Dr. Lisa Dixon (00:07):

Welcome to our podcast, Psychiatric Services From Pages to Practice. In this podcast, we highlight new research or columns published this month in the Journal Psychiatric Services. I'm Lisa Dixon, editor of Psychiatric Services, and I'm here with podcast editor and my co-host Josh Berezin. Hi Josh.

Dr. Josh Berezin (00:26):

Hi Lisa.

Dr. Lisa Dixon (00:27):

Today, we're going to talk with Dr. Simon about an article that addresses the issue of involuntary police, transport of individuals being taken to the hospital for evaluation. It's very disturbing, compelling, and important.

Dr. Josh Berezin (00:44):

So we're very happy to have Dr. Kevin Simon, who is the Chief Behavioral Health Officer for the City of Boston, here to talk with us about his and co-author's article, Understanding Involuntary Hospitalization Application Submitted to an Urban Police Department. So Dr. Simon, thanks so much for joining us.

Dr. Kevin Simon (01:02):

Yeah, it's a pleasure to be here.

Dr. Josh Berezin (01:03):

Just to start us off, tell us a little bit about your career path and what you're doing now, and how they kind of led to this particular paper and topic area.

Dr. Kevin Simon (01:13):

Yeah, yeah. So again, thanks for having me on the air. In terms of career path, so as you noted, I'm the Chief behavioral health Officer for the City of Boston, and I got appointed to that role back in 2022. By clinical training, I'm a child psychiatrist, adult psychiatrist, and addiction medicine doc, so I still maintain some clinical privileges in the Boston area at Boston Children's Hospital. In terms of how did I end up here.

(01:41):

Even during residency, I've always had the idea of wanting to be involved in public policy, mental health policy, mental health care, reform. And after clinical fellowships, I was in a leadership fellowship called the Commonwealth Fund Fellow, and there it's been in existence greater than 28 years. And there are a number of alumni who are involved in local, federal, on the payer side, leadership, and it happened to be at right time, right place that the city, along with many municipalities, secured ARPA funding or American Rescue Plan Act funds in response to COVID.

(02:26):

And at the time, the city, like many cities, has a public health department but did not have someone necessarily charged with thinking about and executing a citywide plan as it pertains to mental health and behavioral health. And so while the Boston Public Health Commission or BPHC has many bureaus and we are responsible for two shelters, we're responsible for an engagement center where individuals

that might have substance use challenges go for services and EMS where we are responsible for, there wasn't a person and team thinking strategically about behavioral health.

(03:08):

And so the Commissioner, Dr. Ojikutu, and the Mayor, Michelle Wu will recognize that it potentially would be beneficial to the city to think about it. And so I was recruited, and through the support of mentors, advisors and recognizing wanting to have an impact other than just impact by where is it that we publish in the academic medicine, thought that being in community is where I feel kind of like most myself. And so that's how I am in the role that I'm in.

Dr. Josh Berezin (03:42):

So you've been doing it for two years. And I'm asking because it's a really... it does seem like somewhat of a unique role. I mean, I think that a lot of cities have somebody who's within the health department and is-

Dr. Kevin Simon (03:55):

Mm-hmm.

Dr. Josh Berezin (03:56):

... the behavioral health person there, but your role seems even a little bit more, I'm not sure, all-encompassing. So I'm just wondering how it's been to be at that perch and how you found the job or even crafted it since you're the first one.

Dr. Kevin Simon (04:11):

Yeah, yeah. So, from a clinical standpoint, I kind of consider myself a liaison within the city in that regularly communicate with our school district, our police department. In part, to operate a city, there are many different sectors that are involved with each other. And again, many are engaging in mental health services, behavioral health services sometimes whether they recognize it or not.

