EVALUATION OF THE INDIANAPOLIS MOBILE CRISIS ASSISTANCE TEAM
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EXECUTIVE SUMMARY

In May 2016, Indianapolis Mayor Joe Hogsett formed the Criminal Justice Reform Task Force to address, among other issues, the significant number of individuals entering the criminal justice system with mental health or substance abuse issues. This resulted in the establishment of a Mobile Crisis Assistance Team (MCAT) pilot program that integrated police, paramedics and mental health professionals into teams to respond to emergency calls involving people with behavioral health and/or substance use issues. The pilot program aimed to divert those people to mental health and social services instead of the criminal justice system, and to relieve other first-responders from the scene of these time-consuming and complicated emergency situations. The MCAT pilot began in the Indianapolis Metropolitan Police Department (IMPD) East District.

The Center for Criminal Justice Research at the Indiana University Public Policy Institute evaluated the pilot program using data from MCAT run reports between August 1 and December 9, 2017. Additionally, East District IMPD officers were surveyed, key stakeholders and program designers were interviewed, focus groups were held with the MCAT team members, and field observations were completed.

KEY FINDINGS

• MCAT transported a person to jail in less than 2% of all responses during the pilot

• MCAT units were able to relieve one or more other first response units from the scene of an emergency in two-thirds of all runs during the study period

• The majority of MCAT encounters were completed in under 90 minutes - In encounters that took longer than 90 minutes, MCAT had relieved other first response units 80% of the time

• MCAT units encountered a small subset of “frequent flyers”—individuals receiving multiple MCAT responses during the study period—who were more likely to be gravely disabled and/or have mental health issues than those who had only received one MCAT response

• Eighty-five percent of IMPD East District police officers surveyed indicated the MCAT unit was very useful or extremely useful to them as an additional resource in responding to emergencies

• One-third of IMPD East District police officers surveyed indicated being interested in serving as an MCAT officer in the future

• A lack of outpatient treatment options and clear policies and procedures appeared as the most salient barriers to implementation of the MCAT pilot program

• Access to and triangulation of collaborating agency information on persons experiencing emergencies; support from city officials; and team building exercises during MCAT training emerged as the most salient facilitators to implementation of the MCAT pilot program.
BACKGROUND

According to the Marion County Sheriff’s Office, approximately 40% of detainees in Marion County’s jails at any one time suffer from mental illness, resulting in $8 million of medical care and services annually (McQuaid, 2015). In addition, roughly 85% of detainees with a mental illness are also diagnosed as suffering from substance abuse issues (McQuaid, 2017). The past five years have shown an alarming increase in police and emergency medical service runs involving individuals suffering from mental illness and drug addiction. Although law enforcement experts estimate that as many as 7% to 10% of patrol officer encounters involve persons with mental illness, historically police officers report feeling ill equipped to respond (Deane, Steadman, Borum, Veysey, & Morrissey, 1999).

In May 2016, Indianapolis Mayor Joe Hogsett formed the Criminal Justice Reform Task Force. In December of that year, the Task Force issued a comprehensive plan for criminal justice reform that included, among other initiatives, diverting persons suffering from mental illness and addiction away from the criminal justice system and into evidence-based treatment and services, when appropriate.

This resulted in the establishment of a Mobile Crisis Assistance Team (MCAT) pilot program, an integrated co-responding police-mental health team model with the addition of a medical professional. The MCAT pilot began August 1, 2017 with four teams operating within the boundaries of the Indianapolis Metropolitan Police Department (IMPD) East District. The MCAT teams consist of specially-trained police officers (IMPD), paramedics from Indianapolis Emergency Medical Services (IEMS), and crisis specialists from Eskenazi Health Midtown Community Mental Health (Midtown). The pilot program aimed to divert time-consuming, challenging, and complicated pre-arrest situations to a dedicated, specially-trained team that could better assess and engage individuals, routing them to mental health and social services instead of the criminal justice system.

The Indianapolis Office of Public Health and Safety partnered with the Indiana University Center for Criminal Justice Research (CCJR) of the Indiana University Public Policy Institute (PPI), to provide an evaluation of the MCAT pilot program. This evaluation was based on an expansion design where evaluators used a mixed-methods approach to extend the scope, breadth, and range of inquiry (Greene, Caracelli, & Graham, 1989). In this approach, qualitative methods are generally used to assess program implementation and quantitative methods to assess program outcomes. For the MCAT evaluation, qualitative data collection included: focus groups with MCAT units, interviews with key program developers and community stakeholders, field observations with an MCAT unit, and a survey of East District police officers. Quantitative analysis examined MCAT response data provided by MCAT units. The primary purpose of qualitative data collection was to better understand barriers and facilitators to program implementation, while quantitative data points from MCAT runs were developed using a program-theory approach whereby the measures captured are based on stakeholder beliefs regarding the important outcomes of the pilot program.

This report begins by providing an overview of the academic literature on the challenges presented by persons with a mental illness and co-occurring substance use to police officers and the criminal justice system as a whole, along with efforts to mitigate these challenges. Next, this report describes the MCAT pilot program in greater detail before presenting the study design and results. Implications for research and future pilot programs are discussed.
Since the 1970s, persons with mental illness (hereafter, “PMI”) have been handled increasingly by the criminal justice system, a process referred to as the “criminalization of mentally-disordered behavior.” Many suspect that deinstitutionalization contributed to increases in the incarceration of PMI (Lamb & Grant, 1982; Stelovich, 1979; Swank & Winer, 1976; Whitmer, 1980), as these individuals were no longer in hospitals, but out in the community and at risk of arrest (Whitmer, 1980). Today, PMI are three times more likely to be in jail or prison than in a hospital receiving appropriate treatment (Taheri, 2016). This is largely because the criminal justice system is the only social institution that cannot turn away these cases. Private centers can refuse to treat patients they deem to be risky or disruptive; community mental health providers can reject those who have a criminal history; and hospitals can turn away those who appear threatening or intoxicated.

Criminal justice systems across the country have responded by developing programs aimed at reducing incarcerated PMI by diverting them away from the criminal justice system and into community-based treatments and services. Services provided by many of these programs occur “post-booking” (e.g., mental health courts) and can only be accessed once an individual has been arrested or charged with a crime. Many studies suggest, however, that the most effective way of diverting PMI from the criminal justice system is by intervening “pre-booking” as police officers respond to 911 emergency calls (Muntez & Griffin, 2006).

