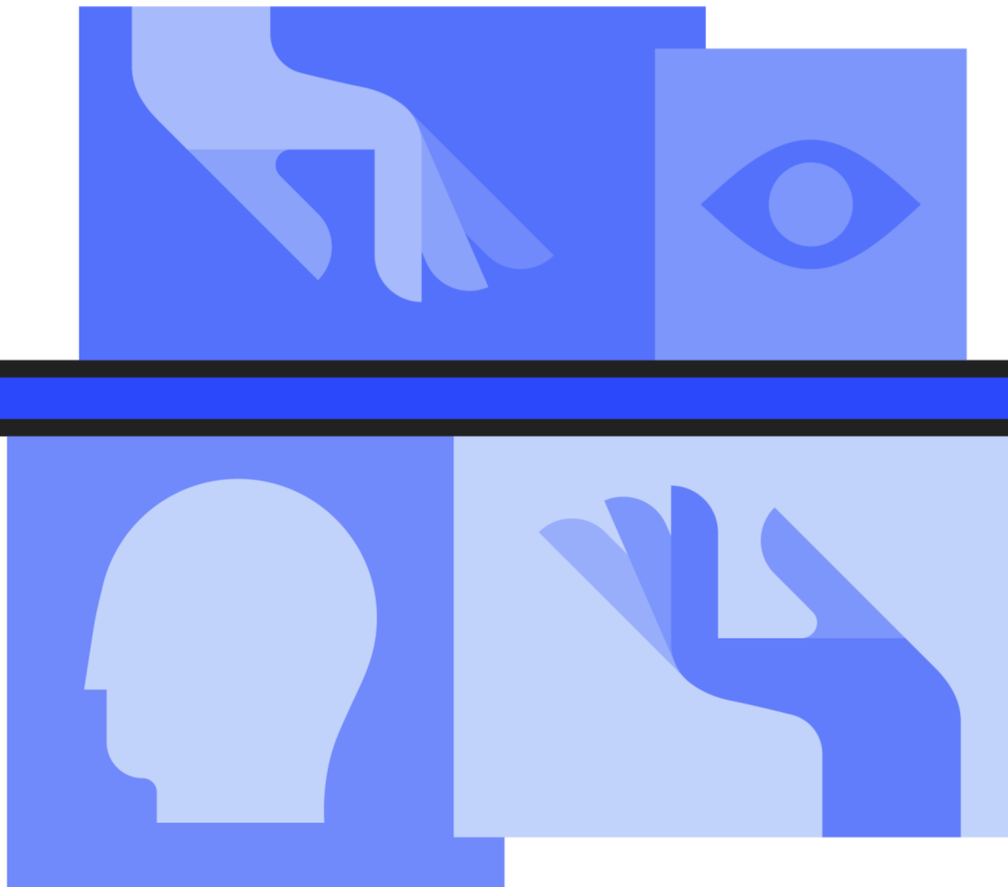
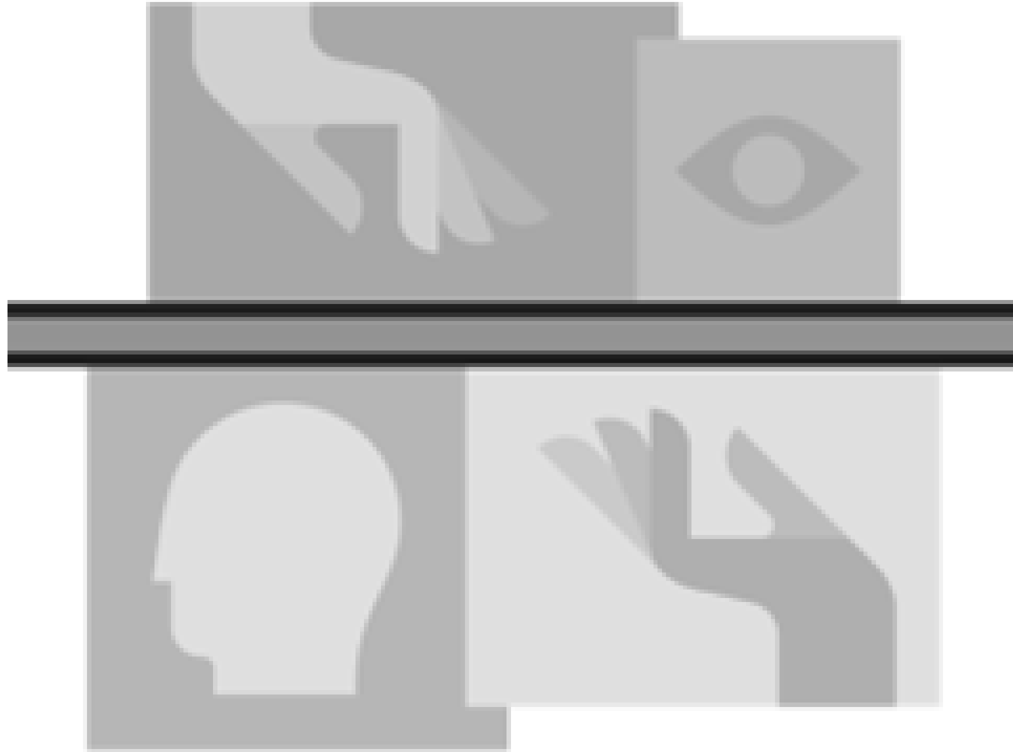


Dispatch Triage, Alternative Responders and Co-Response:

Ending Police-Only Responses To Mental Health 911 Calls

Communities United Against Police Brutality



Dispatch Triage, Alternative Responders, and Co-Response:

Ending Police-Only Responses to Mental Health 911 Calls

Communities United Against Police Brutality

Cover art, tables and graphics designed by Abigail Grewenow

This white paper is dedicated to Archer Amorosi, Benjamin Evans, Kobe Heisler, Travis Jordan, Keaton Larson, Phil Quinn and others who lost their lives at the hands of law enforcement during a mental health crisis.

