June 16, 2021

A Reimagining Police Subcommittee Proposal

To: Recommend legislation to: 1) implement the federally mandated 988 crisis hotline system; 2) enhance and expand behavioral health crisis response and suicide prevention services statewide; and 3) fund the system through SAMSHA and DMHAS grants, reimbursements from private and public insurers, and funds raised by imposing a federally-authorized excise tax on commercial mobile services or IP-enabled voice services.

I. Introduction

Police officers perform the indispensable service of protecting our communities from crime and violence and promoting public safety. Police recruitment and training necessarily focus on fielding officers equipped by temperament and training for the dangerous job of "containing and controlling" criminal and violent behaviors.

Yet, as communities have repeatedly failed to provide adequate resources for addressing recurring crises in behavioral health (e.g. mental illness, substance abuse, homelessness, domestic violence, child neglect and abuse), we have asked our police to expand their services to address innumerable behavioral health emergencies well beyond their core vocation and training. There is an old saying that "when your only tool is a hammer, it is tempting to view every problem as a nail." Similarly, when your principal tool is "contain and control" by the use or prospect of force, then too many behavioral emergencies will seem like threats to be controlled instead of illnesses to be treated.

There will always be, of course, some percentage of behavioral health emergencies that present a sufficient, imminent threat of violence that a police presence will be necessary, but sending police as the default first responders in every case reflects a lack of nuanced judgment that inevitably results in multiple adverse consequences. First, turning reflexively to armed law enforcement officers misuses and overextends our already thinly-stretched police departments. Second, we deprive the individuals suffering behavioral crises of the professional mental health response they need. Third, we cycle behavioral patients through repeated, costly, and ineffective emergency department admissions and discharges instead of referring them to the care resources that might break the cycle of substance abuse, homelessness, mental

illness, etc. at a fraction of the cost. Fourth, we end up unnecessarily routing a significant percentage of behavioral crisis sufferers into the criminal justice system, with the multiplying expenses of arrest, adjudication, incarceration, and probation. Finally, we dramatically increase the risk of police use of lethal force, particularly when the subject is person of color.

Research conducted over the past decade by the United States Department of Justice and other federal agencies has generated repeated recommendations for more nuanced responses to persons suffering behavioral crises.[1] These recommendations have been echoed by calls from many organizations such as the United States Conference of Mayors[2], the Leadership Conference on Civil and Human Rights[3], the National League of Cities and Arnold Ventures[4], and the Center for Policing Equity[5] for adoption of "mobile crisis unit", "co-responder", and/or "crisis intervention team" alternatives to relying exclusively on armed law enforcement "contain and control" responses.

In several ways, Connecticut police departments and state agencies have taken a leadership position in experimenting with or deploying mobile crisis unit, co-responder and/or crisis intervention team models, often with funding from the Connecticut Department of Mental Health and Addiction Services ("DMHAS"). For instance, in 2002, the Connecticut Department of Children and Families ("DCF") began shifting crisis responses from armed police officers to mobile crisis teams staffed by mental health professionals ("Emergency Mobile Psychiatric Services," now called: "Mobile Crisis Intervention Services", http://www.empsct.org/.).[6] By 2015,

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[1] Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice (2010) *passim;* U.S. Department of Justice Office of Community Oriented Policing Services ("COPS"), Law Enforcement Best Practices: Lessons Learned from the Field 37-46 (2019); Substance Abuse and Mental Health Services Administration, National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit *passim* (2020).

[2] United States Conference of Mayors, Report on Police Reform and Racial Justice 14-15 (2020)

[3] The Leadership Conference on Civil and Human Rights, New Era of Public Safety: A Guide to Fair, Safe, and Effective Community Policing 152-167 (2019).