Approximately 10% of law enforcement encounters involve PMI, about three quarters of whom have co-occurring substance use disorders (Steadman, 2005; Skubby et al., 2013). Often, police officers don’t have the resources or training to handle mental health crises effectively, or the people who experience them. During these encounters, PMI in crisis can exhibit strange or hostile behavior, creating a situational ambiguity that can compromise the safety of officers (Taheri, 2016). One of the most popular responses to this issue has been the implementation of Crisis Intervention Training (CIT), where police officers are trained about mental illness and how to respectfully and safely interact with PMI (Dupont, Cochran, & Pillsbury, 2007; Compton, Bahora, Watson, & Oliva, 2008). Additionally, CIT curriculum also provides training for officers on co-occurring mental health and substance use disorders that as many as three quarters of PMI experience (Steadman, 2005; Dupont, Cochran, & Pillsbury, 2007). Empirical evidence on CIT has been encouraging and suggests that CIT-trained officers have more positive attitudes, beliefs, and knowledge about mental illness, and agencies with CIT programs have lower arrest rates than other types of diversion programs (Compton, et al., 2008).

Even with the emergence of CIT programs, police agencies struggle to engage with PMI safely in the communities they serve. To this end, several police departments have partnered with community healthcare providers to create co-responding police-mental health teams, known alternatively as mobile crisis intervention teams, crisis outreach and support teams, and ambulance and clinical early response teams (Shapiro et al., 2014). The general co-response team model involves partnering a sworn police officer with a mental health professional, although many agencies create three-person teams by adding a medical professional (such as a nurse or paramedic) or a peer specialist (such as an individual in recovery from mental illness or substance use disorder) (Hay, 2015). Dozens of such teams currently operate in North America from Los Angeles, California to Halifax, Nova Scotia, and have several common goals, including diverting PMI away from the criminal justice system and increasing consumer access to mental health and substance abuse treatment (Steadman et al., 2001; Shapiro et al., 2014). However, one important distinction among these co-responding units is the timing of the response:
some units are first responders to the scene of an emergency while other units provide follow up after a mental health or substance abuse crisis.

As these co-response programs are relatively new, only a handful of studies have examined the effectiveness of this approach, though results have been generally positive in finding that co-response teams are cost effective, well-received by the communities they serve, and reduce burdens on the criminal justice and healthcare systems. For example, a 2005 program evaluation of Victoria City (Canada) Police Department’s Integrated Mobile Crisis Response Team found many positive outcomes, including increased crisis call response rates, decreased reliance on hospital emergency rooms, and increased information sharing between agencies. The findings, however, suggest these outcomes depended on adequate staffing, appropriate vehicles, sufficient team member training, a centralized dispatch location, and access to pertinent medical and criminal histories about the PMI served (Baess, 2005). In 2006, Hartford and colleagues used a mixed-methods approach and reviewed over seven studies and fifty two police department surveys from three continents about pre-booking diversion programs (including co-responding police-mental health teams) and identified four key elements that were associated with positive outcomes: involving all agencies in the program’s development, conducting regular meetings with program stakeholders, creating a 24/7 no refusal policy for drop off centers, and appointing an individual to act as a liaison between all agencies involved. A similar 2014 review by Shapiro and colleagues of over twenty peer-reviewed studies, reports, and dissertations on co-response teams suggested that successful teams created important bonds between PMI and community mental health resources while lessening the burden on the criminal justice system by making fewer arrests and reducing time on scene for first responders.

Finally, an evaluation of a mobile police-mental health crisis team in an urban setting by Kirst and colleagues in 2015 found that stakeholders felt that the program was meeting its goals of reducing criminalization of mental illness and assisting PMI in crisis via positive partnerships between individual team members and their respective agencies. Despite positive outcomes, however, several barriers to co-response program implementation are consistently reported throughout the literature. Most importantly, all studies have reported that the lack of a 24/7 psychiatric drop off location center with a no-refusal policy is a critical barrier to program success. Additionally, there are recurring issues with role clarity and differences in professional cultures between team members as contributing to implementation difficulties.
The Indianapolis MCAT pilot project launched on August 1, 2017 as a police-mental health co-response team model with the addition of a medical professional. The Indianapolis pilot model consists of an IMPD police officer, an IEMS paramedic, and a mental health clinician from Midtown. MCAT is based in and serves the IMPD East District. This district was chosen because it ranks high on the Social Disorder Index and has high rates of mental/ emotional 911 calls and ambulance runs for medical emergencies. Each entity involved identified a coordinator within its leadership to design and implement the MCAT program in concert. These official coordinators developed and implemented training, identified team members from their respective agencies, and made procedural and logistical decisions with support from the Office of Public Health and Safety. In preparation for launch, a business associate agreement between the Health and Hospital Corporation of Marion County, of which IEMS and Midtown are part, and IMPD was created to protect personal health information of those with whom the MCAT teams come in contact.

Four MCAT units were formed for the pilot project, each working in 12-hour shifts, resulting in 24/7 MCAT availability. MCAT members have unique uniforms identifying them as both MCAT personnel and members of their respective agencies. The teams operate out of a non-emergent van with an MCAT logo on the outside. Each team member utilizes their own laptop to access necessary agency-specific information and the MCAT vehicle is additionally equipped with a medical equipment bag, automated external defibrillator and standard issued IMPD equipment. MCAT may transport individuals to an emergency department, other assessment center, or jail when deemed appropriate.

One aspect of the MCAT that is especially important to note is that it is primarily a first-response unit, not a follow-up unit. Thus, the MCAT may respond to the scene of a crisis at the request of other first-responders, or self-dispatch upon hearing of a relevant crisis via IMPD or IEMS dispatch radio. However, when necessary, MCAT may also conduct follow-ups with individuals they previously encountered to encourage linkage with services. The roles of MCAT team members are fluid to allow for them to respond dynamically, but generally the officers ensure security at the scene; clinicians facilitate mental health assessments and treatment linkage; and paramedics address any medical issues, check patient vitals, and perform assessments related to substance use symptoms when necessary. Officers and paramedics are authorized to maneuver the vehicle and any of the three team members may input information regarding runs into the electronic data collection system.

