Introduction

Law enforcement agencies across the country are being challenged by a growing number of calls for service involving people who have mental health needs. Increasingly, officers are called on to be the first—and often the only—responders to calls involving people experiencing a mental health crisis. These calls can be among the most complex and time-consuming for officers to resolve, redirecting them from addressing other public safety concerns and violent crime. They can also draw intense public scrutiny and can be potentially dangerous for officers and people who have mental health needs. When these calls come into 911/ dispatch, the appropriate community-based resources are often lacking to make referrals, and more understanding is needed to relay accurate information to officers. As such, there is increasing urgency to ensure that officers and 911 dispatchers have the training, tools, and support to safely connect people to needed mental health services.

To respond to these challenges, police departments are increasingly seeking help from the behavioral health system. This trend is promising, as historically, law enforcement and the behavioral health system have not always closely collaborated. Absent these collaborations, officers often lack awareness of, or do not know how to access, a community’s array of available services and alternatives to arrest, such as crisis stabilization services, mental health hotlines, and other community-based resources. And even when officers are fully informed, service capacity is typically insufficient to meet the community’s need. As a result, officers experience frustration and trauma as they encounter the same familiar faces over and over again, only to witness the health of these individuals deteriorate over time.

Police Departments Can’t Do it Alone

Many communities continue to face pervasive gaps in mental health services, especially crisis services, placing a heavy burden on law enforcement agencies and, in particular, officers. Without access to appropriate alternatives, officers are often left with a set of poor choices: leave people in potentially harmful situations, bring them to hospital emergency departments, or arrest them.

Understanding a need for greater collaboration, many law enforcement and behavioral health agencies have begun taking important steps to improve responses to people who have mental health needs. These efforts have led to improvements in practices, such as providing mental health training to law enforcement workforces and including mental health, crisis intervention, and stabilization training as part of some states’ law enforcement training standards. (Stabilization training refers to tactics used to defuse and minimize any harmful or potentially dangerous behavior an individual might exhibit during a call for service.) Some of these communities also designate officers to serve as part of specialized teams to respond to mental health-related calls for service. But while these steps are commendable and signify widespread...
acknowledgment of the need to improve law enforcement’s responses to people who have mental illnesses, they also underscore the need for more comprehensive, cross-system approaches.

Communities are learning that small-scale or standalone approaches—such as just providing mental health training or having a specialized team that is only available on certain shifts or in certain geographical areas—are not adequate to achieve community-wide and long-lasting impacts. They have also learned that even the most effective law enforcement responses cannot succeed without mental health services that provide immediate crisis stabilization, follow up, and longer-term support. Moreover, when there are limitations in data collection and information sharing, law enforcement leaders have a difficult time understanding whether the investments they have made in training or programs are working, because success is being defined by anecdotes, impressions, or even by the media’s coverage of isolated, high-profile incidents instead of concrete measures and outcomes.

To address these challenges, some law enforcement agencies have invested in comprehensive, agency-wide approaches and partnerships with the behavioral health system. These cross-system approaches, also known as police-mental health collaborations (PMHCs), build on the success of mental health training and specialized teams by layering multiple types of response models—e.g., Crisis Intervention Teams (CIT), co-responders, and mobile crisis intervention teams—and implementing one or more of these models as part of a comprehensive approach to meet their needs. These agencies may also sometimes link their specialized teams to a designated ‘mental health’ officer in every precinct or neighborhood. PMHCs are distinguished by their leaders’ commitment to integrating responses to people who have mental illness into the day-to-day functions of all officers. In PMHCs, law enforcement executives include the initiative in their agency mission instead of just assigning it to the exclusive domain of a specialized unit.

PMHCs feature strong, demonstrated commitment from law enforcement and political leaders; formal partnerships with community-based mental health providers and organizations representing people living with mental illnesses and their families; quality training on mental health and stabilization techniques that is provided to all officers and 911 dispatchers; and written procedures that are clear and adhered to by staff. And communities that create PMHCs are also committed to building an adequate array of community-based services such as short-term crisis stabilization programs, in-home intervention teams, and programs that can provide ongoing and intensive case management to people with complex mental health needs.

**Police-Mental Health Collaboration Toolkit**

For jurisdictions that are seeking to implement a new PMHC, the U.S. Department of Justice’s Bureau of Justice Assistance provides additional background on PMHCs and the different PMHC response models (e.g., co-responder teams) in the Police Mental Health Collaboration Toolkit.

Visit [pmhctoolkit.bja.gov](http://pmhctoolkit.bja.gov) for more information.
Using Data to Inform Success

Critical to the success of these cross-system PMHCs is the establishment of the baseline number of mental health calls for service that the police department is fielding (as a starting point) and other indicators of PMHC effectiveness, and the use of that data to review progress and troubleshoot any challenges. By using data, leaders have the ability to assess the impact of the approach over time and measure its success against the outcomes that matter most. The four key outcomes identified below, together provide a picture of whether or not a PMHC is successful, recognizing that data limitations and local context may necessitate variation in what data communities collect.

- **Increased connections to resources:** Officers in communities that have PMHCs should routinely refer people who have mental health needs to community services, and they should ensure a successful linkage to the behavioral health system. In these communities, 911 dispatchers also play a critical role in collecting mental health information and relaying it to officers prior to their response to a call for service. As a result, successful PMHCs see an increase in the number of people who have mental health needs connected to appropriate services and resources in the community. Greater success in this area is possible to the extent that adequate services are available in the community, 911/ dispatch capacity is increased, and officers are aware of how to refer people to behavioral health services.5

- **Reduced repeat encounters with law enforcement:** A key measure of performance for a PMHC is the number of people who have repeat mental-health related encounters with law enforcement. Ideally, as PMHCs see an increase in their connections to resources and in officer referrals of people to appropriate services, they would likely also see a reduction in the number of repeat encounters because these individuals are provided the care needed to reduce or prevent future crises.7 Thus, effective PMHCs ensure that the number of people who have mental health needs making or generating repeat calls for service is lower than the baseline number established at the start of the PMHC.

- **Minimized arrests:** With an increase in the availability of community resources and services, officers have a greater set of options/primary interventions other than arrest when responding to calls involving people who have mental health needs. Since one of the primary goals of a PMHC is to connect a person to mental health services (especially for low level and nonviolent offenses, like trespassing and vandalism, in which arrest is at the discretion of the officer and the person does not pose a threat to public safety),8 having more options should ideally result in a lower rate of arrest among people in this population. Additionally, PMHCs are more successful when officers are provided with reliable information about a person’s mental health needs prior to responding to a call. PMHCs should track the full range of disposition outcomes for mental health calls for service to analyze any trends or fluctuations that occur and increase their attention to the rate of these arrests.

- **Reduced use of force in encounters with people who have mental health needs:** A critical measure of performance for a PMHC is the frequency of use of force during encounters with people who have mental health needs. Jurisdictions must determine what constitutes use of force in the context of the PMHC (e.g., use of handcuffs during transport, hands-on maneuvers) so consistent analysis is possible in the future. With training and a comprehensive PMHC in place, police officers are better able to manage encounters with people experiencing a mental health crisis, and force is then proportionate to the situation the officer encounters. It is important to track and analyze this outcome for both mental health calls and non-mental health calls for service.
While law enforcement agencies must partner with the behavioral health system and other community supports to make a PMHC successful, officers and 911 dispatchers are often the first ones interacting with people who have mental health needs, especially during crisis situations. Therefore, the success of a PMHC is largely determined by the level of engagement and commitment of law enforcement executives and the buy-in from their workforce. Thus, this framework’s primary audience is law enforcement executives. It aims to inform and inspire such executives by providing examples of how PMHCs are improving key outcomes in police departments across the country. The framework also provides a list of six questions that law enforcement and political leaders may ask to assess their current responses to people who have mental illnesses and identify steps to improve those responses.

**The Six Questions Law Enforcement Leaders Need to Ask to Develop and Sustain a Police-Mental Health Collaboration**

Whether they are seeking to either implement a new PMHC or to improve an existing one, law enforcement leaders should consider the following six questions to help determine whether their current responses are comprehensive, identify areas in need of improvement, ensure that they are conducting ongoing quality reviews, and ultimately, whether their PMHCs are resulting in the aforementioned four key outcomes. Albeit not a step-by-step guide, by answering these six questions, law enforcement executives can work with their behavioral health counterparts to assess their community resources and better understand what necessary additions and changes are needed. The questions, then, are also designed to assist these leaders in executing changes to produce measurable progress in reducing the number of people who have mental illnesses in their communities who come into contact with law enforcement.

1. **Is our leadership committed?**
2. **Do we have clear policies and procedures to respond to people who have mental health needs?**
3. **Do we provide staff with quality mental health and stabilization training?**
4. **Does the community have a full array of mental health services and supports for people who have mental health needs?**
5. **Do we collect and analyze data to measure the PMHC against the four key outcomes?**
6. **Do we have a formal and ongoing process for reviewing and improving performance?**

Many agencies can likely provide excellent examples of what successfully addressing one or more of these questions looks like, but only a small number of jurisdictions to date have sufficient answers to all of the questions above. If law enforcement executives thoughtfully consider each question, and regularly revisit them, they will be able to determine whether and to what extent their efforts are having a community-wide impact and are built for long-lasting success.
Is Our Leadership Committed?

Are law enforcement and behavioral health executives fully invested in implementing and sustaining a PMHC? Have leaders publicly indicated that effectively responding to people who have mental health needs is essential to the law enforcement agency’s mission? Are there champions within the agency that are empowered to develop, implement, and improve the collaboration? Are staff recognized and rewarded for engaging in day-to-day behavior that supports the goals of the PMHC?

Why it matters

PMHCs have real-world implications. They can help communities address challenges like the toll that repeated arrests and police encounters take on people who have mental health needs. They can also help ensure officer well-being and allow officers to focus on public safety and addressing violent crime. These collaborations often rely on the strength and vision of law enforcement executives (and their behavioral health counterparts) to convey the importance of the PMHC and to lead by example. Law enforcement leaders who demonstrate their commitment to the PMHC through concrete action (such as developing new policies and procedures and rewarding staff who consistently act in support of the goals of the PMHC) find that their officers are more likely to share in the vision. When these leaders become more invested in the collaboration, communicate its importance to all staff, provide incentives for involvement, and incorporate the goals of the PMHC throughout the agency, a trickle-down effect often occurs and more support and buy-in from staff follows. With this buy-in and support, the goals of the PMHC are part of the fabric of everyday policing.

What it looks like

✓ Law enforcement leadership support: The top law enforcement executive sets the tone in the agency for the collaboration and is most critical to its success. The executive is the highest-level leader to serve as the “champion,” has the power to reach out to jurisdictional leadership for support (e.g., commissioners, mayors, and legislative bodies), and provides direction to administrators and managers to secure agency-wide commitment. These leaders reach across systems to develop relationships with executives in the behavioral health system to get buy-in for the collaboration, promote the initiatives to the public and internally in their agencies, and coordinate efforts with advocacy organizations.

✓ Partnership with community champions: In addition to developing strong partnerships with behavioral health, law enforcement also engages local community organizations and advocacy groups that represent consumers of mental health services and people with lived experience and their family members. Community champions engender support and buy-in from local agencies, bringing partners together that might not otherwise have a strong record of collaboration. With firsthand knowledge of how to navigate the behavioral health system, these groups are also able to assist in the PMHC planning process by contributing feedback on developing policies and procedures and building the core components of the PMHC. Advocacy groups are able to mobilize their constituencies to convince legislators and other key stakeholders to help fund PMHC response models and initiatives. They are also instrumental in marketing the initiatives to the community, which helps strengthen law enforcement’s community ties.

✓ Interagency workgroup: A formal interagency workgroup (including law enforcement, behavioral health, and government and community-based organizations) plays a vital role in bringing the partner agencies together to regularly plan, implement, and assess the success of the PMHC. An effective workgroup is reflective of the community’s demographic composition (e.g., racially and economically) and includes members from not just law enforcement and behavioral health, but also local advisory groups, criminal justice coordinating councils, public safety answering points (e.g., 911 dispatchers), hospitals, courts, and corrections, as well as people who have mental illnesses, family members, and other advocates who have a stake in the success of the collaboration. Memorandums of understanding (MOUs)
are created to outline the responsibilities of the partners in the interagency workgroup, such as how often meetings will occur, which staff member(s) will attend, members’ responsibilities to subcommittees, funding, and other agency commitments. Workgroup members ensure that their participating agencies are promoting the PMHC and its milestones for success within their agencies, and help to assess progress toward agreed upon goals, recommending changes to address challenges when necessary.

**Designated chairperson and project coordinator to oversee the PMHC:** The law enforcement executive establishes the interagency workgroup, which appoints a chairperson from the law enforcement agency or behavioral health system. The chairperson oversees the implementation of the PMHC community wide and ensures all efforts and response models adopted fit together to achieve the PMHC’s goals. A coordinator is also designated who is given authority (as clearly represented in the agencies’ organizational charts) and has demonstrated a commitment to the PMHC. The coordinator is selected to oversee the day-to-day operations of the PMHC and report back to the chairperson of the interagency workgroup on the overall implementation and success of the initiative. The coordinator will regularly evaluate the collaboration (e.g., review data on performance and adherence to policies and procedures) to ensure operations are in line with the PMHC’s mission, as well as coordinate outreach and engagement with other partners. The coordinator also organizes subcommittees, facilitates planning meetings, builds agendas, and makes recommendations to the interagency workgroup.

**Funding and resource allocation:** Local leadership (including elected officials) designate funds for the collaboration (e.g., funding specialized training and education, authorizing funds to pay for overtime, and allocating funds for PMHC resources, such as vehicles and office space). The financial investment can vary (e.g., funding a part-time case manager position four hours a week), but designating funds and resources to support the PMHC demonstrates to staff that the collaboration is an agency and community priority worthy of financial investment. Longer-term funding efforts are driven by performance data and other needs assessments.

**Ongoing internal and external recognition of the initiative:** Law enforcement leaders help to affect a cultural shift by modifying officers’ performance evaluations to include the goals of the collaboration, publicly recognizing staff who employ skills to defuse situations, developing commendations or other awards for exemplary staff, and recognizing police and supervisors who volunteer for PMHC positions. These leaders also make it clear that the initiative is part of the overall mission of the department to combat any bias or stigma that staff might hold about collaborating with behavioral health not being true police work.
IN PRACTICE | Effective Leadership in Action, Portland, ME

The Portland Police Department (PPD) implemented their PMHC out of a proactive effort by their leadership, a core collaborative workgroup, and a fully invested department to improve their responses to people who have mental illnesses. The commitment from leadership drove a shift in culture in the department that began in the 1990s, with officers slowly, then enthusiastically, embracing new models and interventions such as CIT training and a mental health liaison program, as well as a year-long internship program for Master’s level students to assist in responding to calls for service with officers.

In place now is a robust program that includes a full-time behavioral health coordinator, mental health liaison, and substance use liaison. Additionally, 100 percent of the officers on the force are mandated to complete CIT training, dispatchers receive training on how best to respond to people who have mental health needs, and PPD has implemented a mental health liaison internship program.

Since the start of these efforts, the police chief and other leaders have been able to secure continued funding from the city’s operating budget to ensure the behavioral health coordinator was expanded to a full-time position. The chief was also able to secure additional funding from a local nonprofit provider to continue the mental health liaison position, as well as secure a commitment from the department to direct funding from the drug forfeiture program to support a full-time substance use liaison.

The behavioral health coordinator role is integral to the day-to-day operations of Portland’s PMHC, managing the mental health liaison and co-responder program and facilitating officer training. The coordinator also oversees a robust working group, the Cumberland County Crisis Providers Meeting, which includes people from the emergency departments, inpatient facilities, substance addiction and mental health partners, shelters, and other community organizations. This group, which has convened for more than 10 years, provides an opportunity for community leaders to come together to discuss the PMHC, strengthen their collaboration, and discuss changes the agencies might be seeing in their staffing or services. A universal release of information developed for all the providers in attendance allows them to discuss clients they have in common. The workgroup members use these meetings to discuss issues that may arise with these individuals, which allows the behavioral health coordinator and mental health liaison opportunities to form relationships with the provider organizations in attendance and better connect their clients to services in the community.
Do We Have Clear Policies and Procedures to Respond to People Who Have Mental Health Needs?

Does the law enforcement agency have documented policies and procedures for how to respond to people who are experiencing a mental health crisis? Do these policies and procedures account for the jurisdiction’s PMHC response models and for each instance in which law enforcement interacts with people who have mental health needs (e.g., dispatch, at the scene, and follow-up)? Do staff have a clear understanding of these policies and procedures and their roles in executing them?

Why it matters

Written policies and procedures that are communicated clearly to staff are critical to the overall success of a PMHC and empower officers to take actions that can enhance their safety and the safety of others. When policies are in place for each type of instance where officers interact with people who have mental health needs, officers are equipped with the knowledge to consistently respond to common events. Combined with skill enhancement and training, clear policies also reduce overall risk for the department. The PMHC will only realize success, and policies and procedures will only be effective, when these policies and procedures are disseminated, followed, and enforced by leaders in both the law enforcement and behavioral health agencies.

What it looks like

✓ Comprehensive process review: Prior to the creation of any new policies or procedures, the law enforcement agency conducts a comprehensive process review of current policies and procedures for encounters with people who have mental health needs. This process review allows the agency to see how people who have mental health needs flow through the criminal justice system and the ways in which police officers regularly interact with them. With proper planning and analysis, the agency can address the full range of issues that officers encounter and reduce opportunities for ambiguous responses during an encounter or call for service. A useful end product of this review is a process flow chart that provides staff with a visual depiction of how people who have mental health needs flow through the criminal justice system. It can also show all potential dispatch and disposition outcomes to help ensure that the policies and procedures account for all possible scenarios and outcomes.

✓ Selected PMHC response models: Based on assessed community needs, law enforcement and behavioral health system partners select a primary intervention or a combination of approaches that their jurisdiction will adopt. The goals of these response models are then integrated into the agencies’ missions and community-wide initiatives. The interagency workgroup starts the process of building new policies and procedures for each response model chosen. People who have mental illnesses, their family members, and advocacy organizations who represent them are involved in the conversations that determine which PMHC response model(s) are selected.

✓ Comprehensive, clearly written policies and procedures: The law enforcement agency has written policies and procedures in place that have been provided to staff, have a clear purpose, and illustrate to supervisors what steps they should take to implement them. These policies and procedures outline roles and responsibilities of all agency staff members, define frequently used terms, give specific response guidelines for scenarios that officers and staff frequently encounter, and are mindful of officer safety and the potential volatility of encounters. When writing their policies and procedures, law enforcement consults with their behavioral health system counterparts and advocacy organizations to ensure they are appropriate from the behavioral health perspective and from that of people who have mental illnesses. Law enforcement also acts as a resource for the behavioral health system as it creates policies and procedures to ensure they align with officers’ needs, culture, and the community’s perspective.

✓ Information-sharing agreements: These agreements establish what information can be shared among the partners
during an encounter (such as physician information, diagnoses, or recent hospitalizations) and give law enforcement and mental health staff the ability to identify a shared population of people who have mental health needs. The interagency workgroup aids in the development of these agreements and facilitates conversations among relevant partners, better equipping officers, dispatchers, and others to stabilize an encounter with a person who has mental health needs. This information also enables law enforcement staff to connect people to needed services and supports, reduce potential injuries to officers and people who have mental health needs, and arrive at the best disposition. In addition to agreements involving medical and protected health information, the interagency workgroup also develops a data-sharing agreement(s).

✓ **Staff awareness of policies and procedures:** Written policies and procedures are posted and circulated to all staff of the partnering agencies, and supervisors are held accountable for ensuring that their staff understand each new policy or procedure and have received training on how to employ them. These policies and procedures are transparent and posted online for the public to view. Staff are notified when changes to the policies or procedures take place.

✓ **Regular review of policies and procedures:** Law enforcement and behavioral health system leaders assess whether established policies and procedures are being followed. In conjunction with the project coordinator, the interagency workgroup conducts regular reviews of the policies and corresponding procedures and ensures that they are being communicated to all supervisors (and their direct reports). Mechanisms are also in place to make sure that these policies and procedures are meeting the needs of the community, and that the community has an opportunity to offer feedback. Periodically, the interagency workgroup revisits all policies and procedures, analyzes them against any internal or community feedback, and makes recommendations for needed changes.

### Types of PMHC Response Models

PMHC response models are the cornerstone for comprehensive, cross-system responses to people who have mental health needs. The leadership team must select the model(s) most appropriate to address the community’s needs. These models are not mutually exclusive, and, depending on their contexts and needs, jurisdictions often adopt and layer multiple response models with comprehensive training and data-driven management to build a comprehensive initiative. For additional information, support, and resources on these models, visit the Bureau of Justice Assistance’s PMHC Toolkit, pmhctoolkit.bja.gov. Below are four of the most common PMHC response models.

**Crisis Intervention Teams (CIT):** These widespread, specialized teams are composed of officers who receive specialized training to respond to mental health calls. CIT officers are dispatched to mental health calls or assist officers who are not CIT trained.10

**Co-responder Team:** Specially trained officers and a mental health crisis worker respond together to address mental health calls. Most commonly, they ride in the same vehicle for an entire shift, but in some agencies, the crisis worker meets officers at the scene, and they handle the call together once the crisis worker arrives.

**Mobile Crisis Team:** A team of mental health professionals, skilled at helping stabilize people during law enforcement encounters as well as general crisis, available to law enforcement and the community. These teams are available to respond to calls for service with the goal of diverting people from unnecessary jail bookings and/or emergency room visits.

**Case Management Team:** A team of behavioral health professionals (with or without officers) and peers that provide outreach, follow up, and ongoing case management to select priority people, such as repeat callers of emergency services. Officers do not treat or diagnose the individuals but work with mental health professionals to develop solutions to reduce repeat interactions. Case management is often used as a proactive response in addition to other selected PMHC response models.
The Houston Police Department (HPD) Mental Health Division (MHD), in partnership with The Harris Center for Mental Health and Intellectual and Developmental Disabilities (the Harris Center), operates a multi-faceted, successful PMHC to respond to people in mental health crisis. Houston’s PMHC response models and initiatives include: a CIT training program for all cadets, co-responder and homeless outreach teams, and a chronic consumer stabilization unit. While already using a comprehensive approach, HPD’s coordination with the Harris Center helps them to regularly assess their models and initiatives and make changes as needed.

In 2015, the MHD identified a new and innovative opportunity to help people in mental health crisis while relieving financial strain on both the criminal justice and behavioral health systems. This early intervention program, called the 911 Crisis Call Diversion (CCD) program, places mental health phone counselors inside Houston’s Emergency Communications Center to work directly with 911 call takers and dispatchers to identify and divert callers with non-emergency mental health concerns away from police or fire/EMS.

To develop this new program, the Houston PMHC first created a response logic tree (or process map) to define when 911 operators could determine that a call was eligible for mental health counselors to intervene and establish how they should respond while accounting for a variety of possible scenarios. HPD and the Harris Center then developed operational guidelines and protocols and rolled them out during a six-month pilot period to ensure they were appropriate for the new program.

During this pilot period, they were able to establish with a great amount of certainty what a majority of their calls would look like, what phone counselors should expect when on a call, and what to do in specific scenarios. Based on these experiences, they also learned that while they were expecting the CCD program to save money and time for the police and fire departments, they could also use it to make more appropriate referrals in the community.

After one full year of implementation, with clearly developed policies and procedures in place, the CCD program has seen significant change in how calls are handled. In one quarter of operation, they were able to divert both the fire/EMS and police from the scene for more than half of calls received. In a short period of time, the unit has shown how important it is to the overall functioning of the department and how resources have been saved as a result.
Do We Provide Staff with Quality Mental Health and Stabilization Training?

Is basic mental health awareness and stabilization training provided to all law enforcement employees at all staffing levels—recruit, in-service, and specialized? Is this training offered in coordination with mental health partners? Are the voices of people who are living with mental illnesses and their families incorporated into the training?

Why it matters

Learning how to defuse situations is foundational to the goals of all PMHCs and helps officers better recognize and address the behaviors they encounter in many mental health calls for service. When officers receive high-quality mental health and stabilization training, they are better prepared to use techniques to stabilize and defuse encounters when responding to people who have mental health needs. While training alone does not ensure an improved response to people who have mental health needs, it is essential to equip officers, supervisors, 911 dispatchers, and mental health staff with the knowledge and support they need to take actions that are grounded in current research and practices. Such training promotes the safety of officers and all involved.

What it looks like

Knowledge and skills training for all staff: Mental health and stabilization training occurs for all agency staff at the beginning of their tenure with the agency and then continually throughout their service to make sure their skills reflect any changes in systems, policies, or evidence-based practices. The knowledge and skills-based training that a jurisdiction includes in its training curriculum varies depending on the needs of the particular jurisdiction, staffing structure, and culture, but at a minimum the law enforcement workforce receives training on basic mental health awareness, recognizing the signs and symptoms of mental illness, and how to manage a person in crisis. Table 1 below provides a list of common basic PMHC training topics.

TABLE 1. BASIC PMHC TRAINING TOPICS

<table>
<thead>
<tr>
<th>Overview of Mental Illness and Wellness</th>
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<td>Compassion Fatigue/Vicarious Trauma and Officer Selfcare</td>
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<tr>
<td>Cultural Sensitivity</td>
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<tr>
<td>Disorders in Children—Autism and Developmental Disorders and Disruptive, Impulse-Control, and Conduct Disorders</td>
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<td>Gender Sensitive Responses</td>
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<td>Identifying Signs, Symptoms, and Behaviors of Mental Illness</td>
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<td>Stigma</td>
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<tr>
<td>Substance-Related, Co-Occurring Mental Health and Addictive Disorders</td>
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<td>Suicide Intervention and Non-Suicidal Self Injury</td>
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Trauma-Informed Responses—Basic

**On Scene Assessment and Response Protocols**

- Active Listening, Nonverbal Communication
- Crisis De-escalation, Stabilization Techniques, and Mediation Skills
- Officer Safety
- Use of Force

**Disposition and Resource Options**

- Community Resources and After Hours Referrals and Resources
- Homelessness and Housing Alternatives
- Involuntary Commitment Process
- Military Personnel/Veterans Resources and Specific Needs
- Transportation of People Who Have Mental Health Disorders, Intellectual and Developmental Disorders (I/DD), and Physical Disabilities
- Understanding of PMHC Policies and Procedures

✓ Training aligned with staff roles and experiences: Training is consistent with staff roles, level of engagement, and interest in selected PMHC response models, as well as skill set and expertise. Topics and skills vary depending on the type of training delivered; for example, a CIT training takes a deeper dive into subject matter than training included as part of an academy for new recruits. Skills topics needed for officers may also be different than training needed for 911 dispatchers. Leadership develops tailored training curriculum to equip staff for their jobs, particularly for specialized units or positions in the department. Table 2 lists advanced topics that are typically included in trainings for specialized teams or officers that play a particular role in a PMHC response model.

**TABLE 2. ADVANCED PMHC TRAINING TOPICS**

<table>
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<th>Topic</th>
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<tr>
<td>Assessment, Commitment, and Legal Considerations</td>
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<td>Data Collection and Demonstrating Program Success</td>
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<td>Guardianship, Power of Attorney, and Issues of Aging</td>
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<tr>
<td>Information Sharing across Law Enforcement and Mental Health</td>
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<tr>
<td>I/DD and Neurodevelopment/Neurocognitive Disorders—Adults</td>
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<tr>
<td>Mood, Psychotic, and Personality Disorders</td>
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<tr>
<td>Motivational Interviewing</td>
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<tr>
<td>Post Incident Debrief and Departmental Support</td>
</tr>
<tr>
<td>Procedural Justice, Fairness, and Bias</td>
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</table>
Training instruction and delivery: Regardless of the curricula chosen, content is taught by law enforcement and mental health provider instructors, subject experts, and others with first-hand knowledge, like people who have mental illnesses and their family members, as appropriate. Trainings taught by people with lived experience and their family members give officers the opportunity to informally interact with people who have mental health needs and their families in a non-crisis setting. The delivery of training comes in both experiential and hands-on opportunities if possible, but also in lecture-style presentations, simulations and/or virtual training, scenario-based role playing, group problem-solving exercises, site visits to mental health facilities, and ride-alongs so that coursework is varied and accessible to people who have different learning styles. Refresher training is provided periodically.

Evaluation of training: Trainings are regularly evaluated to assess their overall quality and impact. A review process ensures that the curriculum is meeting its intended purpose of preparing law enforcement staff to more effectively respond to mental health calls and defuse these encounters. Pre- and post-testing of the training participants ensure that participants have developed new or enhanced existing skills and knowledge as a result of the training. Evaluations are reviewed, and modifications to the training curriculum are made based upon the findings. There is also a process for the interagency workgroup to periodically review the curriculum and assess the need for changes based on community needs or crime trends. Using results from these training evaluations, supervisors assess how well staff understand the training content and use it in their day-to-day activities.
IN PRACTICE | Using Coordinating Councils to Promote Training Across the State: State of Missouri

In partnership with their mental health providers, law enforcement leaders in Missouri developed a successful multi-pronged approach to training officers using a statewide CIT curriculum that every local jurisdiction could adapt. The training includes a core 32-hour base curriculum covering 19 mandatory topics, but each jurisdiction can customize their remaining 8 hours of training (selecting from more than 23 electives). Elective topics cover areas such as homelessness, trauma, officer suicide, and “suicide-by-cop” prevention.

As with many states, Missouri officials determined that while some of their larger cities like St. Louis had the resources and funding to implement the training, other smaller suburban and rural locales did not. To address this challenge, officials allowed some of the smaller jurisdictions to send an officer to larger jurisdictions offering the training once a week for five weeks to complete CIT training.16

Most importantly, Missouri officials leveraged a network of coordinating councils to customize the curriculum and training approach based on local needs. Each council covers a geographic area comprised of local law enforcement agencies and community and state-based organizations. The councils meet at least quarterly to develop local training schedules, adapt the state’s CIT curriculum to meet their local needs, determine which electives from the state curriculum they will adopt, and develop relationships with providers and individuals to deliver core components of the curriculum. The state also hosts a CIT conference bringing together members from all of the coordinating councils each year. During these events, members vote on what topics to include or modify in the state’s CIT curriculum and receive additional professional development.

The state also provides ongoing mentoring and specialized training through a network of 31 mental health professionals called community mental health liaisons who are available to every law enforcement department in Missouri. Similar to a traditional co-responder team, these liaisons respond to calls and provide training on complex cases to jurisdictions and individual officers that may otherwise not have access to more advanced training.
Does the Community have a Full Array of Mental Health Services and Supports for People Who Have Mental Health Needs?

Does an array of mental health and community services exist for people who are experiencing a mental health crisis? Are the services regularly utilized by the PMHC partners? How often are these services available when law enforcement encounters a person in need of them? Have the PMHC partners worked together to leverage additional funding to address gaps in service capacity?

Why it matters

Law enforcement officers can more effectively respond to people who have mental health needs and connect them with appropriate community supports when a full range of mental health and community services is available. Officer awareness of these services further expands the disposition options available to them, reducing the need to arrest as the only option for these encounters. These connections can provide opportunities for long-term treatment. And when long-term treatment options are available, officers are better able to connect people who have more complex needs to these supports in an effort to reduce future encounters and arrests. While intended to be a seamless continuum of services, in practice, law enforcement only controls a subset of these services, namely the PMHC response models (e.g. CIT or co-responder teams). In collaboration with the behavioral health system, law enforcement can help to ensure that the full array of service options (e.g. mobile crisis, crisis stabilization facilities, etc.) is available and that officers are aware of how and when to use them. When law enforcement helps identify missing services and their behavioral health counterparts prioritize existing resources in support of the PMHC, the behavioral health system also benefits. Together, these systems can make a strong, data-driven argument to elected officials for more funding to increase service capacity.

What it looks like

✓ **Inventory of existing services:** Law enforcement leaders partner with their behavioral health counterparts and other community organizations to inventory services in the community. Services appropriate for this inventory include those that address crises (e.g., diversion or crisis facilities, single-point of access facilities, shelters, and detox/rehabs) and longer-term services to reduce repeat encounters (e.g., Assisted Outpatient Treatment, Assertive Community Treatment, outpatient treatment, and housing programs and services). This inventory helps partners identify if there are major gaps in the array of service options for this population, how they can access these services, and eligibility restrictions, such as insurance limitations, diagnostic criteria, or other thresholds. One of the more common techniques used to develop this inventory, or system map, is Sequential Intercept Mapping. In addition to helping promote collaboration and partnership between the criminal justice and mental health partners involved, the mapping helps identify diversion opportunities and resources for people who have mental health needs. For instance, the inventory could reveal that there are crisis services but that the community lacks long-term interventions. Once the interagency workgroup reviews the inventory, it is better positioned to identify services to fill those gaps and determine if additional PMHC response models or services are needed in the community.

✓ **Assessment of program and service capacity:** The interagency workgroup determines whether the existing services and programs are operating at the scale required to meet the needs of the community. This assessment is strengthened when it is informed by data collected on the utilization rates for all existing services and patterns of instances in which a given service is requested but not available. A designated individual or subcommittee is identified to oversee the data collection process and works in tandem with the interagency workgroup to assess the PMHC’s resource capacity and compare it to the volume of what is actually needed on an ongoing basis. This assessment examines which resources may be underutilized due to lack of awareness, over-subscribed because there are more people eligible than spaces available, and which services may not align with what the community needs.
Prioritized behavioral health resources and increased funding: Law enforcement and behavioral health agencies partner to prioritize available services for people who have mental health needs. The interagency workgroup supports these efforts by examining the data and pointing to areas in need of additional service capacity. Law enforcement leaders aid their behavioral health partners in seeking support and buy-in from elected officials by combining their data and showing a specific, quantified need for additional services. Advocacy groups also help to rally support (and members) around these initiatives to bring additional legislative buy-in and potential funding.

IN PRACTICE | The Evolving PMHC: A Data-Informed Approach to Assessing Services and Improving Responses in Tucson, AZ

Since 2000, the Tucson Police Department (TPD) has been working to effectively respond to people in mental health crisis. While they initially began their efforts by employing only acute crisis mobile teams (CMT), TPD’s use of data led them to identify limitations in using just one response model and a need for a more comprehensive PMHC to better respond to this population. For instance, while officers appreciated having access to trained clinicians to help them divert people to behavioral health services, they also expressed concern about how long it took the clinicians to respond—sometimes up to an hour after the officer arrived on scene. Also, TPD determined that the local hospital was unable to keep up with the demand for stabilization services for people in crisis.

Equipped with the number of mental health calls they received per month, the estimated time it took to respond to these calls, the number of mental health and law enforcement staff deployed in the CMTs, and other relevant data, TPD’s Mental Health Investigative Support Team (MHST)—a specially trained unit of the TPD that serves as a mental health resource for other officers—community members, and health care providers identified the need for adding a co-responder team to their resources to address the needs of the community.

To create the co-responder team, they suggested the following: (1) change the staffing of the CMT to one clinician instead of two, and deploy the second clinician to the new co-responder team with an officer, thereby cutting down wait times officers were experiencing (as this would be a direct police resource); and (2) change the new team’s primary focus to answering 911 calls, while the CMT would focus on proactive community outreach and engagement.

MHST presented the plan to TPD and the Pima County Regional Behavioral Health Authority leadership and emphasized the cost savings both partners would realize if a co-responder model was implemented in addition to the CMTs. The plan would also benefit the local hospitals by decreasing crisis placements and promoting stabilization for people in crisis or who have mental health needs.

With these changes approved and implemented, TPD has been able to develop a more comprehensive partnership between law enforcement and the behavioral health system. Instead of standalone programs working in silos, system partners now work in collaboration and have utilized their resources to reduce wait times, more efficiently staff both the CMTs and co-responder teams, and link more people to services. The CMTs and the co-responder teams have been able to take full advantage of the city’s 24-hour crisis center, which opened in 2011 as an initial attempt to help stabilize people in crisis. Law enforcement has also seen a reduction in wait times due to the implementation of the co-responder team; and the co-responder team has helped MHST tailor their case management approach to focus on involuntary commitments, linking these individuals to services before they are in crisis, and significantly decreasing the number of involuntary commitment orders.
Do We Collect and Analyze Data to Measure the PMHC Against the Four Key Outcomes?

Do we collect data to measure our success against the key outcomes of a PMHC, such as the four outlined in the introduction of this framework? Is the data regularly reviewed? Do we assess performance against established goals? Is there a dedicated person responsible for leading the data collection efforts? Are staff assigned to review the data and generate reports?

