

CRITICAL ISSUES IN POLICING SERIES

RETHINKING THE POLICE RESPONSE TO MENTAL HEALTH-RELATED CALLS

Promising Models



OCTOBER 2023



POLICE EXECUTIVE
RESEARCH FORUM

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A Message From Executive Director Chuck Wexler

This report addresses one of the most critical issues in policing today: the role of police in responding to calls for service involving people in mental or behavioral health (MBH) crisis. This has been a serious challenge for policing for decades, ever since mental health institutions were closed, people were discharged without adequate provision of help to live in the community, and many of them landed on the streets.¹ Police found themselves responding to incidents involving people in crisis and doing the best they could. It has been more than 30 years since then-Commissioner of the NYPD, Lee Brown, said that “this country’s social problems are well beyond the ability of the police to deal with on their own.”² Yet that is what they are often called upon to do.

The issue has come into sharper focus in debates about policing reform, especially since the murder of George Floyd. While many calls to reallocate funds from police to social services were not well thought out, many police agree that responsibility for responding to MBH calls for

service should not fall to the police alone, and in some instances not at all.

The scope of the problem is enormous. The American Psychological Association reports that 60 percent of psychologists currently have no openings for new patients.³ Emergency room visits by children and young adults surged by almost 60 percent between 2011 and 2020, and suicide-related visits increased five-fold. In 2021 more than 100,000 people in the U.S. died from drug overdoses, *more than twice as many* as in 2015.⁴ Nearly



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1. Alene Kennedy-Hendricks *et al.*, “Improving Access to Care and Reducing Involvement in the Criminal Justice System for People with Mental Illness,” *Health Affairs* 35, no. 6 (2016): 1076-1083, <https://doi.org/10.1377/hlthaff.2016.0006>; H. Richard Lamb and Linda E. Weinberger, “Deinstitutionalization and other factors in the criminalization of persons with serious mental illness and how it is being addressed,” *CNS Spectrums* 25, no. 2 (2020): 173-180, <https://doi.org/10.1017/S1092852919001524>.
 2. Alan M. Webber, “Crime and Management: An Interview with New York City Police Commissioner Lee P. Brown,” *Harvard Business Review*, May-June 1991, <https://hbr.org/1991/05/crime-and-management-an-interview-with-new-york-city-police-commissioner-lee-p-brown>.
 3. American Psychological Association, “Psychologists Struggle to Meet Demand Amid Mental Health Crisis,” November 2022, <https://www.apa.org/pubs/reports/practitioner/2022-covid-psychologist-workload.pdf>.
 4. National Institute on Drug Abuse, “Drug Overdose Death Rates,” accessed July 6, 2023, <https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates>.

600,000 people in the U.S. experience homelessness on a given night.⁵ All these individuals risk falling victim to crimes, and some pose risks to the safety of themselves or others.

Whether or not there is a threat to safety, police are likely to be called to MBH incidents, which can account for anywhere from 1 to 10 percent of all 911 calls.⁶ There are several reasons why calls come to police even when there is no immediate threat to safety. As a deployed service, patrolling the streets 24/7, police are usually in a position to respond quickly. Many people call 911 for help without thinking about whether another service provider may be more appropriate. And often, no one else is available to call; few mental health and social service providers have rapid-response capabilities and even fewer operate during nights and weekends.

MBH calls are resource intensive. They can be time consuming both on-scene and during the follow-up, which can include transporting subjects to the hospital and writing reports. Often, the subject is arrested; about 2 million times

annually, people with serious mental illness are booked into U.S. jails.⁷

MBH incidents can also be fraught with risk. The great majority of encounters are handled safely but some end tragically. According to the Treatment Advocacy Center, the risk of being killed is 16 times higher for people with untreated serious mental illness than for others approached or stopped by police.⁸

The issue therefore touches on three significant aspects of our current policing crisis, which is the worst in a generation:

- First, a crisis of public trust in policing, driven in large part by high-profile incidents of police shootings and fatalities in police custody.⁹
- Second, a workforce crisis. Recruiting shortfalls in many departments — and budget tightening — have made patrol officers' time more precious than ever.¹⁰
- Third, gun crime rates appear to have risen since 2019 (though early data from 2023 suggest they may be subsiding),¹¹ and violent

5. Tanya de Sousa *et al.*, "The 2022 Annual Homelessness Assessment Report to Congress, Part 1: Point-in-Time Estimates of Homelessness," U.S. Department of Housing and Urban Development, Office of Community Planning and Development, December 2022, <https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf>.

6. Melissa S. Morabito *et al.*, "Police Response to People with Mental Illnesses in a Major U.S. City: The Boston Experience with the Co-Responder Model," *Victims & Offenders* 13, no. 8 (November 17, 2018): 1093–1105, <https://doi.org/10.1080/15564886.2018.1514340>; James D. Livingston, "Contact Between Police and People With Mental Disorders: A Review of Rates," *Psychiatric Services* 67, no. 8 (2016): 850–867, <https://doi.org/10.1176/appi.ps.201500312>; Cynthia Lum, Christopher S. Koper, and Xiaoyun Wu, "Can We Really Defund the Police? A Nine-Agency Study of Police Response to Calls for Service," *Police Quarterly* 25, no. 3 (September 2022): 255–80, <https://doi.org/10.1177/10986111211035002>.

7. Henry J. Steadman *et al.*, "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services* 60, no. 6 (June 2009): 761–765, <https://doi.org/10.1176/ps.2009.60.6.761>.

8. Doris A. Fuller *et al.*, "Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters," Treatment Advocacy Center, December 2015, <https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted>.

9. Jeffrey M. Jones, "Confidence in U.S. Institutions Down; Average at New Low," Gallup, July 5, 2022, <https://news.gallup.com/poll/394283/confidence-institutions-down-average-new-low.aspx>; Pew Research Center, "Majority of Public Favors Giving Civilians the Power to Sue Police Officers for Misconduct," July 9, 2020, <https://www.pewresearch.org/politics/2020/07/09/majority-of-public-favors-giving-civilians-the-power-to-sue-police-officers-for-misconduct/>.

10. Police Executive Research Forum, "Responding to the Staffing Crisis: Innovations in Recruitment and Retention," August 2023, <https://www.policeforum.org/assets/RecruitmentRetention.pdf>; Police Executive Research Forum, "New PERF survey shows police agencies are losing officers faster than they can hire new ones," April 1, 2023, <https://www.policeforum.org/staffing2023>; Scott M. Mountgos, Ian T. Adams, and Justin Nix, "Elevated police turnover following the summer of George Floyd protests: A synthetic control study," *Criminology & Public Policy* 21, no. 1 (February 2022): 9–33, <https://doi.org/10.1111/1745-9133.12556>.

11. Jacqueline Howard, "US records highest increase in nation's homicide rate in modern history, CDC says," CNN Health, October 6, 2021, <https://www.cnn.com/2021/10/06/health/us-homicide-rate-increase-nchs-study/index.html>; Murder Accountability Project, "America's murder surge continues, updated crime data show," March 24, 2023, <https://www.murderdata.org/2023/03/americas-murder-surge-continues-updated.html>; Tim Arango, "Survey of 30 U.S. Cities Shows Nearly 10 Percent Drop in Homicides in 2023," *New York Times*, July 20, 2023, <https://www.nytimes.com/2023/07/20/us/crime-data-homicides.html>.

crime clearance rates have been declining for decades.¹²

This third point also affects public trust in the police. If the role of police officers in mental health-related calls can be focused on instances where the potential risk of the encounter necessitates an armed presence or police powers, police departments should be able to divert their limited resources toward actions that require immediate police response, as well as toward crime prevention and investigation.

We have made significant progress over the years in preparing police for MBH encounters. Mental health awareness training has been widely implemented. Thousands of agencies have conducted Crisis Intervention Training (CIT),¹³ which has been shown to increase understanding and empathy for individuals in crisis.¹⁴ Yet police often have to deal with MBH incidents with inadequate mental health resources. And tragically, some of those encounters end in a fatality.

It was largely for this reason that PERF, after researching these issues for many years, developed the ICAT training program (Integrating Communications, Assessment, and Tactics).¹⁵ ICAT gives officers a comprehensive toolkit for dealing with such incidents — not only how to recognize different behavioral conditions but, crucially, how to communicate more effectively and conduct themselves tactically so as to de-escalate situations and avoid resorting to deadly force, or ideally force at all, wherever possible. Independent, peer-reviewed research found that ICAT led to reductions in use-of-force incidents by 28 percent, in citizen injuries by 26 percent, and in officer injuries by 36 percent.¹⁶ Over 1,000 agencies have received ICAT training to

date, and PERF is now offering ICAT training free of charge to all police officers nationwide at PERF's National ICAT Training Center in Decatur, Illinois.

We can take some satisfaction from this progress, but as we continue to move forward, many agencies are now looking beyond just use-of-force issues to consider more strategic responses to MBH calls. Programs like STAR in Denver (CO) and the Crisis Response System in Anne Arundel County (MD) — both among the examples highlighted in this report — raise questions about how we can construct systems that better serve individuals in crisis while also reducing the strain on police resources. Can some calls be diverted to other services or to co-responder programs that combine mental health professionals with police? Do co-responder programs work and what challenges need to be overcome? What are the costs and are they realistic for smaller cities?

This report, which looks at examples from several jurisdictions and draws on survey feedback from almost 200 different agencies, is intended to help agencies and communities think through what kind of program might work best for them. It describes the basic types of crisis-response programs, explains how selected communities created and operate their programs, and outlines key issues to consider.

It is a truism to say that policing is not a matter for the police alone. Mental illness, drug addiction, and homelessness are not crimes, but they can involve threats to safety — the safety of those in crisis and of others. The health care organizations and other agencies that lead on these matters therefore share some responsibility for public safety and should be involved, together with police, in

12. Weihua Li and Jamiles Lartey, “As Murders Spiked, Police Solved About Half in 2020,” Marshall Project, January 12, 2022, <https://www.themarshallproject.org/2022/01/12/as-murders-spiked-police-solved-about-half-in-2020>.

13. National Alliance on Mental Illness, “Crisis Intervention Team (CIT) Programs,” accessed July 7, 2023, [https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-\(CIT\)-Programs](https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs).

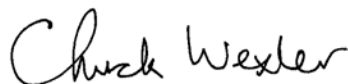
14. Amy C. Watson, Michael T. Compton, and Jeffrey N. Draine, “The Crisis Intervention Team (CIT) Model: An Evidence-Based Policing Practice?” *Behavioral Sciences & the Law* 35, no. 5–6 (September 2017): 431–41, <https://doi.org/10.1002/bsl.2304>.

15. Police Executive Research Forum, “Implementing the ICAT Training Program at Your Agency,” May 2023, <https://www.policeforum.org/assets/ICATImplementation.pdf>.

16. Robin S. Engel *et al.*, “Examining the Impact of *Integrating Communications, Assessment, and Tactics* (ICAT) De-Escalation Training for the Louisville Metro Police Department: Initial Findings,” University of Cincinnati, September 16, 2020, https://www.theiacp.org/sites/default/files/Research%20Center/LMPD_ICAT%20Evaluation%20Initial%20Findings%20Report_FINAL%2009212020.pdf.

developing strategies for MBH crisis response and follow-up. Our research found instances where public agencies were resistant to collaborating with police, so strategic planning should be driven not by police alone but by local government leaders — mayors, city managers, or county leadership. This partnering will also facilitate a community-wide cost-benefit analysis of options for change, for example, the savings to the criminal justice system of fewer arrests and incarcerations of people who are mentally ill.

This is the 48th Critical Issues report that PERF has published with support from the Motorola Solutions Foundation, for which we are deeply grateful. Previous reports in this series are listed on the back cover of this publication; individual reports may be downloaded at <https://www.policeforum.org/critical-issues-series>.

A handwritten signature in black ink that reads "Chuck Wexler". The signature is written in a cursive, flowing style.

Chuck Wexler
Executive Director
Police Executive Research Forum
Washington, D.C.

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Executive Summary

A man calls 911 asking for help finding his brother, who just ran from his house in a paranoid state. Police find him naked in the street after he threw a cinder block through a store window. He is running in and out of traffic and speaking incoherently.

A man without a shirt or shoes walks among the crowd at a public protest but doesn't appear involved with the event. Unprovoked, he approaches a TV cameraman and suddenly starts shouting incoherently and waving a stick.

A hotel employee calls 911 about an intoxicated woman who is disruptive and refuses to leave the property but is not acting violently.

These scenarios — drawn from actual incidents, some of which ended in tragedy — reflect the kinds of mental health-related crisis calls that are becoming increasingly common for police. And this increase in mental health-related calls comes

at a time when law enforcement agencies are facing declining staff levels and weakening public trust, both of which have led to increased calls for alternative responses to mental and behavioral health (MBH) crisis calls.

Many agencies have responded to the rise in MBH-related calls by increasing and improving their training on how officers should respond to MBH calls or by forming specialized crisis intervention units. Some agencies have established multidisciplinary partnerships with health care providers and community-based organizations to co-respond to MBH-related calls. Others have created community-based programs that dispatch MBH clinicians or other civilian professionals to nonviolent crisis calls, with no law enforcement involvement.

This report examines the structure and impact of several crisis-response models and outlines eight action steps that agencies can take to build a new crisis-response program or strengthen an existing one. It is based on a national survey, interviews with police leaders, and a review of the literature on response practices for crises related to MBH conditions, housing insecurity, substance use disorders, and other quality-of-life issues.



Police and sheriff vehicles outside Chippenham Hospital in Richmond, VA. MBH calls can be time-consuming, due in part to the need to transport many subjects to hospitals. CREDIT: CHESTERFIELD COUNTY (VA) POLICE DEPARTMENT FACEBOOK PAGE

Three Categories of Crisis-Response Program

Crisis-response programs take many different forms, according to choices made by communities based on such factors as funding, availability of clinicians, volume of calls for service, and the local culture. But they fall into three broad categories:

1. **Police-based response models**, in which specially trained officers respond to crisis calls. Responding officers have been trained to de-escalate crises, stabilize the subject, and liaise with local mental-health service providers.
2. **Co-response models**, in which multidisciplinary pairs or teams, including police and a mental health professional, respond to crisis calls together.
3. **Community-based alternative models**, in which non-police personnel respond to calls where there is no immediate threat of violence and request police assistance only if needed.

Some communities operate hybrid programs that incorporate elements of all three models: officers are trained to de-escalate crises, a co-responder option is available, and some calls are fully diverted from a police response. Communities should customize their programs to meet their own unique circumstances; there is no “one size fits all” for crisis response.

Crisis Response Training for Police

Whatever crisis-response program a community adopts, all police officers and professional staff who interact with the public should have MBH awareness training to help them recognize various types of behavior as potential signs of an underlying condition, such as mental health or substance use disorders or autism. In addition, all police officers should undergo crisis de-escalation training and periodic refresher training. The ICAT (Integrating Communications, Assessment, and Tactics) training program, developed by PERF, has so far been delivered to officers in 1,000 police departments.

An independent evaluation by researchers from the University of Cincinnati found that ICAT was associated with a 28 percent reduction in use-of-force incidents, a 26 percent reduction in citizen injuries, and a 36 percent reduction in officer injuries.¹⁷

Police-Based Response Models

PERF’s member survey found that smaller agencies are more likely to use police-based crisis responses than some form of co-response or community-based response. Some communities lack the tools, funding, or call volume to support full co-response or community-based response programs. General health care services may be difficult to access in these areas, let alone specialized services for MBH conditions. If such services are available, they are unlikely to be available 24 hours a day. Police may be the only resource reliably available at all times and the best equipped to respond to potentially volatile situations.

One agency that operates a police-based response is the Fort Walton Beach (FL) Police Department.¹⁸ The agency’s small size and relatively low crisis-call volume make it impractical to operate a full co-response program. Instead, the agency relies on crisis intervention and ICAT training to equip its officers to field crisis calls safely and facilitate connections for people in crisis to appropriate services in the community.

Key Issues for Agencies Considering a Police-Based Response

- **Availability of alternative resources.** In rural or remote areas, police may be the only available option for crisis response.
- **Complexity of program structure.** For smaller agencies, police-based responses can be more viable because they do not require management of complex structures or intensive coordination with partner organizations.
- **Cost.** Police-based programs may cost less than co-response or community-based options.

