Policy brief

August 2022

Creating a care response model in Cleveland for those in crisis

Background

National context

Across the country, communities are implementing new approaches to public safety that reduce reliance on police for emergency calls involving individuals experiencing mental and behavioral health crises. Often referred to as a health-first approach or care response, many policymakers and community members see these alternatives as the best way to assist people who most need compassion and support, rather than an armed response. Civilian crisis responders are often mental health workers, peers with lived experience similar to the people needing help, and other specially trained individuals.[1] Such initiatives have gained traction as high-profile killings of Black people by police, including George Floyd, Breonna Taylor and Andrew Brown Jr. and most recently Jayland Walker, have shone a spotlight on the actions of law enforcement.

A recent analysis by the Washington Post found that in 2021 police shot and killed 1,054 people across the United States, including 26 in Ohio; police have killed a similar number of people each year since 2015, and are on track to do the same in 2022. Black Americans, who account for less than 13% of the U.S. population, are killed at more than twice the rate of whites; Hispanic Americans are also killed by police at a disproportionate rate.[2] Research shows that at least one of every four police killings ends the life of a person with severe mental illness.[3]

Local context

In 2015, the history of the Cleveland Division of Police (CDP) using excessive force pushed the city into a consent decree, a legal agreement with the U.S. Department of Justice that requires the CDP to make changes to policies, practices and procedures to address its abuses and failures. The killing of two unarmed residents, Malissa Williams and Timothy Russell, in a hail of 137 bullets, sparked the federal investigation that led to the agreement, the signing of which came not long after the killing of 12-year-old Tamir Rice. Other high-profile killings by police include that of Tanisha Anderson, whose family called 911 for help as she experienced a mental health crisis, only to have her die at the hands of the officers who responded.[4]

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Although Cleveland does have initiatives designed to respond to people in need of help, including crisis hotlines and outreach to people with behavioral health needs, to those without stable housing, and to those living with substance use issues, nonprofit organizations run these initiatives and they are not integrated into local emergency call systems. For its part, the CDP has long relied on the Crisis Intervention Team (CIT) model to connect police to local service providers and community members and to train officers to better respond.[5] Although CDP's use of CIT predates the consent decree, the decree mandates increased CIT training, with stated goals by the police department to provide 40 hours of CIT training to about one-third of patrol officers.

Cleveland also has a limited co-responder pilot, which pairs mental health or social workers with officers on patrol. These do not put non-officers into first-responder roles, as officers must clear the scene before clinicians are allowed to engage. Shaker Heights operates a similar co-responder model. Both are relatively small pilots, with neither yet operating 24/7. Shaker's program is different in that its mental health co-responder works with both police and Emergency Medical Technicians (EMTs), while EMTs are not involved with the Cleveland program.

By February 1 each year, the mayor of Cleveland submits budget recommendations to Cleveland City Council, which must publicly share its version and write it into law by April 1. The city's 2022 General Fund totaled $704 million, of which 55% supported public safety, including police, fire, emergency services and animal control. The CDP, budgeted at $223.3 million or about a third of general taxpayer revenues, is the largest single service the city provides with General Fund monies.[6, 7]

What is care response?

Many Clevelanders are advocating for care response,[8] a health-first unarmed response to certain mental health crises that relies on mental health professionals and peers who understand how to meet the needs of the person experiencing the crisis. Perhaps the best-known program nationally is CAHOOTS, operating in the Eugene-Springfield Metropolitan area in Oregon since 1989. "Crisis Assistance Helping Out On The Streets" is dispatched through the Eugene police-fire-ambulance communications center and a Springfield non-emergency number and staffed by a local health clinic. Each team consists of a nurse or emergency medical technician and a crisis worker with experience in the mental health field. Designed as an unarmed alternative to police response to non-violent calls, CAHOOTS does not have the same authority as police, unable, for example, to arrest or detain.

Care response is a health-first unarmed response to certain mental health crises that relies on mental health professionals and peers who understand how to meet the needs of the person in crisis.

CAHOOTS, created by the Eugene Police Department and a local mental health crisis initiative, trains call-takers and dispatchers to determine which calls are appropriate for CAHOOTS and which require a response by armed patrol officers. In 2021, CAHOOTS staff were dispatched to and arrived at 16,218 calls for service, an increase from just under 10,000 calls in 2014, according to EPD. CAHOOTS diverted between 3% and 8% of calls to EPD for assistance in 2021, with backup from patrol officers required 301 times. The top categories CAHOOTS responded to were non-emergency public assistance calls, welfare checks, and transportation of individuals who were often unhoused or dealing with mental health issues.[9] The program, with an annual budget of about $2.1 million, estimates that it saved EPD an average of $8.5 million per year.[10] Larger cities adapting the CAHOOTS model to their local communities include Denver, Phoenix and Portland.