With deep appreciation to the volunteers who spent many hours researching, writing, editing and reviewing this white paper. Our goal is to end the practice of police-only contacts for people in mental health crisis through presenting evidence and practical information to enable the necessary changes. We believe we have achieved this goal.

--Volunteers with the Mental Health Working Group of
Communities United Against Police Brutality
August 2020

As someone who's been a mental health practitioner for over 35 years, I cannot recommend this position paper strongly enough. Individuals and our society at large are still suffering from the broken promises of the mental health system's de-institutionalization process that began in the 1980s and has flooded our streets, our prisons, and our homes with people who cannot access the mental health care they desperately need. Then, when these people with chronic mental health challenges are in their most desperate moments of crisis, their need is often met with a visit from the police, which further threatens their life and their well-being.

We need a different strategy. This paper is a serious, well researched analysis of this problem that presents a vision of a better way: responding to mental health emergencies with mental health professionals. I encourage you to read it, and endorse these proposals.

Rev. Daniel Wolpert, M.A., M.Div.
Executive Director, Minnesota Institute of Contemplation and Healing

PREFACE

Communities United Against Police Brutality (CUAPB) is a Minnesota all-volunteer grassroots organization that provides advocacy for survivors of police misconduct and the families of people killed by police. We work to address the underlying causes of unjust and harmful policing. Part of that work is research to help communities understand relevant problems and seek better solutions.

This paper addresses field contact between police and people experiencing mental health issues. This is a narrow focus on a key crossroad in time. These contacts are the common points of divergent outcomes that lead to consequences for vulnerable persons, the criminal justice system, and the community. It is time to take a fresh look at how these contacts are handled, who handles them, and how to enable alternative responses when appropriate. This paper challenges the common reflex to simply provide more police training and casually accept the problems that arise thereafter. It is time to ask: Why are police officers responding? Why a police-only response? Why aren't police collaborating on-scene with mental health professionals more often?

These questions are at the heart of the crisis created by the ongoing surge in police contacts with persons who suffer from mental illness. In a September 22, 2017, PoliceOne.com article, Booker T. Hodges, a veteran Minnesota law enforcement officer, explored the relevant questions. His words are an apt starting point for this paper.

> *I have been a Crisis Intervention Team (CIT) coach for over a decade and believe the current push for more mental health care training for police officers is a good thing in part. I say in part because after years of experience and research, I do not believe that law enforcement should be responsible for responding to non-violent mental health calls.*
>
> *As a profession, we are problem solvers. The public and elected officials know this, so they keep heaping societal problems on us with the expectation that we solve them. It is time we start saying no.*
>
> *There are two reasons why I believe society should stop having police officers respond to non-violent mental health calls:*
>
> *1. Cops lack adequate mental health care response training*
>
> *The average psychologist has between 10-12 years of college education in addition to 3,000 hours of supervised training. A licensed mental health care professional has between 7-8 years of college education in addition to hundreds of hours of supervised training.*
>
> *By comparison, a police officer who attends a CIT course receives 40 hours of formalized training. Most police officers receive far less than 40 hours training afforded to those who attend CIT training.*

Yet despite this gap in training, society expects police officers to show up and handle mental health calls with the same precision and expertise of a mental health care professional. This is an unrealistic expectation.

We are setting police officers up for failure by continuing to send them on calls that, in spite of our best efforts, we can never train them well enough to handle.

2. Law enforcement brings the tail of the criminal justice system

There is a consensus within society that the criminal justice system is not the appropriate place to handle those who suffer from mental illness.

In light of this, it makes no sense to send police officers – who bring the tail of the criminal justice system with them – on calls involving non-violent mentally ill individuals.

The chance of a non-violent mentally ill person being interjected into the criminal justice system increases when they come into contact with police. Our jails are full of people suffering from mental illness who have no business being there, yet society keeps sending them because there is no other place for them to go.[1]

[1] 2 reasons cops should not respond to non-violent mental health calls. Hodges, Booker. Police1. Lexipol. September 22, 2017. https://www.policeone.com/patrol-issues/articles/421707006-2-reasons-cops-should-not-respond-to-non-violent-mental-health-cal

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EXECUTIVE SUMMARY

Law enforcement officers have many contacts with persons living with mental illness. Many of these contacts are unnecessary and avoidable. Unfortunately, such contact has become an accepted status quo. In the past several years, a marked increase in the number of mental health-related calls has burdened police agencies. Using police officers in this role has also burdened emergency rooms and filled the jails. Now, there is wider recognition that police officers are wholly inadequate in the role of de facto mobile mental health crisis workers. Using police officers in this way has resulted in greater suffering and tragic outcomes for vulnerable persons.

This paper examines the game-changing reform options that can be applied from the time of 911 call intake to the arrival of responders on-scene. 911 systems will always receive some mental health-related calls and some police contacts are unavoidable. However, a mental health crisis is a medical emergency deserving a medical response – even if the response is initiated through 911 emergency systems. The goal should be to minimize the use of police-only responses to emergency calls involving a mental health crisis.

Three clear avenues exist for improving upon the status quo: 1) robust dispatch triage to deflect calls away from police contact whenever possible, 2) rapid on-scene alternative responder options that utilize highly skilled mental health professionals, and 3) well-utilized co-response options to get mental health professionals on-scene in circumstances where a police presence cannot be avoided. Efforts to bypass 911 systems altogether are essential but outside the scope of this paper. Dispatch triage involves the training and practices needed to enable 911 dispatchers to deflect calls to alternative mobile mental crisis responders. Where there is no law enforcement function or public safety concern, these calls should be deflected to non-police mobile mental crisis responders.