17. *Ibid.*

18. The body of this report provides brief case studies of this and other agencies.

- **Training:** Properly trained officers are critical to the success of any model of crisis response, but in jurisdictions where the response rests entirely with police, robust training is particularly important. These agencies should also cultivate an agency culture that prioritizes de-escalation.

Co-Response Models

Co-response models utilize teams of police in combination with professionals from other disciplines such as MBH clinicians, physicians, emergency medical services, or non-clinical social workers. This model recognizes that police alone may not be the best responders for all types of calls but are important to the safety of other responders as well as the person in crisis. Co-response has been shown to reduce the likelihood of adverse outcomes for people in crisis, such as arrest or injury, as discussed below.

Structure

In some co-response models, the multidisciplinary team responds to active MBH crisis calls. In others, it provides post-event follow-up services after patrol officers have resolved the initial call. MBH professionals may be employed directly by the police agency or by a service provider that collaborates with the department.

The Columbia Heights (MN) Police Department (CHPD) and the Raleigh (NC) Police Department (RPD) illustrate this contrast in approach. CHPD's program pairs police officers and clinicians to respond to active crisis calls together, and clinicians are active partners in defusing crisis situations. CHPD partners with a local behavioral

health service provider to operate the program. In RPD, patrol officers respond to acute crisis calls, and RPD's ACORNS Unit (Addressing Crises through Outreach, Referrals, Networking, and Service) conducts follow-up outreach and case management. ACORNS officers and social workers collaborate to identify the unmet needs of community members in crisis and match them with local services.

Impact

Research suggests that co-responder models may benefit people in need of treatment services while lessening burdens on police agencies, hospitals, and the community. Studies show co-response is likelier to result in referrals to case managers, outpatient treatment centers, and mental health organizations.¹⁹ Co-response programs are also associated with fewer arrests, which means less pressure on the courts and corrections systems.²⁰

In one study, the Seattle Police Department's co-responder team fielded over 3,000 calls in a year but only 1 percent of these ended in arrest. Most were either resolved on site or referred to social service agencies.²¹

Several studies have found that co-response programs give officers a better understanding of MBH conditions, reduce stigma about MBH conditions, and increase officers' confidence in handling MBH-related crises.²² Clinical staff can also benefit; many report that they feel safer responding to calls with officers, and the collaborative co-response approach can give clinicians a greater appreciation of police.²³ This is important research to share with behavioral health professionals in jurisdictions where they are reluctant to partner with police.

19. G. K. Shapiro *et al.*, "Co-Responding Police-Mental Health Programs: A Review," *Administration and Policy in Mental Health and Mental Health Services Research* 42, no. 5 (September 2015): 606–20, <https://doi.org/10.1007/s10488-014-0594-9>.

20. Shapiro *et al.*; Henry J. Steadman *et al.*, "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies," *Psychiatric Services* 51, no. 5 (May 2000): 645–49, <https://doi.org/10.1176/appi.ps.51.5.645>; H. Richard Lamb *et al.*, "Outcome for Psychiatric Emergency Patients Seen by an Outreach Police-Mental Health Team," *Psychiatric Services* 46, no. 12 (December 1995): 1267–71, <https://doi.org/10.1176/ps.46.12.1267>.

21. Jacqueline B. Helfgott, Matthew J. Hickman, and Andre P. Labossiere, "A Descriptive Evaluation of the Seattle Police Department's Crisis Response Team Officer/Mental Health Professional Partnership Pilot Program," *International Journal of Law and Psychiatry* 44 (January 2016): 109–22, <https://doi.org/10.1016/j.ijlp.2015.08.038>.

22. Morabito *et al.*; Stephen Kisely *et al.*, "A Controlled Before-and-after Evaluation of a Mobile Crisis Partnership between Mental Health and Police Services in Nova Scotia," *Canadian Journal of Psychiatry* 55, no. 10 (October 2010): 662–68, <https://doi.org/10.1177/070674371005501005>.

23. Shapiro *et al.*

Key Issues for Agencies Considering a Co-Response Model

- **Availability of co-response teams.** In some co-response models, team response times can be slow, especially if the officer and clinician are not paired together in a single vehicle or if the co-responders are on call rather than on duty. Some agencies limit co-response availability to times or places where crisis calls occur most frequently.
- **Cost.** Putting an officer and a clinician in a patrol vehicle for an entire shift, with MBH calls as their sole priority, may not be cost-effective if the call volume is relatively low. However, the cost assessment should also account for the potential savings to the community as a whole, including the justice system.²⁴
- **Flexibility.** Because co-response teams combine the skills and expertise of police and MBH specialists, they can field a wider range of crisis calls than a community-based response model and are more likely than a police-only response to connect the person in crisis to follow-up services.
- **Potential for genuine collaboration.** While many agencies and communities that have created co-response programs together have had positive experiences, others have found that lack of trust between the partner agencies and police can be hard to overcome.

Community-Based Response Models

In community-based response models, nonviolent crisis calls are typically handled by teams of civilian professionals, such as MBH clinicians, EMS personnel, and peer mentors (people whose personal experience of MBH conditions helps them

communicate effectively with people in crisis). Police are not included in the response but can be called if the situation deteriorates or cannot be resolved by the first responders.

Depending on the jurisdiction, up to one-third of police calls for service can be diverted to community-based responder programs.²⁵ These calls include less acute MBH issues and other quality-of-life issues, such as intoxicated persons, wellness checks, basic first aid, indecent exposure, public urination, and low-level conflicts such as noise complaints.²⁶

Structure

Community-based response programs are typically run by local government agencies or non-profit organizations. Some programs conduct outreach with people such as high-volume service users and the homeless to get them needed help and thereby prevent future crises. Some programs also incorporate ongoing case management services, while others focus exclusively on emergency response and make referrals for follow-up, case management, and other longer-term support.

In New Mexico, the Albuquerque Community Safety Department (ACS) provides services ranging from addressing behavioral health crises to conducting outreach with people such as high service users or unsheltered individuals. Some responders are specialized clinicians assigned to co-respond with police to acute crisis calls, but most field nonviolent calls without involving police, including MBH episodes, minor disputes, minor injuries, and homelessness issues. The approach focuses on meeting the needs of individuals and the community while working to prevent future crises.

24. *Ibid.*

25. Amos Irwin and Betsy Pearl, “The Community Responder Model: How Cities Can Send the Right Responder to Every 911 Call,” Center for American Progress, October 28, 2020, <https://www.americanprogress.org/article/community-responder-model/>.

26. Eric Westervelt, “Mental Health And Police Violence: How Crisis Intervention Teams Are Failing,” NPR.org, September 18, 2020, <https://www.npr.org/2020/09/18/913229469/mental-health-and-police-violence-how-crisis-intervention-teams-are-failing>.

Impact

Community-based response programs provide an option for family members and others who are concerned about a person who is struggling but are hesitant to contact police or unsure how to get help. If there is no indication the scene is unsafe, community-based responders can take the time needed to de-escalate, understand the individual's unmet needs, and directly connect them to appropriate resources. Community-based programs also can substantially reduce the need for police to respond to many calls. In Eugene (OR), for example, responders from the CAHOOTS (Crisis Assistance Helping Out On The Streets) program field nearly 20 percent of all 911-dispatched calls and typically request police backup in fewer than 1 percent of those cases.²⁷

Key Issues for Communities Considering a Community-Based Response

- **Need and resources.** If the demand, resources, and skilled personnel are available, a community-based response may be the best option. It can provide help to people in need while substantially reducing the burden on police and the wider justice system.
- **Communication.** Good communication between partners needs to be established and maintained. Community responders should be equipped with radios to communicate directly with dispatch, fire/EMS services, and police. In addition, police and community responders should share information (to the extent allowable by law) to deconflict any overlapping response issues.

Hybrid or Blended Models

Some communities have opted for a hybrid approach that combines elements of a police-based, co-response, and/or community-based response model. In Anne Arundel County, Maryland, for

example, the police department and mental health agency collaborate to operate the county's Crisis Response System (CRS). The CRS combines elements of all three categories of response model. The police department has patrol officers trained in crisis intervention who respond to some MBH calls without a co-responder, as well as designated officers who co-respond to calls with mental health agency clinicians. And some cases are dispatched to a community-based alternative without involving police.

South Dakota, a largely rural state where co-response or community-based response programs are less practical, provides another example. The South Dakota Unified Judicial System created the Virtual Crisis Care program, which has supplied officers and deputies in 18 counties with mobile tablets and 24-hour telehealth access to behavioral health professionals.²⁸ In this way, a police-based model creatively uses technology to access some of the advantages of co-response.

Key Issues for Communities Considering a Hybrid Program

- **Thorough planning.** Representatives from multiple agencies stressed to PERF the need for a deliberate program development process and a clear vision of goals and outcomes. Inadequate planning can reduce efficiency by leading to situations in which, for example, police are dispatched to a call for which MBH clinicians are more appropriate (or vice versa) and a second team must be called.
- **Setting community expectations.** To build and maintain public support for response programs with a non-police component, agencies need to clearly explain the program's goals to the public. Denver's Support Team Assisted Response (STAR) program deploys teams of MBH clinicians and EMT/paramedics to respond to calls for service that do not need a police presence.

27. Eric Rafla-Yuan, Divya K. Chhabra, and Michael O. Mensah, "Decoupling Crisis Response from Policing — A Step Toward Equitable Psychiatric Emergency Services," edited by Debra Malina, *New England Journal of Medicine* 384, no. 18 (May 6, 2021): 1769–73, <https://doi.org/10.1056/NEJMms2035710>.

28. Crime and Justice Institute, "Virtual Crisis Care," <https://www.cjinsitute.org/virtual-crisis-care/>.

Denver officials have made clear to the public that the purpose of STAR is to address MBH crises, not crime situations, but that in doing so, it helps free up police resources to address violent crime.

- **Finding creative funding solutions.** STAR receives support from multiple sources. Much of its startup funding came from a voter-approved

“mental health tax” to support mental health programs and grants for the city. STAR also receives funding from businesses in districts with frequent complaints about substance use, homelessness, and other MBH issues. This funding helps to provide food, blankets, and other essentials.

Eight Action Steps to Build a Crisis-Response Program

A community’s crisis-response program should reflect both the community’s needs and its resources, laws, and culture. Regardless of agency size or location, all agencies can take the following action steps to create or enhance their crisis-response strategies. (See Section 7 for more detail.)

- 1 Start planning now - don’t wait for a crisis
- 2 Review current response procedures and assess needs
- 3 Research options for response programs
- 4 Identify and assemble community stakeholders
- 5 Create a common vision and team structure
- 6 Draft a response program and implement a pilot test
- 7 Train all agency personnel who interact with the public on how to respond to persons in crisis
- 8 Conduct ongoing evaluation and improvement

Section 1: Challenges for Police Response to Mental Health-Related Calls

The challenges police face in responding to MBH-related calls include the growing demand for mental health services, the risk of violence in encounters with people in crisis, and the worsening pressure on police resources.

Increasing Demand

The demand for mental health services has greatly increased in recent years.²⁹ The rates of major depressive episodes, anxiety, and suicide among young people have risen sharply, exacerbated by events including the COVID-19 pandemic, civil unrest, and gun violence.³⁰ Sixty percent of psychologists report that they no longer have openings for new patients,³¹ and the emergency services provided during acute mental health crises are often the only services readily available. Because the demand for mental and behavioral health treatment services has outpaced the availability of treatment providers, police involvement in MBH crisis intervention

has grown. Today, anywhere from 1 to 10 percent of police calls for service involve a mental health or substance use crisis.³²

Risk of Violence

The great majority of police encounters with people in crisis are handled well, but some go badly wrong. In the *Washington Post's* database of fatal police shootings since 2015, 21 percent of fatal shootings involved someone facing a mental health crisis.³³ Research shows that most people with MBH disorders are no more likely to be violent than other people, but during an acute crisis, some may act erratically or resist police contact, increasing the risk that an officer may resort to force to counter a perceived danger.³⁴ A person with an untreated mental illness is *16 times likelier to be killed* during an interaction with the police than a person without an untreated mental illness.³⁵

29. American Psychological Association.

30. Matt Richtel, “‘It’s Life or Death’: The Mental Health Crisis Among U.S. Teens,” *New York Times*, May 3, 2022, <https://www.nytimes.com/2022/04/23/health/mental-health-crisis-teens.html>.

31. American Psychological Association.

32. Morabito *et al.*; Livingston; Lum, Koper, and Wu.

33. *Washington Post*, “Fatal Force Police Shootings Database,” accessed June 15, 2023, <https://www.washingtonpost.com/graphics/investigations/police-shootings-database/>. Also, as the *Wall Street Journal* reported recently, “Every year since 2015, police in the U.S. have killed between 200 and 300 people who showed signs of mental illness, according to the nonprofit Mapping Police Violence.” Scott Calvert and Julie Wernau, “‘No Hose, No Gun’: Police alternatives for mental-health crises fall short,” *Wall Street Journal*, August 24, 2023, <https://www.wsj.com/us-news/police-mental-health-units-911-responses-f80d4369>.

34. U.S. Department of Health & Human Services, “Mental Health Myths and Facts,” 2017, <https://www.samhsa.gov/mental-health/myths-and-facts>; Michael T. Rossler and William Terrill, “Mental Illness, Police Use of Force, and Citizen Injury,” *Police Quarterly* 20, no. 2 (June 2017): 189–212, <https://doi.org/10.1177/1098611116681480>.

35. Fuller *et al.*; *Washington Post*, “Fatal Force Police Shootings Database.”

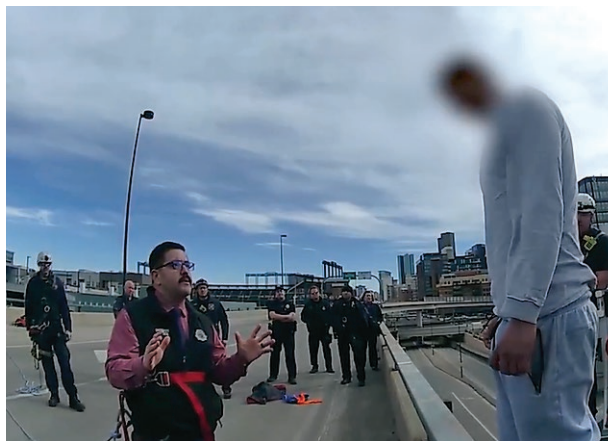
On February 8, 2023, Detective Rueban Garduno, a trained negotiator with the Denver Police Department, responded to a report of a man threatening to jump off a bridge and spoke with the man for several hours. The man was ultimately pulled back to safety. SOURCE: INSTAGRAM @DENVERPOLICE.

Pressure on Police Resources

The policing profession is experiencing a sustained workforce crisis. This was already a serious concern when PERF published a report on this issue in 2019,³⁶ and the situation has worsened since then, as documented in PERF's 2023 report, "Responding to the Staffing Crisis: Innovations in Recruitment and Retention."³⁷ COVID-19 and the backlash against police following the murder of George Floyd accelerated early retirements and resignations and weakened recruitment to a profession that was already struggling to attract applicants. Many agencies are now suffering severe shortfalls in staffing. The *Washington Post* reported recently that the San Francisco Police Department is nearly 30 percent below its allotment of officers, the Phoenix Police Department is 500 officers short, and Washington, DC's Metropolitan Police Department is the smallest it has been in 50 years.³⁸

The calls in 2020-21 for reallocating funds from police budgets to community-based alternatives often were not supported by proper planning.³⁹ But many police have never believed that they should deal with MBH challenges alone. Indeed, some police leaders already resist sending their officers into crisis situations because they feel the officers are ill-equipped to act as mental health professionals.

Even in agencies without severe staffing shortages, MBH calls can place a strain on resources. They can be time-consuming, and for a good reason; rushing them to an early conclusion can lead to adverse outcomes. Frequently officers transport



subjects to hospitals, where they may have to wait for many hours before going back into service. If there is no threat of violence, the most appropriate first responder may not be a police officer. For calls requiring a fast response, there may be cases where police are best positioned to get there first, but even then they might not need to remain there once a health professional has arrived and can take over. By shifting the responsibility for crisis calls to others, or sharing responsibility with them, police can allocate more of their limited resources to crime prevention and investigation — tasks for which they are more qualified and on which their performance is assessed by their communities.

