From Crisis to Care: How Boston's BEST Program is Redefining Mental Health Support

Mental health is an important part of our overall health, but many people confront barriers that keep them from accessing the mental health care they need.

A program in Boston aims to address mental health disparities by disrupting traditional health care models. The Boston Emergency Services Team, or BEST, is led by Dr. David Henderson, chief of psychiatry at Boston Medical Center.

BEST brings together mental health providers, community resources, law enforcement, and the judicial system to deliver care to people in need of mental health services.

Henderson says bringing mental health providers alongside police responding to calls for service for mental health needs has helped reduce the number of people with mental illness ending up in jails and prisons.

“The criminal justice system has, by default, become one of the largest mental health systems … around the country as well,” Henderson says. “People with mental illness are in jails and prisons, at a percentage that they really should not be.”

Henderson speaks with Health Disparities podcast host Hadiya Green about what it takes to ensure people in need of mental health services get the help they need, why it’s important to train providers to recognize unconscious biases, and what it means to provide trauma-informed and culturally sensitive care.

The transcript from today’s episode has been lightly edited for clarity.

Dr. David Henderson: I love it when I meet, you know, family, new patients and I'm doing my history and [I ask], "Anyone in your family ever have mental health problems?" "Oh, no, oh, no." Then the next week, "Well, I talked to my aunt, so and so and she said that," and then all of this was like, Okay, there's a dozen people in my family have had problems. So because simply people don't talk about it. And of course, like, it's not all that you need to see a professional, right? There's a whole level of care and things that people can do to help themselves and so on. But the fact is, I think the biggest point is that one has to recognize that, you know, there's something just not right.

Hadiya Green: You're listening to the Health Disparities podcast from Movement Is Life. I'm Dr. Hadiya Green, your host for today's episode. I'm a steering committee member of Movement is Like, a doctor of physical therapy,

and founder and president of Healthy Healing Communities. Today, we'll be talking about mental health.

Mental health is an important part of our overall health. And just as there are disparities when it comes to physical health, disparities are prevalent as well when it comes to mental health. Many factors contribute to these disparities and mental health care. Fortunately, there are people out there working to advance health equity when it comes to mental health, and to close the health disparity gaps.

Dr. David Henderson, who's with us today, is one of them. He's a psychiatrist and the chief of psychiatry at Boston Medical Center. Dr. Henderson, welcome to the Health Disparities podcast. And thank you so much for being here.

Henderson: Well, thank you for inviting me. This is wonderful to be with you today.

Green: Excellent. So after Henderson, let's jump right into our questions for today. Tell us about the work you do as a psychiatrists in chief at Boston Medical Center, or BMC, and as chair of psychiatry at the Boston Medical School. Please include some information about you leading a program at BMC called BEST, which as I understand stands for Boston Emergency Services Team.

Henderson: That's right. Thank you. Yes, so I head up the Department of Psychiatry here at BMC and BU. And so it's my job to make sure we have the resources and the people to care for our people in our community. And as you know, Boston Medical Center is a large safety net hospital, that we treat anyone who walks through the doors. So we have to have a pretty large capacity in order to care for the community. And so I've been here at BMC for about eight years, prior to that I was at Mass General Hospital. And the two institutions are very different. But I would say that we really had to pretty much quadruple our capacity. Because the need for mental health is so great. And then, you know, speaking of disparities, there's just such a gap in availability

of mental health care, you know, throughout the world, really. And so it's my job to help build capacity so that we can meet the needs of our community.

Green: Thank you. Dr. Henderson. Can you talk about how BEST specifically is disrupting traditional health and mental health health care models?

Henderson: The BEST program, it's our emergency services program. And so it's been in operation for more than 20 years now. And it basically it started with a mobile crisis unit. And so there's a phone number that people can call in, originally it was funded by the Medicaid insurance as a service for the community. And so anyway, people can call this number and speak to a clinician determines whether they should go out and do a home visit or whether there should be another type of intervention, including getting the police involved and bringing the person to the emergency room and that sort of stuff.