Why it matters

Data collection and analysis gives leaders in the law enforcement and behavioral health systems the ability to gauge the effectiveness of their responses to people who have mental health needs. It also arms them with concrete data to present to local officials and the public at large to garner buy-in and support for the PMHC. Establishing baselines or benchmarks early on is important to ensure PMHC progress can be tracked over time. For example, if the jurisdiction determines how many people who have mental health needs come into contact with law enforcement officers prior to the start of the PMHC, they can see progress on this outcome the following year. Additionally, leaders can use data to determine whether current efforts and procedures need modification or improvement, and if there are any gaps in community-based mental health services. Law enforcement leaders may also use data to identify high-need populations that may require a more targeted approach. Data also helps law enforcement leaders place individual instances or cases in context—as exemplary situations, typical examples, or extreme outliers—so that response models can address the typical encounters, rather than respond to rare cases. Critical to this work is the sharing of data across systems; PMHC partners can see which clients they have in common and measure service utilization and dispositions.

What it looks like

✓ Tracking of specific metrics: Jurisdictions establish clear guidelines about what information should be collected and tracked. During planning, all partners working on the PMHC day-to-day (e.g., call takers and dispatchers, officers on the scene) agree on the definition of a “mental health call for service” to establish the level of need in the community. The tracking system also supports changing or re-coding a call based on information learned on the scene. Communities also establish the key indicators of success for the PMHC that measure progress on the four key outcomes. Table 3 provides examples of the types of data agencies can consider measuring to track the PMHC’s success against the four key outcomes.

<table>
<thead>
<tr>
<th>TABLE 3. EXAMPLES OF PMHC DATA TO COLLECT TO MEASURE SUCCESS</th>
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<tbody>
<tr>
<td><strong>Level of Need</strong></td>
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<tr>
<td>Number of calls for service involving people who have mental health needs</td>
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<tr>
<td><strong>Minimized Arrests</strong></td>
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<tr>
<td>Number of arrests involving people who have mental health needs</td>
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<tr>
<td>Number of people who have mental health needs who have &gt;1 arrest in last 12 months</td>
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<tr>
<td>Disposition/Resolution of Call (e.g., arrest, resolved at scene, transported for voluntary evaluation, detained for involuntary evaluation, referral to mental health treatment)</td>
</tr>
<tr>
<td><strong>Reduced Repeat Encounters</strong></td>
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<tr>
<td>Number of repeat calls to the same location</td>
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</tbody>
</table>
Reduced Use of Force

<table>
<thead>
<tr>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Number of encounters with people who have mental health needs where force was used</td>
</tr>
<tr>
<td>Type of force used by officers during encounters with people who have mental health needs</td>
</tr>
<tr>
<td>Injuries to officers during encounters with people who have mental health needs</td>
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Administrative and Process Outcomes

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Number of officers receiving mental health and stabilization training</td>
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<tr>
<td>Number of officers trained in selected PMHC response models</td>
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<tr>
<td>Percentage of shifts covered by trained officers</td>
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<tr>
<td>Percentage of dispatchers trained on PMHC response models</td>
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<tr>
<td>Number of mental health-related calls receiving a response by a trained officer</td>
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✓ Establish baseline data: The PMHC establishes baseline data on the number of mental health calls for service and on the key outcomes. This baseline data is used as a comparison point at regular intervals to assess the PMHC’s progress.

✓ Process for ongoing data collection and tracking: The interagency workgroup takes steps to develop data collection policies and procedures. In addition, the workgroup appoints a subcommittee or staff person to be responsible for collecting and analyzing the available data and producing reports for review by the workgroup.

✓ Process for identifying individuals with frequent arrests and repeat encounters: The interagency work group defines what constitutes “frequent” or “repeat.” Arrest record data and mental health calls for service are disaggregated and examined at the individual level to identify people that both the law enforcement agency and the behavioral health partners frequently see. Since a small number of individuals often account for a large portion of arrests and encounters, the workgroup regularly identifies these individuals and crafts targeted responses for how law enforcement and other PMHC partners should handle their cases. The workgroup explores proactive case management and follow up as a strategy to prevent repeat encounters.

✓ Data-sharing agreements: In addition to coordinating data collection, the interagency workgroup develops mechanisms for how the partner agencies share data. These written formal agreements go beyond what information is shared on the scene between officers and mental health professionals to facilitate PMHC performance assessment. For example, these data-sharing agreements answer questions such as what data points will be shared, who is collecting this information, how it will be accessed (e.g., through a simple file exchange between agencies, in a password protected drive, etc.) and the frequency for sharing datasets. Jurisdictions follow federal, state, and local statutes on information that may be shared among agencies.

✓ Data management system: The law enforcement agency has a mechanism to track its data, such as a dedicated database or fields created in a computer aided dispatch system. The information system has the capability of tracking PMHC’s success rates against the four key outcomes and other key indicators identified by the interagency workgroup. This data collection method or database can be queried, allowing for reports to be generated by dedicated staff members. It also allows for the matching of data among agencies and systems to identify shared clients and to examine their service usage and outcomes.
IN PRACTICE | Weaving Data Collection Practices into Daily Program Operations, Los Angeles Police Department, CA

For the Los Angeles Police Department (LAPD) and its Mental Evaluation Unit (MEU), data collection is the foundation supporting the full range of PMHC response models and initiatives they have implemented. Started in 1993, LAPD’s Systemwide Mental Assessment Response Teams (SMART) was one of the first police-mental health co-responder programs to link people in crisis to appropriate mental health services and contribute to the core data collection practices that the department has implemented.

The success of this program rests in how officers are trained to collect and capture data when they respond to a call for service and how that data is then used to inform the rest of the department and MEU. All 110 MEU officers and 50 mental health clinicians receive 40 hours of training to ensure that calls involving people who have mental health needs are properly categorized, dispatched, and managed. The MEU Operations Guide is distributed to all 160 personnel assigned, providing them with a core understanding of the mission and operation. The MEU’s Triage Desk collects data on all law enforcement contacts with people in mental health crisis, providing guidance and call management. These contacts, including the circumstances of the call and disposition, are documented in a Mental Evaluation Incident Report (MEIR). The MEIR is a structured behavioral health screening tool, data collection instrument, and report that captures information such as a person’s behavior, thought processing, family and personal relationships, religious affiliations, and medication usage. SMART team officers not only respond to field calls but staff the triage desk during assigned times throughout the year (e.g. for a month) to ensure that officers are familiar with what happens during the call taker process.

The department collects data that is used to inform the changes necessary to improve the daily operations of their PMHC. The data collected by the triage desk, for example, is available to staff and leadership at all levels to determine if changes need to be made to the mental health training curriculum that the department provides, an increase in staff during certain shifts is needed, or if different content should be collected in the triage desk assessments. Data is available “real time” to any officer in the MEU to help manage a call or analyze crime trends, and weekly reports are generated to provide the assistant chief with data analysis on the number of calls the unit is handling, types of calls, location, and how they are resolved, among other things. Additionally, dedicated data analysts present data to the chief during monthly COMPSTAT meetings to inform how the MEU is operating overall, based on set performance metrics and if there are any trends that would inform staffing or other resource allocations. Every three months, data is also presented to the Mental Health Crisis Response Program Advisory Board to inform them of how the partnership is operating, with information regarding whether a specific hospital or crisis center has seen an increase or decrease in referrals, if there are more calls from a particular community, or an increase in certain behaviors such as overdoses.
Do We Have a Formal and Ongoing Process for Reviewing and Improving Performance?

Has the interagency workgroup appointed a person or subcommittee to report to leaders on the progress of the PMHC? How are leaders staying informed of overall progress toward the stated outcome goals? Is there a process in place to adapt policies and procedures when performance reviews show a need for improvement? Is there a plan to ensure the sustainability of the PMHC?

Why it matters

Regular, data-driven assessment of the PMHC is critical to ensure the collaboration achieves its goals. When law enforcement leaders and their behavioral health partners use data to review the PMHC’s performance, it gives them the ability to determine if expansions to the collaboration’s capacity are needed, with the decision based on data rather than anecdotal information. A thorough review of the data gives executives and other leaders the ability to address issues they might not have otherwise discovered. Sharing information about the PMHC’s progress and impact is essential for buy-in, sustainability, and growth. The PMHC data analyses should be used to update leaders and to inform budget decisions and recommendations for PMHC refinements. This review process must be transparent to the interagency workgroup, staff in both agencies, and the results should be shared with the public. When these processes are in place, the agency can show short-term success (e.g., the implementation of new policies or evidence-based practices) and/or long-term achievements (e.g., minimizing arrests of people with mental health needs) to secure internal and external support. This continuous monitoring of PMHC performance metrics provides leaders with the justification necessary to make the case for expanding services and securing additional funding, which aid sustainability efforts.

What it looks like

✓ Routine data-driven performance assessments: The collaboration is periodically assessed based on its progress in achieving the four key outcomes described in the introduction and any other agreed upon outcomes. The achievement of short-term, more immediate accomplishments such as the implementation of new procedures, policies, or practices is included in regular reports to the interagency workgroup. Community advocacy organizations representing people with lived experience, along with their family members and peers, are provided information from these regular assessments and reports and given an opportunity to provide feedback.

✓ Results-based refinements to policies and procedures: Data on the agreed-upon measures is analyzed regularly to evaluate the PMHC’s progress and inform the refinement of programs, policies, and/or procedures. This data analysis also helps inform the workgroup’s contemplation of any needed course corrections.

✓ Shared accountability among PMHC partners: Law enforcement leaders and their behavioral health partners share the responsibility to continually review performance data to identify PMHC service capacity issues, such as low utilization rates for a given service or if a service is consistently unavailable. Partners work together to address these issues. Procedures are in place—which are outlined in interagency MOUs and/or information-sharing agreements—that designate key staff to lead the performance review.

✓ Communication with external partners and leaders: Information is shared with county legislators, funders, and
community-based organizations to gain buy-in and support of the collaboration. Sharing successes or challenges with stakeholders leads to the PMHC receiving buy-in from the community and the additional support necessary for its growth. The PMHC establishes regular mechanisms to receive feedback from the community on how to tackle challenges and make improvements. Law enforcement leaders are responsive to the feedback of their officers, community leaders, the media, public officials and other policymakers, and ensure that initiatives are reflective of the public’s interests and concerns.

☑️ Additional PMHC capacity and long-term sustainability: Performance reviews reveal if PMHC response models or community services must be scaled to satisfy the need in the community and to ensure that sustainable funding is in place for various PMHC response models. During the planning phase, a long-term sustainability plan is developed to ensure the interagency workgroup plans for obstacles that the PMHC might encounter in the future.

IN PRACTICE | Improving PMHC Performance Using Data Analysis, Madison, WI

The Madison Police Department (MPD) has advanced their data analysis practices to understand PMHC performance and to enhance their responses to people who have mental health needs. In 2016, with the University of Wisconsin, MPD conducted a program evaluation of their mental health unit using data collected between 2013 and 2016. The main findings confirmed what they had suspected: mental health-related incidents doubled over this timeframe (as a proportion of all calls for service), calls for people with co-occurring substance addictions also quickly grew, and most importantly, a small number of people accounted for a disproportionate amount of mental health calls for service (i.e., 3 percent of unique individuals accounted for 17 percent of their total mental health reports).

The evaluation also showed that when the Mental Health Unit provided follow-up services, the vast majority (over 80 percent) of people served generated no additional incident reports, which cut down on repeat encounters. With evidence that follow-up services produced successful outcomes, MPD was positioned to enhance their follow-up capacity, creating five full-time mental health officer (MHO) positions to help mitigate the increasing demands on patrol officers and to prevent repeated calls for service related to the same person. The MHOs were added to support the existing Mental Health Liaison program already in place. In their work, the MHOs provide follow-up support for people; coordinate with mental health providers, case managers, advocates, and families; and share information with patrol officers to develop response plans.

Based on these demonstrated successes and with this data in hand, the department expanded their in-house crisis worker program to include three part-time crisis workers covering the equivalent of two full-time positions to further support the program.
Acknowledgments

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Representatives from law enforcement agencies in the nation’s 10 Law Enforcement-Mental Health Learning Sites provided extensive feedback on a variety of content areas, attended focus groups, and reviewed multiple versions of the framework. They include: Arlington (MA) Police Department; Gallia, Jackson, Meigs Counties (OH) Sheriffs’ Offices; Houston (TX) Police Department; Los Angeles (CA) Police Department; Madison County (TN) Sheriff’s Office; Madison (WI) Police Department; Portland (ME) Police Department; Salt Lake City (UT) Police Department; Tucson (AZ) Police Department; and University of Florida Police Department.

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- **Police Foundation**: Blake Norton, Senior Vice President and Rebecca Benson, Senior Policy Analyst
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- Polly Knape, Clinical Director, SUN Clinic, Tucson, AZ
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Endnotes


2. The “behavioral health” system refers to both mental health and substance addiction services (and providers). For the purposes of this framework, the focus is solely on people who have mental health needs and the portion of the behavioral health system that serves this population. That said, given the high rate of co-occurring substance addictions among this population, the framework also makes reference to connections to substance addiction treatment for people who have co-occurring conditions.

3. CIT International (CITI), the organization that leads the proliferation of the Crisis Intervention Team model, similarly calls for law enforcement responses to people with mental health needs to be implemented not as a training alone or small-scale programs, but as a comprehensive, community-wide approach. See, Dr. Randolph Dupont, Major Sam Cochran, and Sarah Pillsbury, Crisis Intervention Team Core Elements, (Memphis, TN: The University of Memphis, 2007), http://www.citinternational.org/resources/Pictures/CoreElements.pdf.


6. Before leaders in a PMHC can determine if fewer repeat encounters are occurring, they first must define what constitutes a repeat encounter in their community. For example, it could be defined as a person having a second mental health call in a six-month period or it could be defined as multiple calls for service to the same location. Once properly defined, this target population can be prioritized for tailored interventions and treatment, and more accurate benchmarks can be established to gauge the success of the PMHC. For general discussions on the importance of benchmarking, see, Gregory H. Watson, Benchmarking Workbook: Adapting the Best Practices for Performance Improvement (Portland, Oregon: Productivity Press, 1992); and Theodore H. Poister, Measuring Performance in Public and Nonprofit Organizations (San Francisco, CA: Jossey-Bass, 2003).


9. Portland has adapted elements of the CIT model to meet their local needs. As such, it may not represent fidelity to the CIT model.

10. While many law enforcement agencies are familiar with “CIT” as a specialized team or training program, the Crisis Intervention Team model is a comprehensive, community-wide response in which a specialized team works within a larger agency context and partnership, consistent with the approach outlined in this framework. See, Dr. Randolph Dupont, Major Sam Cochran, and Sarah Pillsbury, Crisis Intervention Team Core Elements (Memphis, TN: The University of Memphis, 2007), http://www.citinternational.org/resources/Pictures/CoreElements.pdf.

11. Houston has adapted elements of the CIT model to meet their local needs. As such, it may not represent fidelity to the CIT model.


14. These topics were compiled from nationally available CIT curricula, as well as feedback-generated conversations held with employees of the 10 national Law Enforcement-Mental Health learning sites. Each of these sites has adopted or customized their own curricula and suggested the most common topics that they use.

15. These topics were compiled from nationally available CIT curricula, as well as feedback generated conversations held with employees of the 10 national Law Enforcement-Mental Health learning sites. Each of these sites has adopted or customized their own curricula and suggested the most common topics that they use.

16. Missouri has built on the CIT model and adapted elements to meet their local needs. As such, it may not represent fidelity to the CIT model.

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One City’s 30-Year Experiment With Reimagining Public Safety: In Eugene, Oregon, it’s normal for medics and crisis workers to respond to public safety calls instead of the police.


July 6, 2020

AMID THE NATIONAL reckoning over systemic racism and policing inspired by the May 25 killing of George Floyd, advocates are calling for a reimagining of American public safety through reforms such as reduced department funding and alternative policing models.

In Eugene, Oregon, a college town of some 170,000 residents, and neighboring Springfield, with some 63,000 residents, one such model has been in place for more than 30 years: A nonprofit mobile crisis intervention program, called CAHOOTS, operates in collaboration with the police department, dispatching social workers instead of officers. The program has an annual budget of roughly $2 million and saves the city of Eugene an estimated $8.5 million annually in public safety costs, in addition to $14 million in ambulance trips and emergency room costs.

U.S. News recently spoke with CAHOOTS operations coordinator Tim Black about the program, and whether it might be a viable model for other cities contemplating police reform. The following interview has been edited for length and clarity.

First of all, can you give me a little more on just the logistics of CAHOOTS? How many team members do you have who are actually going out to these calls?

We have a staff team in total of about 40 folks – actually, exactly 40 team members right now. That includes a couple of administrators who don't work on the van. At any given time of day we have two to three teams that are out responding to calls via police dispatch, and each of those teams is made up of a crisis worker and a medic.

I think I saw it's like 20% of all Eugene-Springfield police calls get routed to you guys?

I'll clarify that: We haven't been able to get a solid percent in Springfield, but 17% of the calls coming from the public through Eugene's public safety communications center go to CAHOOTS.

What's the reception like when a CAHOOTS van shows up?

Generally when the CAHOOTS van shows up folks are really excited. Well maybe not excited – they're happy to see us. And that's either because they're in crisis and they
called for us specifically and now we're showing up for them, or maybe they don't know about CAHOOTS or know that we would be the best resource to help them in that moment, and so when we show up, generally it's relief that they don't have to spend that time interacting with a police officer or with a firefighter or paramedic.

**Can you give me some examples of recent dispatches or recent calls that CAHOOTS showed up to?**

We take almost 24,000 calls a year, so every time I pick out like four or five examples I totally and completely miss [aspects] of the work.

Calls that we have responded to recently have included somebody who was experiencing a lot of anxiety over a chronic medical condition: After the pandemic started, they became fearful of trying to access their physician, and then when the physician moved to telemedicine the individual really struggled with using a phone or a laptop to to communicate with their doctor … and that resulted in them reaching out to CAHOOTS late in the night about, "What is this? What's going on? Should I go to the emergency room or can this wait?" And our medic was able to … provide some assurance that the person didn't need to go into the emergency room, and we were able to walk through the steps of setting up a telemedicine appointment.

Other calls that we've responded to recently have had to do with struggling to access adequate shower facilities. With the pandemic closures a lot of the [public] services in town are restricted, so there was somebody who hadn't been able to get a shower anywhere because they weren't allowed on the bus system for six weeks, and [we] deescalated a behavioral crisis that was really about not being able to meet this basic human of need of getting a shower. … We recently responded to support a family member who had found somebody from their family who had died by suicide, and so we stayed with that person who made that discovery. We stayed with them on the scene and provided them a lot of support, but also really helped maintain the scene.

And then there are a million other things we do, like mediate conflicts between roommates or working with families who are feeling [desperate] because they've got young children and are just kind of cooped up and feeling like they're stacked on top of each other in an apartment.

**We're seeing all these good news reports about CAHOOTS, which is great. What challenges do you have, though?**

I think the bigger challenges that we face here in our own community are mostly around a lack of resources. Depending on how the count is done, we have between 1,200 and 4,000 folks who are unsheltered in our town, and that's when the shelters are running at full capacity. … But alongside that is inadequate resources for mental health, substance use and just somewhere to be.
On a slightly more specific level, the biggest struggle that we're having right now is our point of access. For 31 years, CAHOOTS has been dispatched by and requested through the police nonemergency line exclusively. We still believe that in order to really achieve the high levels of diversion from law enforcement and from the emergency medical system, those are most possible through integration in the public safety system. So what we're working with our community partners on right now is: Does it need to be the police department number that you call to receive this service from public safety? Could there be a stand-alone mobile crisis intervention services number that is still answered by somebody in the call center, or is there a possibility of our own behavioral health hotline number, like 611 or something like that?

What do you make of all this focus on CAHOOTS as sort of a potential national model?

Yeah, I mean it's surreal on some levels, because we've just kind of been doing this for the past 30-plus years, but at the same time it's this … validation for our founders that they had this idea that would catch on and that other cities would be looking to. But we're also just really excited about this opportunity to engage with communities about the lessons that we've learned and to offer up our experiences over the last three decades so that cities across the country – and maybe even a few across Canada, the way things are looking – don't have to start from zero. CAHOOTS isn't some cookie-cutter [program] that you can just pick up from Eugene and just kind of plunk down in Houston and expect it to work the same, just bigger. Every community is different, every community has unique needs, and what we can offer is kind of that foundational service delivery model and training.

What cities are you in touch with?

In the last two weeks we've gotten requests from over 50 cities across the U.S. We previously worked to support the development and the implementation of the crisis response unit in Olympia, Washington, last year, and the Denver STAR program, which just started in June of this year. Other than that, the Portland Street Response project is moving forward and looks like it's going to be a larger pilot than originally anticipated. I've also been spending a lot of time with elected officials and representatives from different organizations in Harris County, Texas. … We've also had a lot of contact with folks in New York City, and presented to Mayor Bill de Blasio's task force on mental health response a year ago. In the Bay Area we are making a lot of headway with groups in San Francisco. Oakland just got funding for its pilot project, and in that first-year budget there's consultation and training [with] CAHOOTS.

I know you said it's not like this cookie-cutter thing that you can just kind of copy and paste – each city's going to have to adapt to its needs. But what are some of the bigger lessons that you want to share with other mayors or city leaders that are talking to you?
I think one of the primary things is the medic and crisis worker combination is what has allowed us to make such significant impacts in our community. By recognizing that behavioral health has a role in physical health, and physical health has a role in behavioral health, you're able to really kind of treat the whole patient. And there are a lot of folks out there where maybe they don't have the upbringing or the background to be able to articulate when they're not feeling well emotionally, but they will reach out to say, "My stomach hurts" – and so [you're] having that medic become this way for folks to [really] open up about what they're experiencing emotionally.

Do you think the lessons from CAHOOTS can apply easily or smoothly to a larger, more diverse city? Or are there some things that might have to shift?

I think the key thing is really kind of like I talked about, with what we're doing here with really trying to create our own dispatch within that public safety system. As we move into larger communities, places that aren't Eugene, that don't have the same relationship that the city of Eugene has with its police department, it's that point of access that is going to be really challenging to pull off, because the impact of our program is most felt when it's integrated into that 911 communication system. We're able to divert so many calls from the police because we're using the same priority channels as they are, and so we're hearing them go out to help somebody on a street corner, and we can hop on the radio and say like, "Hey, it doesn't sound like there's a crime happening, so we'll spin around the block and we'll go check in … and let you know if any patrol is needed for that." We're able to respond to calls that come into dispatch on 911, where somebody is experiencing a crisis. We can't get those calls if we're not plugged into that system the same way.

Whether it's 911 or a separate number, there has to be a relationship within the community that people are willing to reach out and call, right? There has to be sort of a basic trust there.

Yeah, and I think one of the things that's important to highlight is that CAHOOTS is a part of White Bird Clinic, and White Bird Clinic has been serving the Eugene and Springfield community for over 50 years. So for 20 years before CAHOOTS started, White Bird Clinic was doing crisis response over the phone. People could come into our clinic, and we were sending out our volunteers to do community-based crisis work, which then got formalized as CAHOOTS. Our nonprofit, our agency, had that relationship with the community. So then as we move into this conversation with other cities, one of the things that we're asking is, "Are there organizations or community groups that have the trust of your community, and have the skills, that do this kind of work, and could you collaborate with them on this project?"
Effectiveness of Police Crisis Intervention Training Programs

Michael S. Rogers, MD, Dale E. McNiel, PhD, and Renée L. Binder, MD

Approximately 1,000 people in the United States were fatally shot by police officers during 2018, and people with mental illness were involved in approximately 25 percent of those fatalities. Crisis Intervention Team (CIT) training is a specialized police curriculum that aims to reduce the risk of serious injury or death during an emergency interaction between persons with mental illness and police officers. CIT has been implemented widely both nationally and internationally. Given the increasing resources devoted to CIT, efforts to analyze its effectiveness and outcomes relative to other approaches are important. Studies of CIT and similar interventions are found within both the mental health and the criminal justice arenas, which use very different terminologies, approaches, and outcome studies, rendering unified analyses challenging. This article describes the CIT model and reviews several recent systematic analyses of studies concerning the effects of CIT. Studies generally support that CIT has beneficial officer-level outcomes, such as officer satisfaction and self-perception of a reduction in use of force. CIT also likely leads to prebooking diversion from jails to psychiatric facilities. There is little evidence in the peer-reviewed literature, however, that shows CIT’s benefits on objective measures of arrests, officer injury, citizen injury, or use of force.

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Methods

Search keywords were collected by polling experts on the topic and reviewing key articles that had relatively high impact factors or that were highlighted by expert consultation. A literature search was conducted using the U.S. National Library of Medicine's MEDLINE database, Google Scholar, the Excerpta Medica dataBASE (EMBASE), The Cochrane Library, the Web of Science, ProQuest Dissertations and Theses, PsycINFO, Sociological Abstracts, OpenGrey, and the New York Academy of Medicine's Gray Literature Report. Search terms included CIT, crisis intervention, police, mental health, LEO, psychiatric, emergency, crisis, mobile, and logical combinations. Inclusion criteria included papers relating to police interventions for PMI and reports of objective measures or surveys. Priority was given to those papers reporting or analyzing experimental or quasi-experimental design with either intervention and control, matched-cohort or case-control stud-
ies, or those with pretest and posttest data collection. Priority was given to papers published since 1989 (i.e., the deployment of the first CIT) and those written in English. Non–peer-reviewed material, such as theses, were generally excluded from substantive results. After de-duplication, the search identified 198 core CIT-related articles. Of these, two recent systematic analyses were identified as significant.5,6

**Origins**

CIT began in response to an incident that occurred in Memphis, TN. Police encountered 27-year-old Joseph Dewayne Robinson in the street outside his mother’s house as they responded to a 911 emergency dispatch called in by Mr. Robinson’s mother on September 24, 1987.7,8 Mr. Robinson’s mother had called police dispatch to report that her son, who had a reported history of mental illness and substance abuse, had been using cocaine and was cutting himself and threatening people. According to the police officers, Mr. Robinson did not respond to verbal requests and “lunged” at the officers, who shot him multiple times.

In response to this incident, community organizers, civil administrators, the Universities of Memphis and Tennessee, and the Memphis Police Department came together to organize the Memphis Police Department’s Crisis Intervention Team. Its recommendations became the Memphis model of CIT, with a goal to reduce lethality during police encounters with people with mental/substance abuse disorders (i.e., PMI) and to divert such people, when appropriate, away from the criminal justice system and into the civil treatment system. Press reports in 1999 noted that in Memphis during the years prior to 1987, on average seven people with a history of mental illness had been fatally shot per annum by police officers, whereas by 1999 there had been only two such police-involved deaths of people with mental illness.8

The local Memphis city’s chapter of the National Alliance on Mental Illness (NAMI) facilitated police–community discussions, education, and outreach in 1988. Today the national NAMI organization advocates for CIT programs and provides education and volunteer resources to establish and operate such programs throughout the United States. From a small beginning, the CIT approach has spread nationally and internationally.9 The Memphis model of CIT formulated in 1988 and incrementally updated provides a template for CIT deployment.

**The CIT Model**

Codifying specific police responses to PMI is an example of problem-oriented policing,10 which is an approach to reducing the probability of the use of force through research, interventions, and outcome analysis. Following Hails and Borum11 (after work by Deane et al.12), police responses to emergencies involving PMI nationally and internationally generally fall within a tripartite typology:

- **Police-based specialized police response**: Sworn officers obtain special training to interact with PMI. The officers function as first responders to emergency dispatch calls in the community and coordinate with local community mental health resources. CIT falls within this category.
- **Police-based specialized mental health response**: Non-sworn police department employees with mental health training provide on-site or remote consultation and advice to sworn officers in the field. This often involves a centralized resource center and was formerly a prevalent model.13
- **Mental-health-based specialized mental health response**: Police departments coordinate with independent mental health systems and workers to cooperate on emergency response in the field, with mental health workers as primary agents. Mobile crisis units fall within this category, as do neighborhood-based care coordination and street triage.14

The Memphis model CIT program as enumerated within the CIT Core Elements specifies several components.15 The first component is training for self-selected police officers comprising 40 hours of instruction from community mental health workers, PMI and their families and advocates, and police officers familiar with CIT. The University of Memphis provides a sample curriculum suitable for a recommended 40 hours of training. Many local implementations exist, sponsored or funded by state agencies or through federal agencies such as the Substance Abuse and Mental Health Services Administration.

The second component involves training and special coding for dispatch operators to enable them to
recognize community reports with a high probability of PMI involvement and to route CIT officers there preferentially. This is significant because research indicates that the characteristics of the call for service initiating the contact is a strong determinant of the probability of future use of force.16

The third component, a centralized drop-off mental health facility with an automatic acceptance policy to minimize police officer transfer time, was identified in 2000 by Steadman et al.17 as an important element of a successful CIT deployment. Larger metropolitan areas have deployed multiple facilities within geographically dispersed areas. Rural settings present specific challenges.18

The goals of CIT are variably defined between different stakeholders. On its website, the University of Memphis describes CIT as a prearrest jail diversion for those in a mental illness crisis. It adds that the goal of CIT is to provide a system of services that is friendly to individuals with mental illness, their family members, and the police officers.19 On its website, the Memphis Police Department describes CIT as a community partnership working with mental health consumers and family members.20 It adds that the goals of CIT include setting a standard of excellence for its officers regarding treatment of PMI and joining both the police and the community together for the common goals of safety, understanding, and service to people with mental illness and their families.20 NAMI describes CIT as a model for community policing that brings together law enforcement, mental health providers, hospital emergency departments, and individuals with mental illness and their families.21 It adds that the goal of CIT is to improve responses to people in crisis.

The University of Memphis states that outcomes for CIT programs include being able to effectively divert persons in mental health crisis away from jail and into appropriate mental health settings and to be a potent agent for overcoming the negative stereotypes and stigma associated with mental illness.22 On its website, the Memphis Police Department states an outcome for CIT is that CIT-trained officers can offer a more humane and calm approach.20 On its website, NAMI states concrete claims for CIT, stating that it improves officer safety, keeps law enforcement officers’ focus on crime, and reduces community spending.21

CIT’s Success

During the Obama Administration, the U.S. Department of Justice’s Community-Oriented Policing Services (COPS) published information on local policing practices and numbers. According to the President’s Task Force on 21st-Century Policing,23 at the end of 2015 there were 17,985 police agencies within the United States. The Bureau of Justice said in 2013 that there were 15,388 police agencies.24 Various federal or interstate initiatives, such as the U.S. Department of Justice’s Police-Mental Health Collaboration25 or the Justice Center’s Law Enforcement/Mental Health liaison services,26 attempt to provide centralized resources for training and referral.

The fragmented and overlapping U.S. law enforcement system presents challenges in terms of oversight and monitoring, and this extends to gathering statistics. Although the police power rests with the individual states and there are some state-wide police forces, most U.S. police officers work within small, local departments with limited resources.27 Half of all agencies have fewer than ten officers, and nearly 75 percent have fewer than 25 officers. Testimony recorded in the President’s Task Force Report on 21st-Century Policing describes significant difficulties providing training and equipment for such small departments, as well as challenges with local municipal boundaries and traditions that prevent many agencies from combining forces with neighbors. Small departments can have significant difficulties deploying or consistently operating a CIT model that closely follows the core elements of the Memphis approach.

According to Deane et al.,12 in the 1990s, only 45 percent of 174 responding police departments reported any specialized response to PMI, and of those, a distinct minority (n = 6, or 3%) reported using the CIT model. Since then, CIT uptake has been rapid. In a 2008 comprehensive qualitative analysis of CIT, Compton et al.28 noted that there were approximately 400 CIT programs operating across the United States. In 2019, the University of Memphis CIT Center reports 2,700 CIT programs within the United States.22 This national figure of 2,700 CIT programs, while representing only around 15 to 17 percent of the total number of police agencies, probably underestimates the absolute number of people interacting with CIT-trained officers because of CIT’s relative ease of adoption within larger, ur-
ban agencies (compared with smaller, rural, or more dispersed agencies). The form of CIT deployment is also variable, and some may conform more or less closely to the elements of the Memphis model.

CIT’s spread is not limited only to the United States. Two of the founders of the Memphis model CIT in 1988 (i.e., Major Sam Cochrane (Retired) of the Memphis Police Department and Dr. Randolph DuPont of the University of Memphis) are on the Board of Directors of CIT International, an advocacy and training group. CIT International and the University of Memphis CIT posts “Crisis Intervention Team Core Elements” on their websites. This document provides a template for establishing and operating a CIT in the Memphis model. Despite very different policing regimes globally, international uptake within common-law countries has progressed. CIT programs are now found in Canada, the United Kingdom, and Australia.

**CIT’s Effects and Reception**

Given the broad uptake of CIT deployment nationally and internationally, the evaluation of CIT’s effects and benefits is important. As many researchers have noted, this is a difficult question to answer, but it important in terms of resource allocation and social justice. Most of the studies on CIT involve analysis of the planning, deployment, and procedural functioning of the CIT process itself, including the selection, training, operations, and measurement or self-report of CIT-trained officers.

Concerns have been raised previously about evidence-based outcomes measurements for the CIT approach. The 2008 review by Compton *et al.* limited itself to a narrative synthesis because of a paucity of eligible studies as well as heterogeneity of methodology and data. This review produced a critical response by Geller, likening being in favor of educating officers of police departments about mental illness and mental health services with being in favor of motherhood and apple pie. The concern over an uncritical CIT adoption universally is multifactorial. There is concern about the lack of evidence of efficacy for specific goals and concern over the opportunity cost of pursuing this model to the exclusion of others. In addition, there have been concerns regarding the possibility that a jail diversion program such as CIT may shift cost burdens from police budgets (generally relatively politically favored) to community mental health budgets (potentially less relatively politically favored). This relative favoring of one budgetary initiative over others may explain some of the growth of CIT in preference to other alternatives, such as specialized mental health-based response or street triage.

Several recent reviews and a meta-analysis have attempted to summarize the results of research on the effects of CIT with certain specific, quantifiable goals. Whereas published studies of CIT within small, relatively homogeneous regions that adhere closely to the Memphis model’s parameters are often positive, larger-scale multi-site analyses are mixed. The core element of CIT involves 40 hours of training, usually for officers who are voluntary and self-selected. Other agencies have adopted a universal training approach where training is recommended or even mandatory for all officers. Sometimes cash bonus payments are offered as incentives for officers to participate and maintain certification as being CIT-specialized. Other elements may not be available or configured differently, such as CIT-oriented dispatchers (and coding) and integrated community resources, such as a no-refusal, rapid drop-off behavioral health center. Fidelity to some or all of these core elements may be fundamental to enabling quantifiable and replicable CIT outcomes between different deployments.

**Outcomes**

Much research has shown an improvement in attitudes and a reduction of stigma in police officers who received mental health training. There is good evidence for benefit in officer-level outcomes, such as officer satisfaction and self-perception of a reduction in the use of force. A survey of police officers indicated that CIT-trained officers perceived themselves as less likely to escalate to the use of force in a hypothetical mental health crisis encounter.

There is also evidence for CIT’s effect on prebooking jail diversion. One study, which involved 180 officers (roughly 50% CIT-trained) from multiple departments and reported on 1,063 incidents, demonstrated a CIT effect of increased verbal negotiation as the highest level of force used, with referral to mental health units more likely and arrest less likely. The same study noted, however, that there was no measurable difference in the use of force between officers with CIT training and those without it. Other studies have also found a lack of evidence for a reduction in injuries associated with CIT in-
volvement. One reasonable hypothesis is that environmental effects may overwhelm the detection of possible favorable effects of CIT in terms of reducing the lethality of encounters between police officers and PMI.

It has been challenging for researchers to operationalize and then evaluate the relative efficacy of different models of CIT compared to similar specialized interventions. A recent systematic literature review by Kane et al. considered several interventions: CIT; an approach called “liaison and diversion,” which has a primary goal of diversion where specialist mental health-trained staff are located at police custody sites or courts; and an approach called “street triage,” which has a primary goal of timely access to mental health services involving mobile crisis units and specialized mental health-trained staff deployed locally according to individualized protocols. Kane et al. found no clear evidence from the studies reviewed of superiority for one approach over the others in terms of benefit for various criminal justice outcomes, such as the number of arrests or days spent in detention, or for primary health outcomes, such as identification of mental illness at an earlier stage. Each of the structured programs produced some beneficial effects compared with control groups within the relevant studies. The reported effects were variable between programs, however, and the significant outcome heterogeneity made quantitative comparisons challenging. CIT was assessed to be the best program in terms of reducing re-offending and improving mental health outcomes. This was postulated to be related to the fact that CIT was the only intervention that offered an integrated service combining the initial call and response triage with specialized trained police officers and mental health professional intervention.