The Spectrum of Crisis-Response Programs

A crisis-response program is any program, collaboration, or system designed to provide services to people experiencing MBH-related crises, including problems related to substance use, housing instability, and mental disorders. Such programs have existed for decades in some communities, but recent years have seen a proliferation of new programs. These take different forms, reflecting differences in communities' resources, demands, and values.

36. "The Workforce Crisis and What Police Agencies Are Doing About It," September 2019, <https://www.policeforum.org/assets/WorkforceCrisis.pdf>.

37. See <https://www.policeforum.org/assets/RecruitmentRetention.pdf>.

38. Robert Klemko, "Police agencies are desperate to hire. But they say few want the job," *Washington Post*, May 27, 2023, <https://www.washingtonpost.com/national-security/2023/05/27/police-vacancies-hiring-recruiting-reform/>.

39. Lum, Koper, and Wu.

Moving the primary response to certain calls away from the police may make sense in one community but not in another because of funding issues, lack of clinicians, a different local culture, or a smaller population with fewer calls for service.

Police agencies also have different perspectives on the issue. The leaders of some agencies are eager for other agencies or community-based organizations to take responsibility for MBH calls where there is no immediate threat of violence. Others are reluctant to reduce the police role in crisis response because police are an important, though often under-acknowledged, part of the public health and social service network of every community. Chief Michael Noble of the Maynard (MA) Police Department argues that taking police out of the equation is an irresponsible approach: “I don’t believe you can have a program like this without police involvement in some way. . . . [O]bviously safety is a factor, but the institutional knowledge that officers bring to finding solutions for people in crisis is invaluable, too.”

PERF heard from many other police leaders that while alternative response programs can be helpful, they often don’t provide round-the-clock services. If police are expected to respond to less serious crisis calls during off-peak hours, it is important that they coordinate with alternative responders who field those same calls during peak hours.

Crisis-response programs therefore take many different forms, but they fall into three broad categories:

1. ***Police-based response models***, in which specially trained officers respond to crisis calls. Responding officers have been trained to de-escalate the situation, stabilize the subject, and liaise with local mental-health service providers.
2. ***Co-response models***, in which multidisciplinary pairs or teams, including an officer and a mental health professional, respond to crisis calls together. The composition of the co-response team and the processes for activating it can vary greatly, depending on the community.
3. ***Community-based alternative models***, in which non-police personnel respond to calls

where there is no immediate threat of violence and request police assistance only if needed.

These categories are not mutually exclusive. Some communities operate hybrid programs that incorporate elements of all three models: officers are well trained and able to de-escalate crises, a co-responder option is available, and some calls can be fully diverted from a police response.

The remaining sections of this report discuss crisis-response training programs for law enforcement, the three main crisis-response models, and the hybrid programs in some areas. Case studies detail the programs in specific communities.

Survey of Police Executive Research Forum Members

In 2022, PERF conducted a member survey to see how police agencies work with their communities to handle MBH calls, including the variety of response models and their benefits and challenges. PERF received 192 responses from agencies in 36 U.S. states in all regions of the country, the District of Columbia, and Canada. Most respondents (91 percent) were from municipal or local-level agencies, serving populations ranging from under 10,000 to over a million.

A majority of respondents participate in some form of co-response program, our survey found. Figures 1-4 summarize the findings. A majority of respondents participate in some form of co-response program, and most of these agencies lead the program. Not surprisingly, the smallest agencies are least likely to participate in a co-response program, while the largest agencies are the most likely to lead a program. Mental health clinicians, social workers, and medical professionals are among the most common partners of co-response and community-based programs. The large majority of co-response programs handle calls related to mental illness, homelessness, and addiction or overdose. (Note that not all organizations listed as a part of a co-response or community-based response program actively respond to acute crisis incidents. They may provide support for policy development, training, afteraction review, or other functions.)

Figure 1: Respondent Agency Participation in a Multidisciplinary Co-Response Program

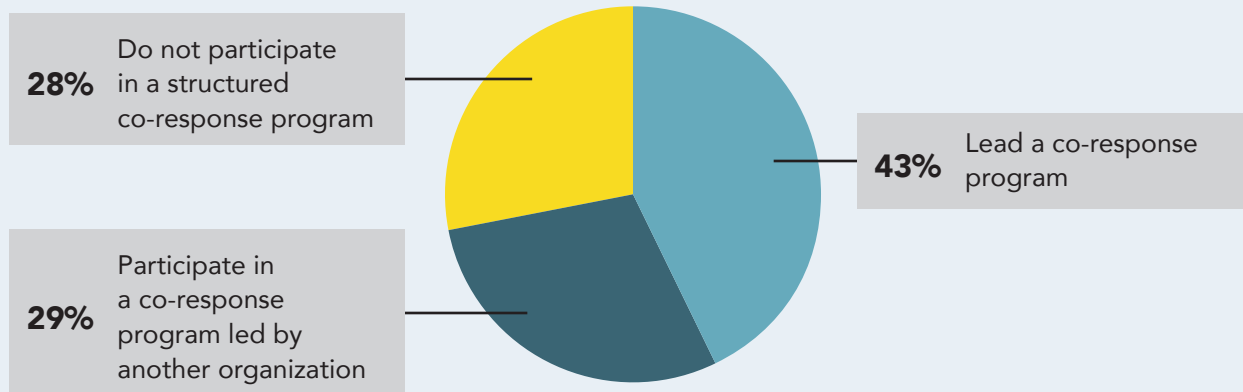


Figure 2: Respondent Agency Participation in a Multidisciplinary Co-Response Program, by Agency Size

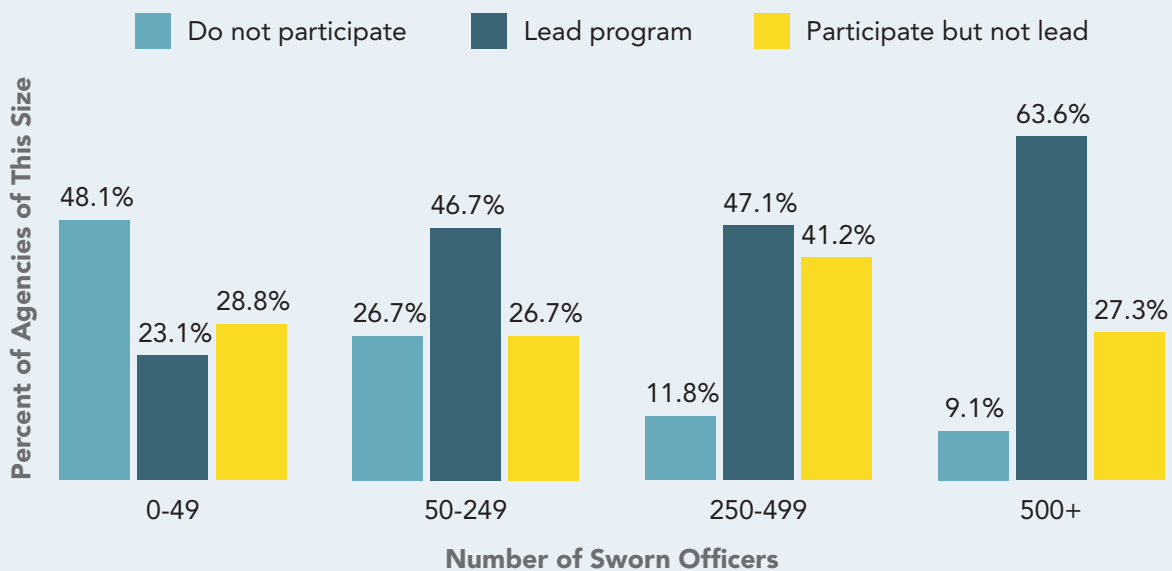


Figure 3: Types of Partner Organizations in Respondent Co-Response and Community-Based Response Programs

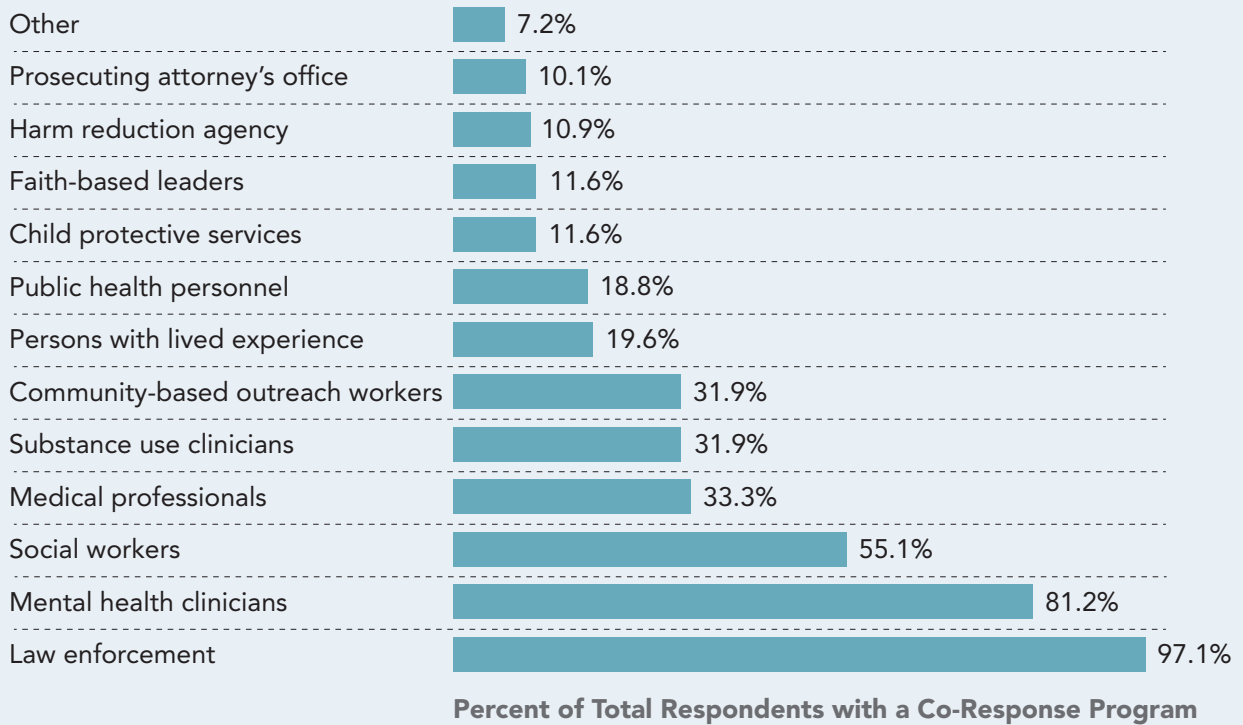
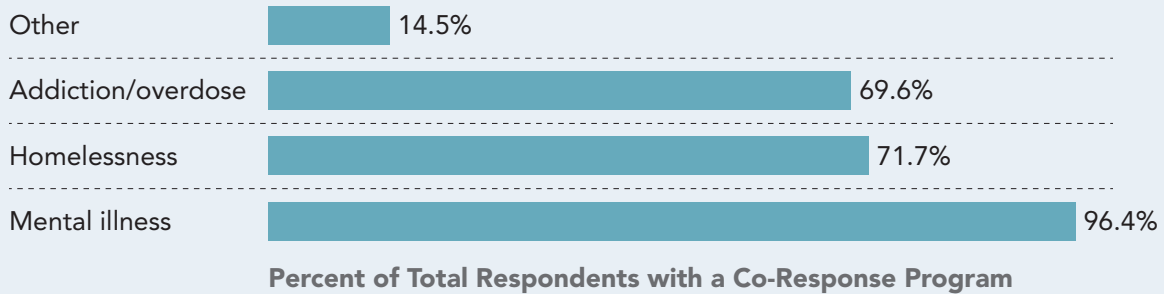


Figure 4: Call Types Handled by Co-Response Programs



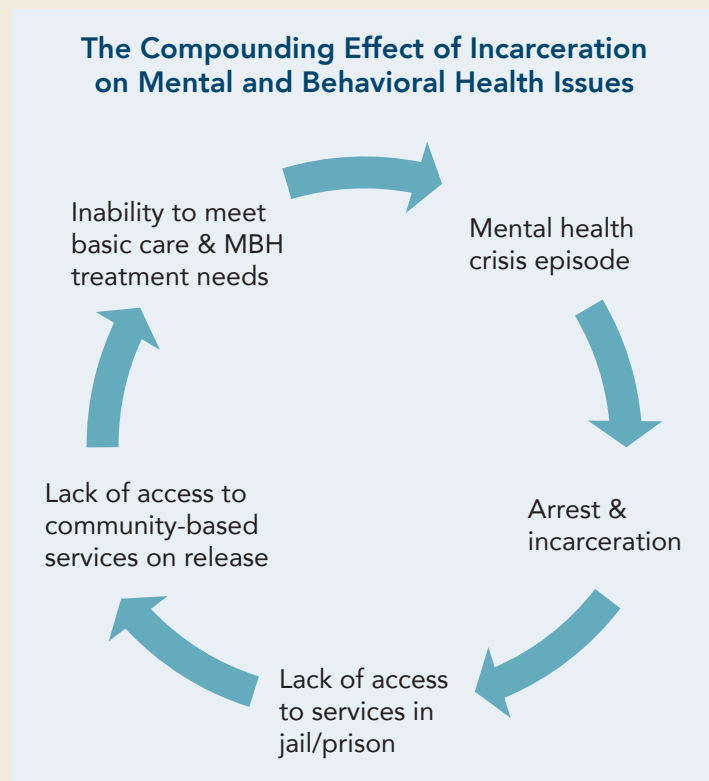
Avoiding Unnecessary Arrests Can Help Prevent a Cycle of Crisis and Incarceration

When people experiencing an MBH crisis receive treatment and services rather than arrest and incarceration, the benefits for both the individual and the community can be substantial.

People with MBH disorders are arrested and incarcerated at disproportionately high rates. Over 40 percent of people in state prisons and local jails have been diagnosed with a mental disorder, and the majority of those in federal or state prisons receive no mental health care while incarcerated.⁴⁰ Even the jails and prisons that can provide MBH-related services to their incarcerated population are not health care facilities focused on mental wellness.

On their release, people with MBH disorders often face additional barriers to services, which compounds their risk of another crisis episode and rearrest. For instance, individuals with a criminal history may be ineligible for community-based services, including access to affordable housing. “Anti-homeless” laws such as prohibitions on urban camping, sleeping in public, panhandling, and loitering increase the likelihood that unhoused people with MBH conditions will be rearrested and their health care needs will continue to go unaddressed.

Providing care rather than arrest and incarceration could break this vicious circle—offering better outcomes for the individual concerned, reducing the incidence of repeated critical episodes, benefiting wider public safety, and lessening the burden on the criminal justice and corrections systems.



40. Prison Policy Initiative, “Research Library: Mental Health,” PrisonPolicy.org, accessed July 11, 2023, https://www.prisonpolicy.org/research/mental_health/.

Section 2: Crisis-Response Training for Police

Effective training for officers is the foundation

for all crisis-response strategy. The types of training described below — presented from most basic to most comprehensive — are not the only available options, but they impart knowledge and skills that officers can employ on MBH calls. Officers need to be able to recognize when a person's behavior may be indicative of a behavioral crisis or an underlying mental health condition or intellectual or developmental disability. Dispatchers and other police professional staff interacting directly with the public also need to be sensitive to such signs and advise officers accordingly.

One example of an awareness-level training program is Mental Health First Aid for Public Safety (MHFA-PS).⁴¹ It is a popular basic training option for many police agencies, in part because it is inexpensive. It provides a general review of common MBH and substance use disorders and basic strategies to calm the situation and support the person in crisis. More than half (53 percent) of PERF survey respondents reported that some or all officers in their agency receive MHFA-PS training. There is limited research available on the program's effectiveness, however.

The Crisis Intervention Team (CIT) concept was first developed in Memphis, Tennessee in 1988. The 40-hour CIT training curriculum has since

become one of the most common forms of crisis-response training for police, adopted by more than 2,700 U.S. police agencies. CIT training covers the range of conditions that contribute to behavioral crises and aims to enhance officers' empathy toward the individuals concerned and improve their skills in managing crisis events safely.⁴²

CIT training requires collaboration with other first responders, medical and mental health care providers, advocacy groups, and other stakeholders. While partner organizations do not co-respond to the scene of crisis incidents, police share ownership of the program with community-based partners such as clinicians and advocates. The team works together to plan and implement the program, establish policies and procedures, create and deliver training for CIT officers and dispatchers, and conduct program evaluation and research.⁴³

Some police agencies have followed the Memphis example of accepting only volunteers for the 40-hour course, believing that volunteers are more likely to be well suited to a CIT role. Others require all officers to participate in CIT training as a standard part of their training, believing that strong communication and de-escalation skills are necessary for daily police duties and that all officers should learn from mental health professionals and people who have experienced an MBH crisis.

