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Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0

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A conceptual model for community-based strategic planning to address the criminalization of adults with mental and substance use disorders, the Sequential Intercept Model has provided jurisdictions with a framework that overcomes traditional boundaries between the agencies within the criminal justice and behavioral health systems. This article presents a new paradigm, Intercept 0, for expanding the utility of the Sequential Intercept Model at the front end of the criminal justice system. Intercept 0 encompasses the early intervention points for people with mental and substance use disorders before they are placed under arrest by law enforcement. The addition of Intercept 0 creates a conceptual space that enables stakeholders from the mental health, substance use, and criminal justice systems to consider the full spectrum of real-world interactions experienced by people with mental and substance use disorders with regard to their trajectories, or lack thereof, through the criminal justice system.

1 | INTRODUCTION

Adults with mental and substance use disorders are overrepresented in the criminal justice system. Four percent of adults aged 18 or older have experienced a serious mental illness compared with 14.5 percent of male inmates and 31.0 percent of female inmates in local jails (Center for Behavioral Health Statistics & Quality [CBHSQ], 2016; Steadman, Osher, Robbins, Case, & Samuels, 2009). Substance use disorders for young adults aged 18 to 25 and adults aged 26 or older were 15.3 percent and 6.9 percent, respectively, compared with 45.0 percent of jail inmates and 53.0 percent of state prison inmates (CBHSQ, 2016; Karberg & James, 2005; Mumola & Karberg, 2006).

In addition to being overrepresented in the criminal justice system, adults with mental and substance use disorders experience comparatively worse outcomes. Adults with mental and substance use disorders are less likely to make bail and more likely to be placed into segregation and to be victimized or exploited while incarcerated (Council of State Governments Justice Center, 2012; Metzner & Fellner, 2010; Wolff, Blitz, & Shi, 2007). Adults with mental and substance use disorders are more likely to experience homelessness in the year prior to jail incarceration (Greenberg & Rosenheck, 2008).

As residents of public institutions, jail and prison inmates have a constitutional right to adequate health care, including care for behavioral health conditions, a cost which must be borne by correctional institutions except in the instance of an overnight hospital stay (Center for Medicaid and State Operations, 1997; Centers for Medicare and Medicaid Services, 2016; Cohen & Dvoskin, 1996; Estelle v. Gamble, 1976; Ruiz v. Estelle, 1980). However, only 17.5 percent of local jail inmates who needed mental health care received hospital care, medications, or therapy, while 19.0 percent of local jail inmates with substance use disorders participated in treatment or other programs (James & Glaze, 2006; Karberg & James, 2005). Once released from custody, former inmates bear an additional mortality risk with drug overdose as the leading cause of death (Binswanger et al., 2007). Even among adults under probation or parole supervision, access to treatment is difficult. Among males aged 18 to 49 on probation, between 2002 and 2012 the need for substance use treatment services remained constant (48.0 percent in 2002 and 45.3 percent in 2012), but for most probationers it remained an unmet need (30.9 percent in 2002 and 29.2 percent in 2012) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

Over the past couple of decades there has been a renewed focus by federal, state, and county governments as well as researchers and policymakers to establish, test, and refine interventions to better address the involvement of people with mental and substance use disorders within the criminal justice system. For example, the first drug court opened its doors in Miami, Florida in 1989. As of 2016 there were over 3,000 drug courts operating in the United States and two volumes of best practice standards had been published by the National Association of Drug Court Professionals (National Drug Court Institute, 2016). The federal government has expanded support for such interventions, including the US Department of Justice's Justice and Mental Health Collaboration Program, which has over 12 years of authorizations since it was first enacted as part of the Mentally Ill Offender Treatment and Crime Reduction Act in 2004 (P.L. 108–414). In 2016 the 114th Congress of the United States of America passed the 21st Century Cures Act (P.L. 114–255), which affirmed the importance of interventions by law enforcement, courts, correctional institutions, community corrections, and behavioral health providers to improve public health and public safety outcomes for people with mental and substance use disorders in the criminal justice system.

A conceptual model for community-based strategic planning to address the criminalization of adults with mental and substance use disorders, the Sequential Intercept Model has provided many states, counties, and municipalities with a framework that overcomes traditional boundaries between the agencies within the criminal justice and behavioral health systems. The Sequential Intercept Model established five intercepts, or a series of intercept points, where communities can implement an intervention to "prevent individuals from entering or penetrating deeper into the criminal justice system" (Munetz & Griffin, 2006, p. 544). This article presents a new paradigm, Intercept 0, for expanding the utility of the Sequential Intercept Model at the front end of the criminal justice system.