The difficulty of establishing clear evidence for CIT’s efficacy in reducing officer and citizen injuries is illustrated by a 2016 systematic review and meta-analysis of research on CIT at multiple sites by Taheri. The difficulties in terms of heterogeneity and lack of intention-to-treat analyses encountered by the earlier study by Compton et al. persisted. It remains challenging to identify agreement between studies about exactly what constitutes a mental health crisis call. Individual programs demonstrate differences in terminology and thresholds to identify an encounter as a mental health crisis.

The lack of high-quality CIT outcome studies suitable for data analysis was illustrated by Taheri’s challenge in identifying suitable candidates. Out of 820 records for potential incorporation in the analysis, only eight met criteria suitable for evaluating quantifiable outcomes for arrests, police officer injury, or use of force. The meta-analysis goal of measuring officer injury outcomes could not be achieved due to the absence of a standardized measurement across the studies satisfying inclusion criteria. None of the analyzed studies showed a positive benefit of CIT on use-of-force outcomes. Analysis of pooled studies found that CIT officers were significantly less likely to arrest PMI compared with a control group of non-CIT officers. This result was based on self-reporting by study participants, however, whereas analysis of the official arrest statistics did not show a consistent effect of CIT for either an increase or decrease in the arrest frequency for PMI.

Discussion

Despite a lack of evidence for effectiveness in terms of its original goal of reducing lethality during police encounters with people with mental health and substance use disorders, CIT has been shown to have some measurable positive effects, mainly in the area of officer-level outcomes. These include increased officer satisfaction and self-perception of a reduction in the use of force. CIT programs have also been promoted to increase diversion to psychiatric services rather than jails and to decrease costs. Studies of specific CIT programs have found some positive but mixed outcomes or trends toward statistical significance in terms of increased diversion to psychiatric services overall. This may lead to cost reductions. For example, one study of the cost effects of CIT in a city with around 600,000 inhabitants found modest cost reductions mainly through a reduction of hospitalization days and inpatient referrals from jail. This was despite a significant outlay for emergency psychiatric evaluations.

CIT may influence the prevalence and frequency of early-stage, outpatient psychiatric referrals. Such emergency services triage may result in an overall reduction in psychiatric health care costs due to a reduction in significantly more expensive inpatient or hospital services. This may represent an analog of preventive health care, where money spent earlier can produce greater benefit than money spent later in a disease process. The variability, effectiveness, and
vertical coordination of the psychiatric services available to PMI referred after CIT intervention is difficult to quantify. There are bound to be significant location- and insurance-specific factors that affect whether such individuals respond to treatment or resume behaviors likely to result in repeat CIT interactions. These unknown variables may also account for the difficulty in demonstrating many consistent, measurable health outcomes of CIT.

Another factor to consider is that, with the thousands of CIT programs deployed, there may be a publication bias leading to a reduction in the likelihood of publication or dissemination of studies identifying a null effect or adverse cost increases or shifts associated with a specific CIT program.

Another important goal of CIT programs is to improve officer and citizen safety. This outcome is harder to demonstrate. After 20 years of CIT training programs and the recent increase in dissemination, large-scale studies of the quantifiable benefits of CIT as applied to the reduction of lethality and effect on overall arrest rates remain limited. Some studies have demonstrated little significant difference between CIT-trained officers and untrained officers in terms of the characteristics of PMI diverted to psychiatric emergency services. Studies have not shown consistent reduction in the risk of mortality or death during emergency police interactions.

These studies, however, are limited by variability in how CIT is implemented across the heterogeneous U.S. police systems and the reality that state and federal databases tend to undercount officer-involved shooting fatalities by wide margins of 30 to 50 percent. This data imprecision could limit sensitivity for detecting improvement associated with CIT. Police use of deadly force itself is relatively rare, and this low base rate, coupled with relatively underpowered studies, creates an elevated risk of Type II error (i.e., false negative error).

There also may be larger trends at work in U.S. society whose effects obscure or counteract those of CIT, including: the effects of race on officer-involved shootings, where African Americans are nearly three times more likely to be killed by police than white Americans; officer characteristics; increased militarization of policing; and gun ownership patterns. One study concluded that there were two significant neighborhood characteristics important in officers’ decisions to use force. One factor was the actual threat level in a neighborhood, as measured by the number of active resistance incidents by residents. The other factor was the officers’ perceived level of threat, as measured by the percentage of non-white residents. The high comorbidity of substance use in PMI means that many people involved in emergency police interactions may be intoxicated. Intoxication is an additional risk factor for violence and a strong predictor of force use during police interactions. This is probably due to increases in aggressiveness and perceived threat of violence.

Police officers perform dangerous jobs within a society distinguished by relatively high homicide rates, high levels of gun ownership, and concomitant gun homicide. The individual characteristics of the encounter are often cited by officers as the primary element informing the decision to use force. This decision to use deadly or injurious force during an encounter may be largely a function of the incidence of high-risk encounters and may remain relatively insensitive to preencounter training such as CIT.

Another concern about the use of CIT programs relates to cost effectiveness and opportunity costs, i.e., not spending money on alternatives. These alternatives could include increased use of mental health-based specialized response or street triage, increased funding for comprehensive or assertive community outreach programs, or an increase in the number of beds at inpatient acute or long-term residential facilities. Alternatives could also include increased focus and intervention on the social determinants of mental health or additional resources devoted to preventive mental health. In their recent systematic literature review, Kane et al. concluded that, in general, diversion programs resulted in lower criminal justice costs and greater health-funded intervention costs. Even if CIT may reduce overall costs to the criminal justice system, this needs to be measured against potential costs shifted to the community mental health systems associated with successful diversion to treatment. Further research is warranted to measure the quantifiable outcomes of CIT, and to consider the opportunity costs versus the benefits of continuing to expand CIT programs.

References

Effectiveness of Police Crisis Intervention Training Programs


Why Crisis Intervention Team Training Should Be the Standard


DEC. 13, 2019

By Ernie Stevens and Joe Smarro

Prior to 1988, police officers in this country had no training to teach them how to handle a mental health crisis. When officers are untrained on how to de-escalate someone in crisis, the possibility of them using force goes up drastically. This is why crisis intervention team (CIT) program and training was created in Memphis, Tennessee, after a tragic incident where a police officer shot a person with mental illness.

Even 31 years later, most communities in this country still do not have CIT for their officers. And sadly, some officers aren’t even aware of what CIT is.

What is CIT?

CIT is a community based program that brings together a variety of stakeholders to change how communities are responding to mental health crises. A significant part of CIT is a 40-hour training meant to educate officers on recognizing when individuals have mental illness and are symptomatic, de-escalating the crisis situation and navigating people toward resources and help. The curriculum was a collaborative effort between the Memphis Police Department, NAMI, the University of Tennessee and the University of Memphis.

The training can be tailored to suit the individual needs of an agency based on the level of available resources. However, most 40-hour CIT trainings consist of:

- Active listening and de-escalation
- Legal considerations
- Mental illness basics
- Various conditions including bipolar disorder, schizophrenia, depression, anxiety, PTSD, etc.
- Suicide detection & prevention; police officer suicide; suicide by cop
- Excited delirium
- Local resources
- Jail diversion
- Role plays

For too long, officers have been more focused on penalizing the behaviors of people in crisis rather than attempting to understand why they are in crisis in the first place. And this training teaches officers how to de-escalate and where to navigate people in a crisis – including understanding the benefits of treatment rather than incarceration. These techniques have been
used to divert thousands of people from jail and prevent thousands more from making potentially fatal decisions.

Implementing CIT

Here are a few things we recommend considering when developing a CIT program in your area.
• A good CIT program highlights the idea of jail diversion.
• If you don’t have quality local resources available for the officers to divert their individuals into treatment, consider how this could negatively impact the CIT program.
• Understand that jails and emergency rooms are not quality treatment options for mental health crises.
• When developing your program, consult with experts or those with experience to gain insight.
• Simply putting an officer in front of a group and reading 40 hours of PowerPoints is not going to have enough impact to shape internal culture.
• The more collaborative your program, the better. Rely on local subject matter experts to teach courses. Get out and talk to people and ask questions about what is available and how partnerships/relationships can be developed.

Creating a Mental Health Unit

In 2003, the San Antonio Police Department in San Antonio, Texas, adopted the 40-hour CIT and in 2008, developed a full-time mental health detail. Sitting through the CIT training is valuable for each individual officer, but the results are quite profound when an agency takes the next step to create an actual mental health unit. When you have a full-time unit, 100% of the calls these officers respond to are individuals during their darkest times. It is some of the best and most rewarding on-the-job training an officer can receive.

Responding to people suffering on a daily basis creates the deepest level of empathy — if you have the right officers filling the role. The San Antonio Police Department is fortunate to have just that. And hopefully, with the spread of CIT, more agencies will follow suit.

CIT is an integral part of developing an officer, simply because of the alternative perspectives it can provide. As Abraham H. Maslow stated, “If the only tool you have is a hammer, everything will look like a nail.” Let’s embrace the notion that just because things have always been done a certain way, doesn’t mean it is the best way. We can be better. We can do better. Quality crisis intervention team training is one simple place to start.

*Officers Joe Smarro and Ernie Stevens are members of the San Antonio Police Department Mental Health Unit. They are featured in the HBO documentary “Ernie & Joe: Crisis Cops.”*
Cities and counties across the country are increasingly adopting the promising co-responder model to improve how they engage with people experiencing behavioral health crises. Co-responder models vary in practice, but generally involve law enforcement and clinicians working together in response to calls for service involving a person experiencing a behavioral health crisis. The model provides law enforcement with appropriate alternatives to arrest as well as additional options to respond to non-criminal calls. Communities and local leaders can use the model to develop a crisis continuum of care that results in the reduction of harm, arrests, and use of jails and emergency departments and that promotes the development of and access to quality mental and substance use disorder treatment and services.

This brief, the first joint product in a series from Policy Research, Inc. (PRI) and the National League of Cities (NLC), details the various co-responder models available to city and county leaders. It reflects the growing interest and experimentation with co-response among jurisdictions that are part of the John D. and Catherine T. MacArthur Foundation’s Safety and Justice Challenge (SJC). In addition, the brief builds upon case studies in NLC’s recent series, Addressing Mental Health, Substance Use, and Homelessness, which explores emergency response and crisis stabilization strategies for cities.
Co-responder models address:

- the training and capacity of law enforcement and other first responders regarding response to individuals experiencing a behavioral health crisis;¹
- the use of jails instead of treatment as a response to unmet behavioral health treatment needs in communities;²
- the ongoing local capacity limitations in quality behavioral health services, as well as weak referral mechanisms;³
- the potential for harmful or fatal police encounters for people in crisis.⁴

When implemented well, the co-responder model has the potential to produce several benefits including:

- the creation of improved and more immediate responses to crisis situations;
- the ability to follow up with individuals, family members, and caregivers after a crisis to reduce the likelihood of further crisis situations;
- a decrease in expensive arrests and jail admissions for individuals in behavioral health crisis;
- a reduction in psychiatric hospitalizations; and
- more accurate on-scene needs assessments.

Co-responder teams fall into Intercepts 0 and 1 in the commonly used Sequential Intercept Model (see figure 1), a conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system. The Sequential Intercept Model, or SIM, recognizes that law enforcement plays a dual role across these two Intercept points, and is often the first to respond to individuals in crisis.⁵,⁶ When law enforcement responds to calls for service involving individuals experiencing a behavioral health crisis, it is often related to unmet treatment needs, not major crimes or violence.⁷ Cities and counties are increasing their use of law enforcement and behavioral health co-responder models, recognizing that many situations cannot be solved by arrest, but instead are best addressed by behavioral health clinicians and crisis specialists.
Benefits of Co-Responder Models

Communities have seen many benefits of implementing co-responder models. In cases where the offense related to the crisis is non-violent, this model often results in a decrease in expensive arrests and jail admissions for individuals experiencing a behavioral health crisis. Some communities have seen an associated reduction in psychiatric hospitalizations, although involvement with behavioral health staff may increase the use of psychiatric holds for some individuals, when appropriate. Individuals also gain better and faster access to effective treatment. Bringing trained clinicians to the scene of a crisis allows them to make more accurate needs assessments that can potentially include collaboration with family and friends (and avoid a costly hospital bill), versus transportation to and assessment at a facility. Each of these changes has the potential to result in a more cost-effective crisis response continuum.

Co-responder models also have positive, measurable effects on how law enforcement and other first responders handle behavioral health crises, including training to better de-escalate intense or emotional crisis situations without the use of force. Individuals in crisis report feeling less threatened and stigmatized in interactions with co-response teams as compared to interactions with law enforcement alone. In a win for both the individual and law enforcement, Johnson County, Kansas’s Mental Health Co-responder program shows reductions in repeat calls for service for the same individual, as well as an increase in officers’ self-reported capacity to respond to people experiencing a mental health crisis. Many first responders also document more efficient use of time as the co-response teams can take over quickly at crisis scenes, allowing patrol officers to resume their regular duties. A 2014 review synthesized the existing literature across seven desired outcomes of the model and found several strengths to build on, including enhanced linkage with community services, less weight on the justice system, and increased police morale and efficiency due to reduced downtime.

What Do Co-responder Models Look Like?

Co-responder models enhance law enforcement’s capacity to develop an immediate and targeted response to acute and non-acute situations. There is a wide variety of co-responder models...
used across the country; indeed, a recent systematic review identified 19 different triage models across the 26 studies. At its core, the co-responder framework typically features a specially trained team that includes at least one law enforcement officer and one mental health or substance abuse professional responding jointly to situations in which a behavioral health crisis is likely to be involved, often in the same vehicle, or arriving on scene at generally the same time. Usually, the team rides together for an entire shift and is either dispatched directly to relevant incidents to be “first on the scene,” or dispatched to the scene post-initial law enforcement contact. Teams may respond city/countywide or focus on areas with high numbers of crisis-related calls. The responders’ goals can include providing clinical support on the scene, conducting screening and assessments, reviewing what is known about client history, and navigating and referring to community resources. Many co-responder models involve clinicians who provide proactive follow-up support to encourage client service and treatment engagement.

Many co-response teams begin in one municipality, expanding to other municipalities after demonstrated success. Some law enforcement agencies, such as in Los Angeles County, California, create a “unit” responsible for co-responder implementation.

Site Example: Pima County, Arizona
The Pima County Sheriff’s Office and Tucson Police Department’s Mental Health Support Team (MHST) in Arizona (established in 2013) is a specially trained unit that includes a captain, lieutenant, sergeant, 2 detectives, and 11 field officers that serve as a mental health resource for other officers, community members, and health care providers. The MHST’s co-responder program (initiated in 2017) pairs an MHST officer with a masters-level licensed mental health clinician. The pair rides together, allowing for rapid dispatch of both law enforcement and mental health resources to calls for service. MHST teams wear civilian clothes and drive unmarked cars to help proactively defuse situations.

CIT and Co-Responder Teams
As a precursor to the co-responder model, the Crisis Intervention Team (CIT) program provides a strong foundation for law enforcement’s response to individuals experiencing a behavioral health crisis. The 40-hour training program is built on community partnerships that help bridge the gap between law enforcement response and behavioral health care. Through CIT, officers engage in specialized mental health training, and many jurisdictions have developed specific CIT units to respond to individuals experiencing a behavioral health crisis. The University of Memphis CIT Center reported in 2019 that there were over 2,700 CIT programs within the United States.
Co-Responder Model Variations

Many jurisdictions modify the core co-response model to meet their communities’ needs and capacities effectively. Below are some examples of variations to the model.

Law Enforcement Calls for After-Event Support
In some co-responder models, responding officers will refer to a behavioral health specialist after encountering someone in need of assistance.

Site Example: Kitsap County, Washington
The Poulsbo, Washington Police Department partners with behavioral health navigators in the city’s Behavioral Health Outreach Program. The program initially began in the court system and expanded to a law enforcement partnership in 2017. It has since been extended to multiple police departments and is funded through the Kitsap County Treatment Sales Tax and participating cities. Navigators are hired as police department employees. Officers in participating departments request the navigators when they identify people in need of behavioral health treatment or services. Navigators are available in crisis situations but are primarily called in after police contact occurs to follow up with individuals, families, and caregivers. Navigators work with individuals to proactively identify treatment options, overcome obstacles to accessing services, and improve communication between the criminal justice and behavioral health systems. They work in partnership with officers in the field and/or independently.

Law Enforcement Obtains Clinical Support Virtually
Virtual crisis support such as telehealth enables the remote delivery of services, overcoming the rural, geographic, and transportation challenges experienced in many models of delivery of care. Officers may request that counselors evaluate individuals experiencing a crisis to help determine the most appropriate course of action. This can include the use of a crisis line to direct the response or video conferencing.

Site Example: Springfield, Missouri
The Springfield, Missouri Police Department and Burrell Behavioral Health introduced the Virtual-Mobile Crisis Intervention (V-MCI) in 2012. Known as the "Springfield Model," the program expanded across southwest and central Missouri, including St. Louis County. Officers are given iPads to connect with behavioral health specialists in real-time for assessments and referrals, as well as follow-up case management. The virtual response has greatly reduced the number of people who were previously transported to the hospital.

Fire Department and/or Emergency Medical Services Join Law Enforcement and Clinicians
Emergency Medical Services (EMS) and fire departments are increasingly involved in specialized crisis response, such as through trained EMS teams that respond to crisis calls with law enforcement. In addition, some fire/medical co-responder teams may proactively reach out to people with mental illness who are frequently involved in calls for service to increase their stability in the community and connect to relevant services.
**Site Example: Colorado Springs, Colorado**

The Colorado Springs, Colorado’s Police Department (CSPD) and the Colorado Springs Fire Department (CSFD) collaborated with AspenPointe, a local behavioral health organization, to form a specially staffed mobile integrated mental health emergency response team. First deployed in December 2014, the Community Response Team (CRT) consists of a CSFD medical provider, a CSPD officer, and a licensed clinical behavioral health social worker. The medical provider performs medical clearance and screens for psychiatric admission eligibility, while the police officer ensures scene safety and the social worker provides behavioral health assistance. This approach significantly reduced admissions to the emergency department by directing individuals in crisis to community resources, like the local Crisis Stabilization Unit or county detoxification facility. The local 9-1-1 call center helps by diverting qualified calls directly to the CRT, therefore decreasing the burden of these calls from the regular EMS, fire department, and police department dispatch.

**Multi-Professional Teams, Especially for Substance Abuse Intervention**

Some co-responder teams are targeted to intervene around specific issues, such as human trafficking, homelessness, and often substance abuse. These targeted interventions may include both proactive outreach and opioid overdose follow-up.

**Site Example: Plymouth County, Massachusetts**

In 2016, Plymouth County Outreach in Massachusetts responded to an upsurge in opioid-related overdoses by creating an innovative collaboration that included the District Attorney’s Office, the Sheriff’s Department, all 27 police departments in the county, 5 major hospitals, recovery coaches, the Department of Children and Families, the District Court, probation services, and community and faith-based coalitions. The two main features of the program are overdose follow-up and community drop-in centers, which serve as the region’s treatment, recovery, and support services. Outreach is conducted within 12 to 24 hours of a non-fatal overdose by a team consisting of plainclothes officers, a licensed clinician, and/or a recovery coach who visit the home of the overdose survivor to provide resources and offer to connect him or her to treatment.

**Law Enforcement Calls for Non-Clinical Support**

Law enforcement can request dispatch of trained civilians, instead of clinicians. These trained civilians may include trained behavioral health volunteers, crisis workers, or other non-clinical professionals. The team may also serve the community on its own as a mobile crisis response.

**Site Example: Albuquerque, New Mexico**

Albuquerque, New Mexico’s Crisis Outreach and Support Team (COaST) is a team of civilian crisis specialists who work with the Albuquerque Police Department. Officers encountering an individual who is experiencing a crisis can call the COaST to the scene. The crisis specialists, who are stationed at the Family Advocacy Center and are assigned to various regions, help connect individuals to services and provide follow-up support, increasing efficiency and trust among officers and service providers.
Peer Support Workers Join Law Enforcement
Peers (peer support staff, peer support specialists, or peer recovery coaches) are individuals with lived experiences of mental illness, substance use disorders, and/or justice involvement who are trained or certified to provide supportive services. Peer support is particularly helpful in easing the potential trauma of the justice system process and encouraging consumers to engage in treatment services.

**Site Example: Mental Health Association of Nebraska**

The Mental Health Association of Nebraska operates the R.E.A.L. (Respond, Empower, Advocate, and Listen) program in partnership with law enforcement, community corrections, and local human service organizations. This program formalized a referral process where service providers can link people with an identified or potential mental health concern to trained peer specialists. The peer staff provides free, voluntary, and non-clinical support with an end-goal of reducing emergency protective orders and involuntary treatment placement. From 2011 to April 2018, the program found that 67 percent of referred individuals accepted services. The referral program is funded through grants from the Community Health Endowment and the Nebraska Department of Correctional Services.

Clinical Staff Advise from Dispatch Centers
Some jurisdictions have integrated behavioral health counselors or other clinicians directly within their 9-1-1/dispatch call centers to provide even earlier crisis resolution and diversion. In other areas, such as Broome County, New York, there can be a warm handoff of some calls from 9-1-1 dispatchers to crisis call lines, to address non-emergent behavioral health treatment needs.

**Site Example: Harris County, Texas**

Houston and Harris County, Texas, created an innovative intervention model through a collaboration with the Houston Police Department (HPD) Mental Health Division, the Harris Center for Mental Health and Intellectual and Developmental Disabilities (the Harris Center), Houston Fire Department (HFD), and the Houston Emergency Center. The 9-1-1 Crisis Call Diversion program places tele-counselors inside Houston’s Emergency Communications Center, providing dispatchers the ability to link callers who have non-emergent mental health-related issues to needed services, rather than dispatching a law enforcement unit or HFD personnel. Since the pilot program began in 2015, it has led to a decrease in the volume of non-emergency mental health-related calls for service for both HPD patrol and HFD emergency medical services and reduced the use of this personnel for non-emergency responses, translating into cost savings and cost avoidance.

Behavioral Health Navigators Join Law Enforcement at Point of Reentry
There is a growing understanding among jurisdictions across the country about the importance of ensuring successful reentry for people with serious mental illness and chronic behavioral health needs. These individuals are often caught in a cycle of hospitalization, homelessness, and jail. Clinicians and peers in this model are part of the larger co-response team but assigned to the local jail or prison to aid in community reentry.
Site Example: Denver, Colorado

Denver, Colorado, created jail-based behavioral health reentry navigators as part of its Crisis Intervention Response Unit (CIRU). The model allows licensed clinicians to work with Sheriff’s Department officers and medical staff to identify and establish appropriate community supports for individuals as they return to the community. At release, the CIRU and the reentry navigators collaborate around the reentry plan, which often includes short-term crisis stabilization, a known person meeting the individual upon release from the facility, a warm handoff to an ongoing treatment team, and transportation to and from appointments, as well as other pro-social activities.

How to Move Forward

Identifying a vocal, sustaining champion or group of key stakeholders is an important first step for city, county, or law enforcement leaders to take to move forward in launching a co-responder model. An external evaluation of the Indianapolis, Indiana Mobile Crisis Assistance Team (MCAT) credited strong buy-in from city leaders as crucial to the coordination across multiple agencies.18 A co-response team may also complement existing city or county priorities, such as the mayor and chief of police’s focus on homelessness and mental illness or a county’s Stepping Up efforts.

Securing funding for a pilot project is often the next step. While many sites rely on federal grant funding to stand up new initiatives, such as through the Substance Abuse and Mental Health Services Administration or the Bureau of Justice Assistance, cities and counties should explore multiple funding options during the planning, implementation, and sustainability/expansion phases of the program. Resources may be available through states’ departments of behavioral or public health and Medicaid funding. Colorado communities, like Denver, blend state and local funds for their co-responder programs, including the Marijuana Tax Cash Fund, Community Mental Health Services Block Grant dollars, Medicaid, and local community mental health centers. In addition to a county or state tax to ensure funding and increase the availability of services, private foundation or local business funding may be a potential source of support. Multiple sites involved in the MacArthur Foundation’s Safety and Justice Challenge, including Lake County, Illinois, Spokane County, Washington, Lucas County, Ohio, and Milwaukee City/County, Wisconsin, have used the initiative’s support to establish or expand co-responder teams. Finally, some hospitals and local mental health centers have shared the cost of co-response teams, as healthcare systems can benefit from cost avoidance under the model.

Key Strategies for Moving Forward:

- Identify a vocal, sustaining champion or group of key stakeholders
- Secure funding for a pilot project
- Staff community-based crisis response teams in a manner that meets the needs of the community
- Develop detailed policies and procedures that ensure and formalize coordination, access to services, communication, and consistency
- Create standards of work, such as client release of information, core intake information, standard data points, and tracking
As shown by the diversity of co-responder models, thoughtful implementation and training are vital. Behavioral health staff may be employed by the law enforcement agency, or by a mental health agency/authority, but co-located with law enforcement. **Regardless of the model, a community-based crisis response must be adequately staffed to respond promptly to crisis calls to be effective. If the community response is not adequate, first responders’ efforts will not lead to systems change, a gap which is often referred to as “divert to what.”** Best practices include:

- Coordinating co-response teams with law enforcement to have 24/7 availability or at least cover during peak call hours

- Ensuring quality staff training for both behavioral health personnel and law enforcement. An example of quality training is in Indianapolis, Indiana’s MCAT, which requires officers to receive training about CIT, mental illness, information sharing, special populations, the use of force, naloxone administration, and team building

- Educating behavioral health staff in the unique working conditions and demands of law enforcement

Cities and counties should develop detailed policies and procedures that ensure and formalize coordination, access to services, communication, and consistency within the team(s). Jurisdictions should also create standards of work where appropriate, such as client release of information, core intake information, standard data points, and tracking. Determining how to measure success will play a role. Metrics may include the ability of law enforcement to return to work quickly, as well as reductions in jail stays, the use of emergency departments and psychiatric hospitalizations, and other examples of cost avoidance and reduction. The Bureau of Justice Assistance’s [Police-Mental Health Collaboration Toolkit](https://www.bja.gov/programs/cjsenforcement/mental-health-collaboration-toolkit) and the Substance Abuse and Mental Health Services Administration’s [Data Collection Across the Sequential Intercept Model (SIM): Essential Measures](https://www.samhsa.gov/data/sequential-intercept-model-sim) may provide specific assistance, as well as the additional resources below.

**Conclusions**

There are many benefits to the co-responder model, including increased efficiencies among first responder agencies, improved overall outcomes of interactions involving people in behavioral health crisis, and improved law enforcement-community relations. However, the model is not an isolated solution. It is vital that community partners support first responders’ diversion efforts in order to enact true system change. These rapidly expanding models highlight challenging situations, and cities and counties should continue to explore and develop evidence-based responses to people experiencing a behavioral health crisis as alternatives to the criminal justice system, in order to meet their communities’ specific needs.
Additional Resources

- The National League of Cities’ series of three briefs examining city-level approaches to emergency response and crisis stabilization.
  - Advancing Coordinated Solutions through Local Leadership
  - Working Across Systems for Better Results
  - Emergency Response and Crisis Stabilization
- The National League of Cities’ How Cities Can Provide Alternatives to Jails and Improve Outcomes for Young Adults with Mental Health Concerns
- The National Association of Counties’ Meeting the Needs of Individuals with Substance Use Disorders: Strategies for Law Enforcement
- The International Association of Chiefs of Police’s Responding to Persons Experiencing a Mental Health Crisis
- The Bureau of Justice Assistance’s Police-Mental Health Collaboration Toolkit
- The Substance Abuse and Mental Health Services Administrations’ Tailoring Crisis Response and Pre-arrest Diversion Models for Rural Communities
Acknowledgments

This report was created with support from the John D. and Catherine T. MacArthur Foundation as part of the Safety and Justice Challenge initiative, which seeks to address overincarceration by changing the way America thinks about and uses jails. More information is available at www.SafetyandJusticeChallenge.org

Supported by the John D. and Catherine T. MacArthur Foundation

policyresearchinc.org | nlc.org

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Endnotes


Dial 211 for Essential Community Services

In many states, dialing “211” provides individuals and families in need with a shortcut through what can be a bewildering maze of health and human service agency phone numbers. By simply dialing 211, those in need of assistance can be referred and sometimes connected to appropriate agencies and community organizations.

Dialing 211 helps direct callers to services for, among others, the elderly, the disabled, those who do not speak English, those having a personal crisis, those with limited reading skills, and those who are new to their communities.

211 is available to approximately 309 million people, which is 94.6 percent of the total U.S. population. 211 covers all 50 states, the District of Columbia, and Puerto Rico. To find out whether 211 services are offered in your area and to obtain more information, visit 211.org.

How 211 Works

211 works a bit like 911. Calls to 211 are routed by the local telephone company to a local or regional calling center. The 211 center’s referral specialists receive requests from callers, access databases of resources available from private and public health and human service agencies, match the callers’ needs to available resources, and link or refer them directly to an agency or organization that can help.

Types of Referrals Offered by 211

- **Basic Human Needs Resources** – including food and clothing banks, shelters, rent assistance, and utility assistance
- **Physical and Mental Health Resources** – including health insurance programs, Medicaid and Medicare, maternal health resources, health insurance programs for children, medical information lines, crisis intervention services, support groups, counseling, and drug and alcohol intervention and rehabilitation
- **Work Support** – including financial assistance, job training, transportation assistance, and education programs
- **Access to Services in Non-English Languages** – including language translation and interpretation services to help non-English-speaking people find public resources (Foreign language services vary by location)
- **Support for Older Americans and Persons with Disabilities** – including adult day care, community meals, respite care, home health care, transportation, and homemaker services
- **Children, Youth and Family Support** – including child care, after-school programs, educational programs for low-income families, family resource centers, summer camps and recreation programs, mentoring, tutoring, and protective services
- **Suicide Prevention** – referrals to suicide prevention help organizations. Callers can also dial the following National Suicide Prevention Hotline numbers, which are operated by the
Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services:

- 1-800-273-TALK (1-800-273-8255)
- 1-800-SUICIDE (1-800-784-2433)
- 1-888-SUICIDE (1-888-784-2433)
- 1-877-SUICIDA (1-877-784-2432) (Spanish)

Those who wish to donate time or money to community help organizations can also do so by dialing 211.

**FCC Consumer Help Center**

For more information on consumer issues, visit the FCC’s Consumer Help Center at [fcc.gov/consumers](http://fcc.gov/consumers).

**Alternate formats**

To request this article in an alternate format - braille, large print, Word or text document or audio - write or call us at the address or phone number at the bottom of the page, or send an email to fcc504@fcc.gov.

Last Reviewed: 12/31/19
Information re Chapel Hill PD 911 Calls and Crisis Unit

The Chapel Hill PD provided the following information to working group staff via email. Staff curated and formatted the information.

June 2020 911 Call Analysis for Chapel Hill

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<th>Nature</th>
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<tr>
<td>MISC OFFICER INITIATED</td>
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<tr>
<td>PUBLIC SERVICE</td>
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<tr>
<td>ALARMS</td>
<td>172</td>
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<tr>
<td>DISTURBANCE/NUISANCE</td>
<td>130</td>
</tr>
<tr>
<td>INFO MESSAGE</td>
<td>126</td>
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<tr>
<td>SUSPICIOUS/WANTED</td>
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<tr>
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</tr>
<tr>
<td><strong>TOTAL</strong></td>
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June 2020 Crisis Unit Activity

A comparative look at the activity of our Crisis Unit in June 2019 and June 2020 shows a significant increase in response activity as well as increases in specific presenting issues. A presenting issue is defined as the initial symptom for which a person may seek help from a professional (i.e. therapist, psychiatrist, doctor). Our Crisis Unit defines the presenting issue as the underlying cause of the current crisis. In June of 2019 the Crisis Unit was dispatched to 58 calls for service; 46 of these responses were co-responses with law enforcement. In June 2020, the Crisis Unit was dispatched to 93 calls for service of which 77 of these responses were co-responses with law enforcement. The Crisis Unit saw a 60% increase in field responses; however, despite the increase in total field responses, the percentage of time requiring a co-responses remained 80% of the time.

In June 2019, 40% of the total field responses were in response to a person whose primary presenting issue was mental health related whereas in June 2020 only 22% of the total field responses were to a person whose primary presenting issue was mental health related. There was a substantial increase in the number of field responses to persons who primary presenting issue was homelessness. In June 2020, the Crisis Unit was dispatched 44 times to a person in crisis due to their lack of housing. Of those 44 responses, the Crisis Unit noted that 12 of the people had co-occurring mental health and substance use disorders as well. The exponential increase in deployments to individuals facing homelessness is likely due to the impact COVID has had on the ability of other community partners to continue to serve these clients. For example, most mental health appointments are now being completed via Telehealth which requires an email address, internet connection, and cellphone or laptop; however, most of our homeless community does not have ready access to these resources without the support of our community partners. As such, our Crisis Unit has been called on to respond and identify creative ways to assist these individuals in accessing the care and services they need. Additionally, some community partners who primarily serve this population suspended all operations due to COVID and have only recently begun serving persons again.
The Crisis Unit also tracks phone contacts with community members including those initiated by the Crisis Unit as follow-up to an incident/police contact or community members contacting the Crisis Unit over the phone requesting assistance or resources. In June 2019, 106 phone contacts were made with community members. This number more than doubled in June 2020 as the Crisis Unit had 219 phone contacts with community members. The Crisis Unit provides consultation to officers who are requesting information on a person, situation, and/or available resources. In June 2019 the Crisis Unit provided 14 officer consults and 43 officer consults in June 2020. The Crisis Unit also engages in case consultation with community agencies to collaborate on treatment/care of a community member. In June 2019, the Crisis Unit engaged in 27 case consults with community agencies and 36 case consults in June 2020.

Summary Description of Crisis Unit

The Chapel Hill Police Crisis Unit provides 24-hour co-response with officers to persons in crisis situations. We believe that a crisis is self-defined and work with any community member who feels they are in a crisis. The Crisis Unit responds to a variety of situations which include:

- Intimate partner or sexual violence
- Victims of crimes (assault, burglary/home invasion, armed robbery, child abuse/assault)
- Persons experiencing psychiatric emergencies or persistent mental health concerns
- Situations requiring safety planning and lethality assessments (suicidal or homicidal subjects)
- Runaway juveniles and missing persons
- Hostages or barricaded persons
- Traumas including fires, natural disasters, and accidents involving serious injury or death
- Incidents involving multiple victims in need of debriefing, including first responders
- Stalking or harassment
- Death notifications
- Outreach to vulnerable persons

The Chapel Hill Police Crisis Unit was established in 1973, and as a result, the co-response model is ingrained within the culture of CHPD and officers consistently request the assistance of the Crisis Unit. The Crisis Unit monitors the police radio throughout the day and offers assistance on calls where their skills would be useful. Officers also regularly recognize that many calls are best resolved with the assistance of (or solely by) our Crisis Unit. For instance, when completing outreach on Franklin Street to vulnerable community members who are often experiencing homelessness, the Crisis Unit does not request officer assistance. On the other hand, an active domestic would necessitate a joint response due to the safety concerns in responding to this type of situation. However, once the scene is secure, the Crisis Unit is able to meet with individuals without an officer present.

Our Crisis Unit also support our partnerships with local efforts including the Refugee Community Partnership, Board Member of National Alliance On Mental Illness (NAMI), Juvenile Crime Prevention Council, Orange County Behavioral Health Task Force, Familiar Faces Workgroup, Jail Mental Health Workgroup, Orange County Partnership to End Homelessness Leadership Team.

Additional Information re Crisis Unit

• Crisis Unit website: https://www.townofchapelhill.org/government/departments-services/police/divisions/specialty-units/crisis-unit
OUR DATA

NC 2-1-1 is an information and referral service provided by the United Way of North Carolina in all 100 NC counties with the support of 53 local United Ways throughout the State.

Our Database

- NC 2-1-1 has a database of more than 19,000 resources available to meet the needs of callers. The resources include food pantries, homeless shelters, utility and rent assistance funds, health clinics, prescription assistance programs, counseling and substance abuse services, child care resources, senior resources, resources for persons with disabilities, and much more.
- The NC 2-1-1 database is managed by a team of data coordinators with the input of leaders from local United Ways and direct service organizations throughout the State.
- The same resource database used by NC 2-1-1 call center specialists is also available at nc211.org for self-search and access to information.