41. <https://www.mentalhealthfirstaid.org/population-focused-modules/public-safety/>

42. National Alliance on Mental Illness, "Crisis Intervention Team (CIT) Programs," [https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-\(CIT\)-Programs](https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs), accessed July 11, 2023.

43. Laura Usher *et al.*, "Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises," CIT International, August 2019, <https://www.citinternational.org/bestpracticeguide>.

CIT training has been shown to improve officers' understanding of MBH conditions.⁴⁴ It may also reduce arrests and increase referrals to mental health services.⁴⁵ There is mixed evidence, however, on whether it reduces the likelihood that police will use force on MBH calls.⁴⁶

Integrating Communications, Assessment, and Tactics (ICAT)

PERF developed the ICAT program in 2016 to address police use of force in a range of critical incidents, including MBH situations.⁴⁷ About 21 percent of fatal police shootings involve a subject displaying signs of mental illness,⁴⁸ but in many officer-involved shootings, the officer had received CIT training. However, it appeared that officers, as crisis situations became more dynamic, often forgot their communication-focused training and reverted to their basic defensive tactics training. ICAT, which is designed as a 12-hour training program, addresses this risk by integrating communications and operational safety tactics.

The ICAT curriculum focuses on the training needs of first-line officers, who are generally the first to respond to volatile situations involving erratic subjects. It

equips them with tools and techniques to slow situations down and resolve them safely. This practice is built around the Critical Decision-Making Model, which teaches officers to better assess a situation, gather information, and make good decisions. (See Figure 5.)

An independent evaluation found that ICAT was associated with a 28 percent reduction in use-of-force incidents, a 26 percent reduction in citizen injuries, and a 36 percent reduction in officer injuries. (See Figure 6.) The rigorous study design gave researchers high confidence that the observed changes were a result of the training.⁴⁹ Another study found that ICAT training improves officer attitudes and perceptions toward people in crisis and improves officers' confidence in handling crisis incidents — an effect that increases over time post-training.⁵⁰



Officers undergo scenario-based training in a mock home at PERF's National ICAT Training Center in Decatur, IL.

44. Watson, Compton, and Draine.

45. Michael T. Compton *et al.*, "The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest," *Psychiatric Services* 65, no. 4 (April 2014): 523–29, <https://doi.org/10.1176/appi.ps.201300108>; Nahama Broner *et al.*, "Effects of Diversion on Adults with Co-Occurring Mental Illness and Substance Use: Outcomes from a National Multi-Site Study," *Behavioral Sciences & the Law* 22, no. 4 (July 2004): 519–41, <https://doi.org/10.1002/bsl.605>.

46. Watson, Compton, and Draine.

47. Police Executive Research Forum, "ICAT: Integrating Communications, Assessment, and Tactics," <https://www.policeforum.org/icat>.

48. <https://www.washingtonpost.com/graphics/investigations/police-shootings-database/>, accessed on July 20, 2023.

49. Robin S. Engel *et al.*, "Assessing the Impact of De-escalation Training on Police Behavior: Reducing Police Use of Force in the Louisville, KY Metro Police Department," *Criminology & Public Policy* 21, no. 2 (May 2022): 199–233, <https://doi.org/10.1111/1745-9133.12574>.

50. Gabrielle T. Isaza, Hannah D. McManus, Robin S. Engel, and Nicholas Corsaro, "Evaluation of Police Use of Force De-Escalation Training: Assessing the Impact of the Integrating Communications, Assessment, and Tactics (ICAT) Training Program for the University of Cincinnati, OH Police Division (UCPD)," International Association of Chiefs of Police / University of Cincinnati Center for Police Research and Policy, December 2019, https://www.theiacp.org/sites/default/files/Research%20Center/UCPD_ICAT%20Evaluation_Final.pdf.

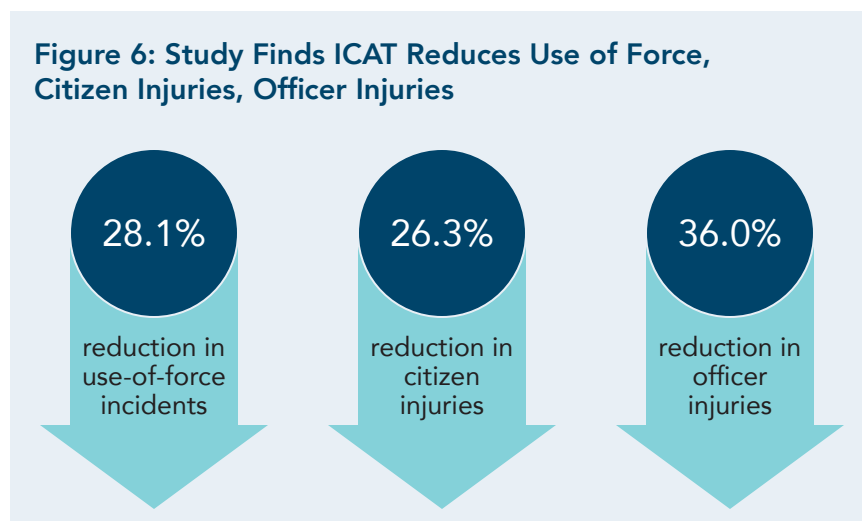
One-quarter of PERF survey respondents provide ICAT training to some or all of their officers, and agencies with ICAT-trained officers can be found in more than 30 states.⁵¹ Agencies can implement ICAT as a stand-alone program, incorporate it

into their existing training, or use it to supplement CIT training. The Fargo (ND) Police Department, for example, decided in 2021 to supplement its existing 40-hour CIT requirement with ICAT training to further sharpen officers' crisis-response skills.

Figure 5: The Critical Decision-Making Model



Figure 6: Study Finds ICAT Reduces Use of Force, Citizen Injuries, Officer Injuries



51. Police Executive Research Forum, "Agencies Implementing ICAT," <https://www.policeforum.org/icat-agencies>.

Section 3: Police-Based Response Models

PERF's member survey found that agencies with fewer than 50 sworn officers are more likely to rely on police-based responses than some form of co-response or community-based response. Smaller communities often lack the services, funding, or call volume to justify developing full co-response or community-based response programs. General health care services may be difficult to access in these areas, let alone specialized MBH services. When such services are available, they are unlikely to be available 24 hours a day. Police may be the

only resource reliably available at all times and the best equipped to respond to potentially volatile situations.

However, officers in some smaller communities may feel ill-prepared for these types of calls.⁵² It is essential to give them the skills and confidence they need to handle crisis calls when police are the sole responders. While PERF recommends that departments require a baseline level of training on MBH crises for all officers, this is especially important for agencies with police-based response models.

Case Study

Fort Walton Beach, Florida

The Fort Walton Beach Police Department (FWBPD) is located on the Florida Panhandle and serves a community of about 21,000 permanent residents as well as seasonal beachgoers. FWBPD employs a police-based response model for crisis calls. Chief Robert Bage explained that this approach reflects the department's lower volume of crisis calls and the area's limited resources to sustain a co-response or community-based response model.⁵³

Program Structure

To serve individuals in crisis in the community despite its resource limitations, FWBPD has invested in thoroughly training its officers; about 80 percent of the agency's officers have received

52. Charlotte Gill, Rachel Jensen, and Breanne Cave, "Exploring Physical Force and Subject Resistance in Police Encounters with People with Behavioral Health Issues," *Victims & Offenders* 13, no. 8 (November 17, 2018): 1106–31, <https://doi.org/10.1080/15564886.2018.1512025>.

53. Interview with Chief Robert Bage (Fort Walton Beach Police Department), May 8, 2023.

both CIT and ICAT training. The western half of the Panhandle is served by a Mobile Response Team (MRT) based in Pensacola, about 45 miles west of Fort Walton Beach. However, the MRT responds only to less urgent or acute calls, and response times may be up to an hour.

Lieutenant Jamieson Ross, who oversees FWBPD's crisis response, explained that the department also partners with a local MBH treatment service provider, Bridgeway Center. Bridgeway "offers voluntary inpatient treatment services . . . [and acts] as a clearinghouse to help identify people's specific needs and match them with additional service providers in the Panhandle region."⁵⁴ Bridgeway acts as a single point of contact for officers to make referrals on calls that don't rise to the level of needing law enforcement intervention or MRT services.

Program Successes

Lt. Ross cited ICAT training as a core part of the department's approach to MBH crisis calls. He recounted a case in which an FWBPD corporal used his ICAT training to de-escalate a situation in which an individual was threatening to hurt or kill himself: "His complete understanding and utilization of ICAT was textbook, and it worked so well. He took his time — about four hours total — and was really committed to talking to this guy for as long as it took. By the time it was all over and the corporal felt comfortable that the man was no longer in acute crisis, he actually asked if he could come outside of his house and give the corporal a hug."



Fort Walton Beach police recover a man experiencing hallucinations from the crawl space of a waterfront restaurant.

SOURCE: TWITTER @FORTWALTONBCHPD

Key Issues for Agencies Considering a Police-Based Response

- **Availability of alternative resources.** In rural or remote areas, police may be the only available option for crisis response.
- **Complexity of program structure.** For smaller agencies, police-based responses can be more viable because they do not require management of complex structures or intensive coordination with partner organizations.
- **Cost.** Police-based programs may cost less than co-response or community-based response options.
- **Training.** Properly trained officers are critical to the success of any model of crisis response, but in jurisdictions where the response rests entirely with police, robust training should be a foundational requirement. These agencies should also cultivate an agency culture that prioritizes de-escalation.

54. Interview with Lieutenant Jamieson Ross (Fort Walton Beach Police Department), June 8, 2023.

Section 4: Co-Response Models

Co-response models are characterized by

teams of police combined with professionals such as MBH clinicians, physicians, emergency medical services, and non-clinical social workers. Co-response programs approach acute MBH crises with the goal of both stabilizing the situation and addressing immediate needs. Many of them also find follow-up services for the person in crisis, thereby helping prevent future crises.

The co-response model recognizes that police officers alone may not be the best responders for all types of calls but need to be present when there is a risk to the safety of other responders or to the person in crisis. The presence of both a mental health clinician and a police officer can be very effective in de-escalating potentially dangerous situations.



Structure

In some iterations of the co-response model, a mental health clinician is assigned to ride with a police partner in the same vehicle. In others, the partners are dispatched together but in separate vehicles. There are also variations in whether vehicles are marked with any type of law enforcement insignia and whether responding officers are in uniform, a modified uniform, or plain clothes.

Other versions of the co-response model conduct follow-up services only. For example, the Portland (OR) Police Bureau (PPB) relies on officers trained in CIT or ECIT (enhanced crisis intervention training) to respond to active crisis calls. Afterward, PPB's behavioral health response teams (composed of a sworn officer and clinical social worker) focus on following up with the person to build rapport and link them to ongoing support services.⁵⁵

PPB is one of a number of agencies that employ MBH professionals directly. In others, such as the Columbia Heights (MN) Police Department, the clinicians work for a service provider that

Members of the Portland Police Bureau Behavioral Health Response Unit pass out handwarmers on a frigid day. SOURCE: PORTLAND POLICE BUREAU

55. Interview with Lt. Christopher Burley (Portland Police Bureau, Behavioral Health Unit), May 17, 2023.

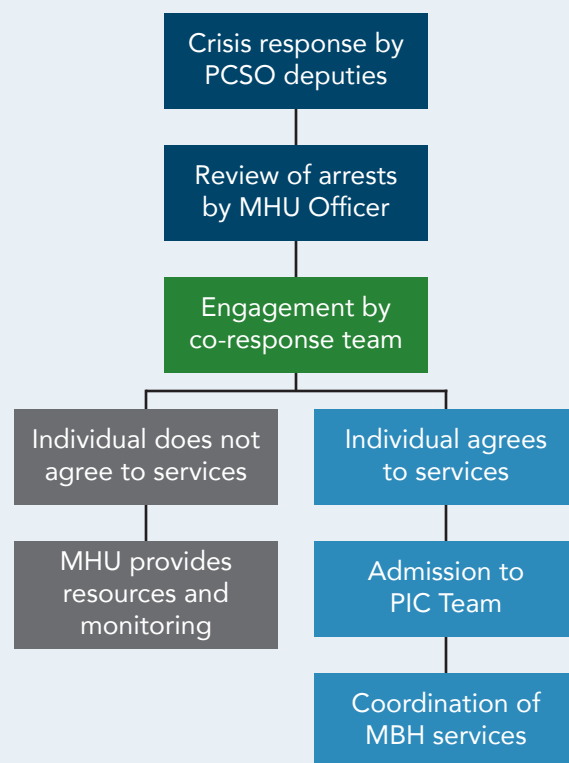
collaborates with the department.⁵⁶ In other cases still, the co-response program is nested within a larger, more complex multi-modal system. (See Section 5.)

Engagement Styles

Co-response programs also vary in their engagement styles. In some, a multidisciplinary team responds to active situations involving people in acute crisis. The Los Angeles Police Department's (LAPD) Systemwide Mental Assessment Response Team (SMART), created in 1993, is one of the first co-responder programs developed for MBH crisis calls. It replaced LAPD's previous approach, whereby clinicians responded to less acute calls while police responded to those with a greater risk of violence. That approach was appropriate for the less acute calls but meant that clinicians were not on scene for people in more volatile states of crisis.⁵⁷ SMART, in contrast, pairs clinicians from the Los Angeles County Department of Mental Health with specially trained LAPD officers in their patrol vehicles. This approach creates a pathway to providing clinical care on higher-acuity⁵⁸ calls and those involving potential violence.

The Pinellas County (FL) Sheriff's Office (PCSO) and its community partners have taken a different approach with their Pinellas Integrated Care Alliance, established in 2018. PCSO patrol deputies respond to acute crises,⁵⁹ and the PCSO Mental Health Unit (MHU) then reviews case reports daily to identify people who may benefit from follow-up visits and mental health support services — for example, people who have been involved in involuntary commitments, have made frequent 911 calls, or have multiple MBH

Figure 7: Crisis Response Structure for Pinellas County, FL



Adapted from Abella, Landers, and Ismajli (2021).

arrests. A deputy and a clinical social worker then co-respond for follow-up engagement, explaining how services from the Pinellas Integrated Care Team (PIC Team) might be helpful moving forward. The PIC Team consists of a group of representatives from four MBH service providers who help individuals navigate local care systems and find resources and services suited to their needs. (See Figure 7 for a visualization of the PIC Team response.)

56. Interview with Captain Matt Markham (Columbia Heights Police Department), May 2, 2023.

57. Lamb *et al.*

58. Acuity refers to the level of severity, complexity, and urgency of a case. High-acuity calls, for example, may involve actual or threatened violence to self or others, presence of a weapon, or other felonious activity. Low-acuity calls involve situations that are less volatile, such as a person who is not posing a safety threat but has unmet resource needs.

59. Anna Davidson Abella, Monica Landers, and Flandra Ismajli, "Pinellas Integrated Care Alliance Evaluation Report," Program Evaluation, University of South Florida, April 9, 2021, <https://www.usf.edu/cbcs/cfs/documents/pica-evaluation-report-y3.pdf>.

Impact

Research suggests that co-responder models can benefit people in need of treatment services while lessening burdens on police agencies, hospitals, and the community.