[4] National League of Cities and Arnold Ventures, Mental Illness, Substance Use, and Homelessness: Advancing Coordinated Solutions through Local Leadership 1-5 (2019)

[5] Center for Policing Equity, A Roadmap for Exploring New Models of Funding for Public Safety 4 (2020)

[6] Fendrich, M., Kurz, B., Ives, M., & Becker, J. *for* The Child Health and Development Institute of Connecticut, Inc., Evaluation of Connecticut's Mobile Crisis Intervention Services: Impact on Behavioral Health Emergency Department Use and Provider Perspectives on Strengths and Challenges 8 (2018). "Connecticut's Mobile Crisis Intervention Service (Mobile Crisis) program, which is grant-funded by the Department of Children and Families (DCF), was first implemented in 2002 (O'Brien, Mulkern, & Day, 2003; Vanderploeg, Lu, Marshall, & Stevens, 2016). The program aims to "serve children in their homes and communities, reduce the number of visits to hospital emergency rooms, and divert children from high-end interventions (such as hospitalization or arrest) if a lower level of care is a safe and effective alternative" (Vanderploeg et al., 2017, p. 6). The program provides free services to youth who are 18 years and younger, and to 19 year-olds who still attend high school (Vanderploeg et al., 2016). Vanderploeg et al. (2016) described three key components and other integral features that comprise Mobile Crisis. The information contained in the following section was adapted from their article. The first key component is the provider network. Mobile Crisis provides coverage to the entire state of Connecticut through six service areas, each of which utilizes up to three sites (there were a of 14 provider sites as of 2016; these numbers expanded, as indicated in Section III), that are responsible for different geographic regions of the state. Each service area has a Mobile Crisis director, access to a child and adolescent psychiatrist, and Master's level clinicians in the fields of social work, psychology, marriage and family therapy, and related fields. Mobile Crisis clinicians work with clients to develop crisis safety plans. Other features of their work include "crisis stabilization and support, screening and assessment, suicide assessment and prevention, brief solution-focused interventions, and referral and linkage to ongoing care" (Vanderploeg et al., 2016, p. 106). The Mobile Crisis team's approach is guided by collaboration with families, schools, hospitals, and other providers. The maximum Mobile Crisis episode length is typically 45 days, but can be extended if necessary. Clients can also return to Mobile Crisis as many times as needed after the episode is closed. The second key component

DCF had already established fifty-three memoranda of understanding with community-based mental health care providers.[7] DMHAS funds a statewide "Call 211" hotline operated by the United Way that provides referral and, occasionally, mobile crises responses staffed by mental health professionals. Most municipalities and many Connecticut State Police troops have sent at least some of their officers for formal crisis intervention team training. Finally, section 18 of the state's recently enacted Police Accountability Act requires the Department of Emergency Services and Public Protection and each municipal police department "to complete an evaluation of the feasibility and potential impact of the use of social workers by the department for the purpose of remotely responding to calls for assistance, responding in person to such calls or accompanying a police officer on calls where the experience and training of a social worker could provide assistance."

These are worthy and important initiatives, and we should certainly recommend a continuation of commitment, research, and development in each of these areas. Yet, we have already experienced the financial and logistical challenges to scaling up these programs further. One need only survey the municipal and state police responses to the feasibility and impact studies required by Section 18 of the Police Accountability Act to see a catalogue of potential obstacles.

Fortunately, federal legislation and regulations mandating a nationwide "988 Hotline" has intersected with concerns underscored by the George Floyd murder to inspire a bipartisan, national movement to implement the federal "988" mandate with statewide mobile crisis response capacities staffed by professional health care workers. States across the country have been moving expeditiously to enact implementing legislation taking advantage of the federal law's grant of authority to fund the mobile crisis response services with fees and charges imposed on commercial mobile services or IP-enabled voice services.[8]

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is the call center. Clients can access Mobile Crisis services by dialing 211 (although our focus groups revealed that there were direct lines of engagement at some sites). A call specialist will solicit basic information from the caller and refer police or ambulances services if warranted. Otherwise, if the call occurs during Mobile Crisis mobile hours (Monday through Friday: 6:00 am-10:00 pm; weekends and holidays: 1:00 pm-10:00 pm), the call specialist will connect the caller to Mobile Crisis through a warm transfer. Based on the call specialist's recommendation, Mobile Crisis will respond in one of three ways: immediate mobile, deferred mobile, or telephone. In mobile responses, Mobile Crisis clinicians will meet clients wherever they are experiencing a crisis in the community. During immediate mobile responses, clinicians will meet the client within 45 minutes of the call (In 2015, Mobile Crisis achieved this response time 89% of the time.). If the call occurs outside of Mobile Crisis mobile hours, the call specialist will connect the caller to a non-Mobile Crisis clinician and Mobile Crisis will follow-up with the caller during mobile hours. The third key component is the Performance Improvement Center (PIC), which was created in 2009 and is housed at the Child Health and Development Institute of Connecticut (CHDI). PIC is charged with "standardized practice development; data collection, analysis, reporting, and quality improvement; and workforce development" (Vanderploeg, 2016, p.105).