Providing a Snapshot of Community-Specific Needs

- NC 2-1-1 collects demographic information from callers including gender, language preference, military status, age, disability status, and health insurance status. This information, when viewed in aggregate form, can be helpful in understanding the need trends in a community.
- NC 2-1-1 was one of two states to initially participate in the national 211Counts.org dashboard. 211Counts.org is a near real-time, on-line dashboard of aggregated 2-1-1 data that reflects the needs of callers presented to 2-1-1 centers around the country.
- NC 2-1-1 data can be viewed by zip code, county, region, state legislative district or federal congressional district at 211Counts.org.

2016 Measurements

In 2016, NC 2-1-1 responded to:

- 129,091 calls reflecting 144,755 needs.
- 103,943 unique web visits to nc211.org were recorded.

Top caller needs in 2016 included:

- Housing and Shelter
- Utility Assistance
- Agency Contact Information
Response to Hurricane Matthew

NC 2-1-1 was officially activated for the first time as part of NC Emergency Management’s State Emergency Response Team (SERT) and as the official number for NC residents to call for assistance during and after disaster.

From October 3, 2016 – December 31, 2016:

- NC 2-1-1 handled 12,067 calls related to the disaster
- 9,417 unique page views were recorded for nc211.org between October 3 and October 31

Top caller needs related to the disaster included:

- Disaster Food Stamps
- Meal Services
- Food Pantries
- Disaster Claims Information
- General Disaster Information
- Shelters

NC 2-1-1 continues to handle an average of 30 calls per week related to Hurricane Matthew, and anticipates continuing to serve those residents impacted by the storm throughout the recovery process.

For more information

Email our data coordinators.
FREQUENTLY ASKED QUESTIONS

What is NC 2-1-1?

NC 2-1-1 is an information and referral service provided by United Way of North Carolina. Accessible via an easy-to-remember, three-digit number, families and individuals can call to obtain free and confidential information on health and human services and resources within their community.

When can I call NC 2-1-1?

2-1-1 is available 24 hours a day, seven days a week, 365 days a year. Dialing 2-1-1 is free, confidential, and available in most languages.

Is NC 2-1-1 statewide?

NC 2-1-1 is available by landline, cell phone, and VOIP in all 100 counties of North Carolina.

What information is available by dialing 2-1-1?

NC 2-1-1 maintains a robust database with information on thousands of programs and services in North Carolina. We refer callers to organizations in their local community best equipped to address their specific health and human services needs including food, shelter, energy assistance, housing, parenting resources, healthcare, substance abuse, as well as specific resources for older adults and for persons with disabilities, and much more.

When an individual calls NC 2-1-1, a trained call specialist will conduct a search based on his or her geographic location to identify resources based on the caller's current needs. In addition to contact information for the community resource, the call specialist will provide eligibility requirements, the intake process for a program, the hours of operation, any requirements for appointments, and accessibility information, when available.

What role does NC 2-1-1 play in the event of a disaster?

NC 2-1-1 is a member of the State Emergency Response Team and is part of the State's Emergency Plan. In the event of a natural or public disaster, NC 2-1-1 is a public information portal for residents to obtain real-time communications and resources related to the disaster. Caller needs are tracked in order to provide information on trends and local circumstances that residents are facing to emergency managers.
In 2016, more than 12,000 North Carolinians dialed 2-1-1 to get information on emergency evacuations, shelters, meal sites, water and food distributions, and post disaster clean-up and recovery assistance during Hurricane Matthew.

**Does the online search tool provide the same results as dialing 2-1-1?**

The online database is the same database used by the call specialists. However, our call specialists are trained to search using specific keywords which may provide additional resources. If you don't find what you need online, we strongly encourage you to dial 2-1-1. Call specialists are available 24/7/365 to help.

**What types of organizations are included in the database?**

The database includes non-profit organizations and government agencies that provide health and human services to citizens in North Carolina based on specific inclusion criteria found here.

**How can I request an update to information about my organization?**

To update your agency's information listed in our public directory, use our updating tool located here.

**How can I share information about NC 2-1-1 in my community?**

Please visit our marketing page for further information.

**I don’t live in North Carolina, but I’d like to talk to NC 2-1-1 about resources. Can I just dial 2-1-1?**

If you are not located in North Carolina, you will need to dial 888-892-1162 to access the NC 2-1-1 call center. To find 2-1-1 call centers outside North Carolina visit 211.org.

**Is 2-1-1 available in languages other than English?**

NC 2-1-1 has Spanish language call specialists on staff and also utilizes professional language interpretation services to assist callers in over 170 languages.

**How is dialing 2-1-1 different from dialing 4-1-1?**

When you dial 2-1-1 you will be connected to a trained call specialist, not an automated service. You don’t need to know the name of the organization you’re trying to reach, only what type of service you need. NC 2-1-1 call specialists have access to a robust database of resources and will have a conversation with you to find the best resources available to meet your unique need. Call specialists also provide descriptions of the services available, eligibility requirements, and intake information for each referral they make when it's available.

**I can’t dial 2-1-1 from my phone. What do I do?**

You can always reach NC 2-1-1 by dialing 1-888-892-1162 if you’re unable to use the easy 3-digit dialing code.
If you find that you are unable to dial the 3-digit dialing code, follow the appropriate steps below:

**I am trying to call from a cell phone:**

Most major cell phone carriers have enabled their systems to allow calls to 2-1-1. However, if you are unable to reach NC 2-1-1 by dialing 2-1-1 from your cell phone, we encourage you to contact your cell phone provider to report the problem.

**I am trying to call from a government agency, private company/business phone system:**

If you are unable to dial 2-1-1 from your work phone, you should contact your technical department or support team and request that they add 2-1-1 access to your system. Many companies and government agencies don’t realize that, unlike 4-1-1 which charges a fee, NC 2-1-1 is a free service that will result in no cost to the company. By providing this information, we hope your company will make the necessary changes to the phone system to allow employees to contact NC 2-1-1 for assistance.

**I am trying to call from my home phone:**

Difficulties dialing 2-1-1 from landline phones are most likely due to one of two issues. Either 2-1-1 has not been programmed as part of your phone service or it has been programmed but it isn't working properly. If you are unable to dial 2-1-1 from your landline home phone, contact your phone service provider and let them know about the problem.

**Let us know about the problem**

Please complete our Report Form to let us know about the problem so we can also work with phone providers to ensure they know about and enable 2-1-1.

**I have a question that wasn’t addressed here. Whom can I contact?**

Fill out our Contact Us form and your question will be forwarded to the appropriate NC 2-1-1 staff member.
Find Help

Search For Resources
Tips for Searching

Professionals
Updating Tool
Inclusion Criteria
Initiatives
Marketing
Resources

eLibrary
211 Counts
Tax Assistance
Emergency Preparedness
Prescription Assistance
Hurricane Matthew
Purpose: The following chart will provide a count of specific calls for police service and the average time officers spend on those calls.

The Raleigh Police Department has responded to 424,748 calls for service from July 1, 2019 to June 30, 2020. Of these calls for service 252,894 were 911 calls made by the public for police services. There are 218 different types of calls for service divided into five different priority types.

The following call types are available for analysis.

<table>
<thead>
<tr>
<th>Call Type</th>
<th>Count</th>
<th>Average Time spent On-scene in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begging</td>
<td>1568</td>
<td>23</td>
</tr>
<tr>
<td>Mental Commitment</td>
<td>1039</td>
<td>135</td>
</tr>
<tr>
<td>Mental Commitment - Paper</td>
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<td>47</td>
</tr>
<tr>
<td>Mental Commitment - Violent</td>
<td>267</td>
<td>165</td>
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<tr>
<td>Overdose</td>
<td>1038</td>
<td>73</td>
</tr>
<tr>
<td>Suicide Threat</td>
<td>1193</td>
<td>98</td>
</tr>
</tbody>
</table>

- Mental Commitments – On average 2.8 per day at an average of 2.25 hours each.
- Mental Commitment – Paper – These are calls in which the officer must transfer the papers from the magistrate to the hospital – on average 3.9 per day at an average of 47 minutes each.
- Overdose – Calls in which a person has overdosed on either an illegal drug or prescription medication – average 2.8 per day at an average of 73 minutes per call.
- Suicide Threats – Calls in which a subject is contemplating suicide. These calls usually evolve into a Mental Commitment. – on average 3.3 per day at 98 minutes per call.

These call types are not all inclusive of the incident’s officers encounter the mentally ill, homeless, or substance abusers.
We train police to be warriors — and then send them out to be social workers

The fatal mismatch at the heart of American policing.

By Roge Karma | Jul 31, 2020, 7:30am EDT

Richard Nixon called police forces “the real front-line soldiers in the war on crime.” Bill Clinton, in his signing ceremony for the 1994 crime bill, called them “the brave men and women who put their lives on the line for us every day.” In 2018, Donald Trump described their job as follows: “Every day, our police officers race into darkened alleys and deserted streets, and onto the doorsteps of the most hardened criminals ... the worst of humanity.”

For decades, the warrior cop has been the popular image of police in America, reinforced by TV shows, movies, media, police recruitment videos, police leaders, and public officials.

This image is largely misleading. Police do fight crime, to be sure — but they are mainly called upon to be social workers, conflict mediators, traffic directors, mental health
counselors, detailed report writers, neighborhood patrollers, and low-level law enforcers, sometimes all in the span of a single shift. In fact, the overwhelming majority of officers spend only a small fraction of their time responding to violent crime.

However, the institution of policing in America does not reflect that reality. We prepare police officers for a job we imagine them to have rather than the role they actually perform. Police are hired disproportionately from the military, trained in military-style academies that focus largely on the deployment of force and law, and equipped with lethal weapons at all times, and they operate within a culture that takes pride in warriorship, combat, and violence.

This mismatch can have troubling — even fatal — consequences. Situations that begin with civilians selling loose cigarettes, attempting to use possibly counterfeit currency, sleeping intoxicated in their cars, recreationally selling or using low-level drugs, violating minor traffic laws, or calling the police themselves because they are experiencing a mental health crisis end with those same civilians, disproportionately Black Americans, unnecessarily killed at the hands of a police force primed for violent encounters and ill-equipped for interventions that demand mediation, deescalation, and social work.
“Cops are very equipped to be the hammer and enforce the law,” says Arthur Rizer, a former police officer and 21-year veteran of the US Army who heads the criminal justice program at the center-right R Street Institute. “They know how to use those tools forcefully and effectively; for everything else, they are lacking. Of course that’s going to end badly.”

There is considerable disagreement about the best way to change policing. But as my colleague Aaron Ross Coleman points out, a cross-factional coalition is emerging, centered on the idea that America relies far too heavily on police to address problems that have nothing to do with what they are trained, hired, and equipped to handle.

“The spectrum of skill sets we are currently asking police to embody is simply not realistic,” says Christy E. Lopez, a legal scholar at Georgetown Law who investigated police misconduct as an attorney for the Obama administration’s Justice Department. “It’s not realistic to ask any profession to do that much.”

In recent weeks, I’ve spoken to a dozen current and former police officers, police reformers, legal scholars, and criminologists to better understand this fatal mismatch at the heart of American policing — and what it would take to fix it.

**How police officers spend their time on the job**

The best information on how police officers spend their time comes from “calls for service” data made publicly available by individual police agencies. These are often defined as calls to emergency operators, 911 calls, alarms, and police radio and non-emergency calls. Most calls for service are initiated by citizens, but the data I draw on here captures the officer’s final categorization of the incident.

The data overwhelmingly finds that police officers in aggregate spend the vast majority of their time responding to non-criminal calls, traffic-related incidents, and low-level crimes — and only a tiny fraction on violent crimes.

My favorite visualization of this data comes from former UK police officer and Temple University criminologist Jerry Ratcliffe, who used 2015 data from Philadelphia, a city with relatively high crime rates, to construct this graphic. The area of each box represents the proportion of reported incidents within that category:
If you squint a bit, you can see that violent crimes like rape, homicide, and aggravated assault are tucked away in the bottom right-hand corner. Less serious crimes like petty theft, drug use, and vandalism take up slightly more space but not all that much. The vast majority of calls have nothing to do with crime. Instead, they involve disorderly crowds, domestic disputes, traffic accidents, minor disturbances, and a whole array of “unfounded” calls where the officer arrived on the scene only to discover nothing was happening.

Of course, the exact incident breakdown will vary by place, but this general picture holds for a number of police departments in major cities. In a June article for the New York
Times, crime analysts Jeff Asher and Ben Horwitz dug through the call data for the 10 police agencies that had made such data available, including in places with relatively high violent crime rates like Baltimore and New Orleans. They found that incidents that met the FBI Uniform Crime Report definition of violent crime made up only around 1 percent of calls for service.

Then, for the handful of police agencies that also provided data on when a given call for service was first reported and when that incident was closed, Asher and Horwitz used the difference between those two numbers to gauge the time officers actually spent on different types of policing activities.

Jeff Asher @Crimealytics
Replying to @Crimealytics @IT4Policy and @UpshotNYT

Of course a murder scene takes longer to process than a false burglar alarm so we also looked at data from 3 cities that provide information on how long each call takes to complete.

Using that we see about 4% of time is spent responding to UCR Part I violent crime.
Across these departments, the biggest category of time spent by police was on “responding to noncriminal calls,” which took up around a third or more of total on-call time. The next biggest categories were “traffic” (mostly car accidents) and “other crime” (low-level crimes like drug use, truancy, disorderly conduct, etc.). Almost 10 percent of police time was spent on “medical” calls, which involve non-crime-related physical emergencies. Meanwhile, police spent only around 4 percent of their time responding to violent crime and even less time (closer to 0.1 percent) on homicides.

“When I was an officer, I got calls about dead animals, ungovernable children who refused to go to school, people who hadn’t gotten their welfare checks, adults who hadn’t heard from their elderly relatives, families who needed to be informed of a death, broken-down cars, you name it,” says Seth Stoughton, a legal scholar at the University of South Carolina and former Tallahassee police officer. “Everything that isn’t dealt with by some other institution automatically defaults to the police to take care of.”

Calls for service data do not include what police often refer to as “unassigned” time — the hours police officers spend between calls patrolling neighborhoods, taking a meal break, or filling out paperwork. Observational studies of patrol officers have found that anywhere from 46 percent to 81 percent of their time is spent on unassigned activities. That means the total percentage of time police spend responding to crime could well be far less than even the call data indicates (the main exception being members of specialized units in major departments like homicide and SWAT whose activities aren’t captured by observational studies).

Numerous academic studies confirm these basic patterns in the data. They find that patrol officers — even in suburban and rural communities for which public data is often lacking — spend the overwhelming majority of their time writing reports, driving around neighborhoods, and responding to non-criminal calls.
“The job is 99 percent boredom and 1 percent sheer panic,” says Matthew Bostrom, a criminologist at the University of Oxford who spent more than 30 years as a police officer, commander, and sheriff in St. Paul, Minnesota. “Most of what you deal with is fairly routine.”

In his recent paper “Disaggregating the Policing Function,” Barry Friedman, the director of the Policing Project at New York University’s School of Law, breaks down this dizzying array of tasks and responsibilities into a handful of distinct roles:

- **The traffic cop:** The majority of police-civilian interactions take place on the road. Police help stranded motorists with broken-down cars, take reports in car accidents, direct traffic around serious incidents in which other responders are needed, set and staff speed “traps,” and issue citations. And when police are off-call, they spend much of their time performing routine street patrol.

- **The mediator cop:** A huge number of calls to the police involve relatively minor interpersonal disputes: disputes over noise levels, trespassing, misbehaving pets, or rowdiness; disputes between spouses, family members, roommates, or neighbors. In these situations, police are called to calm things down, deescalate, and act as counsel.

- **The social worker cop:** Police work often involves populations like the homeless, intoxicated people, people with substance use issues, or those with mental illness. This role isn’t often captured well in the aggregate data, but police spend a huge chunk of their time on these functions.

- **The first responder:** In most jurisdictions, the only government entities that respond to problems 24 hours a day, seven days a week are police, fire, and emergency medical services. That means for the vast majority of social problems, police are often the default institution for people to call. This is how cops get stuck chasing runaway dogs, tracking down welfare checks, dealing with noise complaints, and a whole host of other issues that appear to have nothing to do with policing.

- **The crime-fighting, law enforcement cop:** There is something to be said for rapid response by force- and law-trained individuals to situations involving serious criminal activity. However, studies find that this time is mostly spent interviewing witnesses, gathering evidence, advising victims, and writing reports. “Often cops are just there to pick up the pieces after the fact,” says Peter Moskos, a former Baltimore police officer and criminologist at John Jay College. “By the time you arrive, the crime is usually no longer in progress.”
The time a given officer spends on each of these roles varies greatly. In bigger cities, police work tends to involve dealing with a lot of substance abuse, mental illness, and homelessness. In suburban areas, domestic and other interpersonal disputes take up a larger portion of police time. In rural communities, police deal with a huge number of unique, one-off tasks.

What remains true in each of these cases is that police officers aren’t primarily crime fighters and law enforcers; instead, they fill a huge range of other social functions, often ones that other social services and institutions don’t have the ability to respond to quickly or at all.

“As a society we’ve decided to sweep these problems aside rather than to deal with them,” Friedman tells me. “And the police are the broom. They don’t want to be the broom, but that’s exactly what they are.”

**The job we prepare police for**

This all adds up to a fundamental problem with policing in America: We prepare police for a role vastly different from the one they actually play in society.

**A 2016 national study** of the training of 135,000 recruits across 664 local police academies found that, on average, officers each received 168 hours of training in firearm skills, self-defense, and use of force out of 840 total hours. Another 42 hours were spent on criminal investigations, 38 on operating an emergency vehicle, 86 on legal education aimed primarily at force amendment law, and hundreds more on basic operations and self-improvement. Topics like domestic violence (13 hours), mental illness (10 hours), and mediation and conflict management (9 hours) received a fraction of trainee time. Others, like homelessness and substance abuse, were so rare they didn’t make the data set.

Those averages mask an even more worrying reality. **Almost half** of American police academies utilize what is called the “military model” of instruction — a high-stress, **physically and psychologically excruciating** approach traditionally used to train soldiers for battle. Another third use a hybrid approach that draws heavily on the military model.
In many major-city police departments where this military model is prevalent, training is even more skewed toward force and law enforcement. At Nashville’s police academy, for instance, officers spent **two-thirds of their training time** on law enforcement and use of force and less than 10 percent of their time on “social work/mediation” issues like interpersonal communication and human relations.

“The amount of firearms and use of force training in our academies is completely at odds with the problem we most often ask police to deal with,” says Ratcliffe, the former UK police officer turned Temple criminologist. “Police training is simply not reflective of the role of police in our society.”

In the field, this trend continues. Despite the fact that American police deal with a vast array of different situations, they are equipped with the exact same tools for each one: handcuffs and a firearm. Increasingly, that tool basket also includes **assault rifles, camouflage, and armored vehicles**, even for routine tasks.

The structure of police agencies, too, reflects a commitment to force. Glance at the **organization chart** of any major police department and you’ll see specialized departments like SWAT, bomb squad, narcotics, vice, street crimes, gang unit, criminal intelligence, and counterterrorism. What you won’t see, with **a handful of exceptions**, are departments focused on conflict mediation or social work.
The emphasis on force, law, and crime fighting is undergirded by a powerful ideological ecosystem. As my colleague Zack Beauchamp writes, “The ideology [of policing] holds that the world is a profoundly dangerous place: Officers are conditioned to see themselves as constantly in danger and that the only way to guarantee survival is to dominate the citizens they’re supposed to protect.” That ideology is baked into the culture of policing at all levels.

Crime fighting and deployment of force are also culturally valorized. Take the International Association of Chiefs of Police’s “Police Officer of the Year” award, which “symbolizes the highest level of achievement among police officers,” and selects those who can stand as models for the profession — it’s a big deal in the policing world. In the 30-year period from 1986 to 2015, 25 recipients of the award were honored for actions they took in combat conditions while under attack.

Or just look up any police department recruitment video, where you’re likely to see police officers battering down doors, firing assault rifles, engaging in high-speed freeway chases, and running after suspects through alleyways — sometimes with a few brief shots of community outreach sprinkled in.

As for in-person recruiting efforts, police agencies concentrate primarily on military bases and, to a lesser degree, sports facilities and private security companies. The result is that military veterans — who are more likely to generate excessive force complaints and be involved in unjustified police shootings than non-military cops — represent almost 20 percent of police officers despite being just six percent of the US population. Men more generally make up almost 90 percent of all police officers; they are considerably more likely to use force and aggressive tactics than female officers.

“What excites police is action, and that means ultimately applying violence,” says Rizer. “The people attracted to police work want that type of action — they are giddy about it. The people who don’t want that type of action either never make it in the first place or are ridiculed for it if they do.”

**A mismatch with devastating consequences**

Police officers are functionally generalists responsible for dealing with a vast array of our society’s most sensitive situations; yet we’ve recruited, hired, trained, equipped, and deployed them to be specialists in force. And we’ve done it all using an often
disproportionately white police force with a well-documented racial bias problem entering Black and brown communities that historically distrust the police.

Would it surprise anyone if this occasionally resulted in unnecessary violence?

“Often what these situations require is someone to calm things down, cool things off, and deescalate,” says Tom Tyler, a legal scholar at Yale Law School and a founding director of Yale’s Justice Collaboratory. “But police tend to manage all the problems they face through the threat or use of coercive force. This amplifies the level of emotion and anger in a given situation and can create a spiral of conflict that ends tragically.”

Take the case of Rayshard Brooks. On June 12, Atlanta police officers were sent to respond to a complaint that Brooks was sleeping in his vehicle in a Wendy’s drive-through. Video evidence shows the interaction starts out calm. Brooks repeatedly asks the arresting officer, Garrett Rolfe, if he can leave his car parked and walk to his sister’s home, which he says is nearby. But Rolfe insists Brooks take a field sobriety test, which reveals that Brooks had a blood alcohol level slightly above the legal limit. Rolfe attempts to handcuff Brooks, Brooks resists, and a struggle ensues. Brooks grabs Rolfe’s Taser, begins running away, and turns to fire it. Rolfe shoots Brooks three times.

Brooks died in the hospital.

There are numerous points at which this interaction could have gone differently. If Atlanta had delegated certain responsibilities to non-police agencies, they could have sent an unarmed civilian to drive Brooks home. If the officers on the scene had the mindset of solving a problem without the use of force, they probably wouldn’t have escalated the situation by trying to forcefully handcuff Brooks. If the arresting officer didn’t have a Taser, Brooks would never have taken control of his weapon. If that same officer weren’t armed — or perhaps had stricter use of force requirements — he wouldn’t have shot and killed someone holding a less lethal weapon.

You can do the same kind of analysis for the deaths of George Floyd, Eric Garner, Breonna Taylor, Philando Castile, Euree Martin, Tony Timpa, Erik Salgado, and countless others. In each situation, the mismatch is crystal clear: Officers trained primarily in the deployment of force and law, armed with lethal weapons, and told to think of themselves as warriors were the chosen first responders to situations that demand anything but. And each situation ended with someone killed at the hands of the people ostensibly tasked to protect and serve them.
Police killings of unarmed civilians in the United States are **magnitudes higher** than those in peer countries. Using 2015 data, Franklin Zimring, a UC Berkeley criminologist and author of *When Police Kill*, calculates that the chance of an unarmed civilian being killed by police in the US is three times higher than the chance of any civilian, armed or unarmed, being killed by police in Germany and more than 10 times higher than in the UK (and that’s using a very conservative estimate of unarmed shootings in the US). A separate analysis found that in almost half of police killings of unarmed civilians in the US, the person killed was revealed to be or suspected of experiencing either a mental health crisis or narcotic intoxication.

Even when civilians are armed, that doesn’t necessarily mean police killings are justified. Upon extensively analyzing the 1,100 total fatal police killings in the US in 2015, Zimring **concluded** that “almost half the cases ... were confrontations where the police were not at objective risk of a deadly attack.” And, of course, it is impossible to quantify how many of those confrontations would not have escalated to the point of potential violence in the first place if not for police presence and tactics.

The unnecessary use of deadly force isn’t the only, or even the most likely, consequence of this mismatch. It also leads routinely to the **overcriminalization** of issues like **drug use**, **mental illness**, and **homelessness**; it causes predominantly Black and brown
What we train our police to do — and what they actually do - Vox

community to **live in constant fear** of their own police departments; it **destroys trust** between police officers and the people they are supposed to protect; and it places a **major financial burden** on local government budgets (armed police officers are an expensive way to address social problems) that leads to the underfunding of key social services. All the while, it fails to solve the underlying problems that lead to police being called in the first place.

“The definition of failure is that what we’re doing isn’t solving the problem and is actually causing harm in the process,” says Friedman, the Policing Project director. “That basically describes the state of policing today.”

**Reimagining public safety**

When it comes to addressing the mismatch between the nature of our police forces and the roles we ask them to perform, there are **two broad paths** that stand out.

The first is to transform our police forces — to change how officers are recruited, hired, trained, and equipped to meet the actual demands of their role.

Hiring and recruiting practices can be reformed to increase the diversity of police forces in terms of gender, race, and non-military backgrounds. Training can be refocused to include a stronger emphasis on **procedural justice principles, conflict deescalation, and crisis intervention**. Use of force policies can be made **much stricter**. Tactics like chokeholds, shooting at moving vehicles, and shooting without warning can be banned, as many departments have already done. Military-grade weapons can be **taken off the streets**. Legal protections like **qualified immunity** can be revoked.

On a structural level, police agencies can create an entire department focused on crisis response with specialized units focused on homeless outreach, mental illness, substance abuse, and conflict mediation (as some **progressive departments have already done**). Those officers can be recruited from fields like social work and psychology, hired based on their capacity to calmly handle highly stressful situations, trained primarily in crisis response, and rewarded not for arrests or stops but for peaceably resolving issues and handing them over to the appropriate social services institution.

The challenges associated with this approach aren’t difficult to imagine. Reform would have to take place on numerous levels: training, hiring, recruitment, agency structure, weaponry. You’d have to get buy-in not only from state and local public officials and police chiefs but from rank-and-file officers. You’d have to fight police unions for **even an inch of**
What we train our police to do — and what they actually do - Vox

reform. And even if you fixed one or two of these areas (which could take years or decades), sending armed officers to deal with social problems will always leave open the possibility of unnecessary violence. Cities like Minneapolis, Atlanta, and Tucson — all of which have experienced high-profile police killings recently despite reform efforts — have learned that lesson the hard way.

“It’s impossible to point to one specific problem and say, ‘That’s it — that’s the issue,’” says Tracey Meares, a legal scholar and founding director of Yale University’s Justice Collaboratory. “This is about the system of policing itself. Our communities lack the resources to deal with their social problems. And our response has been to deploy armed first responders to address the issue way down the chain from the source.”

That leads us to a second approach: to transform how we address public safety such that police play a smaller, more targeted role altogether. This would involve communities designating a certain subset of current police duties that don’t require armed police response, delegating those responsibilities — along with requisite funding — to an institution that could better handle the issue, and designing systems for service delivery (like a 911 call diversion program) and coordination (like a silent alert system that unarmed first responders could use to quickly summon police backup).
Models for this approach have been implemented successfully in some places in the US and across the globe. In the UK, certain traffic functions have been designated to unarmed, non-police public servants. In cities across the US, “violence interruption” programs run by community nonprofits have been largely successful in mediating conflict and reducing violence. The much-applauded Cahoots program in Eugene, Oregon, sends a team of unarmed crisis specialists to address many non-criminal 911 calls without having to involve police.

There’s public support for such an approach. A recent poll found that 68 percent of voters support the creation of a “new agency of first responders” (although just a quarter of Americans say they support “reducing funding” for police departments).

The challenge is that designing an entirely new approach to public safety, rather than merely reforming an existing one, means stepping into relatively uncharted territory.

“There is no single, definitive answer to what will work in a given place,” Megan Quattlebaum, director of the Council of State Governments Justice Center, tells me. “Anything we do is going to be in the space of experimentation with different models.”

That means things are bound to go wrong. Some programs might not scale. Others will not receive adequate funding. Crime may temporarily increase in some places. Occasionally, a violence interrupter or mobile crisis worker will be seriously injured or killed. And when those things happen, it will take an incredible amount of political will and community solidarity to persist.

These two approaches are not mutually exclusive. There is general agreement that armed officers should still respond to violent crimes, like an active shooter, and definitively non-criminal, nonviolent activity should be delegated to alternative institutions. There are also a handful of hybrid solutions that combine the approaches — for instance, collaborative models between police and other agencies or nonprofits that co-respond to issues like homelessness or mental health. Or the “civilianization” of police departments: hiring unarmed professionals without arrest powers to fulfill certain police responsibilities, as many European countries have done.

But once you get into the details, difficult trade-offs emerge. There are plenty of cases where there is legitimate ambiguity about whether a situation will escalate to violence: like when a 911 caller isn’t sure whether what she is seeing is a man at a playground with a lethal weapon or a young teenager playing with a toy gun, or when a woman experiencing a
severe mental health crisis is **threatening others with a knife**. In cases like those, do we send unarmed first responders and risk putting them, and others, in harm’s way? Or do we send armed police officers and risk the use of unnecessary state force against civilians?

“This is a conversation that needs to be had with communities,” says Tracie L. Keesee, a former Denver police officer and the co-founder of the Center for Policing Equity. “Where do you want police and where do you not want them? Who would you rather have show up? What kinds of qualities would you like your police officers to have?”

Reimagining the role police play in our society is far from being anti-police. **Plenty of police officers** recognize that our current one-size-fits-all approach to public safety is fundamentally broken. They lament the fact that we ask police to solve far too many of our social problems and don’t give them the training or resources they need to do so — and then point the finger at them when they inevitably come up short.

“The reason I think we need to rethink policing is because I care about police,” says Rizer, the former officer and R Street researcher. “I want to make policing prestigious again — not the prestige of power, but the prestige of respect. But in order to do that, we need to stop underfunding everything else and leaving the police holding a bag of shit.”

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Information re Chapel Hill PD 911 Calls and Crisis Unit

The Chapel Hill PD provided the following information to working group staff via email. Staff curated and formatted the information.

**June 2020 911 Call Analysis for Chapel Hill**

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</table>

**June 2020 Crisis Unit Activity**

A comparative look at the activity of our Crisis Unit in June 2019 and June 2020 shows a significant increase in response activity as well as increases in specific presenting issues. A presenting issue is defined as the initial symptom for which a person may seek help from a professional (i.e. therapist, psychiatrist, doctor). Our Crisis Unit defines the presenting issue as the underlying cause of the current crisis. In June of 2019 the Crisis Unit was dispatched to 58 calls for service; 46 of these responses were co-responses with law enforcement. In June 2020, the Crisis Unit was dispatched to 93 calls for service of which 77 of these responses were co-responses with law enforcement. The Crisis Unit saw a 60% increase in field responses; however, despite the increase in total field responses, the percentage of time requiring a co-responses remained 80% of the time.

In June 2019, 40% of the total field responses were in response to a person whose primary presenting issue was mental health related whereas in June 2020 only 22% of the total field responses were to a person whose primary presenting issue was mental health related. There was a substantial increase in the number of field responses to persons who primary presenting issue was homelessness. In June 2020, the Crisis Unit was dispatched 44 times to a person in crisis due to their lack of housing. Of those 44 responses, the Crisis Unit noted that 12 of the people had co-occurring mental health and substance use disorders as well. The exponential increase in deployments to individuals facing homelessness is likely due to the impact COVID has had on the ability of other community partners to continue to serve these clients. For example, most mental health appointments are now being completed via Telehealth which requires an email address, internet connection, and cellphone or laptop; however, most of our homeless community does not have ready access to these resources without the support of our community partners. As such, our Crisis Unit has been called on to respond and identify creative ways to assist these individuals in accessing the care and services they need. Additionally, some community partners who primarily serve this population suspended all operations due to COVID and have only recently begun serving persons again.
The Crisis Unit also tracks phone contacts with community members including those initiated by the Crisis Unit as follow-up to an incident/police contact or community members contacting the Crisis Unit over the phone requesting assistance or resources. In June 2019, 106 phone contacts were made with community members. This number more than doubled in June 2020 as the Crisis Unit had 219 phone contacts with community members. The Crisis Unit provides consultation to officers who are requesting information on a person, situation, and/or available resources. In June 2019 the Crisis Unit provided 14 officer consults and 43 officer consults in June 2020. The Crisis Unit also engages in case consultation with community agencies to collaborate on treatment/care of a community member. In June 2019, the Crisis Unit engaged in 27 case consults with community agencies and 36 case consults in June 2020.

Summary Description of Crisis Unit

The Chapel Hill Police Crisis Unit provides 24-hour co-response with officers to persons in crisis situations. We believe that a crisis is self-defined and work with any community member who feels they are in a crisis. The Crisis Unit responds to a variety of situations which include:

• Intimate partner or sexual violence
• Victims of crimes (assault, burglary/home invasion, armed robbery, child abuse/assault)
• Persons experiencing psychiatric emergencies or persistent mental health concerns
• Situations requiring safety planning and lethality assessments (suicidal or homicidal subjects)
• Runaway juveniles and missing persons
• Hostages or barricaded persons
• Traumas including fires, natural disasters, and accidents involving serious injury or death
• Incidents involving multiple victims in need of debriefing, including first responders
• Stalking or harassment
• Death notifications
• Outreach to vulnerable persons

The Chapel Hill Police Crisis Unit was established in 1973, and as a result, the co-response model is ingrained within the culture of CHPD and officers consistently request the assistance of the Crisis Unit. The Crisis Unit monitors the police radio throughout the day and offers assistance on calls where their skills would be useful. Officers also regularly recognize that many calls are best resolved with the assistance of (or solely by) our Crisis Unit. For instance, when completing outreach on Franklin Street to vulnerable community members who are often experiencing homelessness, the Crisis Unit does not request officer assistance. On the other hand, an active domestic would necessitate a joint response due to the safety concerns in responding to this type of situation. However, once the scene is secure, the Crisis Unit is able to meet with individuals without an officer present.

Our Crisis Unit also support our partnerships with local efforts including the Refugee Community Partnership, Board Member of National Alliance On Mental Illness (NAMI), Juvenile Crime Prevention Council, Orange County Behavioral Health Task Force, Familiar Faces Workgroup, Jail Mental Health Workgroup, Orange County Partnership to End Homelessness Leadership Team.

Additional Information re Crisis Unit

• 2 minute WRAL story: https://www.wral.com/mental-health-clinicians-helping-police-officers-in-chapel-hill/19183568/
- Crisis Unit website: https://www.townofchapelhill.org/government/departments-services/police/divisions/specialty-units/crisis-unit
Purpose: The following chart will provide a count of specific calls for police service and the average time officers spend on those calls.

The Raleigh Police Department has responded to 424,748 calls for service from July 1, 2019 to June 30, 2020. Of these calls for service 252,894 were 911 calls made by the public for police services. There are 218 different types of calls for service divided into five different priority types.

The following call types are available for analysis.

<table>
<thead>
<tr>
<th>Call Type</th>
<th>Count</th>
<th>Average Time spent On-scene in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begging</td>
<td>1568</td>
<td>23</td>
</tr>
<tr>
<td>Mental Commitment</td>
<td>1039</td>
<td>135</td>
</tr>
<tr>
<td>Mental Commitment - Paper</td>
<td>1433</td>
<td>47</td>
</tr>
<tr>
<td>Mental Commitment - Violent</td>
<td>267</td>
<td>165</td>
</tr>
<tr>
<td>Overdose</td>
<td>1038</td>
<td>73</td>
</tr>
<tr>
<td>Suicide Threat</td>
<td>1193</td>
<td>98</td>
</tr>
</tbody>
</table>

- Mental Commitments – On average 2.8 per day at an average of 2.25 hours each.
- Mental Commitment – Paper – These are calls in which the officer must transfer the papers from the magistrate to the hospital – on average 3.9 per day at an average of 47 minutes each.
- Overdose – Calls in which a person has overdosed on either an illegal drug or prescription medication – average 2.8 per day at an average of 73 minutes per call.
- Suicide Threats – Calls in which a subject is contemplating suicide. These calls usually evolve into a Mental Commitment. – on average 3.3 per day at 98 minutes per call.

These call types are not all inclusive of the incident’s officers encounter the mentally ill, homeless, or substance abusers.
Dial 211 for Essential Community Services

In many states, dialing “211” provides individuals and families in need with a shortcut through what can be a bewildering maze of health and human service agency phone numbers. By simply dialing 211, those in need of assistance can be referred and sometimes connected to appropriate agencies and community organizations.