Any non-police crisis response must utilize highly qualified mental health professionals and provide rapid on-scene response. Unfortunately, many relevant police contacts are unforeseen or unavoidable. Sometimes there is a reported safety concern, a criminal component, or the mental health aspect becomes apparent only after police arrive on-scene. In such cases a co-response option should be utilized whenever possible. The co-response option is an indispensable parallel means of preventing police-only contacts with persons in mental health crisis. Implementing dispatch triage and the parallel response options can reduce waste of taxpayer funds. These silo-breaking reforms can be part of larger campaigns to integrate service delivery for high utilizers of medical and emergency services. Those with co-occurring disorders, including substance use disorder, will be especially well served by these changes.

Funding such reforms is possible because they create efficiencies and address a public need. The status quo, which has normalized the use of police as de facto mobile mental crisis response workers, must yield to more patient-centered approaches. This is both a practical and moral imperative for our society.

I. INTRODUCTION

In Minnesota, in a three-week period between November and December 2018, five people experiencing mental health crises were killed during encounters with law enforcement.[2] Nationally, fully 50% of people killed by police had a disability.[3] [4]

> *Don't get me wrong, I have the highest respect for police officers and those who serve our communities and our countries. But when statistics show that half the people you're shooting are people with a* ***mental health problem****, not a criminal problem, that's really eye-opening.*[5]

Furthermore, people with untreated mental illnesses are a staggering 16 times more likely to be shot and killed by police.[6]

These shocking statistics point unequivocally to the need to limit police-only contacts with people experiencing mental health crises. Yet in this country, for a variety of reasons, police have become de facto mental health crisis responders.

> *The most striking change in the care of persons with mental illness in the United States in the last three decades has been the transfer of responsibility from mental health professionals to law enforcement officers. It is now well-known that jails and prisons have become the de facto frontline "inpatient units" for seriously mentally ill persons. What is less well known is that law enforcement officers are now functioning as the frontline "outpatient system."*[7]

> *But the police – who are trained to give orders and use force when they feel endangered – are generally ill-equipped to handle people with mental health challenges.*[8]

---

[2] CUAPB Stolen Lives. https://www.cuapb.org/stolen_lives

[3] Half Of People Killed Have Disability. https://www.nbcnews.com/news/us-news/half-people-killed-police-suffer-mental-disability-report-n538371

[4] Across Nation, Unsettling Acceptance When Mentally Ill in Crisis are Killed. https://www.pressherald.com/2012/12/09/shoot-across-nation-a-grim-acceptance-when-mentally-ill-shot-down/

[5] Half of Police Shootings Involve People with Mental Illness. https://psychcentral.com/blog/half-of-police-shootings-involve-people-with-mental-illness/

[6] People with Untreated Mental Illness 16 Times More Likely to be Killed By Police. https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness/2976-people-with-untreated-mental-illness-16-times-more-likely-to-be-killed-by-law-enforcement-

[7] 2013 Treatment Advocacy Center Report. https://www.treatmentadvocacycenter.org/storage/documents/2013-justifiable-homicides.pdf

[8] To Stop Police Shootings of People with MH Disabilities. https://theconversation.com/to-stop-police-shootings-of-people-with-mental-health-disabilities-i-asked-them-what-cops-and-everyone-could-do-to-help-126229

Police are poorly trained to fill the role of first responder for people experiencing mental health crises. This is understandable because it takes years of training and experience to become a mental health provider. Furthermore, the role of police in society is to determine if a crime has occurred, investigate individuals' involvement in the crime, and gather evidence for prosecution. By necessity, they approach their work from a public safety perspective. Even specialty training such as Crisis Intervention Training (CIT) is not adequate to allow police officers to replace qualified mental health professionals in addressing mental health crises.

> *"Officers are simply not the most qualified people to respond to a mental health crisis," ACLU-MN Executive Director John Gordon said in a statement*[9]

The current system of police-only response to mental health crisis calls is not only dangerous but practically guarantees that people fall through the cracks by not getting mental health care when they need it. They become heavy utilizers of police and emergency services.

> *Run-ins with the police were a regular occurrence for many of my clients, with officers often knowing them by name. They were overwhelmingly poor, and poor people with mental illnesses are also likely to experience homelessness and substance abuse – issues that place them at increased risk of police contact and incarceration.*[10]

Time for Real Solutions

> *Psychiatric disease is one of the few medical conditions in US public healthcare for which treatment is routinely deferred until people become so sick they require emergency hospitalization and intensive care. Serious mental illness (SMI) is also a disease for which intervention is routinely left to nonclinical facilities such as jails, prisons or homeless shelters. This twin dysfunction has the disastrous outcome of producing a large population of acutely ill people who revolve, untreated or under-treated, through the healthcare and social and criminal justice systems.*[11]

> *It is time to do something different and to humanize people in a mental health crisis.*
>
> *– Tessa Andrews, mother of Keaton Larson, who was killed by Stillwater police in his home while in a mental health crisis*[12]

---

[9] Stillwater Mom Speaks Out. https://patch.com/minnesota/stillwater/stillwater-mom-speaks-out-after-son-shot-killed-police

[10] Where Police Violence Encounters Mental Illness. https://www.nytimes.com/2016/01/13/opinion/where-police-violence-encounters-mental-illness.html

[11] Revolving Door of Serious Mental Illness in Super Utilization. https://www.treatmentadvocacycenter.org/storage/documents/smi-super-utilizers.pdf

[12] Stillwater Mom Speaks Out, op. cit.

A system that enables appropriate responses to mental health crisis calls must include dispatch triage, deflection to a mobile mental health crisis team whenever possible, and co-response when deflection is not possible. Such a system avoids a police-only response to these calls.