A recent study found that the STAR Program reduced reports of targeted, less serious crimes by 34%.

In Denver, the Support Team Assisted Response (STAR) Program, sends EMTs and behavioral health clinicians when calls to 911 and the police department's non-emergency line involve people "experiencing crises related to mental health issues, poverty, homelessness and substance abuse."[11] A recent Stanford University study found evidence that the program reduced reports of targeted, less serious crimes such as trespassing, public disorder and resisting arrest by 34% and had no detectable effect on more serious crimes. According to the researchers, this decrease stems from the fact that health-focused first responders are less likely to report individuals they serve as criminal offenders; the positive results also resulted in reduced crime during hours when the program was not in operation.[12]

Care response in Ohio

In July, Cincinnati started a new initiative that includes three components: certifying 911 staff in Mental Health First Aid and Crisis Intervention, partnering with a local crisis call center, and piloting an Alternative Response to Crisis (ARC) team that will be dispatched to low-risk mental health calls that might otherwise trigger a police response.[13] The ARC team includes a licensed behavioral health expert and a paramedic, both city employees trained in de-escalation, medical assessment and crisis intervention. Their charge is to respond to low-risk calls related to mental health, housing insecurity, substance use and other crisis situations. The team will be able to transport people, connect them to community resources and offer food, water, clothing and other basic needs.

Perhaps most significant is the integration of this non-police response into the city's emergency call center, so callers seeking help can request a response other than police, fire and parking enforcement, the city's current options. (Emergency medical

services are part of the fire department.) The ARC team is planned as a six-month pilot, with a primary goal of gathering data and measuring success to inform decisions about continuing the program.

Columbus also has a part-time alternative response program that, with the permission of callers, connects them to a "Right Response Unit" to determine the appropriate response based on callers' needs. Operating only from noon to 4 p.m. on weekdays, from June 2021 to January 2022 the program handled more than 450 calls. Local advocates want the program to expand.[14]

State policy development

Ohio Crisis Task Force

The Ohio Crisis Task Force, led by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) and Peg's Foundation, wants every Ohioan to have access to a visible crisis continuum of services and supports. These services should be person-centered, quality driven, trauma-informed, and focused on ensuring people are stabilized and thriving in the community. The task force, convened by OhioMHAS in collaboration with community partners, is engaged in crisis planning conversations with a diverse coalition to identify opportunities, develop new approaches, supply recommendations, and drive toward sustainable resources and policy solutions to enhance Ohio's crisis response system.

With the help of national experts and facilitators, HealthCare Perspectives and Zia Partners, the task force has six sub-committees: Community Crisis Coordination, Performance Metrics & Data, Financing the Continuum, Connect-988, Respond, and Stabilize & Thrive. Task force stakeholders include individuals representing state agencies, ADAMH Boards, providers, private foundations, first responders, the justice system, individuals with lived experience and their family members, hospitals and associations. A report culminating from this work, Ohio's Crisis Landscape Analysis and Recommendations Report, due this year, will help guide task force members in their work and future planning.

988 Suicide & Crisis Lifeline

On July 16 of this year, 988 became the new telephone and text/chat number for the National Suicide Prevention Lifeline (1-800-273-TALK). Ohioans who are experiencing suicidal thoughts, a mental health crisis, or an addiction crisis, as well as their family members, will be able to call, chat or text 988 to reach a trained call taker who can offer support and links to community services.

To encourage a successful transition for the launch of 988, OhioMHAS has led meetings with a vast stakeholder group since 2021. Stakeholders include ADAMH boards and providers, community partners, the state 911 Administrator, local law enforcement departments, the telecommunications industry and Public Utilities Commission of Ohio, and youth and adult advocates and family members. There are

five planning workgroups under the committee working to develop various aspects of the system. The workgroups are: 911/988/211 Interoperability, Mobile Response Support Services, Needs Assessment, Marketing, and Lifeline Providers.

Stakeholders have also engaged with legislators and policymakers regarding 988. House Bill 468, sponsored by Representative Gail Pavliga, establishes a 988 Administrator within OhioMHAS to oversee the administration of the 988 Suicide and Crisis Lifeline in Ohio and creates the 988 Fund in the State Treasury to receive all dedicated funds for the operations of the 988 line. The bill has passed the Ohio House and is awaiting its first hearing in the Ohio Senate.

In addition to 988, Ohioans will still be able to call the Ohio CareLine and their local community's crisis and/or support lines.