Dialing 211 helps direct callers to services for, among others, the elderly, the disabled, those who do not speak English, those having a personal crisis, those with limited reading skills, and those who are new to their communities.

211 is available to approximately 309 million people, which is 94.6 percent of the total U.S. population. 211 covers all 50 states, the District of Columbia, and Puerto Rico. To find out whether 211 services are offered in your area and to obtain more information, visit 211.org.

How 211 Works

211 works a bit like 911. Calls to 211 are routed by the local telephone company to a local or regional calling center. The 211 center’s referral specialists receive requests from callers, access databases of resources available from private and public health and human service agencies, match the callers’ needs to available resources, and link or refer them directly to an agency or organization that can help.

Types of Referrals Offered by 211

- **Basic Human Needs Resources** – including food and clothing banks, shelters, rent assistance, and utility assistance
- **Physical and Mental Health Resources** – including health insurance programs, Medicaid and Medicare, maternal health resources, health insurance programs for children, medical information lines, crisis intervention services, support groups, counseling, and drug and alcohol intervention and rehabilitation
- **Work Support** – including financial assistance, job training, transportation assistance, and education programs
- **Access to Services in Non-English Languages** – including language translation and interpretation services to help non-English-speaking people find public resources (Foreign language services vary by location)
- **Support for Older Americans and Persons with Disabilities** – including adult day care, community meals, respite care, home health care, transportation, and homemaker services
- **Children, Youth and Family Support** – including child care, after-school programs, educational programs for low-income families, family resource centers, summer camps and recreation programs, mentoring, tutoring, and protective services
- **Suicide Prevention** – referrals to suicide prevention help organizations. Callers can also dial the following National Suicide Prevention Hotline numbers, which are operated by the
Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services:

- 1-800-273-TALK (1-800-273-8255)
- 1-800-SUICIDE (1-800-784-2433)
- 1-888-SUICIDE (1-888-784-2433)
- 1-877-SUICIDA (1-877-784-2432) (Spanish)

Those who wish to donate time or money to community help organizations can also do so by dialing 211.

FCC Consumer Help Center

For more information on consumer issues, visit the FCC’s Consumer Help Center at fcc.gov/consumers.

Alternate formats

To request this article in an alternate format - braille, large print, Word or text document or audio - write or call us at the address or phone number at the bottom of the page, or send an email to fcc504@fcc.gov.

Last Reviewed: 12/31/19
OUR DATA

NC 2-1-1 is an information and referral service provided by the United Way of North Carolina in all 100 NC counties with the support of 53 local United Ways throughout the State.

Our Database

- NC 2-1-1 has a database of more than 19,000 resources available to meet the needs of callers. The resources include food pantries, homeless shelters, utility and rent assistance funds, health clinics, prescription assistance programs, counseling and substance abuse services, child care resources, senior resources, resources for persons with disabilities, and much more.
- The NC 2-1-1 database is managed by a team of data coordinators with the input of leaders from local United Ways and direct service organizations throughout the State.
- The same resource database used by NC 2-1-1 call center specialists is also available at nc211.org for self-search and access to information.

Providing a Snapshot of Community-Specific Needs

- NC 2-1-1 collects demographic information from callers including gender, language preference, military status, age, disability status, and health insurance status. This information, when viewed in aggregate form, can be helpful in understanding the need trends in a community.
- NC 2-1-1 was one of two states to initially participate in the national 211Counts.org dashboard. 211Counts.org is a near real-time, on-line dashboard of aggregated 2-1-1 data that reflects the needs of callers presented to 2-1-1 centers around the country.
- NC 2-1-1 data can be viewed by zip code, county, region, state legislative district or federal congressional district at 211Counts.org.

2016 Measurements

In 2016, NC 2-1-1 responded to:

- 129,091 calls reflecting 144,755 needs.
- 103,943 unique web visits to nc211.org were recorded.

Top caller needs in 2016 included:

- Housing and Shelter
- Utility Assistance
- Agency Contact Information
Response to Hurricane Matthew

NC 2-1-1 was officially activated for the first time as part of NC Emergency Management’s State Emergency Response Team (SERT) and as the official number for NC residents to call for assistance during and after disaster.

From October 3, 2016 – December 31, 2016:

- NC 2-1-1 handled 12,067 calls related to the disaster
- 9,417 unique page views were recorded for nc211.org between October 3 and October 31

Top caller needs related to the disaster included:

- Disaster Food Stamps
- Meal Services
- Food Pantries
- Disaster Claims Information
- General Disaster Information
- Shelters

NC 2-1-1 continues to handle an average of 30 calls per week related to Hurricane Matthew, and anticipates continuing to serve those residents impacted by the storm throughout the recovery process.

For more information

Email our data coordinators.
Find Help

Search For Resources
Tips for Searching

Professionals
Updating Tool
Inclusion Criteria
Initiatives
Marketing
Resources

eLibrary
211 Counts
Tax Assistance
Emergency Preparedness
Prescription Assistance
Hurricane Matthew

About Us
FAQs
FREQUENTLY ASKED QUESTIONS

What is NC 2-1-1?

NC 2-1-1 is an information and referral service provided by United Way of North Carolina. Accessible via an easy-to-remember, three-digit number, families and individuals can call to obtain free and confidential information on health and human services and resources within their community.

When can I call NC 2-1-1?

2-1-1 is available 24 hours a day, seven days a week, 365 days a year. Dialing 2-1-1 is free, confidential, and available in most languages.

Is NC 2-1-1 statewide?

NC 2-1-1 is available by landline, cell phone, and VOIP in all 100 counties of North Carolina.

What information is available by dialing 2-1-1?

NC 2-1-1 maintains a robust database with information on thousands of programs and services in North Carolina. We refer callers to organizations in their local community best equipped to address their specific health and human services needs including food, shelter, energy assistance, housing, parenting resources, healthcare, substance abuse, as well as specific resources for older adults and for persons with disabilities, and much more.

When an individual calls NC 2-1-1, a trained call specialist will conduct a search based on his or her geographic location to identify resources based on the caller’s current needs. In addition to contact information for the community resource, the call specialist will provide eligibility requirements, the intake process for a program, the hours of operation, any requirements for appointments, and accessibility information, when available.

What role does NC 2-1-1 play in the event of a disaster?

NC 2-1-1 is a member of the State Emergency Response Team and is part of the State's Emergency Plan. In the event of a natural or public disaster, NC 2-1-1 is a public information portal for residents to obtain real-time communications and resources related to the disaster. Caller needs are tracked in order to provide information on trends and local circumstances that residents are facing to emergency managers.
In 2016, more than 12,000 North Carolinians dialed 2-1-1 to get information on emergency evacuations, shelters, meal sites, water and food distributions, and post disaster clean-up and recovery assistance during Hurricane Matthew.

**Does the online search tool provide the same results as dialing 2-1-1?**

The online database is the same database used by the call specialists. However, our call specialists are trained to search using specific keywords which may provide additional resources. If you don't find what you need online, we strongly encourage you to dial 2-1-1. Call specialists are available 24/7/365 to help.

**What types of organizations are included in the database?**

The database includes non-profit organizations and government agencies that provide health and human services to citizens in North Carolina based on specific inclusion criteria found here.

**How can I request an update to information about my organization?**

To update your agency's information listed in our public directory, use our updating tool located here.

**How can I share information about NC 2-1-1 in my community?**

Please visit our marketing page for further information.

**I don’t live in North Carolina, but I’d like to talk to NC 2-1-1 about resources. Can I just dial 2-1-1?**

If you are not located in North Carolina, you will need to dial 888-892-1162 to access the NC 2-1-1 call center. To find 2-1-1 call centers outside North Carolina visit 211.org.

**Is 2-1-1 available in languages other than English?**

NC 2-1-1 has Spanish language call specialists on staff and also utilizes professional language interpretation services to assist callers in over 170 languages.

**How is dialing 2-1-1 different from dialing 4-1-1?**

When you dial 2-1-1 you will be connected to a trained call specialist, not an automated service. You don't need to know the name of the organization you're trying to reach, only what type of service you need. NC 2-1-1 call specialists have access to a robust database of resources and will have a conversation with you to find the best resources available to meet your unique need. Call specialists also provide descriptions of the services available, eligibility requirements, and intake information for each referral they make when it's available.

**I can’t dial 2-1-1 from my phone. What do I do?**

You can always reach NC 2-1-1 by dialing 1-888-892-1162 if you’re unable to use the easy 3-digit dialing code.
If you find that you are unable to dial the 3-digit dialing code, follow the appropriate steps below:

**I am trying to call from a cell phone:**

Most major cell phone carriers have enabled their systems to allow calls to 2-1-1. However, if you are unable to reach NC 2-1-1 by dialing 2-1-1 from your cell phone, we encourage you to contact your cell phone provider to report the problem.

**I am trying to call from a government agency, private company/business phone system:**

If you are unable to dial 2-1-1 from your work phone, you should contact your technical department or support team and request that they add 2-1-1 access to your system. Many companies and government agencies don’t realize that, unlike 4-1-1 which charges a fee, NC 2-1-1 is a free service that will result in no cost to the company. By providing this information, we hope your company will make the necessary changes to the phone system to allow employees to contact NC 2-1-1 for assistance.

**I am trying to call from my home phone:**

Difficulties dialing 2-1-1 from landline phones are most likely due to one of two issues. Either 2-1-1 has not been programmed as part of your phone service or it has been programmed but it isn't working properly. If you are unable to dial 2-1-1 from your landline home phone, contact your phone service provider and let them know about the problem.

**Let us know about the problem**

Please complete our Report Form to let us know about the problem so we can also work with phone providers to ensure they know about and enable 2-1-1.

**I have a question that wasn't addressed here. Whom can I contact?**

Fill out our Contact Us form and your question will be forwarded to the appropriate NC 2-1-1 staff member.
Find Help

Search For Resources
Tips for Searching

Professionals
Updating Tool
Inclusion Criteria
Initiatives
Marketing
Resources

eLibrary
211 Counts
Tax Assistance
Emergency Preparedness
Prescription Assistance
Hurricane Matthew
Why Crisis Intervention Team Training Should Be the Standard


DEC. 13, 2019

By Ernie Stevens and Joe Smarro

Prior to 1988, police officers in this country had no training to teach them how to handle a mental health crisis. When officers are untrained on how to de-escalate someone in crisis, the possibility of them using force goes up drastically. This is why crisis intervention team (CIT) program and training was created in Memphis, Tennessee, after a tragic incident where a police officer shot a person with mental illness.

Even 31 years later, most communities in this country still do not have CIT for their officers. And sadly, some officers aren’t even aware of what CIT is.

What is CIT?

CIT is a community based program that brings together a variety of stakeholders to change how communities are responding to mental health crises. A significant part of CIT is a 40-hour training meant to educate officers on recognizing when individuals have mental illness and are symptomatic, de-escalating the crisis situation and navigating people toward resources and help. The curriculum was a collaborative effort between the Memphis Police Department, NAMI, the University of Tennessee and the University of Memphis.

The training can be tailored to suit the individual needs of an agency based on the level of available resources. However, most 40-hour CIT trainings consist of:

- Active listening and de-escalation
- Legal considerations
- Mental illness basics
- Various conditions including bipolar disorder, schizophrenia, depression, anxiety, PTSD, etc.
- Suicide detection & prevention; police officer suicide; suicide by cop
- Excited delirium
- Local resources
- Jail diversion
- Role plays

For too long, officers have been more focused on penalizing the behaviors of people in crisis rather than attempting to understand why they are in crisis in the first place. And this training teaches officers how to de-escalate and where to navigate people in a crisis – including understanding the benefits of treatment rather than incarceration. These techniques have been
used to divert thousands of people from jail and prevent thousands more from making potentially fatal decisions.

Implementing CIT

Here are a few things we recommend considering when developing a CIT program in your area.

• A good CIT program highlights the idea of jail diversion.
• If you don’t have quality local resources available for the officers to divert their individuals into treatment, consider how this could negatively impact the CIT program.
• Understand that jails and emergency rooms are not quality treatment options for mental health crises.
• When developing your program, consult with experts or those with experience to gain insight.
• Simply putting an officer in front of a group and reading 40 hours of PowerPoints is not going to have enough impact to shape internal culture.
• The more collaborative your program, the better. Rely on local subject matter experts to teach courses. Get out and talk to people and ask questions about what is available and how partnerships/relationships can be developed.

Creating a Mental Health Unit

In 2003, the San Antonio Police Department in San Antonio, Texas, adopted the 40-hour CIT and in 2008, developed a full-time mental health detail. Sitting through the CIT training is valuable for each individual officer, but the results are quite profound when an agency takes the next step to create an actual mental health unit. When you have a full-time unit, 100% of the calls these officers respond to are individuals during their darkest times. It is some of the best and most rewarding on-the-job training an officer can receive.

Responding to people suffering on a daily basis creates the deepest level of empathy — if you have the right officers filling the role. The San Antonio Police Department is fortunate to have just that. And hopefully, with the spread of CIT, more agencies will follow suit.

CIT is an integral part of developing an officer, simply because of the alternative perspectives it can provide. As Abraham H. Maslow stated, “If the only tool you have is a hammer, everything will look like a nail.” Let’s embrace the notion that just because things have always been done a certain way, doesn’t mean it is the best way. We can be better. We can do better. Quality crisis intervention team training is one simple place to start.

Officers Joe Smarro and Ernie Stevens are members of the San Antonio Police Department Mental Health Unit. They are featured in the HBO documentary “Ernie & Joe: Crisis Cops.”
Effectiveness of Police Crisis Intervention Training Programs

Michael S. Rogers, MD, Dale E. McNiel, PhD, and Renée L. Binder, MD

Approximately 1,000 people in the United States were fatally shot by police officers during 2018, and people with mental illness were involved in approximately 25 percent of those fatalities. Crisis Intervention Team (CIT) training is a specialized police curriculum that aims to reduce the risk of serious injury or death during an emergency interaction between persons with mental illness and police officers. CIT has been implemented widely both nationally and internationally. Given the increasing resources devoted to CIT, efforts to analyze its effectiveness and outcomes relative to other approaches are important. Studies of CIT and similar interventions are found within both the mental health and the criminal justice arenas, which use very different terminologies, approaches, and outcome studies, rendering unified analyses challenging. This article describes the CIT model and reviews several recent systematic analyses of studies concerning the effects of CIT. Studies generally support that CIT has beneficial officer-level outcomes, such as officer satisfaction and self-perception of a reduction in use of force. CIT also likely leads to prebooking diversion from jails to psychiatric facilities. There is little evidence in the peer-reviewed literature, however, that shows CIT’s benefits on objective measures of arrests, officer injury, citizen injury, or use of force.

J Am Acad Psychiatry Law 47(4) online, 2019. DOI:10.29158/JAAPL.003863-19

Approximately 1,000 people in the United States were fatally shot by police officers during 2018, and people with mental illness (PMI) were involved in approximately 25 percent of those fatalities. This rate has remained roughly constant between 2015 and 2018. Police are often the first responders to PMI in acute distress, and sometimes they are the only responders. Over the last two decades, a diversion program known as the Crisis Intervention Team (CIT) model for police interactions in crisis situations involving persons in the community with mental, emotional, or developmental challenges has become one of the dominant paradigms in the United States for police–PMI interaction. According to Watson et al., the original, primary goal of CIT was to reduce officer and citizen injuries. There is controversy in the research literature about the extent to which adoption of CIT has reduced the risk of serious injury or death for persons with mental illness during an emergency interaction with police officers. This article describes the history of the CIT model and reviews the research literature on the extent to which it is achieving its goals, including reducing injury to officers and citizens.

Methods

Search keywords were collected by polling experts on the topic and reviewing key articles that had relatively high impact factors or that were highlighted by expert consultation. A literature search was conducted using the U.S. National Library of Medicine’s MEDLINE database, Google Scholar, the Excerpta Medica database (EMBASE), The Cochrane Library, the Web of Science, ProQuest Dissertations and Theses, PsycINFO, Sociological Abstracts, OpenGrey, and the New York Academy of Medicine’s Gray Literature Report. Search terms included CIT, crisis intervention, police, mental health, LEO, psychiatric, emergency, crisis, mobile, and logical combinations. Inclusion criteria included papers relating to police interventions for PMI and reports of objective measures or surveys. Priority was given to those papers reporting or analyzing experimental or quasi-experimental design with either intervention and control, matched-cohort or case-control stud-
ies, or those with pretest and posttest data collection. Priority was given to papers published since 1989 (i.e., the deployment of the first CIT) and those written in English. Non–peer-reviewed material, such as theses, were generally excluded from substantive results. After de-duplication, the search identified 198 core CIT-related articles. Of these, two recent systematic analyses were identified as significant.5,6

Origins

CIT began in response to an incident that occurred in Memphis, TN. Police encountered 27-year-old Joseph Dewayne Robinson in the street outside his mother’s house as they responded to a 911 emergency dispatch called in by Mr. Robinson’s mother on September 24, 1987.7,8 Mr. Robinson’s mother had called police dispatch to report that her son, who had a reported history of mental illness and substance abuse, had been using cocaine and was cutting himself and threatening people. According to the police officers, Mr. Robinson did not respond to verbal requests and “lunged” at the officers, who shot him multiple times.

In response to this incident, community organizers, civil administrators, the Universities of Memphis and Tennessee, and the Memphis Police Department came together to organize the Memphis Police Department’s Crisis Intervention Team. Its recommendations became the Memphis model of CIT, with a goal to reduce lethality during police encounters with people with mental/substance abuse disorders (i.e., PMI) and to divert such people, when appropriate, away from the criminal justice system and into the civil treatment system. Press reports in 1999 noted that in Memphis during the years prior to 1987, on average seven people with a history of mental illness had been fatally shot per annum by police officers, whereas by 1999 there had been only two such police-involved deaths of people with mental illness.8

The local Memphis city’s chapter of the National Alliance on Mental Illness (NAMI) facilitated police–community discussions, education, and outreach in 1988. Today the national NAMI organization advocates for CIT programs and provides education and volunteer resources to establish and operate such programs throughout the United States. From a small beginning, the CIT approach has spread nationally and internationally.9 The Memphis model of CIT formulated in 1988 and incrementally updated provides a template for CIT deployment.

The CIT Model

Codifying specific police responses to PMI is an example of problem-oriented policing,10 which is an approach to reducing the probability of the use of force through research, interventions, and outcome analysis. Following Hails and Borum11 (after work by Deane et al.12), police responses to emergencies involving PMI nationally and internationally generally fall within a tripartite typology:

- Police-based specialized police response: Sworn officers obtain special training to interact with PMI. The officers function as first responders to emergency dispatch calls in the community and coordinate with local community mental health resources. CIT falls within this category.
- Police-based specialized mental health response: Non-sworn police department employees with mental health training provide on-site or remote consultation and advice to sworn officers in the field. This often involves a centralized resource center and was formerly a prevalent model.13
- Mental-health-based specialized mental health response: Police departments coordinate with independent mental health systems and workers to cooperate on emergency response in the field, with mental health workers as primary agents. Mobile crisis units fall within this category, as do neighborhood-based care coordination and street triage.14

The Memphis model CIT program as enumerated within the CIT Core Elements specifies several components.15 The first component is training for self-selected police officers comprising 40 hours of instruction from community mental health workers, PMI and their families and advocates, and police officers familiar with CIT. The University of Memphis provides a sample curriculum suitable for a recommended 40 hours of training. Many local implementations exist, sponsored or funded by state agencies or through federal agencies such as the Substance Abuse and Mental Health Services Administration.

The second component involves training and special coding for dispatch operators to enable them to
recognize community reports with a high probability of PMI involvement and to route CIT officers there preferentially. This is significant because research indicates that the characteristics of the call for service initiating the contact is a strong determinant of the probability of future use of force.16

The third component, a centralized drop-off mental health facility with an automatic acceptance policy to minimize police officer transfer time, was identified in 2000 by Steadman et al.17 as an important element of a successful CIT deployment. Larger metropolitan areas have deployed multiple facilities within geographically dispersed areas. Rural settings present specific challenges.18

The goals of CIT are variably defined between different stakeholders. On its website, the University of Memphis describes CIT as a prearrest jail diversion for those in a mental illness crisis. It adds that the goal of CIT is to provide a system of services that is friendly to individuals with mental illness, their family members, and the police officers.19 On its website, the Memphis Police Department describes CIT as a community partnership working with mental health consumers and family members.20 It adds that the goals of CIT include setting a standard of excellence for its officers regarding treatment of PMI and joining both the police and the community together for the common goals of safety, understanding, and service to people with mental illness and their families.20 NAMI describes CIT as a model for community policing that brings together law enforcement, mental health providers, hospital emergency departments, and individuals with mental illness and their families.21 It adds that the goal of CIT is to improve responses to people in crisis.

The University of Memphis states that outcomes for CIT programs include being able to effectively divert persons in mental health crisis away from jail and into appropriate mental health settings and to be a potent agent for overcoming the negative stereotypes and stigma associated with mental illness.22 On its website, the Memphis Police Department states an outcome for CIT is that CIT-trained officers can offer a more humane and calm approach.20 On its website, NAMI states concrete claims for CIT, stating that it improves officer safety, keeps law enforcement officers’ focus on crime, and reduces community spending.21

**CIT’s Success**

During the Obama Administration, the U.S. Department of Justice’s Community-Oriented Policing Services (COPS) published information on local policing practices and numbers. According to the President’s Task Force on 21st-Century Policing,23 at the end of 2015 there were 17,985 police agencies within the United States. The Bureau of Justice said in 2013 that there were 15,388 police agencies.24 Various federal or interstate initiatives, such as the U.S. Department of Justice’s Police-Mental Health Collaboration25 or the Justice Center’s Law Enforcement/Mental Health liaison services,26 attempt to provide centralized resources for training and referral.

The fragmented and overlapping U.S. law enforcement system presents challenges in terms of oversight and monitoring, and this extends to gathering statistics. Although the police power rests with the individual states and there are some state-wide police forces, most U.S. police officers work within small, local departments with limited resources.27 Half of all agencies have fewer than ten officers, and nearly 75 percent have fewer than 25 officers. Testimony recorded in the President’s Task Force Report on 21st-Century Policing describes significant difficulties providing training and equipment for such small departments, as well as challenges with local municipal boundaries and traditions that prevent many agencies from combining forces with neighbors. Small departments can have significant difficulties deploying or consistently operating a CIT model that closely follows the core elements of the Memphis approach.

According to Deane et al.,12 in the 1990s, only 45 percent of 174 responding police departments reported any specialized response to PMI, and of those, a distinct minority (n = 6, or 3%) reported using the CIT model. Since then, CIT uptake has been rapid. In a 2008 comprehensive qualitative analysis of CIT, Compton et al.28 noted that there were approximately 400 CIT programs operating across the United States. In 2019, the University of Memphis CIT Center reports 2,700 CIT programs within the United States.22 This national figure of 2,700 CIT programs, while representing only around 15 to 17 percent of the total number of police agencies, probably underestimates the absolute number of people interacting with CIT-trained officers because of CIT’s relative ease of adoption within larger, ur-
CIT's Effects and Reception

Given the broad uptake of CIT deployment nationally and internationally, the evaluation of CIT’s effects and benefits is important. As many researchers have noted, this is a difficult question to answer, but it important in terms of resource allocation and social justice. Most of the studies on CIT involve analysis of the planning, deployment, and procedural functioning of the CIT process itself, including the selection, training, operations, and measurement or self-report of CIT-trained officers.

Concerns have been raised previously about evidence-based outcomes measurements for the CIT approach. The 2008 review by Compton et al.28 limited itself to a narrative synthesis because of a paucity of eligible studies as well as heterogeneity of methodology and data. This review produced a critical response by Geller,35 likening being in favor of educating officers of police departments about mental illness and mental health services with being in favor of motherhood and apple pie. The concern over an uncritical CIT adoption universally is multifactorial. There is concern about the lack of evidence of efficacy for specific goals and concern over the opportunity cost of pursuing this model to the exclusion of others. In addition, there have been concerns regarding the possibility that a jail diversion program such as CIT may shift cost burdens from police budgets (generally relatively politically favored) to community mental health budgets (potentially less relatively politically favored). This relative favoring of one budgetary initiative over others may explain some of the growth of CIT in preference to other alternatives, such as specialized mental health-based response or street triage.

Several recent reviews and a meta-analysis have attempted to summarize the results of research on the effects of CIT with certain specific, quantifiable goals. Whereas published studies of CIT within small, relatively homogeneous regions that adhere closely to the Memphis model’s parameters are often positive, larger-scale multi-site analyses are mixed. The core element of CIT involves 40 hours of training, usually for officers who are voluntary and self-selected.36 Other agencies have adopted a universal training approach where training is recommended or even mandatory for all officers. Sometimes cash bonus payments are offered as incentives for officers to participate and maintain certification as being CIT-specialized. Other elements may not be available or configured differently, such as CIT-oriented dispatchers (and coding) and integrated community resources, such as a no-refusal, rapid drop-off behavioral health center. Fidelity to some or all of these core elements may be fundamental to enabling quantifiable and replicable CIT outcomes between different deployments.37

Outcomes

Much research has shown an improvement in attitudes and a reduction of stigma in police officers who received mental health training.38,39 There is good evidence for benefit in officer-level outcomes, such as officer satisfaction and self-perception of a reduction in the use of force.40-42 A survey of police officers indicated that CIT-trained officers perceived themselves as less likely to escalate to the use of force in a hypothetical mental health crisis encounter.43

There is also evidence for CIT’s effect on prebooking jail diversion. One study, which involved 180 officers (roughly 50% CIT-trained) from multiple departments and reported on 1,063 incidents, demonstrated a CIT effect of increased verbal negotiation as the highest level of force used, with referral to mental health units more likely and arrest less likely.44 The same study noted, however, that there was no measurable difference in the use of force between officers with CIT training and those without it. Other studies have also found a lack of evidence for a reduction in injuries associated with CIT in-
volvement. One reasonable hypothesis is that environmental effects may overwhelm the detection of possible favorable effects of CIT in terms of reducing the lethality of encounters between police officers and PMI.

It has been challenging for researchers to operationalize and then evaluate the relative efficacy of different models of CIT compared to similar specialized interventions. A recent systematic literature review by Kane et al. considered several interventions: CIT; an approach called “liaison and diversion,” which has a primary goal of diversion where specialist mental health-trained staff are located at police custody sites or courts; and an approach called “street triage,” which has a primary goal of timely access to mental health services involving mobile crisis units and specialized mental health-trained staff deployed locally according to individualized protocols. Kane et al. found no clear evidence from the studies reviewed of superiority for one approach over the others in terms of benefit for various criminal justice outcomes, such as the number of arrests or days spent in detention, or for primary health outcomes, such as identification of mental illness at an earlier stage. Each of the structured programs produced some beneficial effects compared with control groups within the relevant studies. The reported effects were variable between programs, however, and the significant outcome heterogeneity made quantitative comparisons challenging. CIT was assessed to be the best program in terms of reducing re-offending and improving mental health outcomes. This was postulated to be related to the fact that CIT was the only intervention that offered an integrated service combining the initial call and response triage with specialized trained police officers and mental health professional intervention.

The difficulty of establishing clear evidence for CIT’s efficacy in reducing officer and citizen injuries is illustrated by a 2016 systematic review and meta-analysis of research on CIT at multiple sites by Taheri. The difficulties in terms of heterogeneity and lack of intention-to-treat analyses encountered by the earlier study by Compton et al. persisted. It remains challenging to identify agreement between studies about exactly what constitutes a mental health crisis call. Individual programs demonstrate differences in terminology and thresholds to identify an encounter as a mental health crisis.

The lack of high-quality CIT outcome studies suitable for data analysis was illustrated by Taheri’s challenge in identifying suitable candidates. Out of 820 records for potential incorporation in the analysis, only eight met criteria suitable for evaluating quantifiable outcomes for arrests, police officer injury, or use of force. The meta-analysis goal of measuring officer injury outcomes could not be achieved due to the absence of a standardized measurement across the studies satisfying inclusion criteria. None of the analyzed studies showed a positive benefit of CIT on use-of-force outcomes. Analysis of pooled studies found that CIT officers were significantly less likely to arrest PMI compared with a control group of non-CIT officers. This result was based on self-reporting by study participants, however, whereas analysis of the official arrest statistics did not show a consistent effect of CIT for either an increase or decrease in the arrest frequency for PMI.

Discussion

Despite a lack of evidence for effectiveness in terms of its original goal of reducing lethality during police encounters with people with mental health and substance use disorders, CIT has been shown to have some measurable positive effects, mainly in the area of officer-level outcomes. These include increased officer satisfaction and self-perception of a reduction in the use of force. CIT programs have also been promoted to increase diversion to psychiatric services rather than jails and to decrease costs. Studies of specific CIT programs have found some positive but mixed outcomes or trends toward statistical significance in terms of increased diversion to psychiatric services overall. This may lead to cost reductions. For example, one study of the cost effects of CIT in a city with around 600,000 inhabitants found modest cost reductions mainly through a reduction of hospitalization days and inpatient referrals from jail. This was despite a significant outlay for emergency psychiatric evaluations.

CIT may influence the prevalence and frequency of early-stage, outpatient psychiatric referrals. Such emergency services triage may result in an overall reduction in psychiatric health care costs due to a reduction in significantly more expensive inpatient or hospital services. This may represent an analog of preventive health care, where money spent earlier can produce greater benefit than money spent later in a disease process. The variability, effectiveness, and
vertical coordination of the psychiatric services available to PMI referred after CIT intervention is difficult to quantify. There are bound to be significant location- and insurance-specific factors that affect whether such individuals respond to treatment or resume behaviors likely to result in repeat CIT interactions. These unknown variables may also account for the difficulty in demonstrating many consistent, measurable health outcomes of CIT.

Another factor to consider is that, with the thousands of CIT programs deployed, there may be a publication bias leading to a reduction in the likelihood of publication or dissemination of studies identifying a null effect or adverse cost increases or shifts associated with a specific CIT program.

Another important goal of CIT programs is to improve officer and citizen safety. This outcome is harder to demonstrate. After 20 years of CIT training programs and the recent increase in dissemination, large-scale studies of the quantifiable benefits of CIT as applied to the reduction of lethality and effect on overall arrest rates remain limited. Some studies have demonstrated little significant difference between CIT-trained officers and untrained officers in terms of the characteristics of PMI diverted to psychiatric emergency services. Studies have not shown consistent reduction in the risk of mortality or death during emergency police interactions.

These studies, however, are limited by variability in how CIT is implemented across the heterogeneous U.S. police systems and the reality that state and federal databases tend to undercount officer-involved shooting fatalities by wide margins of 30 to 50 percent. This data imprecision could limit sensitivity for detecting improvement associated with CIT. Police use of deadly force itself is relatively rare, and this low base rate, coupled with relatively underpowered studies, creates an elevated risk of Type II error (i.e., false negative error).

There also may be larger trends at work in U.S. society whose effects obscure or counteract those of CIT, including: the effects of race on officer-involved shootings, where African Americans are nearly three times more likely to be killed by police than white Americans; officer characteristics; increased militarization of policing; and gun ownership patterns. One study concluded that there were two significant neighborhood characteristics important in officers’ decisions to use force. One factor was the actual threat level in a neighborhood, as measured by the number of active resistance incidents by residents. The other factor was the officers’ perceived level of threat, as measured by the percentage of non-white residents. The high comorbidity of substance use in PMI means that many people involved in emergency police interactions may be intoxicated. Intoxication is an additional risk factor for violence and a strong predictor of force use during police interactions. This is probably due to increases in aggressiveness and perceived threat of violence. Police officers perform dangerous jobs within a society distinguished by relatively high homicide rates, high levels of gun ownership, and concomitant gun homicide. The individual characteristics of the encounter are often cited by officers as the primary element informing the decision to use force. This decision to use deadly or injurious force during an encounter may be largely a function of the incidence of high-risk encounters and may remain relatively insensitive to preencounter training such as CIT.

Another concern about the use of CIT programs relates to cost effectiveness and opportunity costs, i.e., not spending money on alternatives. These alternatives could include increased use of mental health-based specialized response or street triage, increased funding for comprehensive or assertive community outreach programs, or an increase in the number of beds at inpatient acute or long-term residential facilities. Alternatives could also include increased focus and intervention on the social determinants of mental health or additional resources devoted to preventive mental health. In their recent systematic literature review, Kane et al. concluded that, in general, diversion programs resulted in lower criminal justice costs and greater health-funded intervention costs. Even if CIT may reduce overall costs to the criminal justice system, this needs to be measured against potential costs shifted to the community mental health systems associated with successful diversion to treatment. Further research is warranted to measure the quantifiable outcomes of CIT, and to consider the opportunity costs versus the benefits of continuing to expand CIT programs.

References

Effectiveness of Police Crisis Intervention Training Programs

One City’s 30-Year Experiment With Reimagining Public Safety: In Eugene, Oregon, it’s normal for medics and crisis workers to respond to public safety calls instead of the police.


July 6, 2020

AMID THE NATIONAL reckoning over systemic racism and policing inspired by the May 25 killing of George Floyd, advocates are calling for a reimagining of American public safety through reforms such as reduced department funding and alternative policing models.

In Eugene, Oregon, a college town of some 170,000 residents, and neighboring Springfield, with some 63,000 residents, one such model has been in place for more than 30 years: A nonprofit mobile crisis intervention program, called CAHOOTS, operates in collaboration with the police department, dispatching social workers instead of officers. The program has an annual budget of roughly $2 million and saves the city of Eugene an estimated $8.5 million annually in public safety costs, in addition to $14 million in ambulance trips and emergency room costs.

U.S. News recently spoke with CAHOOTS operations coordinator Tim Black about the program, and whether it might be a viable model for other cities contemplating police reform. The following interview has been edited for length and clarity.

First of all, can you give me a little more on just the logistics of CAHOOTS? How many team members do you have who are actually going out to these calls?

We have a staff team in total of about 40 folks – actually, exactly 40 team members right now. That includes a couple of administrators who don't work on the van. At any given time of day we have two to three teams that are out responding to calls via police dispatch, and each of those teams is made up of a crisis worker and a medic.

I think I saw it's like 20% of all Eugene-Springfield police calls get routed to you guys?

I'll clarify that: We haven't been able to get a solid percent in Springfield, but 17% of the calls coming from the public through Eugene's public safety communications center go to CAHOOTS.

What's the reception like when a CAHOOTS van shows up?

Generally when the CAHOOTS van shows up folks are really excited. Well maybe not excited – they're happy to see us. And that's either because they're in crisis and they
called for us specifically and now we're showing up for them, or maybe they don't know about CAHOOTS or know that we would be the best resource to help them in that moment, and so when we show up, generally it's relief that they don't have to spend that time interacting with a police officer or with a firefighter or paramedic.

**Can you give me some examples of recent dispatches or recent calls that CAHOOTS showed up to?**

We take almost 24,000 calls a year, so every time I pick out like four or five examples I totally and completely miss [aspects] of the work.

Calls that we have responded to recently have included somebody who was experiencing a lot of anxiety over a chronic medical condition: After the pandemic started, they became fearful of trying to access their physician, and then when the physician moved to telemedicine the individual really struggled with using a phone or a laptop to communicate with their doctor … and that resulted in them reaching out to CAHOOTS late in the night about, "What is this? What's going on? Should I go to the emergency room or can this wait?" And our medic was able to … provide some assurance that the person didn't need to go into the emergency room, and we were able to walk through the steps of setting up a telemedicine appointment.

Other calls that we've responded to recently have had to do with struggling to access adequate shower facilities. With the pandemic closures a lot of the [public] services in town are restricted, so there was somebody who hadn't been able to get a shower anywhere because they weren't allowed on the bus system for six weeks, and [we] deescalated a behavioral crisis that was really about not being able to meet this basic human of need of getting a shower. … We recently responded to support a family member who had found somebody from their family who had died by suicide, and so we stayed with that person who made that discovery. We stayed with them on the scene and provided them a lot of support, but also really helped maintain the scene.

And then there are a million other things we do, like mediate conflicts between roommates or working with families who are feeling [desperate] because they've got young children and are just kind of cooped up and feeling like they're stacked on top of each other in an apartment.