2 | THE SEQUENTIAL INTERCEPT MODEL

The Sequential Intercept Model was developed over several years in the early 2000s by Mark Munetz and Patricia A. Griffin, along with Henry J. Steadman, as a conceptual model to inform community-based responses to the criminalization of people with mental disorders and co-occurring mental and substance use disorders. The Sequential Intercept Model is built upon the premise that the prevalence of mental disorders in the criminal justice system should be equivalent to the prevalence of mental disorders in the community and that the problem can only be addressed through a systematic response, as no one system (mental health, addiction, or criminal justice) bears sole responsibility (Griffin, Munetz, Bonfine, & Kemp, 2015; Munetz & Griffin, 2006). The first communities to test the model that would become the Sequential Intercept Model were Summit County, Ohio and five counties in southeastern Pennsylvania (Griffin, Munetz, Bonfine, & Kemp, 2015). Beginning in 2004, Steadman led a National Institute of Mental Health Small Business Innovation Research (SBIR) study that

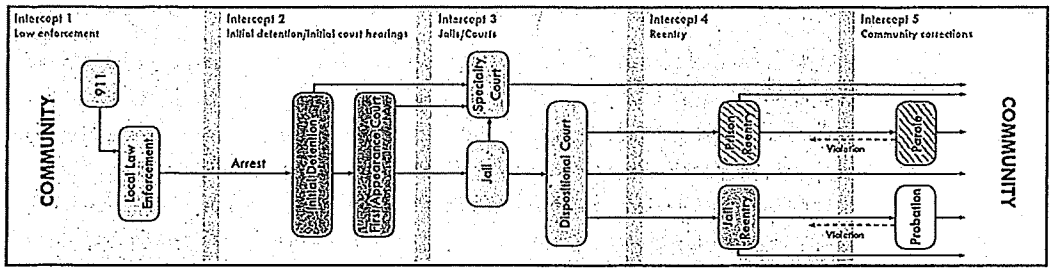

FIGURE 1 Linear depiction of the Sequential Intercept Model, with five intercepts [Color figure can be viewed at wileyonlinelibrary.com]

formalized a strategic planning approach to the Sequential Intercept Model known as "cross-system mapping" (Steadman, 2007).[1]

While the Sequential Intercept Model has been depicted as a series of filters (Munetz & Griffin, 2006), as a revolving door (Munetz & Griffin, 2006), and in a linear format (National GAINS Center, 2005; Steadman, 2007), the components of the model have remained uniform albeit with slightly different labels. Munetz and Griffin (2006) identified the five intercepts as Intercept 1, Law Enforcement and Emergency Services; Intercept 2, Initial Hearings and Initial Detention; Intercept 3, Jails and Courts; Intercept 4, Reentry from Jails, Prisons, and Hospitals; and Intercept 5, Community Corrections and Community Support Services. Figure 1 presents the linear depiction of the Sequential Intercept Model. The linear depiction has used comparatively truncated labels for the intercepts while addressing the same system components. Within the criminal justice system there are numerous intercept points—opportunities for linkage to services and for prevention of further penetration into the criminal justice system. This linear illustration of the model shows the paths an individual may take through the criminal justice system, where the five intercept points fall, and areas that communities can target for diversion, engagement, and reentry.

These five intercepts of the Sequential Intercept Model are intended to serve as a guide for communities to develop systematic responses to reduce criminalization of people with mental and substance use disorders (Munetz & Griffin, 2006; National GAINS Center, 2005).

2.1 | Intercept 1

The primary activity at Intercept 1 is law enforcement and emergency services responses to people with mental and substance use disorders. Intercept 1 ends when an individual with mental and substance use disorders is placed under arrest by a law enforcement officer. Opportunities at Intercept 1 include training of 911 dispatchers to identify a mental health crisis, specialized training for officers in identification of the signs and symptoms of mental disorders and crisis de-escalation skills, and collaboration of law enforcement agencies with mental health mobile crisis outreach teams.

2.2 | Intercept 2

Once an individual is arrested, they have moved to Intercept 2 of the model. The primary activity at Intercept 2 is that an individual is detained in advance of an initial hearing presided over by a judge or magistrate. Initial detention may take place at a police station in a holding cell, in a court lock-up, or at a local jail depending on the community. Opportunities at Intercept 2 include the administration of validated screening instruments for mental and substance use disorders, data-matching to identify whether newly arrested individuals are behavioral health service recipients, and pre-trial diversion for individuals who are charged with low-level offenses.

[1]See the work of Griffin, Heilbrun, Mulvey, DeMatteo, and Schubert (2015) for an analysis of the development and application of the Sequential Intercept Model.

2.3 | Intercept 3

During Intercept 3 people with mental and substance use disorders who have not yet been diverted at early intercepts may be held in pretrial detention at a local jail while awaiting the disposition of their criminal cases. The cases may be transferred to a post-plea problem-solving court (e.g., mental health court, drug court) as an alternative to continued prosecution of the criminal case. For people who are not diverted at Intercept 3, a guilty disposition may result in sentencing to a term of incarceration (Intercept 4) or to community supervision (Intercept 5). Opportunities at Intercept 3 include diversion through problem-solving courts, sometimes referred to as treatment courts or specialty courts, and providing jail-based behavioral health services with linkages to community behavioral health providers.

