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Police and Mental Health: *Exploring Co-Response Models and Best Practices*

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Abstract:

Crisis related to mental health or substance use is creating an increased challenge for emergency departments and law enforcement. Between 5% and 15% of all 911 calls are related to a mental health crisis, making police officers the first to respond and jail or the emergency department the likely outcome [1]. While the responsibility of responding to mental health calls has shifted to law enforcement agencies, there remains concern about training for both mental health clinicians and law enforcement on interventions and effectiveness on how to respond to an individual in mental health crisis. To address the need for community mental health response, several versions of police-mental health partnership programs were created. Several jurisdictions have chosen to implement different contexts and forms of co-response programs and the lack of research regarding the outcomes has created questions as to the effectiveness of co-response programs [1]The mental health responders that comprise one half of the co-response team are integral to the success of this type of programing. Because there is a lack of centralized prerequisites for individuals seeking employment in this capacity, the education, experience, and background requirements are far from standard. Likewise, training for law enforcement officers vary by jurisdiction and co-response model. The paper aims to provide a comprehensive review of current best practices and identify gaps in training and program outcomes for further research.

Keywords: Co-response, Mental Health, Police, CIT, crisis, crisis intervention, policing, mental illness, United States.

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Mental Health Crisis and Co-Response

Crisis related to mental health or substance use is creating an increased challenge for emergency departments and law enforcement. With an increasing number of individuals needing assistance, the number of mental health beds in hospitals and treatment centers just aren't enough. Between 5% and 15% of all 911 calls are related to a mental health crisis, making police officers the first to respond, and jail or the emergency department the likely outcome.[1] More than 2 million individuals with mental illness are booked into jail each year, and the prevalence of mentally ill individuals in jails and prisons is three to four times that of the general population.[2] Due to law enforcement officers becoming the primary responders in mental health calls, they have been described as "de factor mental health providers"[3] "key front-line responders in mental health emergencies[4] and "streetcorner psychiatrists."[5] Identifying best practices and desired outcomes in co-response can give law enforcement and mental health clinicians a clearer goal when creating and expanding these programs. The goal of this paper is to highlight the needs of such programs, provide an overview of current models, identify gaps, and future directions both for research and practice.

A quarter of police shooting deaths are related to mental illness, and half happen in the individual's home.[6] Social justice movements in recent years have created a platform for advocating towards a better way to approach this crisis. Solution to these complex issues, require collaboration, and understanding of the limits of civilian clinicians responding to potentially dangerous calls without law enforcement.[7] For this response to be successful a system is necessary to provide individuals with the care needed and the safest and least restrictive environment.[8]

The law enforcement role in the United States has historically been described as balancing between providing public safety, serving the community, and enforcing the laws. In the U.S. over the last several years there has been a social drive/demand toward less police involvement in interactions with civilians in the middle of a mental health crisis. Crisis intervention Teams Program began in the 1980s in Memphis in response to a police shooting of a Black man with mental illness.[9] However, this is not the first time the international law enforcement community has shifted toward collaborating with mental health, the first being in the mid 1900s.[10]

The *co-responder model* seemed to gain prevalence in Australia, Canada, and the United Kingdom. The co-responder team model is defined as *"a model for crisis response that pairs trained police officers with mental health professionals to respond to incidents involving individuals experiencing a behavioral health crisis."*[11] In practice, the hope was the co-response teams alleviate the pressure on the criminal justice program by helping individuals in crisis find resources rather than engage them in a punitive process. It reduces the number of arrests (possibly due to the de-escalation techniques), lowers the number of mental health detentions by police, and overall reduces the amount of time spent on calls for service that could be better addressed by people with specialized training.[12]

The Bureau of Justice Assistance within the U.S. Department of Justice has created Police-Mental Health Collaboration (PMHC) training programs to help partially address the mental health crisis in this country. The United States Department of Justice's Bureau of Justice Assistance offers a Police-Mental Health Collaboration (PMHC) Toolkit which provides information aimed at enabling law enforcement to respond to individuals with mental illness appropriately and safely. This toolkit describes the benefits of collaboration between mental health workers and police, outlines different types of PMHC programs and offers resources to better inform the public. Among the different PMHC programs, the co-response team (i.e., a team made up of specialty-trained officer and a mental health crisis worker) is deployed to mental health calls for service and aims to provide an

effective and appropriate response that benefits the community at large.[13]