The mission of the MCAT pilot program is to provide a real-time response to individuals in crisis by facilitating assessment, triage, and linkage with appropriate services. In doing so, MCAT aims to (1) utilize alternatives to arrests of citizens in behavioral health and substance use crises, when appropriate; (2) seek safe outcomes for individuals, families, and public safety personnel during a crisis; (3) reduce the overutilization of emergency services through linking individuals to appropriate support resources; (4) encourage utilization of appropriate community-based support resources as an alternative to emergency room and inpatient hospitalizations; and (5) decrease the time other first response units (i.e., police, fire, and EMS) spend at the scene of a crisis by assuming control when appropriate.

MCAT training was primarily developed by Midtown leadership and included classroom learning, stakeholder and expert presentations, site visits, and police ride-alongs. Training included the following topics:
1. Mental health overview – including CIT training for those who had not yet received it, study of the mental health and treatment system, language use and stigma, and relevant legislation;

2. First person accounts – including input from individuals with experience in substance use recovery;

3. Legal and Risk management – including discussion of relevant legal and ethical issues of inter-agency information sharing and overview of relevant aspects of the criminal justice system;

4. Clinical information – including training related to populations with behavioral health and substance abuse issues as well as self-care;

5. Special populations – including topics related to persons with developmental disabilities and autism, persons experiencing homelessness, the LGBTQ population, older adults, sex trafficking and prostitution, veterans, and youth and family issues;

6. IMPD related training – including use of force, situational awareness, drug and narcotic identification, de-escalation strategies and street safety;

7. IEMS related training – including first aid, CPR and naloxone use;

8. Faith-Based community solutions – including introductions to existing programs aimed at assisting relevant populations; and,

9. Organizational team building.

**STUDY DESIGN**

The MCAT evaluation focused on barriers and facilitators of program implementation as well as outcomes associated with crisis responses. Barriers are problems, setbacks, challenges or obstacles to program development or implementation, whereas facilitators are support systems, synergies or bridges that made program development or implementation easier. The evaluation included qualitative data collection from focus groups with MCAT members, interviews with key stakeholders, and field observations during MCAT responses. In order to examine MCAT crisis responses, CCJR researchers worked with key stakeholders to identify the necessary data points and develop data collection protocols. The following types of data were collected for this evaluation.

**Focus Groups**

CCJR researchers conducted two semi-structured focus groups with members of the MCAT units. Each focus group consisted of two teams (six members in each focus group) and lasted approximately 2 hours each. There was a broad interview guide that was used to facilitate these focus groups in a semi-structured manner, allowing for diversion and probing when appropriate. One lead researcher guided the focus group and two additional trained researchers took notes.
**Interviews with Stakeholders**

CCJR researchers completed nine, one-on-one interviews with MCAT program developers and stakeholders. This included leadership personnel from IMPD, IEMS, the Indianapolis Department of Public Health & Safety, and Eskenazi Health. Interviews followed a structured survey guide, were audio recorded, and lasted approximately one hour each.

**Field Observations**

Two CCJR researchers conducted observations of an MCAT unit via a “ride-along” which lasted approximately five hours. This field observation began in the MCAT office based at the IMPD East District Headquarters. Researchers then accompanied the MCAT unit in the van to three separate responses and took field notes on observations.

Qualitative data were transcribed and researchers reviewed transcripts using content analysis to identify barriers and facilitators to MCAT development and implementation. To establish inter-rater agreement, researchers individually coded three qualitative sources using NVivo qualitative analysis software, and met again to discuss emerging themes around barriers and facilitators and to develop coding procedures for the additional qualitative sources. Upon individually coding all qualitative materials, researchers met a final time to review the major themes gleaned. Major themes are those identified by four or more individuals from at least two different agencies during qualitative data gathering.

**Officer Survey**

In an effort to triangulate these qualitative results, researchers also conducted a survey of officers from the IMPD East District in which MCAT operates. CCJR researchers developed a web-based survey using Qualtrics survey software to solicit knowledge, attitudes and opinions of officers who share the district with the MCAT units. The survey was anonymous and sent via email to approximately 140 patrol officers who were given one month to complete the survey.

**MCAT Response Data**

Finally, the research team collected quantitative data on each MCAT crisis response. CCJR researchers developed a database where MCAT members were responsible for inputting information for each response completed. MCAT stakeholders assisted in designing these data collection points.

Quantitative data were imported into SPSS for statistical analysis. Analysis largely consisted of descriptive statistics regarding MCAT responses, but variation in response and outcomes based on key measures were also examined. To this end, CCJR researchers examined statistically significant differences using t-tests and Chi-square difference of proportion tests.
BARRIERS TO PROGRAM IMPLEMENTATION

Policies and Procedures

Because the MCAT was established as a pilot program, little was known initially about the ways in which the teams would most effectively address their behavioral health and substance use agenda. This was made more problematic with the absence of detailed policies and procedures. As one team member noted,

“We need a clear mission statement; we don’t know whether we’re supposed to be responding to certain runs or not. Right now we’re all taking different approaches to these calls. What is our role supposed to be? Because I don’t think we have a clearly defined role.”

However, leadership was hesitant to limit the ways in which MCAT could respond to emergencies, preferring to allow for creativity and flexibility in their response:

“I think putting too many bright line rules on [this program] would probably be detrimental to it. Because then it’s like when you have these bright line rules and officers are held accountable to these rules they could get in trouble.”

While this fluidity allowed for MCAT to continuously learn and adjust to real-time needs, a lack of clear direction sometimes led to confusion and variation among the teams, both in this pilot program and previous co-response programs studied in the literature. As noted by one MCAT stakeholder, “teams are inconsistent as far as their operations and decision making.”

Balancing the needs for fluidity and consistency is key for further clarifying the role of the MCAT and could lead to greater buy-in from team members. For some, it is unclear whether they can or should perform duties of their traditional roles while serving as an MCAT member. Greater definition and clarification of on-the-scene procedures can help prevent team members from feeling underutilized. Additionally, determining to which emergency situations MCAT should prioritize responding could lead to more consistency between teams and greater confidence that teams are doing “what they should.”

Finally, developing common procedures and resources for post-crisis action can increase consistency between teams and reduce inefficiencies or confusion for the teams in deciding where to take patients, who to contact, and how to follow up. CCJR researchers witnessed evidence of at least one MCAT member who began the process of consolidating phone numbers, addresses, forms, pamphlets and other resources for MCAT use. Formalizing and regularly updating this consolidated information should be prioritized.