2.4 | Intercept 4

This intercept addresses the need for continuity of care when people transition from incarceration in jails or prisons back to the community. In addition, Munetz and Griffin (2006) argued that the transition from psychiatric hospitals of forensic cases was an element of Intercept 4. Opportunities at Intercept 4 include the implementation of transition planning by correctional staff or in-reach behavioral health providers and psychotropic medication and prescription access upon release (Osher, Steadman, & Barr, 2003; Vogel, Noether, & Steadman, 2007).

2.5 | Intercept 5

The majority of people under correctional supervision are on probation or parole (Kaeble & Glaze, 2016). Opportunities at Intercept 5 include the use of specialized probation or parole caseloads for people with mental disorders, medication-assisted treatment for substance use disorders, and access to housing, employment, and recovery supports (Fontaine, Gilchrist-Scott, Roman, Taxy, & Roman, 2012; Friedmann et al., 2012; Skeem, Emke-Francis, & Eno Louden, 2006). Intercept 5 is also a diversion intercept. Persons with mental illness have higher parole and probation violation rates than persons without mental illness and disproportionately re-enter jails on technical violations (Dauphinot, 1996; Porporino & Motiuk, 1995). Where probation departments use graduated sanctions and specialized caseloads, violations can be avoided or minimized by enhancing services and supervision strategies—in effect diverting jail admissions (Skeem & Eno Louden, 2006).

2.6 | Application of the Sequential Intercept Model

As a strategic planning tool, the Sequential Intercept Model has grown dramatically since its introduction. States have established centers of excellence to support community adoption of the Sequential Intercept Model in Pennsylvania, Florida, Virginia, Massachusetts, and Oregon. In the 21st Century Cures Act (Public Law 114–255, Title XIV, Subtitle B, Section 14021), the 114th Congress of the United States of America identified the Sequential Intercept Model, specifically the mapping workshop, as a means for promoting community-based strategies to reduce the justice system involvement of people with mental disorders. SAMHSA has supported community-based strategies to improve public health and public safety outcomes for justice-involved people with mental and substance use disorders through Sequential Intercept Model mapping workshop national solicitations and by providing workshops as technical assistance to its criminal justice and behavioral health grant programs. The Bureau of Justice Assistance has supported the Sequential Intercept Model mapping workshop by including it as a priority for the Justice and Mental Health Collaboration Program grants (US Department of Justice, 2015). In addition, the Sequential Intercept Model has been employed to promote housing strategies (Diana T. Myers & Associates, 2010), health care coverage (Joplin, 2014), and the diversion of veterans (Blue-Howells, Clark, van den Berk-Clark, & McGuire, 2013; Pinals, 2010).

As the Sequential Intercept Model has enabled communities to establish systemic responses that divert people with mental and substance use disorders from the criminal justice system and into community-based behavioral health services, innovation at the behavioral health/criminal justice interface has resulted in an emphasis on pre-arrest strategies. In 2006, Munetz and Griffin (p. 545) submitted that "an accessible mental health system" was the "ultimate intercept," and offered

an outline of that system, including competent clinicians, accessible care, use of evidence-based practices, and access to recovery supports (e.g., peer support, housing, employment services). These features are addressed in the Sequential Intercept Model mapping workshops as they relate to intercepting justice-involved individuals with co-occurring mental and substance use disorders (Griffin, Heilbrun, et al., 2015). In Intercept 1, law enforcement and emergency services partnerships address the dual roles of officers as responders to behavioral health crises and law enforcement, but merging civil and public safety roles of officers in Intercept 1 blurs fundamental differences in roles, strategies, and partnerships.

To better understand these dual roles, it is important to examine the nature of law enforcement and police powers. The power of police to act is derived from two constitutional principles: police powers and *parens patriae*. Police powers derive from the 10th Amendment of the Constitution of the United States of America, which provides for the right of states to make laws governing safety, health, welfare, and morals. The *parens patriae* doctrine vests the state with authority to protect citizens unable to protect themselves, often construed as a set of vulnerable populations, including dependent children, people with mental disorders, people lacking mental competency, and people with disabilities (Shah, 1975). Under the *parens patriae* doctrine, state mental health laws commonly require or permit law enforcement officers to transport people for emergency care as ordered by the local mental health authority, a judge, or their own observation when there is an issue of dangerousness to self or others or a grave disability. As a result of this authority, law enforcement officers have a responsibility to respond to calls involving people experiencing behavioral health crises (Cornwell, 1998; Teplin & Pruett, 1992). Intercept 1 involves the police powers of law enforcement and focuses on pre-booking diversion strategies and behavioral health partnerships and services that avoid and prevent entrance into the criminal justice system.