Co-Response Model

Education

The mental health responders that comprise one half of the co-response team are integral to the success of this type of programing. Because there is a lack of centralized prerequisites for individuals seeking employment in this capacity, the education, experience, and background requirements are far from standard. Some organizations case a wide net in terms of educational requirements: For example, Pima County, Arizona Sheriff's Office and Tucson, and Arizona Police Department, established in 2014, employs master's level Mental Health Clinicians.[14] In Northern Colorado, the typical educational requirement is at least a bachelor's degree in social work, Psychology, Counseling or "Behavioral Health Related Field." Some organizations require a master's degree. Preferred licensures and certifications include Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Counselor (LPC), or a Licensed Addiction Counselor (ACD).[15] All applicants are required to submit to a background check. Some organizations are more specific in their educational requirements: The Family Services of Rhode Island, hires only licensed social workers for the co-response position. Still other places prefer to deploy medical professionals such as nurses, paramedics, or even psychiatrists.[16] Interestingly, some organizations deviate from the two-person team set-up: in one Indianapolis Metropolitan Police Department (IMPD) district pilot project the co-response team consisted of a master's level mental health clinician, an EMS paramedic, and a trained law enforcement officer.[17]

Preparation

Much like the variation in educational background, preparatory and/or on the job training looks different across jurisdictions. For example, in the IMPD pilot project described above, preparation consisted of approximately two months of training in "behavioral health, crisis de-escalation, use of force, and legal implications of interagency collaboration."[18] More formally, in 2022, William James College began offering a Graduate Certificate in Crisis Response in Behavioral Health, the first program of its kind.[19] Notably, clinician applicants to this program are required to have a master's degree prior to applying. Additionally, applicants must either already be serving in the role of a co-responder or be willing to commit to working in Co-response in Massachusetts for at least two years upon completing the certification. The certificate requires 100% campus-based in-person attendance, for 10 credits spread across 150 classroom hours. Massachusetts-based applicants who meet criteria are eligible for a scholarship though the Mental Health Jail Diversion Program.[20]

"Do No Harm"

In the last fifteen to twenty years, mental health clinicians have begun to take a substantively visible role in emergency intervention, particularly in the wake of armed conflicts and natural disasters. This expanded functional application of psychosocial intervention can certainly be termed a positive development, specifically in addressing trauma[21] and promoting resilience.[22] However, there are risks associated with implementing interventions in this context, particularly with regards to causing unintentional harm.[23] Notably, many of the examples of this occurring in the literature are evidenced in the context of humanitarian crises[24] but given the paucity of research specific to unintentional harm of co-responders, it is not unreasonable to hypothesize that many of the same risk factors apply.

In a 2009 article detailing recommendations of appropriate psychological support in international

emergencies, Wessels describes several "do-no-harm" issues that he consistently witnessed in his global-emergency response work, some of which are applicable in the context of co-response. For example, Wessels describes the issue of "insensitivity to emergency contexts and systems."[25] Applied to the co-response framework, this can look like a lack of understanding of the power dynamics in a particular community or failing to coordinate in a sensitive manner between community stakeholders and members of law enforcement. This can apply both to a lack of cultural humility and understanding of cultural differences, but also to something as simple as using an intervention that is ineffective in the work setting: What works in a cushy, comfortable office, may not work in a super-charged situation happening on a poorly lit street in the middle of the night.

Another concern is that a mental health clinician member of the co-response team may have low awareness of the implications of their presence on a call, both in terms of security considerations, and the potentially stigmatizing underlying message. Finally, as discussed in the above section education, experience and preparation requirements vary greatly. The current lack of standardization in training can lead to inadequately prepared clinicians, the consequences of which can be catastrophic.

Police and Mental Health Co-Response Programs

Beginning in the 1950-1960s, deinstitutionalization (i.e., the closure of psychiatric hospitals, legislative changes, and decrease in psychiatric services) contributed to an increasing trend of criminalization for people experiencing mental health problems.[26] Because people with mental health problems often struggle to access medical, social, and community resources[27] police contact has increased significantly for those with mental health problems and crises.[28] With the increased interaction between police officers and individuals with mental health crises, between 7% and 31% of police calls involve a person with mental illness in North America.[29]

While the responsibility of responding to mental health calls has shifted to law enforcement agencies, there remains a concerning absence of proper training on interventions and effectiveness on how to respond to an individual in mental health crisis. This creates costly consequences that impact both the police department and individuals experiencing mental health crises. High profile incidents of injury and/or deaths reflect on the department and have longstanding implications for the person with mental illness, their families, and the community.[30] Additionally, consequences result from the criminalization of many individuals with mental illness who have committed minor crimes and are placed in jail rather than treatment facilities[31] because of not having the resources to take someone in mental health crisis to a more appropriate facility[32] or a "mercy booking" to allow the person to get mental health resources through the justice system.[33]

The lack of intervention law enforcement training and knowledge of mental illness often results in arrests related to opportunities, activities, and life circumstances (e.g., housing, employment) rather than mental health symptoms or criminal acts.[34] Fisher et al.[35] described diverting individuals with mental illness and mental health crises a "worthy endeavor" with several benefits. For example, effectively deescalating crises, preventing injuries to both the individual in crisis and the response team, connecting people in mental health crisis to appropriate community and hospital resources, and reducing pressure on the justice system from expending time on arrests and de-escalation.[36] Furthermore, these programs increase cost effectiveness for both mental health providers (e.g., decrease in hospitalization) and law enforcement agencies (e.g., arrests).