OhioRISE and MRSS

As part of its work to launch the next generation of Medicaid and to target the growing needs of our state's most vulnerable youth, the Ohio Department of Medicaid (ODM) has developed OhioRISE (Resilience through Integrated Systems and Excellence). Evidence has shown that kids with the most complex behavioral health and multi-system needs require better care coordination and service delivery than that of traditional Ohio Medicaid eligible children and youth. OhioRISE will meet the immediate behavioral health needs of children and youth served by multiple systems by offering new and improved services, including Intensive and Moderate Care Coordination, Improved Intensive Home-Based Treatment, Behavioral Health Respite, Primary Flex Funds, Mobile Response and Stabilization Services (MRSS), and In-state Psychiatric Residential Treatment Facilities. OhioRISE officially launched on July 1, 2022.

OhioRISE Advisory Council and Workgroup meetings began in early 2021. Development of major services and components of the program have been championed by four work groups: Child and Adolescent Needs and Strengths assessment and Care Coordination, MRSS, Intensive Home-Based Treatment, and Psychiatric Residential Treatment Facility. Stakeholders on the Advisory Council include state agencies, Aetna Better Health of Ohio, advocacy associations, youth and families with lived experience, service providers and local system partners.

Available through OhioRISE, MRSS is a service for young people experiencing significant behavioral or emotional distress in their families. The purpose of MRSS is to help youth and families build needed skills to ensure that future distress is less frequent and less intense. MRSS consists of a series of three stages: triage and screening, mobile response, and stabilization. A statewide network of community-based Care Management Entities (CMEs) was established in February 2022. ODM made transition grant funding available to the CMEs and MRSS providers to launch the new OhioRISE services and support provider and workforce development. MRSS will also be available to children who are not enrolled in OhioRISE.

Policy and funding considerations

Financial context

Ohio has the 12th highest incarceration rate in the United States, with over 18,000 people held in jails alone. Black Ohioans, who make up 13% of Ohio's population and 45% of the people in Ohio state prisons, are incarcerated at 5.6 times the rate of white Ohioans.[15] The number of people incarcerated in Ohio's jails and prisons has grown nearly three-fold since 1978.[16] People with serious mental illness and substance use disorder are much more likely to be arrested and booked multiple times, and less likely to have graduated from high school or have a steady income.[17] Additionally, 2020 surpassed 2017 as the worst year for unintentional drug overdose deaths in Ohio, with 5,017 deaths and an age-adjusted rate of 45.6 deaths per 100,000 population.[18] Over 60 percent of arrests in Ohio are tied to drug offenses, with 26 percent of those arrests leading to jail or prison.[19] This is consistent with national data that showed drug arrests stayed high even as imprisonment fell between 2009 and 2019.[20] Given the strong relationships between health needs, discrimination, and mortality, a care response model may provide significant benefit to Ohioans.

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According to a 2006 study, every dollar spent on Medication-Assisted Treatment or Substance Use Disorder treatment saves $4 in health care costs and $7 in criminal justice costs.[21] The cost of mental health treatment through community-based diversion is nearly 1/10th that of such care in a carceral setting.[22] As such, local, state and federal policymakers should be exploring, funding and expanding models that close gaps in service navigation and de-prioritize law-enforcement involvement at the point of public response. To do this, there are a few local opportunities that the City of Cleveland and Cuyahoga County should explore to advance this work.

Key considerations

1: ARPA and mobile crisis response
The American Rescue Plan Act (ARPA) has a community mobile crisis intervention services provision and Ohio has already pursued a model focused on adolescents through its MRSS program.[23] And while OMHAS continues to develop its Crisis Task Force work, which includes an adult mobile crisis component, Ohio could maximize the reach of this program by partnering with Ohio Medicaid.

ARPA includes $15 million in state planning grants to support their efforts to develop a state plan amendment or waiver request (e.g., Section 1115, 1915(b) or 1915(c)) to take up a mobile crisis intervention option between April 2022 and March 2027.[24] This option includes additional federal dollars from Medicaid and new federal regulations that allow Medicaid to pay for health-related services for individuals in crisis. Rather than relying on law enforcement alone, this approach uses nurses, social workers, psychiatrists and emergency medical professionals associated with a community mental health agency, hospital or a governmental agency such as a health department.

2: Opioid settlement support
While Medicaid may provide a pathway for reimbursable services that can offset direct costs for alternative response models, both Cuyahoga County and the City of Cleveland will be receiving money over the next 18 years from opioid settlement agreements. These agreements, resulting in the payment by pharmaceutical companies of $26 billion to governments across the country, resolve some of the recent legal claims against the companies for their actions that fueled the opioid addiction epidemic. And though Cuyahoga specifically settled its own funds outside of the statewide settlement process known as "OneOhio," obligating many of those dollars already through appropriation, policymakers in both levels of government should collaborate and re-examine those allocations and work with the OneOhio Foundation Board to leverage resources to finance a care response approach. Given the incredible expense of the proposed new jail in Cleveland, such a program may provide a significant benefit, decreasing the resources needed for a population the carceral system has kept from adequate treatment.