(04:36):

And so, in terms of being in the role, the first kind of operation that was important was we had this funding that we needed to ensure was allocated I have to say [inaudible 00:04:49]. In 2024, after a year of planning, we were successful in initiating and distributing $21 million as it pertains to behavioral health activities across the city, the predominant resources being allocated around school behavioral health, improving pathway for people that are from the Boston area BIPOC to pursue careers in behavioral health that we all recognize that there's a shortage.

(05:15):

And then also funding efforts in local kind of K to 12 schools and then also upskilling because we'd often hear from constituents staff that are not clinicians, "I had young people and old people coming to me revealing things that I not fully equipped to necessarily manage." And so now we have a kind of training institute where if you are the local water department if for some reason they want training there, can identify a subset of people that will then be kind of like the champions of the local department. And then a lot of these things came from our community health needs assessment, and so surveying thousands of people. One of the messages we regularly heard was, "We don't know what's available."

(06:04):

And if you're not a major kind of for-profit entity that can put commercials out very regularly, it's like, "Oh, wait a minute, let's use some of our funds for a public mental health campaign." And so we just completed that. It's called Heads Up. In part, we wanted to make sure that people knew what services actually are available across the city. So in terms of being in the role for two years, I like thinking about social determinants of mental health, and this role affords that because I talked to housing colleague, and we created an RFP for credible messengers, which I'm sure you all knew.

(06:48):

And it's like, "Well, with the credible messenger be best if it was done through a community behavioral health center or actually, oh, what about if we did it at a housing complex because a good chance that there are credible messengers at the housing complex." And so that RFP came out from our Boston Housing Authority, not from the Boston Public Health Commission, but they certainly collaborated with us on what to do. So having that public policy, mental health, social determinants frame of reference, I'm able to be helpful to many different departments across the city.

Dr. Lisa Dixon (07:29):

It's very impressive that you've been able to both be generative and be sort of... I mean, creative generative and sort of make all these things happen. I'm just sitting here going, "Wow."

Dr. Kevin Simon (07:45):

Appreciate the comment. I think this is certainly not like Kevin unto himself. There's a team. Our local public health leadership, the mayoral leadership, being truly intentional about wanting to bring people to the table is imperative. And in terms of the leadership that we have across the city, when... if it's me in my role and someone has called our 311 system and they send me a message, "Hey, Dr. Simon, there's some issue," I actually want to really resolve the issue. And the team recognizes, "He's not asking us to do anything that he himself wouldn't do."

(08:29):

And so I think it... there's certainly a cultural shift in change that seems palpable to others. But yeah, really, I think the clinical training that I received, the public health training, and I think just being a psychiatrist, we tend to want to understand not just the symptoms that are coming and the persons presenting, but that factor must be, "Tell me about your family or tell me about work or tell me about some other aspect?"

(09:01):

But often in clinical work, we can ask and may not necessarily have some tool to actually impact that other element or domain of that person's life. In this realm, I'm certainly not creating housing policy, but certainly can think about, "Well, how can we have mental health be a part of the discussion even in housing or in the school transportation it comes up?"

Dr. Josh Berezin (09:28):

I mean, it's a fascinating role. It's like your clinical training, it's policy, it's social determinants work, and it's this, I think, you mentioned kind of like a systems council liaison role as well. So it's a really unique viewpoint that you have. And so I'm really happy you're here to share some of that with us here today. And in terms of this collaboration, who are your co-collaborators, and how did those particular ones develop?

Dr. Kevin Simon (09:58):

Yeah, so there are a couple of graduate students, but then there are senior scientists and faculty. So, Jenna Savage, she's within the Office of Research and Development at the Boston Police Department, and then Melissa Morabito. She's on faculty at UMass Lowell. A professor of criminology. And Jenna and I came across paths in part in me just trying to understand all of the different departments, and I'm having meetings with the police department, I'm like, "Oh wait, there's an Office of Research."