External Coordination

Inter-agency coordination can be difficult when combining multiple agencies in one emergency response initiative, particularly around the topics of mental health and substance use. A culture shift is necessary for all entities involved to both understand one another’s initiatives and coordinate a cohesive, appropriate response. IEMS, IMPD and Midtown have taken strides to successfully coordinate; however, coordinating and communicating MCAT goals and responsibilities with external actors was a salient barrier that emerged. For example, team
members often recalled being asked who they were, noting that “People don’t know who MCAT is or what they do.” MCAT members stated that this occurred among fellow officers in the East District but also among other first response agencies. For example, one MCAT stakeholder noted:

“[MCAT leadership] probably could have communicated it a little better amongst supervisors and officers on East District, so they had a better idea. There was a little confusion about what the responsibilities were. And there were officers that really didn’t know the [MCAT teams] were out there.”

Similar statements were made regarding other community treatment providers. It was suggested that prior to launch, key stakeholders “should have met with other hospitals before the MCAT program started because they need to know who we are and why we’re bringing in patients” and that “most people don’t even know what MCAT is so I don’t even think that most [doctors] would realize that their patient was brought by MCAT to the emergency department.”

There was also a perceived need to better “market” MCAT to the public in order to differentiate this program from other initiatives in the East District; one stakeholder explained that other initiatives imbedded in East District had misconceptions about what MCAT would and wouldn’t do. It is important to involve other actors in the area; as an MCAT stakeholder advises:

“I would want other agencies to know that you have to be out there selling the program. When I say out there, I mean other stakeholders in the community and you have to find outside partners...It’s not just a police program or a city program or an EMS program or a clinician program. It is a collaborative approach and I think you have to have people who understand that.”

By coordinating with other programs and initiatives aimed at helping similar populations, future implementation efforts might better ensure all stakeholders are aware of the roles of one another. Additionally, it is important to disseminate coordinated messages to the community and patients receiving MCAT assistance to avoid confusion about roles and capabilities.

**Outpatient Resources**

The difficulty presented by a lack of outpatient services for populations served by MCAT surfaced multiple times throughout researcher’s review of both this data and data from previous studies. One MCAT stakeholder conveyed:

“This is the biggest fear for me; you do all of this work on the front end, but there are no real services on the back end, so these people aren’t getting the help, because there are not enough beds or there are not enough mental health professionals that will work with them, or they don’t have any insurance.”

Addressing the needs of the populations with behavioral health and substance use issues goes beyond responding to acute emergencies and performing follow up. MCAT team members can provide resources or transport patients to a hospital or other crisis center, but this does not guarantee the availability of necessary treatment for people. An MCAT stakeholder suggested that “the city was under the impression that there are places to take people; there are not.” Future implementations should first consider expanding treatment options,
“If we are talking about launching this in a thoughtful way in other places, then making sure that treatment resources are available [is crucial]. You sort of have to work backwards: if you’re going to go out and find people who need help, you probably want to have that help available.”

This was an especially prominent issue in terms of substance abuse treatment. In the midst of an opioid crisis in Indianapolis, MCAT members noted that they “really don’t have anywhere to send people who need help with heroin addiction.” Given the available resources, MCAT members lamented that crisis responses were “going to have to continue with the emergency department and the jail” but expressed a desire to “work with providers to build relationships and find providers that are willing to participate with a clientele that does not have the best resources but who are most in need of treatment.”

Limited treatment resources can be a barrier to long-term health for patients, and can also lead to frustration and burn-out from staff committed to serving people experiencing behavioral health and substance use issues. For example, as one MCAT member noted, “people come out of [the hospital] not making changes because they were just given a pamphlet, not services” while another stakeholder suggested that,

“A lot of time and effort and money is being spent on innovative programs when really probably a lot more time and effort and energy should be spent building the capacity of our behavioral health system to take care of people.”

Addressing these issues requires bolstering a broader system of behavioral health care beyond the purview of MCAT, follow-up units, emergency departments and first-responders.

**Role Conflict and Stigma**

Switching from a traditional role to a special unit, particularly for police officers and paramedics, was identified as a difficult process. Some MCAT members experienced personal discomfort with new roles and were met with negative feedback from within their respective agencies, similar to team members in other types of co-response teams studied in the literature. For example, one MCAT officer suggested that “[Other officers say] we’re jokes now; we aren’t the real police.” This type of criticism was also heard from other first responders; members stated that “firefighters have been particularly resistant to understand what we do” and that “every ambulance I’ve run into thinks we are there to do their legwork.”

Some MCAT team members had difficulty adjusting to the new identity associated with their special unit roles. One way this manifested was concern about the MCAT uniforms; as one officer stated, “there is honor in your uniform and this MCAT uniform is a halfway-police officer uniform.”

Leadership was aware that certain aspects of a new role as well as riffs with non-special unit personnel might contribute to team member dissatisfaction or frustration. As one key stakeholder stated,

“One of the most difficult things is coming out of what they are normally doing... they have all been on the street... so I think that’s an adjustment for them. Any time law enforcement leaves the first position (which is street officer position and goes to investigation or something else) it’s often difficult to make that transition.”
Leadership also noted that:

“There was a lot of pressure and push back, just culturally within the organization. Oh, why are you going to a special unit? What are you even going to be doing? And [officers] couldn’t really answer that... It takes a certain type of officer with a lot of self-confidence and an open mind.”

Having buy-in from MCAT members is not only crucial for the success of the current program, but also something to be considered in future implementation efforts. For example, one MCAT team member stated, “I have over 20 years of seasoned experience, I feel like I am being wasted in that van.” Efforts to carefully select, retain and motivate team members are important to long-term program success.

**FACILITATORS TO PROGRAM IMPLEMENTATION**

**Initial Citywide Collaboration and Buy-In**

As evidenced in the literature, the success of an emergency response team like the MCAT requires buy-in from many people and agencies who do not necessarily interact with this level of coordination ordinarily. Fortunately, Indianapolis has multiple years of collaboration between mental health providers and IMPD, has incorporated CIT training for many officers, and has the full support of the Mayor’s Office for the MCAT program. For example, one respondent noted “this is a collaborative approach and you have to have people who understand that and can work in a collaborative environment.” Another stakeholder established,

“Even before [MCAT] we had a good relationship with medical services here, a good relationship with Eskenazi, and a good relationship with mental health workers. So, from the top down there had been a lot of history and a lot of associations with individuals who have thought the same way.”