[7] Department of Children and Families, Connecticut Children's Behavioral Health Plan: Progress Report 8 (2015)

[8] Substance Abuse and Mental Health Services Administration, "Blog: Groundbreaking Developments in Suicide Prevention and Mental Health Crisis Services Provision" https://blog.samhsa.gov/2021/05/14/groundbreaking-developments-suicide-prevention (May 14, 2021)

II. Federal 988 Legislative and Regulatory History

The federal 988 legislative and regulatory history was ably summarized in a May14, 2021 blog posted by the Substance Abuse and Mental Health Services Administration entitled, entitled, "Groundbreaking Developments in Suicide Preventiion and Mental Health Crisis Service Provision":

"In 2018, Congress passed and the President signed into law, the National Suicide Hotline Improvement Act in which SAMHSA and the Veterans Administration were called upon to report to the Federal Communications Commission (FCC) regarding the effectiveness of the existing National Suicide Prevention Lifeline and the potential value of a three digit number being designated as the new national suicide prevention number. The FCC subsequently recommended to Congress that the number 988 be designated as the new national suicide prevention number. On July 16, 2020, the FCC issued a final order designating 988 as the new NSPL and Veterans Crisis Line (VCL) number. This order gave telecom providers until July 16, 2022 to make every land line, cell phone, and every voice-over internet device in the United States capable of using the number 988 to reach the Lifeline's existing telephony structure. On October 17, 2020, the National Suicide Hotline Designation Act of 2020 was signed into law, incorporating 988 into statute as the new Lifeline and VCL phone number."

One of the most significant provisions of the 988 legislation was the express provision of authority to the states to impose and collect fees or charges "applicable to a commercial mobile service or an IP-enabled voice service" to fund "9-8-8 related services if the fee or charge is held in sequestered account to be obligated or expended only in support of 9-8-8 services, or enhancements of such services."

Permitted expenses included:

"(A) ensuring the efficient and effective routing of calls made to the 9–8–8 national suicide prevention and mental health crisis hotline to an appropriate crisis center; and (B) personnel and the provision of acute mental health, crisis outreach and stabilization services by directly responding to the 9–8–8 national suicide prevention and mental health crisis hotline."

III. State Responses to the Federal 988 Legislation and Regulation

Many states have recognized that the federal legislation and regulation, particularly its grant of authority to impose fees and charges on mobile and IP-enabled voice call services, provides a powerful tool that can be used to address both the suicide and mental health crises and the concerns underscored by the George Floyd murder.

Three states have already passed and signed 988 legislation into law (Washington, Virginia, and Utah); three states have passed 988 legislation (Alabama, Indiana, and Nevada), twelve states have introduced 988 legislation (Oregon, California, Colorado, Idaho, Kansas, Kentucky, Massachusetts, Nebraska, New York, New Jersey, Rhode Island, and Wisconsin), and new 988 legislation is already anticipated in at least three more states (Arkansas, Pennsylvania, and South Carolina.)[9]

Many of the state bills already enacted or introduced reflect guidances provided by SAMSHA's published best practices for behavioral health crisis care[10] as well as model bills promoted by various mental health advocacy groups.[11] While there is substantial variation among and between the various state bills, virtually all of them seek to capture the advantages identified by SAMSHA:

1. More people in suicidal and mental health crisis will be helped. Sources of increased contacts (calls, chats, and texts) include baseline contact volume, new contact volume, and contacts diverted from 911 and other crisis hotlines.
2. Those in crisis will be more likely to receive help from those most qualified to provide support.
3. More effective triage means less burden on emergency medical services, emergency departments, law enforcement, etc. so that their agencies can be appropriately focused their limited resources on those areas for which they are best trained.
4. The attention the transition to 988 has brought to crisis services has led to an opportunity for states to reimagine their crisis service provision, and to ensure adequate financing of 1) mobile crisis services, 2) crisis center hubs and 3) crisis stabilization services.[12]