A. Law Enforcement Response to Mental Health Crises

Law enforcement has frequent, often unavoidable, contact with persons experiencing mental health crises. The scale of this problem can be reduced by deflecting these interactions away from police through better practices at 911 call centers. This paper explores this option in depth.

Unfortunately, many mental health-related police contacts will continue to occur through necessity or unforeseeable circumstances. Survey data indicates that 30% of the police contacts that result in a transport to care are made during regular patrol, not on mental health-related calls for service.[13] Two Minnesota cases highlight this situation. Both Dominic Felder and David Smith were killed by police dispatched to disturbance calls.[14] [15] Both victims were unarmed. In cases where unavoidable police contact occurs, on-scene co-response by mental health professionals can enable the response to quickly evolve into a professional crisis care response.

The status quo in the U.S. does not promote deflection to mental health clinicians or real-time co-response. When calls for service have a mental health aspect, there is broad failure to deflect those calls to teams comprised of mobile mental health professionals. There is also systemic resistance to real-time, on-scene co-response by mental health professionals. This should not be the case.

B. Law Enforcement Officers as De Facto Mobile Mental Health Crisis Workers

Decades ago, the process of de-institutionalization greatly reduced the number of persons confined to state mental hospitals. But deinstitutionalization is half the story. The old system of confinement was supposed to be replaced with an large and effective system of community-based care. This failure promoted policies and practices that increasingly leveraged police officers as de facto mobile mental health crisis workers.[16] Thus, responding officers become gatekeepers to proper mental healthcare.[17]

There are a number of consequences of this paradigm. Community members in mental health crisis are at elevated risk of physical harm. There is reduced access to and efficacy

[13] Road Runners, p. 28. https://www.treatmentadvocacycenter.org/storage/documents/Road-Runners.pdf
[14] Dominic Felder Verdict. https://www.mprnews.org/story/2010/10/25/excessive-force-verdict
[15] David Smith Verdict. http://www.startribune.com/feb-7-2012-man-s-death-puts-minneapolis-police-tactic-under-scrutiny/138821999/
[16] Police as Streetcorner Psychiatrist. https://www.sciencedirect.com/science/article/abs/pii/016025279290010X?via%3Dihub
[17] Heyman, I., & McGeough, E. (2018). Cross-Disciplinary Partnerships Between Police and Health Services for Mental Health Care. *25*(5–6), 283–284. doi: 10.1111/jpm.12471

of crisis and stabilization services. Specifically, officers who do not collaborate on-scene create the potential for avoidable trauma, police use of force, incarceration, costly ambulance transfers, revolving door emergency room visits, inappropriate dispositions, and poor handoffs to mental health workers or stabilization services. There is real potential for waste and missed treatment opportunities.

Inefficiencies and lack of deflection to or collaboration with mental health clinicians are symptoms of a "separate silo" response to co-occurring conditions often experienced by people in crisis. The failure to increase collaboration and to utilize proper expertise is an expensive mistake for taxpayers. The focus on managing the problem "downstream" of initial contact creates burdens that could have been mitigated with reforms like dispatch triage and on-scene collaboration when police make first contact.

The least-inspired approaches to the problem, and its consequences, tend to focus on expanding budgets within the existing frameworks of operation. Bartkowiak-Theron and Asquith have shared a better way of thinking about the problem and its consequences.[18] They have added their voices to previous calls for collaboration between the mental health system and police agencies. They sought to identify the conceptual dissonance that continues to frame the debate about law enforcement and public health. This "conceptual dissonance" is the problem as much as any policy, practice, law, or budget limitation:

> *The divide between law enforcement and public health is futile. The everyday 'reality' of police officers and health professionals in their interactions with vulnerable people is a constant reminder of how law enforcement and public health are inextricably linked. However, the siloed operationalization of vulnerability in current policies is counterproductive. Addressing the layers of universal human vulnerability and situational vulnerability presented in every law enforcement or public health encounter requires the abandonment of siloed policies and practices. It also requires the operationalization of collaborative partnerships as core business, which are budgeted and integrated in strategic directions. Policing and public health organizations could inculcate an ethics of care as a first step in moving beyond selective approaches currently adopted. Public safety and public health have long been linked at the practice level but estranged at the level of the concepts and policies underpinning these practices. Reframing the critical issues facing both public health and law enforcement through the lens of vulnerability may provide the building blocks required to create space for more productive law enforcement and public health synergies and fewer instances of dissonance.*

[18] Bartkowiak-Théron, I. & Asquith, N.L. (2017) Conceptual Divides and Practice Synergies in Law Enforcement and Public Health: Some Lessons From Policing Vulnerability In Australia, Policing and Society, 27:3, 276-288, DOI: 10.1080/10439463.2016.1216553

It is a truism for those providing crisis services that outcomes and efficiency are optimized by providing *THE RIGHT SERVICE, AT THE RIGHT PLACE, AND AT THE RIGHT TIME*. This paper seeks to challenge the reader to overcome "conceptual dissonance" and question how the above truism (and the implied goal) can be applied to law enforcement field contacts involving mental illness.

C. The Scope of the Problem

In most counties in the United States the largest mental healthcare facility is the county jail. Furthermore, the police are filling a primary role as de facto mobile mental health crisis workers.

