Multi-Site Feasibility Evaluation of Crisis Stabilization Units Across Three Jurisdictions with High Opioid Use Disorders and a Proposed Follow-Up RCT

Summary of Findings, Feasibility Evaluation Results, & Policy Considerations

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Research Purpose

The purpose of the Post-Crisis Stabilization study is to deepen policymakers, practitioners, and researchers' understanding of crisis stabilization units (CSUs) and their utilization by law enforcement, and to pilot an intervention designed for individuals that have been brought to a CSU by police with the goal of minimizing future contact with both law enforcement and CSUs. This research project provides an in-depth analysis of these areas by collecting data from law enforcement, CSU staff, mental health professionals, as well as with the individuals themselves that are brought to a CSU by law enforcement.

As part of our original grant goals, we took a close look at the utilization of CSUs and the collaboration between law enforcement and CSU employees. This analysis allowed us to examine law enforcement decision processes, procedural guidelines, and the overall barriers and facilitators to utilizing and transporting someone to a CSU.

We also conducted a pilot feasibility study with individuals admitted to a CSU under a law enforcement initiated involuntary psychiatric hold. In our pilot study, individuals were randomized to either receive our mobile and technology-assisted aftercare or to receive the standard services offered upon discharge at the CSU and no mobile aftercare program. We assessed the feasibility of this intervention and the overall psychosocial well-being, stabilization, and contact with law enforcement and CSUs for all participants in the pilot study.

Our team then obtained approval to extend our study and project goals. During this extension we increased the scope of our alternative-to-arrest analysis by including data on non-CSU alternatives that law enforcement may utilize during mental health and/or substance related calls. These other alternatives incorporated mental health clinicians on scene either through co-response teams or mobile response teams.

Ultimately, our project aimed to identify ways to reduce repeated interactions between individuals with mental health, substance-use, or co-occurring disorders with both law enforcement and CSU agencies, and to optimize services and support for individuals after discharging from a CSU.

Research Questions for the original study and approved extension:

1. Original study - What are the key elements to CSU implementation and utilization?
2. Original study - What is the feasibility and acceptability of implementing an aftercare program for individuals brought to a CSU by law enforcement?

3. Extension - What is the true demand for mental health alternatives to incarceration for law enforcement?
4. Extension - How are CSUs and other mental health alternatives incentivized to be used?
5. Original and Extension - What structural and communication factors are facilitating or hindering the use of alternatives?

Project Components:

Original Study:

Aim 1. Identify key elements and implementation factors for CSU dissemination.

- Interviews with law enforcement agencies to identify barriers and facilitators to utilizing crisis stabilization units and the procedural considerations involved in mental health & substance-use response overall.
- Interviews with employees of CSUs to capture their procedures and collaboration processes with law enforcement, especially during the admission process.
- Collection and review of administrative agency records to identify the scope, frequency, and outcome of mental health calls for law enforcement.

Aim 2. Develop an implementation guide and conduct a pilot RCT with mobile and technology-assisted aftercare with individuals admitted into a CSU under a law enforcement initiated involuntary hold.

- Synthesizing information collected in Aim 1, we developed an implementation guide for mobile and technology-assisted aftercare.
- Recruitment of individuals brought to a CSU under a law enforcement initiated involuntary hold to receive either our piloted mobile aftercare intervention or the standard services for individuals discharging from a CSU. We then tracked and collected data with participants for 6 months to gauge a variety of biopsychosocial factors and subsequent arrests.
- Assessed the feasibility and acceptability of the mobile aftercare intervention with stakeholders to document relevant policy considerations to implementation.

Aim 3. Design a multisite RCT to compare the relative impact to CSUs with mobile and technology-assisted aftercare to CSUs without mobile and technology-assisted aftercare.

- Design of a multisite RCT to compare CSUs with and without mobile technology-assisted aftercare on short and long-term outcomes: individual stabilization post-crisis, arrest rates, use of acute services, and increased engagement with longer term treatment. Our team has completed this Aim through the submission of our "Future RCT Protocol" report.
- The pilot and feasibility study executed through this grant has equipped our research team with the necessary tools to successfully manage this RCT. For instance, due to completion of this pilot study, our team has reduced the opportunity for error in a follow up RCT by allowing for relationship building between the researchers, practitioners, and law enforcement officers within the context of a research study. Additionally, challenges addressed in our pilot test will result in an economically advantaged RCT because the need to make implementation changes during a larger multisite RCT will be significantly reduced

thus saving time and costs. Ultimately, the pilot study foundation also leads to increases in rigor, fidelity, and quality in a follow up trial.

Extension Study.

To include changes in the mental health response options for law enforcement, as well as additional mental health and law enforcement collaborative initiatives, we modified our original project design to include an extension analysis.

- Interviews with law enforcement and mental health professionals with a focus on better understanding the use of CSUs by law enforcement as well as other specialty collaborative teams, like co-response and mobile response teams, to explore additional arrest-alternatives that law enforcement may utilize.

Project Terminology

Crisis stabilization units (CSUs) – CSUs are short term treatment facilities designed to stabilize individuals that are an imminent threat to themself or others. The duration of treatment at CSUs varies but the average is typically around 72 hours.

Co-response teams – co-response teams are units that pair an officer with a mental health professional (sometimes a licensed clinician and sometimes not) to respond to mental health related calls. Co-response teams are housed within a law enforcement agency. However, the assigned clinician may be staffed by an outside mental health agency. These teams act as a primary responder to a scene, meaning they arrive before, instead of, or in conjunction with regular patrol.

Mobile response teams – mobile response teams are entirely staffed by mental health professionals and housed under a local mental health agency. These teams act as secondary response to a scene for law enforcement, meaning they are alerted to a scene from a regular patrol officer that is already on scene. These teams operate as an additional resource for officers to utilize when interacting with individuals that are in crisis.

Findings

- **Part 1** - Qualitative interviews with law enforcement and mental health stakeholders
- **Part 2** - Pilot feasibility study and feasibility evaluation results
- **Part 3** - Re-engagement with law enforcement and readmission at CSU across study conditions

Findings pt. 1 - Qualitative Interviews with Law Enforcement & Mental Health Stakeholders

I. Qualitative Interviews with Law Enforcement & Mental Health Stakeholders

To address Aim 1 and the Extension project components, the JSP research team conducted qualitative interviews with law enforcement and mental health stakeholders throughout 2021 and 2022. Stakeholders and agencies interviewed represented four counties that ranged in size from about 43K population to about 292K according to 2020 Census allowing representation from both rural and urban settings.

In total we were able to capture qualitative data with over 140 stakeholders. These stakeholders encompass a variety of agencies and roles including:

- Eight law enforcement agencies: (patrol and leadership)
- Staff at two Crisis Stabilization Units: (staff positions ranged from admission screeners, case managers, psychiatric doctors, nurses, and CSU unit managers).
- Staff from two mental health agencies that staffed co-response and mobile response clinicians: (staff positions ranged from co-response clinicians, mobile response clinicians, and team managers)
- Total qualitative analysis included 99 law enforcement stakeholders and 44 mental health stakeholders.

Law Enforcement Perception of Mental Health & Mental Health Response

We would like to start this report by highlighting the six major themes that arose from law enforcement stakeholders about their overall perception of mental health crises and officer response. These six themes set the foundation for the project findings by acknowledging the predominate beliefs observed across our law enforcement stakeholders.

1. Law enforcement routinely differentiated mental health from the criminal activity that may or may not ensue and emphasized beliefs that criminal activity and mental illness are not directly correlated.
    - *I personally do not believe there's a direct correlation between mental illness and criminal activity. There is a direct correlation between mental illness and homelessness, substance abuse, all the other issues that cause criminality. – Officer*
2. Officers would prefer not to be the sole responders to mental health calls.
    - *They [MH worker] can show up on scene and they know exactly what to say to this person. They know exactly what to do versus us, we're going off of experience. We're going off of what we've seen before. It makes us feel more comfortable and it makes us feel better. - Officer*
3. Across all agencies, officers routinely made statements that mental health disorders should not predicate criminal justice involvement.
    - *I'm a big advocate of being mentally ill is not against the law. – Officer*

4. Officers recognized that their involvement could exasperate mental health issues especially if the law enforcement interaction results in transporting the individual somewhere.
    - *Also, if that person is truly having a mental episode, now you're taking them from their home, so it adds, if they have to go with you, and they want to resist that or fight that, because they don't want to leave their comfort zone. – Officer*
5. Law enforcement often felt that their repeated interaction with individuals with mental health disorders is in part due to the lack of long-term treatment resources available.
    - *We owe it to them to give them service. I think the problem is, is the continuum of service. I think we give them that band-aid and then we boot them right back out into a world in which they're not able to adequately survive – Officer*
6. Sometimes people threaten suicide and involve law enforcement as a way to ask for help and law enforcement intervention can then point these individuals to services.
    - *You get a lot of people just say, "Hey, I'm going to kill myself." They don't necessarily have the intention of doing so. It's a cry for help. They want the assistance, but they call up and they say, "Hey, I have a bottle of pills right here." "Hey, I have a knife." "Hey, I have--" whatever. - Officer*

True Demand

As part of this grant, our research team sought to answer, "what is the true demand for CSUs and other alternatives to arrest for law enforcement?" To thoroughly answer this question, we reviewed administrative records from two crisis stabilization units, and incorporated direct questions about frequency-of-use into our interviews with law enforcement and mental health stakeholders.

Review of administrative records

In review of administrative records, we analyzed law enforcement admissions into two different CSUs over a nine-month period. During these nine months, 40% of the clients who received CSU treatment services were admitted following contact with police. This means that law enforcement initiated 40% of CSU admission through either issuing involuntary hold paperwork or simply transporting the individual to the facility for admission. We then took a closer look at those admitted following law enforcement contact and found that 82% were admitted for mental health crises, less than 1% were admitted for strictly substance-related crises, and for the remaining 18% the data was unclear if it was mental health, substance-use, or a combination that led to admission. These figures average out to about 98 individuals total admitted across these two CSUs per month through law enforcement.

An important piece to illustrate the *true demand* of CSUs for law enforcement, is the number of voluntary transports that law enforcement bring to CSUs. Voluntary transports are individuals that law enforcement choose to bring to a CSU, to receive mental health and/or substance-use services, with the willing participation of the individual. As described in the below section, Utilization of Crisis Stabilization Units, law enforcement may transport someone voluntarily for several reasons including at the person's request. Current administrative data systems suggest around 12% of CSU clients overall are admitted under a

voluntary status and less than 1% of these are from law enforcement. Unfortunately, critical barriers exist to capturing the number of voluntary transports. One barrier to capturing voluntary transports from law enforcement is due to these voluntary individuals transitioning to an involuntary status upon evaluation by CSU medical staff. In these situations, such individuals are documented in administrative records as an involuntary admission through CSU staff rather than a voluntary transport from law enforcement. In other words, current data systems reflect the source of the admission decision which may then exclude documentation of the law enforcement transportation to the CSU. A second barrier to capturing the true demand of law enforcement voluntary transports to CSUs are due to voluntary transports being turned away due to not meeting crisis criteria or they decline admission after being dropped off. These individuals are currently undocumented by our partnering CSUs limiting a reference to the total CSU voluntary transports by police. Due to the above restrictions in data tracking, our research team urges caution in referring conclusions about true demand of voluntary transports from administrative record review. However, in conjunction with our qualitative interviews with stakeholders, we believe the true demand for CSUs, both as a voluntary and involuntary option, suggests a frequent and critical need for officers.

Review of interviews with stakeholders

Law enforcement stakeholders provided a range of perceived frequency of the need for transports to the CSU from a couple per day to a few per week. When we asked law enforcement how often they felt they were responding to calls with mental health concerns or crises they reported anywhere from several times per day to 50% of calls matching this description. We have organized our true demand analysis of law enforcement stakeholders by county. Doing this allows a closer look at how things like proximity and population size play into demand for alternatives, like the CSU, for law enforcement.

As seen below, there is a large variety in perceived frequency of transporting to the CSU. The below quotes represent two different law enforcement agencies within this county. These agencies varied greatly in their size and geographic coverage. The second quote being from an officer in the smaller agency that covers a smaller area within the county.

Least populated, rural, county:

Transporting to a CSU under an involuntary psychiatric hold

- *I think we probably [place under an involuntary psychiatric hold] what? Two or three a day, probably somewhere in there, roughly on estimate from the county. - Officer*

- *I'm going to just off top my head. I'm going to guess. I know that me and my partner have dealt with two in three months. – Officer*

Asking officers about responding to calls with mental health and/or substance use concerns present.

- *In this agency, which is in this town, which is small, not too often. - Officer*

- *I'd say about 50% of our calls are related to some mental health issue. They're not always a [involuntary psychiatric hold]. – Officer*

Mid-range size, suburban-rural blend, county:

Transporting to a CSU under an involuntary psychiatric hold

- *It's not super often. I've only got not even two handfuls of [involuntary psychiatric holds] under my belt. - Officer*

Asking officers how often they are responding to calls with mental health and/or substance use concerns present.

- *Probably at least once a day at most. - Officer*
- *It's not that often, really. Maybe I just get lucky, but it's not that much. Maybe two, three times a week. – Officer*

Most populated, urban county:

Our study was able to include two different counties that were similar in size and resources. These two counties provided urban county representation for this project. The below quotes come from officers in each of these two counties.

- *I'd at least say weekly. I wouldn't necessarily say daily, which I don't know about the other shifts-- day shift or whatever- but it's pretty common on our shift. – Officer*
- *I [place under an involuntary psychiatric hold] two or three times a month. - Officer*

When asked simply how often officers were responding to mental health or substance related calls regardless of a CSU outcome. Interestingly, we had multiple officers across these two counties estimate 10 calls per day.

- *We're getting about eight to 10 calls a day just in the county. That's not [agency name redacted]. It upticks more during holidays or bigger events - Officer*
- *I would say guaranteed 10 a day. – Officer*
- *Per agency. Calls for service, where we get called out when there's some sort of substance abuse, I would say no less than 10 a day. - Officer*

Mental health stakeholders:

Mental health stakeholders provided a range of frequency for admissions into the CSU through law enforcement with some saying as frequently as several a day to several per week.

- *Your average day, I will say maybe about five or six, depending on the entire day – CSU staff*
- *Interviewee: The majority of our clients come in from there [law enforcement]. Say we have 30 beds here, 31 beds, so probably 25 of them*

are [law enforcement involuntary psychiatric holds]. The rest are volunteer. – CSU staff

- *Interviewee: Sometimes we can get anywhere from five to seven law enforcement officers here.*
  Interviewer: In one day?
  Interviewee: Sometimes, and sometimes we don't see them for three days. It really just depends. – CSU staff

Special Note

Capturing the true demand for CSU utilization, mental health crisis calls, and substance use crisis calls was challenging due to infrastructure barriers that were consistent across the eight law enforcement agencies represented in this project. Infrastructure barriers included an absence of tracking law enforcement civilian interactions that did not result in a formal report, mental health or substance calls being coded as something else (such as whatever code came under 9-1-1 dispatch or a code that reflects other activity on scene), and an inability to decipher the outcome of a call coded as mental health without individually reading the system notes. These infrastructure barriers meant that our partnering law enforcement predominately had no easy way to pull figures detailing the quantity of types of calls, outcomes to the calls, or resources utilized. Assisting partners in tracking these data is imperative. Similarly, 911 calls are an underutilized resource in research related to this study.

Incentivization

As part of this grant, we asked how alternatives, like the CSU, co-response, and mobile response teams, are incentivized for officers to use. Through our analysis we determined that the incentivization of these alternatives occurs in four ways:

- A top-down incentive from the leadership of the law enforcement agency down to the officers
- A lateral incentive from officer-to-officer
- An internal incentive, meaning the officer has ascribed to the notion that these alternatives are a beneficial option for oneself to utilize.
- An outside incentive, meaning that community members are encouraging the incorporation of these alternatives.

Incentive #1: top-down incentive

One of the ways that leadership incentivizes the utilization of alternatives to their officers is by acknowledging and giving positive attention to their existence. Our data analysis revealed that officers perceived their department leadership as rarely formally discussing or giving attention toward alternatives like mobile response teams or co-response teams. However, officers did note that leadership over mental health response or involved with alternative response teams, do discuss the utilization of these options, and encourage patrol officer utilization.

- *Interviewer: have you seen any other promotion of the [co-response] unit or anything like that through other staff or anything?*
  Interviewee: Like throughout the agency?
  Interviewer: Yes.
  Interviewee: Not really. Just through [the co-response team supervisor].

- *Interviewer: How does [Agency name] encourage officers to utilize the team when they're out on patrol?*
  Officer: We just know to ask. If it's non-violent mental health call, you don't have to really encourage it if you don't have to go to a call. That's encouragement enough,

- *They [regular patrol officers] were really overloaded. As time's gone by, they've seen how great the [co-response] unit works. It's encouraged throughout patrol. Everyone on patrol supervisors on down, encourage the team to be used. – co-response officer*

The incentivization for utilizing crisis stabilization units was notably different because training for utilizing CSUs was predominately a formal part of officer training. Our analysis revealed that shadowing the utilization of a CSU and conducting an involuntary hold was one of the items that new officers in training often were required to shadow and observe. Therefore, officers are being incentivized to utilize the CSU through formal acknowledgement from their agency.

- *Then when you're a trainee, they'll try and specifically get you everything that you need before you get out of training. . .They show you how to handle the call, what question you should ask to see what's going on. Then if you determine a[n] [involuntary psychiatric hold] needs to happen and they walk you through that procedure as well. - Officer*

Incentive #2: a lateral encouragement from officer-to-officer

Our analysis indicated a low presence of lateral encouragement from officer-to-officer to join an alternative response team, like a co-response program. For instance, in one agency, an officer noted that less than 10% of agency officers had signed up to serve on the co-response unit.