Mental health co-response programs were created to address the deficit in mental health de-escalation and reduce pressure on law enforcement to intervene during psychiatric crises. However, these programs differ greatly in the populations that they serve, the funding they receive, the guidelines for each program, the type of response, hours of operation, staff training and expertise, and equipment resources.[37] Although the available programs share a common goal, providing on-scene mobile crisis outreach and intervention, the activities and approach of each program may differ from one another.[38]

Types of Programs

To decrease the amount of people with mental illness in the criminal justice system, several police organizations have developed specialized programs[39] While the primary goal of these programs is to reduce police use of force and arrests, people with serious mental illness and psychiatric crises are still overrepresented in prisons[40] and more likely to be killed by a police officer than those without mental illness.[41]

Several types of programs have been developed to respond to mental health calls, but there is still a limited understanding of the effectiveness and mechanisms that increase successful response.[42] However, co-responding police-mental health programs have demonstrated strong connections with community services and help to reduce the pressure on the justice system.[43] As mentioned, many of the available programs vary in the services that they provide including program capacity, maintaining presence in vulnerable areas, staff preparedness and training, partnership building, following-up with consumers, short-term counseling, referral, and evaluating program outcomes.[44]

To address these differences and create more effective programs, a coordinated approach is needed to optimally achieve the goals and provide adequate services. To fill the need for community mental health response, several versions of police-mental health partnership programs have materialized[45] In general, one of three approaches is used to respond to mental health crisis; crisis intervention teams, mental health consultants hired by police departments, and co-responding police-mental health programs.[46.]

The first model, crisis intervention teams (CIT), or the Memphis model, began in Memphis in 1988 as a response to the need for mental health training for law enforcement.[47] CIT is the first and most popular type of program for mental health response.[48] Law enforcement officers are given the opportunity to volunteer to become part of a CIT team and they are provided with 40 hours of training on mental health issues and de-escalation techniques.[49] Officers are taught about symptoms associated with mental illness, effective intervention and communication strategies, types of services offered by different agencies, and risk assessment.[50] CIT teams are generally called to the scene when traditional patrol officers consider the situation one that can benefit through CIT support to assess the situation and transport the person with mental illness to a specialized center for further psychiatric evaluation.[51]

While there is evidence that CIT teams help to change police attitudes and knowledge regarding mental health[52] and teach officers the differences between mental health crisis and acts of resistance and hostility,[53] research on CIT teams is mixed and several deficits have been identified. For example, 40 hours of curriculum training might be deficient in teach police to counter the quick and decisive response that is established in law enforcement training, and they may still respond based on their original training in dangerous and unpredictable circumstances.[54] Furthermore, officers are limited in the effectiveness of de-escalation training and must consider multiple and sometimes competing problems to ensure safety of all individuals while defusing a crisis. The second model uses mental health consultants that are hired by police departments to provide phone-based or on-site assistance for officers.[55] This model is used the least of the three types.

The third type of program, corresponding police-mental health programs, include both local community mental health workers and police officers that respond collaboratively to mental health crisis calls.[56] Co-response programs seek to reduce the limitations found in CIT programs by having a mental health specialist paired with a law enforcement officer that collaboratively respond to calls.

In these scenarios, the officer oversees handling situations that involve a potential risk for violence or injury, whereas the specialist provides mental health intervention, risk assessment, and immediately connect the person in crisis to the appropriate services.[57] Furthermore, co-response programs increase the collaboration and sharing of information between mental health and law enforcement organizations while providing effective triage during the mental health call.[58] According to Shapiro et al.[59] co-responding programs have four main objectives: reducing pressure on the criminal justice system, connecting individuals with mental health issues to community services, averting crisis escalation and injury, and reducing hospital admissions.

