Research Brief

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Early Learnings from Louisville Metro's Crisis Call Diversion Program

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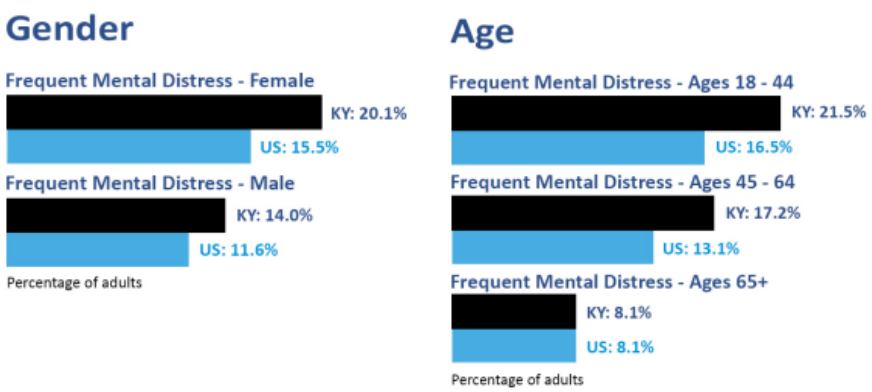
BACKGROUND

The prevalence of behavioral health conditions in the United States is high, with nearly one in five adults over the age of 18 living with a mental illness. In 2020, 17% of youth reported experiencing a major depressive episode, a condition that the World Health Organization has projected to be the leading cause of the burden of disease in the world by 2030.[1] Globally, the burden of mental disorders is on the rise and has been made worse by the COVID-19 pandemic. In 1990, mental disorders contributed to approximately 1,510 disability-adjusted life years (DALYs), compared to 1,620 DALYs in 2019.[2,3] Larger increases in depressive and anxiety disorders have been experienced by females and younger individuals.[4] Serious mental illness (SMI) constitutes about 6% of mental illness among adults over the age of 18 in the United States.[5,6,7] In Kentucky, approximately 746,000 adults live with a behavioral health condition, and 189,000 of those individuals report having a SMI.

- **Serious Mental Illness:** A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.
- **Major depressive episode:** Diagnosed when an individual has a persistently low or depressed mood, decreased interest in previously pleasurable activities, lack of energy, poor concentration, sleep disturbances, or suicidal thoughts.
- **DALY:** A measure of overall disease burden. One DALY is equal to the loss of one year of full health.
- **Frequent Mental Distress:** Defined as 14 or more self-reported mentally unhealthy days in the last 30 days.

Figure 1. Frequent Mental Distress by Gender and Age, 2020, KY and U.S.[8]



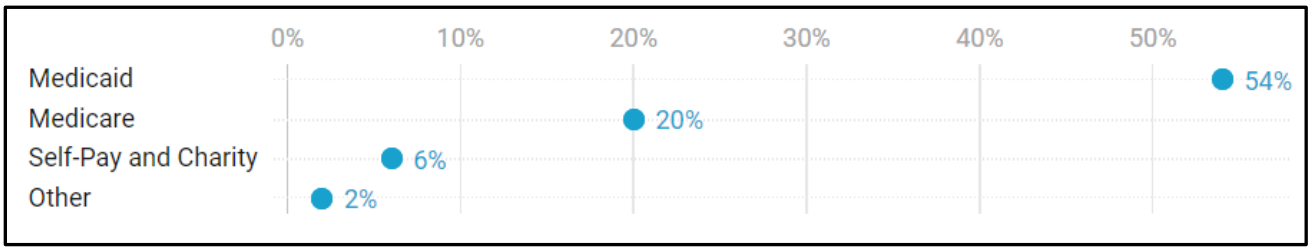
The Lack of Treatment Options for Mental Illness