3 | INTRODUCTION TO INTERCEPT 0

Intercept 0 encompasses the early intervention points for people with mental and substance use disorders before they are placed under arrest by law enforcement. These early intervention points consist of the components of the behavioral health crisis care continuum (e.g., mobile crisis outreach teams, crisis respite services) and first responders, including emergency medical services, fire departments, and law enforcement. Crisis response models provide short-term assistance to people experiencing behavioral health crises and can prevent people from coming into contact with the criminal justice system. Law enforcement responses (e.g., crisis intervention teams, serial inebriate programs, and homeless outreach teams) and coalition-based initiatives, such as Law Enforcement Assisted Diversion, provide officers with treatment-based alternative responses to arrest for people experiencing behavioral health crises or who are chronically in contact with the criminal justice system for behavioral health reasons. The addition of Intercept 0 to the Sequential Intercept Model recognizes that law enforcement officers have dual roles as first responders and as protectors of public safety. Therefore the addition of Intercept 0 to the Sequential Intercept Model involved a modification of Intercept 1 so that law enforcement and 911 bridge Intercept 0 and Intercept 1. See Figure 2 for the full, revised linear depiction.

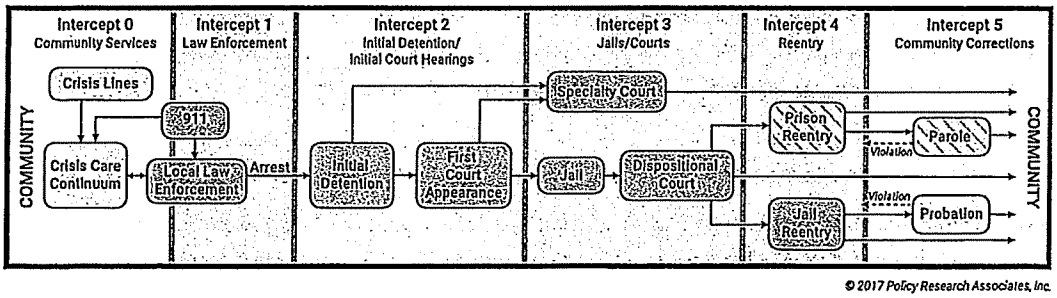

FIGURE 2 Linear depiction of the Sequential Intercept Model, with Intercept 0 [Color figure can be viewed at wileyonlinelibrary.com]

Intercept 0 involves the *parens patriae* power of law enforcement and focuses on varied police responses, behavioral health partnerships, and strategies to link individuals with unmet behavioral health needs or who are experiencing a crisis to appropriate services.

There is basis in law, policy, and practice to recognize one of the roles of law enforcement officers, as first responders, as a component of the crisis care continuum (Deane, Steadman, Borum, Veysey, & Morrissey, 1999; Steadman, Deane, Borum, & Morrissey, 2000; Teplin & Pruett, 1992). The addition of Intercept 0 more accurately reflects the collaboration and interdependency necessary for the crisis care continuum and law enforcement agencies in communities to address people with mental and substance use disorders who experience behavioral health crises or engage in chronic patterns of behavior that result in penetration into the criminal justice system if not for their efforts.

The addition of Intercept 0 to the Sequential Intercept Model is important to:

- highlight the need to include law enforcement in the planning and development of behavioral health crisis response strategies,
- allow for additional focus by communities on the *parens patriae* or "Guardian" (President's Task Force on 21st Century Policing, 2015) role of law enforcement and the specific funding streams, planning, programs, and partnerships needed to address prevention and crisis response strategies, and
- clarify research and evaluation approaches to law enforcement and behavioral health interventions and the importance of researching and evaluating law enforcement's role in engaging persons with unmet behavioral health needs in treatment.

In 2016, Steadman and Morrissette argued that "Rather than asking what police need to do when they encounter a person in distress in order to deescalate the situation and make appropriate referrals, the reframed question should focus on how police can be engaged as partners with behavioral health providers who are designing and implementing services in the crisis care continuum" (p. 1054). The absence from the Sequential Intercept Model of the delineation of the dual roles of law enforcement officers, the emerging specialized police response strategies and partnerships, and the need for upstream responses apart from law enforcement is corrected through addition of the concept of Intercept 0 (Steadman & Morrissette, 2016; Wood & Beierschmitt, 2014). Below we will expand on Intercept 0 program models and activities.

4 | INTERCEPT 0 COMPONENTS

As depicted in Figure 2, Intercept 0 has four primary components: crisis phone lines, crisis care continuum, 911 call centers and law enforcement dispatchers, and law enforcement specialized responses. Two of the components, crisis phone lines and the crisis care continuum, solely reside in Intercept 0. While crisis phone lines are a component of the crisis care continuum, we place emphasis on them in Intercept 0 as a gateway to the rest of the crisis care continuum, a referral source for non-crisis behavioral health services, and an opportunity for collaboration with 911 call centers and law enforcement dispatchers. The remaining components—911 call centers and law enforcement dispatchers and law enforcement specialized responses—are part of Intercept 0 and Intercept 1.