(10:29):

And Jenna and I spark up a conversation recognizing that we're actually really vested in understanding the nuances in slowing down. And so interesting enough, within our state, we have a department of mental health. And because of the role I'm in, I got alerted to a concern that one of the medical directors or one of the houses that DMH clients are in that the police were asked to come to escort somebody to the hospital. And I was actually being alerted that the police did not, quote, unquote, escort the person to the hospital. And my clinical colleague was very frustrated by that.

(11:12):

And so I said, "Hey, I don't have jurisdiction over what the police do, but I'll certainly look into it." And in the summer of what I say, the summer of Floyd, 2020 post-George Floyd, Breonna Taylor, and the kind of racial reckoning that the country was in, there was a recognition by police leadership, of which by that time actually had not had any egregious acts happen, but said, "We certainly want to engage our citizens constituents differently." And by differently, they said, "Well, what can we do better?"

(11:47):

And one of those things tends to be this mental health evaluation or transport to the hospital for mental health evaluation. And what they did was they increased the amount of crisis intervention training or CIT, the hours that they have, and then they formed a specialized unit that when these orders come in, this particular unit that even has more training is going to be the one that goes out and makes their own actual assessment.

(12:15):

At the time, apparently, the assessment was they went to the residence, asked the individual if there was a concern, then the person fully knowing how to utilize the system said, "No, if I have an issue, I know how to call 911. I know how to get to the hospital." And they said, "Oh, this person doesn't seem to actually meet criteria for Section 12(a)," is what we call it.

(12:38):

And that then made me say, "Oh, wait a minute. There's been a shift. You all were doing things one way pre-2020, now you're doing something different, but that's a study." So I was like, "Can we look at the Section 12 applications that have been submitted from June of '21 to July '22, and let's just characterize who sections are being written on and what information is gleaned from the applications."

Dr. Josh Berezin (13:09):

Just to give folks some context, [inaudible 00:13:11] you do this beautifully in the paper, could you talk just what is Section 12? How does it work? What is it? What is the context of these police involvement in these involuntary transports?

Dr. Kevin Simon (13:22):

Yeah, so Section 12(a) or involuntary transport to the hospital for a mental health evaluation is a process that exists in Massachusetts as well as most of the other states in our country, where if somebody is deemed to be experiencing a mental health crisis that is organic in nature also, that certain people can

make that assessment and sign this petition or order to have that person transported to a hospital emergency room and get evaluated.

(13:56):

In Massachusetts, on the form, you realize that there's actually five professions that can fill out a section, a licensed physician, a licensed psychologist, a licensed clinical social worker, a licensed nurse, and a police officer. Now, of those five professions, only one is actually legally allowed to take some person against their will, which is the police officer, which is why even when a person calls 911, if the person says, "I don't want to get on the gurney," 911, or EMS does not have the jurisdiction and say, "No, no, you must."

(14:34):

And so a lot of times, police officers show up with the ambulance in the event that they really do need to go, even against their will. And so an interesting facet here is many providers are aware of the section order, but then sometimes, myself included, we don't always think about the full mechanism by, "Wait a minute, if I wrote this section, the person's not actually coming in my car, and they're often not going in the clinician's car," you are actually necessitating some legal involvement.

(15:12):

And so we can talk about alternative response models, but as it currently stands when... in Massachusetts, when you file a Section 12(a), you are actually necessitating that police officers show up because they're the only ones that actually have the legal jurisdiction to take someone involuntarily. And I'm not sure how often the person who's writing the order is communicating to the individual, "Hey, I'm writing this order on you, and I'm calling the police."

(15:49):

So sometimes I think constituents feel, "I was experiencing this distress, and then the police showed up. What the heck happened?" That communication of, "Oh, actually, this process necessitates that they're involved," I think that's another thing that we're trying to convey through the paper that there's a lot more that we can do across the field in improving what this process looks like.

Dr. Lisa Dixon (16:14):

I would just say that I really can relate to that because there's so many complex parts of that process that you've described but that you don't really think about as a clinician. So it's like, "Oh yeah, there is a transportation issue here."