It has been pretty amazing, because the program started with simply just this. And then it has evolved into numerous other programs that are connected, that really allow us to kind of, you know, fill in the continuum of care. So that, you know, in many places, in many communities, they do one slice of it, but then there's nothing else. And so, we over the course of the 20 years have built other programs that help kind of fill all the gaps, so that people get the care that they need when they need it, in the least restrictive environment, as well. So it's been, I think, quite a journey. And for me as a researcher, my role, because I didn't start BEST, it was here when I arrived, but my role was to really take a look at the data, and to see how we can, what we can learn from the data. We looked at, like we had 80,000 lives in acute distress over the course of 15, 16 years. And I felt that we could learn from our patients. And so we started using the data to to teach us to make better decisions, or to develop new programs, and so on. So that's, I think that's actually critically important as well.

Green: You mentioned the police. What can you tell us about some of the access points to BEST? In other words, how would I, if I'm someone in the community, even know that BEST exists? So how does that inform, how's that information disseminated? Or how does one come in contact with BEST? And

secondarily, can you name some of the types of members that make up the BEST team?

Henderson: So the first is the BEST team, the clinicians are primarily masters level clinicians, who are backed up by a psychiatrist. We have a psychiatrist on call 24 hours a day, seven days a week. And master's level clinicians are usually social workers or licensed mental health counselors, and they do the majority of the work and evaluations and then they have a consultation with the psychiatrists. So that's one piece, I think it's really important. Many other programs around the country, they don't provide the psychiatrists as a backup. And so there are some challenges there as well.

And so working with the police, and particularly, you know, we work in several communities, not just Boston, but Boston is certainly one of our main partners. We first started, you know, simply by, you know, when, you know, again, somebody calls, the information is readily available. It's publicized to the Department of Mental Health and, you know, every hospital knows that this is the number to call, when they want somebody evaluated. And so, so they're very, there's a number of options, like somebody calls and says, I'm having a problems and that sort of stuff. Sometimes we can just send a clinician out to their home and evaluate them. Sometimes they go to the shelter or wherever they are. When it's determined that they may need a level of care, particularly an evaluation in the hospital in an emergency room, then we in Massachusetts, we have what we call a section 12 and that gives you know, the doctors signs it and says I'd like this person brought to the emergency room so they can be evaluated. Doesn't commit them to anything other than to that evaluation. And typically those are executed oftentimes by police, sometimes by ambulance EMS system.

Now as our program has evolved, the system has changed, for instance, we for years, we've had three clinicians in the Boston Police Department, and the clinicians would ride out with the police on calls that they thought were appropriate for, you know, there's a question of a mental health crisis associated with the call. So our clinician would ride out with police and then help determine working with the police officers, you know, what's the best intervention. And so we had three and then around the time of the George

Floyd tragedy, and everybody wanted to do something, and so on the city of Boston came to us and said, Okay, we want one of your clinicians in every precinct. And so we went from three to 20 clinicians. So every police precinct in Boston, has a clinician, that goes along with the police officers when there's a question about mental health.

And this has, I think, a significant impact in decision making. And so, for instance, we can, you know, one of the major issues that we're concerned about is that many of our patients end up in jails, arrested for various minor offenses, and so on. But with our program, called the co-responder program, we're able to kind of help, come as a tool for the police officers, so that they can make different decisions, and lead to different outcomes. So we've been able to show that we've reduced arrest rates, significantly utilizing these programs. And so it's been a wonderful partnership. And when it first started, the police officers were really reluctant to have a civilian in, in the car with them. And now they're asking for it. They're like, Oh, can I have the clinician with me today? So we're really, we're able to change their attitudes as the system evolved until for every section 12 that the police will execute, now they go out with one of our clinicians. So it's been really great to see.

Green: You are leading me into the two things that I wanted to talk to you about, namely, access, as well as the criminalization part, but let's start with access first. So when we talk about mental health, access to care, what would you say are some of the disparities that persist in our nation when it comes to mental health?