4.1 | Crisis phone lines

Crisis phone lines consist of 24/7 crisis hotlines and warm lines. Crisis hotlines are a service provided via telephone for people experiencing distress. Hotline services provide support to people in distress, such as assistance in developing a plan for coping with the situation, and may facilitate access to community-based services, such as referrals to medical or behavioral health providers or mobile crisis outreach teams if on-site assistance is demanded by the situation (SAMHSA, 2014). Hotline services are effective in reducing psychological distress in suicidal callers and non-suicidal

callers (Gould, Kalafat, Munfakh, & Kleinman, 2007; Kalafat, Gould, Munfakh, & Kleinman, 2007). Warm line services are operated by mental health consumers (i.e., peers) to provide telephone-based peer support. Warm lines do not provide the emergency services available from a 24/7 hotline and have limited operating hours, but are effective in reducing use of other crisis services (Dalgin, Maline, & Driscoll, 2011; SAMHSA, 2014). Crisis lines may be part of a centrally managed set of crisis services in communities, serving as a front door to behavioral health care and an alternative to hospital emergency department services (Guo, Biegel, Johnsen, & Dyches, 2001; Technical Assistance Collaborative, 2005).

4.2 | Crisis care continuum

The crisis care continuum is an umbrella term for a set of services provided to people experiencing mental health crises. Services in the crisis care continuum have a brief duration, ranging from minutes for a crisis line call to a couple of days for crisis residential services (SAMHSA, 2009, 2014; Steadman & Morrissette, 2016). Common components of the crisis care continuum consist of 23-hour crisis stabilization/observation beds, short-term crisis residential stabilization services, mobile crisis services, peer crisis services, and the 24/7 hotlines and warm lines discussed above (SAMHSA, 2014). Crisis care services provide an alternative to hospital emergency departments, which are not equipped to handle psychiatric emergencies and often have to board people in need of inpatient care (American College of Emergency Physicians, 2008, 2014; Clarke, Dusome, & Hughes, 2007).

Crisis care services have the opportunity to prevent people experiencing a crisis from entering the criminal justice system by providing assessment, short-term treatment, and engagement with an appropriate level of care to address behavioral health needs and recovery supports (National Association of Counties, 2010). The states of Texas, Virginia, Wisconsin, Minnesota, California, and Colorado, among others, have sought to develop a crisis care continuum that is responsive to the needs of people experiencing behavioral health crises (California Senate, 2013; Colorado Senate, 2013; Minnesota State Legislature, 2014; Texas Department of State Health Services, 2008; Strode, 2009; Wisconsin State Legislature, 2013). Although most states have some components of a crisis care continuum, few places have all of the components as a result of the complexity of financing crisis services, which poses a problem for law enforcement officers in identifying an alternative to the hospital emergency department (Compton et al., 2010; SAMHSA, 2014).

For the crisis care continuum, the primary interfaces outside of behavioral health providers are with hospital emergency departments and law enforcement (Technical Assistance Collaborative, 2005). A Washington State study of crisis encounters found that 50 percent had been booked into jail and/or received crisis services in the past 3 years (Burley, 2016), and further overlap between the crisis care continuum, criminal justice system, and hospital populations has been identified in a study in Camden, New Jersey (Camden Coalition of Healthcare Providers, 2016). For law enforcement and the crisis care continuum to collaborate at Intercept 0, specialized protocols are necessary. These protocols include a centralized drop-off site where officers can transport people experiencing a behavioral health crisis as an alternative to the hospital emergency department that can provide security, evaluate for involuntary commitment, offer no-refusal policies for officers, and be engaged with other services and supports (Dupont, Cochran, & Pillsbury, 2007; Steadman et al., 2001; Strauss et al., 2005). Collaboration with law enforcement through complementary on-site responses to crisis situations by mobile crisis outreach teams or co-responder models assists officers in deescalating crises and connecting people experiencing behavioral health crises with necessary services (Shapiro et al., 2015; Steadman & Morrissette, 2016; Wood, Watson, & Fulambarker, 2017).

4.3 | 911 call centers and law enforcement dispatchers

As with crisis phone lines, 911 call centers and law enforcement dispatch are a mechanism for initiating responses to people experiencing behavioral health crises (Watson & Fulambarker, 2012). Depending on the nature of the call and

available resources, crisis lines may send a mobile crisis outreach team to the scene or request law enforcement support through a 911 call center. In communities that lack mobile crisis teams, a crisis line may request that law enforcement officers respond to a crisis situation. Although 911 call centers and law enforcement dispatchers play a critical role in identifying crisis calls, providing requisite information for officers, and identifying appropriate officers (e.g., Crisis Intervention Team officers) to respond to a situation, this component of Intercept 0 often poses challenges to communities (Compton et al., 2010). Screening for mental health issues, training on responding to callers with mental health issues or eliciting information regarding mental health indicators, and tracking of mental health calls vary widely across jurisdictions. Most centers do have a code for a mental health call and there may be a manualized protocol to follow when responding to such a call. However, call data may not be analyzed and used to improve responses to crisis callers. Other call centers may provide a condensed version of Crisis Intervention Team training or include 911 operators in officer trainings (Compton et al., 2010).