**We're seeing all these good news reports about CAHOOTS, which is great. What challenges do you have, though?**

I think the bigger challenges that we face here in our own community are mostly around a lack of resources. Depending on how the count is done, we have between 1,200 and 4,000 folks who are unsheltered in our town, and that's when the shelters are running at full capacity. … But alongside that is inadequate resources for mental health, substance use and just somewhere to be.
On a slightly more specific level, the biggest struggle that we’re having right now is our point of access. For 31 years, CAHOOTS has been dispatched by and requested through the police nonemergency line exclusively. We still believe that in order to really achieve the high levels of diversion from law enforcement and from the emergency medical system, those are most possible through integration in the public safety system. So what we’re working with our community partners on right now is: Does it need to be the police department number that you call to receive this service from public safety? Could there be a stand-alone mobile crisis intervention services number that is still answered by somebody in the call center, or is there a possibility of our own behavioral health hotline number, like 611 or something like that?

What do you make of all this focus on CAHOOTS as sort of a potential national model?

Yeah, I mean it's surreal on some levels, because we've just kind of been doing this for the past 30-plus years, but at the same time it's this … validation for our founders that they had this idea that would catch on and that other cities would be looking to. But we're also just really excited about this opportunity to engage with communities about the lessons that we've learned and to offer up our experiences over the last three decades so that cities across the country – and maybe even a few across Canada, the way things are looking – don't have to start from zero. CAHOOTS isn't some cookie-cutter [program] that you can just pick up from Eugene and just kind of plunk down in Houston and expect it to work the same, just bigger. Every community is different, every community has unique needs, and what we can offer is kind of that foundational service delivery model and training.

What cities are you in touch with?

In the last two weeks we've gotten requests from over 50 cities across the U.S. We previously worked to support the development and the implementation of the crisis response unit in Olympia, Washington, last year, and the Denver STAR program, which just started in June of this year. Other than that, the Portland Street Response project is moving forward and looks like it's going to be a larger pilot than originally anticipated. I've also been spending a lot of time with elected officials and representatives from different organizations in Harris County, Texas. ... We've also had a lot of contact with folks in New York City, and presented to Mayor Bill de Blasio's task force on mental health response a year ago. In the Bay Area we are making a lot of headway with groups in San Francisco. Oakland just got funding for its pilot project, and in that first-year budget there's consultation and training [with] CAHOOTS.

I know you said it's not like this cookie-cutter thing that you can just kind of copy and paste – each city's going to have to adapt to its needs. But what are some of the bigger lessons that you want to share with other mayors or city leaders that are talking to you?
I think one of the primary things is the medic and crisis worker combination is what has allowed us to make such significant impacts in our community. By recognizing that behavioral health has a role in physical health, and physical health has a role in behavioral health, you're able to really kind of treat the whole patient. And there are a lot of folks out there where maybe they don't have the upbringing or the background to be able to articulate when they're not feeling well emotionally, but they will reach out to say, "My stomach hurts" – and so [you're] having that medic become this way for folks to [really] open up about what they're experiencing emotionally.

Do you think the lessons from CAHOOTS can apply easily or smoothly to a larger, more diverse city? Or are there some things that might have to shift?

I think the key thing is really kind of like I talked about, with what we're doing here with really trying to create our own dispatch within that public safety system. As we move into larger communities, places that aren't Eugene, that don't have the same relationship that the city of Eugene has with its police department, it's that point of access that is going to be really challenging to pull off, because the impact of our program is most felt when it's integrated into that 911 communication system. We're able to divert so many calls from the police because we're using the same priority channels as they are, and so we're hearing them go out to help somebody on a street corner, and we can hop on the radio and say like, "Hey, it doesn't sound like there's a crime happening, so we'll spin around the block and we'll go check in … and let you know if any patrol is needed for that." We're able to respond to calls that come into dispatch on 911, where somebody is experiencing a crisis. We can't get those calls if we're not plugged into that system the same way.

Whether it's 911 or a separate number, there has to be a relationship within the community that people are willing to reach out and call, right? There has to be sort of a basic trust there.

Yeah, and I think one of the things that's important to highlight is that CAHOOTS is a part of White Bird Clinic, and White Bird Clinic has been serving the Eugene and Springfield community for over 50 years. So for 20 years before CAHOOTS started, White Bird Clinic was doing crisis response over the phone. People could come into our clinic, and we were sending out our volunteers to do community-based crisis work, which then got formalized as CAHOOTS. Our nonprofit, our agency, had that relationship with the community. So then as we move into this conversation with other cities, one of the things that we're asking is, "Are there organizations or community groups that have the trust of your community, and have the skills, that do this kind of work, and could you collaborate with them on this project?"
A long-planned program to remove police from some 911 calls launched as Denver’s streets erupted in police brutality protests

The timing was a coincidence, but the stakes have never been higher.

Roshan Bliss has been trying to find ways to curb police violence for years and scored a major victory at the beginning of the month, just as Denver started protesting racism and police brutality.

Bliss, a volunteer and co-chair of the Denver Justice Project, helped shepherd a pilot project into existence that’s now diverting some 911 calls away from armed officers to an unassuming van manned by a Denver Health paramedic and a social worker from the Mental Health Center of Denver. It’s called Support Team Assisted Response, or STAR, and the idea is to send more appropriate responses to 911 calls that have to do with substance abuse, mental...
health crises or people who just need help connecting to services. A grant from the Caring 4 Denver fund (http://caringfordenver.org/), which voters approved in 2019, has given STAR at least six months to prove it can be effective.

STAR is one way to “dismantle policing,” Bliss says, an idea that’s become talked about widely and loudly during protests reacting to the killing of George Floyd. The pilot program coincidentally began while massive actions against police brutality entered their fifth consecutive day in Denver.

Bliss and his colleagues began publicly talking about the program — or elements of it, at least — in 2017, including to a then-Denver police commander named Paul Pazen (https://denverite.com/2019/06/10/community-groups-will-begin-taking-on-911-calls-and-low-level-cases-from-the-denver-da/). When Pazen became chief in 2018, he was primed to help get the ball rolling. Last year, Bliss, some fellow activists and a delegation of local lawmakers took a trip to Eugene, Oregon, where a system like STAR has been in operation for more than 30 years (https://whitebirdclinic.org/cahoots/). Bliss believes Denver is the first major city in the nation to copy Eugene’s model, removing police from situations that they themselves could make more dangerous.

The stakes are high, activists say.

If mental health workers had been sent to the motel where Michael Marshall, who had schizophrenia, was accused of trespassing, Bliss believes he could have avoided the Denver jail where he was later killed by sheriff’s deputies (https://www.denverpost.com/2017/11/01/michael-marshall-jail-death-settlement/). Many of the names heard shouted at marches this week — Paul Castaway (https://kdvr.com/news/no-charges-filed-against-officer-in-shooting-death-of-paul-castaway/), Paul Childs (https://www.denverpost.com/2005/06/07/cop-recounts-slaying-of-teen/), Marvin Booker (https://denverite.com/2017/09/28/seven-years-marvin-booker-died-denver-jail-da-beth-mccann-asks-grand-jury-investigate/) — are people who died after contacts with police; Bliss thinks these cases very well could have been diverted to STAR, had it started sooner.

Most 911 calls, he said, stem from deeper issues like a lack of affordable housing or difficulty accessing food or mental health resources. He said American society has passed too many of our problems on to police departments, which are ill-equipped to deal with many non-violent emergencies.

“We can work towards different ways to address our social problems,” Bliss said. “You don’t need armed and badged gunmen.”

That structural racism contributes to crime (https://denverite.com/2020/06/08/montbello-leaders-ready-for-a-potentially-violent-summer-fueled-by-inequality-made-worse-by-the-coronavirus/) has also been
Carleigh Sailon, one of two Mental Health Center of Denver workers who’s been riding around in the van taking calls, said she’s excited to be a part of a creative way to change how the city deals with crises. Helping people, and finding better ways to do it, are what motivates her.

“I’m in this field because social justice is my passion. Bucking systems that have historically not worked is what I decided I wanted to do,” she said, especially “during this time when there’s just so clearly a movement going on, calling for a better response.”

**STAR hit the ground running.**

Sailon and her colleague, Chris Richardson, have been taking turns working the mental health side of STAR since it launched last Monday. Richardson said they’ve been very busy.

“The past three days have been just a blur,” Richardson said. “It’s actually gone incredibly well.”
From 10 a.m. to 6 p.m., Monday through Friday, STAR picks up 911 calls within the downtown “lollipop” area, which is basically a large circle around Civic Center, Capitol Hill and Downtown with a long stem stretching south down Broadway. Bliss said historical 911 call data informed the timing and location choices for this trial period. Richardson said they’ve since added the National Western Center to its service area, since the city set up a makeshift homeless shelter there as it sought to mitigate COVID-19 (https://denverite.com/2020/04/08/just-looking-at-the-national-western-emergency-shelter-puts-denvers-housing-crisis-into-perspective/).

Many of the cases Richardson and Sailon take involve people living in homelessness. Sailon said she helped some people in shelters dealing with suicidal thoughts and people on the street wrestling with substance abuse. Because they’re so deeply involved in the city’s social-work world, she and Richards can use their networks and knowledge of the system to connect people directly with case managers or other resources. They’ll even give people a ride to wherever they need to go.

They can navigate the city’s mental health landscape more quickly than police officers can, Richardson said, while also spending more time to make sure people get what they need.

“We have time on our side to see what’s really going on to make sure that person is connected,” he said. “It’s the idea of being able to provide the right resource at the right time.”

Richardson and Sailon have helped operate the Mental Health Center of Denver’s co-responder program (https://www.colorado.gov/pacific/cdhs/co-responder-programs), which embeds social workers with police officers to help cops navigate tricky situations. STAR goes one step further.
The number of unhoused patients they’ve seen so far is partially influenced by the service area they’re working.

“Policing has always been about keeping down marginalized people, from its origins, and that has included Black folks and other folks not considered ‘white’ and poor people,” Bliss said. “You can’t have racial justice without economic justice.”

The fact that Pazen helped green light the project, Richardson says, shows DPD leadership is committed to morphing the department into a more modern organization.

“I think Denver is doing a lot of steps to change the culture, change their approach,” Richardson said. “They want to move to a 21st-century policing model.”

Bliss hopes STAR can grow, treating the symptoms of systemic problems while the city deals with some root causes.
He’d like to see 15 or 20 vans doing this kind of work across the whole city, each with a different service area that caters to a neighborhood’s specific needs. A van on the west side, for instance, might employ bilingual EMTs and mental health staff.

In the next six months, Richardson and Sailon will work to identify ways in which the program needs to be tweaked, while they, Bliss and other interested parties try to drum up data on how things are going.

Bliss said the next step would involve a request for proposals. He hopes a community organization steps up to own the project for the long haul, like has happened in Eugene, while taxpayer dollars help fund it.

An existing network of street medics and community service providers, like the Denver Alliance for Street Health Response (DASHR), helped advocate for the pilot and are working to make sure it can grow.

In a prepared statement, DASHR’s Vinnie Cervantes said supporters “insist that a program like this must be community-owned and led.”

Many of these people are working on a volunteer basis to make it happen.

Bliss, for instance, has a day job helping run the nonprofit Project VOYCE. He works on STAR, he said, “doing what is right in my copious free time.”

As he thinks about minimizing damage to communities at the hands of police, he’s hoping for some big changes. Not all are new ideas.

“To abolish police we need serious affordable housing. We need food programs,” he said. “We need to address the causes of inequality, poverty and suffering and create ways communities can support themselves in dealing with hard things.”

**Correction: Our original story misspelled Chris Richardson’s last name. We fixed the error.**
**Introduction**

Law enforcement agencies across the country are being challenged by a growing number of calls for service involving people who have mental health needs. Increasingly, officers are called on to be the first—and often the only—responders to calls involving people experiencing a mental health crisis. These calls can be among the most complex and time-consuming for officers to resolve, redirecting them from addressing other public safety concerns and violent crime. They can also draw intense public scrutiny and can be potentially dangerous for officers and people who have mental health needs. When these calls come into 911/ dispatch, the appropriate community-based resources are often lacking to make referrals, and more understanding is needed to relay accurate information to officers. As such, there is increasing urgency to ensure that officers and 911 dispatchers have the training, tools, and support to safely connect people to needed mental health services.1

To respond to these challenges, police departments are increasingly seeking help from the behavioral health system.2 This trend is promising, as historically, law enforcement and the behavioral health system have not always closely collaborated. Absent these collaborations, officers often lack awareness of, or do not know how to access, a community’s array of available services and alternatives to arrest, such as crisis stabilization services, mental health hotlines, and other community-based resources. And even when officers are fully informed, service capacity is typically insufficient to meet the community’s need. As a result, officers experience frustration and trauma as they encounter the same familiar faces over and over again, only to witness the health of these individuals deteriorate over time.

**Police Departments Can’t Do it Alone**

Many communities continue to face pervasive gaps in mental health services, especially crisis services, placing a heavy burden on law enforcement agencies and, in particular, officers. Without access to appropriate alternatives, officers are often left with a set of poor choices: leave people in potentially harmful situations, bring them to hospital emergency departments, or arrest them.

Understanding a need for greater collaboration, many law enforcement and behavioral health agencies have begun taking important steps to improve responses to people who have mental health needs. These efforts have led to improvements in practices, such as providing mental health training to law enforcement workforces and including mental health, crisis intervention, and stabilization training as part of some states’ law enforcement training standards. (Stabilization training refers to tactics used to defuse and minimize any harmful or potentially dangerous behavior an individual might exhibit during a call for service.) Some of these communities also designate officers to serve as part of specialized teams to respond to mental health-related calls for service. But while these steps are commendable and signify widespread...
acknowledgment of the need to improve law enforcement’s responses to people who have mental illnesses, they also underscore the need for more comprehensive, cross-system approaches.

Communities are learning that small-scale or standalone approaches—such as just providing mental health training or having a specialized team that is only available on certain shifts or in certain geographical areas—are not adequate to achieve community-wide and long-lasting impacts. They have also learned that even the most effective law enforcement responses cannot succeed without mental health services that provide immediate crisis stabilization, follow up, and longer-term support. Moreover, when there are limitations in data collection and information sharing, law enforcement leaders have a difficult time understanding whether the investments they have made in training or programs are working, because success is being defined by anecdotes, impressions, or even by the media’s coverage of isolated, high-profile incidents instead of concrete measures and outcomes.

To address these challenges, some law enforcement agencies have invested in comprehensive, agency-wide approaches and partnerships with the behavioral health system. These cross-system approaches, also known as police-mental health collaborations (PMHCs), build on the success of mental health training and specialized teams by layering multiple types of response models—e.g., Crisis Intervention Teams (CIT), co-responders, and mobile crisis intervention teams—and implementing one or more of these models as part of a comprehensive approach to meet their needs. These agencies may also sometimes link their specialized teams to a designated ‘mental health’ officer in every precinct or neighborhood. PMHCs are distinguished by their leaders’ commitment to integrating responses to people who have mental illness into the day-to-day functions of all officers. In PMHCs, law enforcement executives include the initiative in their agency mission instead of just assigning it to the exclusive domain of a specialized unit.

PMHCs feature strong, demonstrated commitment from law enforcement and political leaders; formal partnerships with community-based mental health providers and organizations representing people living with mental illnesses and their families; quality training on mental health and stabilization techniques that is provided to all officers and 911 dispatchers; and written procedures that are clear and adhered to by staff. And communities that create PMHCs are also committed to building an adequate array of community-based services such as short-term crisis stabilization programs, in-home intervention teams, and programs that can provide ongoing and intensive case management to people with complex mental health needs.

**Police-Mental Health Collaboration Toolkit**

For jurisdictions that are seeking to implement a new PMHC, the U.S. Department of Justice’s Bureau of Justice Assistance provides additional background on PMHCs and the different PMHC response models (e.g., co-responder teams) in the *Police Mental Health Collaboration Toolkit*. Visit pmhctoolkit.bja.gov for more information.
Using Data to Inform Success

Critical to the success of these cross-system PMHCs is the establishment of the baseline number of mental health calls for service that the police department is fielding (as a starting point) and other indicators of PMHC effectiveness, and the use of that data to review progress and troubleshoot any challenges. By using data, leaders have the ability to assess the impact of the approach over time and measure its success against the outcomes that matter most. The four key outcomes identified below, together provide a picture of whether or not a PMHC is successful, recognizing that data limitations and local context may necessitate variation in what data communities collect.

- **Increased connections to resources**: Officers in communities that have PMHCs should routinely refer people who have mental health needs to community services, and they should ensure a successful linkage to the behavioral health system. In these communities, 911 dispatchers also play a critical role in collecting mental health information and relaying it to officers prior to their response to a call for service. As a result, successful PMHCs see an increase in the number of people who have mental health needs connected to appropriate services and resources in the community. Greater success in this area is possible to the extent that adequate services are available in the community, 911/ dispatch capacity is increased, and officers are aware of how to refer people to behavioral health services.5

- **Reduced repeat encounters with law enforcement**: A key measure of performance for a PMHC is the number of people who have repeat mental-health related encounters with law enforcement. Ideally, as PMHCs see an increase in their connections to resources and in officer referrals of people to appropriate services, they would likely also see a reduction in the number of repeat encounters because these individuals are provided the care needed to reduce or prevent future crises.7 Thus, effective PMHCs ensure that the number of people who have mental health needs making or generating repeat calls for service is lower than the baseline number established at the start of the PMHC.

- **Minimized arrests**: With an increase in the availability of community resources and services, officers have a greater set of options/primary interventions other than arrest when responding to calls involving people who have mental health needs. Since one of the primary goals of a PMHC is to connect a person to mental health services (especially for low level and nonviolent offenses, like trespassing and vandalism, in which arrest is at the discretion of the officer and the person does not pose a threat to public safety), having more options should ideally result in a lower rate of arrest among people in this population. Additionally, PMHCs are more successful when officers are provided with reliable information about a person’s mental health needs prior to responding to a call. PMHCs should track the full range of disposition outcomes for mental health calls for service to analyze any trends or fluctuations that occur and increase their attention to the rate of these arrests.

- **Reduced use of force in encounters with people who have mental health needs**: A critical measure of performance for a PMHC is the frequency of use of force during encounters with people who have mental health needs. Jurisdictions must determine what constitutes use of force in the context of the PMHC (e.g., use of handcuffs during transport, hands-on maneuvers) so consistent analysis is possible in the future. With training and a comprehensive PMHC in place, police officers are better able to manage encounters with people experiencing a mental health crisis, and force is then proportionate to the situation the officer encounters. It is important to track and analyze this outcome for both mental health calls and non-mental health calls for service.
While law enforcement agencies must partner with the behavioral health system and other community supports to make a PMHC successful, officers and 911 dispatchers are often the first ones interacting with people who have mental health needs, especially during crisis situations. Therefore, the success of a PMHC is largely determined by the level of engagement and commitment of law enforcement executives and the buy-in from their workforce. Thus, this framework’s primary audience is law enforcement executives. It aims to inform and inspire such executives by providing examples of how PMHCs are improving key outcomes in police departments across the country. The framework also provides a list of six questions that law enforcement and political leaders may ask to assess their current responses to people who have mental illnesses and identify steps to improve those responses.

The Six Questions Law Enforcement Leaders Need to Ask to Develop and Sustain a Police-Mental Health Collaboration

Whether they are seeking to either implement a new PMHC or to improve an existing one, law enforcement leaders should consider the following six questions to help determine whether their current responses are comprehensive, identify areas in need of improvement, ensure that they are conducting ongoing quality reviews, and ultimately, whether their PMHCs are resulting in the aforementioned four key outcomes. Albeit not a step-by-step guide, by answering these six questions, law enforcement executives can work with their behavioral health counterparts to assess their community resources and better understand what necessary additions and changes are needed. The questions, then, are also designed to assist these leaders in executing changes to produce measurable progress in reducing the number of people who have mental illnesses in their communities who come into contact with law enforcement.

1. Is our leadership committed?

2. Do we have clear policies and procedures to respond to people who have mental health needs?

3. Do we provide staff with quality mental health and stabilization training?

4. Does the community have a full array of mental health services and supports for people who have mental health needs?

5. Do we collect and analyze data to measure the PMHC against the four key outcomes?

6. Do we have a formal and ongoing process for reviewing and improving performance?

Many agencies can likely provide excellent examples of what successfully addressing one or more of these questions looks like, but only a small number of jurisdictions to date have sufficient answers to all of the questions above. If law enforcement executives thoughtfully consider each question, and regularly revisit them, they will be able to determine whether and to what extent their efforts are having a community-wide impact and are built for long-lasting success.
Is Our Leadership Committed?

Are law enforcement and behavioral health executives fully invested in implementing and sustaining a PMHC? Have leaders publicly indicated that effectively responding to people who have mental health needs is essential to the law enforcement agency’s mission? Are there champions within the agency that are empowered to develop, implement, and improve the collaboration? Are staff recognized and rewarded for engaging in day-to-day behavior that supports the goals of the PMHC?

Why it matters

PMHCs have real-world implications. They can help communities address challenges like the toll that repeated arrests and police encounters take on people who have mental health needs. They can also help ensure officer well-being and allow officers to focus on public safety and addressing violent crime. These collaborations often rely on the strength and vision of law enforcement executives (and their behavioral health counterparts) to convey the importance of the PMHC and to lead by example. Law enforcement leaders who demonstrate their commitment to the PMHC through concrete action (such as developing new policies and procedures and rewarding staff who consistently act in support of the goals of the PMHC) find that their officers are more likely to share in the vision. When these leaders become more invested in the collaboration, communicate its importance to all staff, provide incentives for involvement, and incorporate the goals of the PMHC throughout the agency, a trickle-down effect often occurs and more support and buy-in from staff follows. With this buy-in and support, the goals of the PMHC are part of the fabric of everyday policing.

What it looks like

- **Law enforcement leadership support:** The top law enforcement executive sets the tone in the agency for the collaboration and is most critical to its success. The executive is the highest-level leader to serve as the “champion,” has the power to reach out to jurisdictional leadership for support (e.g., commissioners, mayors, and legislative bodies), and provides direction to administrators and managers to secure agency-wide commitment. These leaders reach across systems to develop relationships with executives in the behavioral health system to get buy-in for the collaboration, promote the initiatives to the public and internally in their agencies, and coordinate efforts with advocacy organizations.

- **Partnership with community champions:** In addition to developing strong partnerships with behavioral health, law enforcement also engages local community organizations and advocacy groups that represent consumers of mental health services and people with lived experience and their family members. Community champions engender support and buy-in from local agencies, bringing partners together that might not otherwise have a strong record of collaboration. With firsthand knowledge of how to navigate the behavioral health system, these groups are also able to assist in the PMHC planning process by contributing feedback on developing policies and procedures and building the core components of the PMHC. Advocacy groups are able to mobilize their constituencies to convince legislators and other key stakeholders to help fund PMHC response models and initiatives. They are also instrumental in marketing the initiatives to the community, which helps strengthen law enforcement’s community ties.

- **Interagency workgroup:** A formal interagency workgroup (including law enforcement, behavioral health, and government and community-based organizations) plays a vital role in bringing the partner agencies together to regularly plan, implement, and assess the success of the PMHC. An effective workgroup is reflective of the community’s demographic composition (e.g., racially and economically) and includes members from not just law enforcement and behavioral health, but also local advisory groups, criminal justice coordinating councils, public safety answering points (e.g., 911 dispatchers), hospitals, courts, and corrections, as well as people who have mental illnesses, family members, and other advocates who have a stake in the success of the collaboration. Memorandums of understanding (MOUs)
are created to outline the responsibilities of the partners in the interagency workgroup, such as how often meetings will occur, which staff member(s) will attend, members’ responsibilities to subcommittees, funding, and other agency commitments. Workgroup members ensure that their participating agencies are promoting the PMHC and its milestones for success within their agencies, and help to assess progress toward agreed upon goals, recommending changes to address challenges when necessary.

✓ **Designated chairperson and project coordinator to oversee the PMHC:** The law enforcement executive establishes the interagency workgroup, which appoints a chairperson from the law enforcement agency or behavioral health system. The chairperson oversees the implementation of the PMHC community wide and ensures all efforts and response models adopted fit together to achieve the PMHC’s goals. A coordinator is also designated who is given authority (as clearly represented in the agencies’ organizational charts) and has demonstrated a commitment to the PMHC. The coordinator is selected to oversee the day-to-day operations of the PMHC and report back to the chairperson of the interagency workgroup on the overall implementation and success of the initiative. The coordinator will regularly evaluate the collaboration (e.g., review data on performance and adherence to policies and procedures) to ensure operations are in line with the PMHC’s mission, as well as coordinate outreach and engagement with other partners. The coordinator also organizes subcommittees, facilitates planning meetings, builds agendas, and makes recommendations to the interagency workgroup.

✓ **Funding and resource allocation:** Local leadership (including elected officials) designate funds for the collaboration (e.g., funding specialized training and education, authorizing funds to pay for overtime, and allocating funds for PMHC resources, such as vehicles and office space). The financial investment can vary (e.g., funding a part-time case manager position four hours a week), but designating funds and resources to support the PMHC demonstrates to staff that the collaboration is an agency and community priority worthy of financial investment. Longer-term funding efforts are driven by performance data and other needs assessments.

✓ **Ongoing internal and external recognition of the initiative:** Law enforcement leaders help to affect a cultural shift by modifying officers’ performance evaluations to include the goals of the collaboration, publicly recognizing staff who employ skills to defuse situations, developing commendations or other awards for exemplary staff, and recognizing police and supervisors who volunteer for PMHC positions. These leaders also make it clear that the initiative is part of the overall mission of the department to combat any bias or stigma that staff might hold about collaborating with behavioral health not being true police work.
IN PRACTICE | Effective Leadership in Action, Portland, ME

The Portland Police Department (PPD) implemented their PMHC out of a proactive effort by their leadership, a core collaborative workgroup, and a fully invested department to improve their responses to people who have mental illnesses. The commitment from leadership drove a shift in culture in the department that began in the 1990s, with officers slowly, then enthusiastically, embracing new models and interventions such as CIT training and a mental health liaison program, as well as a year-long internship program for Master’s level students to assist in responding to calls for service with officers.

In place now is a robust program that includes a full-time behavioral health coordinator, mental health liaison, and substance use liaison. Additionally, 100 percent of the officers on the force are mandated to complete CIT training, dispatchers receive training on how best to respond to people who have mental health needs, and PPD has implemented a mental health liaison internship program.

Since the start of these efforts, the police chief and other leaders have been able to secure continued funding from the city’s operating budget to ensure the behavioral health coordinator was expanded to a full-time position. The chief was also able to secure additional funding from a local nonprofit provider to continue the mental health liaison position, as well as secure a commitment from the department to direct funding from the drug forfeiture program to support a full-time substance use liaison.

The behavioral health coordinator role is integral to the day-to-day operations of Portland’s PMHC, managing the mental health liaison and co-responder program and facilitating officer training. The coordinator also oversees a robust working group, the Cumberland County Crisis Providers Meeting, which includes people from the emergency departments, inpatient facilities, substance addiction and mental health partners, shelters, and other community organizations. This group, which has convened for more than 10 years, provides an opportunity for community leaders to come together to discuss the PMHC, strengthen their collaboration, and discuss changes the agencies might be seeing in their staffing or services. A universal release of information developed for all the providers in attendance allows them to discuss clients they have in common. The workgroup members use these meetings to discuss issues that may arise with these individuals, which allows the behavioral health coordinator and mental health liaison opportunities to form relationships with the provider organizations in attendance and better connect their clients to services in the community.
Does the law enforcement agency have documented policies and procedures for how to respond to people who are experiencing a mental health crisis? Do these policies and procedures account for the jurisdiction’s PMHC response models and for each instance in which law enforcement interacts with people who have mental health needs (e.g., dispatch, at the scene, and follow-up)? Do staff have a clear understanding of these policies and procedures and their roles in executing them?

Why it matters

Written policies and procedures that are communicated clearly to staff are critical to the overall success of a PMHC and empower officers to take actions that can enhance their safety and the safety of others. When policies are in place for each type of instance where officers interact with people who have mental health needs, officers are equipped with the knowledge to consistently respond to common events. Combined with skill enhancement and training, clear policies also reduce overall risk for the department. The PMHC will only realize success, and policies and procedures will only be effective, when these policies and procedures are disseminated, followed, and enforced by leaders in both the law enforcement and behavioral health agencies.

What it looks like

✓ Comprehensive process review: Prior to the creation of any new policies or procedures, the law enforcement agency conducts a comprehensive process review of current policies and procedures for encounters with people who have mental health needs. This process review allows the agency to see how people who have mental health needs flow through the criminal justice system and the ways in which police officers regularly interact with them. With proper planning and analysis, the agency can address the full range of issues that officers encounter and reduce opportunities for ambiguous responses during an encounter or call for service. A useful end product of this review is a process flow chart that provides staff with a visual depiction of how people who have mental health needs flow through the criminal justice system. It can also show all potential dispatch and disposition outcomes to help ensure that the policies and procedures account for all possible scenarios and outcomes.

✓ Selected PMHC response models: Based on assessed community needs, law enforcement and behavioral health system partners select a primary intervention or a combination of approaches that their jurisdiction will adopt. The goals of these response models are then integrated into the agencies’ missions and community-wide initiatives. The interagency workgroup starts the process of building new policies and procedures for each response model chosen. People who have mental illnesses, their family members, and advocacy organizations who represent them are involved in the conversations that determine which PMHC response model(s) are selected.

✓ Comprehensive, clearly written policies and procedures: The law enforcement agency has written policies and procedures in place that have been provided to staff, have a clear purpose, and illustrate to supervisors what steps they should take to implement them. These policies and procedures outline roles and responsibilities of all agency staff members, define frequently used terms, give specific response guidelines for scenarios that officers and staff frequently encounter, and are mindful of officer safety and the potential volatility of encounters. When writing their policies and procedures, law enforcement consults with their behavioral health system counterparts and advocacy organizations to ensure they are appropriate from the behavioral health perspective and from that of people who have mental illnesses. Law enforcement also acts as a resource for the behavioral health system as it creates policies and procedures to ensure they align with officers’ needs, culture, and the community’s perspective.

✓ Information-sharing agreements: These agreements establish what information can be shared among the partners...
During an encounter (such as physician information, diagnoses, or recent hospitalizations) and give law enforcement and mental health staff the ability to identify a shared population of people who have mental health needs. The interagency workgroup aids in the development of these agreements and facilitates conversations among relevant partners, better equipping officers, dispatchers, and others to stabilize an encounter with a person who has mental health needs. This information also enables law enforcement staff to connect people to needed services and supports, reduce potential injuries to officers and people who have mental health needs, and arrive at the best disposition. In addition to agreements involving medical and protected health information, the interagency workgroup also develops a data-sharing agreement(s).

- **Staff awareness of policies and procedures:** Written policies and procedures are posted and circulated to all staff of the partnering agencies, and supervisors are held accountable for ensuring that their staff understand each new policy or procedure and have received training on how to employ them. These policies and procedures are transparent and posted online for the public to view. Staff are notified when changes to the policies or procedures take place.

- **Regular review of policies and procedures:** Law enforcement and behavioral health system leaders assess whether established policies and procedures are being followed. In conjunction with the project coordinator, the interagency workgroup conducts regular reviews of the policies and corresponding procedures and ensures that they are being communicated to all supervisors (and their direct reports). Mechanisms are also in place to make sure that these policies and procedures are meeting the needs of the community, and that the community has an opportunity to offer feedback. Periodically, the interagency workgroup revisits all policies and procedures, analyzes them against any internal or community feedback, and makes recommendations for needed changes.

### Types of PMHC Response Models

PMHC response models are the cornerstone for comprehensive, cross-system responses to people who have mental health needs. The leadership team must select the model(s) most appropriate to address the community’s needs. These models are not mutually exclusive, and, depending on their contexts and needs, jurisdictions often adopt and layer multiple response models with comprehensive training and data-driven management to build a comprehensive initiative. For additional information, support, and resources on these models, visit the Bureau of Justice Assistance’s PMHC Toolkit, [pmhc Toolkit.bja.gov](http://pmhc Toolkit.bja.gov). Below are four of the most common PMHC response models.

**Crisis Intervention Teams (CIT):** These widespread, specialized teams are composed of officers who receive specialized training to respond to mental health calls. CIT officers are dispatched to mental health calls or assist officers who are not CIT trained.²⁰

**Co-responder Team:** Specially trained officers and a mental health crisis worker respond together to address mental health calls. Most commonly, they ride in the same vehicle for an entire shift, but in some agencies, the crisis worker meets officers at the scene, and they handle the call together once the crisis worker arrives.

**Mobile Crisis Team:** A team of mental health professionals, skilled at helping stabilize people during law enforcement encounters as well as general crisis, available to law enforcement and the community. These teams are available to respond to calls for service with the goal of diverting people from unnecessary jail bookings and/or emergency room visits.

**Case Management Team:** A team of behavioral health professionals (with or without officers) and peers that provide outreach, follow up, and ongoing case management to select priority people, such as repeat callers of emergency services. Officers do not treat or diagnose the individuals but work with mental health professionals to develop solutions to reduce repeat interactions. Case management is often used as a proactive response in addition to other selected PMHC response models.
IN PRACTICE | Building a New Program with Clearly Defined Policies and Procedures: 911 Crisis Call Diversion Program, Houston, TX

The Houston Police Department (HPD) Mental Health Division (MHD), in partnership with The Harris Center for Mental Health and Intellectual and Developmental Disabilities (the Harris Center), operates a multi-faceted, successful PMHC to respond to people in mental health crisis. Houston’s PMHC response models and initiatives include: a CIT training program for all cadets, co-responder and homeless outreach teams, and a chronic consumer stabilization unit. While already using a comprehensive approach, HPD’s coordination with the Harris Center helps them to regularly assess their models and initiatives and make changes as needed.

In 2015, the MHD identified a new and innovative opportunity to help people in mental health crisis while relieving financial strain on both the criminal justice and behavioral health systems. This early intervention program, called the 911 Crisis Call Diversion (CCD) program, places mental health phone counselors inside Houston’s Emergency Communications Center to work directly with 911 call takers and dispatchers to identify and divert callers with non-emergency mental health concerns away from police or fire/EMS.

To develop this new program, the Houston PMHC first created a response logic tree (or process map) to define when 911 operators could determine that a call was eligible for mental health counselors to intervene and establish how they should respond while accounting for a variety of possible scenarios. HPD and the Harris Center then developed operational guidelines and protocols and rolled them out during a six-month pilot period to ensure they were appropriate for the new program.

During this pilot period, they were able to establish with a great amount of certainty what a majority of their calls would look like, what phone counselors should expect when on a call, and what to do in specific scenarios. Based on these experiences, they also learned that while they were expecting the CCD program to save money and time for the police and fire departments, they could also use it to make more appropriate referrals in the community.

After one full year of implementation, with clearly developed policies and procedures in place, the CCD program has seen significant change in how calls are handled. In one quarter of operation, they were able to divert both the fire/EMS and police from the scene for more than half of calls received. In a short period of time, the unit has shown how important it is to the overall functioning of the department and how resources have been saved as a result.
3 Do We Provide Staff with Quality Mental Health and Stabilization Training?

Is basic mental health awareness and stabilization training provided to all law enforcement employees at all staffing levels—recruit, in-service, and specialized? Is this training offered in coordination with mental health partners? Are the voices of people who are living with mental illnesses and their families incorporated into the training?

Why it matters

Learning how to defuse situations is foundational to the goals of all PMHCs and helps officers better recognize and address the behaviors they encounter in many mental health calls for service. When officers receive high-quality mental health and stabilization training, they are better prepared to use techniques to stabilize and defuse encounters when responding to people who have mental health needs. While training alone does not ensure an improved response to people who have mental health needs, it is essential to equip officers, supervisors, 911 dispatchers, and mental health staff with the knowledge and support they need to take actions that are grounded in current research and practices. Such training promotes the safety of officers and all involved.

What it looks like

✓ Knowledge and skills training for all staff: Mental health and stabilization training occurs for all agency staff at the beginning of their tenure with the agency and then continually throughout their service to make sure their skills reflect any changes in systems, policies, or evidence-based practices. The knowledge and skills-based training that a jurisdiction includes in its training curriculum varies depending on the needs of the particular jurisdiction, staffing structure, and culture, but at a minimum the law enforcement workforce receives training on basic mental health awareness, recognizing the signs and symptoms of mental illness, and how to manage a person in crisis. Table 1 below provides a list of common basic PMHC training topics.