Dr. Kevin Simon (16:30):

Mm-hmm.

Dr. Lisa Dixon (16:31):

And I have to say, just being aware of it is probably important. I mean, there's help making it work better and more fairly, but it just feels to me like some of this is just so invisible at times.

Dr. Kevin Simon (16:47):

Right, right. No, you're correct. Because we learned this in vivo, you end up practicing it the same way that you learned it. And there are many times that I've been in the hospital, and someone's like, "Wait, who fills out the section?" It's like, "Oh, you don't. Maybe you do, but you haven't looked at it to

recognize, wait, who are the people that can actually fill this out?" And then what does that mean that I filled it out? So that's what this paper and our evaluation was trying to characterize.

Dr. Josh Berezin (17:17):

When we've talked about papers around involuntary commitment in the past, I'm just always surprised about not so much what we know but how much we don't know about the details around both in terms of what happens generally sort of across the country, but even within municipalities or smaller geographic areas about just even basic information about who's filling out the form, how often are people getting transported.

(17:51):

So maybe by way of getting into some of the details of the paper, you could tell us a little bit about what we or you knew about involuntary commitment in Boston prior what questions you had, and then how you went about answering them in the study.

Dr. Kevin Simon (18:07):

Yeah, so certainly knew that there likely or... well, I suspected that there were likely disparities and inequities in reference to the process. Knowing the data about involuntary transport to be evaluated as well as involuntary and hospitalization in a psychiatric unit, there is a disproportionate rate of individuals that identify as BIPOC, Black Indigenous People of Color, experiencing those outcomes.

Dr. Josh Berezin (18:34):

You also mentioned that there's an actual form that people are filling out, which seems like it was probably a very rich source of data for you. So what did the form... What other things does the form collect, and how did you use that when you were trying to analyze what was actually happening?

Dr. Kevin Simon (18:51):

So the form collects the identified patient's information. While there is race, the race... because the person who's filling it out is not oftentimes the person that is going to be transported, the race is actually subjective on the persons filling it out. So we recognize that that nuance is important because maybe somebody phenotypically looks a certain way, and so then I say, "Oh, this person is Asian," yet, entirely, they may not actually be it. This might be my own bias of what I think an Asian person looks like. Also, on the form, it does. Is this a psychiatric?

(19:30):

And they put broad generalizations of bipolar, psychosis diagnoses there. Also, is this actually not primary psychiatric from a condition standpoint, but is there a threat of HI or homicidal ideation? Also, it notes that much like many of our DSM criteria, it says, "Cannot be due to substance use," and then it [inaudible 00:19:58] the person who's filling it out, what your credentials are, and then where is it that you're trying to transport the person. And so that's the 12(a). And then on the backside... We didn't fully go into this in the study.

(20:11):

The backside is you've had the evaluation and the 12(b) is usually for the person that's being admitted and the admitting physician says, "Yes, I accept this person to our unit voluntarily." And so I think over the year timeline that we looked, it was more than 450 that we were able to assess, a little bit less than 500. But the findings themselves again helped us think, "Wait a minute, there's more here." And so, for

instance, in real-time right now in Massachusetts, and I know in other states and cities, we have alternative response model or co-response model.

(20:52):

And so another iteration of a study that we want to do is what does it look like when the section is ordered, and all sections get sent to the Boston Police... at least in Greater Boston, the Boston Police Department. What does it look like for the co-response team to actually go even separately and different than the current street outreach team that does have a little bit more mental health training but is co-responsible to actually have a clinician and trying to see what that looks like?

(21:26):

The other thing that we want to look at is how many of the involuntary transport orders actually result in an admission, right? Because I could be the clinician in the community, I send the person, and what percentage of those emergency room admissions result in a 24-hour observation person? Maybe they sober up, that they deem that they're just not actually suicidal, and then result in the discharge. There's a suspicion that there's actually a high percentage that do not convert into an admission, yet that is an expense because, again, hospital transportation.