Despite some agencies experiencing low-levels of officers signing up to be on these types of teams, our analysis did indicate high levels of officer-to-officer encouragement to utilize the co-response teams. Interestingly, a majority of regular patrol officers noted prior feelings of skepticism for co-response teams until having worked with and experienced the teams in action, after which these officers wildly encouraged and utilized the teams.

- *We explain our role and stuff so it's really been accepted very easily. The first couple of months, it was a little challenging because they had to get used to us being out there . . . Now, they know when we work, they know what we do, so they have gotten a really good handle on when to call us. There hasn't been really any negative pushback on any of it. - Officer*

- *Now we come with this unit that's going to only respond to mental health calls. Of course, it wasn't received very well until we got on the ground and started running with it. Then they realize it is very much applauded now. - Officer*

Incentive #3: an internal ascription to the use of alternatives and belief they are a viable option for yourself.

As noted under incentive 2, most officers enthusiastically believed in the benefit of co-response teams after having worked with them. Some of the officers we spoke to that experienced these shifts in attitude pointed to having previously been assigned to work nights or shifts that were not currently covered by co-response teams. They did not have any exposure to the teams until they switched to a shift that was covered by the team. These officers shared the desire to have more co-response teams and availability of co-response teams on every shift. Officers on co-response teams felt these shifts in attitude as well and shared how their teams were highly valued by patrol officers.

- *our officers are extremely short on the street and I'm a tool in the toolbox specifically designed for a specific function and so they would much rather use me than them do it themselves. . .They want me to come handle their call for them because it's less paperwork for them, there's less, I hate to say responsibility, and thus less liability. – co-response officer*

- *I think the more when we start going 18 hours a day and the night shift guys get exposure to it, they'll be like, oh man, it's one less call I have to go to and that'll be nice. They'll catch on. – Officer*

Incentive #4: outside community members encourage the incorporation of alternatives.

In addition to encouragement and incentivization within law enforcement agencies to utilize CSUs, co-response teams, or mobile response teams. Law enforcement stakeholders noted that community members sometimes request and therefore encourage the utilization these resources.

- *People that are requesting the mental health unit directly because they're educated on that we are here and they're requesting mental health unit directly. A couple of instances we had but the people they said it right out, "We want the mental health unit because we knew you all going to have patience." – Officer*

Overall Facilitators & Barriers to Law Enforcement Response to Mental Health and/or Crises Calls.

Officer Barriers

In addition to the barriers detained from stakeholders specific to utilization of alternatives like CSUs, co-response teams, and mobile response teams, our analysis revealed overall or general barriers to mental health response that officers face.

Difficulties communicating with someone in crisis. Officers pointed to difficulties in communicating with someone who was in a state of crisis, making assessment, or transportation very difficult.

- *It really is just trying to rationalize with people who aren't capable of doing that in that moment, because even people who don't have a mental illness, if they're going through a crisis, they're not thinking straight. That's a lot of it. – Officer*

Training. Officer recognized that a lack of mental health training is a barrier to their response to mental health crises and individuals with mental health disorders overall.

- *A lot of times we make contact with these people, and we don't really understand exactly what's going on in their head because we haven't been trained that much in dealing with mental health crisis. – Officer*

Time. Many of our law enforcement stakeholders referred to the time that is often required when responding to someone in a mental health crisis as a significant barrier.

- *I don't have the capability to sit here and be your guidance counselor for two hours because I've got six other calls pending in my zone that I am required to go respond to. – Officer*

Safety concerns. Officers often elaborated on the unpredictable nature of mental health calls and how individuals in a mental health or substance-use triggered crisis can experience abrupt changes in their moods creating safety concerns for both the officer and the individual.

- *Some can be violent, some are just in crisis and looking for help. Some can change. He can be calm and he can go off and go into a violent direction. There's no regular one. They're all different and can be very volatile or very simple. –Officer*

- *they can be really unpredictable and at the end of the day, we have to take our safety into account before anything else or the safety of the population as whole in account over everything else – Officer*

Communication from dispatch. Information relayed to officers through dispatch is not always an accurate representation of what the officer is responding to creating an inability to thoroughly prepare.

- *I think the biggest problem that we have is what gets relayed to us as we're going to the call and what we actually show up to may not be the exact same thing. We don't really know fully what we going into. We're left to try and pick up and figure out exactly what it is that we're there for. – Officer*

Officer Facilitators

Our analysis indicated several barriers at the individual level and agency level that acted as supports to officers during response to mental health and/or substance-use related crises calls.

Personal experience with mental health disorders or developmental disabilities. In our interviews we had several officers that disclosed a personal or familiar connection with someone with a mental health disorder. Officers shared how these experiences impact their role as an officer making them feel more comfortable, more capable at responding to individuals with mental health needs. We also had officers that referenced their personal passion/interest in mental health and psychology and their preference to responding to these types of calls. Lastly, we had officers acknowledge overall that personal experiences in their fellow officers can lead to different judgement calls on scene or methods used in responding.

- *I grew up with a brother that would have different temper tantrums as well as just crises in general when we were growing up. I learned how to respond, especially to autistic kids. He doesn't like loud noises when he's stressed out, he doesn't really like any changes in his daily routine. . .I think drawing from those personal experiences can be an advantage. Increases your awareness of little things like the noise or whatever else. - Officer*

- *Somebody who had a sister that committed suicide maybe by pills, that element might weigh a lot heavier on one officer than someone who's never experienced anything that firsthand. We just take the totality of all the information we have and we make a determination. – Officer*

Dealing with the same individuals. A facilitator for mental health and substance-related response for law enforcement, is the fact that they will often respond to individuals they have responded to before. This allows for a rapport to be established.

- *As you discussed earlier, a lot of the times it's people that we have a familiarization with, so we try to, supervisors try to keep us in specific zones or specific areas so we kind of get to know our area and get to know the people inside of it, so 9 times out of 10, a name comes out or an address comes out, and we are already familiar with that person, so we kind of know what to expect when we're on the way there. - Officer*

Mental health awareness of civilians. A facilitator for law enforcement during mental health and substance-related response is that they individuals they respond to often communicate about their mental health needs or treatment routine.

- *Off the top, they'll tell you they're having a mental health crisis. They'll tell you, especially the frequent fliers that they know, they'll tell you that this is what they're experiencing. This is the medication they're on. This is why they take the medication. This is where they need to go. - Officer*

Presence of mental health programs or teams within agency. Some law enforcement recognizes that a facilitator for their agency to use alternative responses is that the agency prioritizes budget to mental health specific programming:

- *I think a lot of education and understanding the CIT class that-- I know most of our deputies have been through it or some variation, small version of it. A lot of the city guys have, and I think that's opened up their heart or their minds a little bit. – Officer*

Utilization of Crisis Stabilization Units

Interviews with law enforcement stakeholders detailed that the decision to transport someone to a CSU may be under either a voluntary or involuntary context. The criteria for involuntary transporting someone to a CSU required evidence that the individual was a harm to themselves or others. Meanwhile, an officer may choose to voluntary transport someone to a CSU for a variety of reasons ranging from because the officer feels the services at the CSU would benefit the person, to the officer simply routinely asks people if they would like to go to the CSU. The criteria for involuntary and voluntary transportation to a CSU is listed below with corresponding quotes.

Criteria for Involuntary Transport to a CSU

All law enforcement stakeholders vehemently pronounced that transporting someone to a CSU under an involuntary hold required criteria to be met that the person was a harm to self or others. In fact, if an individual made statements that were in alignment with this criteria, officers are legally obligated to transport to a CSU.

- *Or she would say like, "Oh, I'm going to kill myself," or "I'm going to throw myself in traffic." Now we've got it. You have threatened harm to yourself. That's what we need to do that [involuntary psychiatric hold] – Officer*

- *If they make statements that they have thoughts or intents on killing themselves or killing somebody else, I'm legally bound to taking them - Officer*

When stakeholders were pressed to elaborate further on the above criteria, officers explained:

- *Well, [involuntary hold] is specifically for somebody who's in mental health crisis, who can't recognize their need for help. Who is a threat to themselves, who are suffering from neglect, lack of self-care, from suicide, self-harm, not just suicide but any form of self-harm, or someone who would pose a threat to someone else. Those are the basic criteria. - Officer*

Importantly, law enforcement also revealed that involuntary psychiatric holds may be placed, not necessarily because of current mental state of an individual, but due to the officer's perception that the individual would very soon be at criteria or be in harm's way if action to transport the individual to a CSU was not taken.

- *For law enforcement, we have to be able to show that they are either a danger to themselves or others at that time when we are speaking with them or that there is a significant likelihood that if they don't receive help, they won't be able to care for themselves and it would be a detriment to them. -Officer*

- *I feel as though he's homicidal or suicidal and I leave and myself or another law enforcement agency is going to be working a homicide or suicide later on, then I'm going to take them whether or not he wants to go or not. - Officer*

Criteria for Voluntary Transport to a CSU

Voluntary transport to a CSU is voluntary for both the civilian and the officer. In other words, the office does not have legal or procedural criteria that would require them to transport an individual to a CSU under a voluntary context. Rather there are several reasons officers provided as to why and when voluntary transport to a CSU may be utilized. Our analysis indicated five main reasons that law enforcement utilize the CSU under voluntary transport. These five reasons are provided below along with officer quotes.

Law enforcement often try to convince people that are not quite meeting criteria for an involuntary psychiatric hold to go to the CSU voluntarily.

- *Yes, we go to a lot of these calls or phone calls that, "I want to do, I feel like jumping in front of the car." Most of the time they are homeless people. We've been out there before and they've never jumped in front of the car. . . I'll take them to [the CSU] voluntarily - Officer*

- *They were like, can you guys [place under an involuntary hold] him? and I'm like, they're not really meeting criteria right now but we were able, actually, me and my co-worker, we were actually able to talk to him, and convince him, like I said, maybe you need help. He actually after a while agreed, and we're able to give him a ride there voluntarily - Officer*

Law enforcement try to convince someone to go to the CSU voluntarily because they believe the individual needs some type of service provided by the CSU agency:

- *Sometimes you may get them to voluntarily go say to a facility just to refill their meds. You talk them into saying, "This would be a good thing. You get this off your chest, refill your medication." Things that nature. - Officer*

Voluntary transport is just something that is standard practice to offer to individuals when officers perceive a mental health component or emotional distress.

- *Then sometimes if I feel like they don't meet the [involuntary hold] criteria for me I often ask them, "Would you like to go talk to someone?" Then lot of times they say yes, even though they don't fit the [involuntary hold] criteria. – Officer*

- *Even if they don't meet the criteria, I always ask, "Do you want to go?" – Officer*

- *Just because we don't put them under [an involuntary hold] or something, we'll still transport them if they want assistance. If they're willing to go,*

we'll transport them to a receiving facility so they can get the help that they need. - Officer

A civilian asks the officer to transport them to a CSU.

- *If somebody voluntarily wants to go, and they're saying, "Hey, I just need to speak to somebody, I'm just having problems," then we'll provide transportation for them to the facility. - Officer*

- *A lot of times, some people they voluntarily want to go, and then we don't have to necessarily do the [involuntary hold] but we can still help them get to the facility to get treatment. - Officer*

LEOs push for voluntary because it takes pressure or liability off them.

- *Once you start talking to somebody and give them that option, a lot of people will take it. . . It takes a little bit of pressure off of us as far as solving because essentially when you [involuntarily hold] somebody, you're detaining them. You're taking away their freedom. I always give people the option [to go]. - Officer*

- *A lot of times, if they're on the fence, I try to talk them into going voluntarily because I don't want to cross that line of [involuntarily holding] them when they don't quite meet the criteria. - Officer*

Atypical Utilization of the CSU

Outside of the criteria for involuntary or voluntary utilization of the CSU, analysis of law enforcement stakeholder data revealed two less common or atypical scenarios that also may result in officer utilization of a CSU. The first scenario involves assessment of the individual's environment. For example, if an officer encounters someone whose living environment is perceived to be hazardous or unfitting to meet the basic needs of life, they may choose to transport the individual to a CSU due to the perceived harm of their environment. The second atypical scenario where utilization of a CSU may occur is when officers feel there are not any other options available, they believe the person needs help, and they do not have any more time to spend with the individual.

Environmental reasons.

- *It's an area in which they're not properly cleaning their selves, their own bodies, or cleaning up their space. Maybe there's maggots from old food trays laying around, things like that. These are situations we're presented with that while they may not tell us, "Hey, I want to take my life," it becomes evident that they're not properly caring for themselves and that that inability to care for themselves could also lead to their demise. – Officer*

Officer is out of time and options.

- *Well, let's see. I've been talking to this person for 30 minutes. I'm not getting anywhere, [clap] let's go." They know they've got to clear that call screen, got to get out of here. "I know the persons in crisis. Me talking to them isn't really helping, isn't solving it. – Officer*

- *I've had situations where we've had to go out to houses two or three times in the night with a juvenile that's running away. At that point, it's, okay, let's [place them under an involuntary psychiatric hold] because we really have nothing else to do with them. - Officer*

Barriers to Officer Utilization of CSUs

Our analysis indicated several barriers to officer utilization of crisis stabilization units. These barriers address critical questions from our research about how things like time and distance affect CSU utilization. We have detailed CSU barriers below.

Denied admission into CSU.

There are times when law enforcement brings someone to a CSU who is then released after evaluation by the CSU staff. We explored reasons for this denial of admission or release after evaluation with our mental health stakeholders that worked within the CSU. Nine reasons for denial of admission into the CSU or release upon evaluation were provided. These nine reasons were:

- Not enough or correct information on paperwork.
- CSU staff turning people away that are voluntarily asking to be there.
- Individuals are heavily intoxicated.
- Individuals require medical clearance or medical aid.
- Individuals refuse (or are unable) to participate in CSU admission screening process.
- Individuals were previously removed from CSU property and issued a trespassing warning.
- The type of insurance of individuals.
- Individuals are determined to not meet crisis level eligibility.
- Age limit in terms of youngest age..

Not enough, or correct, information on the paperwork. When law enforcement brings someone to a CSU under an involuntary psychiatric hold, they are required to fill out a form explaining the situation and reasons behind their decision to execute the involuntary hold. Law enforcement providing improperly filled out forms was the most common reason for denial of admission and/or release upon evaluation that was provided by mental health stakeholders.

- *If they leave and the [involuntary hold order] is void we can't use it. We have to send those to the State for reporting. If they see there's something wrong with it they'll be like, "Okay, why did you reset this?" Everything has to be right. Every little box has to be shaped correctly. – CSU staff*

Issues with the paperwork submitted by law enforcement were also the most common barrier cited by our mental health stakeholders effecting their collaboration with officers. Paperwork was often noted as not having enough information and having errors or typos on the form. Such paperwork issues gravely hinder CSU staff's ability to utilize the form or properly incorporate the officers' field perceptions into their evaluation.

- *The name is not spelled correctly, the date is not right, they checked "AM" instead of "PM" or "PM" instead of "AM". That is an issue with the [form]. We call law enforcement back because we need an original [form], and it has to be accurate.– CSU staff member*

CSU staff turning people away that are voluntary. The occurrence of CSU staff turning people away that were brought to the CSU under a voluntary basis was seldom reported in our interviews. However, some CSU staff did mention that voluntaries are sometimes denied admission due to space restraints.

- *Interviewee 2: Not when I-- The nurse would tell you, just tell we're not accepting somebody.*
  Interviewee 1: Yes they have.
  Interviewer: They tell a law enforcement that?
  Interviewee 1: No. They'll tell us to tell voluntary. They're voluntary don't see law enforcement and nurses. Like, just tell them we're at capacity or we're not accepting anybody right now. – CSU staff (group of 2)

It's important to note that CSUs cannot turn away individuals that are brought under an involuntary psychiatric hold regardless of bed space constraints. Rather, it is the CSUs responsibility to locate bed space for the individual. However, CSUs can deny admission to a voluntary admission due to bed space.

- *if we don't have the beds available, then they would transfer them. They sometimes will transfer them to the other hospital. Sometimes the person literally has to just wait in Central Receiving for a couple of days or however many days before a bed opens up, so it just depends. -Mental health stakeholder*

Individuals are heavily intoxicated. When law enforcement brings someone to a CSU that is heavily intoxicated, CSU staff require the individual to be taken for medical clearance. If the individual is evaluated and granted medical clearance by a medical provider, then law enforcement can bring them back to the CSU. This barrier potentially adds significant time onto the transportation of someone to a CSU by law enforcement.

- *We used to tell them at the door if we see that they were, noticeably in the camera, stumbling, couldn't talk, slurred speech. We do the breathalyzer at the door. We can't take them in like that. You got to take them and get med clearance. – CSU staff*

Individuals require medical attention or medical aid. CSUs are stabilization units, not full medical facilities and therefore, often are not adept to provide medical care that exceeds a typical stabilization process. If law enforcement determines to transport an individual to a CSU to address a mental health or substance-use crisis, the individual must not fall into one of the exclusion categories requiring medical attention.

- *There's certain criteria, certain exclusions, like, definitely, if somebody's injured and they need to go to the hospital. We're not a medical hospital here. Or if there's a woman that's pregnant, and really pregnant. You know what I mean? They probably don't want to come here if they have a seizure disorder or a head injury or something, or even if it's a child with severe autism. . .There's a list of medical exclusions. – CSU staff*

Individuals refuse to participate in CSU admission screening. If an individual refuses to participate in the CSU screening and evaluation process they may be denied admission and released. This denial is because without participation during evaluation, CSU staff cannot always confirm the criteria for stabilization services.

- *Let's say you come in here and you made a suicidal statement. "What did you say?" "I'm not talking to you." "What brought you here?" "Go to hell." They will cuss you out. They will scream at you and we're in an area where I'm not going to purposely irritate them. "What brought you in here today?" "Can't you read it yourself?" Then I have to put, "The patient refused to participate in screening." -CSU staff*

Individuals were previously removed from CSU property by law enforcement and issued a trespassing warning. If an individual has previously received a trespassing warning from the CSU property due to their behavior, then CSU staff may attempt to deny their future admission into the facility.