> *Police departments have become a de facto arm of the American mental-health system. Research suggests that about 2 million people with serious mental illness are booked into jails in the United States each year. A 2016 review of studies estimated that 1 in 4 people with mental illness has a history of police arrest. The Treatment Advocacy Center, a nonprofit that studies topics related to mental health, has calculated that the odds of being killed during a police encounter are 16 times as high for individuals with untreated serious mental illness as they are for people in the broader population.*[19]

These realities are due, in great part, to under-resourcing of the mental healthcare system in the United States. However, it is equally true that inadequate efforts have been made to deflect patients from contact with police and divert persons with mental illness from incarceration. Persons with serious mental illness (SMI) represent 4% of the population but 17% of the jail population.[20]

One reason this vulnerable population is overrepresented in jails is the enforcement of quality of life violations. Co-occurring conditions such as substance use disorder (SUD) and homelessness are common and problematic.[21] Longer lengths of incarceration are also a factor.[22] Lack of treatment and poor treatment in the jail setting set up this population to experience a "revolving door" cycle of contact with the criminal justice system.[23]

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[19] Police and Psychiatrist Team. https://beta.washingtonpost.com/national/health-science/police-encounter-many-people-with-mental-health-crises-could-psychiatrists-help/2018/07/20/20561c26-7484-11e8-b4b7-308400242c2e_story.html?noredirect=on

[20] Serious Mental Illness in Jails and Prisons. https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf

[21] Mental Health Problems of Prison and Jail Inmates. https://www.bjs.gov/content/pub/pdf/mhppji.pdf

[22] More Mentally Ill People in Jails and Prisons Than Hospitals. https://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf

[23] MI Revolving Door. https://www.calhospital.org/sites/main/files/file-attachments/grand_jury_mental_illness_website_0.pdf

The results of this system-wide failure are clear. Los Angeles County, California, currently operates a jail that is the largest mental health facility in the United States.[24] The incidence of mental illness within some county jail systems can be very high. A 2014 spot survey of the population in the Hennepin County Jail showed a 52% incidence of mental illness.[25] [26]

Somewhat ironically, county jails are the sector of the criminal justice system that is making a noticeable effort to link into the care continuum for mental illness and substance abuse treatment. There are more psychiatric services being offered within jails, and special jail units are being constructed. Tragedies and liability have been a factor in this, but so too has the realization that treatment reduces recidivism. Whatever the rationale, no one believes jails offer adequate care, much less appropriate environments, for this population. The best overall outcomes (including taxpayer benefits) come from avoiding the incarceration of persons with mental illness. Unfortunately, while jails become de facto mental health institutions, there continues to be far too little investment and innovation "upstream" at the point of police contact.

> *Upstream-downstream thinking has great relevance for jail-SMI interventions. Much of current jail diversion efforts focus on post-booking interventions such as mental health courts, mandated treatment, and mental health probation. All of these represent downstream interventions trying to rescue people who have already flowed into the criminal justice system. Although necessary, such efforts alone are not sufficient. We also need to be looking for upstream prevention strategies that can help to intercept and divert the flow of persons with SMI into local jails.*[27]

Much is at stake when police have contact "upstream" of the other systems. These contacts often happen at times of deep crisis. For the person in crisis, this police contact can be a life-altering event—for good or ill. There is the risk of trauma, use of force, arrest, monetary punishments (fines, court fees), and tragedy. There is also tremendous opportunity to help people if innovative methods and collaborations are applied. These collaborations, at these key moments in time, are even more important when there are co-occurring conditions such as substance abuse. Preventing harm at this point can have a cascading positive affect on multiple government systems. The important thing, however, is to help the person get through a psychiatric crisis or emergency.

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[24] More Than Half of LA Inmates Mentally Ill. https://laist.com/2020/01/07/mentally-health-jail-la-diversion.php
[25] Mental Illness Far Higher in Hennepin County Jail. http://www.startribune.com/mental-illness-in-hennepin-county-jail-far-higher-than-previous-estimates-new-study-finds/394483221/
[26] Mental Health Services in County Jails. https://robinainstitute.umn.edu/sites/robinainstitute.umn.edu/files/mn_leg_auditors_report.pdf
[27] When Political Will is Not Enough. (p. 12) http://www.safetyandjusticechallenge.org/wp-content/uploads/2015/05/White-Paper-hjs-jpm-final.pdf

The opportunity to help people was very much on the mind of the Pitkin County, CO, Undersheriff, Roy Ryan, when his department began a collaborative on-scene police/mental-health-professional response program:

> *"I also appreciate that our community's initial contact with their public servants will not be enforcement-minded as much as it will be big-picture problem solving, knowing that many of the people we contact are struggling with other, much larger, issues than the reason for our contact," Ryan said.*[28]

Police contacts with persons in mental health crises are nothing new. Back in 1979, academic researchers began to refer to the "gray area" of police work, where the law and order function blends with informal work to help vulnerable people in need. One thought leader of the time went so far as to label police the "secret social service."[29] Teplin called police "street-corner psychiatrists" due to their routine interactions with persons living with mental illness.[30] In fact, most police contacts with persons with mental illness are firmly within the "gray area" where there is no criminality, no violence, and no need for emergency apprehension.[31] As a society we responded to these "gray area" contacts by adding more police training. That simple solution was woefully inadequate.

In these modern times, the evolution of public policy toward complete and effective "care continuums" can and should be applied to police contacts. Police contacts should be considered nodes in the care continuum for persons with SMI. Failing to do so will ensure that critical opportunities to help people will be missed or poorly leveraged.

