Reviewing the Co-Responder Approach to Serving People with Mental Illnesses: The Boston Model

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Nature and Extent of Police Encounters with People with Mental Illnesses in the US and Boston

- Responding to people experiencing crises related to mental illness and/or substance abuse comprises approximately 10-20% of police calls for service (White et al., 2006).
- Boston Police Department serves a sizeable population of individuals with mental illnesses / substance abuse issues
- In 2017, BPD and Boston EMS received 5,953 EDP2 calls for service and 3,255 EDP3 calls for service
  - EDP2 calls: EMS and BPD both respond
  - EDP3 calls: EMS response only

Police-Based Specialized Police Responses: The Co-Responder Model

- A dearth of available research
  - Fewer than 20 studies of the model (Shapiro, 2015)
  - Much of the existing literature is outside of criminal justice (Lamanna, 2018)
- No “gold standard model”
  - Many different approaches to Co-Responder
    - Credential level of clinician: social worker v. nurse
    - Dedicated cars
    - Civilian Officers
- The immediacy and availability of mental health services is a critical component of these results

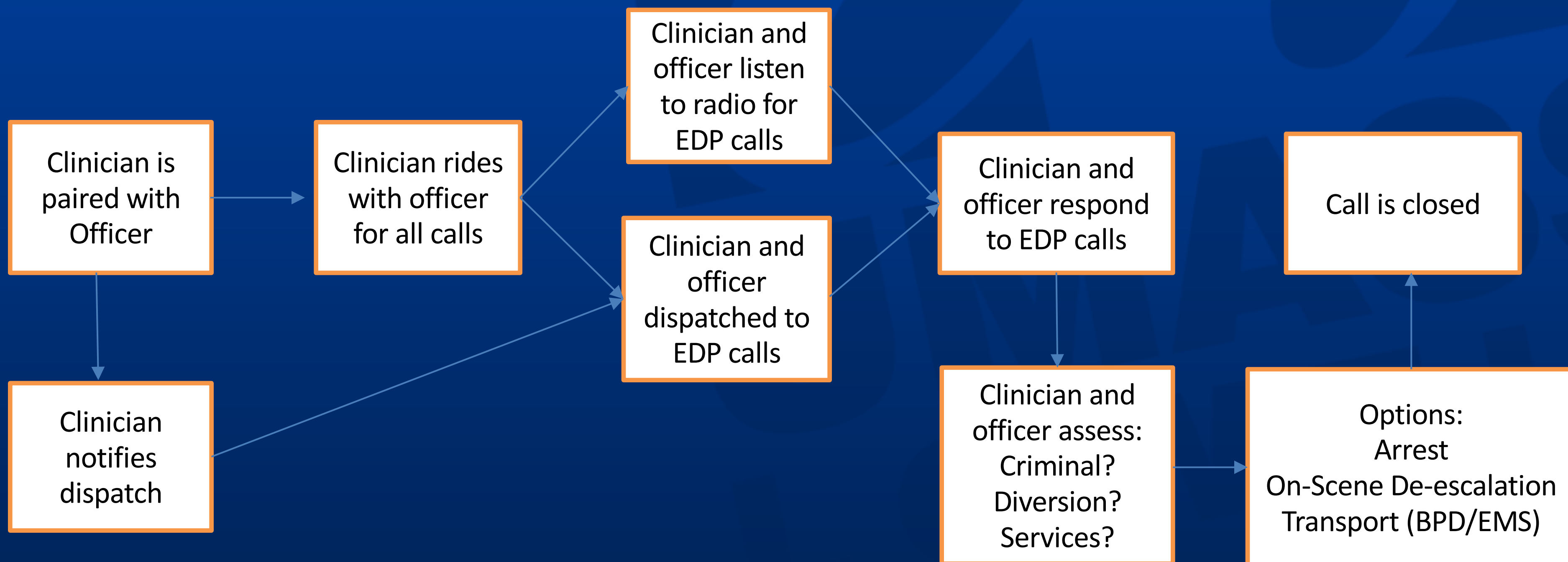
Co-Responder Outcomes

- Evidence suggests that Co-Responder Programs:
  - decrease injuries (Lamanna, 2018)
  - increase in escorts to hospitals and treatments
  - decrease involuntary commitment (Dryer et al. 2017)
  - and decrease the time officers spend at the hospital (Kane et al. 2017)
  - Increase in satisfaction among people with mental illnesses
  - Cost-effective response (Scott, 2000)