- *Sometimes an individual might be trespassed from [CSU agency name redacted] because if they assaulted staff, which unfortunately happens a lot, they might not be able to stay there for a reason like that. -Mental health stakeholder*

Type of insurance. The CSUs in our project did not accept Medicare. When individuals with Medicare were brought to the facility by law enforcement, the CSU would transfer the individual to a different facility. This transfer process varied in time and could take until the next day if the individual was brought to the CSU at nighttime.

- *Interviewer: What are you transferring people most often for?*
  Interviewee: Medicare.
  Interviewer: For Medicare?
  Interviewee: Medicare.
  Interviewer: Is that to go to a different facility for treatment?
  Interviewee: A facility that accepts Medicare. Medicare is number one.

Individuals are determined to not meet crisis eligibility. CSUs are short-term treatment facilities for individuals in crisis. When individuals are evaluated by CSU staff and determined to not be in a state of crisis, they may be denied admission.

- *We've had people who want to lure a homeless who just want to find a place to sleep. This is not a homeless shelter, unfortunately. We do have law enforcement who will bring them and try to drop them off but we can't*

take you in unless you have an actual reason. You not being able to have anywhere to lay your head is not a reason. – CSU staff

CSU age limit. CSUs generally have age restrictions that limit how old someone must be to be admitted. In the CSUs represented in this project, the age limit appeared to be six years old.

- *We don't take babies, of course, but we take juveniles, we take kids. I think the youngest I've seen is six. I don't know that there's necessarily a cutoff, but that's the youngest I've seen and anyone else. -CSU staff*

Wait time to be admitted into CSU. Officers noted a barrier to using the CSU was the wait time to complete the admission process with CSU staff. These sentiments were largely shared by officers that worked night-shift, however, officers at all hours remarked on long wait times at the CSU.

- *My biggest thing would be probably the wait time, . . .She's just sitting there, I don't know what she's doing. Anyways. It doesn't look like she's busy doing anything, and she'll just make us wait outside. – Officer*

Denial of voluntary CSU admission forces involuntary hold by officer. Officers also perceived a barrier to CSU utilization as the denial or push-back to have voluntary transports they brought to the facility admitted. In some cases, officers mentioned that the denial of the voluntary candidate they brought to the CSU may result in them initiating an involuntary hold in order to force the individual's admission.

- *They [CSU employees] talk them into not coming in, they force us to [initiate an involuntary hold order]. . .Which, if you just promised somebody that you're not going to [involuntarily hold] them, it's a bit of a problem. -Officer*

Time required to transport someone to the CSU. The issue of time to transport someone to the CSU was most common amongst our law enforcement agencies that were positioned furthest away from the CSUs, such as agencies in rural counites. However, time to transport was noted by the majority of our law enforcement stakeholders, regardless of distance to the CSU, due to staffing shortages and the overall time that admitting someone into the CSU can take.

- *We can still do it depending on just how busy we are, if we've got five people in a domestic, and there's only one person for the whole entire zone, I'm not going to get the permission to transport someone because they're like, if something pops off, I can't have you out of zone - Officer*

Resistance from civilians to go to CSU. In the course of our interviews, several law enforcement stakeholders shared experiences where civilians resisted going to the CSU. Importantly, this resistance was specified as not a resistance to receive services but a resistance to the specific CSU agency. In fact, some law enforcement stakeholders noted a difference that civilians are sometimes requesting to be taken to a private in-patient facility rather than to be taken to the public receiving facility, the CSU.

- *I do know a lot of people do not like to go to [CSU agency name redacted]. I don't know. Obviously, I've heard people say it does not help, they do not help. . .I'm sure it helps someone. It helps people, but most of the people that have to constantly go there don't want to go back there, and I don't know why. Maybe they feel like it's not going to help. – Officer*

- *Sometimes our repeat customers will tell you, while you're taking them, they get upset, "I don't want to go there. They didn't do nothing for me. They don't fix anything for me. - Officer*

Paperwork must be complete prior to admission. Lastly, when our interviews with law enforcement stakeholders began in early 2021, officers routinely shared discontent for a new policy at the CSUs that civilians were no longer allowed inside the CSU building until all of the officer's paperwork was completed. This was explained as a COVID-19 policy that was implemented along with other COIVD-19 related procedures. Officers shared concerns that individuals sometimes get agitated waiting in the back of the police car while paperwork is being written. Additionally, officers noted concern that the individuals could easily read the paperwork the officer was writing up through the plexiglass which may agitate the individual even more to read the officer's evaluation of their mental health.

- *I don't know why, but the last two or three months they've been doing that. . . Luckily, I haven't had a bad one yet as far as being combative, none of that, but they just complain about it's hot back there. They're ready to go inside, which I understand. We get there. Sometimes they have to sit there for 30 minutes while I do the report - Officer*

Additional Barriers to Collaboration with Law Enforcement During CSU Utilization - CSU Staff Perspective

Crisis stabilization unit staff critiques of law enforcement initiated involuntary psychiatric, or substance-use holds. We have provided examples of the most common themes that arose when analyzing the perspectives of mental health stakeholders processing law enforcement initiated psychiatric or substance-use holds.

Individuals not knowing they are under an involuntary hold. Another barrier noted by CSU staff came from dealing with agitated or upset clients that were unaware they were brought to the CSU under an involuntary hold. CSU staff believed that law enforcement mislead individuals who said they felt that officers had omitted information about the involuntary status. However, CSU staff emphasized that the agitation clients express when they realize they are under an involuntary hold creates strenuous situations for the individual and CSU staff.

- *Some people come in thinking that, it comes across as the officer explaining to them that this is a voluntary thing, and then they'll write up the[involuntary hold] paperwork and then they'll ask, "Well, how long am I going to be here?" Then you have to explain to them, "You can't leave on your own accord." – CSU staff*

Greater training required. Overall CSU staff repeated a desire to increase officer training on involuntary holds in order to minimize the inappropriate utilization of involuntary holds that they perceived.

- *Yes, and I think it's because law enforcement is not educated enough to know what's a good [involuntary psychiatric hold] and what's not. – CSU staff*

Inappropriate people being brought to the CSU. Outside of paperwork issues, the perception that individuals were being brought to the CSU by law enforcement that were inappropriate for admission, was the second largest barriers. Data analysis uncovered several reasons as to why CSU staff may perceive someone as inappropriate for admission.

Inappropriate for the CSU because the individual was simply misleading law enforcement to avoid arrest. CSU staff perceived some individuals as tricking or misleading law enforcement regarding their mental health status in an attempt to avoid arrest. CSU staff perceived these insincere mental health afflictions as inappropriate for admission.

- *Then I'd say 8 times out of 10, the officer leaves, the client denies everything, we have to let them go. They know, "I can just tell them I'm suicidal, they'll bring me here voluntarily, they can go, and then I can leave." They know that then they don't get arrested. They can come here instead to be let go and not be arrested and continue on their life. – CSU staff*

Inappropriate for CSU due to not wanting to quit substance. CSU staff perceived the individual with substance-use concerns brought to the CSU by law enforcement were predominately not wanting to actually quit using and therefore, CSU staff did not recommend them being brought to the CSU. People brought to the CSU for substance use are generally not wanting to quit.

- *The ones law enforcement do bring, they shouldn't bring them in unless they're willingly ready to go to detox, so they're just going to get out, and it's going to be even worse. It's like they detox for those so many hours and they get out and they think they can shoot up or smoke the same amount they're smoking. They get out and do it, they overdose. That's another thing too. – CSU staff*

Inappropriate for CSU because the person's behavior is not related to a mental health issue. CSU staff shared that some individuals are brought to the CSU by law enforcement that they consider to be inappropriate because the individual has a developmental disability issue rather than a mental health issue.

- *They [law enforcement] will [involuntary hold] people for autism, which you're not supposed to do behavioral outbursts, anger outbursts, because of autism, or people that have developmental delays. – CSU staff*

Inappropriate for CSU because an individual should have been arrested. CSU staff shared sentiments that law enforcement will sometimes bring individuals to the CSU that they believe should have been arrested instead due to the presence of criminal behavior.

- *We get a lot of people that are on meth that get brought in from being high. . .They're here on [an involuntary hold], but yet the officers see*

they're high or on drugs or doing drugs but yet you bring them here instead of charges, other charges could be done. – CSU staff

Facilitators to CSU Utilization

Facilitators to CSU utilization for officers included the availability of the CSU as an option to take individuals to, proximity to the CSU, and general relations with CSU staff.

The sheer existence of the CSU as a resource. Overwhelmingly the number one facilitator for CSU utilization by officers was their enthusiasm and gratitude toward the availability of CSUs as an option to transport individuals to. Officers recognize that many of the individuals they interact with have mental health or substance-use disorders and the existence of CSUs is a valuable option for officers.

- *That there is another resource, which is CSU and we could take this person to, whether we feel like they're going to get the proper help or not. There is something else available for that person to get help rather than us having to try to figure out how to solve that solution. - Officer*

Proximity to CSU. For the agencies that existed in the same town as the CSU, officers noted proximity as a facilitator to the ease of CSU utilization.

- *I think it is a lot easier for us to involuntarily commit somebody than somebody in another county. I am sure they think about it a little bit harder knowing that they have to make a 30 minute-40 minute drive. Versus us, we have it available right here. – Officer*

Relationships are fairly positive. Officers perceived their relationship with the CSU agency and CSU employees to be fairly positive. Although law enforcement stakeholders noted many concerns with CSU utilization (as described above), for the most part, officers felt that their relationship with staff was neutral to fairly positive.

- *I wouldn't say we don't have any issues. Just like anything else, they get bombarded on a busy night and we come in there and they're not happy to see us with another patient. Overall, I wouldn't say there's any issues, we work well together. - Officer*

Utilization of Co-Response Team Alternative

Law enforcement contact resulted in utilization of the co-response team alternative. Our study spanned four counties varying in size, population, and resource availability. Critical to this study, differences in resource availability for mental health and substance use services meant that our law enforcement partners varied in what non-CSU alternatives were at their disposal.

In our two counties that represented urban areas, officers had the greatest number of resources available to them to utilize as alternatives. This included mobile response teams, over-the-phone support, and specialty co-responder teams consisting of a paired law enforcement officer and mental health clinician.

How are Officers Utilizing Co-Response Teams?

Our analysis pointed to three main ways that co-responder teams are initiated to respond to a scene or utilized to connect with an individual. These three ways are:

1. Co-responder teams actively listen to the police radio for mental health calls that they can assist with
2. Co-responder teams are requested by regular patrol (who may call them directly or call dispatch and have dispatch alert them of where they are being requested on an active scene).
3. Co-responder teams are provided information via email or phone message or someone to follow-up with from regular patrol.

    - *If we get on-scene on a call-- anything, with a domestic argument, or a shoplifter, or anything-- and we see that there's a need for mental health, we'll key up, and ask for [co-response team name redacted] to come. - Officer*

    - *Most of the time we go in-route with patrol if we hear the calls, and if we don't hear it on the radio, then we're summoned by the patrol supervisor when patrol gets there. -Co-Response Officer*

Many regular patrol officers discussed incorporating and utilizing the co-response team even when co-response teams were not available. In these scenarios, regular patrol officers would provide the civilians with information on the co-response team and then send an email or voicemail to the co-response team requesting them to follow-up. Regular patrol officers utilized the co-responder team by positioning them in a follow-up role when: 1) the co-responder team was not working during the time a deputy needed them; 2) The co-responder team was unavailable due to being occupied with other calls; or 3) the deputy requested the follow up as a means to have someone check-up on the individual and assist them with further resources.

Facilitators to Co-Response Team Utilization

Overwhelmingly, law enforcement agencies with co-response teams in place reported several benefits to having the teams for officers and the agency overall. Perceived facilitators of co-response teams for the agency, officers, and mental health response are described below.

Perhaps most astoundingly, co-responder teams were pointed to as a huge benefit to regular patrol because they allow regular patrol officers to turn mental health calls to a trained team, with trained counselors, and have them determine which type of assistance or whether initiating an involuntary psychiatry hold on someone is necessary.

    - *It is such a relief. I'm telling you whenever I know that she's going for that call too I'm just like, "Okay, cool, I don't have to be--" because I'm telling you I've been at calls that . . we are like counselors. I've been talking to someone for 45 minutes trying to help them just feel better about what they're going through and then after that. - Officer*

Officers and co-response teams perceived a benefit of co-responder teams as the ability to help increase positive association between police and their community members since these teams focus on services and welfare rather than charging criminal behavior.

- *Even to get that ball rolling so people know that that's an option. Just because the police are here doesn't mean you're getting [placed under an involuntary psychiatric hold]. Why don't you talk to the counselor and go from there. They know when they start to see us they go, "Okay, last time wasn't so bad." - Officer*

The co-responder team lessens the workload on regular patrol by responding to mental health related calls instead of regular patrol. Thus, clearing regular patrol officers to respond to other calls. This is especially significant for law enforcement agencies, like many of the agencies we partnered with, that were short on staff.

- *Honestly, I think it's a good addition. It will probably lessen the types of calls that we get a little bit more. They'll take some of that burden away from patrol deputies necessarily more. That will be good. – Officer*

A facilitator to mental health response from co-responder teams is the additional system information that the mental health clinician brings. The mental health clinicians have access to administrative records that law enforcement do not. This allows for a more accurate assessment of the individual when the clinician can provide insight and context to what the team may be responding to, and recommend a best course of action.

- *[clinician name redacted], she has access to all this stuff that we don't have access to. She's like, "Oh, yes. They've missed this appointment, this appointment. You can see where they're declining on the computer." She's like, "Let's go out here and try to pinpoint this issue." She has a lot more access than we have in that field. -Officer*

Regular patrol officers perceived co-response teams as a valuable additional resource they could provide to someone, especially when the individual was not meeting criteria to be transported to a crisis stabilization unit. Therefore, having co-response follow-up with individuals and providing civilians an option to contact co-responders became a new outcome available to officers during mental health calls.

- *If somebody we know just isn't getting the help they need, and they need somebody like her I'll say, "Listen, [co-response officer name redacted] is amazing. She's not here today. I'm going to have her call you tomorrow," or whatever. Then it gives them a little bit of hope that somebody cares. - Officer*

The co-response teams are inherently training officers to understand the complexities and dynamics of mental health and abuse from a different lens. In our analysis this spark of conversation and the potential for law enforcement to catch things they would not have prior to this knowledge came forward.

- *I was saying something to the officer about, if they're not going to follow up, then I may need to file a report for medical neglect to DCF. The officer was like, "Really?" He's like, "I didn't get that at all." I was explaining to him*

why I felt like that. . . Neglect can be just as severe, if not more severe sometimes, than actual abuse to a child. I said it has the same effect on the child as abuse. We did so, so he was like, "Huh," he's like, "I never would've thought that. I never would've thought to do that or to look for that." It just sparked a conversation. - Co-Response Clinician

Stakeholders also noted that co-response teams may discern mental health crises that regular patrol would not be able to due to the on-site expertise of the mental health clinician.

- *When we were talking about it later, Officer [name redacted] was like, "Yes." He's like, "See, that's why we need you guys here because--" he's like, "Until she threatened her daughter, I didn't see the psychosis." I said, "I know." I said, "Because she was trying to hide it and she was doing a good job. I'm sure that's what she did last night." He's like, "Yes, those officers, of course, are not going to see that." He's like, "I barely saw it until she went off the chart, but with the night before, it didn't get to that point." – Co-Response Clinician*

Co-response clinicians overall stated that they felt their partnership with law enforcement rarely involved disagreements and disagreements that did occur were handled fairly easily. Additionally, co-response clinicians made positive remarks about their partnership with law enforcement.

- *it's very different professions, so I'm glad that this partnership is actually meshing well. I think we're just learning from each other. – Co-Response Clinician*

- *It doesn't happen often, maybe three times tops in the past 10 months. . .We will just sit and talk about like, okay, here's why, yes, here's why no. We'll just come to an agreement. – Co-Response Clinician*

Lastly, co-response clinicians acknowledged the skills their law enforcement partners brought to interactions with individuals and that these skills acted as important facilitators in their interactions with individuals.

- *They're really good at looking at body language and interpreting what this person's next move may be, or if they're concealing a weapon, or they're concealing something illegal that they're doing, the officers are trained to look for that stuff. That's not what we're looking for, so it's not on our radar, but we have to defer to them when they think that, "Hey, this is not a safe situation for you to be coming out to."– Co-Response Clinician*

Barriers to Utilizing Co-Response Teams

The two most common barriers to officer utilization of co-response teams are deeply intertwined and are the sheer demand of mental health calls coming in compared to the quantity of staff available on co-response teams. Additional noteworthy barriers were the operating hours of co-response teams and the approach styles to individuals with mental health disorders for officers versus mental health clinicians.

Demand and staffing. The most frequently cited barrier for officer utilization of co-response teams was the desire to staff and fund more co-response teams, and that the current amount of co-response teams did not meet the demand for mental health calls coming into the law enforcement agency. The demand and staffing barriers also meant that sometimes officers were filling into assist with co-response teams did not have the same mental health training as co-response officers.

- *when we first started the [co-response] program because they were all substitutes. . . but for the most part, the substitute officers now, they're handpicked to sub and they've either, most of them now have already worked on the unit before, they know what to do. We don't have those same problems anymore. -Co-Response Clinician*

Operating hours. The operating hours of the co-teams were another significant barrier to officer utilization. Limited operating schedules of co-response teams meant assistance from the co-response team was not always available to regular patrol. Additionally, limited co-response availability meant that some mental health calls for an agency were responded to through a specialized co-response team, while others were responded to by regular patrol. Many of our law enforcement stakeholders noted that co-responder teams were predominately available during the day rather than at night which left mental health calls at night to be entirely under regular patrol response.