<table>
<thead>
<tr>
<th>TABLE 1. BASIC PMHC TRAINING TOPICS</th>
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<tr>
<td><strong>Overview of Mental Illness and Wellness</strong></td>
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<tr>
<td>Compassion Fatigue/Vicarious Trauma and Officer Selfcare</td>
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<tr>
<td>Cultural Sensitivity</td>
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<tr>
<td>Disorders in Children—Autism and Developmental Disorders and Disruptive, Impulse-Control, and Conduct Disorders</td>
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<tr>
<td>Gender Sensitive Responses</td>
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<tr>
<td>Identifying Signs, Symptoms, and Behaviors of Mental Illness</td>
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<tr>
<td>Stigma</td>
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<tr>
<td>Substance-Related, Co-Occurring Mental Health and Addictive Disorders</td>
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<tr>
<td>Suicide Intervention and Non-Suicidal Self Injury</td>
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Training aligned with staff roles and experiences: Training is consistent with staff roles, level of engagement, and interest in selected PMHC response models, as well as skill set and expertise. Topics and skills vary depending on the type of training delivered; for example, a CIT training takes a deeper dive into subject matter than training included as part of an academy for new recruits. Skills topics needed for officers may also be different than training needed for 911 dispatchers. Leadership develops tailored training curriculum to equip staff for their jobs, particularly for specialized units or positions in the department. Table 2 lists advanced topics that are typically included in trainings for specialized teams or officers that play a particular role in a PMHC response model.

<table>
<thead>
<tr>
<th>TABLE 2. ADVANCED PMHC TRAINING TOPICS 15</th>
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<tbody>
<tr>
<td>Assessment, Commitment, and Legal Considerations</td>
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<tr>
<td>Data Collection and Demonstrating Program Success</td>
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<tr>
<td>Guardianship, Power of Attorney, and Issues of Aging</td>
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<tr>
<td>Information Sharing across Law Enforcement and Mental Health</td>
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<tr>
<td>I/DD and Neurodevelopmental/Neurocognitive Disorders—Adults</td>
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<tr>
<td>Mood, Psychotic, and Personality Disorders</td>
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<tr>
<td>Motivational Interviewing</td>
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<tr>
<td>Post Incident Debrief and Departmental Support</td>
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<tr>
<td>Procedural Justice, Fairness, and Bias</td>
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</tbody>
</table>
✓ **Training instruction and delivery:** Regardless of the curricula chosen, content is taught by law enforcement and mental health provider instructors, subject experts, and others with first-hand knowledge, like people who have mental illnesses and their family members, as appropriate. Trainings taught by people with lived experience and their family members give officers the opportunity to informally interact with people who have mental health needs and their families in a non-crisis setting. The delivery of training comes in both experiential and hands-on opportunities if possible, but also in lecture-style presentations, simulations and/or virtual training, scenario-based role playing, group problem-solving exercises, site visits to mental health facilities, and ride-alongs so that coursework is varied and accessible to people who have different learning styles. Refresher training is provided periodically.

✓ **Evaluation of training:** Trainings are regularly evaluated to assess their overall quality and impact. A review process ensures that the curriculum is meeting its intended purpose of preparing law enforcement staff to more effectively respond to mental health calls and defuse these encounters. Pre- and post-testing of the training participants ensure that participants have developed new or enhanced existing skills and knowledge as a result of the training. Evaluations are reviewed, and modifications to the training curriculum are made based upon the findings. There is also a process for the interagency workgroup to periodically review the curriculum and assess the need for changes based on community needs or crime trends. Using results from these training evaluations, supervisors assess how well staff understand the training content and use it in their day-to-day activities.
IN PRACTICE | Using Coordinating Councils to Promote Training Across the State: State of Missouri

In partnership with their mental health providers, law enforcement leaders in Missouri developed a successful multi-pronged approach to training officers using a statewide CIT curriculum that every local jurisdiction could adapt. The training includes a core 32-hour base curriculum covering 19 mandatory topics, but each jurisdiction can customize their remaining 8 hours of training (selecting from more than 23 electives). Elective topics cover areas such as homelessness, trauma, officer suicide, and “suicide-by-cop” prevention.

As with many states, Missouri officials determined that while some of their larger cities like St. Louis had the resources and funding to implement the training, other smaller suburban and rural locales did not. To address this challenge, officials allowed some of the smaller jurisdictions to send an officer to larger jurisdictions offering the training once a week for five weeks to complete CIT training.16

Most importantly, Missouri officials leveraged a network of coordinating councils to customize the curriculum and training approach based on local needs. Each council covers a geographic area comprised of local law enforcement agencies and community and state-based organizations. The councils meet at least quarterly to develop local training schedules, adapt the state’s CIT curriculum to meet their local needs, determine which electives from the state curriculum they will adopt, and develop relationships with providers and individuals to deliver core components of the curriculum. The state also hosts a CIT conference bringing together members from all of the coordinating councils each year. During these events, members vote on what topics to include or modify in the state’s CIT curriculum and receive additional professional development.

The state also provides ongoing mentoring and specialized training through a network of 31 mental health professionals called community mental health liaisons who are available to every law enforcement department in Missouri. Similar to a traditional co-responder team, these liaisons respond to calls and provide training on complex cases to jurisdictions and individual officers that may otherwise not have access to more advanced training.
4 Does the Community have a Full Array of Mental Health Services and Supports for People Who Have Mental Health Needs?

Does an array of mental health and community services exist for people who are experiencing a mental health crisis? Are the services regularly utilized by the PMHC partners? How often are these services available when law enforcement encounters a person in need of them? Have the PMHC partners worked together to leverage additional funding to address gaps in service capacity?

Why it matters

Law enforcement officers can more effectively respond to people who have mental health needs and connect them with appropriate community supports when a full range of mental health and community services is available. Officer awareness of these services further expands the disposition options available to them, reducing the need to arrest as the only option for these encounters. These connections can provide opportunities for long-term treatment. And when long-term treatment options are available, officers are better able to connect people who have more complex needs to these supports in an effort to reduce future encounters and arrests. While intended to be a seamless continuum of services, in practice, law enforcement only controls a subset of these services, namely the PMHC response models (e.g. CIT or co-responder teams). In collaboration with the behavioral health system, law enforcement can help to ensure that the full array of service options (e.g. mobile crisis, crisis stabilization facilities, etc.) is available and that officers are aware of how and when to use them. When law enforcement helps identify missing services and their behavioral health counterparts prioritize existing resources in support of the PMHC, the behavioral health system also benefits. Together, these systems can make a strong, data-driven argument to elected officials for more funding to increase service capacity.

What it looks like

✓ Inventory of existing services: Law enforcement leaders partner with their behavioral health counterparts and other community organizations to inventory services in the community. Services appropriate for this inventory include those that address crises (e.g., diversion or crisis facilities, single-point of access facilities, shelters, and detox/rehabs) and longer-term services to reduce repeat encounters (e.g., Assisted Outpatient Treatment, Assertive Community Treatment, outpatient treatment, and housing programs and services). This inventory helps partners identify if there are major gaps in the array of service options for this population, how they can access these services, and eligibility restrictions, such as insurance limitations, diagnostic criteria, or other thresholds. One of the more common techniques used to develop this inventory, or system map, is Sequential Intercept Mapping. In addition to helping promote collaboration and partnership between the criminal justice and mental health partners involved, the mapping helps identify diversion opportunities and resources for people who have mental health needs. For instance, the inventory could reveal that there are crisis services but that the community lacks long-term interventions. Once the interagency workgroup reviews the inventory, it is better positioned to identify services to fill those gaps and determine if additional PMHC response models or services are needed in the community.

✓ Assessment of program and service capacity: The interagency workgroup determines whether the existing services and programs are operating at the scale required to meet the needs of the community. This assessment is strengthened when it is informed by data collected on the utilization rates for all existing services and patterns of instances in which a given service is requested but not available. A designated individual or subcommittee is identified to oversee the data collection process and works in tandem with the interagency workgroup to assess the PMHC’s resource capacity and compare it to the volume of what is actually needed on an ongoing basis. This assessment examines which resources may be underutilized due to lack of awareness, over-subscribed because there are more people eligible than spaces available, and which services may not align with what the community needs.
Prioritized behavioral health resources and increased funding: Law enforcement and behavioral health agencies partner to prioritize available services for people who have mental health needs. The interagency workgroup supports these efforts by examining the data and pointing to areas in need of additional service capacity. Law enforcement leaders aid their behavioral health partners in seeking support and buy-in from elected officials by combining their data and showing a specific, quantified need for additional services. Advocacy groups also help to rally support (and members) around these initiatives to bring additional legislative buy-in and potential funding.

IN PRACTICE | The Evolving PMHC: A Data-Informed Approach to Assessing Services and Improving Responses in Tucson, AZ

Since 2000, the Tucson Police Department (TPD) has been working to effectively respond to people in mental health crisis. While they initially began their efforts by employing only acute crisis mobile teams (CMT), TPD’s use of data led them to identify limitations in using just one response model and a need for a more comprehensive PMHC to better respond to this population. For instance, while officers appreciated having access to trained clinicians to help them divert people to behavioral health services, they also expressed concern about how long it took the clinicians to respond—sometimes up to an hour after the officer arrived on scene. Also, TPD determined that the local hospital was unable to keep up with the demand for stabilization services for people in crisis.

Equipped with the number of mental health calls they received per month, the estimated time it took to respond to these calls, the number of mental health and law enforcement staff deployed in the CMTs, and other relevant data, TPD’s Mental Health Investigative Support Team (MHST)—a specially trained unit of the TPD that serves as a mental health resource for other officers—community members, and health care providers identified the need for adding a co-responder team to their resources to address the needs of the community.

To create the co-responder team, they suggested the following: (1) change the staffing of the CMT to one clinician instead of two, and deploy the second clinician to the new co-responder team with an officer, thereby cutting down wait times officers were experiencing (as this would be a direct police resource); and (2) change the new team’s primary focus to answering 911 calls, while the CMT would focus on proactive community outreach and engagement.

MHST presented the plan to TPD and the Pima County Regional Behavioral Health Authority leadership and emphasized the cost savings both partners would realize if a co-responder model was implemented in addition to the CMTs. The plan would also benefit the local hospitals by decreasing crisis placements and promoting stabilization for people in crisis or who have mental health needs.

With these changes approved and implemented, TPD has been able to develop a more comprehensive partnership between law enforcement and the behavioral health system. Instead of standalone programs working in silos, system partners now work in collaboration and have utilized their resources to reduce wait times, more efficiently staff both the CMTs and co-responder teams, and link more people to services. The CMTs and the co-responder teams have been able to take full advantage of the city’s 24-hour crisis center, which opened in 2011 as an initial attempt to help stabilize people in crisis. Law enforcement has also seen a reduction in wait times due to the implementation of the co-responder team; and the co-responder team has helped MHST tailor their case management approach to focus on involuntary commitments, linking these individuals to services before they are in crisis, and significantly decreasing the number of involuntary commitment orders.
Do we collect data to measure our success against the key outcomes of a PMHC, such as the four outlined in the introduction of this framework? Is the data regularly reviewed? Do we assess performance against established goals? Is there a dedicated person responsible for leading the data collection efforts? Are staff assigned to review the data and generate reports?

**Why it matters**

Data collection and analysis gives leaders in the law enforcement and behavioral health systems the ability to gauge the effectiveness of their responses to people who have mental health needs. It also arms them with concrete data to present to local officials and the public at large to garner buy-in and support for the PMHC. Establishing baselines or benchmarks early on is important to ensure PMHC progress can be tracked over time. For example, if the jurisdiction determines how many people who have mental health needs come into contact with law enforcement officers prior to the start of the PMHC, they can see progress on this outcome the following year. Additionally, leaders can use data to determine whether current efforts and procedures need modification or improvement, and if there are any gaps in community-based mental health services. Law enforcement leaders may also use data to identify high-need populations that may require a more targeted approach. Data also helps law enforcement leaders place individual instances or cases in context—as exemplary situations, typical examples, or extreme outliers—so that response models can address the typical encounters, rather than respond to rare cases. Critical to this work is the sharing of data across systems; PMHC partners can see which clients they have in common and measure service utilization and dispositions.

**What it looks like**

✓ Tracking of specific metrics: Jurisdictions establish clear guidelines about what information should be collected and tracked. During planning, all partners working on the PMHC day-to-day (e.g., call takers and dispatchers, officers on the scene) agree on the definition of a “mental health call for service” to establish the level of need in the community. The tracking system also supports changing or re-coding a call based on information learned on the scene. Communities also establish the key indicators of success for the PMHC that measure progress on the four key outcomes. Table 3 provides examples of the types of data agencies can consider measuring to track the PMHC’s success against the four key outcomes.

<table>
<thead>
<tr>
<th>TABLE 3. EXAMPLES OF PMHC DATA TO COLLECT TO MEASURE SUCCESS</th>
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</thead>
<tbody>
<tr>
<td><strong>Level of Need</strong></td>
</tr>
<tr>
<td>Number of calls for service involving people who have mental health needs</td>
</tr>
<tr>
<td><strong>Minimized Arrests</strong></td>
</tr>
<tr>
<td>Number of arrests involving people who have mental health needs</td>
</tr>
<tr>
<td>Number of people who have mental health needs who have &gt;1 arrest in last 12 months</td>
</tr>
<tr>
<td>Disposition/Resolution of Call (e.g., arrest, resolved at scene, transported for voluntary evaluation, detained for involuntary evaluation, referral to mental health treatment)</td>
</tr>
<tr>
<td><strong>Reduced Repeat Encounters</strong></td>
</tr>
<tr>
<td>Number of repeat calls to the same location</td>
</tr>
</tbody>
</table>
Reduced Use of Force

| Number of encounters with people who have mental health needs where force was used |
| Type of force used by officers during encounters with people who have mental health needs |
| Injuries to officers during encounters with people who have mental health needs |

Administrative and Process Outcomes

| Number of officers receiving mental health and stabilization training |
| Number of officers trained in selected PMHC response models |
| Percentage of shifts covered by trained officers |
| Percentage of dispatchers trained on PMHC response models |
| Number of mental health-related calls receiving a response by a trained officer |

✓ Establish baseline data: The PMHC establishes baseline data on the number of mental health calls for service and on the key outcomes. This baseline data is used as a comparison point at regular intervals to assess the PMHC’s progress.

✓ Process for ongoing data collection and tracking: The interagency workgroup takes steps to develop data collection policies and procedures. In addition, the workgroup appoints a subcommittee or staff person to be responsible for collecting and analyzing the available data and producing reports for review by the workgroup.

✓ Process for identifying individuals with frequent arrests and repeat encounters: The interagency work group defines what constitutes “frequent” or “repeat.” Arrest record data and mental health calls for service are disaggregated and examined at the individual level to identify people that both the law enforcement agency and the behavioral health partners frequently see. Since a small number of individuals often account for a large portion of arrests and encounters, the workgroup regularly identifies these individuals and crafts targeted responses for how law enforcement and other PMHC partners should handle their cases. The workgroup explores proactive case management and follow up as a strategy to prevent repeat encounters.

✓ Data-sharing agreements: In addition to coordinating data collection, the interagency workgroup develops mechanisms for how the partner agencies share data. These written formal agreements go beyond what information is shared on the scene between officers and mental health professionals to facilitate PMHC performance assessment. For example, these data-sharing agreements answer questions such as what data points will be shared, who is collecting this information, how it will be accessed (e.g., through a simple file exchange between agencies, in a password protected drive, etc.) and the frequency for sharing datasets. Jurisdictions follow federal, state, and local statutes on information that may be shared among agencies.

✓ Data management system: The law enforcement agency has a mechanism to track its data, such as a dedicated database or fields created in a computer aided dispatch system. The information system has the capability of tracking PMHC’s success rates against the four key outcomes and other key indicators identified by the interagency workgroup. This data collection method or database can be queried, allowing for reports to be generated by dedicated staff members. It also allows for the matching of data among agencies and systems to identify shared clients and to examine their service usage and outcomes.
In Practice | Weaving Data Collection Practices into Daily Program Operations, Los Angeles Police Department, CA

For the Los Angeles Police Department (LAPD) and its Mental Evaluation Unit (MEU), data collection is the foundation supporting the full range of PMHC response models and initiatives they have implemented. Started in 1993, LAPD’s Systemwide Mental Assessment Response Teams (SMART) was one of the first police-mental health co-responder programs to link people in crisis to appropriate mental health services and contribute to the core data collection practices that the department has implemented.

The success of this program rests in how officers are trained to collect and capture data when they respond to a call for service and how that data is then used to inform the rest of the department and MEU. All 110 MEU officers and 50 mental health clinicians receive 40 hours of training to ensure that calls involving people who have mental health needs are properly categorized, dispatched, and managed. The MEU Operations Guide is distributed to all 160 personnel assigned, providing them with a core understanding of the mission and operation. The MEU’s Triage Desk collects data on all law enforcement contacts with people in mental health crisis, providing guidance and call management. These contacts, including the circumstances of the call and disposition, are documented in a Mental Evaluation Incident Report (MEIR). The MEIR is a structured behavioral health screening tool, data collection instrument, and report that captures information such as a person’s behavior, thought processing, family and personal relationships, religious affiliations, and medication usage. SMART team officers not only respond to field calls but staff the triage desk during assigned times throughout the year (e.g. for a month) to ensure that officers are familiar with what happens during the call taker process.

The department collects data that is used to inform the changes necessary to improve the daily operations of their PMHC. The data collected by the triage desk, for example, is available to staff and leadership at all levels to determine if changes need to be made to the mental health training curriculum that the department provides, an increase in staff during certain shifts is needed, or if different content should be collected in the triage desk assessments. Data is available “real time” to any officer in the MEU to help manage a call or analyze crime trends, and weekly reports are generated to provide the assistant chief with data analysis on the number of calls the unit is handling, types of calls, location, and how they are resolved, among other things. Additionally, dedicated data analysts present data to the chief during monthly COMPSTAT meetings to inform how the MEU is operating overall, based on set performance metrics and if there are any trends that would inform staffing or other resource allocations. Every three months, data is also presented to the Mental Health Crisis Response Program Advisory Board to inform them of how the partnership is operating, with information regarding whether a specific hospital or crisis center has seen an increase or decrease in referrals, if there are more calls from a particular community, or an increase in certain behaviors such as overdoses.
6 Do We Have a Formal and Ongoing Process for Reviewing and Improving Performance?

Has the interagency workgroup appointed a person or subcommittee to report to leaders on the progress of the PMHC? How are leaders staying informed of overall progress toward the stated outcome goals? Is there a process in place to adapt policies and procedures when performance reviews show a need for improvement? Is there a plan to ensure the sustainability of the PMHC?

Why it matters

Regular, data-driven assessment of the PMHC is critical to ensure the collaboration achieves its goals. When law enforcement leaders and their behavioral health partners use data to review the PMHC’s performance, it gives them the ability to determine if expansions to the collaboration’s capacity are needed, with the decision based on data rather than anecdotal information. A thorough review of the data gives executives and other leaders the ability to address issues they might not have otherwise discovered. Sharing information about the PMHC’s progress and impact is essential for buy-in, sustainability, and growth. The PMHC data analyses should be used to update leaders and to inform budget decisions and recommendations for PMHC refinements. This review process must be transparent to the interagency workgroup, staff in both agencies, and the results should be shared with the public. When these processes are in place, the agency can show short-term success (e.g., the implementation of new policies or evidence-based practices) and/or long-term achievements (e.g., minimizing arrests of people with mental health needs) to secure internal and external support. This continuous monitoring of PMHC performance metrics provides leaders with the justification necessary to make the case for expanding services and securing additional funding, which aid sustainability efforts.

What it looks like

✓ Routine data-driven performance assessments: The collaboration is periodically assessed based on its progress in achieving the four key outcomes described in the introduction and any other agreed upon outcomes. The achievement of short-term, more immediate accomplishments such as the implementation of new procedures, policies, or practices is included in regular reports to the interagency workgroup. Community advocacy organizations representing people with lived experience, along with their family members and peers, are provided information from these regular assessments and reports and given an opportunity to provide feedback.

✓ Results-based refinements to policies and procedures: Data on the agreed-upon measures is analyzed regularly to evaluate the PMHC’s progress and inform the refinement of programs, policies, and/or procedures. This data analysis also helps inform the workgroup’s contemplation of any needed course corrections.

✓ Shared accountability among PMHC partners: Law enforcement leaders and their behavioral health partners share the responsibility to continually review performance data to identify PMHC service capacity issues, such as low utilization rates for a given service or if a service is consistently unavailable. Partners work together to address these issues. Procedures are in place—which are outlined in interagency MOUs and/or information-sharing agreements—that designate key staff to lead the performance review.

✓ Communication with external partners and leaders: Information is shared with county legislators, funders, and
community-based organizations to gain buy-in and support of the collaboration. Sharing successes or challenges with stakeholders leads to the PMHC receiving buy-in from the community and the additional support necessary for its growth. The PMHC establishes regular mechanisms to receive feedback from the community on how to tackle challenges and make improvements. Law enforcement leaders are responsive to the feedback of their officers, community leaders, the media, public officials and other policymakers, and ensure that initiatives are reflective of the public’s interests and concerns.

✓ Additional PMHC capacity and long-term sustainability: Performance reviews reveal if PMHC response models or community services must be scaled to satisfy the need in the community and to ensure that sustainable funding is in place for various PMHC response models. During the planning phase, a long-term sustainability plan is developed to ensure the interagency workgroup plans for obstacles that the PMHC might encounter in the future.

IN PRACTICE  | Improving PMHC Performance Using Data Analysis, Madison, WI

The Madison Police Department (MPD) has advanced their data analysis practices to understand PMHC performance and to enhance their responses to people who have mental health needs. In 2016, with the University of Wisconsin, MPD conducted a program evaluation of their mental health unit using data collected between 2013 and 2016. The main findings confirmed what they had suspected: mental health-related incidents doubled over this timeframe (as a proportion of all calls for service), calls for people with co-occurring substance addictions also quickly grew, and most importantly, a small number of people accounted for a disproportionate amount of mental health calls for service (i.e., 3 percent of unique individuals accounted for 17 percent of their total mental health reports).

The evaluation also showed that when the Mental Health Unit provided follow-up services, the vast majority (over 80 percent) of people served generated no additional incident reports, which cut down on repeat encounters. With evidence that follow-up services produced successful outcomes, MPD was positioned to enhance their follow-up capacity, creating five full-time mental health officer (MHO) positions to help mitigate the increasing demands on patrol officers and to prevent repeated calls for service related to the same person. The MHOs were added to support the existing Mental Health Liaison program already in place. In their work, the MHOs provide follow-up support for people; coordinate with mental health providers, case managers, advocates, and families; and share information with patrol officers to develop response plans.

Based on these demonstrated successes and with this data in hand, the department expanded their in-house crisis worker program to include three part-time crisis workers covering the equivalent of two full-time positions to further support the program.
Acknowledgments

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Representatives from law enforcement agencies in the nation’s 10 Law Enforcement-Mental Health Learning Sites provided extensive feedback on a variety of content areas, attended focus groups, and reviewed multiple versions of the framework. They include: Arlington (MA) Police Department; Gallia, Jackson, Meigs Counties (OH) Sheriffs’ Offices; Houston (TX) Police Department; Los Angeles (CA) Police Department; Madison County (TN) Sheriff’s Office; Madison (WI) Police Department; Portland (ME) Police Department; Salt Lake City (UT) Police Department; Tucson (AZ) Police Department; and University of Florida Police Department.

Special thanks are due to the agencies below and the staff who provided expertise and reviewed multiple drafts, including:

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- Police Foundation: Blake Norton, Senior Vice President and Rebecca Benson, Senior Policy Analyst
- Policy Research Associates: Dan Abreu, Senior Project Associate; Travis Parker, Senior Project Associate; and Chan Noether, Program Area Director

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Endnotes


2. The “behavioral health” system refers to both mental health and substance addiction services (and providers). For the purposes of this framework, the focus is solely on people who have mental health needs and the portion of the behavioral health system that serves this population. That said, given the high rate of co-occurring substance addictions among this population, the framework also makes reference to connections to substance addiction treatment for people who have co-occurring conditions.

3. CIT International (CITI), the organization that leads the proliferation of the Crisis Intervention Team model, similarly calls for law enforcement responses to people with mental health needs to be implemented not as a training alone or small-scale programs, but as a comprehensive, community-wide approach. See, Dr. Randolph Dupont, Major Sam Cochran, and Sarah Pillsbury, *Crisis Intervention Team Core Elements*, (Memphis, TN: The University of Memphis, 2007). [http://www.citinternational.org/resources/Pictures/CoreElements.pdf](http://www.citinternational.org/resources/Pictures/CoreElements.pdf).


6. Before leaders in a PMHC can determine if fewer repeat encounters are occurring, they first must define what constitutes a repeat encounter in their community. For example, it could be defined as a person having a second mental health call in a six-month period or it could be defined as multiple calls for service to the same location. Once properly defined, this target population can be prioritized for tailored interventions and treatment, and more accurate benchmarks can be established to gauge the success of the PMHC. For general discussions on the importance of benchmarking, see, Gregory H. Watson, *Benchmarking Workbooks: Adapting the Best Practices for Performance Improvement* (Portland, Oregon: Productivity Press, 1992); and Theodore H. Poister, *Measuring Performance in Public and Nonprofit Organizations* (San Francisco, CA: Jossey-Bass, 2003).


9. Portland has adapted elements of the CIT model to meet their local needs. As such, it may not represent fidelity to the CIT model.

10. While many law enforcement agencies are familiar with “CIT” as a specialized team or training program, the Crisis Intervention Team model is a comprehensive, community-wide response in which a specialized team works within a larger agency context and partnership, consistent with the approach outlined in this framework. See, Dr. Randolph Dupont, Major Sam Cochran, and Sarah Pillsbury, *Crisis Intervention Team Core Elements* (Memphis, TN: The University of Memphis, 2007). [http://www.citinternational.org/resources/Pictures/CoreElements.pdf](http://www.citinternational.org/resources/Pictures/CoreElements.pdf).

11. Houston has adapted elements of the CIT model to meet their local needs. As such, it may not represent fidelity to the CIT model.


14. These topics were compiled from nationally available CIT curricula, as well as feedback-generated conversations held with employees of the 10 national Law Enforcement-Mental Health learning sites. Each of these sites has adopted or customized their own curricula and suggested the most common topics that they use.

15. These topics were compiled from nationally available CIT curricula, as well as feedback generated conversations held with employees of the 10 national Law Enforcement-Mental Health learning sites. Each of these sites has adopted or customized their own curricula and suggested the most common topics that they use.

16. Missouri has built on the CIT model and adapted elements to meet their local needs. As such, it may not represent fidelity to the CIT model.

Cities and counties across the country are increasingly adopting the promising co-responder model to improve how they engage with people experiencing behavioral health crises. Co-responder models vary in practice, but generally involve law enforcement and clinicians working together in response to calls for service involving a person experiencing a behavioral health crisis. The model provides law enforcement with appropriate alternatives to arrest as well as additional options to respond to non-criminal calls. Communities and local leaders can use the model to develop a crisis continuum of care that results in the reduction of harm, arrests, and use of jails and emergency departments and that promotes the development of and access to quality mental and substance use disorder treatment and services.

This brief, the first joint product in a series from Policy Research, Inc. (PRI) and the National League of Cities (NLC), details the various co-responder models available to city and county leaders. It reflects the growing interest and experimentation with co-response among jurisdictions that are part of the John D. and Catherine T. MacArthur Foundation’s Safety and Justice Challenge (SJC). In addition, the brief builds upon case studies in NLC’s recent series, Addressing Mental Health, Substance Use, and Homelessness, which explores emergency response and crisis stabilization strategies for cities.
Co-responder models address:

• the training and capacity of law enforcement and other first responders regarding response to individuals experiencing a behavioral health crisis;¹
• the use of jails instead of treatment as a response to unmet behavioral health treatment needs in communities;²
• the ongoing local capacity limitations in quality behavioral health services, as well as weak referral mechanisms;³
• the potential for harmful or fatal police encounters for people in crisis.⁴

When implemented well, the co-responder model has the potential to produce several benefits including:

• the creation of improved and more immediate responses to crisis situations;
• the ability to follow up with individuals, family members, and caregivers after a crisis to reduce the likelihood of further crisis situations;
• a decrease in expensive arrests and jail admissions for individuals in behavioral health crisis;
• a reduction in psychiatric hospitalizations; and
• more accurate on-scene needs assessments.

Co-responder teams fall into Intercepts 0 and 1 in the commonly used Sequential Intercept Model (see figure 1), a conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system. The Sequential Intercept Model, or SIM, recognizes that law enforcement plays a dual role across these two Intercept points, and is often the first to respond to individuals in crisis.⁵,⁶ When law enforcement responds to calls for service involving individuals experiencing a behavioral health crisis, it is often related to unmet treatment needs, not major crimes or violence.⁷ Cities and counties are increasing their use of law enforcement and behavioral health co-responder models, recognizing that many situations cannot be solved by arrest, but instead are best addressed by behavioral health clinicians and crisis specialists.

Figure 1
Benefits of Co-Responder Models

Communities have seen many benefits of implementing co-responder models. In cases where the offense related to the crisis is non-violent, this model often results in a decrease in expensive arrests and jail admissions for individuals experiencing a behavioral health crisis. Some communities have seen an associated reduction in psychiatric hospitalizations, although involvement with behavioral health staff may increase the use of psychiatric holds for some individuals, when appropriate. Individuals also gain better and faster access to effective treatment. Bringing trained clinicians to the scene of a crisis allows them to make more accurate needs assessments that can potentially include collaboration with family and friends (and avoid a costly hospital bill), versus transportation to and assessment at a facility. Each of these changes has the potential to result in a more cost-effective crisis response continuum.

Co-responder models also have positive, measurable effects on how law enforcement and other first responders handle behavioral health crises, including training to better de-escalate intense or emotional crisis situations without the use of force. Individuals in crisis report feeling less threatened and stigmatized in interactions with co-response teams as compared to interactions with law enforcement alone. In a win for both the individual and law enforcement, Johnson County, Kansas’s Mental Health Co-responder program shows reductions in repeat calls for service for the same individual, as well as an increase in officers’ self-reported capacity to respond to people experiencing a mental health crisis. Many first responders also document more efficient use of time as the co-response teams can take over quickly at crisis scenes, allowing patrol officers to resume their regular duties. A 2014 review synthesized the existing literature across seven desired outcomes of the model and found several strengths to build on, including enhanced linkage with community services, less weight on the justice system, and increased police morale and efficiency due to reduced downtime.

What Do Co-responder Models Look Like?

Co-responder models enhance law enforcement’s capacity to develop an immediate and targeted response to acute and non-acute situations. There is a wide variety of co-responder models.
at least one law enforcement officer and one mental health or substance abuse professional responding jointly to situations in which a behavioral health crisis is likely to be involved, often in the same vehicle, or arriving on scene at generally the same time. Usually, the team rides together for an entire shift and is either dispatched directly to relevant incidents to be “first on the scene,” or dispatched to the scene post-initial law enforcement contact. Teams may respond city/countywide or focus on areas with high numbers of crisis-related calls. The responders’ goals can include providing clinical support on the scene, conducting screening and assessments, reviewing what is known about client history, and navigating and referring to community resources. Many co-responder models involve clinicians who provide proactive follow-up support to encourage client service and treatment engagement.

Many co-response teams begin in one municipality, expanding to other municipalities after demonstrated success. Some law enforcement agencies, such as in Los Angeles County, California, create a “unit” responsible for co-responder implementation.

CIT and Co-Responder Teams

As a precursor to the co-responder model, the Crisis Intervention Team (CIT) program provides a strong foundation for law enforcement’s response to individuals experiencing a behavioral health crisis. The 40-hour training program is built on community partnerships that help bridge the gap between law enforcement response and behavioral health care. Through CIT, officers engage in specialized mental health training, and many jurisdictions have developed specific CIT units to respond to individuals experiencing a behavioral health crisis. The University of Memphis CIT Center reported in 2019 that there were over 2,700 CIT programs within the United States.¹³

Site Example: Pima County, Arizona

The Pima County Sheriff’s Office and Tucson Police Department’s Mental Health Support Team (MHST) in Arizona (established in 2013) is a specially trained unit that includes a captain, lieutenant, sergeant, 2 detectives, and 11 field officers that serve as a mental health resource for other officers, community members, and health care providers. The MHST’s co-responder program (initiated in 2017) pairs an MHST officer with a masters-level licensed mental health clinician. The pair rides together, allowing for rapid dispatch of both law enforcement and mental health resources to calls for service. MHST teams wear civilian clothes and drive unmarked cars to help proactively defuse situations.¹⁴
Co-Responder Model Variations

Many jurisdictions modify the core co-response model to meet their communities’ needs and capacities effectively. Below are some examples of variations to the model.

Law Enforcement Calls for After-Event Support
In some co-responder models, responding officers will refer to a behavioral health specialist after encountering someone in need of assistance.

Site Example: Kitsap County, Washington
The Poulsbo, Washington Police Department partners with behavioral health navigators in the city’s Behavioral Health Outreach Program. The program initially began in the court system and expanded to a law enforcement partnership in 2017. It has since been extended to multiple police departments and is funded through the Kitsap County Treatment Sales Tax and participating cities. Navigators are hired as police department employees. Officers in participating departments request the navigators when they identify people in need of behavioral health treatment or services. Navigators are available in crisis situations but are primarily called in after police contact occurs to follow up with individuals, families, and caregivers. Navigators work with individuals to proactively identify treatment options, overcome obstacles to accessing services, and improve communication between the criminal justice and behavioral health systems. They work in partnership with officers in the field and/or independently.

Law Enforcement Obtains Clinical Support Virtually
Virtual crisis support such as telehealth enables the remote delivery of services, overcoming the rural, geographic, and transportation challenges experienced in many models of delivery of care. Officers may request that counselors evaluate individuals experiencing a crisis to help determine the most appropriate course of action. This can include the use of a crisis line to direct the response or video conferencing.

Site Example: Springfield, Missouri
The Springfield, Missouri Police Department and Burrell Behavioral Health introduced the Virtual-Mobile Crisis Intervention (V-MCI) in 2012. Known as the "Springfield Model," the program expanded across southwest and central Missouri, including St. Louis County. Officers are given iPads to connect with behavioral health specialists in real-time for assessments and referrals, as well as follow-up case management. The virtual response has greatly reduced the number of people who were previously transported to the hospital.

Fire Department and/or Emergency Medical Services Join Law Enforcement and Clinicians
Emergency Medical Services (EMS) and fire departments are increasingly involved in specialized crisis response, such as through trained EMS teams that respond to crisis calls with law enforcement. In addition, some fire/medical co-responder teams may proactively reach out to people with mental illness who are frequently involved in calls for service to increase their stability in the community and connect to relevant services.
Site Example: Colorado Springs, Colorado

The Colorado Springs, Colorado’s Police Department (CSPD) and the Colorado Springs Fire Department (CSFD) collaborated with AspenPointe, a local behavioral health organization, to form a specially staffed mobile integrated mental health emergency response team. First deployed in December 2014, the Community Response Team (CRT) consists of a CSFD medical provider, a CSPD officer, and a licensed clinical behavioral health social worker. The medical provider performs medical clearance and screens for psychiatric admission eligibility, while the police officer ensures scene safety and the social worker provides behavioral health assistance. This approach significantly reduced admissions to the emergency department by directing individuals in crisis to community resources, like the local Crisis Stabilization Unit or county detoxification facility. The local 9-1-1 call center helps by diverting qualified calls directly to the CRT, therefore decreasing the burden of these calls from the regular EMS, fire department, and police department dispatch.

Multi-Professional Teams, Especially for Substance Abuse Intervention

Some co-responder teams are targeted to intervene around specific issues, such as human trafficking, homelessness, and often substance abuse. These targeted interventions may include both proactive outreach and opioid overdose follow-up.

Site Example: Plymouth County, Massachusetts

In 2016, Plymouth County Outreach in Massachusetts responded to an upsurge in opioid-related overdoses by creating an innovative collaboration that included the District Attorney’s Office, the Sheriff’s Department, all 27 police departments in the county, 5 major hospitals, recovery coaches, the Department of Children and Families, the District Court, probation services, and community and faith-based coalitions. The two main features of the program are overdose follow-up and community drop-in centers, which serve as the region’s treatment, recovery, and support services. Outreach is conducted within 12 to 24 hours of a non-fatal overdose by a team consisting of plainclothes officers, a licensed clinician, and/or a recovery coach who visit the home of the overdose survivor to provide resources and offer to connect him or her to treatment.

Law Enforcement Calls for Non-Clinical Support

Law enforcement can request dispatch of trained civilians, instead of clinicians. These trained civilians may include trained behavioral health volunteers, crisis workers, or other non-clinical professionals. The team may also serve the community on its own as a mobile crisis response.