This level of citywide effort in developing multi-agency responses to behavioral health and substance use issues coupled with dedicated buy-in from agency leadership for development of the MCAT program facilitated a relatively cooperative implementation and opened avenues for future coordination. Respondents especially noted support from the Mayor’s Office, as it provided a platform for resource negotiation and agency accountability. As one MCAT stakeholder said, “there is going to be push-back any time there is change; having the support from the top is crucial.” Another respondent asserted that:

“It has to start from the top down because this is an ask from everybody... there has to be a return on investment for everybody involved that’s not money...So we have all of these different moving parts, and when you put the leadership together in a collaborative way, and these folks all want to solve the same problem, we can sort of understand, ‘ok I can lose over here if I win over here.”

Programs like MCAT can take advantage of already-existing synergies between agencies, and further combining efforts can open doors for future collaboration by breaking down communication and coordination barriers. This allows leadership to leave their agency silos to address common issues in concert. As one respondent expressed, “MCAT helps with pushing uncomfortable change and having collaboration. It has also helped us look at the other ways we can work together to make additional changes [to the system].”
Information Sharing

One of the most salient facilitators of implementation noted by participants in the current and previous studies was the ability to share information within legal purview. MCAT units benefit from the combination of patient information from three different entities that serve the same populations. This triangulation of informational resources results in a greater ability to address a specific patient in the moment of crisis and link or re-engage them with treatment services. Combining information also helps to identify the patterns and needs of “frequent flyers” of city emergency resources. This facilitator was expressed by multiple stakeholders throughout the qualitative data. For example:

“It has enabled us to have a deeper understanding of the city enterprise as a whole... We are able to really have a clear picture of [a patient’s] process through the system. And we are able to see where we have very distinct weaknesses in our system. Whether that’s lack of services, lack of support, a lack of communication...”

“There is a Midtown clinician that...is able to link [a patient] back to their treatment team via our own medical record and communicate that this person is having a problem, and then you can go in and see [if] this person is getting a follow up from the treatment team the next day, versus kind of just letting them go.”

During field observation, researchers recognized the usefulness of combining the Eskenazi and IMPD information systems to identify the correct address of a specific patient. One MCAT team member stated, “I love that the clinician can get on the computer and look up any existing mental health issues that a person has; I’ve never seen that before.” Stakeholders realized that, “Combining the systems and software of three agencies creates a powerful tool.”

Upon responding to an emergency scene, officers and clinicians can compare criminal justice and healthcare records on their laptops within legal parameters to better prepare the team to respond to a particular patient. This triangulation can help teams anticipate potential hazards and also allows them to reconnect patients with treatment services they received in the past when applicable. As one MCAT stakeholder stated,

“We can look at [a situation] from multiple different angles. We can do searches... We typically try to do our homework when we go out and see somebody, especially if we have a name ahead of time. Or if it’s on the back end we will look at it after we get back to the office to try to see what has happened with this person in the past. The police officer will go and look at what their record is. Our clinician can look to see if they are in the Midtown system to see if they have been there before for some other mental health treatment... and then from the medical side we can see...how many times they have called in the past few years and now we are putting together a better picture on things.”

As noted, combining multiple agencies to address emergencies had the unintended consequence of identifying some of the frequent flyers of city resources. While these people may have been contacted individually by the three agencies involved prior to MCAT, coordinated efforts to identify, record information and support those individuals were not as efficient as they can be through MCAT.
**Team Building**

One of the most useful aspects of initial training was the ability for MCAT team members to learn about one another, adopt useful skills from one another and build relationships. Team members were introduced to the philosophies, language and procedures of the other agencies involved with MCAT during an almost two-month training. As one MCAT stakeholder suggested, “It was apparent that each different agency needed to be a little more aware of the other agencies in order to work more closely together.” Team members found that, “The best part [about training] was learning one another’s role” and “The training brought this unit together and I think all the teams are functioning pretty good.” The MCAT members also noted that being able to select their teams was a facilitator to program implementation, suggesting that “If we were assigned teams, we may not have been as successful, but we got to pick our teams and get along better for it.”

Researchers observed collegiality among the team members they accompanied during ride-along observations. The clinician expressed observations of subtle changes in EMS team members’ interaction with persons with behavioral health issues as a result of collaborating with other MCAT members. This change was also self-identified by IMPD and IEMS members of the MCAT, stating that their “mindset was changed because of the training.”

**IMPD EAST DISTRICT OFFICER SURVEY**

The CCJR survey of IMPD East District officers yielded 63 responses which is approximately a 45% response rate. Respondents were an average age of 39 (SD = 10.49, Range: 18 to 65) and primarily male (76%) and Caucasian (75%). Slightly more than half of respondents had at least a four-year college degree (56%) and had been in law enforcement for an average 13.10 years (SD = 10.39, Range: 1 to 40) with most currently employed as patrol officers (78%).

CCJR researchers first asked respondents to evaluate their level of knowledge and contact with the MCAT teams. Leadership made efforts to introduce the MCAT teams to East District officers during roll-call, short meetings that occur before every shift. However, this method did not reach all officers according to the survey as 29% of officers indicated that they were not formally introduced to the MCAT program before its launch. Next, researchers looked at perceptions regarding the roles and expectations of the MCAT unit before and after launch.