While the burden of mental illness is high and the need for treatment is extensive, there are few options available and accessible, particularly for those experiencing a behavioral health crisis. Emergency departments (ED) across the country often serve as the primary point of care for those experiencing a behavioral health crisis. ED visits for psychiatric illnesses are expensive, costing an average of $2,264 per patient, and are often not effective in linking the patient with long-term treatment options.[9] There is an increasing trend of ED visits for mental and substance use disorders in Kentucky. In 2016, approximately 45% of ED patients

[1] We also want to recognize the research team who spent countless hours planning, collecting and analyzing data, and writing the final evaluation report for CCDP's pilot phase. In alphabetical order: Ashley Barnette, Craig Blakely, Amira Bryant, Sara Choate, Khalilah Collins, Liza Creel, Melissa Eggen, McKeeya Faulkner, Jacelyn Grimes, Seyed Karimi, Hannah Kay, Tanisha Howard Lewis, Brian Schaefer, Katherine Yewell, and Tony Zipple.

in Kentucky had a mental illness or substance use disorder. By 2020, the percentage had increased to nearly 60%, with Medicaid recipients representing the largest portion of these visits (54%).[10]

Figure 2. ED Visits for Mental and Substance Use Disorder by Payer, Kentucky, 2020[11]



Law Enforcement and Behavioral Health

Nationally, 10% of all law enforcement responses are related to a behavioral health crisis. Police officers across the country and in Louisville are not equipped, given their training and expertise, to effectively handle behavioral health crises.[12] It is well documented that individuals with a behavioral health condition are disproportionately impacted by the criminal legal system. Up to 28% of people living with a behavioral health condition have been arrested, compared to 7-10% of individuals without a diagnosis.[13] Individuals with disabilities, both psychiatric and otherwise, account for one-third to one-half of all people killed by law enforcement officers.[14] In Kentucky, about 25% of adults with an SMI have been arrested by the police at some point in their lives, resulting in over 2 million annual jail bookings of people with SMI.[15]

Alternative Responder Models

One strategy to address the growing need for behavioral health and build a more effective safety net for those with behavioral health conditions is the implementation of alternative responder models (ARMs). These models deflect responses from law enforcement to address needs more adequately and appropriately during a behavioral health crisis. A national poll indicates that 70% of likely voters support alternatives to law enforcement responses for 911 calls that involve behavioral health crises, and 68% like the idea of creating non-police emergency response programs.[16]

ARMs work in tandem with law enforcement to identify individuals who might benefit from crisis intervention and address the root causes of the situation rather than transporting the person to jail or a hospital. In many cases, the alternative responders are health care or behavioral health providers with training and expertise in stabilizing crises and connecting individuals to needed social services. The use of ARMs is emerging in communities across the United States, with models varying in structure, design, and funding support. Many of them require years of formative adaptation to fit into or fundamentally change existing structures and processes to accommodate the inherent innovation in the model. Cities such as Austin and Denver have implemented small-scale ARMs as pilot projects, then adapted and expanded them as capacity and interest increased.[17,18]

Louisville's Crisis Call Diversion Program

Using successful models from other cities across the country, Louisville developed and implemented a pilot project, the Crisis Call Diversion Program (CCDP), to test the effectiveness of an ARM in designated areas of the city. In March 2022, the CCDP was launched in Louisville Metro's Fourth Division. It has since been expanded to the First, Second, Third, Fifth, and Sixth Divisions with plans

for additional expansion in the future. The CCDP is led by MetroSafe, the Louisville Metro Government agency responsible for handling all public safety communications. Seven Counties Services (SCS), a local community mental health center and behavioral health provider, is contracted to provide mobile crisis response services to eligible callers. There are several components of the CCDP (Figure 3), each contributing to the overall goals of:

- Providing support to eligible callers experiencing a behavioral health crisis in the designated divisions of Louisville Metro;
- Deflecting non-emergent calls from Louisville Metro Police Department.