Henderson: Yeah, access is, remains a huge problem in this country. And in even, you know, in some communities now, the funny story is that I tell people, that in Boston, you can't walk down the street without passing a psychiatrist, every block. There's so many of us here, right? However, it's hard to staff our hospitals, and our community health centers, and so on, because the large population is in private practice. And so giving access to those who can afford it, but for others, who will have to rely on insurance, government insurance, or even commercial insurance, the access is really difficult.

You know, we wake up, you know, and like, we've got 2,000 people on our waiting list that we have to try to get to see, and so on. And so, it's a challenge here. Now, I have a different perspective, however, because you know, I do global work. And I've worked in countries where there are no psychiatrists or one psychiatrist, and no other kind of clinician-level specialists around mental health and stuff. And so that's a challenge. That's a different type of challenge. But we, you know, we really have to work hard to improve access, and of course, it it cuts across the disparity line and the racial line, and so on. And so, you know, many of our, you know, Black and Brown communities are underserved when it comes to mental health. And so our goal is to be able to bring access as best we can to our patients.

Green: Thank you. And as far as caring for those marginalized communities, like you started to allude to that don't have the same access to mental health care, including people living with schizophrenia and other serious mental illness. You have of experience working both locally and internationally, as you mentioned, and resource limited areas and communities impacted by mass violence and disasters, what kinds of things make it particularly challenging to reach these groups? You touched on some of it being almost insurance, or cost impacted. What other things or if you'd like to go further in depth on that, would you say?

Henderson: Sure, thank you. Yeah, every place and country and state or city, you know, their problems are different. And the challenges are different. And so, I think that, you know, for me, my global work has put things into perspective for me, in that when I'm in Boston, and people saying, We have no resources, and I just kind of laugh, because they have not seen what it's really like to have no resources. And so, I'm working in a country like Liberia, where, you know, for many years, there was just one psychiatrist for the whole country. It's, you know, so the question is, how does one care for people when, number one, they had been through 18, 20 years of violence, with a war, so they're post conflict? You know, so that's one group of people who are affected, right? And then they have the typical, like, those with serious mental illness like schizophrenia and so on. And they, you know, but they still have to be able to provide some care. And so for me, it's really thinking of the long

game in that, you know, that's, yeah, well, we can do something today. But what can we do tomorrow, that's going to change the course of this situation.

So for Liberia, for instance, we got involved in 2009, and help the Ministry of Health, right, the mental health policy for the country. But that really didn't change the mental health care, it was just a piece of paper. But finally, we were able to work with the one Liberian psychiatrist, Dr. Ben Harris. And we started a psychiatry residency training program in Liberia. So we've been training Liberian doctors to be psychiatrists. And we utilize some of our partners, for instance, we'd send them to Nigeria to get substance use training, and so on. And our team in Boston would supplement the teaching on the ground, and we would travel periodically as well. And so now, in September, we will graduate two more. And so we've already graduated four doctors, who are now psychiatrists in Liberia, and we'll get to six in September. And these doctors are now taking over the mental health system for the country. They're in the Ministry of Health are and so on. And so, so just by doing that, we I think we dramatically change the outlook for for that country. Where, you know, I met with, you know, the President the country before many, many times and all yes, we need help a mental health, but actually, they weren't ready to do it. And so we just waited them out. And then finally, the government supported the training program. And now they have to have specialists who will build their mental health system. And so, you know, so that's just one example of how, you know, we figure out where we're at, and then how to improve that system. And we do the same thing in Boston as well.

Green: I love that you mentioned that differences or disparities is different depending on where you're at. And what we might perceive as a lack of resources is, relative to where we are, and that and that if we haven't seen what nothing actually looks like. And so maybe you can touch on this integrated mental health care model, specifically, BEST, and how it plays a role in addressing mental health disparities and what that means to you, and what it looks like in practice?

Henderson: Thank you. That's great. And to get back to your comment about the criminal justice system, I think this is a critical piece to this story, because,

you know, everybody's heard of the, you know, deinstitutionalization of people with mental illness decades ago, pushing people out into the communities even though the community system was poorly set up in order to really care for individuals and so on. And so the criminal justice system has, by default, become one of the largest mental health systems in certainly in Massachusetts, but I think around the country as well, meaning that people with mental illness are in jails and prisons, at a percentage that they really should not be.