3: Existing Medicaid payment
The Cuyahoga County Diversion Center enables law enforcement and others to help individuals who are exhibiting signs and symptoms of a mental illness and/or addiction by providing individuals in crisis with the care and linkage to community resources they need in a treatment environment rather than going to the county jail. Law enforcement has used the center the most, although it can take referrals from family members, friends and others. Importantly, in addition to enhanced payments for specific models outlined earlier, transportation to the Diversion Center by Emergency Medical Services (EMS) is a covered type of non-emergency medical transportation. In Ohio Administrative Code section 5160-15-28, the appendix for

services allows for non-emergency medical transportation to a therapeutic site using a billing code modifier.[25] Any local government interested in utilizing the center can deploy EMS, without law enforcement involvement, to provide transportation for Medicaid recipients to the center and have that transportation reimbursed by Medicaid.

Financing recommendations

The best approach would take advantage of all three funding options. First, the ongoing mobile crisis response work of the state is an opportunity for collaboration between local government and OMHAS. The Diversion Center Board, in collaboration with the relevant officials from the City of Cleveland and the Alcohol, Drug Addiction and Mental Health Services Board, could review state policy tied to adult mobile crisis policy development and develop a proposal that meets local needs while also taking advantage of any grant or federal funding that may be available.

The best approach would take advantage of all three funding options:

1. **ARPA and mobile crisis response**
2. **Opioid settlement support**
3. **Existing Medicaid payment**

However, while a comprehensive approach is desirable, Cuyahoga County has not yet identified its representative with the OneOhio Foundation. This prevents local officials from maximizing those resources as a potential resource in a collaborative approach with the state. For example, settlement funds could be used as a "state match" for a demonstration waiver to implement a care response model through an intergovernmental transfer. This may be attractive to the state as it would not encumber any general revenue and it augments the intended purpose of the opioid settlement. Additionally, the same approach is true of any local ARPA resources, serving as a model to use those funds in ways that can be replicated across the state.

Additionally, there remains a significant, ongoing revenue opportunity for the City of Cleveland to more fully integrate its EMS into the continuum of care as a part of a care response model. There are no rules or policies currently inhibiting EMS from transporting people to the diversion center and, in fact, there is an incentive. As such, one component of a mobile crisis demonstration project could and should include identifying a role for EMS that would leverage alternative non-emergency transport and service deliveries through community paramedicine. For example, in North Carolina, Medicaid Managed Care entities partnered with teams of emergency medical technicians as a part of a crisis management system by being dispatched to behavioral health crisis calls to provide triage, behavioral health crisis assessment, on-site intervention and referral to continuum of crisis intervention services and supports. Depending on the triage and assessment, community paramedics would

treat and release or treat and transport to crisis receiving centers. This model could be enhanced through the mobile crisis demonstration being developed by the state. If allowable, it could also be enabled by the state plan without a waiver — though there would be less federal funding due to the lack of enhanced federal funds and, by nature of the state plan, federal law would require the program to be statewide.

Conclusion and recommendations

For too long, our local governments have relied primarily on law enforcement and the criminal legal system to address community behavioral health challenges. Rather than center the needs of individuals in crisis and connect them to supports built around recovery and stabilization, elected and institutional leaders have designed and perpetuated our system around a punitive model that sees crime, addiction and mental health as inextricably linked. But as we now well know, the outcomes of this system have deepened inequality, consumed too many of our limited resources, and caused unnecessary harm.

Regardless of funding mechanism or specific policy design, research and experience clearly show that more can be done on a local level to advance a care response model when local and state governments work together to transform public safety and our criminal legal system into a health justice system for those in need. To do so, today's elected and institutional leaders must:

- Immediately begin to scale up a mobile crisis response pilot based on the care response model.
- Provide funding through the Cuyahoga County ADAMHS Board or other sources, leveraging available federal matching funds as described in this report.
    - Convene partners at the local and state level to review potential state matching options.
    - Determine which path minimizes or eliminates expenses on the local and state levels.
    - Launch an effort with an eye toward permanence and sustainability.
- Accelerate statewide access to care response programs linked to the rollout of 988.
- Include funding for evaluation of and public reporting on the efficacy of CIT, Co-response and Care Response programs in place or being planned at the local level.
- Invest in expanding the peer and behavioral health workforce in Cuyahoga County.

The sense of crisis and increased awareness of problems in our criminal legal system, aligned with new funding opportunities, present our communities with a rare opportunity to truly transform how our public safety systems respond to our neighbors who need support. We know what can be done, now we must act.

Recommendations

- Immediately begin to scale up a mobile crisis response pilot based on the care response model.
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    - Convene partners at the local and state level to review potential state matching options.
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Endnotes

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