Photo by Jovelle Tamayo

Behavioral Health Crisis Alternatives

Shifting from Police to Community Responses

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Police are ill-equipped to safely and effectively serve people experiencing behavioral health crises. With more than 240 million 911 calls made each year, police have become the default first responders for a wide range of social issues, from mental illness to substance use to homelessness.[1] The dire shortcomings of this approach are reflected in the disproportionate number of people with mental illnesses and substance use disorders killed by police every year and the disproportionate numbers held in jails and prisons.[2] Although many officers may possess de-escalation skills, the mere presence of armed, uniformed officers with police vehicles can exacerbate feelings of distress and escalate mental health-related situations, particularly in Black communities and other communities of color, where relationships with police

are historically characterized by tension and distrust.[3] Too often, encounters between the police and people in crisis end in handcuffs with an enforcement action or emergency department transport. Too often, they do not end in voluntary assessment and referral to the long-term supports people with mental illnesses and substance use disorders need to thrive.

> *Police themselves have been saying for years that they are asked to do too much. Why do we continue to ask them to respond to crisis calls that health professionals could address more safely and effectively?*

For communities to shift away from police-led responses to people experiencing behavioral health crises, they must engage and fund new partners who can plan and implement different approaches. But developing alternatives that reduce police involvement in crisis response and divert people from jail does not require reinventing the wheel. There are many existing examples of community-based, health-centered responses that can lead to better outcomes for people with behavioral health issues. This report provides an overview of crisis response programs, including a typology of approaches organized by the involvement of law enforcement, before examining the efforts of three communities—Eugene, Oregon; Olympia, Washington; and Phoenix, Arizona—to reduce the number of crisis calls directed to police. Although these efforts involve varying degrees of police participation and collaboration, and each reflects different stages of program implementation, they all promote the use of alternative first responders who can intercept calls concerning mental health and substance use that would have otherwise gone to police. Finally, the report offers key considerations to aid communities in planning and implementing programs that shift responses from police to community.

Crisis response programs in context

Recent decades have seen severe reductions in behavioral health services due to a series of events, including deinstitutionalization and the failure to fund promised community-based services and supports.[4] Because of this failure, increasing numbers of people with mental illness and substance use disorders have come into contact with the police, experiencing trauma during these encounters and even ending up in jail, where they stay longer than people without behavioral

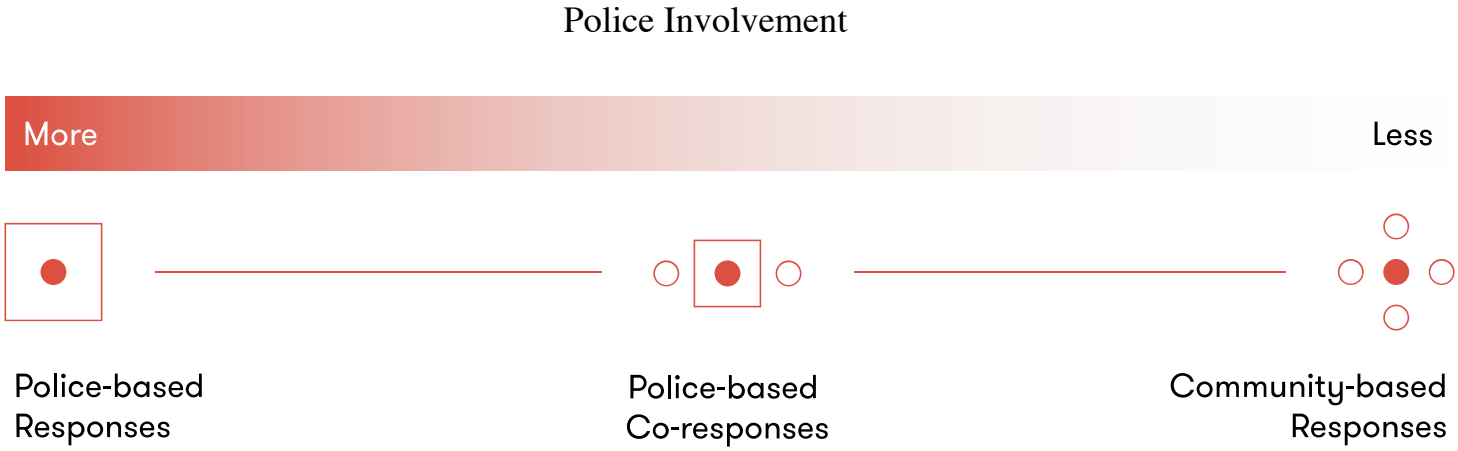
health conditions facing similar charges.[5] Many communities have increased both funding for correctional facilities and mental health treatment in jails; Rikers Island in New York City, Cook County Jail, and Los Angeles County Jail hold more people with behavioral health conditions than the dedicated mental health treatment facilities across the country.[6]

At the same time, some communities have introduced crisis response programs designed to address urgent concerns. These concerns include repeat encounters with police, poor connections to care, incarceration of people with mental illness for low-level offenses, and deaths of people with behavioral health conditions at the hands of police. The resulting programs, including Crisis Intervention Team (CIT) and co-responder models, often involve ongoing collaboration among police, advocates, and health and social service providers; extensive crisis scenario training for officers that includes de-escalation practice; and diversion from arrest to appropriate services and supports.