And so one of the challenges is to say, how do we address that as well? And so, BEST started with the emergency services and the kind of the mobile unit and then we added the police side along, and then we started working with the courts, and established mental health and substance use courts, so that we could try to prevent people from having to go to jail. And then it you know, which I think it's a critical piece, and then we added an outpatient assisted treatment program that allows people coming out of jails to immediately get connected to mental health and healthcare. Because we know that the data has shown that if you, when you come out of jail, if you don't get connected to health care, within a month, you end up back in jail. So there's very clear data, so we get them immediately and connect them.

Now, I'll have to tell you a little story. I love to tell stories, but during the George Floyd thing, you know, everybody was calling me I don't know why they were calling me like, hey, Dave, what do we do? And I'm like, I have no idea like, tell the police stop doing it. That's all I could think of. But then I had an experience that really brought a new level of insight to me, and a new idea. So I was, you know, it was during the pandemic, and I was like, at a local grocery store at the town next to me. And I, as I came out with my groceries, I got to my car was loading the groceries in the trunk, I saw that there was a police officer, a police car with lights flaring, and had pulled over a young white male, and it was searching just this young man's car. And then I saw that, you know, he must have called for backup because another police car was coming into the parking lot. It had a direct line towards where the other police car was and and this young man was directly driving towards it, and then somehow saw me at my car, putting my groceries in the car, and deviated and pulled up right next to me. Even though, like the police car is

over there, like how you couldn't miss it, the lights are flaring and so on. And I thought to myself, but how powerful is that? Right? Like that's, like, your brain is, you're headed right for the danger, and your brain is telling you 'no, no, no, there's a black man over there. That's where your danger is.' And I thought, Man, that's absolutely amazing. And now if I just processed it, you know, like, the police officer looked at me, I looked at him like, you know, I'm sure, I was thinking some not so great things. And then he went around and you know, went to the other police car.

And then that night, I woke up at three in the morning. And I like to say that, you know, I got it. Because everybody's asking how can we have an impact with and prevent the George Floyds again? and that sort of stuff. And I said, Wait a minute. We have the relationships, the BEST program. We're working, we're in the community, working with community organizations, we're working with the police. We're working with the courts. We're working, you know, in the schools, and so on. So we actually have the right partners in the room. We just simply have to shift what we do, and how we do it. And so from that we decided that like, you know, we needed to add a kind of racial and social justice piece to it. And so when we train the police, we need to bring that content into it.

We're lucky at BMC we have a multicultural psychology program that's been in existence for 50 years, teaches people how to, you know, understand their own, you know, biases and how it impacts decisions and that sort of stuff. And so, we're starting to bring all those things into everything that we do, in this really comprehensive program that touches just about every data point.

Green: You've talked about some of the pieces of having a vicious cycle between unmet health needs and people and recidivism and going in and out of the criminal system. And you've also touched on the importance of community based options for treatment so that there's actually that care over so people don't end up back in the system, or at least untreated. This makes me think about trauma-informed care in general, another word that seems growing in people's knowledge, even though it's something that has existed for quite some time, um, it seems that more clinicians not just in it, who are trained specifically in health, mental health, are trying to infuse this method or

knowledge into their care, what does it mean to provide mental health care that's truly trauma informed?