- *It limits our mental health teams that we had out working. They work Monday through Friday, eight to five. Really great idea. [stated sarcastically] – Officer*

- *I don't know because we don't run on the weekends, so, on the weekends, patrol has to respond to all the mental health calls. What they do is when those calls are closed out, there's a special code that they have to put in, and it'll automatically be put on our list to follow up with. – co-response clinician*

Approach styles. A less common barrier that arose in our analysis were comments referring to differences in the way mental health clinician approach individuals with mental health disorders compared to law enforcement. Mental health stakeholders attributed this barrier to differences in professional training. This barrier did not appear to be any type of significant derailing to interactions.

- *Just in general, they're [officers] very different. Clinicians tend to be, not all but most, open-minded and accepting of different people. There has been times where I've been like, "Woah, you probably shouldn't have said that. That's just because they don't have the same educational background or training. – Co-response clinician*

Utilization of Mobile Response Teams Alternative

Law enforcement contact resulted in utilization of a mobile response team alternative for our two counties that represented rural and rural/suburban combination. The mental health responder alternatives available for law enforcement included a mental health agency staffed mobile response team or calling the CSU

agency for input/advice over the phone. The mobile response team consisted of trained mental health workers with a variety of backgrounds that could be called by regular patrol to come out to a scene after law enforcement requested their assistance. These teams could be dispatched 24/7, however, due to the large geographic area the team covered, response time varied greatly. This team was also available to officers over the phone 24/7 and officers were able to simply call them for their advice/in-put when on a scene instead of initiating the team to come out to where the officer was.

Our analysis indicated that regular patrol utilizes the mobile response team primarily in ONE way: to request assistance where the need for an involuntary psychiatric hold is not clear-cut. Regular Patrol can then utilize the mobile response team for assistance with these grey situations either by requesting the mobile response team to come out on scene and evaluate, or by talking to them over the phone and discussing the situation to gain their advice.

Facilitators to the utilization of mobile response teams for law enforcement:

- The accessibility of having someone trained in mental health available immediately over the phone.
- The sheer existence of these options is a positive for officers (especially those in rural areas where this is their only resource 24/7)
- MRT or MH workers alternatives have shown to be useful on scene at dealing with civilians so law enforcement can address the paperwork or things required of them

- *That's kind of what she explained to us that if we have a situation where it's not just a cut and dry, then you need [to place under an involuntary psychiatric hold], to take them in. We can call them out there, and they can, I guess, do what [CSU agency name redacted] would do once they get there but out in the field like at their house. - Officer*
- *They can talk to him over the phone right there. That's helpful all on its own. That's having a resource right at your fingertips and say, "Yes. We'll talk to them tomorrow. They don't meet criteria tonight. You're good. Do whatever report you need to do and you can go on," or "yes, you should take them up to [CSU agency name redacted] and we'll catch up later.. - Officer*
- *We have the MRT team that responds. I've used them maybe twice and they were effective, they were able to come out. The schools use them a lot. – Officer*

Our analysis revealed two facilitators that were significant to our stakeholders and mirrored for mobile response teams and co-response teams. These facilitators were the buy-in or support for the teams from officers, especially regular patrol, and the belief that the utilization of these teams, especially co-response teams, can minimize involuntary holds.

Buy-in and support from officers for alternative response teams.	Mental health alternatives may possibly minimize the utilization of involuntary psychiatric holds.
"To be honest, I wasn't all for of the mental health co-responder team when they first came out, but seeing what he was doing and actually going out and talking to people and doing follow-ups, I think it's a really good thing." – Officer "I've had deputies flat out come up to me and say, "In the beginning, I thought this was bullshit, but you guys are actually helping, and I appreciate that." – co-response clinician	"The mental health unit got there, the counselor came up and talk to him, it was resolved right there. We didn't need to [place under an involuntary psychiatric hold], we got him some help elsewhere in the backend, but nothing happened that day. It was a good, peaceful resolution." - Officer

Main Barriers to Officer Utilization of Mobile Response Teams.

Response time for mobile response teams. Long wait time for officers creates a burden for officers to stay locked on a call and be unavailable for other calls. There is also concern about the wait time impact on civilians, as they wait with the officer for the mobile response team to arrive.

- *I would say the response time of the MRT [mobile response team] would be the main thing because, like I said, that's why a lot of times I don't call them because it takes them an hour, hour and a half, two hours to get out there. – Officer*

- *Their response is a little long sometimes. They're like, "Oh, I'm 45 minutes, an hour away," which isn't always feasible but there is times they've told me that, and I pull up and they're there, too. They're right behind me. - Officer*

There is also concern about the wait time impact on civilians, as they wait with the officer for the mobile response team to arrive. When someone is experiencing a mental health crisis, waiting for extended periods of time may heighten one's distress. Additionally, the wait time may lead officers to forgo using the mobile response team resource and instead, simply transport the individual to a CSU.

- *We're waiting. We're waiting. This person's just getting more worse and worse and now they're in my car sitting," rather than them hurting themselves by beating their head against the cage or something, I'm just going to go ahead and take them to [CSU agency name redacted]. I'll call them back and say, "Hey. Listen, we're just going to leave and go to [CSU agency name redacted]." - Officer*

Mobile response teams' transportation regulations. The mobile response teams represented in this project had transportation regulations that enabled their ability to transport individuals to a CSU. This inability to transport individuals meant that when regular patrol chooses to utilize the team and request their presence on a scene, the officer would remain on scene and potentially still act as the authority conducting an involuntary psychiatric hold.

- *they come and typically they do the interview just like we are. Especially a seasoned law enforcement officer, they're going to ask the same questions we ask. Ultimately, they're going to look at us and say they need [CSU agency name redacted]. – Officer*

Crisis Role Stipulations. The mobile response team represented in this project described their role as strictly responding to crises, meaning an individual that is considered an imminent threat to self or to others. However, the resistance or refusal to respond to situations outside of immediate crises meant that law enforcement was inhibited from using the team for the magnitude of mental health calls they respond to that are not quite at crisis level.

- *We see those things, which is abuse of MRT, in my opinion, because you're not in that true crisis. If we're the only clinicians and I'm on this call with you when you are not in a true crisis, but of course, I'm still going to assess you. That's why I think it needs to be streamlined just a little bit to make sure it is an appropriate call. What we are doing, we're not there to give you a counseling session. – MRT staff*

Law Enforcement Contact Did Not Result in Utilization of Any Alternative – No Formal Outcome

Law enforcement stakeholders made it abundantly clear that their patrol staff are responding to mental health and substance related calls frequently and that many of these calls do not include any criminal activity nor is the individual at the point of crisis where a crisis stabilization unit is appropriate. In these situations, the interaction between the officer and the civilian may not result in any type of formal outcome or utilization of alternative to arrest.

Our analysis identified four most common situations where police find themselves responding to a scene where arrest or the utilization of a mental health or substance use alternative is not used.

- ❖ Family or friends of someone call the police expressing their concerns about the individual.

- ❖ A random community member will call the police reporting an individual acting abnormally or in some type of way that they feel police investigation is necessary.
- ❖ Individuals call the police themselves for assistance but does not meet criteria.

Family or Friends Call Police. Police reported that when they are called to check-on an individual by family or friends that these calls are sometimes made with good intent and others are done in malice. As a result, police make a point to arrive on scene without any preconceived outcome in mind and will prioritize talking with the individual and gathering more information.

- o *We got called to track on a young lady that according to her boyfriend was suicidal. . .We sat and talked to her for a little bit. I talked to the deputy, talked to her, and it turned out she didn't meet criteria at all, all the things that boyfriend was saying weren't actually transpiring at all once we start talking to other people" – Officer*

Community Member Calls Police. Police may receive calls from concerned citizens about individuals acting in ways perceived as abnormal or suspicious. However, police noted that if the individual is not breaking any laws there is not much that they can do.

- o *They [community members] call thinking they're doing us a favor, but they're really putting stress on us because there's nothing that I can do. If somebody's not a threat to themselves or others, I can't take them somewhere. I can offer it but if they don't want to take it, if they don't want the help, they don't want to accept my offer I can't do anything. – Officer*

Individual in Distress Calls Police. Police receive calls for service from individuals themselves and then when police arrive on scene, they realize there is no police assistance needed. Police shared that many calls meeting this description come from individuals with mental health conditions.

- o *Sometimes people themselves will call, and they'll say, "Hey, there's 50 people trying to kidnap me," or something like that. . . Then as you talk to the person, you realize, "Oh, this is not happening." This is happening in your head . . but again, they're not having a real emergency. They don't need to be [committed]. They don't feel like hurting themselves or hurting others. This is just the way they think. - Officer*

Reasons an Interaction Between Police and Civilian May End Without a Formal Outcome

An interaction between law enforcement and a distressed civilian may end without deflection to a treatment or service provider or a formal outcome because the civilian refused to go and did not meet criteria to be forced to go under an involuntary order.

- *Interviewee: Sometimes it's a hard place because this guy I'm afraid he's going to get hurt, but we can't force him to go. He doesn't meet—[involuntary hold criteria" - Officer*

- *Not displaying any threat to themselves or others. . . Hasn't committed a crime, so I can't do anything. I can talk to you and hope for the best and try to convince you to go. -Officer*

- *Then I've been on scenes to where people protest, and they say, "I'm not in need of medical care. I don't want your help. Leave me alone. Just leave me alone. - Officer*

Additionally, officers may choose to not transport or take the individual to some sort of treatment/service facility because of a lack of resources that meet the civilian's needs:

- *Some people will be crazy, that's what we tell people. Unless there's some sort of threat, we'll leave them there. We don't have a facility basically for that. I don't know if [CSU agency name redacted]-- A lot of times they don't take people like that. They're not causing a threat and the doctor will release them in that hour. – Officer*

- *There's not a lot of help for those people either, even though they don't meet the criteria for [an involuntary psychiatric hold] they have a mental health crisis because they're in dementia, they know something's going wrong, but there's no help for those folks, either. – Officer*

What happens during calls where there is no utilization of an alternative or formal outcome?

When law enforcement responds to a scene where there is an apparent mental health component, but alternatives are not utilized, nor is the individual arrested, the officer mitigates the scene himself/herself and ends the call without a formal outcome. Our analysis indicated that in these situations, police typically talk to the individual, connect them with a family or friend they trust, and may leave them with a phone number or information for a resource to use at their discretion.

- *do a report so you create a paper trail. You say, "Listen, they didn't meet the criteria. However, this is recommended that they go talk to somebody here and get some resources." and blah, blah, blah. You can't just take somebody because you want to. They have to meet the criteria. – Officer*

- *"If you're acting erratically in your house and you're not a harm yourself or others, and you're eating and you're showering and everything's fine, it's not really law enforcement thing and I'll [say]-- "Hey, do you have anyone? Do you have a sister in town?" Okay, let me talk to them." – Officer*

- *There's people like, "I got laid off from my job, I'm depressed, I'm not going to kill myself, I'm not going to hurt myself, I'm just sad and adjusting." "Okay, if you need anything, let us know." People have emotions, they're allowed to. - Officer*

Utilization of Arrest

A third possible scenario when officers respond to a scene where mental health or substance-use concerns may be present, is to arrest the individual and bring them to jail. The difference between misdemeanor and felony offenses proved to massively impact officer's utilization of arrest. Law enforcement made statements that misdemeanors are generally allowed far greater discretion and potential ability to avoid arrest and utilize an alternative like a CSU, whereas felonies required formal outcome of arrest every time.

- *Generally, when we get called places, it is an allegation of a crime of some sort, so I need to determine if a crime has occurred, if so, what crime has occurred? Once you can determine if a crime has or has not occurred, you can determine the level of the crime, is it a misdemeanor, is it a felony? Then that can guide your decision into, is this person going to be [involuntarily committed] if they meet criteria? Is this person going to be arrested regardless? – Officer*

As noted above, felony and violent offense do not possess the same discretion to utilize alternatives for law enforcement. Law enforcement have a duty to keep the public safe and ss a result, severe crimes, even when mental health issues are present result in arrest.

- *If it's a violent felony, then you're going to have to deal with that before you address the mental health side of it. – Officer*

- *If you have a murder probably not going to take a murderer over to CSU and let them sit there for three days and put charges through later on. – Officer*

Other offenses that may result in the outcome of arrest but are non-violent may be felony-level offenses such as felony level possession of substances:

- *Well, if you have a person that you're dealing with that are in possession of some type of narcotics, of course, you have to make the arrest and transport them to jail. – Officer*

Special Note

Overwhelmingly law enforcement stakeholders emphasized that is it rare for officers to respond to a scene where a severe crime has occurred, and the individual is also having a mental health crisis. Rather mental health and substance related crises appear to primarily involve contact with law enforcement that is either void of any criminal behavior or the criminal activity are of low-level misdemeanor status.

"Most of the time I respond to criminal activity. However, when something is a mental health issue, most of the time, it is indeed a mental health issue. My experience very rarely is mental and mental health issues been in conjunction with a severe crime." – Officer

"I would say 85% of the times that I've [involuntarily committed] somebody it has nothing to do with them doing anything like not committing a crime at all." – Officer

Sometimes situations are not as cut-and-dry of a decision for officers on whether arrest will be the outcome or not. We found five main areas that officer consider when determining to make an arrest:

- severity of crime
- presence of victims and wishes of victims.
- circumstances surrounding the law-breaking behavior (AKA their intent)
- if law enforcement has a familiar history with the individual's mental health condition
- the discretion of the officer's supervisor

Severity of crime.

Severity of crime determines outcomes because of the difference in allotted officer discretion between misdemeanor offenses versus felony offenses.

- *If it is a misdemeanor and you determined that the subject is in crisis and meets [involuntary commitment] criteria, then getting that person treatment and help is going to be more important than arresting a person for a misdemeanor. If it's a violent felony, then you're going to have to deal with that before you address the mental health side of it. It all depends on what crime you're there to investigate. – Officer*

Violent crimes require arrest.

- *If they commit a crime and it's a violent crime against a person, a lot of times the priority goes towards the criminal aspect, not deferring to a mental health care facility simply because if we find that they are aware of the crimes that they did commit, then they have to answer at the jail. – Officer*

The presence of victims.

Victims appear to greatly increase the likelihood that law breaking activity will result in a formal arrest regardless of the presence of mental health or substance use crises.

- *Just in terms of the relationship between the person and the victim. What is that relation? If it's a perfect stranger, I may look at it a little bit differently. - Officer*

Law enforcement officers will acquire the wishes of victim(s) as part of their arrest decision making. If a victim is requesting for charges to be filed or not, their voiced desires may influence the officer decision to arrest. This influence is dependent on the severity of the crime.

- *I found that a lot of people when they can tell that somebody is in mental health crisis, and I have heard this a lot, "I don't want to press charges, I just want them to get help." A lot of times, people don't want to play the role of victim, they just want to say, "Get them somewhere where they can get some help." We have a lot of citizens who can differentiate. If the citizen can do that, that gives me more options. –Officer*

Circumstances surrounding law breaking behavior.

The officer will consider the circumstances surrounding the engagement in law breaking activity as part of their arrest decision. Specifically, law enforcement officers appear to make decisions based on if there was an intent to commit a crime by the individual. Conversely, if the law-breaking activity was the result of a mental health or substance related condition that impaired rational behind decisions, there may be greater discretion involved in whether to arrest or not.

- *If they just shot up Molly or heroin or something and they run into a store and steal a Gatorade and run out because they think they're about to have a heart attack or something like that, they committed a theft, but the circumstances are showing that they were having some kind of medical or mental issue or situational issue when they committed the crime. – Officer*

Officers are also bound to prove intent when submitting charges against someone. When the law-breaking behavior appears to be an untended outcome of mental health or substance related conditions, that intent is difficult to show.

- *Then they have to actually show that the person actually knew that it was wrong what he was doing. They had to have the criminal intent. To do that, it's pretty hard to get the statement to bite on. – Officer*

- *Typically, the criminal charges are not going to be filed on them because it's something like, "Hey, obviously, this person's in crisis." Whatever's going on, there's no criminal intent that we can prove. - Officer*

Officer has familiar awareness of individual's mental health status.

If the civilian that engaged in law breaking activity is someone law enforcement is familiar with and aware that the individual has a mental health disorder, that can affect the officer's behavior.

- *When we know that the person's on medication and it's most likely a result of them being in a mental health crisis, or they didn't have their meds right to actually know what they were doing because of the mental health issues, you got to weigh it out and sometimes you actually do have to take the person to jail, but sometimes treating the individual is number one priority – Officer*

Discretion of Officer's Supervisor

The decision can come down to the officer's supervisor who may be contacted for final decision in situations that are not clear-cut to what the outcome should be.

- *With a situation like that where we're going to make a judgment call, I usually bring my sergeant and like, "Hey, this is what we're looking at, this is what I want to do, here are the factors." Sometimes they say, "Yes, go ahead," or "No, make the arrest," "Don't make the arrest." They've been around, just about all of our sergeants have been investigators so they know. - Officer*

Outlier Situations Resulting in Arrest

In our interviews with law enforcement, three important outlier situations surfaced where arrest outcome may be utilized. Some law enforcement discussed utilizing arrest, not because the CSU and other alternatives were not available, but because they believe that involvement in the criminal justice system may help the individual.

Appeal of court-ordered treatment

- *Again, as the officer who I know that sometimes even somebody in a drug offense who's not mental health, they're a drug addict. Maybe for this person, the best course is to get them in the criminal justice system, because that's where they'll get court-ordered help or mental health. Sometimes it's the best thing to do is get them in the criminal justice system. Not because you want to charge them with a crime, based on your experience that's their best route to help. – Officer*

Officer has utilized CSU many times and feels it is not helping.

- *she'd gone many times to get help and wasn't working. He was like, "Everything else has failed, let's put you in jail and hopefully-- – Officer*

- *I've [placed under an involuntary psychiatric hold] five times in one month and they just kept releasing her [crosstalk]. Finally, I carried her to the hospital and had the doctor do it, and they still released. Then, I just carried her to jail. -Officer*

In areas without enough resources, individuals may call 9-1-1 to be arrested in order to receive the services at jail.