As shown in Exhibit 1, 57% stated that roles and responsibilities surrounding the MCAT unit were somewhat clear or extremely clear prior to launch and at the time of the survey (mid-late November) 84% said the roles were somewhat or extremely clear. This increased trend in role clarity is likely attributable to the fact that a high proportion of respondents, 87%, reported having been on the scene of an emergency call with the MCAT. The survey also allowed for opportunities for officers to express, through open-ended questions, what would make the MCAT more useful to them as officers and 6 respondents mentioned a desire for clarification on MCAT roles and that these expectations be consistent between MCAT teams. Officers said, “It would be helpful to know exactly what MCAT can and can’t do” and “I just want a clearer understanding of the situations they will/will not respond to.”
Researchers also looked at perceptions of MCAT emergency responses. Most survey participants reported that they had specifically requested MCAT assistance on a scene (83%) and 79% reported that the MCAT unit arrives all or most of the time when requested. Discussion with MCAT team members and field-observations with one team revealed a few reasons why the MCAT does not always arrive when requested. Teams are either unavailable due to being at the scene of another crisis or cannot arrive fast enough due to their limited ability to travel quickly across the district. The survey also revealed that East District officers would like for the MCAT to be more available: in an open-ended question, 17 respondents said the MCAT would be more useful if it was more available. One officer suggests, “Get more of them working at one time...maybe two or three would help. There have been multiple times we have asked for [assistance] where they were already out on something.”
Finally, researchers looked at perceptions of MCAT usefulness. Overall, East District officers find that the MCAT is a very useful resource because it allows officers to return to duty more quickly and because the team provides the ability to better address mental health crises. A majority of officers believe the East District is better at responding to mental health crises because of the MCAT. As shown in Exhibit 2, respondents overwhelmingly rated the MCAT unit as very or extremely useful to them as officers (75%). Officer respondents were asked to report the reasons for which they find the MCAT to be useful. Respondents were most likely to endorse the MCAT team as being useful because they allow other officers to return to duty more quickly (86%); the unique combination of an IEMS, IMPD, and clinician (73%); mental health expertise (64%); ability to complete follow-up (52%); and additional equipment and resources (49%). In contrast, respondents were less likely to view the MCAT as useful for its ability to handle non-emergency calls (44%) or provide substance abuse expertise (35%). Focus group data with MCAT members suggests that part of the reason officers in the East District might not perceive the unit as useful in terms of substance abuse is because on the scene of overdose they don’t have the ability to arrive in time to revive a person before other first-responders do so, and an overdose patient is often not in a state of mind to engage in discussion about treatment in the moment.

In evaluating the improved ability of the East district to address mental health and substance abuse issues, a greater proportion of respondents rated East District having a better response to mental health issues due to the presence of MCAT (79%) relative to substance use issues (49%). A considerable 89% of respondents believed the MCAT unit met or exceeded expectations set prior to its launch. One officer states, “I honestly think the MCAT crew is doing a phenomenal job.” This is also evident in the fact that 33% of officers indicated being interested in serving in the officer role on the MCAT.
In examining the data on MCAT responses, researchers looked at the characteristics of the people to whom MCAT responded and then proceeded to look at response results chronologically: first looking at the reason for the response, then what happened on the scene of a response, and then the outcome of the response. Following this, researchers examined repeat encounters and differences by teams.

The data used in this analysis come from all MCAT responses that occurred between August 1, 2017 and December 9, 2017 that were recorded by MCAT team members. During these 19 weeks, there were a total of 566 responses at approximately 4.4 runs per day. Every day during the study period there was at least 1 response and a day high number of 11 responses. It is also important to note that the 566 MCAT responses occurred among 488 unique individuals as 11% of the responses were repeat encounters.

CLIENT DEMOGRAPHICS

Exhibit 3 displays the demographic characteristics among the 488 individuals that MCAT responded to during the study period. More than half (58%) of the response encounters were with males and more than half (55%) were Caucasian, 41% were Black or African American, and 3% Hispanic. The average age of individuals with an MCAT encounter was 38 years and ranged from 10 years old to 90 years old.

**EXHIBIT 3. Demographic Characteristics of MCAT Response Cases**

- **Average Age**: 37.9 years old
  - Standard Deviation: 15.3
- **Gender**
  - Male: 58% (N=286)
  - Female: 42% (N=210)
- **Race/Ethnicity**
  - White: 55%
  - Black: 41%
  - Hispanic: 3%
  - Other: 1%
REASON FOR RESPONSE

MCAT team members were asked to record whether they self-dispatched to a given crisis scene or if another agency requested their response. Here, researchers found that nearly two-thirds (63%) of responses were the result of MCAT self-responding and the other one-third (35%) were from IMPD requests; there were 8 responses requested from EMS, 5 from other agencies, and 16 response sources not recorded. MCAT also recorded what the primary crises were and were able to select all responses that applied from six categories: (1) Suicide or self-harm attempt or threat (2) Other mental health issues, (3) Overdose or other substance abuse problem, (4) Domestic violence, (5) Physical health issue, (6) and Gravely disabled. Exhibit 4 shows the frequency that each of the categories were recorded as well as the instances in which only one category was recorded: at 59%, mental health concerns were the most common primary reason for response and was the only crisis type in 37% of responses. The second most frequent response reason was an overdose or other substance abuse problem which was indicated 35.4% of the time and was the only reason for a response in 23% of the encounters. Only slightly less than substance abuse was self-harm or threat of suicide which was indicated in 34% of the encounters and the only response reason indicated in 18% of the encounters. MCAT responses for domestic violence, physical health, or gravely disabled were less common and together were recorded in 10% of encounters and each recorded as the only reason for a response in less than 2% of encounters.

EXHIBIT 4. Reasons for MCAT Response

Primary Crisis

<table>
<thead>
<tr>
<th>Crisis Type</th>
<th>Percent of runs in which crisis type was indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>37%</td>
</tr>
<tr>
<td>Overdose or Substance Abuse</td>
<td>23%</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>18%</td>
</tr>
<tr>
<td>Gravely Disabled</td>
<td>1%</td>
</tr>
<tr>
<td>Physical Health</td>
<td>2%</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>2%</td>
</tr>
</tbody>
</table>

Percent of runs in which crisis type was indicated

- Only Indication
- Any Indication

Another important point to examine with the MCAT data is whether responses or encounters changed over time. As shown in Exhibit 5, researchers display the top three kinds of responses (mental health, self-harm, and substance abuse) during the first four months and found some fluctuation over time in the types of MCAT responses. While mental health related calls have remained the most frequent response, the number of self-harm related responses has increased from 27 to 41. The number of substance abuse related responses started
high at 50 but decreased during September and October to 29 and 30 respectively and increased to 49 in November. This is a very limited follow-up period and additional data are needed to further examine these trends. This fluctuation may be due to the number of emergency calls that come through for each crisis type, the availability of MCAT to respond, response decisions of MCAT teams, or a combination of these factors.

**SCENE OF AN MCAT RESPONSE**

When MCAT responded to a crisis scene there were often other emergency or first response units already present: in only 9% of responses was MCAT the only unit responding. IMPD was also on the scene for 85% of responses, EMS at 58% of responses, and IFD at 18%. Both EMS and IMPD were at the scene of 52% of responses and IMPD, EMS, and IFD at 16% of responses. While generally not the only unit on the scene, in two-thirds (66%) of encounters, MCAT was able to relieve other emergency or first response units from the scene. Among those encounters where MCAT was able to relieve other units, 63% of the time it was one unit (EMS, IMPD, or IFD), 31% of the time it was two units, and 6% of the time it was all three units. The MCAT also reported additional hazards present at the scene for 16% of the encounters with the most common hazard reported as violent behavior toward others but only occurred in 7% of encounters. The next most common hazard reported was the presence of weapons which occurred in 3% of encounters.

