RESPONDING TO INDIVIDUALS IN BEHAVIORAL HEALTH CRISIS VIA CO-RESPONDER MODELS:

The Roles of Cities, Counties, Law Enforcement, and Providers

By: Ashley Krider & Regina Huerter, Policy Research, Inc.
Kirby Gaherty & Andrew Moore, National League of Cities

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
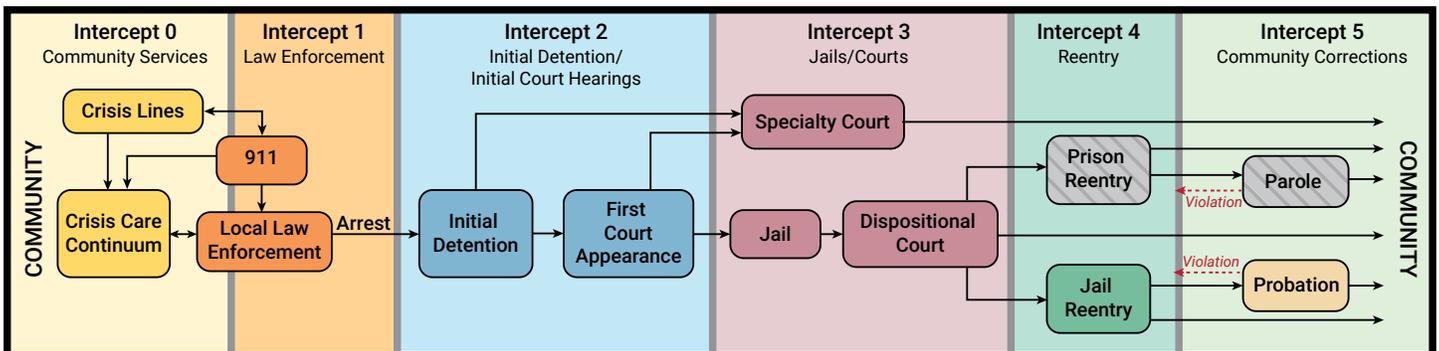
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Benefits of Co-Responder Models

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.[8] 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

How Can it Help?

There are many benefits to the co-responder model, including reduced pressure on the justice system and stronger linkages to community supports. Other potential benefits that should be areas for future study include:

Increased
- Access/speed of access to care
- Cost avoidance or cost savings
- Efficiency of officer time
- Collaboration and communication between law enforcement and behavioral health practitioners

Decreased
- Arrests/jail admissions
- Use of force by law enforcement
- Psychiatric hospitalizations
- Repeat calls for service

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.[9] 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.[10] 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.[11]

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

Law Enforcement Officer **+** Mental Health or Substance Abuse Professional → **Respond to** → Scene of Crisis

used across the country; indeed, a recent systematic review identified 19 different triage models across the 26 studies.[12] **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.

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.
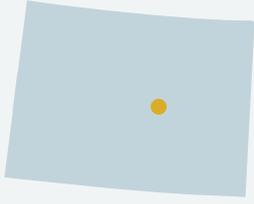
The Colorado Springs, Colorado's Police Department (CSPD) and the Colorado Springs Fire Department (CSFD) collaborated with AspenPointe, a local behavioral health organization, to form a specially staffed mobile integrated mental health emergency response team. First deployed in December 2014, the Community 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.[15] 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.
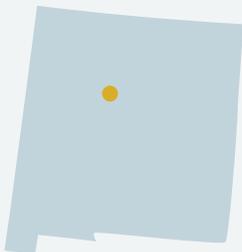
Site Example: Albuquerque, New Mexico

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.[16] 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.
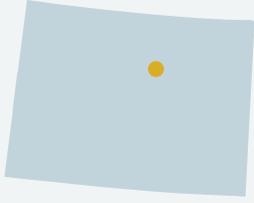
Site Example: Harris County, Texas

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.[17]

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.

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 variety 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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