In our view, SAMSHA's summary of benefits omits one of the most consequential benefits of shifting the primary burden of responding to behavioral health crisis from armed law enforcement officers to mental health professionals. At

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[9] Substance Abuse and Mental Health Services Administration, "Blog: Groundbreaking Developments in Suicide Prevention and Mental Health Crisis Services Provision" https://blog.samhsa.gov/2021/05/14/groundbreaking-developments-suicide-prevention (May 14, 2021)

[10] Substance Abuse and Mental Health Services Administration, National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit (2020). https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

[11] National Association of State Mental Health Program Directors, Model Bill for Core State Behavioral Health Crisis Services Systems (2021). https://www.nasmhpd.org/sites/default/files/Model%20Bill%20for%20a%20Core%20State%20Behavioral%20Health%20Crisis%20Services%20System.pdf.

[12] Substance Abuse and Mental Health Services Administration, "Blog: Groundbreaking Developments in Suicide Prevention and Mental Health Crisis Services Provision" https://blog.samhsa.gov/2021/05/14/groundbreaking-developments-suicide-prevention (May 14, 2021)

least 23% of all fatal shootings by police officers in the line of duty since 2015 involved victims with known mental illness.[13]

"*Mental illness, unlike age, is its own risk factor for police violence. The Fatal Force project found that approximately one in four people shot and killed by police were experiencing a mental or emotional crisis at the time of the shooting.*

However, the finding that Black men exhibiting signs of mental illness are also at higher risk of police killing than white men, particularly while unarmed, is indicative of a concerning pattern in policing: While white men with mental illness are more likely to be given treatment, Black men with similar behaviors are more likely to be criminalized for their actions."[14]

To put the matter as starkly as possible, every behavioral health crisis successfully addressed by mental health professionals instead of by armed policer will significantly reduce the risk of the patient being fatally shot. No one has ever been shot by a police officer who was not at the scene.

IV. Recommendation

The Reimagining Police Subcommittee proposes that the Connecticut Bar Association Task Force on Policing recommend legislation to 1) implement the federally mandated 988 crisis hotline system; 2) enhance and expand behavioral health crisis response and suicide prevention services statewide; and 3) fund the system through SAMSHA and DMHAS grants, reimbursements from private and public insurers, and funds raised by imposing a federally-authorized excise tax on commercial mobile services or IP-enabled voice services.

Legislation implementing the federally mandated 988 crisis hotline system has already been introduced, passed, and/or signed into law in eighteen states. We propose a recommendation that the General Assembly enact legislation in a form that aligns with the Substance Abuse and Mental Health Services Administration's National Guidelines for Behavioral Health Crisis Care Best Practices Toolkit[15] the model bill published by the National Association of Mental Health Program

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[13] Washington Post Database of Police Shootings, https://www.washingtonpost.com/graphics/investigations/police-shootings-database/.

[14] Kara Manke, "Stark racial bias revealed in police killings of older, mentally ill, unarmed Black men" U.C. Berkeley.News, October 5, 2020. *Citing* The Washington Post Database of Police Shootings *and* Marilyn D.Thomas PhD, MPH[a], Amani M.Allen PhD, MPH[b], "Black and unarmed:statistical interaction between age, perceived mental illness, and geographic region among males fatally shot by police using case-only design," 53 Annals of Epidemiology, January 2021, 42-49. https://www.sciencedirect.com/science/article/abs/pii/S1047279720302957?via%3Dihub

[15] Substance Abuse and Mental Health Services Administration, National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit (2020). https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

Directors[16] and reflects the robust approaches reflected in the bills passed in Washington State[17] and introduced in New York State.[18]

[16] National Association of State Mental Health Program Directors, Model Bill for Core State Behavioral Health Crisis Services Systems (2021). https://www.nasmhpd.org/sites/default/files/Model%20Bill%20for%20a%20Core%20State%20Behavioral%20Health%20Crisis%20Services%20System.pdf.
[17] http://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1477-S2.SL.pdf?q=20210617050746
[18] https://legislation.nysenate.gov/pdf/bills/2021/A7177B.