There are some metrics that describe the scope of the problem of police being used as de facto mobile mental crisis workers. Law enforcement agencies have been seeing the number of mental health-related calls for service increase dramatically over recent years.[32] [33] [34] [35] [36]

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[28] Mental Health Assistance Now Available During Police Encounters. https://www.aspendailynews.com/news/mental-health-assistance-now-available-during-police-response/article_e7cfdafe-9246-11e9-a8b6-abf0e499a7f0.html
[29] Punch, M. Secret Social Service. 1979, Sage Publications. https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=66566
[30] Teplin, L.A., & Pruett, N.S., op. cit.
[31] Wood, J. & Watson, A. Improving Police Interventions. http://dx.doi.org/10.1080/10439463.2016.1219734
[32] Police Calls Involving Mental Health in St. Paul Have Doubled. https://www.twincities.com/2018/03/31/new-st-paul-mental-health-officers-look-at-policing-differently/
[33] Brooklyn Park PD Adopts Vitals. https://thevitalsapp.com/announcements/brooklyn-center-police-launch-app
[34] Wichita PD Explosion of Growth. https://www.ksn.com/news/local/an-explosion-of-growth-wichita-pd-on-mental-health-calls-taxing-on-officers/
[35] Lakeville PD Follow Up on Mental Health Calls. http://www.startribune.com/lakeville-police-team-formed-to-follow-up-on-mental-health-calls/307636751/
[36] NYPDs Mental Illness Response Breakdown. http://nymag.com/intelligencer/2019/03/special-report-nypds-mental-illness-response-breakdown.html

The number of police calls for service involving mental illness is certainly large and yet difficult to pinpoint with precision. Many such calls are hidden under call descriptors having nothing to do with mental illness. This problem with police record management and dispatch systems was first described by CSGJC in 2002 and remains unaddressed.[37] Thus, there is little value in the call tally estimates based on call descriptors that suggest only 7%–11% of calls have a mental health aspect.[38] Newer estimates, created when officials explore the call records in minute detail, reveal the real scope. For example, the St. Paul Police Department (SPPD) demonstrated that the number of calls "hidden" in non-related call descriptors in 2016 was greater than the number of calls for service recorded under mental health-related call descriptors.[39] Notably, the SPPD's total tally of mental health-related calls in 2016 was 21,049. This was 33% of the total number of calls for service.

Back in 2014, the Minnesota Chiefs of Police Association documented the trend of increasing police contacts with persons in mental health crisis.

> *According to a 2014 MCPA survey, approximately 95 percent of Minnesota law enforcement agencies say such calls have increased over the last five years with 20 percent of agencies saying the calls more than doubled in the last five years.*[40]

It was part of a national trend that only worsened. Some jurisdictions realized that a very large percentage of calls have a mental health aspect. In Albuquerque, a large police survey showed that mental health was the primary factor in 33% of calls.[41] Locally, the 2015 Annual Report of the St. Anthony Police Department included a frank description of how often their officers encounter mental illness.

> *Training officers to deal with mental and behavioral health issues was a priority this year. Calls for assistance, welfare checks, disturbances, domestics, run-aways, medicals and other like service calls, places a front-line officer on over 50% of the calls in direct contact with drug impaired, mentally unstable, mentally ill, psychotic, suicidal, and others in crisis.*[42]

While county jails are the largest mental healthcare institutions in many counties, it seems apparent that law enforcement agencies, as a group, are the major suppliers of mobile mental health crisis services in many U.S. counties. Police contacts are usually so great in number that they dwarf the capacity of local county mobile mental crisis

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[37] CSG Consensus Report, p. 64. https://csgjusticecenter.org/publications/the-consensus-project-report/
[38] PCSO Creates MH Crisis Unit. https://www.wfla.com/news/pasco-county/pasco-sheriff-creates-new-unit-to-tackle-mental-health-crisis/
[39] Police Calls Involving MH in St. Paul Have Doubled, op. cit.
[40] MCPA Legislative Update. https://mcpa.memberclicks.net/assets/Magazine/final_spring_2016.pdf
[41] Police Perceptions Albuquerque. https://www.cabq.gov/mental-health-response-advisory-committee/documents/survey-of-police-officers-for-calls-for-services-as-mental-illness.pdf
[42] St. Anthony PD 2015 Annual Report, p. 14. https://www.savmn.com/Archive/ViewFile/Item/52

response teams. With call volumes exploding, many law enforcement agencies are eager to escape the trap that old practices have created.

Unfortunately, some police agencies are hesitant to embrace on-scene collaborative solutions or deflection options. These intractable agencies typically seek “downstream” public investments to ease the burden of handling mental health contacts without collaboration. There is, frankly, too much at stake for our communities and vulnerable individuals to allow those who fear innovation and collaboration to prevail.

D. The Comparison That Matters: Police Officers vs. Mental Health Professionals

In Minnesota, the mental health credentials required to respond to a mental health emergency are defined by statute.[43] The lead worker in a mobile crisis response team usually has a master’s degree in social work (MSW) with appropriate state licensure (LICSW). Mental health crisis workers become licensed by completing 4000 hours of supervised experience and passing an exam.[44] Hiring for the positions is highly competitive. Successful applicants bring additional qualifications including being bi- or multilingual, certified to conduct substance abuse (Rule 25) assessments, and/or have additional experience in the field.[45] There is a significant path to earning the right to be a mental health professional employed as a mobile mental health crisis responder.

By contrast, standard preparation for police officers who come in contact with persons in mental health crisis is Crisis Intervention Team (CIT) training. This is a 40-hour certification course for peace officers designed to improve empathy, de-escalation skills, and the ability to recognize symptoms of mental illness.[46] There is no prerequisite requirement for experience, education, or even interest in the subject; agencies often make it mandatory. There is no requirement for periodic re-training to maintain the certification. Lastly, this training emphasizes approaches that are often in conflict with the nature and substance of other ongoing police training and socialization.[47]

It should be no surprise that results in the field often reflect officers’ relative lack of expertise. In the field, officers’ core training tends to fills in gaps in knowledge and perception.