- *they'll call for us and they're homeless or they're hungry or whatever and they'll-- We have people that have little warrants, broken containers out when it gets cold, they'll call and be like, "I got a warrant." . . . Yes, so we can drive them to jail so they get a shower, a meal, they're warm. – Officer*

Avoiding Arrest

In our interviews with law enforcement stakeholders, we found an overwhelming consensus among law enforcement to avoid arrest and utilize alternatives whenever possible.

- *Somebody truly in crisis, it's rare that I have a crime like that. It's more like if you end up having to arrest on this because they've destroyed somebody's property. . . I'd really try to get their victims not to want to have me arrest them for property. I say, "Listen, if we [commit] them, we can write it up. They can be held accountable for restitution and all that. – Officer*

- *I'm not going to take somebody to jail just for the hell of taking somebody to jail. – Officer*

- *I'm probably going to take them to CSU instead of jail. I don't think it's fair to give someone a record when mental health is causing whatever they're doing. That's not every cop situation, but I'd rather them get the help and get it fixed then. If you were to throw a rock at a child and hit him in the head, obviously you can go to jail regardless. It just depends. – Officer*

End of findings Part 1.

Findings pt. 2 – Pilot Feasibility Study & Feasibility Evaluation Results

II. Pilot Feasibility Study

Our pilot feasibility study consisted of 22 participants that were randomized into one of two groups (11 – Mobile Aftercare group; 11 – Standard Services group). Data collection interviews with these participants occurred at four points, baseline, T1, T2, and T3. The timeline for these interviews points is illustrated in the graph below.

Baseline (occurred during recruitment following the consent process)	April 2021 – July 2021
T1 (approximately 2 weeks after recruitment)	April 2021 – July 2021
T2 (approximately 3 months after recruitment)	July 2021 – October 2021
T3 (approximately 6 months after recruitment)	October 2021 – January 2022

Upon recruitment into the study, participants were randomly assigned into either the mobile aftercare program or the standard services group. Participants randomized into the mobile aftercare program received the mobile and technology-assisted aftercare intervention for six months following their discharge from the CSU. Participants randomized into the standard services group received the standard services available to individuals leaving the CSU. Standard services included a follow-up appointment with a mental health professional approximately one week after discharge from the CSU, as well as access to any acute and long-term services available from our partnering mental health agency and/or any other service agency in the participant's community.

The mobile aftercare intervention included two major components. 1) A master's level mental health professional called the Community Support Specialist (CSS) who meets with participants at their home or a mutually agreed upon community location. 2) Behavioral health mobile applications that provide participants with 24-hour access to support. The details of these two components, in-person (home) sessions with the CSS, and the mobile applications, are further described below.

Home Sessions: The CSS meets with participants for up to one session per week. During these sessions, the CSS provided counseling, goal management, connection and assistance with community resources, psychoeducation, and social support. The focal point for each session involved discussing the participants' goals and experience working towards them. Participant goals were created by the participant in collaboration with the CSS. Throughout the first two sessions with the CSS (or more if the conversation was not completed), each participant was asked exploratory questions to identify three goals and provide a plan for future sessions. For instance, participants were asked about their motivation to join the study, what areas in their life were the biggest priority to address, and generally what things were important to them. Importantly, in these conversations the CSS was instructed to use goal-oriented and future-focused language so that participant goals were phrased as something they were working towards rather than something they were trying to avoid or stop. For instance, rather than a goal of 'stop being so anxious', the

participant's goal would be phrased as, 'increase feelings of self-security and self-acceptance.' Throughout sessions, the CSS used motivational interviewing (MI), solution-focused brief therapy (SFBT), and future-focused language to explore barriers participants were facing at reaching their goals, as well as things that were going well for them. Lastly, the CSS also incorporated conversations about the mobile applications into each session, checking in on use, satisfaction, and education on the app's functions.

Mobile Applications. The inclusion of mobile applications served to augment the in-person support provided by the CSS. The mobile apps were free for the participants and uploaded onto their smartphones. If the participant did not have reliable access to a smartphone or did not wish to have the apps uploaded to their device, they were provided a smartphone for free by the research team. There was no cost to participants for the smartphone or technology used for the duration of their participation in the study.

Four mobile applications were chosen for this intervention. These apps were selected after a thorough investigation to meet the standard of being created by mental health professionals or have undergone randomized control trial (RCT) or a clinical trial and showed positive impacts on our intended outcomes. The four apps include Moodtools-Depression Aid, Virtual Hope Box, Recovery Path, and Intellicare Hub. A brief description of activities and tools available on each of the above apps is listed below.

For the intervention, participants were not required to use the mobile applications. However, the CSS encouraged the participants to use the apps and discussed the potential benefits of doing so. During sessions, the CSS asked participants about their general use of the apps, what they liked and did not like about the apps, and provided encouragement on how the apps may assist the participant in reaching their goals.

Mobile Applications			
Moodtools-Depression Aid Targets anxiety & depression functions include: • thought diary • safety planning • PHQ-9 test • tracking of symptoms • psychoeducation material • links to outside resources	**Virtual Hope Box** Targets depression and suicide prevention functions include: • lessons on coping skills • relaxation and positive thinking activities • guided meditation • visual and audial guides	**Recovery Path** Targets substance use functions include: • coping skills • psychoeducation material • goal setting & planning • locations for nearby addiction recovery resources • daily check-ins	**Intellicare Hub** Targets stress, anxiety, & depression functions include: • symptom tracking • PHQ-9 test • GAD-7 test • psychoeducation material • relaxation and positive thinking activities • goal setting

Recruitment of individuals at CSU

The recruitment window for this project lasted about 14.5 weeks.

- ❖ During this time the research team assessed 312 individuals for eligibility
- ❖ Of these 266 or 85.26% were not approached due to either:
  - Ineligibility
  - residing in a county outside of recruitment or the county they resided in had already met the quota for recruitment.
  - the situation at the CSU or with the individual was determined to be unsafe by CSU staff.
  - the individual had an unexpected discharge time outside of research team awareness.
  - The individual declined to meet with the research team. (Please note that only 18 or 6.77% of these 266 individuals declined to meet with the research team).

Attritions and Constancy of our Recruited Participants

- ❖ 73% of participants participated in at least one follow-up data collection session.
  - 68% of participants were interviewed during our T1 data collection session.
  - 55% of participants were interviewed during our T2 data collection session.
  - 41% of participants were interviewed during our T3 data collection session.
- ❖ Of the 27% of participants that were recruited at the CSU and did not participate in any of our follow-up data collection interviews:
  - 9% formally withdrew from the study.
  - 9% were unable to be tracked down or reached by the research team.
  - 5% were incarcerated shortly after recruitment and remained incarcerated.
  - 5% passed away.

As part of our Mobile Aftercare intervention, a trained Community Support Specialist (CSS) was available to meet with participants, up to once per week, for six months. All together our CSSs delivered over 50 intervention sessions with participants for this project. 36% of participants randomized into the intervention group received intervention services for over 4 months. 64% of participants recruited into the Mobile Aftercare group met with the Community Support Specialist at least once. The average number of intervention sessions received was six sessions.

Measures Used with Participants

We used a several measurement tools with participants to collect a range of data on their psychosocial wellbeing, financial and social stability, utilization of resources, and more. The table below details the measures used with participants during baseline interviews (which occurred at the CSU immediately following recruitment), and the measures used during the T1, T2, and T3 interviews. Please refer to our codebook for the extensive description of each measure we used.

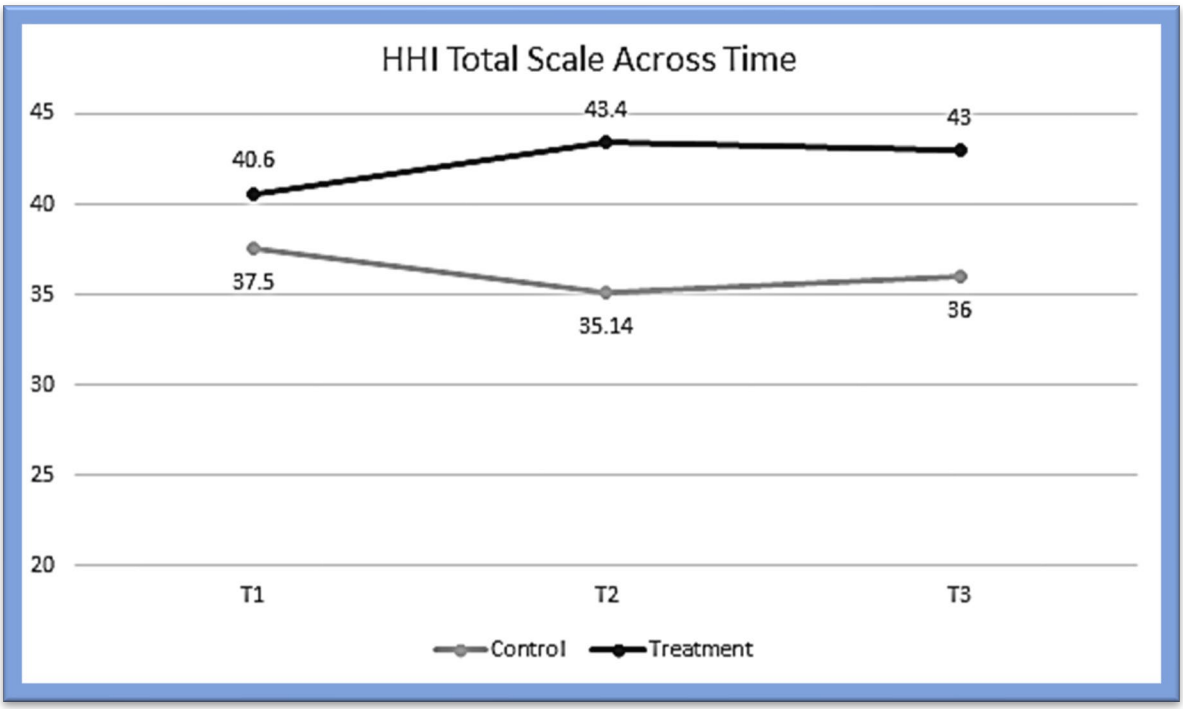
Measures used during Baseline	
Encounters with law enforcement	Police-Community Interaction Survey
Demographic and Contact Information	Demographical information survey and participant locator form
Measures used during T1, T2, & T3	
Individual stabilization and wellbeing	Brief Symptom Inventory Brief Cope Hearth Hope Index Trauma History Questionnaire Financial Security Education and Employment Education Employment Aspiration and Satisfaction Network Composition survey
Acute and long-term treatment use	Service Assessment for Children/Adults California Psychotherapy Alliance Scale Qualitative CSU Experience Qualitative Technology Use
Admission into CSU	Administrative data of re-admission into CSU
Arrest rates/re-encounters with law enforcement	Administrative data of Arrest Rates Lawbreaking Police-Community Interaction Survey
Contact Information	Participant locator form

Data Analysis

Analysis of data from participants suggests higher rates of stability, such as employment, psychosocial wellbeing, utilization of community resources, and fewer readmissions into the CSU for mental health or substance uses crises for participants that were randomized into the treatment group to receive the mobile and technology-assisted aftercare. The details of scoring for reach measure can be found in the submitted codebooks**.** We have summarized the main findings from the analysis below.

Hearth Hope Index (HHI)**.** The treatment group consistently scoring higher than the control group in the subscales of the Hearth Hope Index. Although the treatment and control

groups rated relatively similar scores at T1, by T2 and T3, the treatment group on average rated their scores about 2 points higher than the control group. At T2 and T3, on average, the treatment group reported their positive readiness and expectancy scores about 3 points higher than the control group. We see the largest difference between the groups at T2 with Interconnectedness with Self and Others score, on average, the treatment group is reporting 4 points higher than the control group, by T3, the difference decreases to two points. The below scale reflects total scores on the HHI for each group at the T1, T2, and T3 interviews.



Education and Employment Aspiration Survey (EEAS). Across time, high scores for both education and employment aspiration and satisfaction were present in both the treatment and control group. Notably, for education we see participants report high scores at T1, the scores decrease for T2 and then increase again for T3. Overall, it seems like most participants were satisfied with their current education and aspired to obtain more. Employment followed a similar pattern, aspiration and satisfaction were extremely high for T1, decreased at T2 and then increased again at T3 but not to the levels they were at T1. Still, overall, participants were satisfied with their current work situation and aspired to improve it across the study. When comparing the treatment to the control group we see the control group consistently rate their education aspiration and satisfaction as higher than the treatment group, however, the treatment group consistently reports higher satisfaction and aspiration than the control group over time.

Measurement Scores	Education Control	Education Treatment	Employment Control	Employment Treatment
T1				
Low (1-1.99)	-	-	-	-
Medium (2-2.99)	25%	57.1%	-	-

High (3-4)	75%	42.9%	100%	100%
T2				
Low (1-1.99)	14.3%	-	-	-
Medium (2-2.99)	28.6%	60%	42.9%	-
High (3-4)	57.1%	40%	57.1%	100%
T3				
Low (1-1.99)	-	-	-	-
Medium (2-2.99)	20%	25%	40%	-
High (3-4)	80%	75%	60%	100%

Brief Symptom Inventory (BSI). The mean raw scores for each primary symptom dimensions are listed in the table below. The scores range from 0 to 4 with higher scores indicating a greater number of reported symptoms. The control group overall consistently reported higher levels of symptoms on the BSI scale across the entirety of the study.

	Control T1	Control T2	Control T3	Treatment T1	Treatment T2	Treatment T3
Somatization	1.25	0.92	1.09	1.18	0.54	0.61
Obsessive-Compulsive	2.21	1.93	2	1.4	1.33	1.46
Interpersonal Sensitivity	2.22	2	1.55	1.5	1.45	1.38
Depression	1.73	1.79	1.6	1.21	0.5	0.67
Anxiety	1.96	1.67	1.4	1.67	1.27	1.38
Hostility	1.6	1.6	0.76	0.83	0.6	0.8
Phobic Anxiety	1.32	1.69	0.96	1.1	1.16	0.75
Paranoid Ideation	2.73	2.37	1.76	1.74	1.48	1.05
Psychoticism	1.78	1.69	1.68	1.09	0.6	0.7

Brief Cope (BC). The Brief Cope measure served to assess coping strategies utilized by the treatment and control groups. BC assess for 14 different coping strategies including self-distraction, denial, humor, positive reframing, and instrumental support. The below graphs illustrate the raw scores for both groups across time for a couple of the coping strategies.

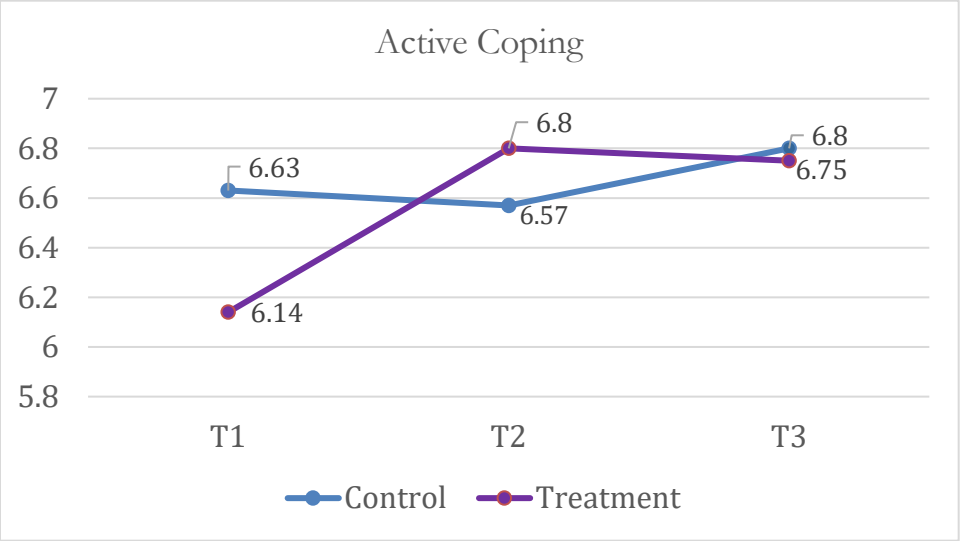


Figure A

In Figure A, Active Coping, data analysis indicated that the treatment group had the largest increase in rates of active coping between T1 – T2 and these higher rates relatively remained through T3. This indicates that treatment group participants utilized or had the ability to take actionable steps when confronted with a stressful situation at higher rates than control group participants. In comparison, the control groups rates of active coping made little change throughout the duration of the study.

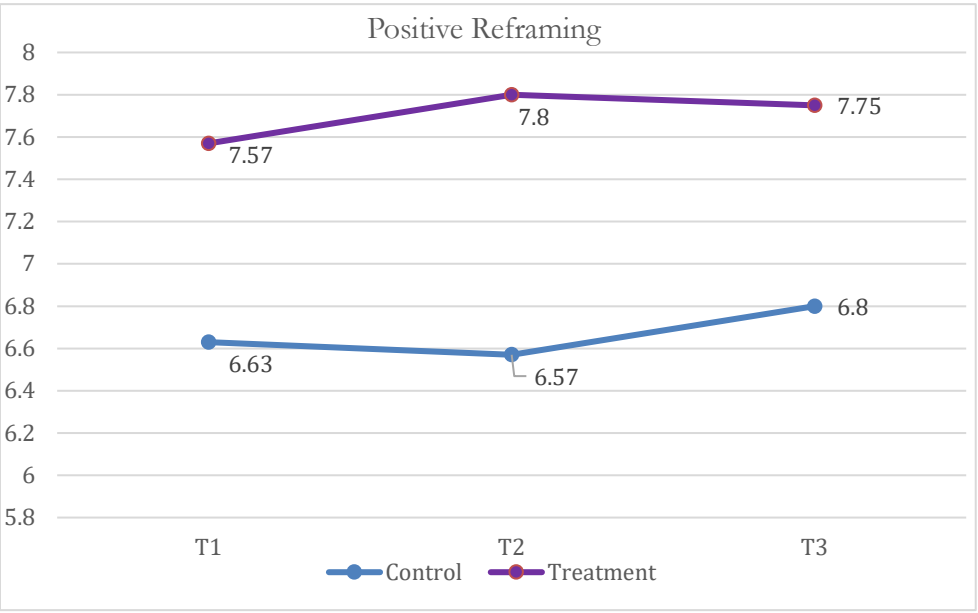


Figure B

In Figure B, Positive Reframing, data analysis indicated higher scores for treatment groups participants consistently across time. This indicates greater utilization or ability to positively reframe stressful situations for individuals in treatment group.