Unfortunately, many existing programs are hindered by an overreliance on police, limited community collaboration, and underinvestment in community-based resources. Communities must pursue new approaches that minimize trauma and distress, promote dignity and autonomy, and reduce repeat encounters with police for people who experience behavioral health crises. Reducing law enforcement involvement in crisis calls is a critical step toward these goals.

Typology

Community- and police-based crisis response approaches



Current crisis response approaches are wide ranging, with varying degrees of police involvement, and communities might pursue multiple approaches simultaneously. Why, then, do communities choose one strategy over another or adopt multiple, layered approaches? These decisions are

typically based on the specific problems that communities face and the resources available to address them. A lack of non-police resources often demonstrates how much local governments have prioritized criminal justice investments to address public health problems.[7]

As the following typology illustrates, existing approaches to crisis response are designed to handle a wide variety of situations, and multiple approaches may be needed to build a robust crisis response system that meets local needs. As communities rethink the role of police in crisis response, they must seek out and invest in community-based solutions.

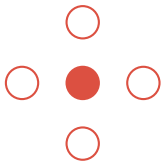
Police-based responses

- **Crisis Intervention Team (CIT) model**—Police officers with 40 hours of specialized training respond to behavioral health crisis calls, de-escalate the situation, and direct people to services when appropriate.[8] The model is based on strong community partnerships.
- **Case management teams**—Police convene multidisciplinary teams that use law enforcement and health data to identify people who frequently use emergency and behavioral health services and develop individualized response plans to connect them to services and other supports. The teams might involve proactive outreach of co-responding clinician/police officer teams, with the goal of developing solutions that reduce repeat interactions.

Police-based co-responses

- **Primary co-response teams**—Behavioral health clinicians co-respond with officers in patrol cars as first responders to situations involving someone in behavioral health crisis. These teams may include peer specialists. Clinicians may also co-respond remotely via phone or telehealth support.

- **Secondary co-response teams**—Behavioral health clinicians co-respond with officers in patrol cars at the request of police officers who respond first to situations involving someone in behavioral health crisis. Clinicians may also co-respond remotely via phone or telehealth support.



Community-based responses

- **Crisis and "warm" lines**—Crisis telephone lines are staffed by trained call-takers who provide remote counseling to people in crisis as an alternative to calling police. Warm lines are staffed by specially trained peers, who have lived experience with mental illness and provide phone support to people who are not in crisis.

- **Peer navigator programs**—Programs in which peers support recovery for people with behavioral health disorders. These programs hire and train peers who have lived experience with mental illness and/or substance abuse.[9] Programs may focus on people at risk of criminal justice involvement, offering them direct peer-to-peer support to avoid calls to police or trips to the emergency department.

- **Mobile crisis teams (MCTs)**—Teams composed variously of medics, crisis workers, and/or peers available to respond to people in crisis and provide immediate stabilization and referral to community-based mental health services and supports. When available, police may coordinate with MCTs for an alternative to police response, or community members can request them by calling appropriate service providers.

- **EMS-based responses**—Teams consisting of licensed counselors, clinical social workers, physicians, and EMTs who respond to people in crisis instead of police. The goal is to reduce arrests. These teams can transport people to services other than the emergency department to facilitate more appropriate treatment.[10]

- **911 diversion programs**—Procedures used by police, fire, and EMS dispatchers to divert eligible non-emergency, mental health-related calls to behavioral health specialists. These

specialists manage the behavioral health crisis by telephone and offer referrals to needed services.

Case Studies

This report highlights three communities—Eugene, Oregon; Olympia, Washington; and Phoenix, Arizona—that employ unique approaches to reduce police involvement in crisis calls and have layered several approaches in their efforts to address multiple problems:

- In Eugene, Oregon, the Crisis Assistance Helping Out on the Streets (CAHOOTS) program, housed in the White Bird Clinic, dispatches teams of mental health clinicians with a medic to respond to calls involving someone in crisis when safety is not an issue.

- Olympia, Washington, has introduced complementary initiatives to help people in crisis, including the Crisis Response Unit (CRU), which is modeled after CAHOOTS, and Familiar Faces, which provides peer outreach to people who are repeatedly coming to the attention of police.

- In Phoenix, Arizona, which has a comprehensive crisis response apparatus as well as a CIT program, 911 call-takers and dispatchers can refer crisis-related calls to a crisis line specialist who manages crises and makes referrals over the phone or deploys mobile crisis teams as needed, instead of police.

The case studies in this report are based on a review of the literature on police responses to people in behavioral health crisis, interviews with experts, and interviews with stakeholders in the highlighted communities. Communities were selected for their innovative approaches to reducing on-scene police response and shifting responsibility to behavioral health experts. You can read more about the methodology below.