Outcomes for Citizens in Crisis

The most basic test of co-responder programs is whether they lead to positive outcomes for the individuals experiencing MBH crises. A study of the Seattle Police Department's co-responder team, which found that more than 3,000 calls were diverted to the team over one year, also found that only 1 percent of cases involving the co-responder team culminated in arrest. The most common outcomes were on-site resolution or referral to other social service agencies.⁶⁰

Co-response programs may also provide better connection to longer-term care and support services for people with MBH conditions. Studies show that co-response contacts are likelier to result in referrals to case managers, outpatient treatment centers, and mental health organizations, whereas a police-based response is likelier to result in transportation to a hospital, detoxification unit, or psychiatric hold facility.⁶¹

Outcomes for Law Enforcement Agencies and Communities

As the Seattle study showed, co-responder programs can ease the call volume for line officers, allowing them to focus on calls better suited to their skills and training. By diverting crisis clients from hospitals, these programs also reduce the amount of time officers spend out of service waiting at a hospital. Co-response teams can allow first-responding patrol officers to return to service more quickly if relieved

by the co-response team (though some agencies require the patrol officer to keep responsibility for the case report). By reducing arrests, co-response models reduce pressure on the justice system.⁶² Officers spend less time on paperwork associated with arrests or involuntary commitment holds; the corrections system has less pressure on its facilities and services; and the courts have fewer cases to process.

Some officers may feel that having a clinician present on the scene of a crisis adds pressure by making them responsible for the safety of an additional person. On the other hand, studies show that co-response programs have helped officers better understand and handle MBH crises.⁶³

Having co-responders in the same car can have an unintended benefit for officer wellness. Chief Paul Pazen (Ret.) of the Denver (CO) Police Department (DPD) said that when DPD began a co-response program, officers often wanted to be paired with a clinician because it gave them informal opportunities to talk to a mental health professional in a private space about issues in their personal and professional life.

Co-response models can have a positive impact on clinical staff as well. While some MBH service providers have distanced themselves from partnerships with police, notably during the recent “defund the police” outcry, many others say they prefer responding to calls with officers because they feel safer than if they were to respond alone.⁶⁴ Sheriff Shannan Moon of the Nevada County (CA) Sheriff's Office added that the collaborative co-response approach has given clinicians a greater appreciation of police. “In speaking with our clinicians, they each have said they have learned a tremendous amount by working in the field with law enforcement. They underestimated the work that is already being done and are amazed at the level of care and concern our staff show in their calls each day.”

60. Helfgott, Hickman, and Labossiere. Other studies (see, for example, Morabito *et al.*) have found that co-response programs are associated with lower arrest rates.

61. Shapiro *et al.*

62. Shapiro *et al.*; Henry J. Steadman *et al.*, “Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies”; Lamb *et al.*

63. Morabito *et al.*; Kisely *et al.*

64. Shapiro *et al.*

The Raleigh Police Department (RPD), with about 640 sworn officers, serves a city of nearly half a million residents across an area of roughly 150 square miles.⁶⁵ The ACORNS Unit — short for Addressing Crises through Outreach, Referrals, Networking, and Service — is the center of the RPD’s program for responses related to homelessness, mental health concerns, and substance use issues.⁶⁶

Program Development

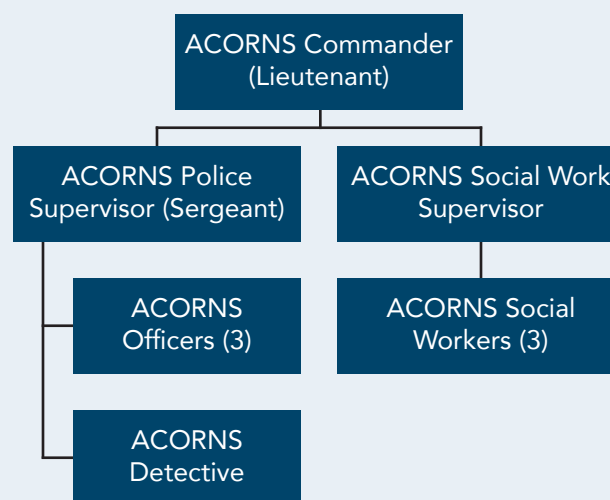
Under the direction of then-Chief Cassandra Deck-Brown (Ret.), RPD began developing its crisis-response program by conducting outreach to stakeholders and facilitating focus groups to identify the program’s scope, focus, and structure. Lieutenant Renae Lockhart, who oversees ACORNS, explained that this outreach included external stakeholders such as community members and community-based service providers as well as internal stakeholders such as officers and professional staff. What emerged is a “care and safety first, enforcement last” approach that connects people in crisis with resources to meet their individual goals for healing.⁶⁷

Program Structure

The ACORNS Unit comprises Lieutenant Lockhart and her team of police and social workers, including a police sergeant, three ACORNS officers, a detective, a social work supervisor, and six ACORNS social workers. (See Figure 8.)

All RPD staff — sworn and non-sworn — are trained in Mental Health First Aid, and over half of RPD’s officers are CIT-trained. RPD also incorporates CIT training into the curriculum of its police academy so that all recruits complete CIT training prior to graduation. The ACORNS program primarily focuses on case management because RPD patrol officers are trained to recognize and

Figure 8: ACORNS Unit Structure



65. Joe Fisher, “Facing Shortage of 160 Officers, Raleigh Proposes 12% Pay Raises for Rookie Officers,” WRAL News, February 23, 2022, <https://www.wral.com/story/facing-shortage-of-160-officers-raleigh-proposes-12-pay-raises-for-rookie-officers/20153799/>.

66. Raleigh Police Department, “ACORNS Unit,” January 2023.

67. Raleigh Police Department, “ACORNS: Addressing Crises through Outreach, Referrals, Networking, and Service,” Raleigh.gov, February 10, 2023, <https://raleighnc.gov/safety/acorns>.

appropriately address calls involving a person in crisis, but ACORNS staff will also assist on active crisis calls if needed.

The ACORNS Unit receives follow-up referrals from RPD personnel (for example, from patrol officers or detectives who encounter an individual on a call or during an investigation), but ACORNS staff also initiate outreach.⁶⁸ In particular, the unit's detective works with the RPD Threat Assessment Unit to identify individuals whose behavior is concerning but not necessarily threatening and where outreach to them or their family may help prevent an escalation. Lieutenant Matt Frey, who oversees the RPD Research and Planning Unit, describes this as a paradigm shift for officers: "Normally police get called to a specific incident at its climax, where something is already on fire. But ACORNS comes in before things get to that ignition point and puts all the tinder under water, so it doesn't ignite in the first place."

If a person referred to the ACORNS Unit chooses to receive services (participation is voluntary), ACORNS officers and social workers provide care coordination and support tailored to their individual needs. Among other services, ACORNS has helped a person track down their European birth certificate, provided transportation to pick up medicine, and facilitated housing access through the Raleigh Housing Authority.⁶⁹ ACORNS staff also help connect individuals to services such as community-based shelters, mental health treatment providers, and substance use treatment providers.

Program Challenges

Like other departments rolling out new crisis-response initiatives, RPD has faced criticism from some community members who believe police should pull back from, rather than lean into, integration with social workers to respond to MBH crises. Those critics don't give her team enough credit, Lockhart says: "People sometimes see police officers as robots . . . but we actually have an ACORNS officer who has a degree in clinical psychology, and a few of us have training in social work. We have great officers who understand and want to do this work."

Program Successes

While it's difficult to quantify the success of a program designed to prevent people from reaching the point where they are in crisis, ACORNS identifies each connection to services they make as a "win." Officer buy-in is another sign of success, Lt. Frey explains: "They've started to see what a good resource it is, and the referrals to ACORNS from our officers have increased steadily over the past two years when we started."

68. Interview with Lieutenant Renae Lockhart (Raleigh Police Department), May 19, 2023.

69. Cullen Browder, "Gentle Policing: Social Workers Team up with Raleigh Officers to Successfully Respond to over 1,000 Calls," WRAL News, January 17, 2023, <https://www.wral.com/gentle-policing-social-workers-team-up-with-raleigh-officers-to-successfully-respond-to-over-1-000-calls/20676502/>.

The Columbia Heights Police Department (CHPD) serves both Columbia Heights, a Minneapolis suburb of roughly 22,000 people, and Hilltop, a small neighboring city with a population under 1,000. CHPD has 29 full-time sworn officers, all of whom must undergo 40 hours of CIT training and 12 hours of ICAT training. CHPD officers also regularly participate in ongoing refresher training on de-escalation and implicit bias awareness.

Program Development

CHPD developed its co-response program in response to increases in calls related to MBH issues, homelessness, substance use, and other quality-of-life issues. CHPD also recognized that the needs of some high service users in the community were better met by services and case management than by public safety resources like police, fire, and EMS. (One resident required close to 200 calls for service per year.) “We wanted to find a better way of handling those calls,” explained Captain Matt Markham, “not just to address the strain on our resources but also so we are not just in a constant cycle of taking people to the hospital or jail without really addressing their underlying needs.”⁷⁰

Program Structure

Clinical social workers contracted through Canvas Health, Inc. are embedded in CHPD and accompany CHPD officers to calls as available. Because CHPD requires all officers to have CIT and ICAT training, all officers do crisis co-response shift rotations with their clinical colleagues.



Columbia Heights social workers Eileen Crosby (left) and Erin Buller (right) and their supervisor Jessica Torrey (center) receive the department's T. Nightingale Community Service Award in 2022 for outstanding efforts in the co-responder social worker program. SOURCE: COLUMBIA HEIGHTS POLICE DEPARTMENT

When crisis calls come in to 911, dispatchers assign them to available units as they would any other call. All CHPD officers are expected to field these call types regardless of whether a clinician co-responder is available. However, the on-duty officer-clinician team will also monitor calls over the radio and respond to those related to MBH issues, substance use, intoxication, welfare checks, and domestic assaults, as well as other calls related to crisis and trauma, in order to provide support for victims and witnesses.

Officers are required to activate their body-worn cameras when responding to all calls for service and most civilian- or officer-initiated interactions, so their response practices are routinely reviewed, audited, and used for training as needed.

70. Interview with Captain Matt Markham (Columbia Heights Police Department), May 2, 2023.

Program Challenges

During program implementation, CHPD had some difficulty getting officers comfortable with having social workers in cars with them. **Reminding officers that the social workers are their coworkers, not simply observers, helped them adjust to the program.**

Some officers also resisted CHPD's decision to move responsibility for making determinations about involuntary psychiatric holds from officers to social workers. Communication and reinforcement were needed to convince officers that once they made sure the scene was safe, they should let the social workers do the job they are trained to do.

Program Successes

The co-response system has yielded both external and internal benefits. In one example, Capt. Markham talked about the difference a social worker made in a domestic assault call involving a mother and son:

"An adult son assaulted his mother in her home and made it unsafe for her to be there. We got a warrant and charged him out of custody and the mom got an order of protection against her son. When the Sheriff's Office came down to serve the order for protection and evict her son from the home so she could get back into it, he was threatening violence toward the officers. We were planning to bring SWAT in, but our social worker stayed engaged with the subject and eventually she was able to get him to come out and end it peacefully."

Like many other agencies, CHPD has experienced considerable officer turnover in recent years and now employs many younger, less experienced officers. Having highly trained, licensed clinical social workers respond with newer officers has enabled the department to identify some training needs that it otherwise might have missed, particularly around interactions with crime victims, people with MBH issues, and people who have experienced traumatic events. **In a survey of CHPD officers conducted by the department in partnership with Canvas Health, all 26 respondents said the embedded social worker program added value to the department. Three-quarters said it made their job easier and reduced the number of times they needed to use force to resolve calls.**⁷¹

Key Issues for Agencies Considering a Co-Response Model

- **Availability of co-response teams.** In some co-response models, response times can be slow, especially if the officer and clinician are not paired together in a single vehicle or if the co-responders are on call rather than on duty. Some agencies limit co-response availability to times or places where crisis calls occur most frequently.
- **Cost.** Putting an officer and a clinician in a patrol vehicle for an entire shift, with MBH calls their sole priority, may not be cost-effective if the call volume is relatively low. However, the cost assessment should also account for the potential savings to the community as a whole, including the justice system.⁷²

Creative problem-solving and partnerships are useful when resources are limited. Chief Peter

71. Canvas Health, Inc., "Columbia Heights Police Department in Partnership with Anoka Mobile Crisis: Embedded Mental Health Professional Utilization and Outcome Data, January 2022 - December 2022," 2023.

72. Shapiro *et al.*

Mahuna of the West Linn (OR) Police Department described his agency's cost-sharing strategy: "We share the cost of the clinician with a neighboring city. They have 38,000 residents and we have 28,000 residents. The clinician spends time in both police departments during the week but is available to respond to any call in either city. We share a dispatch center and operate on one radio net."

- **Flexibility.** Because co-response teams combine the skills and expertise of police and MBH specialists, they can field a wider range of crisis calls than a community-based response model and are more likely than a police-only response to connect the person in crisis to follow-up services.
- **Potential for genuine collaboration.** While many agencies and communities that have

created co-response programs together have had positive experiences, others have found that lack of trust between the partner agencies and police can be hard to overcome.

For example, in one community a new co-response program was launched soon after a fatal officer-involved incident, but the program has struggled. Department staff described the development process as adversarial and more focused on publicly rebuking the police department than on improving the delivery of services to the community. This has made it difficult to build trusting and collaborative relationships between agencies and created tension about general procedures as well as individual cases. The lesson from this experience is to set up co-response programs proactively rather than in the aftermath of an ugly incident.

“““

I would like to see agencies across the nation implement similar types of teams. The benefits to officers and the community are immense. These types of interactions help reduce the use of force and officer-involved shooting issues facing departments. Law enforcement needs to embrace the team concept and get rid of the "us vs. them" mentality. Clinicians want to work with law enforcement and help them.

Sergeant William Sweetwood, Durango (CO) Police Department

Section 5: Community-Based Response Models

In community-based response models, nonviolent crisis calls are typically handled by teams of civilian professionals such as MBH clinicians, peer mentors, and EMS personnel — teams that do *not* include police officers. Police can be requested if needed, but the default response to less acute calls does not include them. At least 14 of the 20 most populous U.S. cities are hosting or starting community-based programs, according to the Associated Press.⁷³

Depending on the jurisdiction, up to a third of police calls for service could be diverted to community-based responder programs.⁷⁴ These calls include less acute MBH issues and other quality-of-life issues such as intoxicated persons, wellness checks, and basic first aid, as well as low-level community conflicts such as noise complaints.⁷⁵ In the community-based responder model, high-risk calls will still be directed to police but may or may not include co-response from the community-based program.

While interest in community-based models has grown in the past few years, such programs have

existed for some time. Perhaps the best known is CAHOOTS (Crisis Assistance Helping Out On The Streets), a partnership between the City of Eugene (OR) and the White Bird Clinic that launched in 1989.⁷⁶ The CAHOOTS model pairs a non-police crisis intervention worker and a medic (EMT or nurse) to respond to a broad range of noncriminal, nonemergency police and medical calls. CAHOOTS is organizationally housed in the Eugene Springfield Fire Department's (ESF) budget. In some instances, such as higher-risk MBH crisis calls, CAHOOTS also co-responds to calls with Eugene Police Department officers.⁷⁷ Many communities have implemented programs that replicate parts of the CAHOOTS model.⁷⁸

Structure

In community-based models, non-police personnel respond to crisis calls on their own, though police may be called if the situation takes a more threatening turn and the first responders are unable to de-escalate it. They may be dispatched by 911

73. Jennifer Peltz and Jesse Bedayn, "Many big US cities now answer mental health crisis calls with civilian teams — not police," Associated Press, August 28, 2023, <https://apnews.com/article/mental-health-crisis-911-police-alternative-civilian-responders-ca97971200c485e36aa456c04d217547>.

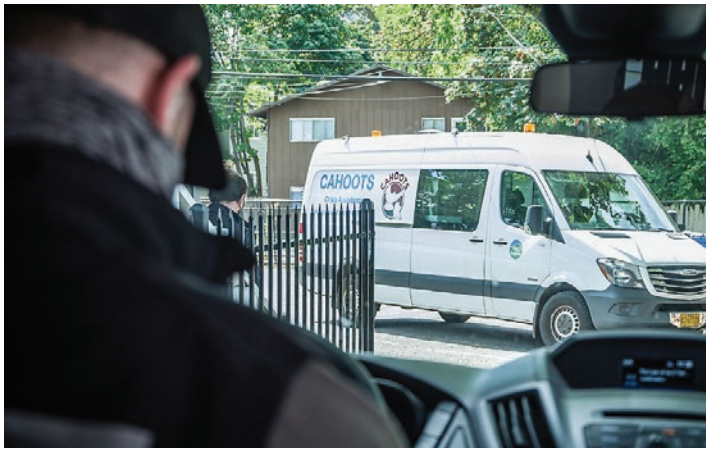
74. Irwin and Pearl.