Traditional BPD Response

- The traditional police response to persons with mental illness in Boston led to 3 possible outcomes:
  - referring the person to EMS for transport to an emergency department, which is costly and doesn't necessarily help person get services they need;
  - requiring the person with mental illness to move along, with no attempt to address the person's underlying behavioral health issues; or
  - arresting the person with mental illness, thereby involving the individual in the criminal justice system.
- Since 2010, BPD has collaborated with the Boston Emergency Services Team (BEST) to enhance this response.

How does the BPD-BEST Program Work?



Outcomes to Date

- Per BEST's electronic medical record (EMR), police referred 25 individuals directly to BEST in 2010.
- By comparison, in 2017, BPD referred 509 individuals directly to BEST—an increase of 1,936%.
- In 2017:
  - 37 interventions where ambulance/ED services avoided
  - 42 people were seen in a holding cells while in police custody
  - Boston Police referred or sought consultation on 209 people through the BEST 800#, plus an additional 95 were referred by contacting BEST jail diversion clinicians directly

The Data

- N=1,127 incidents where a BEST clinician co-responded to an EDP-related call for service or holding cell evaluation that resulted in an entry into BEST clinician spreadsheet that resulted in an incident report being filed
- Incidents occurred between 2011-2015 and involved two different clinicians
- Clinicians were only assigned to two areas in the city, but could respond out of area
- For vast majority of this time period, these were not dedicated cars – i.e., clinicians responded to all calls for service with officers

What do we know about these calls?

Type of Call	% of total calls	N
Involved Criminal Charges	9.8%	102
Explicitly Involved Substance Abuse	10.3%	116
Related to Suicidal Ideation	15.4%	174
Involved a Family Dispute	13.7%	155
Related to a Child's Mental Health Crisis	16.5%	186

How do Co-Responder Team Calls End?

Outcome of Call	% of total calls	N
Arrest	.8%	9
Drop-off at Urgent Care Center	14%	158
Boston EMS transport to ED	28.7%	323
Police transport to ED	1.6%	18
Section 12	8.4%	95
Left at scene	36%	406
Holding cell evaluation	6.4%	72
Follow up and Referral	22.3%	251

Challenges in Collecting Data

- Difficulty of tracking calls for service that involve PWMI
  - Dispatch may not have record of MI
  - Disposition may be informal
- What is a call for service that involves a PWMI?
  - A definition must be created before data collection can occur
  - Currently, BPD tracks EDP calls
  - Must the call explicitly involve symptoms of mental illness?
- Rules are not formalized
- Tracking data (BPD vs. Boston EMS vs. BEST)
  - All three data sets include different numbers of incidents

Challenges Moving Forward

- Lack of Resources
  - Lack of systematic adoption due to resource issues means that it is difficult to fully measure the effects of the program
- Residents of Boston are in crisis and rely on police to address immediate problems like suicidal ideation
- Police are also being relied on for respite care
- No dedicated co-response car
- Dispatchers and BEST
- What about EMS?
  - EDP 3 calls don't trigger a clinician response

Next Steps

- Three clinicians currently working (3 full-time, 1 part-time)
- New part-time clinician starting this month, and still hiring more (through grants and operating budget funds)
- Researcher ride alongs
- Upcoming dedicated car time for study purposes
- Use data to track how calls are being handled and adjust response accordingly
  - Not a measure of success or failure
- Understanding the Impact of the Program on Boston
  - Benefit Cost Analysis
  - Use of Boston EMS services
  - Repeat visits by the police

Thank you for your time and interest.

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