CAHOOTS - Eugene, Oregon

CRU and Familiar Faces - Olympia, Washington

Robust Crisis Care and Diverting 911 Calls to Crisis Lines - Phoenix, Arizona

Key considerations in program development

To reduce police involvement in crisis calls, communities have had to surmount challenges and work together to determine how best to meet their goal of providing the right response at the right time for the right person. Ultimately, they have worked together creatively—police, behavioral health, advocacy, community residents, and others—to create programs that use existing resources and source funding for new ones to promote health and safety for all.

Identifying funding, configuring on-scene responses (who does what, when) while maintaining safety for everyone, and training needed personnel will form the backbone of any effort to replicate these models.

Funding

Programmatic efforts to reform police responses to people in behavioral health crisis around the country have been touted as adding few new costs to policing budgets.[11] Though this may have been true for police agencies, communities often need additional funds for the behavioral health services that would augment or replace police responses. The three communities Vera researchers studied each required significant funding (see case studies), and acquired it through a combination of grants, levies, and federal and state funds. Communities looking to implement new models should consider the following possible funding sources:

- police department budgets, which can be reallocated to support more comprehensive non-police response approaches;
- state grants, including police association grants that support non-police first responders or peer outreach;

- braided funding pooled together from local, state, and federal sources, as demonstrated in Arizona; and
- public safety levies that explicitly carve out funding for enhanced non-police crisis response.

911 call diversion

To truly reduce the police response to scenes involving people with mental illness, dispatchers must divert calls to 911 (and non-emergency numbers) to non-traditional responders. At the heart of the ability to divert 911 calls are two important needs. Departments must establish policies in conjunction with agency legal staff and train police department staff—and communications personnel—to understand that they are not going to be held liable for situations in which they do not respond to the call. Communities looking to implement new models should consider the following possibilities for 911 diversion practices:

- alternative first responders carry police radios so they can be dispatched to the scene or monitor and proactively intercept calls that might benefit from their behavioral health expertise; and
- legal staff address any potential liability for police or mental health service personnel by developing clear guidelines to determine which calls will be dispatched to mental health services or transferred to a mental health expert at the 911 call center.

On-scene response models

The task of removing the police from encounters with people in crisis requires extensive coordination among various responders to reduce potentially dangerous situations and foster connections to services for people with a wide range of needs. The sites Vera talked with have creatively managed to place the right person at the scene of a crisis to help manage a person's ongoing needs outside of the crisis and establish long-term solutions. Communities looking to implement new models should consider the following possible on-scene response approaches:

Eugene, OR

Specialists responding instead of police	• 911 operators dispatch CAHOOTS teams composed of a crisis worker and a medic to calls involving a person in crisis. • CAHOOTS teams can respond instead of or alongside police. • CAHOOTS offers voluntary services only, but can encourage treatment more effectively than police.

Olympia, WA

Specialists responding instead of police	• Behavioral health specialists monitor a police radio to identify situations that might require their skills. They can respond on-scene based on what they hear and work with officers at the scene on timing of engagement. • These teams of two specialists also conduct outreach at encampments of people experiencing homelessness to provide support and make connections to needed services.
Peer outreach	• Catholic Community Services hired two peers with lived experience in the criminal legal system as well as behavioral health conditions to respond to people frequently in contact with emergency service providers. • These peers identify in a novel way with clients referred to the program—they share lived experiences that can enable trust and provide extensive support. The peers do not respond to police dispatch and can work with people over time. Because of valuable relationship building, clients appear to be more willing to engage in strategies to address underlying needs, according to program staff.

Phoenix, AZ

Triaging calls from 911 to behavioral health experts	• Dispatchers identify calls appropriate for a behavioral-health-only response and forward them to the Crisis Response Network (CRN). • If they determine that an on-scene response is necessary, CRN specialists can dispatch a non-police mobile team trained in crisis intervention.

Recruiting and training personnel

The case studies reveal that people with certain traits and abilities are needed to do the work of compassionately and patiently helping people in crisis get the help they need. In addition, extensive training is needed because job responsibilities may be new to staff in these roles. Communities looking to implement new models should consider the following strategies for recruiting and training alternative responders and dispatchers:

- Rather than prioritizing responders with graduate-level training, programs like CAHOOTS identify team members based on their passion for serving people with behavioral health conditions and their ability to learn about the full range of community resources, work with police, engage people during crisis, and connect them to appropriate services;
- Training for line-level crisis workers features cross-training with officers to learn about police experiences in their communities, as well as building relationships with community-based organizations to learn about specific treatments and supports;
- Officers themselves dedicate time to learning about behavioral health outreach strategies and treatment approaches; and
- Dispatcher trainings include information about the crisis response system and the activities of behavioral health partners to ensure dispatcher confidence in those partners as they conduct their own assessments to deliver alternatives to police response.

Conclusion

Many community partners clearly have a role to play in supporting safe responses to people in crisis that center their dignity and long-term health outcomes. This report highlights important strategies and approaches to help communities navigate ways to reduce police involvement in situations involving someone in behavioral health crisis. Reducing police involvement in crisis response hinges on a robust and flexible crisis continuum that enables access to effective and appropriate treatments, services, and supports for a wide range of clients. Ultimately, creating alternatives to police responses will connect people in the community with the services they need, reduce arrest rates and the potential for violent police encounters, and promote the health and safety of community members.

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