75. Westervelt.

76. White Bird Clinic, "CAHOOTS," <https://whitebirdclinic.org/cahoots/>; Tatiana Parafiniuk-Talesnick, "In CAHOOTS: How the unlikely pairing of cops and hippies became a national model," *Register-Guard*, October 20, 2019, <https://www.registerguard.com/story/news/2021/12/10/cahoots-eugene-oregon-unlikely-pairing-cops-and-hippies-became-national-model-crisis-response/6472369001/>.

77. <https://www.eugene-or.gov/4508/CAHOOTS>

78. Ben Adam Climer and Brenton Gicker, "CAHOOTS: A Model for Prehospital Mental Health Crisis Intervention," *Psychiatric Times*, January 29, 2021, <https://www.psychiatrictimes.com/view/cahoots-model-prehospital-mental-health-crisis-intervention>.



A CAHOOTS response vehicle. SOURCE: WHITE BIRD CLINIC INSTAGRAM (@WHITEBIRDCLINIC)

or referred by the 988 National Suicide and Crisis Lifeline, or may have their own hotlines that can be called directly.

San Francisco (CA) uses this strategy in its Street Crisis Response Team (SCRT).⁷⁹ Each SCRT unit includes a paramedic, a behavioral health clinician, and a behavioral health peer specialist (a person with lived experience who can empathetically relate to individuals in crisis). SCRT found that in its pilot year, only 3 percent of calls required backup by police, and more than two-thirds of those cases were nonviolent and did not require restraint.⁸⁰

As in San Francisco, community response teams elsewhere include medical personnel such as nurses and EMTs, social workers, peer specialists, or other mental health clinicians. The programs are typically run by governmental community service agencies or non-profit organizations. Some community-based programs conduct outreach with people such as high service users or the homeless to help meet their needs and prevent future crisis episodes. For example, Street Outreach and Resource Responders in the Albuquerque (NM) Community Safety department distribute resources like food, water, and blankets; conduct welfare checks; provide

first aid and conflict mediation; and provide assistance and referrals for access to other government services. Similarly, the Washington, DC Department of Behavioral Health has a Community Response Team that conducts homeless outreach in addition to its mobile crisis response and pre-arrest diversion services.⁸¹

Some community-based response programs also incorporate ongoing case management services. Others focus exclusively on emergency response and make referrals for follow-up, case management, and other longer-term support.

Impact

Community-based response programs provide an option for family members and others who are concerned about a person who is struggling but are hesitant to contact police or unsure how to get help. The person needing assistance may be in an acute emergency (like an episode of psychosis) or may be experiencing a longer-term issue. In either case, if there is no indication that the scene is unsafe, community-based responders can take the time needed to de-escalate the situation, understand the individual's needs, and make direct connections to services that can help.

Community-based response programs also have tangible benefits for the community at large. In Eugene, CAHOOTS responders field nearly 20 percent of all 911-dispatched calls and typically request police backup in fewer than 1 percent of those cases. The program is estimated to save the city about \$8.5 million annually by reducing burdens on police and local emergency departments.⁸²

79. <https://sf.gov/street-crisis-response-team>

80. San Francisco Street Crisis Response Team, "Street Crisis Response Team Pilot: Final Report," May 2022, https://sf.gov/sites/default/files/2022-06/SCRT%20Final%20Report_FINAL-%201%20year.pdf.

81. DC Department of Behavioral Health, "Community Response Team," <https://dbh.dc.gov/service/community-response-team>.

82. Rafla-Yuan, Chhabra, and Mensah.

Case Study

Albuquerque, New Mexico

With a population of over half a million, Albuquerque is New Mexico's largest city. Albuquerque Community Safety (ACS), a cabinet-level department, was created in 2021 to "make Albuquerque safer by providing a holistic, empathetic, and informed response to behavioral, mental health-related and other 911 calls that do not require a police officer, firefighter, or paramedic, such as homelessness, minor injury and non-injury calls for service."

ACS is *not* a non-emergency form of the Albuquerque Police Department: it does not make arrests or issue citations but rather focuses exclusively on connecting community members in need with resources. ACS often enables people to avoid being diverted into the criminal justice system inappropriately.



ACS responders talk with a resident about available resources. SOURCE: ALBUQUERQUE COMMUNITY SAFETY

Program Development

The Albuquerque community was discussing alternate response models to MBH calls when the death of George Floyd in the spring of 2020 accelerated the process. New Mexico already had one of the highest rates of police-shooting fatalities in the U.S. (about three times the national average)⁸³ when Bernalillo County Sheriff's Office deputies fatally shot Elisha Lucero in July 2019 after she ran toward them with a knife during a mental health crisis.⁸⁴ Further, the Albuquerque Police Department (APD) was (and remains) subject to a Department of Justice (DOJ) consent decree requiring reforms to the way its officers are trained to respond to crisis calls. These factors propelled city leadership to develop a new crisis-response strategy.

Historically, the police and fire departments were dispatched to crisis calls. But city administrators recognized that redirecting many of these calls would allow officers, firefighters, and EMS to focus their efforts where their skills are most needed, while connecting people in crisis with resources that better meet their needs. According to ACS Director Mariela Ruiz-Angel, Albuquerque ultimately chose to create a new public safety department because the city believed it was more sustainable than a program-based model, which could be more easily defunded or neglected over time.

"At this point we were also trying to get to staffing levels of police that were never going to happen. Morale was low at police departments and a lot of people didn't trust the police."

83. Jon M. Shane, Brian Lawton, and Zoë Swenson, "The Prevalence of Fatal Police Shootings by U.S. Police, 2015–2016: Patterns and Answers from a New Data Set," *Journal of Criminal Justice* 52 (September 2017): 101–11, <https://doi.org/10.1016/j.jcrimjus.2017.05.001>.

84. Elise Kaplan, "BCSO: Woman Fatally Shot by Deputies Armed with Knife," *Albuquerque Journal*, July 29, 2019; Ted Alcorn, "Albuquerque's Vision for Non-Police First Responders Comes Down to Earth," *New Mexico in Depth*, January 17, 2021, <https://nmindepth.com/2021/albuquerques-vision-for-non-police-first-responders-comes-down-to-earth/>.

At the end of the day we already knew that we needed to create something different, and we had already been playing with alternatives to policing. So after George Floyd's death, there was no hesitation to jump in fully. We had everything align for us: we had the right city council members, our mayor was very supportive, we had really strong leadership at the top, and the political and community will. It really just opened the doors for us, and so we moved very quickly to create the department.”

The city worked with officials, residents, and local organizations to inform development of the ACS; this included researching other alternative or community-based crisis response models and holding community engagement sessions. The city also involved its Mental Health Response Advisory Committee, Office of Civil Rights, and Office of Equity and Inclusion to ensure the policies and practices being implemented were sound.⁸⁵

Program Structure

Together, ACS, APD, and Albuquerque Fire Rescue (AFR) form the city's three-pronged public safety system. The ACS Deputy Director for Field Response oversees two divisions with multiple types of responders, each focusing on a different type of need:

Behavioral Health Response Division

- Behavioral Health Responders respond in person or by phone to calls related to lower-acuity or chronic MBH issues, substance use, and homelessness.
- Mobile Crisis Team clinicians respond in partnership with uniformed police officers to high-acuity MBH crisis calls.

Community Response Division

- Street Outreach and Resource Responders conduct outreach to unhoused community members and focus on connecting individuals to long-term services.
- Community Responders field calls related to minor injuries (not requiring EMS response), incapacitation, abandoned vehicles, non-injury accidents, needle pickups, and other calls for service in the community.

For emergencies, community members are directed to call 911, and a dispatcher will determine whether the matter is suitable for an ACS or police response. Residents are directed to dial 311 for non-emergencies or follow-ups. (See Figure 9.) In cases where a co-response would be beneficial, ACS works closely with the Albuquerque police and fire departments, but it generally functions as a community-based alternative response program.

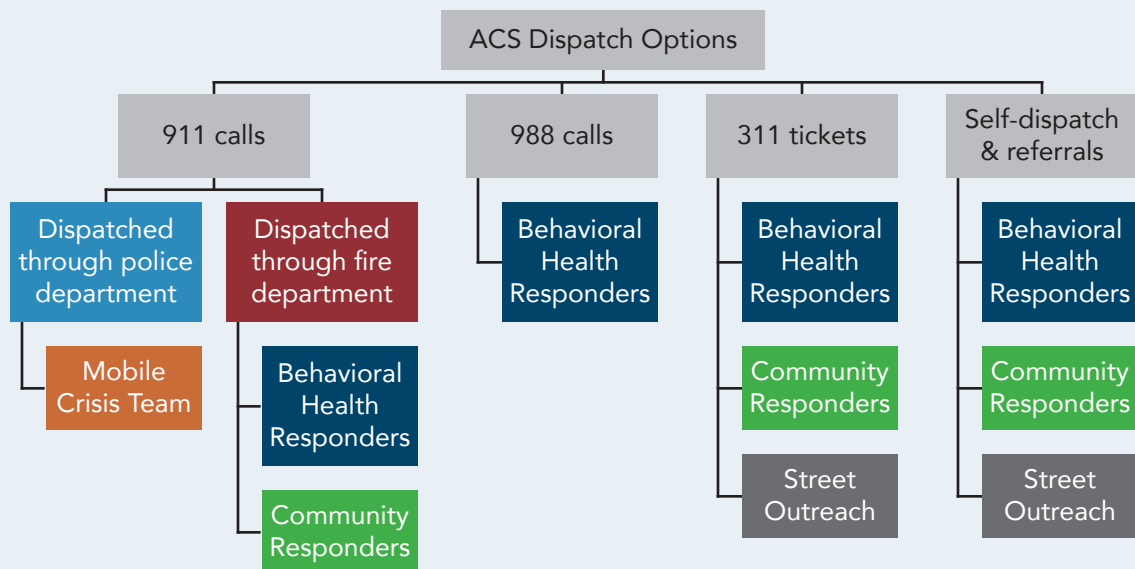
Safety for First Responders

A common concern for communities considering co-response or community-based response models is the safety of unarmed responders in the event a call becomes violent. A number of ACS policies are designed to address this concern.

First, aside from Mobile Crisis Team clinicians who co-respond with police to acute crisis calls, ACS responders are only dispatched in circumstances where there is no indication of imminent

85. City of Albuquerque, “Community Engagement Report,” Albuquerque Community Safety, January 2021, <https://documents.cabq.gov/acs/acs-community-engagement-report-v9.pdf>; City of Albuquerque, “FY2022 Organizational Plan,” Albuquerque Community Safety, December 2021, <https://www.cabq.gov/acs/documents/acs-organizational-plan-20211207.pdf>.

Figure 9: ACS Dispatch Structure



threat or danger. ACS responders are trained in de-escalation techniques, and department policy requires them to leave the scene when a subject becomes aggressive and to request APD assistance as needed. No ACS responders go to calls alone, regardless of the call type or level of risk. Additionally, ACS responders are provided with radios on the same dispatch system as APD and AFR so they can communicate with dispatch, each other, and other public safety services.⁸⁶

Program Challenges

Director Ruiz-Angel explained that it was important to have a strong and clear vision for the new department while being sensitive to the concerns of partner agencies, such as APD and AFR, and local mental and behavioral health care providers. The role of ACS was clearly defined as complementing, not duplicating, existing services. To alleviate the concerns of local MBH health care organizations, ACS agreed to provide acute services only, not long-term care or case management.

Program Successes

In its first two years of service, ACS has fielded nearly 30,000 calls for service, over 19,000 of which were diverted from APD. ACS Behavioral Health Responders handle the majority of those calls, which usually involve unhoused individuals, welfare checks, and MBH issues. An ACS Mobile Crisis Team is involved in fewer than 10 percent of ACS calls.⁸⁷

86. City of Albuquerque, “FY2022 Organizational Plan.”

87. City of Albuquerque, “Albuquerque Community Safety Monthly Informational Report, March 2023,” Albuquerque Community Safety, March 2023, <https://www.cabq.gov/acs/documents/acs-monthly-informational-report-march-2023.pdf>.



Peer Support Workers with the ACS Violence Intervention Program offer residents resources and support following recent homicides in the area. SOURCE: ALBUQUERQUE COMMUNITY SAFETY

In one example of ACS's impact, APD was called to tow a car following multiple traffic infractions. When officers arrived and encountered a couple, including a pregnant woman, they requested an ACS response. Behavioral Health Responders learned that the couple's home had been broken into and burned down, and all they had left were the possessions in their car. The responders found them a room at a local shelter and helped move their belongings. APD/ACS was thereby able to address the couple's problems instead of compounding them by towing (removing their shelter) or adding a ticket to their financial distress.⁸⁸

In April 2023, DOJ announced that it was partnering with APD to revise its 2015 consent decree monitoring regime, citing APD's significant changes to bring the department into compliance with most of the decree's requirements. Among the accomplishments DOJ noted were the creation of ACS and its success in diverting calls for service from APD, which enabled individuals in crisis to get needed help while allowing APD officers to focus on violent crime and other enforcement issues.⁸⁹

Key Issues for Communities Considering a Community-Based Response

- **Need and resources.** If the demand, resources, and skilled personnel are available, a community-based response may be the best option.

Some jurisdictions, however, may not have the necessary resources, such as crisis-related nonprofits, detoxification centers, or dedicated mental health care centers. If sufficient partners do not exist in the community or resist working with police, community-based response may not be feasible. In such cases, police must still develop

connections with MBH service providers so that officers can make informed referrals for people in crisis. Police should also consider how to work with local service providers to provide referrals for case management or help for individuals who frequently require crisis response.

- **Communication.** Good communication between partners needs to be established and maintained. Community responders should be equipped with radios to communicate directly with dispatch, fire/EMS services, and police. In addition, police and community responders should share information (to the extent allowable by law) to deconflict any overlapping response issues.

88. City of Albuquerque, "Albuquerque Community Safety Monthly Informational Report, January 2022," Albuquerque Community Safety, January 2022, <https://www.cabq.gov/acs/documents/acs-monthly-informational-report-january-2022.pdf>.

89. U.S. Department of Justice, "Justice Department Announces Major Milestones Achieved in Policing Reform Efforts for the City of Albuquerque and Albuquerque Police Department," April 12, 2023, <https://www.justice.gov/opa/pr/justice-department-announces-major-milestones-achieved-policing-reform-efforts-city>.

Section 6: Hybrid or Blended Models

The sections above describe the three basic categories of response model: police-based, co-response, and community-based. Some communities may opt for a hybrid approach combining elements from multiple categories.

For example, the South Dakota Unified Judicial System created and piloted the Virtual Crisis Care program, which so far has supplied officers and deputies in 18 counties with mobile tablets and 24-hour telehealth access to behavioral health professionals.⁹⁰ The Norman (OK) Police Department recently piloted a similar program, in which officers are equipped with iPads to access

mental health resources via telehealth technology. The city of Norman also has a mobile crisis unit staffed by mental health professionals; the telehealth program provides service when that unit is unavailable. The Oklahoma Department of Mental Health and Substance Abuse Services plans to expand the program and increase access to MBH services in more rural areas by providing iPads to police departments across the state.⁹¹

These innovative programs begin with a police-based response model but use modern technology to achieve some of the benefits of co-response.

Case Study

Anne Arundel County, Maryland

A suburban county in the Washington, DC – Baltimore, MD metropolitan region, Anne Arundel County covers nearly 500 square miles along the Chesapeake Bay, including the state capital of Annapolis, and is home to nearly 600,000 residents. The Anne Arundel County Police Department (AACoPD) employs about 770 sworn officers.

The county's Crisis Response System (CRS) is administered as a collaboration between AACoPD and the Anne Arundel County Mental Health Agency ("County Mental Health"). The CRS combines elements of all three categories of response model: AACoPD has CIT-trained officers, but also has designated officers to co-respond to calls with clinicians, and some cases are dispatched to a community-based alternative without police involvement.

90. Crime and Justice Institute.

91. Mindy Ragan Wood, "Police expanding mental health crisis project after successful pilot," *Norman Transcript*, April 27, 2023, https://www.normantranscript.com/news/police-expanding-mental-health-crisis-project-after-successful-pilot/article_67368206-e46f-11ed-aee6-130597adc4eb.html.