Trauma History Questionnaire (THQ). Participants reported a moderate amount of trauma throughout their lifetime. However, six months after discharge from the CSU participants reported a minimal amount of trauma. The most common trauma in their lifetime participants experienced included an auto accident, seeing a dead body, or seeing someone be seriously injured.

Participants reported moderate to high levels of general trauma throughout their lifetime, however 6 months after discharge from the CSU the participants, reported low levels. The most common general trauma

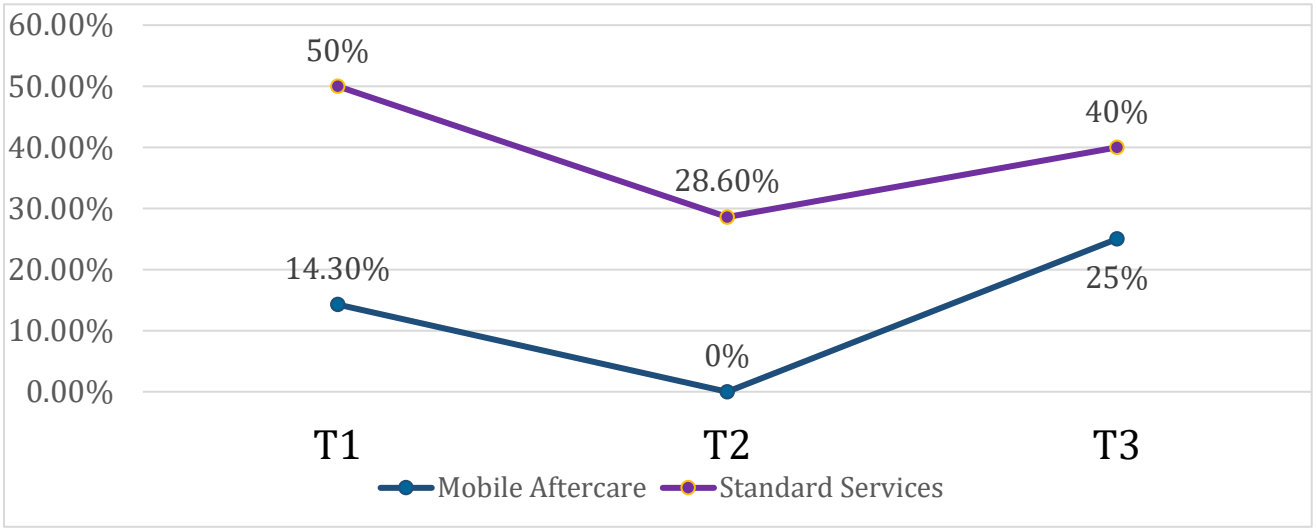
reported was learning of a serious injury, life-threatening illness, or unexpected death of someone close to them. Thirty-eight percent of participants had loved ones either die or diagnosed with unexpected illness within six months after discharge from the CSU. The second most common was learning of a serious or life-threatening illness of themself after being discharged from the CSU. For example, one participant was diagnosed with stage one breast cancer, one was hospitalized for a stroke, and another was diagnosed with a heart condition. For other extraordinarily stressful situations within six months of discharge from the CSU, participants listed being homeless, financial struggles, relationships with family, and moving.

Financial History Survey (FHS). Over time, the treatment group consistently reported higher levels of financial security compared to the control group.

Question	Control T1	Treatment T1	Control T2	Treatment T2	Control T3	Treatment T3
[T1: Since your discharge from the CSU; T2, T3: Since the last interview], how often have you had difficulty paying for current expenses (for example, food, clothing, transportation etc…)?						
None of the time	12.5%	28.6%	28.6%	40%	-	25%
A little of the time	-	28.6%	-	20%	-	25%
Once or twice	-	-	-	-	20%	-
Some of the time	25%	-	-	40%	-	50%
Much of the time	37.5%	14.3%	28.6%	-	40%	-
Most or all of the time	25%	28.6%	42.9%	-	40%	-
[T1: Since your discharge from the CSU; T2, T3: Since the last interview], how often did you worry about your economic situation?						
Never	-	14.3%	-	20%	-	25%
Less than once a week	-	14.3%	14.3%	-	20%	25%
Not more than once a week	-	14.3%	-	-	-	-
A few times a week	50%	28.6%	28.6%	60%	20%	-
Virtually every day	50%	28.6%	57.4%	20%	60%	50%
In an unforeseen situation, could you get a hold of $250 within a week?						
No	25%	42.9%	42.9%	20%	60%	-
Yes, with difficulty	62.5%	14.3%	28.6%	-	20%	25%
Yes, without difficulty	12.5%	42.9%	28.6%	80%	20%	75%
[T1: Since your discharge from the CSU; T2, T3: Since the last interview], has your economic situation allowed you to pay for unexpected bills of $50 or greater?						
Yes	37.5%	28.6%	28.5%	80%	40%	75%
Do you own or make payments on a car or another motor vehicle?						
Yes	12.5%	71.4%	14.3%	40%	0%	50%
How hard is it to make ends meet each month?						
Very Hard	50%	14.3%	57.1%	-	40%	-
Hard	25%	28.6%	14.3%	20%	-	50%
Not hard, not easy	12.5%	42.9%	28.6%	60%	60%	25%

Easy	12.5%	-	-	20%	-	25%
Very Easy	-	14.3%	-	-	-	-
Do you have difficulty paying your bills?						
Yes	75%	57.1%	85.6%	40%	80%	50%
Do you have money left over at the end of the month?						
Yes	25%	71.4%	42.9%	40%	0%	75%

Lawbreaking assessment (LWB). The Lawbreaking assessment served to capture data on interactions with law enforcement, and/or law-breaking behavior, that was self-disclosed participants. This measure enabled us to include participant contact with law enforcement that did not result in arrest. The below graph illustrates the rates of contact with law enforcement, or law-breaking behavior, by our treatment group (Mobile Aftercare) and our control group (standard services). The control group (standard services) had higher rates across each data collection window.



Police Community Interaction Survey (PCIC). PCIS was the only measure, other than participant demographic and locator information, that was conducted at baseline (immediately following recruitment at the CSU). The purpose of including this measure at baseline, was to ensure we captured participant's perspective of the encounter with law enforcement that led to them being admitted to the CSU, as close to the actual date of the encounter as possible. The measure was used to ask participants' about their experience with law enforcement officers who brought them to the CSU. The PCIS measures the participant's subjective evaluation of the encounter, how helpful the officer is during the encounter, participant's perception of the officer's competence, officer use of social etiquette (such as saying hello and stating their name during the encounter), emotional control (how much officers remained calm during the situation), how neutral and respectful the officer was during the encounter, the level of empathy displayed by the officer and if the officer used force or threat of force. Additionally, the measure looks at

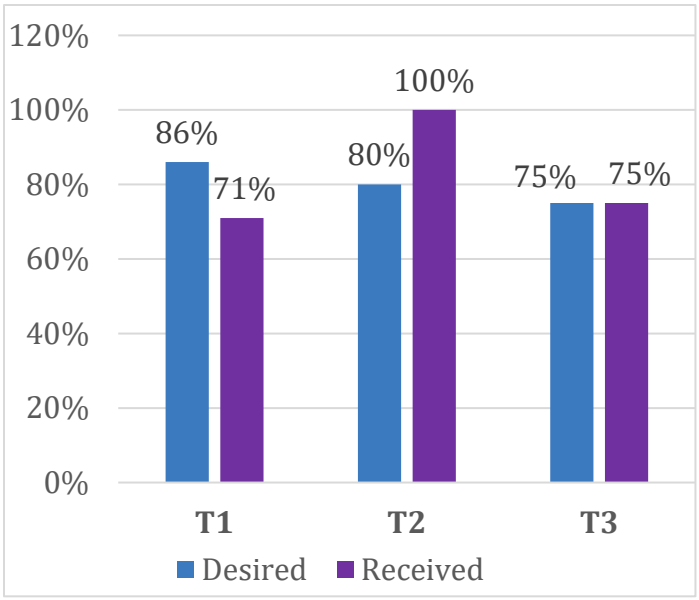
organizational factors such as the participant's impression of how effective law enforcement is and their general confidence and trust in the ability of law enforcement to do their job.

Overall, at baseline participants reported high satisfaction of the interaction and that the officer was helpful, competent, respectful, and used empathy and did not use force. The below table reflects scores from the PCIS measure during baseline.

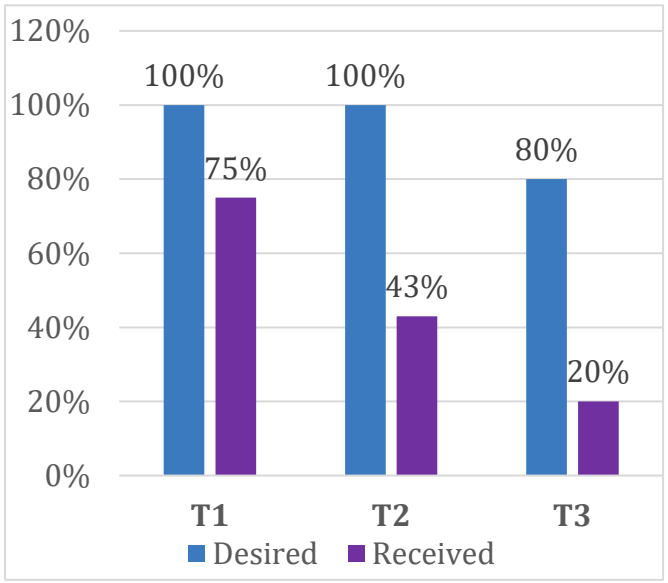
Participant Satisfaction of How They Were Treated by Officer	Percent
Very Dissatisfied	17.4
Dissatisfied	8.7
Satisfied	43.5
Very Satisfied	30.4

At the follow up interviews we asked participants about their experience with any law enforcement they had contact with since they were discharged from the CSU. We used the Police-Citizen Interaction Survey to measure the participant's experience. The scale runs from 0 to 4, with higher scores indicating more positive views. Perceptions of law enforcement did not significantly change throughout the duration of the project. Scores for T1, T2, and T3 can be found in the codebooks.

Service Assessment for Children/Adult (SACA). The SACA measure was used to assess self-disclosed service utilization, treatment engagement, desire for resource/service, and reasons why individuals may not have engaged with services. In the below bar charts, we have illustrated results for the rate of services or treatment desired versus received for participants in the treatment group and participants in the control group. Treatment group and control group participants had relatively similar rates of desiring services and/or treatment engagement. However, the rate of actually receiving such services is significantly higher for individuals in the treatment group. This finding suggests that when participants receive the mobile and technology-assisted aftercare they are more likely to be connected to and receive other types of services and/or treatment than participants randomized to the control group.



Treatment group



Control group

Education and Employment Survey (EE). The EE measure served to capture data on participant engagement employment and educational activities. Across time, participants in the mobile aftercare (treatment) group experienced significantly higher rates of employment than individuals in the standard services (control) group. The below table illustrates rates of employment status that was at least part-time. It's important to note that even at T1, the treatment group possess higher rates of employment suggesting that participants randomized into the treatment group, may have had higher rates of employment prior to involvement in the study.

Rates of employment status that were at least part-time		
Data collection window	Treatment group	Control group
T1	43%	25%
T2	80%	43%
T3	75%	20%

CSU Administrative Data. Administrative data from CSUs were collected to examine rates of re-admission into CSUs following recruitment into the study. Records examining admissions into the CSU were assessed for each participant's duration in the study, this meant a six -month window of examining CSU administrative data to assess any admissions. During this time period, 18% of participants randomized into the treatment group were re-admitted and 18% of participants in the control group were re-admitted into a

CSU. However, the18% of individuals in the treatment group that were re-admitted to a CSUs, did not receive the intervention due to refusing or becoming unreachable. None of the individuals who received the mobile and technology-assisted aftercare intervention experienced a re-admission into a CSU for the six months following their recruitment into the study.

III. Feasibility and Acceptability of the Mobile Aftercare Intervention

Ten individuals that were directly involved with the intervention either as an interventionist or manager role at the CSU mental health agency were interviewed post-completion of the pilot study to assess the feasibility and acceptability of the intervention details with mental health stakeholders. The feasibility and acceptability interviews were conducted with the following stakeholders:

- 3 stakeholders that acted as a CSS interventionist with participants.
- 4 stakeholders that served in leadership roles within our partnering mental health agency.
- 2 stakeholders that served as supervisors to the individuals assigned to us as interventionists.
- 1 research staff member that managed the pilot study and served as a temporary interventionist for a few weeks due to the unexpected loss of a staff member.

Acceptability

Overall, many of our mental health stakeholders found the mobile aftercare intervention to be a program they liked, believed to the appropriate for the target audience, and perceived the intervention as being effective. In fact, 50% of stakeholders interviewed made positive or neutral comments about the intervention.

- *It was all right for me. . .no, honestly, I wouldn't have changed anything. – MH Stakeholder*

- *No, I think it was a good program. I think it absolutely had the potential to be beneficial. – MH Stakeholder*

- *I think the approach, I think was the main thing that you guys having that out-of-the-box approach, having the fly flexibility, I liked the app. I like the flexibility of the app as well. – MH Stakeholder*

Stakeholders also shared valuable constructive criticism toward the program. Only 1 out of the 10 follow up interviewers expressed not liking the intervention. This particular stakeholder shared beliefs that the intervention was more likely to be accepted by the agency than by the individuals the intervention hopes to serve.

- *If you're looking for the a realistic probability of it being successful, that they would use the apps and do what program was suggesting they do, I think that that is probably lower than the realistic expectation that the program could be implemented and introduced. – MH stakeholder. – MH Stakeholder*

Acceptability of the mobile aftercare program with stakeholders also revolved around their perception of how effective the program was at responding to client's needs.

- *It was very beneficial and helpful to some people because some people wasn't able to actually come into the office to do a session. – MH Stakeholder*

- *I like the apps because you could use them outside of the counseling time. You could take and use your app now. I do think it was very helpful. – MH Stakeholder*

A couple of stakeholders brought up perspectives on ways the mobile aftercare intervention was unhelpful to the target population. These beliefs about unhelpfulness revolved around participant comfort with technology and utilizing the applications, and the content of the mobile applications provided in this intervention. These perspectives are highlighted in the quotes below:

- *I know at least one client, or one participant in particular was not tech-savvy at all. He had difficulty navigating the phone itself, much less the apps. That proved challenging, - MH Stakeholder*

- *Well, the only way the app helped with that was because they provided Ted Talks inside the app. That was helpful, but the remaining of the stuff, the tools inside the app wasn't really as helpful towards her goal. She could use it to journal inside the app, whatever she thought it might be but I don't think it was as helpful towards her goals. Another person, those apps wasn't related to his goals.*

Lastly, acceptability of the aftercare intervention was also measured in how appropriate stakeholders perceived the program to be for the target audience and for their agency as a whole. Forty-five percent of stakeholders felt the intervention was an appropriate fit for their agency. Stakeholders felt the intervention was appropriate because the agency already had infrastructure in place to incorporate site visits and has previously incorporated technology in the form of telehealth with clients.

- *Initially, there's, of course, a training barrier and a learning curve. I would say, on the initial end, we used to do Telehealth site to site. We always had it on our roadmap to start doing tele from the clients being at home, but we just implemented that super rapidly because of COVID. I think that was an initial learning curve. – MH Stakeholder*

- *She had experiences just based on being on the MRT team because they respond to crises everywhere. They would have to go to the homes, in the schools, wherever they would be responding to the crisis. They were*

accustomed to being out in the community and seeing people face to face. – MH Stakeholder

Stakeholder concerns over inappropriateness of the intervention revolved around technological issues and perspective on the incorporation of mobile applications with clients. Stakeholders noted that connectivity issues may make utilizing mobile applications difficult for the clients they serve from rural areas. Additionally, clients that are not used to or interested in utilizing mobile applications may put up resistance or have disinterest in this portion of the intervention.

- *We don't get very many people who want to use the gizmos. They're really not into doing that. Then we have to deal with connectivity issues and all of those kinds of things in those areas. It's a hard sell, honestly. – MH Stakeholder*

Some Mental Health Stakeholders also voiced concerns over appropriateness due to the therapy approaches utilized in our intervention. Specifically, a minority of stakeholders made comments that they believed the therapy with clients should focus more on their past and the events that led them to admission at a CSU rather than the mobile and aftercare technology intervention that focused on participant's futures and goals.

- *I think motivational interviewing is great, but I think it maybe [it] could use more. . . I think maybe if it was a longer-term program, in the future adding maybe some cognitive behavioral therapy or some trauma focus to try to see what's going on, what brought them there, and see if we can resolve it. – MH Stakeholder*

Feasibility Barriers to Agency Implementation

Feasibility analysis indicated two main categories, feasibility within the agency and feasibility due to external community concerns. These categories are described below.