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[43] MN Statute 256B.0624 creates the requirements which utilize the terms Mental Health Professional and Mental Health Practitioner. See Glossary for definitions of these terms. https://www.revisor.mn.gov/statutes/cite/256B.0624

[44] MN Board of Social Work LICSW Requirements. https://mn.gov/boards/social-work/applicants/applyforlicense/licsw.jsp

[45] MN Rule 9530.6615. https://www.revisor.mn.gov/rules/9530.6615/

[46] CIT Core Elements. http://cit.memphis.edu/pdf/CoreElements.pdf

[47] Police Command and Control Culture is Often Lethal. https://www.aclu.org/blog/criminal-law-reform/reforming-police/police-command-and-control-culture-often-lethal-especially

> *Being overwhelmed can cause people with psychiatric and intellectual disabilities to shut down. If this behavior is interpreted as obstinate, it can lead to arrest, detention or police aggression.*
>
> *People with these disabilities are also often disbelieved by the police. A woman I interviewed – who communicated slowly due to her disabilities – said she called 911 on her boyfriend for hitting her. But the police believed the boyfriend's story that she was the violent one and arrested her instead.*
>
> *"When they find out that you're not capable of understanding what's going on, it's a free for all," another interview subject told me.*[48]

Added concern arises from the pervasive warrior ethos that has spread throughout police culture. Recently, police administrators have attempted to supplant this with the concept of police as guardians.[49] The following is a quote from a 2016 Police Executive Research Forum publication:

> *Several forum participants noted that while the traditional approach to police hiring has skewed heavily toward the "warrior" aspects of the profession, agencies today need to focus attention on recruiting and hiring for the "guardian" role that police officers must be prepared to play. In fact, some forum participants argued that agencies should concentrate most of their attention on ensuring that applicants coming into the system have the necessary qualities of the guardian, because the warrior elements of the job can be taught.*[50]

However, the "warrior problem" persists, and it poisons officers' ability to manage contacts with persons in mental health crisis.[51] Seth Stroughton, an ex-law enforcement officer turned university law professor, is a well-known critic of the "warrior perspective."[52]

> *From their earliest days in the academy, would-be officers are told that their prime objective, the proverbial "first rule of law enforcement," is to go home at the end of every shift. But they are taught that they live in an intensely hostile world. A world that is, quite literally, gunning for them. As early as the first day of the police academy, the dangers officers face are depicted in graphic and heart-wrenching recordings that capture a fallen officer's last moments. Death, they are told, is*

[48] Police Encounters Gone Wrong. https://nationalinterest.org/blog/buzz/police-encounters-gone-wrong-draw-attention-mental-health-issues-96161
[49] Minneapolis Bans Warrior Training. http://www.startribune.com/minneapolis-to-ban-warrior-training-for-police/508756392/
[50] Hiring 21st Century LEO. https://digitalcommons.cedarville.edu/history_and_government_presentations/190
[51] Time to Rethink MN Police Training. https://www.minnpost.com/community-voices/2016/07/it-s-time-rethink-minnesotas-system-police-education-and-training/
[52] Law Enforcement's Warrior Problem. https://harvardlawreview.org/2015/04/law-enforcements-warrior-problem/

> *constantly a single, small misstep away. A recent article written by an officer for* Police Magazine *opens with this description: "The dangers we expose ourselves to every time we go [on duty] are almost immeasurable. We know this the day we sign up and the academy certainly does a good job of hammering the point home." For example, training materials at the New Mexico Police Academy hammer that point quite explicitly, informing recruits that the suspects they will be dealing with "are mentally prepared to react violently." Each recruit is told, in these words, "[Y]ou could die today, tomorrow, or next Friday"…*
>
> *For Warriors, hypervigilance offers the best chance for survival. Officers learn to treat every individual they interact with as an armed threat and every situation as a deadly force encounter in the making. Every individual, every situation – no exceptions…*
>
> *From the warrior perspective, the solution is simple: the people with whom officers interact must accede, respecting officers' authority by doing what they are told. The failure to comply is confirmation that the individual is an enemy for the Warrior to vanquish, physically if necessary. And this creates avoidable violence.*

The "warrior problem" doesn't lead to avoidable use of force in every instance, but it certainly can play a role when officers encounter a person who is non-communicative, agitated, or acting erratically. It only adds to the evidence indicating that it is folly to use police as stand-alone, de facto mobile mental health crisis workers.

To be fair, consideration should be given to the psychological burdens placed on police officers by failing to implement "dispatch triage" and collaborative response models. Persons performing crisis response work are subject to Secondary Traumatic Stress (STS), which can eventually lead to a diagnosis of Post-Traumatic Stress Disorder (PTSD). Mental health professionals have long understood this problem. Researchers have found that many social workers are likely to experience at least some symptoms of STS, and when working with traumatized persons, as many as 15% may even eventually meet the diagnostic criteria for PTSD. The burnout rate of social workers is reportedly 39%.[53]

Police officers face just as much stress and might come to the task of a mental health-related call with trauma from many types of experiences. Even routine encounters in policing can create STS in many officers. Ellen Kirschman, Ph.D., a licensed clinical psychologist specializing in police and public safety, is one of many who see a cause for concern.

Ellen Kirschman, Ph.D.:

> *There are approximately 900,000 sworn officers in the United States. According to some studies, 19% of them may have PTSD. Other studies suggest that*

[53] Social Worker Burnout. https://sophia.stkate.edu/cgi/viewcontent.cgi?article=1806&context=msw_papers

> *approximately 34% suffer symptoms associated with PTSD but do not meet the standards for the full diagnosis.*
>
> *This is pretty alarming. An officer with PTSD cannot think clearly. He is probably hyper vigilant, has a short fuse, may not be sleeping well because of nightmares, might be policing in a reckless manner, constantly triggered by reminders of the event, self-medicating, or making such great efforts to avoid a similar situation that he isn't doing the job properly.*[54]

Mobile mental health crisis response is difficult work. Both groups of workers—police officers and mobile mental crisis social workers—can be affected by STS, but the officer group differs in how they are selected, trained, and supervised. This affects how each group copes with psychological burdens of their jobs.