Henderson: Thank you, I think this is an important area, I think, first is to recognize that not everybody has a history, and everybody has had experiences, and some of those experiences could be good, and some of those experiences could be bad. And, particularly as it relates to health care. In, you know, for instance, and you know, Black and Brown populations, you know, depending on, you know, where they get their healthcare and so on, could has a big impact on how well they feel they're treated, and so on. Do they feel welcomed in the environment, as well? Now at Boston Medical Center, because of the, you know, the population that we care for, we are always thinking about trauma and trauma exposure, and therefore, you know, how do we present ourselves to patients and communities with the understanding that many folks have been exposed to various types of traumatic events, and those traumatic events are often with them every day, and they have multiple exposures, and so on? So for us, it's, it's important for us to be aware, of this, and then to, you know, like, just, you know, training people on how to how to greet people, how to deal with somebody who's upset how to, you know, recognize that. Like, every time we do a survey, we see that the percentage of individuals who have experienced traumatic events. And even like, I'm, you know, in my global work, I'm not a big PTSD person in that post traumatic stress disorder, because I don't think Post Traumatic Stress Disorder captures every everything that happens when somebody has a traumatic event. And so, you know, it's one thing, I think it's one outcome of trauma, but it's not all encompassing, and so for us, it's really, you know, we have to integrate everything that we do with the mindset that this could be in somebody who's had traumatic experience, how would we do that differently? How would we interact with them differently? How would we even set up our waiting room and, and where they can, you know, exits it, you know, just just know all all sorts of stuff at all levels. And I think it's absolutely critical.

Green: You've mentioned throughout the talk of the George Floyd, tragedy, and we know in this country that George Floyd is not, it's not unique. It happened during the pandemic, time when everyone had to sit down and be

still, and it was so much more in our faces. And we're in an era of technology where things are telling us a lot televised and easily, information is more easily disseminated, right? It was the perfect storm of time for people to actually receive and in this case, feel what happened. But being that these disparities in life existence in the U.S., I'll speak to U.S. specifically, is there some shining light on mental health and mental health disparities? Even if there's some exacerbating of mental health conditions in number that happened a cause to the pandemic? And in your expert opinion, would you say that we're still recovering that, or is there a silver lining? Do you think there's a heightened sense of awareness among healthcare professionals and lay people about the importance of mental health care?

Henderson: I think, thank you, I think that, coming out of the pandemic, and you're, you're right about George Floyd like situations, it's been going on forever, right, but the attention, I think given to it, I think, you know, brought us to a new level, I think, of focus. And the pandemic itself, simply because it had created whole a whole new population of people with mental health problems that we've still have not addressed or to have the capacity to do. So. I've, you know, I've spoken to many people recently who, you know, have mentioned the fact that, that there, they feel that they certainly have been more aware about mental illness now. And even more open to talking about it. And, you know, as you know, stigma is huge, across many cultures, and populations and countries. And so there seems to be, you know, as a result of the pandemic, and exposures and stuff that people there, we're at a place where people are more willing to talk about, talk openly about mental illness, get help for their mental health problems, and so on.

So I hope that this continues, you know, as you know, many times, these things get hot, and then they just cool off and disappear. And then we go back to, to where we were and stuff, but my hope is that the attention around mental health really, needs to stay in the light, because quite simply, everybody's affected by it. Every family has been impacted. You can't go, like I love it when I meet, you know, family, new patient, and I'm doing my history. And [I ask], “Anyone in your family ever have mental health problems?” “Oh, no. Oh, no.” Then the next week, 'well, I talked to my aunt, so and so. And she said that,' then all of this was like, Okay, there's a dozen people in my family,

who have had problems. So because simply people don't talk about it. And so, and of course, like, it's not all that you need to see a professional, right, there's a whole level of care and things that people can do to help themselves, and so on. But the fact is, I think the biggest point is that one has to recognize that, you know, there's something just not right.

Green: Thank you. So BEST, the Boston emergency services team has been a trailblazer in mental health crisis intervention for over 20 years. And you mentioned in the care that best delivers, acknowledging that we all have our biases, even healthcare professionals. And so one term that people are familiar with is being culturally competent or culturally competent care, which may suggest to some people but that there's an end to becoming culturally competent. There could be some confusion about what it means and how it plays out. Tell us from your perspective, what culturally competent mental health care looks like four teams that you lead.

Henderson: Well, I almost laughed because I don't believe in the term cultural competence, because I don't think it exists. I don't, I'm an African American, I don't really think I'm culturally competent in my own community. Because there's such a variety and differences and that sort of stuff. I couldn't say that I could speak for African Americans and so on. So but I do recognize that cultural sensitivity to build the ability to recognize and value others cultures and differences, I think is absolutely critical.