Feasibility Within the Agency

The two most common barriers impacting the feasibility of this intervention amongst stakeholders were financial barriers and staffing barriers. Throughout our project, our community mental health partners mentioned several times the struggle for their agencies and similar agencies to fill positions and retain individuals. Having dedicated staff is extremely important to carry out this intervention long-term and was vocalized as a concern by our stakeholders. Financial barriers that stakeholders shared mostly revolved around difficulty at funding all of the components of the mobile aftercare intervention such as the travel costs and technology. Additionally, stakeholders brought up financial barriers to establishing funding that will pay for attempted services to clients because of the inevitably that clinicians will travel out to the homes of participants who will then cancel or no-show.

Staffing

- *What we struggle to be able to find, to be able to dedicate people for the grant is the same thing that we have on a broader scale. When we talk to*

our peer agencies, it's the same thing. There's just such a low amount of people to do mental health services, who are qualified to do that. – MH Stakeholder

- *Staffing and recruitment is a challenge. Often, we're trying to, and we saw this multitask for staff, and do a couple of different things. That's right now the climate. That's a big challenge I think for folks is finding the staff to do some of these things. Not all staff want to go in the community. I think that's a factor. – MH Stakeholder*

Financial barriers

- *Another barrier I think within is funding for the small things, the gas money, the tablets, those little things. How do you get those? – MH Stakeholder*

- *The travel cost. . . If you get somewhere and they're [the clients] not home, that adds to the expense, where basically, that would be revenue that is very hard to come by in a community behavioral health setting. . .we would not be reimbursed, and we would still, of course, have to pay that employee for their time. – MH Stakeholder*

Feasibility Within the Community

Stakeholders frequently mentioned feasibility concerns to implementing the mobile aftercare program due to one main community barrier, technology and communication difficulties present in rural counties. Our partnering mental health agency serves several counties that range from extremely rural to urban. Clients that reside in these rural areas were reported to have frequent inconsistencies with Wi-Fi and phone service. These technological and communication realities of the area added concern to our stakeholders at the ability to incorporate mobile applications into client sessions or encourage clients to utilize the applications overall, beyond general barriers to communicate between client and clinician.

- *Because even with cell phone service, there are places in the territory that did not have cell phone service. It was great that the clients were able to be given cell phones. However, there were places in the territory that they wouldn't have been able to use it anyway, because there just wasn't service. – MH Stakeholder*

Facilitators to Agency Implementation

Our mental health stakeholder noted several facilitators that would enhance the agency's ability to implement a program like the mobile aftercare program. The two main facilitators were: 1) the agency has increased their utilization of technology and is seeing the push for technology in their field overall 2) the agency has staff that conduct home-visits with clients and so they feel comfortable in how to manage that program component.

Utilization of technology

- *As far as technology, the workforce and also in community behavioral health, mental health services, we have made that shift to technology. It is in there with just doing their own paperwork and documentation. We have the training and the staff are comfortable using it. Majority of the staff are fine with using technology. – MH Stakeholder*

Already implementing project components

- *having someone go out, we already are doing that on our [program name redacted] type of services. . .That is going to include a community-based in-home therapy model. – MH Stakeholder*

End of findings part 2.

Findings pt. 3 – Re-Engagement with Law Enforcement Across Study Conditions

IV. Re-Engagement with Law Enforcement Across Study Conditions

Re-Engagement with Law Enforcement Following Involuntary Transportation to a CSU by Law Enforcement: Study Conditions 1 & 2:

Our project importantly asked how a mobile-aftercare program, implemented with individuals that had been brough to a CSU under a law enforcement initiated involuntary hold, may affect future rates of re-engagement with law enforcement. Participants fitting these criteria were recruited prior to their discharge from the CSU and randomized into either study condition 1 (treatment condition to receive the mobile aftercare program) or study condition 2 (control condition to receive standard CSU aftercare services that do not include mobile aftercare). To analyze rates of re-engagement with law enforcement across study conditions 1 & 2, our team pulled state-wide arrest records and conducted the Lawbreaking assessment with participants at our T1, T2, and T3 data collection interviews.

The data analysis for the Lawbreaking assessment is described in the Pilot Feasibility Study section of this report beginning on page 48. Instances covered in this measure include being pulled over while driving, officers being called to your place of residence, or other general encounters with law enforcement that did not result in arrest. Ultimately, the Lawbreaking assessment indicated that participants in the control group experienced higher rates of self-disclosed engagement with law enforcement that did not necessarily result in arrest.

Statewide arrest records were pulled for one-year prior to recruitment up to three months after project completion. This window allowed for assessment of arrests throughout the pilot study activities, six months, and for three months after, totaling nine months of analysis of re-engagement with law enforcement that resulted in arrest.

Percentage of participants in the control group that experienced at least one arrest in the nine months following recruitment – 27%

Percentage of participants randomized to the treatment group that experienced at least one arrest in the nine months following recruitment – 27%; of those participants who were randomized to the treatment group and actually received treatment, 0% experienced arrest in the 9 months following recruitment.

Thus, the 27% of individuals randomized to the treatment group that experienced at least one arrest in the nine months following recruitment, did NOT receive the mobile-aftercare intervention. Rather, these individuals were randomized to receive the mobile-aftercare intervention but did not engage in services due to the research team being unable to locate the participant and deliver the intervention to them.

The above context also means that **100%** of the individuals that received the mobile aftercare intervention services experienced **zero arrests** for the nine months following recruitment. Our research team believes this is a critical piece of context that suggests the mobile-aftercare program may greatly reduce future rates of arrest for individuals that engage in CSU stabilization treatment.

Re-Engagement with Law Enforcement Following Arrest: Study Condition 3:

As a comparison to the participants that were taken to a CSU by law enforcement, our research team assessed individuals with mental health or substance-use concerns that were *not* transported to a CSU and were instead arrested. We partnered with two county jails that were embedded within the counties where our recruitment of participants from CSUs for our pilot study occurred. This decision was strategic to assess individuals that were coming in contact with the same law enforcement agencies that frequented the CSUs where our research occurred.

Each of these jails had a screening process in-place that was conducted with everyone upon admission and included assessment of medical, mental health, and substance-use conditions. Both detention facility screeners included an opportunity for the officer or detention facility employee, to document perception of mental health or substance-use concerns, and for the individual themselves to disclose any mental health or substance-related information.

Our research team examined these screeners to quantify the number of admissions into both detention facilities where mental health or substance-use concerns were flagged.

- Jail A: our research team examined 35% of all admission screeners over a three-month period (November 1st, 2021 – February 28th, 2022)
  - Out of the 35% of admission screeners assessed by our research team, 29% were flagged as having mental health or substance-use concerns.
- Jail B: our research team examined 100% of all admission screeners over a one-month period (June 2022).
  - Out of the entirety of adult admission screeners into the detention facility for the month of June 2022, 32% were flagged as having mental health or substance-use concerns

Our research team then asked, **what was the rate of re-arrest for the individuals arrested and flagged with mental health or substance-use concerns in the six-months following their arrest?**

Additionally, our research investigated how detention facility staff, conducting the admission screeners, may assess an individual as having a mental health or substance-use concern. Overall staff shared a belief that individuals being admitted into the jail mostly do not disclose mental health or substance-use concerns even if they in-fact do have such conditions. However, some individuals do disclose, while others are observed to be under the influence, or make self-harm statements to the detention facility staff or the arresting officer. Law enforcement stakeholders noted that the transfer of information between arresting officer and detention facility staff is based on an informal word-of-mouth system. This means that the mental health or substance-use concerns that the patrol officer may assess on-scene are communicated verbally to the admission staff at the jail. As noted in the quote below:

- *There's no form or anything that we use to tell them [staff at jail]. When we go into the sally port to do the arrest or transfer it over to them, whenever they step out, we say, "Hey, just so you know. This person is a suicide risk. This is what they said." They say, okay, and then they handle it. - Officer*

We had arrest records pulled for the sample of individuals flagged with mental health or substance-use concerns on the jail admission screener for six months following their arrest. Our analysis found that 19% of these individuals experienced at least one arrest in the six months following the arrest where they were flagged as having a mental health or substance-use concern**.** Our research team recommends further investigation be conducted into the rate of re-engagement with law enforcement for individuals with mental health or substance-use concerns that were arrested because this 19% only reflects rates of arrest. Our project has importantly showcased that often these individuals have re-engagement with law enforcement that do not result in arrest. Further investigation of these repeat contacts with law enforcement is critical to further assess mental health and substance-use encounters that are appropriate for a CSU versus appropriate for other formal action.

Re-Engagement with Law Enforcement Following Officer Contact That Did Not Involve a Formal Outcome or Consequence: Study Condition 4

To respond to policy makers that may ask what happens when there is no arrest or transportation to a CSU, we included a "do nothing" or "no formal outcome" study condition, study condition 4. In this study condition, a law enforcement response to an individual was coded as including or relating to mental health concerns. The law enforcement officer mitigated the situation on-scene and there was no formal outcome such as transportation or arrest. To do so we worked with one of our partnering agencies to assess all mental health calls, responded to by a regular patrol officer over a 3-month period (January 1st, 2022 – March 31st, 2022). Those calls were then narrowed down to incidents where there was no formal report attached meaning the interaction did not result in a formal outcome like arrest or transportation to a CSU. Finally, 9% of these incidents without formal outcomes were then randomly chosen to be a part of our analysis. The 9% figure was chosen due to what was feasible for our partnering agency considering the work involved in pulling our requested data. Our research team asked: **how many times after the no-formal outcome interaction with law enforcement, did these individuals come back in contact with law enforcement over a six-month period?**

This resulted in a rate of 56% of re-engagement with law enforcement following a mental health interaction that did not result in arrest or transportation such as transportation to a CSU. However, our current data analysis timeframe and infrastructure barriers with our partnering agency's data system did not allow us to discern the 56% into four important categories that are necessary to appropriately understand this figure as a rate of re-engagement. These four areas of needed clarification are:

- Percent of these re-contacts with law enforcement that were requested by the civilian.
- Percent of these re-contacts with law enforcement that were initiated by law enforcement for follow-up, previous other open cases, or non-law-breaking purposes.
- Percent of these re-contacts that were initiated by law enforcement due to criminal or law-breaking behavior of the individual.
- Percent of these re-contacts with law enforcement that are due to mental health or substance-use crises.

Without the above clarification, our research team cautions conclusions to be made from the 56% rate of re-engagement with law enforcement after a mental health call that did not result in a formal outcome such as transportation to a CSU or arrest. What we can say, is that the 56% rate of re-engagement signals a need

for further research and exemplifies what are law enforcement stakeholders shared during our interviews, that interacting with the same individuals, and individuals with mental health concerns, is very common.

End of findings part 3.

Conclusions

V. Conclusions

Discussion and Policy Implications

The results showcased in this summary of findings report emphasize the magnitude of information obtained in our pilot study and point to the complexity of law enforcement response to mental health or substance-use crises, utilization of CSUs, and overall collaboration between officers and mental health professionals. With that being said, there are eight critical thematic findings concluded from our data that we would like to highlight that have actionable policy relevance. These eight thematic findings are listed and expounded below.

- The complicated relationship of CSUs as an alternative to arrest or criminal justice involvement
- Impact of officer discretion
- The important of paperwork
- A closer look at substances
- Concerns from mental health professionals
- Critical need for policy on resource allocation
- The weight of CSU detention
- Impact on insurance policy

The Complicated Relationship of CSUs as an Alternative to Arrest or Criminal Justice Involvement

Our research study proposed to analyze how CSUs and similar response options can serve law enforcement as an alternative to arrest. Our study importantly revealed that utilization of CSUs does not always function as an alternative to involvement in the criminal justice system, and that CSUs can initiate criminal justice involvement for their patients. For instance, our analysis indicated that law enforcement are sometimes called to CSUs to assist or respond to CSU patients who are being violent. The request for law enforcement assistance appears to be primarily in-response to safety concerns of CSU staff when CSU patients become violent such as physically attacking staff, or when CSU patients are perceived as a harm to other patients.

- *We had a patient . . .She was threatening to harm herself. We thought she had a weapon. She was pulling the vents out of the ceiling which can be used as a weapon, the metal stuff. . .We called law enforcement, and they came right in and helped us. – CSU staff*

- *We have to call law enforcement for backup. We have to call law enforcement to break up fights or to break up things when clients are aggressive. – CSU staff*

- *Oh, we've had to call law enforcement here just to come in to hold if a client's acting out, being aggressive to the staff. We've had to call that law enforcement to come in to help us, if we have to administer an injection. . . We've had to call, so we can make an incident report. – CSU staff*

Mental health stakeholders are sometimes the ones to discourage utilization of CSUs as alternatives and instead favor arrest. Most statements suggesting the individual should have been arrested instead of being brought to a CSU were directly related to safety concerns. However, there were a small number of mental health stakeholders who perceived arrest as more appropriate than CSUs when criminal behavior existed in addition to mental health symptoms. Addressing safety concerns of CSU staff is a priority in order to minimize diversion of individuals to the criminal justice system and is further described in the Mental Health Safety Concerns section of this report. Without feelings of safety, our analysis indicates that staff may be less on-board with the option of the CSU acting as an alternative to arrest and may in fact encourage criminal justice involvement.

- *Interviewee 1: We have this man that wrecked his car under the influence, and they brought him here because he said he was suicidal instead of taking him to jail. Like I said, we have this one young kid that comes every month that beats up his grandma.*
  Interviewee 2: That's behavioral. Why not take him to juvie? Why do you keep bringing them here? – CSU staff (group of 2)

- *You have a patient who is extremely volatile. You bring him in and he is punching and kicking and you literally think he's going to come through that wall. "Why is he here?" Because I can't get anything out of him. . . "Automatically it's got to be a mental health issue and you bring him here? You probably should bring him to a holding cell." – CSU staff*

- *We don't know what the right answer is, but when you say the client stripped naked on the side of the road and refused to put on clothes, okay, that is indecent exposure. To me, that would be, if you want to do something, you can arrest them, but that's not a mental health issue. – CSU staff*

Utilization of a CSU does not necessarily mean an individual is being deflected from the criminal justice system. Rather, many law enforcement and mental health stakeholders shared scenarios where individuals were brought to a CSU under detainment. Detainment means that that individual was brought to the CSU for treatment services, under the stipulation that once they were discharged from the CSU, law enforcement would pick them up to bring them to jail and process criminal charges. The use of detainment was echoed by law enforcement stakeholders as a way to both advocate for treatment services but also make an arrest.

- *If it's somebody that they're arresting for a crime and they see that they are suicidal or homicidal or something like that they keep bringing them directly here, give us the paperwork. Let us know, "Hey this client is detained, blah blah blah the process." When the process is over you call us, we come back and pick them up and then they'll go to jail for this crime. - CSU staff*

- *9 times out of 10 they're going to go to [CSU name redacted]. . . until the doctor releases them, and then we'll go pick them up and then they go to jail . . . Write up the probable cause for the arrest so once they're released and they get that help first, then we'll execute the arrest. – Officer*

Perceived frequency of detainments at the CSU

- *Interviewer: How often does that happen?*
  Interviewee 2: Not every day, but it does happen quite often. I could at least say once a month for sure. – CSU staff

These critical findings means that CSUs do not necessarily act an alternative to arrest and that both CSU staff and law enforcement discretion may greatly affect the likelihood for criminal justice involvement.

Notably, several interviewees also pointed out that involuntary commitment to a CSU is detention against one's will that restricts their freedom. They cautioned to not think of CSUs as an alternative to confinement against one's will, but rather an alternative (sometimes temporarily) to criminal charges that result in detention in jail.

Impact of Officer Discretion

Officer discretion may impact the utilization of alternatives like CSUs or other treatment deflection options, arrest, or no formal outcome. Our analysis indicated three main areas of critical impact from officer discretion. These areas are, 1) officer discretion depending on the type and quantity of substance; 2) officer discretion when responding to misdemeanors; 3) officer discretion to utilize community resources with individuals that are determined to not meet criteria for mandatory intervention due to being an immediate harm to self or others.

Interestingly, our findings revealed that the timing of when the substance was discovered by the officer can greatly impact officer discretion to arrest for the substance or utilize a CSU. Specifically, did the officer find the substance before or after they decided to transport the individual to a CSU? Officers indicated that if they had determined the individual to meet criteria for an involuntary hold and then found substances on the individual, they were more likely to continue with their original plan of action and transport the individual to a CSU rather than arrest. This pattern is illustrated in the below quote.

- *"Well, I start patting 'em down I find one marijuana joint cigarette in their pocket. It's arrestable, but I've already determined that they're going to get [an involuntary psychiatric hold]. Am I going to take them to jail instead of the [involuntary psychiatric hold]? No, they need to go get-- in my opinion, I've already made up the mind that I am going to [involuntary psychiatric hold] them." – Officer*

Officers expressed a level of discretion toward misdemeanors that was absent when interacting with an individual where felony level criminal behavior has occurred. As detailed in the Arrest section of this report, there are several discretion related decisions that officers consider when determining to make an arrest or

utilize a resource like a CSU. The most common, after considering the severity of the crime, was the presence of victims at the misdemeanor and the circumstances surrounding the engagement in criminal behavior. The discretion officers have around misdemeanors means that sometimes the presence of a misdemeanor along with mental health or substance-use concerns may result in arrest, or transportation to a CSU, or utilization of some other informal outcome to the interaction. From a policy perspective, discourse should explore whether felonies should be blanket exclusions from CSUs or other treatment options for individuals.

- *"In other words, the only time you cannot arrest and do the [involuntary psychiatric hold] instead is if you have first discretion, which means it's not a felony. Secondly, it looks like there was no intent because they are suffering some mental health issue." -Officer*

Officers have discretion to utilize CSUs or community resources if they individual is determined to not meet the criteria of harm to themselves or harm to others. In these situations, the officer's discretion to utilize the resource may be impacted by their perception of how truthful the individual is being, or time restraints of using the resource. For instance, many law enforcement stakeholders shared stories where individuals they believed to be insincere about their mental health severity, called 9-1-1. Officers noted that often these types of calls came in during winter or inclement weather when the individual was looking to get a ride to a facility/shelter.