4.4 | Law enforcement specialized responses

In the Final Report of the President's Task Force on 21st Century Policing, the task force recommended that officers should have access to Crisis Intervention Team training as recruits and through in-service opportunities (Recommendation 5.6). In addition, the task force recommended that "Law enforcement agencies should engage in multidisciplinary, community team approaches for planning, implementing, and responding to crisis situations with complex causal factors," (Recommendation 4.3) (President's Task Force on 21st Century Policing, 2015, p. 44). However, recent studies have determined that people with mental disorders are more likely to experience police contacts (Crocker, Hartford, & Heslop, 2009) and to be charged as a result of an "indirect procedural bias" (Schulenberg, 2016). Given the dual roles of law enforcement officers (Steadman & Morrissette, 2016), it is important for law enforcement officers to have access to specialized responses and to the other components of Intercept 0 as an alternative to hospital emergency departments and to arrest.

Specialized law enforcement responses to people with mental disorders have been documented since 1999, when Deane and colleagues identified three general approaches through a survey of law enforcement agencies: (i) a law enforcement-based specialized response where officers receive special training and act as liaisons to the mental health system; (ii) a law enforcement-based specialized response where civilian mental health professionals hired by law enforcement co-respond or provide remote consultation to officers; and (iii) a mental health-based specialized response where mobile crisis outreach teams co-respond with law enforcement officers. Of these general approaches, the law enforcement-based specialized response is the most widely implemented through the Crisis Intervention Team model. Developed in 1988 in Memphis, Tennessee, the Crisis Intervention Team Model has been implemented in 1,000 law enforcement agencies across the country (Watson & Fulambarker, 2012). The Crisis Intervention Team model has been shown to reduce injuries to civilians and instances of use of force by officers and increase transport to crisis and emergency services (Bibeau & Skeem, 2008; Compton et al. 2014a, 2014b; Morabito et al., 2012; Teller, Munetz, Gil, & Ritter, 2006). In addition to the growth of the Crisis Intervention Team model, specialized police–mental health co-response programs continue to grow (Shapiro et al., 2015). In a literature review of specialized law enforcement–mental health co-responses, Shapiro et al. (2015) found evidence for averted crisis escalation and injuries, improved collaboration across systems, and reduced hospital admissions.

Not depicted in Figure 2, but critical to partnerships at Intercept 0, are first responders from fire departments and emergency medical services. These services, including private ambulance companies, provide transport from the scene to the hospital emergency department, crisis stabilization center, or alternative service depending on how such services are organized from community to community, yet many communities do not include emergency medical services in mental health training initiatives or crisis response planning (US Department of Homeland Security, 2015).

5 | SUBSTANCE USE DISORDERS AND INTERCEPT 0

Although substance use disorders are not depicted in the illustration of Intercept 0 (Figure 2), responding to substance use is a major focus for behavioral health providers, hospitals, and law enforcement officers. The increase in opioid-related deaths has placed a particular emphasis on the role of substance use treatment within Intercept 0, given that in the 15-year period from 1999 to 2014 drug-poisoning deaths per 100,000 increased from 6.1 to 14.7 for deaths due to opioid analgesics and from 0.7 to 3.4 for deaths due to heroin (National Center for Health Statistics, 2015). Law enforcement, other first responders, the crisis care continuum, and hospitals have been hard pressed to reduce opioid use (e.g., heroin, fentanyl, illicit use of prescription opioids) and a rise in opioid-related overdose deaths (Davis, Ruiz, Glynn, Picariello, & Walley, 2014; National League of Cities & National Association of Counties, 2016).

As with the crisis care continuum, many communities lack components of the substance use continuum of care (Mee-Lee, 2013) or lack capacity to meet demand (George Washington University School of Medicine & Health Sciences, 2013). Response to substance use calls has parallels to crisis response, including the need for alternatives to the hospital emergency department, access to levels of withdrawal management, specialized training for law enforcement and first responders (e.g., naloxone administration), and specialized response initiatives (Banta-Green, Beletsky, Schoeppe, Coffin, & Kuszler, 2013; Davis, Carr, Southwell, & Beletsky, 2015; DeBeck et al., 2008). While the Sequential Intercept Model has had a conceptual focus on co-occurring mental and substance use disorders since its development (Munetz & Griffin, 2006; National GAINS Center, 2005; Steadman, 2007), it is important for Intercept 0 and the full model to consider the continuum of levels of care and opportunities for service engagement for substance use disorders.