Now at Boston Medical Center, you know, my challenge is, and I tell this to all of our trainees is that, like, how do you develop a mental health system that cares for people from 70 different countries every day? So people from 70 different countries everyday come to the hospital. How do you develop a system for that? Keep in mind, like when you when they were back in their country, like in Ethiopia, like if they had to go to the doctor, like they pack up the family, they pack up some food and water and they go to the doctor and they expect to just spend the whole day and they would just be there with a family too. It's their turn to be called, and so on. And we here at Boston Medical, is like, Okay, you have a 9:10 appointment. And if you're 10 minutes late you cannot be seen. And so, so we have to be adaptive to people's, you

know, histories and culture and so on and try to understand, like, how, how do they best engage with the health system?

And then also like, how does their culture influence their illness and their, you know, when they seek treatment, and where they seek treatment, all of that stuff? So for me, it's a lifelong process of learning. But it comes with the basic is that being respectful and curious about another human beings, right, and and where they're from, what their history is, and how did they get here? And what do they think about this? So asking our patients like, what do you think about this? Like, how do you explain it? Because I have my explanation, which oftentimes, completely wrong, or different from their explanation. So, anyway, so I think there is a process of being, you know, clinicians can get to cultural sensitivity and each, and learn from each and every patient, and take that information and apply it to their care, maybe even change the system, if there's, you know, tremendous insights and stuff. And so I'm a supporter of that. For folks who say they're culturally competent, I, I usually just like to shake their hands, you know? Because I have never could say that I'm culturally competent, you know?

Green: All right. So we have with us, Dr. Henderson have the pleasure of crossing over several topics under mental health, and specifically, as it relates to best that emphasizes culturally sensitive and trauma informed practices, is there anything that you'd care to elaborate on that this approach, and how it supports marginalized marginalized communities, or any topics that we didn't have an opportunity to touch on in our last minute or so?

Henderson: I'll just say that I want to mention some of our global work, because really, we use Boston Medical Center, we use establish a global and local program. And the reason for that was because like many of the countries we are working in, we have patients from those countries coming to our hospital. And so the learning was bi-directional. So we learned some things in Boston, we take it over there, they we learned some things in these countries, and we bring it to Boston and implemented.

But one of the one of the best things that we've done is to we established this organization called the Africa Global Mental Health Institute. And what it is, is

it's designed to bring together mental health leaders and clinicians from 25 different countries in Africa and the diaspora to improve the care for African descended people, the mental health care. And so what it is, is that we have we've got these countries now working together, sharing resources. For instance, if you want to start a program, you know, we're like we did in Liberia, and in her case of Somaliland, to train doctors to become psychiatrists. But in there was no doctors in the country, we relied on our partners like in Ethiopia, and Nigeria, and so on, to help us train them. And so it's getting people to work together for our clinical care, research, education and training and policy and advocacy. And we're in our eighth year, and it's in it's remarkable, because as I tell people, like we're out of time, we're out of time, and we really have to accelerate the capacity building to provide mental health care globally, and particularly in the African diaspora because the care for these populations is lagging way behind. And so we're out of time.

Green: And unfortunately, I could talk to you about this for hours I am sure, but we are, too, out of time. I am very appreciative that you mentioned that there is a school so there is a way programming that people outside of Boston Medical Center can actually either contact the Center or or contact you so that they can replicate in a way that is sensitive to their own communities and meeting their mental health care needs. You can learn more about the Boston Medical Center's best program at the link in our show notes. I'd like to thank and honor my guest, Dr. David Henderson for joining us today. Thanks for being with us.

Henderson: Thank you. It's been a wonderful opportunity for me to be here today. Thank you.

Green: That brings us to the end of another episode of the Health Disparities podcast, a program of movement is life, which is a nonprofit organization committed to advancing health equity. If you like what you hear, be sure to subscribe wherever you get your podcasts and take a moment to leave us a rating. It really makes a difference. I'm Hadiya Green. Until next time, be safe and be well.