Program Development

The origins of the CRS date back to 1999, when the then-chief of AACoPD expressed frustration to County Mental Health leadership that officers lacked options beyond arrest when responding to calls involving individuals with mental health diagnoses.⁹² County Mental Health first established a Mobile Crisis Team (MCT) of clinicians to respond to certain MBH calls; the program grew over time with additions such as longer-term case management and a “community warmline” — an alternative to 911 for persons requesting acute mental health crisis services. In 2014, Anne Arundel County established its first two Crisis Intervention Teams (CITs), consisting of a police officer and a clinician, to expand the range of crisis calls to which mental health practitioners could respond.⁹³

Program Structure

MCTs and CITs constitute Anne Arundel’s two primary response options for crisis calls for service. MCTs respond to less acute situations, addressing the needs of people in crisis and thereby reducing the pressure on police or emergency medical resources. CITs respond to calls where a threat exists from the presence of a weapon or active violent behavior, or if there is real need for arrest. CIT units also conduct post-call follow-ups as necessary.

AACoPD trains all officers in Mental Health First Aid, which provides officers with more awareness to better understand mental illnesses and respond to mental health-related situations appropriately without compromising safety. After at least two years on the job, an officer can choose to attend CIT training. “Everyone needs to be able to identify mental health issues for calls, but we only want to push the passionate ones forward to CIT,” explained Lieutenant Thomas of the AACoPD Crisis Intervention Team Unit. More than a quarter of AACoPD officers are CIT-certified, though not all of those actively serve on the CIT unit.

Response Protocols

Anne Arundel County operates the community warmline as a central point through which the MCTs and CITs are dispatched. The warmline is available to anyone – including direct calls from community members, calls directed through 911, and calls from patrol officers requesting the services of an MCT or CIT team.



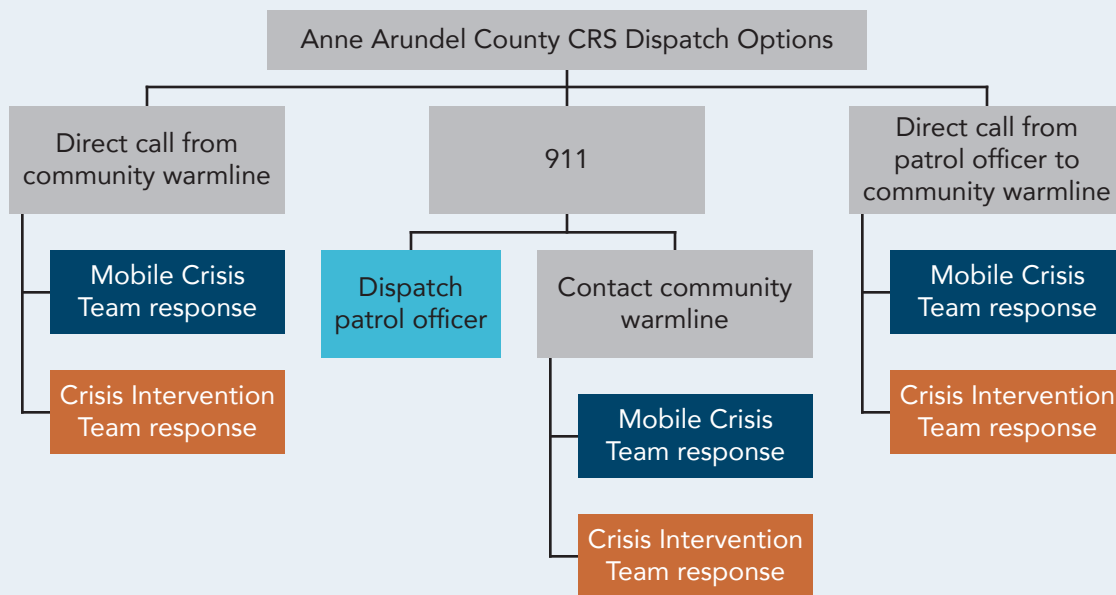
Roundtable discussion about policy, procedures, and best practices to serve those in crisis.

SOURCE: ANNE ARUNDEL COUNTY POLICE DEPARTMENT

92. Rick Hutzell, “Jen Corbin is telling the story of Anne Arundel’s crisis response system. Maryland is listening,” *Baltimore Banner*, February 10, 2023, <https://www.thebaltimorebanner.com/opinion/column/maryland-hopes-medicaid-funding-will-replicate-anne-arundel-success-with-crisis-response-3KCUZMOGA5G6NA2BUKA7WR7VQQ/>.

93. Alex Mann, “Anne Arundel police crisis response team named best ‘on the planet,’” *Capital Gazette*, July 13, 2020, <https://www.capitalgazette.com/news/ac-cn-crisis-response-team-award-20200713-nx4ajblzujgd5p4mwqorl6tnmi-story.html>.

Figure 10: Anne Arundel County Dispatch Structure



If an MBH crisis call comes in through 911, a patrol officer is dispatched, and CIT-trained officers are expected to self-dispatch to any calls on which they believe they can assist. Patrol officers are also trained to call the warmline for MCT or CIT support if needed, either to request response or receive guidance. (See Figure 10.) If a clinician cannot get to the scene, CIT can live-view any officer's body-camera feed and provide support remotely. Warmline operators also conduct follow-up support for people who have received CRS services.

Program Challenges

A current challenge for the CRS is capacity. The county's CIT team is well regarded and was recognized by the organization CIT International as the Crisis Intervention Team of the Year in 2020.⁹⁴ However, this success has put a strain on the CRS system due to calls from nonresidents who travel into Anne Arundel County from the surrounding area to access services. AACoPD and County Mental Health have responded by being strategic about how they advertise the CRS so as not to make promises they cannot keep with their current resources.

Program Successes

The CRS warmline received 50,000 calls from June 2021 to June 2022. For almost 80 percent of these calls, individuals' crisis needs were resolved on the call with no physical response necessary. MCTs or CITs only needed to respond in 20 percent of calls.⁹⁵

A CIT unit's involvement does not necessarily end when an acute crisis incident is resolved. In 2021 a CIT unit responded to a call about an individual driving erratically toward the Chesapeake

94. In 2018, Corporal Allen Marcus was also recognized by the organization as International Crisis Officer of the Year.

95. Hutzell.

Discussion of a plan for a safe station client and how to proceed with the needs of the client.

SOURCE: ANNE ARUNDEL COUNTY POLICE DEPARTMENT

Bay Bridge⁹⁶ and reported to have weapons. The bridge was temporarily shut down, and the CIT unit convinced the man to surrender so he could be taken to a local hospital for evaluation. Prosecutors sought a two-month sentence for disorderly conduct, but CIT members testified at his hearing that jail was not an appropriate place for someone suffering from mental illness and that more effective rehabilitation could be achieved at home with ongoing follow-up from the CRS.⁹⁷ As a result, the judge sentenced the man to home confinement with a treatment plan.



Case Study

Denver, Colorado

The Denver Police Department's (DPD)⁹⁸ nearly 1,500 officers serve a city of just under 700,000 residents across an area of 155 square miles. The best-known element of Denver's approach to crisis response is the Support Team Assisted Response (STAR)⁹⁹ program, an example of community-based response. But DPD also operates a police-based co-responder program for acute crisis calls — the Crisis Intervention Response Unit (CIRU) — and provides follow-up outreach and care coordination services.

Program Development

DPD established the CIRU in 2016 in collaboration with WellPower (formerly the Mental Health Center of Denver).¹⁰⁰ The program, which pairs police officers with licensed mental health clinicians, expanded over time and now has 45 clinician co-responders.

96. The colloquial name for the William Preston Lane Jr. Memorial Bay Bridge.

97. Lily Price, "Man Who Held up Chesapeake Bay Bridge during Mental Health Crisis Sentenced to House Arrest after Anne Arundel Team Supports Him in Court," *Capital Gazette*, October 8, 2021, <https://www.capitalgazette.com/news/ac-cn-bay-bridge-stand-off-mental-health-police-20211008-lgr6bjyh5jdyjguoeh4nkgthy-story.html>.

98. City of Denver, "Police Department," <https://www.denvergov.org/Government/Agencies-Departments-Offices/Agencies-Departments-Offices-Directory/Police-Department>.

99. City of Denver, "Support Team Assisted Response (STAR) Program," <https://www.denvergov.org/Government/Agencies-Departments-Offices/Agencies-Departments-Offices-Directory/Public-Health-Environment/Community-Behavioral-Health/Behavioral-Health-Strategies/Support-Team-Assisted-Response-STAR-Program>

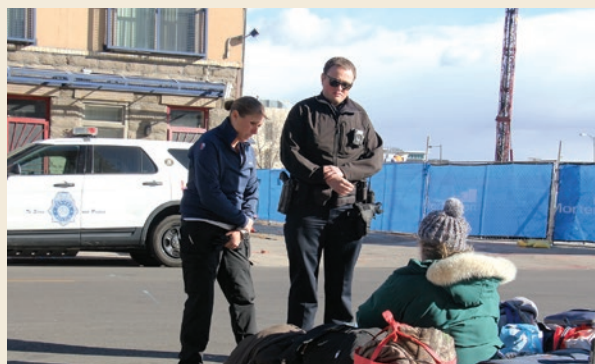
100. WellPower, "Programs and Services," <https://www.wellpower.org/>.

Building on that success, the city began planning for the STAR program in 2018 as a partnership between DPD and community-based organizations (including the Denver Justice Project and Denver Homeless Out Loud).¹⁰¹ Former DPD Chief Paul Pazen explained that the goal was to set up an alternative program that would prove more successful in aiding citizens dealing with mental health issues. STAR formally launched in 2020 to begin fielding less acute calls without police involvement.

Program Structure

Two primary teams respond to calls for service:

1. CIRU teams respond to higher-risk calls involving weapons or the threat of violence. CIRU provides nearly complete shift coverage for all areas of the city.
2. STAR teams, which consist of MBH clinicians and EMT/paramedics, respond to calls for service that do *not* need police presence — nonviolent calls related to mental health, housing insecurity, substance use, and other quality-of-life issues.¹⁰² STAR is available between 6 a.m. and 10 p.m. and in certain areas of the city.



Co-responder Heather Crawford and Sgt. Kyle Sauner assisting a woman in distress who reported ongoing depression. The co-response team assisted the woman and connected her to mental health support. SOURCE: DENVER POLICE DEPARTMENT

Outreach Case Coordinators follow up post-crisis with individuals served by the CIRU or STAR teams. They conduct interviews to determine eligibility for services and help clients develop individual service plans as well as provide coaching to remain engaged with services.

Dr. Matthew Lunn, DPD Director of Strategic Initiatives, described how DPD determines its staffing strategy for CIRU and STAR:

“There’s certainly no way to predict what district is going to have the most mental health calls at any given time, but we can take a look at historical data to understand trends across the city, where there tend to be greater needs around homelessness for example. We then use that information to inform what areas to prioritize co-responder and STAR staffing in.”

Response Protocols

Both STAR and the CIRU are dispatched exclusively by Denver 911. (There is no direct public access; members of the public must request STAR via 911.) Dispatchers are trained to evaluate the nature of the call and determine which team should respond.

DPD requires all officers to have CIT training, so all officers have the opportunity to do CIRU rotations with their clinical colleagues. Assignment of officer and clinician teams is determined at roll call, and that unit becomes the “mental health car” on shift. Officers on scene can request that the CIRU unit also respond so that a clinician is present, or they can request STAR if they think the call subject would be better served by a non-police response. About 30 percent of STAR calls are initiated by DPD officers.

101. Denver Justice Project, <https://www.denverjusticeproject.org/>; Denver Homeless Out Loud, <https://denverhomelessoutloud.org/>.

102. City of Denver, “STAR Alternate Response Combined Reference Guide,” November 1, 2022.

Program Challenges

An early challenge that DPD and its partners faced when founding STAR was to find the right balance of communication to gain support for the initiative. Some organizations were very supportive of the program and DPD's role, while others were enthusiastic about STAR but not about DPD's involvement, seeing STAR as a means to further their objective of defunding or abolishing the police. STAR's founding partners emphasized the message that the program would complement, not replace, police services.¹⁰³

A second challenge STAR has faced is that, while a community advisory committee was established to help create and implement the program, its precise role and authority were never codified in the city charter or any ordinance. This has led to conflict over the program's management between the advisory committee and the city's health department, which administers STAR. Among the committee's chief objections is that the health department ended its regular meetings with the committee, leading to concerns about the "silencing" of committee members' voices and a lack of public transparency about the STAR program.¹⁰⁴

Program Successes

STAR teams responded to 5,700 calls for service in 2022, and so far they have never had to request police backup on a call due to a safety issue.¹⁰⁵ Chief Pazen told PERF that he attributes that strong record to the training for dispatch staff on appropriate call screening and good safety practices on the STAR staff teams. He also credits the CIT training that all DPD officers receive, as about 30 percent of STAR calls are initiated by DPD officers.

A study found that over a six-month period, in areas of Denver where STAR was available it reduced public-disorder offenses by 34 percent but had no measurable impact on violent crime.¹⁰⁶ This is exactly what STAR was designed to do, Chief Pazen explained:

"What we know from the data is that STAR likely provides better outcomes for individuals in crisis, and that is special. . . . This is not a crime reduction strategy. . . . The goal, and what STAR does, is to improve the way we respond and meet the needs of people in crisis in the community."

The study's researchers attributed part of the drop in public-disorder offenses to a reduction in the number of *recorded* offenses; diversion of these calls to STAR means that DPD officers are not on scene to make arrests and issue citations. But they also noted that STAR, by connecting people with mental health services and other resources, may reduce the likelihood of re-offending. Public-disorder offenses also fell during STAR's off-duty hours, indicating that the program reduced actual crime, not just the number of recorded offenses.¹⁰⁷

One example of STAR's impact concerns a report of indecent exposure related to a naked woman in an alleyway. When STAR responded, the woman explained that she had no housing and

103. Paul Pazen, "Creating 'A Force Multiplier': Lessons from Denver on Developing a Comprehensive Alternative Response Program," <https://lnwprogram.org/content/creating-%E2%80%9Cforce-multiplier%E2%80%9D-lessons-denver-developing-comprehensive-alternative-response>.

104. Julia Cardi, "Denver Civilian Law Enforcement Watchdog Concerned with Strengthening STAR's Community Oversight," *Denver Gazette*, March 22, 2023, https://denvergazette.com/news/local/denver-citizen-oversight-board-report/article_10ed264a-c776-11ed-b417-b76bf3c08eff.html.

105. Peltz and Bedayn.

106. Thomas S. Dee and Jaymes Pyne, "A Community Response Approach to Mental Health and Substance Abuse Crises Reduced Crime," *Science Advances* 8, no. 23 (June 10, 2022): eabm2106, <https://doi.org/10.1126/sciadv.abm2106>.

107. *Ibid.*

was simply trying to change her clothes. STAR responders transported her to a women's day shelter where she could use the restroom, take a shower, do laundry, and rest. Consequently, her immediate needs were met, she was not subjected to arrest or citation, and she was made aware of a resource she could use again, which might prevent future 911 calls.¹⁰⁸

Members of DPD have also found that riding in a car with a mental health clinician during a shift allows officers to talk through personal or professional issues while avoiding the perceived stigma of receiving mental health care or establishing a formal patient-provider relationship. Chief Pazen explained:

"I've got multiple examples of real gruff officers going through some tough times saying, hey, you know, I want to ride with the clinician today. . . . Instead of clinicians being viewed as 'the other,' . . . officers have seen the importance of being able to talk about some of their own issues with clinicians."

Scott Snow, DPD's Director of Crisis Services, similarly stated that destigmatizing mental health issues has been an ancillary benefit of the program: "We've heard anecdotally since the first year of the co-responder program about that positive mental health benefit for our officers. It was not a program design, but it's certainly an outcome that has been reported."



Co-responder Heather Crawford and Sgt. Kyle Sauner offer assistance to another individual in potential need of support services. SOURCE: DENVER POLICE DEPARTMENT

Key Issues for Communities Considering a Hybrid Program

- **Thorough planning.** Representatives from multiple agencies stressed to PERF the need for a deliberate program development process and a clear vision of goals and outcomes. As Dr. Matthew Lunn of the Denver Police Department put it:

"You have to do the leg work up front. You have to understand what's likely to work for each type of response and what's not. One of the things I think was really successful when we created STAR was that we were able to identify seven broad call types that would be eligible for that type of response. Then within those call types, we identified

the factors that made it more appropriate for STAR to respond versus a traditional police response. If you don't do that work, you're not going to have the outcomes you want.