Site Example: Albuquerque, New Mexico

Albuquerque, New Mexico’s Crisis Outreach and Support Team (COaST) is a team of civilian crisis specialists who work with the Albuquerque Police Department. Officers encountering an individual who is experiencing a crisis can call the COaST to the scene. The crisis specialists, who are stationed at the Family Advocacy Center and are assigned to various regions, help connect individuals to services and provide follow-up support, increasing efficiency and trust among officers and service providers.
Peer Support Workers Join Law Enforcement
Peers (peer support staff, peer support specialists, or peer recovery coaches) are individuals with lived experiences of mental illness, substance use disorders, and/or justice involvement who are trained or certified to provide supportive services. Peer support is particularly helpful in easing the potential trauma of the justice system process and encouraging consumers to engage in treatment services.

Site Example: Mental Health Association of Nebraska
The Mental Health Association of Nebraska operates the R.E.A.L. (Respond, Empower, Advocate, and Listen) program in partnership with law enforcement, community corrections, and local human service organizations. This program formalized a referral process where service providers can link people with an identified or potential mental health concern to trained peer specialists. The peer staff provides free, voluntary, and non-clinical support with an end-goal of reducing emergency protective orders and involuntary treatment placement. From 2011 to April 2018, the program found that 67 percent of referred individuals accepted services. The referral program is funded through grants from the Community Health Endowment and the Nebraska Department of Correctional Services.

Clinical Staff Advise from Dispatch Centers
Some jurisdictions have integrated behavioral health counselors or other clinicians directly within their 9-1-1/dispatch call centers to provide even earlier crisis resolution and diversion. In other areas, such as Broome County, New York, there can be a warm handoff of some calls from 9-1-1 dispatchers to crisis call lines, to address non-emergent behavioral health treatment needs.

Site Example: Harris County, Texas
Houston and Harris County, Texas, created an innovative intervention model through a collaboration with the Houston Police Department (HPD) Mental Health Division, the Harris Center for Mental Health and Intellectual and Developmental Disabilities (the Harris Center), Houston Fire Department (HFD), and the Houston Emergency Center. The 9-1-1 Crisis Call Diversion program places tele-counselors inside Houston’s Emergency Communications Center, providing dispatchers the ability to link callers who have non-emergent mental health-related issues to needed services, rather than dispatching a law enforcement unit or HFD personnel. Since the pilot program began in 2015, it has led to a decrease in the volume of non-emergency mental health-related calls for service for both HPD patrol and HFD emergency medical services and reduced the use of this personnel for non-emergency responses, translating into cost savings and cost avoidance.

Behavioral Health Navigators Join Law Enforcement at Point of Reentry
There is a growing understanding among jurisdictions across the country about the importance of ensuring successful reentry for people with serious mental illness and chronic behavioral health needs. These individuals are often caught in a cycle of hospitalization, homelessness, and jail. Clinicians and peers in this model are part of the larger co-response team but assigned to the local jail or prison to aid in community reentry.
Site Example: Denver, Colorado

Denver, Colorado, created jail-based behavioral health reentry navigators as part of its Crisis Intervention Response Unit (CIRU). The model allows licensed clinicians to work with Sheriff’s Department officers and medical staff to identify and establish appropriate community supports for individuals as they return to the community. At release, the CIRU and the reentry navigators collaborate around the reentry plan, which often includes short-term crisis stabilization, a known person meeting the individual upon redace from the facility, a warm handoff to an ongoing treatment team, and transportation to and from appointments, as well as other pro-social activities.

How to Move Forward

Identifying a vocal, sustaining champion or group of key stakeholders is an important first step for city, county, or law enforcement leaders to take to move forward in launching a co-responder model. An external evaluation of the Indianapolis, Indiana Mobile Crisis Assistance Team (MCAT) credited strong buy-in from city leaders as crucial to the coordination across multiple agencies. An co-response team may also complement existing city or county priorities, such as the mayor and chief of police’s focus on homelessness and mental illness or a county’s Stepping Up efforts.

Securing funding for a pilot project is often the next step. While many sites rely on federal grant funding to stand up new initiatives, such as through the Substance Abuse and Mental Health Services Administration or the Bureau of Justice Assistance, cities and counties should explore multiple funding options during the planning, implementation, and sustainability/expansion phases of the program. Resources may be available through states’ departments of behavioral or public health and Medicaid funding. Colorado communities, like Denver, blend state and local funds for their co-responder programs, including the Marijuana Tax Cash Fund, Community Mental Health Services Block Grant dollars, Medicaid, and local community mental health centers. In addition to a county or state tax to ensure funding and increase the availability of services, private foundation or local business funding may be a potential source of support. Multiple sites involved in the MacArthur Foundation’s Safety and Justice Challenge, including Lake County, Illinois, Spokane County, Washington, Lucas County, Ohio, and Milwaukee City/County, Wisconsin, have used the initiative’s support to establish or expand co-responder teams. Finally, some hospitals and local mental health centers have shared the cost of co-response teams, as healthcare systems can benefit from cost avoidance under the model.

Key Strategies for Moving Forward:

- Identify a vocal, sustaining champion or group of key stakeholders
- Secure funding for a pilot project
- Staff community-based crisis response teams in a manner that meets the needs of the community
- Develop detailed policies and procedures that ensure and formalize coordination, access to services, communication, and consistency
- Create standards of work, such as client release of information, core intake information, standard data points, and tracking
As shown by the diversity of co-responder models, thoughtful implementation and training are vital. Behavioral health staff may be employed by the law enforcement agency, or by a mental health agency/authority, but co-located with law enforcement. Regardless of the model, a community-based crisis response must be adequately staffed to respond promptly to crisis calls to be effective. If the community response is not adequate, first responders’ efforts will not lead to systems change, a gap which is often referred to as “divert to what.” Best practices include:

- Coordinating co-response teams with law enforcement to have 24/7 availability or at least cover during peak call hours
- Ensuring quality staff training for both behavioral health personnel and law enforcement. An example of quality training is in Indianapolis, Indiana’s MCAT, which requires officers to receive training about CIT, mental illness, information sharing, special populations, the use of force, naloxone administration, and team building
- Educating behavioral health staff in the unique working conditions and demands of law enforcement

Cities and counties should develop detailed policies and procedures that ensure and formalize coordination, access to services, communication, and consistency within the team(s). Jurisdictions should also create standards of work where appropriate, such as client release of information, core intake information, standard data points, and tracking. Determining how to measure success will play a role. Metrics may include the ability of law enforcement to return to work quickly, as well as reductions in jail stays, the use of emergency departments and psychiatric hospitalizations, and other examples of cost avoidance and reduction. The Bureau of Justice Assistance’s Police-Mental Health Collaboration Toolkit and the Substance Abuse and Mental Health Services Administration’s Data Collection Across the Sequential Intercept Model (SIM): Essential Measures may provide specific assistance, as well as the additional resources below.

Conclusions

There are many benefits to the co-responder model, including increased efficiencies among first responder agencies, improved overall outcomes of interactions involving people in behavioral health crisis, and improved law enforcement-community relations. However, the model is not an isolated solution. It is vital that community partners support first responders’ diversion efforts in order to enact true system change. These rapidly expanding models highlight challenging situations, and cities and counties should continue to explore and develop evidence-based responses to people experiencing a behavioral health crisis as alternatives to the criminal justice system, in order to meet their communities’ specific needs.
Additional Resources

• The National League of Cities’ series of three briefs examining city-level approaches to emergency response and crisis stabilization.
  › Advancing Coordinated Solutions through Local Leadership
  › Working Across Systems for Better Results
  › Emergency Response and Crisis Stabilization

• The National League of Cities’ How Cities Can Provide Alternatives to Jails and Improve Outcomes for Young Adults with Mental Health Concerns

• The National Association of Counties’ Meeting the Needs of Individuals with Substance Use Disorders: Strategies for Law Enforcement

• The International Association of Chiefs of Police’s Responding to Persons Experiencing a Mental Health Crisis

• The Bureau of Justice Assistance’s Police-Mental Health Collaboration Toolkit

• The Council of State Governments Justice Center’s Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs

• The Substance Abuse and Mental Health Services Administrations’ Tailoring Crisis Response and Pre-arrest Diversion Models for Rural Communities
Acknowledgments

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Endnotes


A long-planned program to remove police from some 911 calls launched as Denver’s streets erupted in police brutality protests

The timing was a coincidence, but the stakes have never been higher.

Roshan Bliss has been trying to find ways to curb police violence for years and scored a major victory at the beginning of the month, just as Denver started protesting racism and police brutality.

Bliss, a volunteer and co-chair of the Denver Justice Project, helped shepherd a pilot project into existence that’s now diverting some 911 calls away from armed officers to an unassuming van manned by a Denver Health paramedic and a social worker from the Mental Health Center of Denver. It’s called Support Team Assisted Response, or STAR, and the idea is to send more appropriate responses to 911 calls that have to do with substance abuse, mental
health crises or people who just need help connecting to services. A grant from the Caring 4 Denver fund (http://caringfordenver.org/), which voters approved in 2019, has given STAR at least six months to prove it can be effective.

STAR is one way to “dismantle policing,” Bliss says, an idea that’s become talked about widely and loudly during protests reacting to the killing of George Floyd. The pilot program coincidentally began while massive actions against police brutality entered their fifth consecutive day in Denver.

Bliss and his colleagues began publicly talking about the program — or elements of it, at least — in 2017, including to a then-Denver police commander named Paul Pazen (https://denverite.com/2019/06/10/community-groups-will-begin-taking-on-911-calls-and-low-level-cases-from-the-denver-da/). When Pazen became chief in 2018, he was primed to help get the ball rolling. Last year, Bliss, some fellow activists and a delegation of local lawmakers took a trip to Eugene, Oregon, where a system like STAR has been in operation for more than 30 years (https://whitebirdclinic.org/cahoots/). Bliss believes Denver is the first major city in the nation to copy Eugene’s model, removing police from situations that they themselves could make more dangerous.

The stakes are high, activists say.

If mental health workers had been sent to the motel where Michael Marshall, who had schizophrenia, was accused of trespassing, Bliss believes he could have avoided the Denver jail where he was later killed by sheriff’s deputies (https://www.denverpost.com/2017/11/01/michael-marshall-jail-death-settlement/). Many of the names heard shouted at marches this week — Paul Castaway (https://kdvr.com/news/no-charges-filed-against-officer-in-shooting-death-of-paul-castaway/), Paul Childs (https://www.denverpost.com/2005/06/07/cop-recounts-slaying-of-teen/), Marvin Booker (https://denverite.com/2017/09/28/seven-years-marvin-booker-died-denver-jail-da-beth-mccann-asks-grand-jury-investigate/) — are people who died after contacts with police; Bliss thinks these cases very well could have been diverted to STAR, had it started sooner.

Most 911 calls, he said, stem from deeper issues like a lack of affordable housing or difficulty accessing food or mental health resources. He said American society has passed too many of our problems on to police departments, which are ill-equipped to deal with many non-violent emergencies.

“We can work towards different ways to address our social problems,” Bliss said. “You don’t need armed and badged gunmen.”

That structural racism contributes to crime (https://denverite.com/2020/06/08/montbello-leaders-ready-for-a-potentially-violent-summer-fueled-by-inequality-made-worse-by-the-coronavirus/) has also been
discussed during protest in recent weeks.

Carleigh Sailon, one of two Mental Health Center of Denver workers who’s been riding around in the van taking calls, said she’s excited to be a part of a creative way to change how the city deals with crises. Helping people, and finding better ways to do it, are what motivates her.

“I’m in this field because social justice is my passion. Bucking systems that have historically not worked is what I decided I wanted to do,” she said, especially “during this time when there’s just so clearly a movement going on, calling for a better response.”

**STAR hit the ground running.**

Sailon and her colleague, Chris Richardson, have been taking turns working the mental health side of STAR since it launched last Monday. Richardson said they’ve been very busy.

“The past three days have been just a blur,” Richardson said. “It’s actually gone incredibly well.”
From 10 a.m. to 6 p.m., Monday through Friday, STAR picks up 911 calls within the downtown “lollipop” area, which is basically a large circle around Civic Center, Capitol Hill and Downtown with a long stem stretching south down Broadway. Bliss said historical 911 call data informed the timing and location choices for this trial period. Richardson said they’ve since added the National Western Center to its service area, since the city set up a makeshift homeless shelter there as it sought to mitigate COVID-19 (https://denverite.com/2020/04/08/just-looking-at-the-national-western-emergency-shelter-puts-denvers-housing-crisis-into-perspective/).

Many of the cases Richardson and Sailon take involve people living in homelessness. Sailon said she helped some people in shelters dealing with suicidal thoughts and people on the street wrestling with substance abuse. Because they’re so deeply involved in the city’s social-work world, she and Richards can use their networks and knowledge of the system to connect people directly with case managers or other resources. They’ll even give people a ride to wherever they need to go.

They can navigate the city’s mental health landscape more quickly than police officers can, Richardson said, while also spending more time to make sure people get what they need.

“We have time on our side to see what’s really going on to make sure that person is connected,” he said. “It’s the idea of being able to provide the right resource at the right time.”

Richardson and Sailon have helped operate the Mental Health Center of Denver’s co-responder program (https://www.colorado.gov/pacific/cdhs/co-responder-programs), which embeds social workers with police officers to help cops navigate tricky situations. STAR goes one step further.
The number of unhoused patients they’ve seen so far is partially influenced by the service area they’re working.

“Policing has always been about keeping down marginalized people, from its origins, and that has included Black folks and other folks not considered ‘white’ and poor people,” Bliss said. “You can’t have racial justice without economic justice.”

The fact that Pazen helped green light the project, Richardson says, shows DPD leadership is committed to morphing the department into a more modern organization.

“I think Denver is doing a lot of steps to change the culture, change their approach,” Richardson said. “They want to move to a 21st-century policing model.”

Bliss hopes STAR can grow, treating the symptoms of systemic problems while the city deals with some root causes.
He’d like to see 15 or 20 vans doing this kind of work across the whole city, each with a different service area that caters to a neighborhood’s specific needs. A van on the west side, for instance, might employ bilingual EMTs and mental health staff.

In the next six months, Richardson and Sailon will work to identify ways in which the program needs to be tweaked, while they, Bliss and other interested parties try to drum up data on how things are going.

Bliss said the next step would involve a request for proposals. He hopes a community organization steps up to own the project for the long haul, like has happened in Eugene, while taxpayer dollars help fund it.

An existing network of street medics and community service providers, like the Denver Alliance for Street Health Response (DASHR), helped advocate for the pilot and are working to make sure it can grow.

In a prepared statement, DASHR’s Vinnie Cervantes said supporters “insist that a program like this must be community-owned and led.”

Many of these people are working on a volunteer basis to make it happen.

Bliss, for instance, has a day job helping run the nonprofit Project VOYCE. He works on STAR, he said, “doing what is right in my copious free time.”

As he thinks about minimizing damage to communities at the hands of police, he’s hoping for some big changes. Not all are new ideas.

“To abolish police we need serious affordable housing. We need food programs,” he said. “We need to address the causes of inequality, poverty and suffering and create ways communities can support themselves in dealing with hard things.”

**Correction:** Our original story misspelled Chris Richardson’s last name. We fixed the error.
We train police to be warriors — and then send them out to be social workers

The fatal mismatch at the heart of American policing.

By Roge Karma | Jul 31, 2020, 7:30am EDT

Richard Nixon called police forces “the real front-line soldiers in the war on crime.” Bill Clinton, in his signing ceremony for the 1994 crime bill, called them “the brave men and women who put their lives on the line for us every day.” In 2018, Donald Trump described their job as follows: “Every day, our police officers race into darkened alleys and deserted streets, and onto the doorsteps of the most hardened criminals ... the worst of humanity.”

For decades, the warrior cop has been the popular image of police in America, reinforced by TV shows, movies, media, police recruitment videos, police leaders, and public officials.

This image is largely misleading. Police do fight crime, to be sure — but they are mainly called upon to be social workers, conflict mediators, traffic directors, mental health
counselors, detailed report writers, neighborhood patrollers, and low-level law enforcers, sometimes all in the span of a single shift. In fact, the overwhelming majority of officers spend only a small fraction of their time responding to violent crime.

However, the institution of policing in America does not reflect that reality. We prepare police officers for a job we imagine them to have rather than the role they actually perform. Police are hired disproportionately from the military, trained in military-style academies that focus largely on the deployment of force and law, and equipped with lethal weapons at all times, and they operate within a culture that takes pride in warriorship, combat, and violence.

This mismatch can have troubling — even fatal — consequences. Situations that begin with civilians selling loose cigarettes, attempting to use possibly counterfeit currency, sleeping intoxicated in their cars, recreationally selling or using low-level drugs, violating minor traffic laws, or calling the police themselves because they are experiencing a mental health crisis end with those same civilians, disproportionately Black Americans, unnecessarily killed at the hands of a police force primed for violent encounters and ill-equipped for interventions that demand mediation, deescalation, and social work.
“Cops are very equipped to be the hammer and enforce the law,” says Arthur Rizer, a former police officer and 21-year veteran of the US Army who heads the criminal justice program at the center-right R Street Institute. “They know how to use those tools forcefully and effectively; for everything else, they are lacking. Of course that’s going to end badly.”

There is considerable disagreement about the best way to change policing. But as my colleague Aaron Ross Coleman points out, a cross-factional coalition is emerging, centered on the idea that America relies far too heavily on police to address problems that have nothing to do with what they are trained, hired, and equipped to handle.

“The spectrum of skill sets we are currently asking police to embody is simply not realistic,” says Christy E. Lopez, a legal scholar at Georgetown Law who investigated police misconduct as an attorney for the Obama administration’s Justice Department. “It’s not realistic to ask any profession to do that much.”

In recent weeks, I’ve spoken to a dozen current and former police officers, police reformers, legal scholars, and criminologists to better understand this fatal mismatch at the heart of American policing — and what it would take to fix it.

**How police officers spend their time on the job**

The best information on how police officers spend their time comes from “calls for service” data made publicly available by individual police agencies. These are often defined as calls to emergency operators, 911 calls, alarms, and police radio and non-emergency calls. Most calls for service are initiated by citizens, but the data I draw on here captures the officer’s final categorization of the incident.

The data overwhelmingly finds that police officers in aggregate spend the vast majority of their time responding to non-criminal calls, traffic-related incidents, and low-level crimes — and only a tiny fraction on violent crimes.

My favorite visualization of this data comes from former UK police officer and Temple University criminologist Jerry Ratcliffe, who used 2015 data from Philadelphia, a city with relatively high crime rates, to construct this graphic. The area of each box represents the proportion of reported incidents within that category:
If you squint a bit, you can see that violent crimes like rape, homicide, and aggravated assault are tucked away in the bottom right-hand corner. Less serious crimes like petty theft, drug use, and vandalism take up slightly more space but not all that much. The vast majority of calls have nothing to do with crime. Instead, they involve disorderly crowds, domestic disputes, traffic accidents, minor disturbances, and a whole array of “unfounded” calls where the officer arrived on the scene only to discover nothing was happening.

Of course, the exact incident breakdown will vary by place, but this general picture holds for a number of police departments in major cities. In a June article for the New York
Times, crime analysts Jeff Asher and Ben Horwitz dug through the call data for the 10 police agencies that had made such data available, including in places with relatively high violent crime rates like Baltimore and New Orleans. They found that incidents that met the FBI Uniform Crime Report definition of violent crime made up only around 1 percent of calls for service.

Then, for the handful of police agencies that also provided data on when a given call for service was first reported and when that incident was closed, Asher and Horwitz used the difference between those two numbers to gauge the time officers actually spent on different types of policing activities.

Jeff Asher (@Crimealytics)
Replies to @Crimealytics @IT4Policy and @UpshotNYT
Of course a murder scene takes longer to process than a false burglar alarm so we also looked at data from 3 cities that provide information on how long each call takes to complete.

Using that we see about 4% of time is spent responding to UCR Part I violent crime.
Across these departments, the biggest category of time spent by police was on “responding to noncriminal calls,” which took up around a third or more of total on-call time. The next biggest categories were “traffic” (mostly car accidents) and “other crime” (low-level crimes like drug use, truancy, disorderly conduct, etc.). Almost 10 percent of police time was spent on “medical” calls, which involve non-crime-related physical emergencies. Meanwhile, police spent only around 4 percent of their time responding to violent crime and even less time (closer to 0.1 percent) on homicides.

“When I was an officer, I got calls about dead animals, ungovernable children who refused to go to school, people who hadn’t gotten their welfare checks, adults who hadn’t heard from their elderly relatives, families who needed to be informed of a death, broken-down cars, you name it,” says Seth Stoughton, a legal scholar at the University of South Carolina and former Tallahassee police officer. “Everything that isn’t dealt with by some other institution automatically defaults to the police to take care of.”

Calls for service data do not include what police often refer to as “unassigned” time — the hours police officers spend between calls patrolling neighborhoods, taking a meal break, or filling out paperwork. Observational studies of patrol officers have found that anywhere from 46 percent to 81 percent of their time is spent on unassigned activities. That means the total percentage of time police spend responding to crime could well be far less than even the call data indicates (the main exception being members of specialized units in major departments like homicide and SWAT whose activities aren’t captured by observational studies).

Numerous academic studies confirm these basic patterns in the data. They find that patrol officers — even in suburban and rural communities for which public data is often lacking — spend the overwhelming majority of their time writing reports, driving around neighborhoods, and responding to non-criminal calls.
“The job is 99 percent boredom and 1 percent sheer panic,” says Matthew Bostrom, a criminologist at the University of Oxford who spent more than 30 years as a police officer, commander, and sheriff in St. Paul, Minnesota. “Most of what you deal with is fairly routine.”

In his recent paper “Disaggregating the Policing Function,” Barry Friedman, the director of the Policing Project at New York University’s School of Law, breaks down this dizzying array of tasks and responsibilities into a handful of distinct roles:

- The traffic cop: The majority of police-civilian interactions take place on the road. Police help stranded motorists with broken-down cars, take reports in car accidents, direct traffic around serious incidents in which other responders are needed, set and staff speed “traps,” and issue citations. And when police are off-call, they spend much of their time performing routine street patrol.

- The mediator cop: A huge number of calls to the police involve relatively minor interpersonal disputes: disputes over noise levels, trespassing, misbehaving pets, or rowdiness; disputes between spouses, family members, roommates, or neighbors. In these situations, police are called to calm things down, deescalate, and act as counsel.

- The social worker cop: Police work often involves populations like the homeless, intoxicated people, people with substance use issues, or those with mental illness. This role isn’t often captured well in the aggregate data, but police spend a huge chunk of their time on these functions.

- The first responder: In most jurisdictions, the only government entities that respond to problems 24 hours a day, seven days a week are police, fire, and emergency medical services. That means for the vast majority of social problems, police are often the default institution for people to call. This is how cops get stuck chasing runaway dogs, tracking down welfare checks, dealing with noise complaints, and a whole host of other issues that appear to have nothing to do with policing.

- The crime-fighting, law enforcement cop: There is something to be said for rapid response by force- and law-trained individuals to situations involving serious criminal activity. However, studies find that this time is mostly spent interviewing witnesses, gathering evidence, advising victims, and writing reports. “Often cops are just there to pick up the pieces after the fact,” says Peter Moskos, a former Baltimore police officer and criminologist at John Jay College. “By the time you arrive, the crime is usually no longer in progress.”
The time a given officer spends on each of these roles varies greatly. In bigger cities, police work tends to involve dealing with a lot of substance abuse, mental illness, and homelessness. In suburban areas, domestic and other interpersonal disputes take up a larger portion of police time. In rural communities, police deal with a huge number of unique, one-off tasks.

What remains true in each of these cases is that police officers aren’t primarily crime fighters and law enforcers; instead, they fill a huge range of other social functions, often ones that other social services and institutions don’t have the ability to respond to quickly or at all.

“As a society we’ve decided to sweep these problems aside rather than to deal with them,” Friedman tells me. “And the police are the broom. They don’t want to be the broom, but that’s exactly what they are.”

**The job we prepare police for**

This all adds up to a fundamental problem with policing in America: We prepare police for a role vastly different from the one they actually play in society.

*A 2016 national study* of the training of 135,000 recruits across 664 local police academies found that, on average, officers each received 168 hours of training in firearm skills, self-defense, and use of force out of 840 total hours. Another 42 hours were spent on criminal investigations, 38 on operating an emergency vehicle, 86 on legal education aimed primarily at force amendment law, and hundreds more on basic operations and self-improvement. Topics like domestic violence (13 hours), mental illness (10 hours), and mediation and conflict management (9 hours) received a fraction of trainee time. Others, like homelessness and substance abuse, were so rare they didn’t make the data set.

Those averages mask an even more worrying reality. *Almost half* of American police academies utilize what is called the “military model” of instruction — a high-stress, **physically and psychologically excruciating** approach traditionally used to train soldiers for battle. Another third use a hybrid approach that draws heavily on the military model.
In many major-city police departments where this military model is prevalent, training is even more skewed toward force and law enforcement. At Nashville’s police academy, for instance, officers spent **two-thirds of their training time** on law enforcement and use of force and less than 10 percent of their time on “social work/mediation” issues like interpersonal communication and human relations.

“The amount of firearms and use of force training in our academies is completely at odds with the problem we most often ask police to deal with,” says Ratcliffe, the former UK police officer turned Temple criminologist. “Police training is simply not reflective of the role of police in our society.”

In the field, this trend continues. Despite the fact that American police deal with a vast array of different situations, they are equipped with the exact same tools for each one: handcuffs and a firearm. Increasingly, that tool basket also includes **assault rifles, camouflage, and armored vehicles**, even for routine tasks.

The structure of police agencies, too, reflects a commitment to force. Glance at the **organization chart** of any major police department and you’ll see specialized departments like SWAT, bomb squad, narcotics, vice, street crimes, gang unit, criminal intelligence, and counterterrorism. What you won’t see, with a **handful of exceptions**, are departments focused on conflict mediation or social work.
The emphasis on force, law, and crime fighting is undergirded by a powerful ideological ecosystem. As my colleague Zack Beauchamp writes, “The ideology [of policing] holds that the world is a profoundly dangerous place: Officers are conditioned to see themselves as constantly in danger and that the only way to guarantee survival is to dominate the citizens they’re supposed to protect.” That ideology is baked into the culture of policing at all levels.

Crime fighting and deployment of force are also culturally valorized. Take the International Association of Chiefs of Police’s “Police Officer of the Year” award, which “symbolizes the highest level of achievement among police officers,” and selects those who can stand as models for the profession — it’s a big deal in the policing world. In the 30-year period from 1986 to 2015, 25 recipients of the award were honored for actions they took in combat conditions while under attack.

Or just look up any police department recruitment video, where you’re likely to see police officers battering down doors, firing assault rifles, engaging in high-speed freeway chases, and running after suspects through alleyways — sometimes with a few brief shots of community outreach sprinkled in.

As for in-person recruiting efforts, police agencies concentrate primarily on military bases and, to a lesser degree, sports facilities and private security companies. The result is that military veterans — who are more likely to generate excessive force complaints and be involved in unjustified police shootings than non-military cops — represent almost 20 percent of police officers despite being just six percent of the US population. Men more generally make up almost 90 percent of all police officers; they are considerably more likely to use force and aggressive tactics than female officers.

“What excites police is action, and that means ultimately applying violence,” says Rizer. “The people attracted to police work want that type of action — they are giddy about it. The people who don’t want that type of action either never make it in the first place or are ridiculed for it if they do.”

A mismatch with devastating consequences

Police officers are functionally generalists responsible for dealing with a vast array of our society’s most sensitive situations; yet we’ve recruited, hired, trained, equipped, and deployed them to be specialists in force. And we’ve done it all using an often
disproportionately white police force with a well-documented racial bias problem entering Black and brown communities that historically distrust the police.

Would it surprise anyone if this occasionally resulted in unnecessary violence?

“Often what these situations require is someone to calm things down, cool things off, and deescalate,” says Tom Tyler, a legal scholar at Yale Law School and a founding director of Yale’s Justice Collaboratory. “But police tend to manage all the problems they face through the threat or use of coercive force. This amplifies the level of emotion and anger in a given situation and can create a spiral of conflict that ends tragically.”

Take the case of Rayshard Brooks. On June 12, Atlanta police officers were sent to respond to a complaint that Brooks was sleeping in his vehicle in a Wendy’s drive-through. Video evidence shows the interaction starts out calm. Brooks repeatedly asks the arresting officer, Garrett Rolfe, if he can leave his car parked and walk to his sister’s home, which he says is nearby. But Rolfe insists Brooks take a field sobriety test, which reveals that Brooks had a blood alcohol level slightly above the legal limit. Rolfe attempts to handcuff Brooks, Brooks resists, and a struggle ensues. Brooks grabs Rolfe’s Taser, begins running away, and turns to fire it. Rolfe shoots Brooks three times.

Brooks died in the hospital.

There are numerous points at which this interaction could have gone differently. If Atlanta had delegated certain responsibilities to non-police agencies, they could have sent an unarmed civilian to drive Brooks home. If the officers on the scene had the mindset of solving a problem without the use of force, they probably wouldn’t have escalated the situation by trying to forcefully handcuff Brooks. If the arresting officer didn’t have a Taser, Brooks would never have taken control of his weapon. If that same officer weren’t armed — or perhaps had stricter use of force requirements — he wouldn’t have shot and killed someone holding a less lethal weapon.

You can do the same kind of analysis for the deaths of George Floyd, Eric Garner, Breonna Taylor, Philando Castile, Euree Martin, Tony Timpa, Erik Salgado, and countless others. In each situation, the mismatch is crystal clear: Officers trained primarily in the deployment of force and law, armed with lethal weapons, and told to think of themselves as warriors were the chosen first responders to situations that demand anything but. And each situation ended with someone killed at the hands of the people ostensibly tasked to protect and serve them.
Police killings of unarmed civilians in the United States are **magnitudes higher** than those in peer countries. Using 2015 data, Franklin Zimring, a UC Berkeley criminologist and author of *When Police Kill*, calculates that the chance of an unarmed civilian being killed by police in the US is three times higher than the chance of any civilian, armed or unarmed, being killed by police in Germany and more than 10 times higher than in the UK (and that’s using a very conservative estimate of unarmed shootings in the US). A separate analysis found that in almost half of police killings of unarmed civilians in the US, the person killed was revealed to be or suspected of experiencing either a mental health crisis or narcotic intoxication.

Even when civilians are armed, that doesn’t necessarily mean police killings are justified. Upon extensively analyzing the 1,100 total fatal police killings in the US in 2015, Zimring concluded that “almost half the cases ... were confrontations where the police were not at objective risk of a deadly attack.” And, of course, it is impossible to quantify how many of those confrontations would not have escalated to the point of potential violence in the first place if not for police presence and tactics.

The unnecessary use of deadly force isn’t the only, or even the most likely, consequence of this mismatch. It also leads routinely to the **overcriminalization** of issues like drug use, mental illness, and homelessness; it causes predominantly Black and brown
communities to live in constant fear of their own police departments; it destroys trust between police officers and the people they are supposed to protect; and it places a major financial burden on local government budgets (armed police officers are an expensive way to address social problems) that leads to the underfunding of key social services. All the while, it fails to solve the underlying problems that lead to police being called in the first place.

“The definition of failure is that what we’re doing isn’t solving the problem and is actually causing harm in the process,” says Friedman, the Policing Project director. “That basically describes the state of policing today.”

Reimagining public safety

When it comes to addressing the mismatch between the nature of our police forces and the roles we ask them to perform, there are two broad paths that stand out.

The first is to transform our police forces — to change how officers are recruited, hired, trained, and equipped to meet the actual demands of their role.

Hiring and recruiting practices can be reformed to increase the diversity of police forces in terms of gender, race, and non-military backgrounds. Training can be refocused to include a stronger emphasis on procedural justice principles, conflict deescalation, and crisis intervention. Use of force policies can be made much stricter. Tactics like chokeholds, shooting at moving vehicles, and shooting without warning can be banned, as many departments have already done. Military-grade weapons can be taken off the streets. Legal protections like qualified immunity can be revoked.

On a structural level, police agencies can create an entire department focused on crisis response with specialized units focused on homeless outreach, mental illness, substance abuse, and conflict mediation (as some progressive departments have already done). Those officers can be recruited from fields like social work and psychology, hired based on their capacity to calmly handle highly stressful situations, trained primarily in crisis response, and rewarded not for arrests or stops but for peaceably resolving issues and handing them over to the appropriate social services institution.

The challenges associated with this approach aren’t difficult to imagine. Reform would have to take place on numerous levels: training, hiring, recruitment, agency structure, weaponry. You’d have to get buy-in not only from state and local public officials and police chiefs but from rank-and-file officers. You’d have to fight police unions for even an inch of
reform. And even if you fixed one or two of these areas (which could take years or decades), sending armed officers to deal with social problems will always leave open the possibility of unnecessary violence. Cities like Minneapolis, Atlanta, and Tucson — all of which have experienced high-profile police killings recently despite reform efforts — have learned that lesson the hard way.

“It’s impossible to point to one specific problem and say, ‘That’s it — that’s the issue,’” says Tracey Meares, a legal scholar and founding director of Yale University’s Justice Collaboratory. “This is about the system of policing itself. Our communities lack the resources to deal with their social problems. And our response has been to deploy armed first responders to address the issue way down the chain from the source.”

That leads us to a second approach: to transform how we address public safety such that police play a smaller, more targeted role altogether. This would involve communities designating a certain subset of current police duties that don’t require armed police response, delegating those responsibilities — along with requisite funding — to an institution that could better handle the issue, and designing systems for service delivery (like a 911 call diversion program) and coordination (like a silent alert system that unarmed first responders could use to quickly summon police backup).
Models for this approach have been implemented successfully in some places in the US and across the globe. In the UK, certain traffic functions have been designated to unarmed, non-police public servants. In cities across the US, “violence interruption” programs run by community nonprofits have been largely successful in mediating conflict and reducing violence. The much-applauded Cahoots program in Eugene, Oregon, sends a team of unarmed crisis specialists to address many non-criminal 911 calls without having to involve police.

There’s public support for such an approach. A recent poll found that 68 percent of voters support the creation of a “new agency of first responders” (although just a quarter of Americans say they support “reducing funding” for police departments).

The challenge is that designing an entirely new approach to public safety, rather than merely reforming an existing one, means stepping into relatively uncharted territory.

“There is no single, definitive answer to what will work in a given place,” Megan Quattlebaum, director of the Council of State Governments Justice Center, tells me. “Anything we do is going to be in the space of experimentation with different models.”

That means things are bound to go wrong. Some programs might not scale. Others will not receive adequate funding. Crime may temporarily increase in some places. Occasionally, a violence interrupter or mobile crisis worker will be seriously injured or killed. And when those things happen, it will take an incredible amount of political will and community solidarity to persist.

These two approaches are not mutually exclusive. There is general agreement that armed officers should still respond to violent crimes, like an active shooter, and definitively non-criminal, nonviolent activity should be delegated to alternative institutions. There are also a handful of hybrid solutions that combine the approaches — for instance, collaborative models between police and other agencies or nonprofits that co-respond to issues like homelessness or mental health. Or the “civilianization” of police departments: hiring unarmed professionals without arrest powers to fulfill certain police responsibilities, as many European countries have done.

But once you get into the details, difficult trade-offs emerge. There are plenty of cases where there is legitimate ambiguity about whether a situation will escalate to violence: like when a 911 caller isn’t sure whether what she is seeing is a man at a playground with a lethal weapon or a young teenager playing with a toy gun, or when a woman experiencing a
severe mental health crisis is **threatening others with a knife**. In cases like those, do we send unarmed first responders and risk putting them, and others, in harm’s way? Or do we send armed police officers and risk the use of unnecessary state force against civilians?

“This is a conversation that needs to be had with communities,” says Tracie L. Keesee, a former Denver police officer and the co-founder of the Center for Policing Equity. “Where do you want police and where do you not want them? Who would you rather have show up? What kinds of qualities would you like your police officers to have?”

Reimagining the role police play in our society is far from being anti-police. **Plenty of police officers** recognize that our current one-size-fits-all approach to public safety is fundamentally broken. They lament the fact that we ask police to solve far too many of our social problems and don’t give them the training or resources they need to do so — and then point the finger at them when they inevitably come up short.

“The reason I think we need to rethink policing is because I care about police,” says Rizer, the former officer and R Street researcher. “I want to make policing prestigious again — not the prestige of power, but the prestige of respect. But in order to do that, we need to stop underfunding everything else and leaving the police holding a bag of shit.”

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