6 | IMPLEMENTATION OF INTERCEPT 0 CONCEPTS

Clearly law enforcement has a significant and growing role in responding to mental health crises, and specialized police response programs have grown in both number and variety since the development of the Crisis Intervention Team model in 1988. However, the wide adoption of the Crisis Intervention Team model should not overshadow the contribution of other innovative models to address people with mental and substance use disorders in crisis or in repeated contact with law enforcement, the crisis care continuum, and hospital emergency departments. The implementation of Intercept 0 concepts is highlighted below in the descriptions of four interventions: Law Enforcement Assisted Diversion (LEAD) (King County, Washington), Serial Inebriate Program (San Diego, California), Mental Health Investigative Support Team (Pima County, Arizona), and Project Early Diversion, Get Engaged (EDGE) (Boulder County, Colorado).

6.1 | Law Enforcement Assisted Diversion

A model developed in King County, Washington in 2011, LEAD is a diversion program for people engaged in criminal behavior due to behavioral health conditions. LEAD does not focus on behavioral health crisis response; rather, it targets people with mental and substance use disorders who commit certain offenses, such as low-level drug and prostitution charges, within a defined geographic area. Participants receive case management and access to behavioral health treatment and support services, such as housing, health care, and job training. Studies of LEAD have identified a 60 percent comparative reduction in arrests and reduced criminal justice system costs (Beckett, 2014; Collins, Lonczak, & Clifasefi, 2015a, 2015b).

6.2 | Serial Inebriate Program

The San Diego Police Department's Serial Inebriate Program, operated since 2000, targets people experiencing homelessness who are repeatedly in contact with law enforcement, hospital emergency departments, and a local

sobering center as a result of public intoxication. Dunford et al. (2006) measured a 50 percent reduction in utilization of emergency medical services, hospital emergency department services, and inpatient services for people who engaged in the program.

6.3 | Mental Health Investigative Support Team

The Mental Health Investigative Support Team is a collaboration between the Pima County Sheriff's Office and the Tucson Police Department in Pima County, Arizona, to connect people with behavioral health services before people with mental and substance use disorders who engage in public nuisance behavior experience a crisis situation. The team facilitates sharing of information with behavioral health providers and collaborates with the local Crisis Response Center and mobile crisis teams. In addition, the team is responsible for serving civil commitment transport orders in a person-centered approach, avoiding call-outs of special weapons and tactics (SWAT) officers (Balfour, Winsky, & Isely, 2017).

6.4 | Project Early Diversion, Get Engaged

A collaboration among the Boulder County (Colorado) Sheriff's Office, Longmont Police Department, Boulder Police Department, and Mental Health Partners, Project EDGE provides on-scene crisis de-escalation and mental health intervention. EDGE clinicians stationed at law enforcement agencies provide a mobile response to crisis encounters with law enforcement. EDGE clinicians are dispatched to encounters through law enforcement dispatchers and assess for an emergency psychiatric hold or provide a warm hand-off to mental and substance use services. Peer support specialists provide follow-up to people with behavioral health conditions after the crisis encounter to support engagement in behavioral health services or recovery supports (Colorado Legislative Council, 2015).

7 | DISCUSSION

Intercept 0 opens up opportunities to explore system integration issues from a public health perspective and formally address the "the ultimate intercept" issues discussed by Munetz and Griffin (2006). After all, the Sequential Intercept Model addresses health care access for justice-involved people with mental and substance use disorders as well as diversion mechanisms. Oftentimes challenges that arise when communities use the Sequential Intercept Model as a strategic planning tool relate to health system barriers regarding continuity of care from the community to the jail or obtaining timely access to care as people leave the justice system at the various intercepts. If healthcare needs of the justice-involved population are addressed during planning and funding discussions of a community's health care systems, many of the barriers can be proactively addressed. However, planning and budgeting for the behavioral health system and criminal justice system is often fragmented, siloed, and not collaborative.

The healthcare landscape is changing rapidly and there has never been a more opportune time for community health systems and the criminal justice system to collaborate for improved healthcare and public safety outcomes. Health homes, Medicaid expansion, Medicaid waivers, and health information exchanges present exciting opportunities for implementing systems of care that are seamless and responsive to the needs of justice-involved individuals with mental and substance use disorders (Community Oriented Correctional Health Services, 2012; DiPietro & Klingenmaier, 2013; National Association of Medicaid Directors, 2014).

In the 21st Century Cures Act (Public Law 114–255, Title XIV, Subtitle B, Section 14021), the 114th Congress of the United States of America provides for expansion and creation of programs for justice-involved people with mental and substance use disorders through authorizations to programs of the US Department of Justice and the US Department of Health and Human Services. Some of the funding for the Cures Act (e.g.,

Opioid Treatment funds) is currently available. Other funding will be available in 2018. While some of the initiatives and programs may not be fully funded, there is sufficient funding for states and communities to take notice and to develop the partnerships necessary to take full advantage of the opportunities. If funded, these authorizations will support innovation through state block grants as well as competitive grant programs. Successful utilization of these funds and program implementation will require criminal justice and behavioral health partnerships.