(22:09):

The EMS thing in Boston, it's around $1,500. And if we're talking about a population that has serious mental illness, for instance, oftentimes maybe they're on Medicaid, or we call it MassHealth, but maybe they're not, well then who... the $1,500, some municipality has to pay for it.

Dr. Josh Berezin (22:29):

So another one of your findings, when you looked at these 500-odd sectioned petitions, were that 70% of them resulted in an involuntary transport to a hospital for evaluation. Did you have a sense of what's happening between those 70% and the 30% that don't result in a transport?

Dr. Kevin Simon (22:50):

Yeah, yeah, yeah. So good question. In terms of the 30% that don't result in the transport, strong suspicion here is the team went out, the police department team went out, could not find the person, right.

(23:06):

Because again, the section that is being written. Sometimes it's being written from a clinician that, yes, [inaudible 00:23:13] has the individual in their office, but it could have been that the request for the section or the petition for it might've been written by someone that was at a housing facility.

(23:26):

And oftentimes, we may not know, "Well, where'd the person go?" So I think that's what's happening in that... Well, at least a percentage, that 30% that are not completed is they did go out, and we don't even know where the person is.

Dr. Josh Berezin (23:42):

Once the section petition is completed and the police go out, if they do find the person, are they obligated to do the transport, or do they have discretion if they find the person and they're like in the example you offered earlier [inaudible 00:23:55].

Dr. Kevin Simon (23:55):

Yeah, yeah. So this is [inaudible 00:23:59]. Technically, by the letter of the law in terms of the profession that can fill out the section, the police officer can show up, say, "Hey, we've done our own mutual assessment, and we don't deem it necessary." However, from a professional courtesy standpoint and historical kind of precedent standpoint, someone submits the order, the police officers will say, "This has been done," and we'll want someone at the hospital to justify that this person does not need to be admitted.

(24:36):

And so in shifting how, and the Boston Police Department is shifting how they want to actually better engage constituents that are experiencing a crisis, there's also trying to reshift the cultural dynamic of what this process is. And just because the police department might recognize, "Hey, we want to engage people differently and do it better, more humane, ethically" the thousands of clinicians that are in the community may not recognize, "Oh, this is what they're doing."

(25:09):

And so still, a lot of times when the orders are submitted, they will bring the person to the emergency room to be formally, clinically evaluated. So this question here kind of hinting at system change, and if you want improve something and we could all know it's meant to be improved, is everyone brought in to the idea that this has to be improved? And are there professional nuances where people might feel, "Why are you changing my aspect of my role in my field, but you're not doing anything to your field?"

(25:46):

And so kind of recognize these dynamics in an interdisciplinary team where we have EMS colleagues that are like, "Oh, yeah, section. We're actually not even one of the five professions on the section," which is true, but they certainly are first responders. Psychiatrists, a lot of times, when presenting about involuntary transport, first question is, are the police trained enough? It's like, "Well, [inaudible 00:26:13], they're pretty trained to engage people that are in distress of all sorts," but how often do we actually engage people in distress in the community?

(26:23):

It is a different thing to say when you're on an inpatient unit or in the hospital, and you can call on staff. But in part one of the things on the form that you asked me earlier, not characterizing why I'm filling out this order, I now of it as an egregious fault of ours, because you're then asking an officer whether they have a hundred hours of CIT training or not, "Hey, go pick up this person that I think is distressed enough to need a hospitalization. And by the way, figure out how to do that just talking nicely to them."

(27:05):

I actually am more in recognition that we all have areas to improve. And in terms of one of your earlier questions was how did we get engaged in thinking about this as a study? One of the challenges in being in this new role, and yes, I am a psychiatrist, there was a lot of relationship building that was required with the idea that I want to look at police data and [inaudible 00:27:37], "Who are you, Dr. Simon?" And so there truly was, "Hey, let's just get coffee."