In looking at the time spent on the scene the majority of MCAT encounters were completed in under 90 minutes (88%) with 62% taking an hour or less. For those encounters that took longer to complete, the MCAT was significantly more likely have relieved other emergency or first response units. For example, among those encounters that were over an hour, 80% of the time other agencies were reported as having been relieved from the scene.
MCAT RESPONSE OUTCOMES

One of the main goals of the MCAT team is to divert persons away from jail or incarceration when possible and appropriate, and transport them into needed treatment or services. Following an MCAT encounter, two-thirds of patients (65%) were transported somewhere, the majority of whom (87%) were transported to a hospital (33% were transported to Eskenazi Hospital). This means that 56% of all MCAT runs resulted in transporting a person to a hospital. In 25% of MCAT responses there was an immediate detention decision and in nearly all of these cases the MCAT team provided transportation. Exhibit 6 shows the location and outcome of other transports provided by MCAT. 7% of crises to which MCAT responded resulted in an arrest and among these arrests 74% of the time it was an IMPD officer already on the scene that initiated an arrest, rather than an MCAT officer. In fact, MCAT only directly transported someone to jail 9 times during the study period, or otherwise stated, in less than 2% of all encounters. There was no statistically significant variation in individual characteristics or response type in the likelihood to arrest.

EXHIBIT 6. MCAT Response Outcomes

REPEAT ENCOUNTERS

A large majority of individuals received only one MCAT response; however, 11% of the overall sample received two or more MCAT responses. These repeat encounters involved independent crises and resulting MCAT responses, they were not follow-ups from a previous response. The average number of responses provided to this subpopulation ranged from 2 to 7 encounters and the average amount of time between individuals’ first and last MCAT encounter was 17 days (M=27.84, SD=27.84). To explore the possibility that individual characteristics and encounter circumstances can distinguish individuals who receive one MCAT response from individuals who receive two or more MCAT responses, comparisons are made between individuals’ first MCAT response. The first response was purposely selected as the comparison point as this encounter sets the foundation for sequential
activities. Three factors provide some insights. First, individuals who receive two or more MCAT responses were more likely to have “gravely disabled” as the primary crisis type with no other crisis classifications in their initial response. Second, a larger proportion of individuals who experienced repeat encounters with MCAT were recorded as having mental health issues (59%) as a primary crisis than individuals who received a single MCAT response (45%). There were no differences between repeat and sole encounters across the remaining combinations of response categories. Third, a smaller proportion of individuals who received more than one MCAT response were transported (52%) in relation to individuals who received one response (66%). When comparing the locations to which individuals are transported, there are no differences between the locations to which they are delivered that would signal the need for subsequent encounters. In combination, this third factor provides evidence that it is the decision to transport and not the location to which one is transported that influences whether an individual receives a repeat encounter.

Beyond these indicators, there were no other statistically dependable characteristics or circumstances that enabled an ability to differentiate repeat and sole MCAT encounters. The responding MCAT unit, presence of emergency or first response units at the scene, existence of hazards during the encounter, timing of the encounter, and actions taken during the first encounter did not help to identify individuals who would receive multiple responses.

### DIFFERENCES BY MCAT UNITS

In order to understand the impact of a specific MCAT unit on responses, CCJR researchers examined differences across the four unique units, referred to hereafter as Unit A, Unit B, Unit C, and Unit D. Researchers also looked at variation between day and night shifts with Unit A and Unit B as the day shifts and Unit C and Unit D as the night shifts. Exhibit 8 displays the statistically significant differences researchers found across these four units. For example, as illustrated in Exhibit 8, Unit A and Unit B were significantly more likely to self-dispatch to a call whereas Unit C and Unit D were more likely to have been dispatched by IMPD. In terms of the type of calls, researchers examined those cases where only one type of crisis type was indicated and found that Unit A was more likely than the other units to respond to a self-harm and mental health related crisis calls but least likely to respond to a substance abuse call. As shown in Exhibit 8, over one-quarter (26%) of Unit D’s responses were exclusively substance abuse related which was significantly higher than the other units.
In terms of what happened at the scene, there were no significant differences in the likelihood to transport or arrest. Unit B was also significantly more likely to relieve other first response units and also had the quickest response time with 23% of responses lasting 30 minutes or less and 72% lasting less than an hour. This rate of expeditious response was also shared by Unit A. Finally, Unit B was least likely to have had repeat responses. Researchers also examined differences between shifts that occurred at day and at night and between those instances where there was a full MCAT team available and those responses where a member of the team was missing. While there was some variation in encounter characteristics and circumstances by shift and by complete or incomplete MCAT teams, much of the differences were between units rather than shifts or complete versus incomplete teams. Moreover, given the data available at this time, researchers cannot say that any of these configurations were better or worse but simply want to note the variability in response types and time spent on the scene.