While an abundance of research exists on the CIT model, there is little information for the effectiveness of the corresponding model.[60] The theory reinforced by these programs is that a joint response is preferable to enhance the collaboration of police as specialists in handling situation with violence and potential injury, whereas mental health professionals specialize in providing mental health consultation, intervention, and risk assessment that can be provided on real-time.[61]

How Co-response has Changed

Due to the increasing frequency at which law enforcement officers are responding to mental health calls and the media coverage of individuals with mental illness being mortally injured by police officers, awareness, and concerns about the criminalization of mental illness and police officer's ability to provide psychiatric first aid was raised.[62] To address these concerns, several programs were started in the 1980s for implementing American police organizations to improve knowledge and attitudes toward mental health vulnerabilities and teaching de-escalation techniques.[63] However, the outreach, acceptability, implementation, and maintenance of co-response programs has been questioned.[64]

Several different jurisdictions have chosen to implement different contexts and forms of co-response programs and the lack of research regarding the outcomes has created questions as to the effectiveness of co-response programs.[65] An example of this, is the co-response program in Knoxville, Tennessee, which responds to only 40% of mental disturbance calls[66], which is still comparably higher than the co-response program in Toronto, Ontario who reportedly responded to 11% of mental disturbance calls.[67]

Other concerns have arisen regarding the 'ownership' rather than partnership between two culturally different organizations and perspectives, leading to scarcity in police drop off centers, collaboration while upholding confidentiality, and appropriate organizational structures to support co-response operations.[68] Due to these problems, there has been issues initiating and sustaining programs in many settings.[69] Despite the lack of research for co-responding police-mental health programs, they are being implemented in several countries including the Integrated Mobile Crisis Response Team in British Columbia, the Mobile Crisis Intervention Team in Ontario, the Crisis Outreach and Support Team in Ontario, the Mental Health Mobile Crisis Team in Nova Scotia, and the Police, Ambulance and Clinical Early Response in Australia.[70]

Police-Mental Health Co-Response: The Memphis Model

In the United States, several co-response programs exist including the Mobile Mental Health Crisis Unit in Knoxville, Tennessee, the Mobile Crisis Program in DeKalb County, Georgia, and the Systemwide Mental Assessment Response Team in Los Angeles, California.

In Memphis, Tennessee, they use a police-based program with specially trained officers and is considered the most visible prebooking diversion program in the United States. It was developed after a police shooting incident in 1987 that involved a mentally ill person. Under the Memphis mayor's office, a police department formed a partnership with the Memphis chapter of the Alliance for the Mentally Ill, the University of Memphis, and the University of Tennessee to develop a specialized unit within the police department. The services are provided voluntarily with no expense to the city of Memphis. Other crisis intervention teams have been based on the Memphis model and have developed programs in Waterloo (Iowa), Portland (Oregon), Albuquerque (New Mexico), ad Seattle (Washington).[71]

The Memphis PD developed a crisis intervention team with trained officers that transport individuals suspected of having mental illness to the University of Tennessee psychiatric emergency service after the situation has been assessed and diffused. The current team is composed of 130 patrol officers (out of a force of 1,354 officers). They provide specialized response to mental disturbance calls in addition to regularly assigned patrol. They cover four overlapping shifts that provide 24-hour service. The officers are selected for the crisis intervention program and receive 40 hours of specialized training from mental health providers, family advocates, and mental health consumer groups who provide information about mental illness and techniques for intervening in a crisis. Officers are issued a crisis intervention team medallion that allow immediate identification and they are designated in charge when they arrive on scene. Data shows they transport to a hospital in around half the calls.[72]

The most popular model for collaboration among police departments and mental health services is referred to as the "Memphis Model." The model is so named because it was developed in 1988 in Memphis, Tennessee, to provide mental health services to people living with mental illness rather than place them in the criminal justice system.[73] A review of the history of this model identifies two principal components: training on responding to mental health emergencies for police officers and partnerships among law enforcement and community mental health services.[74] The model accomplishes this by establishing a Crisis Intervention Team (CIT) composed of police officers and mental health professionals who collaboratively respond to "emotionally disturbed persons" in the community.[75] A national registry of such programs in the United States lists over 3000 in the nation, while even more exist internationally.[76]

The first core element of the CIT model is a 40-hour training for police officers according to the University of Memphis' manual.[77] This training consists of lectures, visits to mental health facilities, and conversations with people living with mental illnesses, all intended to build officers' knowledge about the impact and treatment of psychological disorders.[78] A practical component of the training involves vignettes based on real-life examples of crisis calls in which officers are coached on how to verbally de-escalate the emotionally disturbed person.[79] The second core element of CITs involves partnerships among criminal justice and mental health agencies. Collaboration between these systems allows for individuals who interact with trained police officers to immediately access mental health care following an emergency. For example, some programs

offer drop-off centers that cannot refuse admission to individuals referred to by police officers.[80] The underlying theory for these collaborations is that while trained police officers can prevent violence in crisis situations, mental health professionals are better equipped to provide care for individuals following that crisis.[81]