(27:42):

Or the baseball game between, or the basketball game between the fire department and the police department. "Hey, I'll join. I'll ride the bench." This is relationship building, and it's necessary because we come in and we want to make changes, but who are you to say that this thing has to be changed? What are you actually demonstrating to me as a person that respects my profession that I want to be helpful? And so I say, "Oh, hey, I do not want to make this harder for you. I just want to make this easier for you." But that a lot of relationship-building.

Dr. Josh Berezin (28:17):

I mean, there's so many cross-systems, ethical, equity, historical issues that are tied up in this process and this topic and a lot of different lenses that people bring to this. Do you have a vision of how this should work or could work better? From your vantage point, what do you see as maybe we won't make you solve the whole thing, but even sort of as a next step for improvement?

Dr. Kevin Simon (28:52):

There are models across our country where this looks different. Before even referencing some of the models I will say, in each of those cities where these models do exist, where we would say there's been improvement, there are still constituents advocacy groups that say, "We want zero involvement of the police." And that continuously also exists in Massachusetts. In reference to models that have some evidence and seem to be working, there's cahoots out in the West.

(29:25):

Recently, in the Midwest, in Detroit, they have a specialized mental health unit a part of their police department, that when they go out, they do not have any firearm. They have a whole different color uniform, and they have had positive results of being able to bring people in or even, again, verbally de-escalate individuals in the field. I think in Massachusetts or in Boston, we have multiple alternative response models. So we do have a co-response where a clinician and a police officer go out.

(30:00):

You also have a co-response of a clinician and EMS go out. You also have tele EMS, i.e., if the dispatcher asks certain questions, come to realize that, "Oh, this is actually behavioral health," further inquires, "Okay, could this actually be virtually done?" So I would say for as nuanced as individuals are, we do need to have multiple pathways to being to help people who are experiencing distress.

(30:29):

Because, oftentimes, the moment or the episode of distress is an episode, and how do we connect the person that's in the episode to the right types of longitudinal outpatient services if they don't have those services? And so there is no one solution. And I think I fully understand advocates that say they don't want any police involved. I also fully recognize sometimes, just by the necessity of suggesting that we have to bring a person against their will.

(31:03):

And so one could argue ethically, "Well, is there a space where taking people against their will doesn't exist, right?" And again, that seems like a theory question, but right now, in many of our states, somebody might be experiencing distress, and people recognize this person needs help. They then say, "Why did you let me exist that way in the street?" So this is a very complicated area, and that's why I think in terms of solutions, it has to be [inaudible 00:31:37] many pathways and opportunities to treat people right even when they may not recognize it for themselves.

Dr. Josh Berezin (31:43):

So I think that's a good place to wrap up, and we just wanted to thank you for the paper, and for joining us today, and all the really interesting work that you're doing in Boston, and we're looking forward to hearing more on this topic and others from you in the future.

Dr. Kevin Simon (32:00):

Yeah, no, thank you for sharing this platform for us to talk about it. Really [inaudible 00:32:06].

Dr. Lisa Dixon (32:07):

And I concur. And I think the really careful almost microscopic components of this whole process are so important because this is what people experience, and so you're sort of taking it apart and sharing it and critiquing it and coming up with alternatives is really important and valuable.

Dr. Kevin Simon (32:28):

Thank you.

Dr. Lisa Dixon (32:29):

That's it for today. Thanks to Aaron Van Dorn for mixing and editing and Demarie Jackson for additional production support. We invite you to visit our website, ps.psychiatryonline.org, to read the article we discussed in this episode, as well as other great research. We also welcome your feedback. Please email us at psjournal.psych.org. I'm Lisa Dixon.

Dr. Josh Berezin (32:53):

I'm Josh Berezin.

Dr. Lisa Dixon (32:54):

Thank you for listening. We'll talk to you next time.

Speaker 4 (32:57):

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(33:04):

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