As depicted in Figure 3, the 21st Century Cures Act authorizations specific to Intercept 0 include expanding services to people experiencing homelessness, enhancing crisis response systems, health home expansion, fire and emergency response mental health training, and training to improve law enforcement responses to people with mental and substance use disorders. Intercept 0 opportunities specific to US Department of Justice grants include Fire and Emergency Response Mental Health Training, Law Enforcement Academy Training, and specialized training of law enforcement to recognize signs of mental disorders, respond appropriately, and engage in community partnerships to improve community responses to mental disorders.

The Intercept 0 concept arrives at an opportune moment, where the federal government and policymakers, through the 21st Century Cures Act (Pub. L. 114–255, Title XIV, Subtitle B, Section 14021), have recognized the need for early and integrated services for people with mental and substance use disorders whose trajectories may lead them into contact with the criminal justice system. Intercept 0 provides a conceptual bridge, which enables communities to identify the connections between their law enforcement and the crisis care continuum.

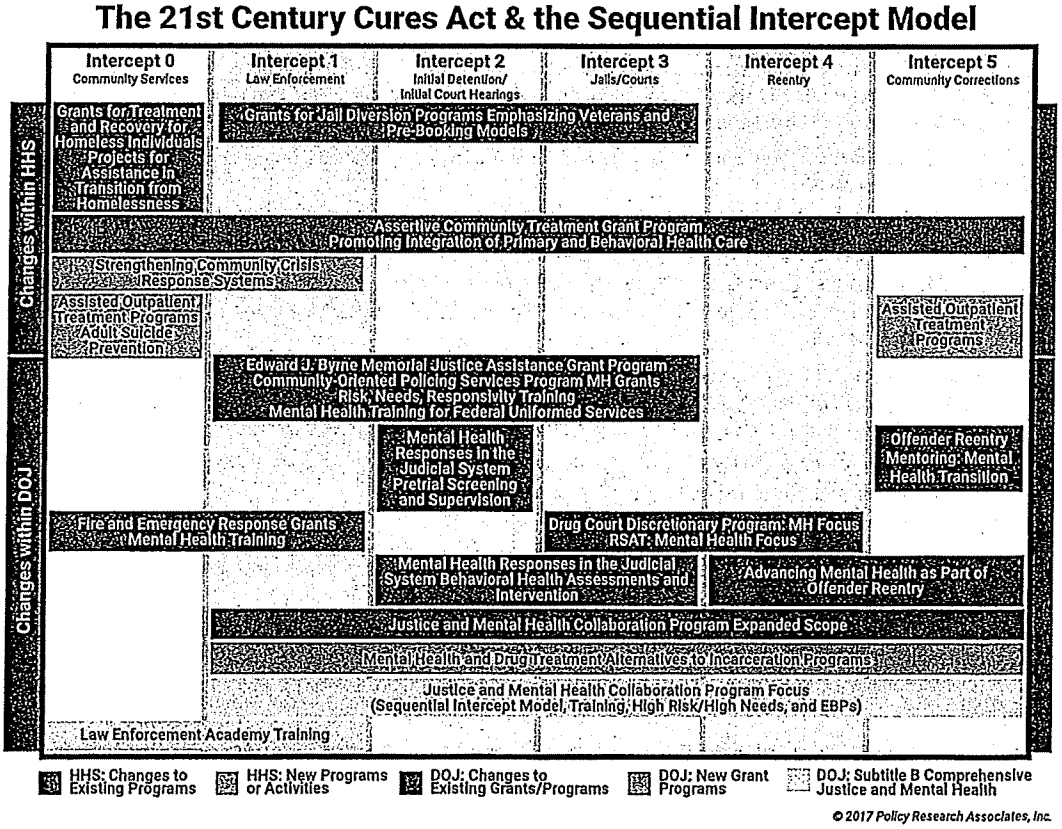

FIGURE 3 The 21st Century Cures Act and the Sequential Intercept Model [Color figure can be viewed at wileyonlinelibrary.com]

8 | CONCLUSION

Intercept 0 encompasses the early intervention points for people with mental and substance use disorders. These early intervention points consist of the components of the behavioral health crisis care continuum (e.g., mobile crisis outreach teams, crisis respite services) and first responders, including emergency medical services, fire departments, and law enforcement. The Intercept 0 concept widens the scope of systems and services represented within the Sequential Intercept Model. By reflecting these developments at the front end of the criminal justice system and in the behavioral health system, the Sequential Intercept Model with Intercept 0 provides stakeholders with a framework for the implementation of robust linkages between law enforcement and behavioral health agencies.

As with the other intercepts, responding to the needs of people with mental and substance use disorders is challenging work, which requires specialized responses, collaboration, and coordination across multiple stakeholders and a variety of funding strategies. While strategies to address the responses to behavioral health crisis overlap with strategies to address pre-booking diversion, Intercept 0 more accurately reflects the real-world interactions between crisis services and law enforcement. Intercept 0 provides the Sequential Intercept Model with an expanded conceptual framework to explore these interactions.

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