</p> <p>3. Case management is used in agencies in conjunction with other police-mental health collaboration strategies.</p>	<p>1. A tailored approach is one in which an agency intentionally selects various response options from multiple PMHC programs to build a comprehensive and robust program</p> <p>2. This allows the agency to adhere to a consistent policing philosophy while being responsive to community needs.</p> <p>Other factors agencies consider when choosing this approach can include the size of the jurisdiction and the number of officers on a given shift</p> <p>3. When using the tailored approach, a law enforcement agency begins with the expectation that every patrol officer must be able to respond effectively to mental health calls.</p>

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