Figure 3. CCDP Components

Component of CCDP	What is it?	What does it do?
Crisis Triage Worker (CTW)	These individuals work in the call center alongside MetroSafe call takers to identify caller needs, divert calls, and de-escalate the situation, if necessary.	CTWs can: 1. Resolve caller needs or de-escalate over the phone, 2. Send the caller to the SCS Crisis Information Center for more assistance, 3. Dispatch the MCRT for an in-person response, or 4. Return the call back to MetroSafe call takers for police response when a call is found to be ineligible (in cases of violence, active suicide, or medical emergency).
Mobile Crisis Response Team (MCRT)	A two-person team that can provide in-person assistance to a caller in need. The team is mobile, using a van to respond and transport if needed.	The team uses trauma-informed approaches to assist the caller in need, provide de-escalation, and connect the caller to services if needed. The team can: 1. Make referrals to services, 2. Transport the person to the hospital (e.g., the University of Louisville Emergency Psychiatric Services), 3. Transport the person to respite and/or 4. Connect the person to friends or family members.
Respite Center	This stabilization space is located at SCS Addiction Recovery Center.	The Respite Center provides a space for stabilization, services, and referrals for up to 24 hours. A caller is not required to have a substance use disorder to utilize the respite space. Only individuals dropped off by the MCRT are eligible to use the respite space.

Early Findings from Louisville's CCDP

The University of Louisville's Commonwealth Institute of Kentucky was contracted to provide an evaluation of the CCDP's pilot launch as well as the second phase of implementation, which is currently underway. Findings from the evaluation thus far indicate enthusiasm about the CCDP as well as its effectiveness in deflecting behavioral health calls from law enforcement. Select findings from the pilot phase of the CCDP include:

1. In the first 49 days of the project, *119 individuals experiencing a behavioral health crisis received additional crisis support* and social support referrals through the CCDP.
2. The pilot was effective in deflecting behavioral health-related calls from law enforcement, *saving a total of 100 hours of Louisville Metro Police Department officer time* between March 21 and May 8, 2022.

3. There is limited awareness and understanding of the CCDP, both inside partner organizations and outside the community. *More education and awareness are needed to increase engagement in and use of the CCDP* and, ultimately, ensure support for more individuals experiencing behavioral health challenges.

Overall, findings from the pilot phase of the CCDP identified a community-wide need for the program from the perspectives of both law enforcement and behavioral health providers. There are opportunities for increasing awareness of the CCDP and its current and potential benefits to a variety of stakeholders, ranging from individuals affected by behavioral health conditions to local healthcare systems that provide care for those in crisis.

More details regarding the overall structure and operation of the CCDP, the research and evaluation plan, and early findings from the pilot project can be found in the full report.

Kentucky Legislative Action

In 2022, the White House proposed model legislation to encourage states to develop and use programs to "deflect" individuals with substance use and/or mental health disorder away from law enforcement and into recovery and treatment services.[19] The Kentucky General Assembly has proposed several pieces of legislation in alignment with the White House model legislation and, generally, to improve the system of behavioral healthcare in the Commonwealth. Some examples are below:

- **Senate Bill 90:** Signed into law in April 2022. Creates pilot programs in at least ten Kentucky counties to provide eligible individuals an alternative to receiving treatment for a behavioral health disorder rather than incarceration, resulting in the dismissal of criminal charges when the program is successfully completed.[20]
- **House Bill 373:** Filed in the 2022 Kentucky General Assembly but did not pass. This bill would have established a fund for Kentucky's mental health crisis and suicide hotline, also known as 988, by imposing a fee on cell phone users.[21]
- **House Bill 592:** Filed in the 2023 Kentucky General Assembly. HB 592 would establish the Kentucky Youth Mobile Crisis Response Program to create mobile crisis response teams, dispatched through the 988 hotlines, to provide behavioral health emergency response services for youth experiencing substance use, mental health, or suicidal crisis.[22]

Conclusion

The pilot phase of the Louisville Metro Crisis Call Diversion Program showed promise in more appropriately addressing behavioral health crises and in reducing police officer time spent on these crises, allowing them to spend more time on community safety. The University of Louisville's Commonwealth Institute of Kentucky continues to evaluate the longer-term time and cost-savings of the CCDP with plans to release an updated report in summer 2023.

CONTACT INFORMATION

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