**EXHIBIT 8. Variation by MCAT Units**

<table>
<thead>
<tr>
<th></th>
<th>UNIT A</th>
<th>UNIT B</th>
<th>UNIT C</th>
<th>UNIT D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response Request</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCAT Self Dispatch</td>
<td>51%</td>
<td>72%</td>
<td>66%</td>
<td>59%</td>
</tr>
<tr>
<td>IMPD Request</td>
<td>48%</td>
<td>27%</td>
<td>32%</td>
<td>37%</td>
</tr>
<tr>
<td><strong>Reason for Response</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(mutually exclusive)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Harm</td>
<td>26%</td>
<td>50%</td>
<td>14%</td>
<td>19%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>40%</td>
<td>33%</td>
<td>30%</td>
<td>24%</td>
</tr>
<tr>
<td>Overdose or Substance Abuse</td>
<td>12%</td>
<td>15%</td>
<td>18%</td>
<td>26%</td>
</tr>
<tr>
<td><strong>Units Relieved</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMPD</td>
<td>41%</td>
<td>67%</td>
<td>58%</td>
<td>65%</td>
</tr>
<tr>
<td>IEMS</td>
<td>21%</td>
<td>36%</td>
<td>17%</td>
<td>27%</td>
</tr>
<tr>
<td>Any Unit</td>
<td>51%</td>
<td>75%</td>
<td>60%</td>
<td>72%</td>
</tr>
<tr>
<td><strong>Response Scene and Outcome</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeat Encounter</td>
<td>30%</td>
<td>23%</td>
<td>30%</td>
<td>18%</td>
</tr>
<tr>
<td>Immediate Detention</td>
<td>17%</td>
<td>36%</td>
<td>17%</td>
<td>26%</td>
</tr>
<tr>
<td><strong>Time at Scene</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 Minutes</td>
<td>23%</td>
<td>23%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>Under 60 Minutes</td>
<td>69%</td>
<td>72%</td>
<td>48%</td>
<td>59%</td>
</tr>
</tbody>
</table>
After a review of the academic literature and a detailed description of the Indianapolis MCAT pilot program, this study identified a number of important barriers and facilitators to the pilot program’s implementation. In terms of barriers, much like the academic literature on co-response teams, researchers found that ambiguity in terms of policies and procedures was identified as a barrier and manifested itself in a number of ways throughout the evaluation. There was difficulty with external coordination, in part because the MCAT units are unable to clearly express the purview of the program to other first response and community agencies. This barrier was also evident in the East District survey, where nearly half of officers (42.8%) stated that the program was not made clear to them prior to launch. This survey suggests that as the MCAT unit became a regular part of the district officers’ interactions, they came to better understand its roles; however, it’s unclear if the crystallization of these roles actually occurred among the MCAT units themselves. The biggest indicator of a lack of policies and procedures was in the analysis of the quantitative data where researchers found MCAT units were responding to different kinds of calls for service. Given the available data and the time of that the pilot program has been in existence, researchers are not in a position to say which units were operating better or worse; rather, researchers would speculate that this variation is due to the lack of fidelity in program implementation which might be addressed by establishing clear guidelines as part of an MCAT policies and procedures document.

Strong support from city officials and key stakeholders was identified as a facilitator towards program implementation. However, this support might be codified and extended by creating an advisory group and/or program coordinator for the MCAT units. An advisory group and/or program coordinator could communicate what the goals and guidelines of the MCAT are to other key community stakeholders and agencies, improving external coordination, which was identified as a barrier to program implementation. The advisory group or coordinator could also regularly evaluate the consistency of MCAT responses amongst teams and serve as a liaison between team members and city officials to centralize communication.

Team building was also identified as a facilitator to MCAT implementation. Specifically, researchers found that MCAT members felt training led to a sense of unity among team members. Unfortunately, feelings of ostracization from fellow first responders were also present, as several MCAT members noted feeling discomfort in their new roles as a result. However, these feelings are not entirely consistent with the survey in which East District officers were overwhelmingly supportive of the MCAT pilot and felt that it met or exceeded expectations. It is possible that the negative stigma expressed towards MCAT members was an impactful, but relatively rare event, or was something that occurred only initially in the pilot. It is also worth noting that one-third of officers surveyed in the East District were interested in serving as an MCAT officer, which suggests a potential pool of future MCAT officer team members.

The most significant barrier to successful implementation of MCAT as a way to divert people from the criminal justice system and into treatment services was a lack of community treatment options. This was commonly cited as source of frustration by the MCAT members, leadership, and the community stakeholders in this study, as well as participants in previous studies of similar co-response teams. Further research may attempt to follow up with people who interacted with MCAT to understand the extent of their post-MCAT treatment.

By and large, the most salient facilitator to MCAT implementation was the ability share information in real time between agencies. MCAT members from IMPD and IEMS regularly noted the advantages to having additional
information on persons. This information allowed them to locate individuals more efficiently and better understand unique treatment needs. Given the importance of this facilitator, it is worth exploring how other IMPD officers, who are not a part a specialized unit, might acquire access to this kind of information. Moreover, it would be helpful to find a way of acquiring similar information from providers other than Midtown.

Finally, our analysis of preliminary quantitative data from MCAT responses suggests that the program is meeting its primary goal of diverting persons away from jail. For example, two thirds of MCAT responses resulted in a transport; nearly 90% of these persons were transported to a hospital or other treatment facility while less than 2% were transported to jail. Future comparative studies can determine whether this differs significantly from other similar crisis situations where MCAT is not present. While the jail diversion trend is promising, this finding also raises questions about the aim of MCAT to reduce the utilization of emergency services and seek alternatives to hospitalizations given the high rate of transport to hospitals.

Also noteworthy is that in two-thirds of all MCAT responses they were able to relieve one or more other first response units thereby improving overall emergency system efficiency by freeing them to respond to other calls for service. As noted above, there was variability across MCAT units in the kinds of calls they responded to; however, at this time, researchers cannot determine whether these are meaningful differences that will be related to outcomes or due to a lack of clear policy and procedure guidelines for MCAT units.

Also of note were the repeat MCAT encounters. As their time in the field increased, MCAT teams came to discover persons who were “frequent flyers” and in some cases the MCAT members report having become the primary response unit for these persons. While this led to mild frustration among MCAT members, it is also important to note that these frequent flyers were more likely to be disabled and mentally ill than the population of people involved in only a single MCAT encounter. It might be innovative to accept that, given the nature of the program, MCAT units are likely to identify these cases and supply them with resources or provide additional interventions.

This study represents a very brief snapshot of the first five months of the MCAT program. Much more research is necessary to fully understand whether the MCAT program is effective in having a long term impact on the communities it serves. Generally speaking researchers suggest at least three additional types of studies need to occur to examine program effectiveness. First, data from the MCAT responses need to be linked to other available data sources. In doing so, researchers will be able to look at changes in criminal justice involvement, the use of IEMS, and potentially treatment engagement. Second, the MCAT responses need to be compared to similar emergency calls for which MCAT is not present. This would allow researchers to determine whether the rate of arrest for the MCAT is truly lower than if an MCAT had not responded. Findings in the literature have suggested that the arrest rate of PMI is somewhere between 2% and 19%, depending on the officer training, the availability of special units to address mental health crises and other factors (Borum and Franz, 2010; Reuland et. al. 2009). Finally, researchers need to better understand the perceptions and experiences of individuals who are consumers of MCAT services. These individuals could elaborate on how their experiences with MCAT differ from previous calls for service, whether their experiences had an impact on impressions of IMPD, IEMS or Midtown, and whether the MCAT response had any short-term or long-term effects on behavioral health changes and treatment linkage.
REFERENCES


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