Specific activities of CITs vary widely across programs.[82] Some programs hire mental health consultants who provide phone-based assistance to police officers while they are in the field.[83] Yet other programs designate two units within the CIT- a police unit and a mental health unit, which only responds to the crisis once the police unit deems it is safe.[84]

In contrast, some programs establish CITs composed of both police officers and mental health workers, who arrive and respond to crisis calls simultaneously.[85] Even programs that use similar co-response methods may vary in hours of operation, staff expertise, and equipment.[86] These programs vary not only in strategy, but also in the goals they pursue with their various methods of co-response. Some programs prioritize the de-escalation of crises to prevent emotionally disturbed persons from inappropriately being involved with criminal justice, while others also seek to decrease the use of police force in crises and mitigate unnecessary visits to the emergency department.[87]

Given the heterogeneity of CITs that all follow the Memphis model, there is a wide variability in the outcomes achieved by these programs in the U.S. and abroad. Some program evaluation data indicates that these programs result in lower use of force by police officers responding to crises[88] while other program evaluations found no difference in use of force between officers trained in CIT and those who are not.[89] A recent review comparing CIT to other models for crisis response found conflicting results regarding whether CITs result in fewer emergency department admissions, with some reporting an increase and others a decrease.[90] A different review of program outcomes found that results are also mixed on whether CITs result in fewer inpatient hospitalizations for emotionally disturbed persons served by this program.[91] The conflicting nature of these findings highlights the need for systematic adherence to program guidelines, which is currently variable between districts. Failure to do so may continue to lead to poor outcomes for people who need crisis response.

These concerns notwithstanding, there is greater consensus from program evaluation data on other CIT outcomes. Many programs have shown that CITs lead to fewer arrests by police officers when responding to mental health crises.[92] People who receive crisis response from CIT also report more referrals to community mental health agencies than individuals who do not.[93] Although the method of follow-up after a crisis call varies by program (from 24 hours to 7 days afterwards), individuals who receive follow-up from CIT staff report a greater likelihood of continuing to receive services from the places they were referred to by the CIT.[94] These results suggest that many individuals who interact with CITs benefit from increased access to mental health resources in their community. Indeed, proponents of CITs hypothesize that police officers' greater knowledge of these resources is the mechanism that drives this connection to them for emotionally disturbed person.[95]

Co-Response Outcome

The intersection between measurement-based outcomes and various co-response model outcomes has not been delineated in psychological, public safety, or law enforcement literature. Due to the heterogeneity in the operationalized definitions of what a co-response model is itself, the outcomes are not necessarily comparable to each other and must be interpreted with caution. While our goal here is to create a general sense of comprehension in terms of co-response, there are limitations in how we may be able to interpret some outcomes as they may not all be measurement-based.

When comparing CIT models, co-response models, police-only models, and non-police models, co-response models were found to be the most efficacious but only when compared to police-only models.[96] CIT models have shown little evidence of impacting crisis outcomes.[97] However, they have resulted in more referrals to psychiatric emergency rooms, general hospital emergency rooms, detoxification units, or psychiatric facilities[98] Co-response models, in comparison, have resulted in more referrals to community resources such as case managers, mental health centers, and

outpatient treatments.[99] Additionally, another factor of consideration by some departments was to consider the rate of arrests being made. While co-response models reflected a decrease in arrest rates compared to departments with no co-response models, the findings were inconsistent and not generalizable. With a significant amount of variation in the factors that affect co-response, there are not many generalizable outcome data points available for researchers to use as a foundation for understanding co-response outcomes.

Cultural Considerations and Limitations of Co-Response Models

The impact of culture is an important consideration when studying the efficacy of co-response models. While culture can and does refer to race, ethnicity, socioeconomic status, sexual and gender identities and more, we are specifically referring to law enforcement and mental health cultures. Barriers to successful co-response program implementation come from role conflict and stigma coming from other groups of first responders as well as from within police agencies.[100] Other barriers were found to be a lack of agency collaboration, information sharing between agencies, and of team building.[101] Co-response teams must be comfortable in their roles during a crisis, their ability to engage with the individual in need is imperative for a successful outcome. Barriers to successful co-response program implementation comes from role conflict and stigma coming from other groups of first responders as well as from within own agency.[102] Some identified limitations in the literature include, the lack of high quality, controlled studies,[103] lack of research on civilian-led mobile crisis models[104] and gaps in development and evaluation of models tailored to equity-seeking communities.[105]

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