- *The ones that truly made their mind up aren't going to call the police and say, "Hey, I think I'm going to kill myself." - Officer*

- *"I would say the response time of the MRT would be the main thing because, like I said, that's why a lot of times I don't call them because it takes them an hour, hour and a half, two hours to get out there." - Officer*

The Importance of Paperwork as an Easy Policy Intervention

Paperwork, or lack thereof, from law enforcement was one of the most common barriers and points of frustration noted by CSU staff. Paperwork provided to CSU staff by law enforcement, when admitting an involuntary psychiatric hold, acts as a source of critical information explaining and providing insight to an individual's environment and mental state that may not otherwise be observed in the confines of the CSU facility. Furthermore, without documented details, CSU staff are forced to center their admission evaluation around what the individual states to them.

- *They are saying [to officers], "Y'all, I am going to kill myself, I am going to kill myself." and when they get with the [CSU] screener, "Oh, I was just upset, I've gone through a hard time." The screener is like, "Okay." and releases them. - Officer*

Interestingly, our analysis indicated that stakeholders request more paperwork and more information on the paperwork. CSU staff routinely requested more information to be included on paperwork from law enforcement such as greater detail in their analysis of the person's mental state and inclusion of names and contact information for other witnesses. Likewise, law enforcement stakeholders noted the desire to transfer their expertise, from spending potentially a significant amount of time with the individual prior to bringing

them to the CSU, to CSU staff. One notable policy solution that came forward in our interviews was the prospect of implementing paperwork for voluntary transport to the CSU. Currently, individuals transported to the CSU by law enforcement for a CSU voluntary admission are dropped off without any paperwork and sometimes without much conversation between CSU and officer. During our interviews, stakeholders requested a way to capture information on voluntary CSU transports to assist in CSU admission evaluation.

- *"I think I've seen sometimes where clients are brought in voluntarily that appear to be criteria for [involuntary hold] and that part is not helpful because then we don't have any information about why they've been brought in. . .this is what I would change, is [for] clients brought in voluntarily by law enforcement still come with some type of narrative or report about why they've been brought in voluntarily" – CSU staff*

A Closer Look at Substances and the (in)ability for CSUs to Respond – A note for Policy and Public Health Resource Allocation

This project asked how substances, especially opioids, affect the decision making and overall utilization of CSUs or similar alternatives to arrest by law enforcement. Through our interviews we asked law enforcement stakeholders how frequently they were responding to substance-use related calls or substance-use crisis calls. Most officers perceived substance-use as a major concern for their community and an extremely common component in the calls they respond to.

- *Drugs are a real bad issue here and with meth going around, it's really ramping, it's bad. – Officer*

- *We have a lot of drug issues, especially fentanyl, heroin and stuff. I think a lot of times, we deal with people that are dealing with both of those more. – Officer*

- *It's a hub for narcotics they're cheap, they're abundant. We constantly are out here fighting the war on narcotics but it's the users. - Officer*

Similarly, analysis from mental health stakeholder interviews showed that the majority of clients at CSUs have co-occurring mental health and substance-use disorders. This finding emphasizes the entangled relationship of mental health and substance use, and points to the critical need for resources and treatment facilities that can respond to both of these disorders within their client population.

- *Interviewer: About how many clients would you say are here for co-occurring mental health and substance?*
  Interviewee: Mostly all of them. – MH Stakeholder

- *I think everywhere I've worked in mental health; you have an issue with drug abuse in a CSU. . . In seven days, you probably have two people that does not have a co-occurring issue. Just a mental health diagnosis. – MH Stakeholder*

Law enforcement officers noted several beliefs about contributors to the substance-use concerns in their communities such as availability and ease of access (especially due to major intestates running through the community possibly transporting substances), large transient populations, and a depletion of resources in communities that were thought to contribute to substance use.

Although opioids and fentanyl were concerns for stakeholders, our analysis indicated that our officers and mental health stakeholders perceived a larger interaction with meth than opioids across our study counties. Stakeholders mentioned that accessibility to cheap substances appeared to trump over opioids, especially prescription opioids.

- *Mostly it's meth and molly type of calls, but also, we don't 100% know what they took anyway. Yes, I don't think opioids is as big of an issue here as meth and heroin like those cheaper substances are an issue. – MH stakeholder*

- *Just substance. It's usually meth. - Officer*

The type of substance that is present when officers respond matters because the substance type may impact utilization of the CSU if the substance type is considered a misdemeanor or a felony. In the region where our pilot study occurred, marijuana is predominately a misdemeanor offense, meanwhile substances like narcotics are considered felonies. As previously detailed, officer discretion is a weighted factor during misdemeanor interactions. As the quotes below describe, misdemeanor substances may be more likely to be brought to a CSU compared to felony labeled substance-use.

- *Well, if you have a person that you're dealing with that are in possession of some type of narcotics, of course, you have to make the arrest and transport them to jail. - Officer*

- *I've had that happen a couple of times with small amounts of contraband. . .find them in possession of something like that, it's a misdemeanor. In my opinion, it is more important for 'em to go there [to the CSU]. - Officer*

Another critical point to consider from our analysis, is the utilization of arrest for substances not because the person didn't meet criteria for an alternative like a CSU, but because the officers perceived the CSU or other alternatives as not helping the individual for their mental health or substance use disorders. We heard several stories from law enforcement stakeholders where individuals were arrested after the officer had attempted to transport the individual to treatment facilities on several occasions and perceived transporting them to jail as the only other option available. Some officers believed involvement in the criminal justice system was going to help the individual overcome their substance addiction. These sentiments from our law enforcement stakeholders emphasize the need for treatment facility options and the frequency to which officers are responding to the same individuals with substance-use disorders and looking for viable options to minimize this contact.

- *Sometimes it's the best thing to do is get them in the criminal justice system. Not because you want to charge them with a crime, based on your experience that's their best route to help. -Officer*

- *I remember the lady, she'd gone many times to get help and [it] wasn't working. He was like, "Everything else has failed, let's put you in jail and hopefully-- – Officer*

As noted in this section, the policy push to decriminalize and re-route substance-use to alternatives like CSUs, must exist in conjunction with amplifying community resources. In our interviews with stakeholders, we found attitudes toward criminalizing substance-use to be present within law enforcement and mental health stakeholders. Several stakeholders within CSUs suggested individuals should be brought to jail rather than their facility as illustrated in the quote below. However, our team believes that these criminalization statements are related to the demand for services and staff burnout rather than intrinsic belief systems. We emphasize the need for resource allocation that responds to high-level and low-level substance-use in order to successfully re-route and minimize criminalization of substance-use disorders.

- *We get a lot of people that are on meth that get brought in from being high. . .They're here on [an involuntary hold], but yet the officers see they're high or on drugs or doing drugs but yet you bring them here instead of charges, other charges could be done. – CSU staff*

Concerns from Mental Health Professionals to Respond to Mental Health Crises

In our conversations with mental health stakeholders several concerns were raised in discussing response to mental health crises. These concerns ranged from procedures designed to increase safety, to hesitations or flat-out refusal to respond under certain circumstances. We bring attention to these concerns because they emphasize an important policy reality of crisis response, through the perspective of those engaging in this type of work, crisis response has to first and foremost ensure the people conducting the crisis response feel secure and safe to do their job.

Our mental health stakeholders shared several encounters where they felt unsafe with an individual in crisis. This unsafe feeling came from individuals in crisis becoming angry and/or physical with staff. Interestingly, our analysis revealed possible concerns for heighted volatility with clients when they find out they are being placed under an involuntary hold.

- *Also like with that, we've seen there's been instances where we [place under an involuntary psychiatric hold] and they get very triggered or they go into psychosis and they-- especially when I've had that experience where someone went to psychosis and that was actually attacked. – MRT staff member*

- *Some of them get combative. . .Yes, they get aggressive" – MRT staff member*

Our findings indicated that one of the concerns in crisis response is the unknown of the scene you are responding to. Often our crises response staff respond to people's homes where factors like the presence of weapons or animals were a reality. Although staff mentioned protocols to ask individuals about the presence of these or other cautious signaling factors, sometimes call takers may forget to ask, or the individual themself could omit this information.

- *It's your safety was one of the things that scared the life out of me. . . it's the safety part of it being out in the field is one of my concerns with this when you don't know. Even though they might have told you they put up all the weapons. . . any dogs, but if they don't say it and then sometimes the person taking a call might forget to ask. That's a safety concern sometimes – MRT staff member*

Mobile response team staff echoed safety concerns to respond to certain crises situations. Ultimately, if the mobile response team feels unsafe about a situation, they can call law enforcement to respond instead as noted in the below quote.

- *Anything where it jeopardizes our safety. Safety comes first because we are not law enforcement and we don't have the tools or the skills to be able to combat that. . .We're going to send law enforcement. We'll document that but we're not going, safety is always first for us. – MRT staff member*

Lastly, officers on co-response teams noted heightened priority concerns over safety of their mental health partner. Across our interviews, mental health professionals in the co-responder role reported higher levels of perceived job safety than mental health professional on response teams that responded without a law enforcement partner.

- *It just depends on what it is on the response. Some scenes, I don't let the counselor out until I have secured it and made sure it was safe and especially anything that involves weapons or those types of things. – Co-Response officer*

The above safety concerns expressed by mental health professionals, and often echoed by law enforcement stakeholders, suggest that certain situations or individuals perceived as risky may delay or pause crisis response. Ultimately, these delays may act as a barrier to consistent utilization of such alternatives.

Critical Need for Policy on Resource Allocation

A profound finding throughout our study, is the pattern of inadequate systems of support or absence of resources to respond to the community's needs which lead to a reliance on law enforcement response and demand on CSUs that exceeds their intended operation or abilities.

As a result, policy must ensure adequate systems of support prior to removing or replacing law enforcement responses. Without increasing systems of support and resources within communities, law enforcement

response to individuals with mental health and substance-use related disorders is not necessarily a bad thing. In fact, in many areas in our study where supports, both formal and informal, were absent or severely limited in communities, law enforcement response offered a familiar response to individuals who often had established rapport and relationships with their local officers.

- *As you discussed earlier, a lot of the times it's people that we have a familiarization with, so we try to, supervisors try to keep us in specific zones or specific areas so we kind of get to know our area and get to know the people inside of it, so 9 times out of 10, a name comes out or an address comes out, and we are already familiar with that person, so we kind of know what to expect when we're on the way there. - Officer*

Law enforcement frequently encounter persons, or individuals who caretake for persons, with mental or behavioral health conditions that want help. However, with an absence of facilities and resources available for behavioral and mental health conditions that are **not** in a state of crisis, law enforcement are predominately mitigating these calls themselves with only the training and skills they have.

- *There's not a lot of help for those people either, even though they don't meet the criteria for [an involuntary psychiatric hold] they have a mental health crisis because they're in dementia, they know something's going wrong, but there's no help for those folks, either. – Officer*

The Weight of CSU Detention on Policy Considerations.

A predominate concern that echoed through our interviews with law enforcement and mental health stakeholders, was the concern of involuntarily detaining someone at a CSU. Although CSUs offer a critical treatment service and can function as an alternative to being detained in jail, the act of an involuntary hold at a CSU was still perceived as a serious act of detainment for our stakeholders. For these reasons law enforcement stakeholders appeared to favor a voluntary transport to a CSU if possible, and mental health stakeholders at CSUs suggested a conservative approach to their admission to ensure crisis criteria, requiring intervention, was present.

- *. . .when you [involuntarily hold] somebody, you're detaining them. You're taking away their freedom. I always give people the option [to go]. - Officer*

As a result, policy should be careful in delineating CSUs as a blanket benefit to being detained in jail. Rather, we emphasize the need for policies to increase non-crisis level supports that do not require a full-blown involuntary detention, should be implemented.

- *health crisis because they're in dementia, they know something's going wrong, but there's no help for those folks, either. – Officer*

Impact on Insurance Policy

A poignant barrier to the implementing of the mobile-aftercare intervention or similar types of programs for stakeholders was due to financial barriers from insurance billing. Specifically, stakeholders noted the inability to bill for things like the time required for clinicians to drive to patient's homes and deliver a mobile session and the inability to bill for services attempted. As observed in our pilot study, several times clinicians had scheduled appointments with clients who then canceled at the last minute or did not show up for their session. However, there was still, sometimes significant, time spent by the clinician to go to the client's home or where the appointment was scheduled. These scenarios where services are attempted but unfilled are not currently billable in many insurance policies leaving CSUs or mental health agencies to compensate this expense. Continuing to pay for these types of expenses that go into client service is not feasible for many mental health agencies and limits the types of programs available for their communities. We urge Medicare, Medicaid, and other insurance policies to be further explored in their impact on successful systems of community care and appropriate policy adjustments made.

Recommendations

VI. Recommendations

Recommendations for Further Research

The promising results of our pilot study and critical conclusions from our qualitative interviews stress the consequential impact of a future large multi-site RCT. Our protocol for this vital recommendation for future research is outlined in the "Future RCT Protocol" document. In addition to the future RCT, analysis from our pilot study revealed several critical gaps in understanding that would add significant value to the field if explored in-depth. We have detailed three of these recommendations for further research below.

Recommendation A**:** Future research should explore if individuals that are placed under involuntary holds for substance-use are more likely to come back in contact with law enforcement and CSUs than individuals placed under involuntary holds for mental health reasons. Considering the resistance from CSU staff to admit individuals under involuntary holds for substance-use (described in Part 1 of this report), and the frequency to which law enforcement and CSU staff note the presence of substance-use in the individuals they serve, delineating the experience for primary substance-use versus mental health concerns, would be extremely valuable to the creation of policy related to CSU utilization.

- *I have had situations, where I've [placed under an involuntary hold] somebody and they're out within 10 hours of me [placing under an involuntary hold] and then I'm doing it all over again. It's just a constant battle and cycle. - Officer*

Recommendation B: Future research should examine how job satisfaction of employees and staff consistency at CSUs impact the denial or admission of someone into a CSUs. Our pilot study indicated staff shortages, low job satisfaction, and high turnover among our partnering CSUs and we have provided examples below. We highly recommend these circumstances be explored further and how they impact CSU clients and the overall environment of the CSU.

Staffing shortages and high turnover cannot keep up with the demand for the CSU:

- *It's a struggle. Staffing and our limit for census is extremely low to the amount of intake that we get. – MH Stakeholder*

Current environment at the CSUs often lead to long waiting times for clients:

- *God, sometimes our clients sit there for 24 hours before they can get transportation because we only have one transport and that's [company name redacted]. – MH stakeholder*

- *It can get really crowded and really hectic and people have really long wait times which makes everybody more agitated and increases safety risk both with like clients, with each other waiting in this room. Also with us because*

clients will get agitated about long wait times and then take it out on us. – MH Stakeholder

Although CSU staff reported liking the type of work they did, we had many staff report safety concerns, high stress, and low satisfaction with the environment of the CSU.

- *Interviewee 1: I love my job and we don't get paid enough to deal with the stuff we deal with.*
  Interviewee 2: Yes, . . .dealing with what we deal with, at least in the booth, I can say is very mentally and physically draining on us as well. – MH Stakeholders (group of 2)

Recommendation C: Future research should examine if increased communication and training between law enforcement and CSU staff increases the utilization of CSUs as a means of deflection from future criminal charges. Throughout our project, officers pointed to a lack of understanding to the decisions made at CSUs and a desire to increase communication. In particular, officers would like to know why individuals they bring to a CSU may be denied admission or released within hours. Future research should examine law enforcement agencies with various degrees of communication and integration with the local CSU to explore how mutual understanding and communication impacts officer utilization of CSUs.

- *It would be nice to know why the doctors rescind him. Like, "Hey. This isn't meeting your criteria? Even though he's actively on the floor, we're picking him up and putting him on the stretcher because he's taken 15 pills and tried to kill himself?" Why did he rescind that? It would have been nice to know. – Officer*

Simple and Policy Relevant Recommendations for Stakeholders that Could Have Large Impact

The findings from this pilot study uncovered several areas where collaboration between law enforcement and mental health stakeholders could be adjusted to improve efficiency, working relationships, and overall understanding of one another's procedures. We have synthesized these gaps into nine tangible strategies that may be implemented into both law enforcement and mental health agencies. Our research team has already begun disseminating the viable strategies below with our partnering agencies and will continue to do so.

1. Have law enforcement officers include their names and work phone numbers on CSU paperwork so they can be quickly and easily reached should there be questions or issues with the form(s).
2. Have law enforcement include the name and phone numbers of any witnesses or other persons involved on scene so that CSU staff can confirm statements with witnesses as part of their admission evaluation.
3. Implement a formal process to document information on voluntary CSU transports.
4. Implement semi-regular communication between local mental health agencies, CSUs, and law enforcement agencies to communicate updates to policies or programs.

5. Have CSUs implement procedures of review so that individuals that are identified as high-users or have been admitted to the CSU multiple times under involuntary psychiatric holds, are connected to additional systems of support and treatment.
6. Expand the Mobile Response Teams to respond to more than immediate crisis situations so they can act as a response option for mental health/substance-use related concerns that are not at crisis level.
7. Implement procedures to increase safety of CSU facilities and staff.
8. CSUs must implement strategies at an organizational level that can respond to difficulties evaluating individuals for CSU admission (such as refusing to participate or communicate) without prematurely releasing them.
9. Implement semi-regular refresher trainings to law enforcement agencies on the available resources and treatment options in the area. This helps law enforcement be able to:
    - Point civilians to appropriate options for their needs.
    - Have greater ability to explain the options and resources to individuals.
    - Understand which options are available or best to utilize during certain times of days to increase the likelihood of a warm handoff.

VII. Future Plans

Wellbeing & Equity Innovations is committed to continuing to investigate and determine best practices for law enforcement and CSU agencies that will enhance effectiveness of collaboration and minimize repeated contact with the same individuals. Please visit our website, wellbeingandequity.org, to keep informed on our up-and-coming projects related to this topic, and to find additional findings and material from this study.

Thank you,