"In particular, the up-front work improves efficiency because otherwise you're going to be dispatching your alternative response, but they'll get to the call and say, 'Well hold on, we're the wrong crew,' and then have to dispatch a traditional response on top of that. Or you'll have the reverse problem: you'll have officers going to too many STAR-appropriate calls where then they have to say 'No, I'm not the best response for this,' and have to have the STAR crew respond after the fact."

108. Pazen.

- **Setting community expectations.** A major part of the development and launch process for STAR was to set expectations with community-based organizations and the public about what the goals were and were not. STAR is meant to provide better service to people in MBH crisis, while also allowing police officers to spend more time on their core functions of patrolling, crime prevention, and investigation. It can be difficult to convince the public to buy into a public safety program that does not directly reduce violent crime, but STAR has been successful in reducing public-disorder offenses.
- **Finding creative funding solutions.** In 2018, Denver voters approved a ballot initiative to create a “mental health tax” to support mental health programs and grants for the city. The foundation Caring for Denver, established as a result of the initiative, administers the revenue from this tax and provided much of the startup funding for the STAR program.

Other components of STAR are funded through a partnership with businesses in districts that have frequent complaints and MBH crisis calls. A group of businesses set up a fund to help STAR meet the needs of the people causing public order disturbances, including food, water, blankets, personal hygiene items, and other essentials.

Section 7: Eight Action Steps to Build a Crisis-Response Program

Regardless of their size or location, all agencies can take the following action steps to create or enhance their crisis response strategies.

Action Step 1: **Start planning now —** **don't wait for a crisis**

Building a successful crisis-response program requires deliberate and thorough planning. Representatives of several agencies told PERF that a response program created as a hurried response to a tragic incident is less likely to succeed.

Some agencies may not have the resources, call volume, or community partners to make co-response a realistic option, but even the smallest agencies exist in communities with other stakeholders and should incorporate their perspectives into the program.

To secure cooperation among stakeholders, overcome potential resistance to working with police, and ensure the sustainability of the response system, community leadership must be fully engaged in the planning and setup.

Action Step 2: **Review current response procedures** **and assess needs**

Agencies should begin by reviewing their current procedures, partnerships, and resources to identify areas needing improvement, such as places where additional resources are needed, policies and processes that should be clarified or streamlined, or available services that are currently underutilized.

The Police-Mental Health Collaboration (PMHC) Toolkit¹⁰⁹ from the Bureau of Justice Assistance and Council of State Governments can assist with this process. The PMHC Self-Assessment Tool¹¹⁰ is designed to help law enforcement agencies assess their current response strategies and create action plans to improve their processes. It covers essential topics such as leadership buy-in, formalized structure, training, service provider availability, and data collection and analysis.

Action Step 3: **Research options** **for response programs**

This report provides an overview of several types of response models but is only a starting point. Several agencies told PERF that they began their process by reviewing existing models like STAR

109. Bureau of Justice Assistance, “Police-Mental Health Collaboration (PMHC) Toolkit,” <https://bja.ojp.gov/program/pmhc>.

110. Police-Mental Health Collaboration, “Police-Mental Health Collaboration Self-Assessment Tool,” <https://pmhc.csgjusticecenter.org/assessment/login>.

in Denver or SMART in Los Angeles and then contacting those agencies to learn more, in some cases arranging site visits.

The Bureau of Justice Assistance funds more than a dozen Law Enforcement-Mental Health Learning Sites¹¹¹ and a Support Center¹¹² that provides free technical assistance to agencies looking to improve their response to MBH crises. Also, the Stepping Up initiative¹¹³ and Mark43¹¹⁴ host searchable online databases of programs focused on crisis response and diversion of individuals with unmet MBH treatment needs away from jails and prisons.

These resources can be invaluable tools to aid police agencies as they seek a model that corresponds with the community's needs.

Action Step 4: **Identify and assemble** **community stakeholders**

Based on their research of program models and current procedures, agencies should identify community stakeholders to help develop the crisis-response program, including emergency communications personnel, justice system professionals, medical and behavioral health care providers, advocates, public health professionals, and people with MBH disorders and their loved ones. Organizations that have been critical of police can be important participants in the discussion and help gain wide public support for new arrangements if they are willing to work constructively to help design such a program.

Action Step 5: **Create a common vision** **and team structure**

Sustainable, systems-level change comes from the coordinated efforts of many organizations. But balancing the needs and priorities of multiple stakeholders can be difficult, especially when some distrust law enforcement. Some community members may want to remove law enforcement from crisis response as much as possible.

Several respondents to PERF's member survey reported facing opposition to working with law enforcement to improve crisis services in their community. As Chief Michael Diekhoff of the Bloomington (IN) Police Department said, "There has been opposition from some in the social work field, saying it is a conflict of interest for social workers to work with the police." In Ann Arbor, Michigan, Interim Chief Aimee Metzger describes this tension another way: "On the one hand, police abolitionist groups do not want the police involved at all in any of the proposed response plans. On the other, local mental health experts do not wish to respond without the police. In between, there has been little input sought from police department leadership on how to move forward."

Since even the most independent community-based programs rely on co-response with police for higher-risk calls, working together toward a common goal is critical. One approach is to ask each stakeholder to set out its guiding principles and goals, then identify areas where these principles and goals do or do not align. Agreement should be possible on key principles such as ensuring the safety of community members and first responders during crisis calls, minimizing resort to the criminal legal system, and increasing access to health care resources.

111. Council of State Governments Justice Center, "Law Enforcement-Mental Health Learning Sites," <https://csgjusticecenter.org/projects/law-enforcement-mental-health-learning-sites/>.

112. Council of State Governments Justice Center, "Law Enforcement-Mental Health Collaboration Support Center," <https://csgjusticecenter.org/resources/le-mh-collaboration-support-center/>.

113. Stepping Up initiative, <https://stepuptogether.org/explore/discover-local-strategies/>.

114. Mark43, "Crisis Response Directory," <https://mark43.com/crisis-response-directory/>.

Team structures will vary but it is useful to form a leadership committee and working groups responsible for reporting on specific tasks (for example, creating policies and training standards, evaluation, and documentation). Written protocols detailing the team's structure and processes will provide consistency and sustainability.

Action Step 6: Draft a response program and implement a pilot test

Prior to large-scale implementation of a new crisis-response program, the team should run a pilot test to assess whether the program works as intended. Pilot programs generally run between six months and one year and take place in a defined geographic location or during a limited range of service hours. PERF spoke with many law enforcement agencies that created heat maps or conducted analysis of historical data to identify busy sectors and peak hours to guide the pilot testing.

Scott Snow, Director of the Denver Police Department's (DPD) Crisis Services Bureau, described the evolution of DPD's co-response program based on its initial pilot:

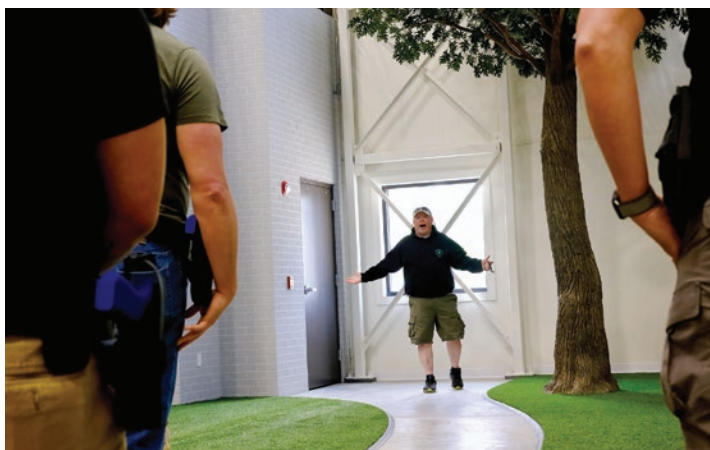
"Our initial co-responder model was that we had a dedicated uniformed police officer and three clinicians covering normal business

hours during the week. Sometimes they would go together to calls; sometimes they would go separately. As we were able to grow and identify additional need in various areas of the city, we then tried a single officer and clinician in a car per district to create a kind of 'mental health car' in that district.

"What we've now evolved to over time is that the co-responder is assigned with the officer they're going to ride with for that shift at roll call, and over time every officer in the district is going to end up riding with the clinician. This shift happened not because the previous structures failed, but because we learned more and developed new ideas as we gained more experience."

Action Step 7: Train all agency personnel who interact with the public on how to respond to persons in crisis

Regardless of whether they are responding alone or with other professionals, all officers should be trained to recognize when they might be dealing with an MBH crisis, and all should have the tactical, communication, and de-escalation skills needed to address it effectively. For example, PERF's ICAT program teaches officers to slow situations down, make use of time, distance, and cover, and communicate with the subject. ICAT materials are available free of charge and can be used to supplement existing agency training programs; information on upcoming training dates is also posted on the PERF site.¹¹⁵



Officers participate in live scenario-based training at PERF's National ICAT Training Center in Decatur, IL.

115. "ICAT: Integrating Communications, Assessment, and Tactics," <http://www.policeforum.org/icat-training-guide>.

Other individuals who may interact with people in crisis — such as call-takers, dispatchers, social workers, and community engagement staff — should also receive training so they can appropriately relay information to officers and direct resources. Providing routine refresher training for all personnel and having them practice crisis response skills together are vital.

Training police and non-police responders together can be an excellent way to reinforce cooperation and trust between agencies.

Action Step 8: Conduct ongoing evaluation and improvement

Ongoing data collection and analysis are essential. They enable agencies to make evidence-based decisions about program management based on a better understanding of data, including call volume and type, uses of force, injuries to officers and citizens, arrests, hospital transports, emergency petitions, and referrals to services. Collection of baseline data should begin prior to launch of a pilot program.

When the Norman (OK) Police Department (NPD) launched its pilot telehealth crisis response program in 2022, it initially had no way to track how often the department-issued iPads were being used, whether citizens were willing to speak with MBH crisis workers via video chat, or whether officers were using the technology to request remote consultations with the on-call social workers. As a partial solution, NPD created a prompt in its CAD system for officers to report basic data points after each call, such as whether the contact was MBH-related and if telehealth services were offered and

accepted. NPD has also launched a partnership with the University of Oklahoma's departments of social work and criminal justice to study the efficacy of its CIT program overall.¹¹⁶

In another example, Howard Center — the community-based clinical partner of the South Burlington (VT) Police Department — used its program data to determine the approximate amount of police resource time saved by diverting certain calls for service from police- to community-based response.¹¹⁷ The community-based response is funded in part by the police department's budget; this data helps the agency show the city council why this funding is needed and how it is improving officer availability.

In addition, agencies should collect data on the experiences of community members interacting with law enforcement and co-responders in crisis situations. For example, some agencies conduct qualitative analysis of body-worn camera footage in order to assess and improve officer interactions with the public. Information gleaned from video analysis can be helpful in supervision and training.

Evaluating data can also provide insight into officers' perceptions of the response program. As noted above, for example, a survey of Columbia Heights (MN) Police Department officers found that *all* respondents said the community's embedded social worker program added value to the department and three-quarters said it made their job easier.¹¹⁸ Those results are a powerful testament to the program's acceptance into agency culture and the effectiveness of the partnership in improving call outcomes.

116. Interview with Captain Eric Lehenbauer (Norman Police Department), June 29, 2023.

117. Howard Center, "Howard Center Community Outreach Quarterly Report FY22 Q2 (October 1, 2021 - December 31, 2021)."

118. Canvas Health, Inc., "Columbia Heights Police Department in Partnership with Anoka Mobile Crisis: Embedded Mental Health Professional Utilization and Outcome Data, January 2022 - December 2022."

Conclusion: Now Is the Time

The dramatic rise in need for mental health

services in recent years has not been met by a corresponding increase in treatment services. As a result, police have often had to fill the void as first responders — a role they did not seek. Police responses to mental health crises have also come under increased scrutiny, and a movement is underway to reduce their role in certain situations. Thus, there is a compelling need for law enforcement agencies and the communities they serve to develop better approaches to serving people in crisis compassionately and effectively while keeping everybody safe from harm.

Communities that haven't yet taken a hard look at their current approaches and developed a community-wide strategy for addressing MBH-related issues should begin doing so now. That strategy should still call upon police officers when necessary; while many will argue that the primary purpose of the police is crime prevention and apprehension, the reality is that when someone in crisis calls in the middle of the night, the police will be expected to respond if no other options exist. Where communities have identified professionals who are able to respond to emergencies, that is ideal, but the police must always be trained and ready to assist as needed. This is what police do when others are not able to: they step up to the challenge. And, at a time when the legitimacy of police is being questioned, responding effectively to persons in crisis is one way police can strengthen their bonds with the community.

This report has described the primary models for crisis response and given examples of how they have been adopted across the country. In some communities, such as those in Columbia Heights and Raleigh, the police department has established partnerships with health care providers and community-based organizations to co-respond to MBH-related calls. Other communities, such as Albuquerque, have created programs that dispatch MBH clinicians or other civilian professionals to nonviolent crisis calls, with no law enforcement involvement. In areas with fewer MBH-related calls or fewer resources to help address them, some police departments have focused on improving the training their officers receive on how to respond to MBH calls or by forming specialized crisis intervention units.

With roughly 18,000 law enforcement agencies across the country, no one model equally meets all agencies' needs. Communities should develop whatever program best suits their own circumstances, in light of factors such as cost and potential for collaboration with local partners. For example, many smaller agencies in rural parts of the county do not have the same resources as agencies in metropolitan areas. But regardless of the approach chosen, each agency should ensure officers receive quality MBH response training and build partnerships with MBH service providers and other community partners.

Also, while the action steps in this report constitute a set of best practices based on current evidence, more research is clearly needed. As new

programs grow into maturity, agencies and their partners should invest in methodologically rigorous evaluations of their impact.

We hope this report helps communities think through the best way to tackle this difficult challenge, which is among the most important issues

facing the policing profession today. Now is the time to capitalize on the public attention to an issue that police have long grappled with alone. The policing profession and the wider community will both benefit enormously if we get this right, but we need a community-wide effort to do so.

About the Police Executive Research Forum

The Police Executive Research Forum

(PERF) is an independent research organization that focuses on critical issues in policing. Since its founding in 1976, PERF has identified best practices on fundamental issues such as reducing police use of force; developing community policing and problem-oriented policing; using technologies to deliver police services to the community; and developing and assessing crime reduction strategies.

PERF strives to advance professionalism in policing and to improve the delivery of police services through the exercise of strong national leadership; public debate of police and criminal justice issues; and research and policy development.

The nature of PERF's work can be seen in the reports PERF has published over the years. Most of these reports are available without charge online at <http://www.policeforum.org/free-online-documents>. All of the titles in the *Critical Issues in Policing* series can be found on the back cover of this report and on the PERF website at <https://www.policeforum.org/critical-issues-series>.

In addition to conducting research and publishing reports on our findings, PERF conducts management studies of individual law enforcement agencies; educates hundreds of police officials each year in the Senior Management Institute for Police, a three-week executive development program; and provides executive search services to governments that wish to conduct national searches for their next police chief.

All of PERF's work benefits from PERF's status as a membership organization of police officials, who share information and open their agencies to research and study. PERF members also include academics, federal government leaders, and others with an interest in policing and criminal justice.

All PERF members must have a four-year college degree and must subscribe to a set of founding principles, emphasizing the importance of research and public debate in policing, adherence to the Constitution and the highest standards of ethics and integrity, and accountability to the communities that police agencies serve.

PERF is governed by a member-elected President and Board of Directors and a Board-appointed Executive Director.

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As the charitable and philanthropic arm of Motorola Solutions, the Motorola Solutions Foundation partners with organizations around the globe to create safer cities and equitable, thriving communities. We focus on giving back through strategic grants, employee volunteerism and other community investment initiatives. Our strategic

grants program supports organizations that offer first responder programming and technology and engineering education, and align to our values of accountability, innovation, impact, diversity and inclusion. The Foundation is one of the many ways in which the company lives out its purpose of helping people be their best in the moments that matter.



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POLICE EXECUTIVE
RESEARCH FORUM

Police Executive Research Forum
1120 Connecticut Avenue, NW, Suite 930
Washington, DC 20036
202-466-7820
www.PoliceForum.org

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