> *New research from the Buffalo School of Medicine and Biomedical Science points to links between police brutality and pre-existing post-traumatic stress disorder (PTSD) in the officers themselves.*
>
> *For the public, the danger of police officers developing PTSD comes from an increased startle response, suspicion, and aggressiveness. These tendencies can make officers more likely to lash out at the public and result in the deadly overreactions that sometimes occur.*[55]

The growing scope of the problem has garnered attention from researchers, law enforcement, and even the public.[56] [57]

One shocking video tells the story of a CIT-trained officer whose own traumatization overcame his training. Ofc. Bryant is a CIT officer and de-escalation trainer who acted out the worst-case scenario of a traumatized officer's behavior and almost killed his own son.[58]

Add this to the list of reasons law enforcement officers do not deserve the burden, or responsibility, of handling mental health-related calls absent on-scene collaboration with mental health professionals.

E. Our Scope: A Narrow Focus on the Point of Contact with Police

This writing explores the specific circumstances in which police are so often used as de facto mobile mental health crisis workers in our communities. We will examine potential

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[54] Cops and PTSD. https://www.psychologytoday.com/us/blog/cop-doc/201811/cops-and-ptsd
[55] Officers with PTSD. https://www.psychologytoday.com/us/blog/talking-about-trauma/201511/officers-ptsd-greater-risk-police-brutality
[56] Work Environment and Officer PTSD. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3974929/
[57] 2017 Police Suicides. https://www.lawofficer.com/2017-police-suicides-continuing-crisis/
[58] CIT Officer Loses Control. https://youtu.be/QT4_EXD-PtU

reforms with a focus on dispatch triage and collaborative methods to reduce the use of police in this capacity. The focus of this paper is to improve outcomes for contacts made in the window from 911 call intake to the arrival of a police officer on scene. This scope does not cover the necessary and commendable efforts to prevent the use of the 911 systems for mental health crises. Those efforts are extremely important, and this discussion is not an endorsement for using the 911 system.

Both public policy planning and the implementation of reforms should be done with clear adherence to guiding principles. One purpose of this paper is to illuminate the need for ethical and moral principles to guide the decision-making that determines who responds to mental health crises in the community. It is no small irony that, in this case, the most patient-centered approaches can often create the greatest efficiencies and cost savings.

This discussion must involve multiple systems: the criminal justice system, the mental health service provider system, and broader social services systems. Within each of these separate spheres, there exist innumerable related and very important issues and dilemmas. We must be aware of how potential reforms affect, or are affected by, issues in the broader systems. Finding better approaches may mitigate problems "downstream." This matters a lot, but to be useful this paper must also focus on ameliorating the issues at hand. Improving service "upstream"—at the point of police contact—is the essential and logical place to start in this imperfect collection of systems.

We will also explore the costs and harm resulting from the status quo. Fortunately, significant savings and improved outcomes can be realized through common-sense reform. Research data and cost savings statistics will be presented.

The needs of the patient remain central throughout this work, including needs based on complicating effects of co-occurring conditions. Thus, our recommendations will not be a simple checklist of reforms each community is different. There will be differences in demographics, population density, and the availability of provider and social services. All these considerations must play a part in creating improved service that is also faithful to guiding principles. We ask readers to resist cynicism, to revive a stagnant debate on the status quo, and to have the courage to advocate for change. The ultimate goal must be better policies and practices to drive better outcomes for people whose mental illness brings them in contact with law enforcement.

II. KEY PRINCIPLES

Policy debates around police contact with persons in mental health crisis are often centered on questions of what contacts are necessary and what reforms are possible. As the previous criticisms suggest, many agree it is unfortunate that the status quo has made police officers de facto mobile mental health crisis workers. But agreement often ends there.

One way to spur the collective imagination and draw new life to this debate is to start from a set of principles. We offer an example set of principles here. By centering debate on a set of principles, parties can draw on common values to identify why improvements are needed and how to define success.

Principle 1: An on-scene mental health response is the proper response to a mental health problem.

The role of police officers in our society is to determine if a crime has occurred, determine who was involved in that crime, and gather evidence for prosecution. Police officers are trained to recognize signs of criminal conduct. Mental health crisis often presents with behavioral components. These must not lead to entanglement in the criminal justice system.

Much as one doesn't call a barber when a plumber is needed, people in mental health crisis need mental health professionals, not law enforcement officers.

Principle 2: Avoid police-only contacts with people in mental health crisis.

A mental health crisis may not always be recognized for what it is. Police officers may be called to scenes such as "disturbances" when people perceive that criminal conduct is afoot. There may be instances where people in crisis are self-injurious or potentially injurious to others. Police may have a role in addressing these situations, but they should never be the only professionals on the scene.

When addressing mental health crises, response priorities should be:

1. Mobile mental health crisis team response
2. Co-response by mobile mental health crisis workers and police officers

The goal in addressing mental health crises in the community should always be to avoid police-only contacts.

Principle 3: "The right service at the right place at the right time" creates efficiencies and improves outcomes.

Ambulance services were developed to address medical emergencies in the community, treating some illnesses and injuries in the field, and stabilizing and transporting people with more serious medical issues to facilities for more advanced care.

Mobile mental health crisis teams operate in much the same way. Some individuals can be stabilized in the community and connected to services that help them remain stable. For others, the crisis is more acute and requires more advanced care, often in a facility. Mental health professionals have the expertise to make those assessments. By contrast, police officers—even those with specialty mental health crisis training—often default to transporting people experiencing mental illness to emergency rooms or mental health drop-off centers. These transports can exacerbate mental illness, are often unnecessary, and create added expense. They are a poor use of community resources when lesser interventions may have been all that were needed.

Principle 4: Collaboration is key—"separate silos" is the problem.

Although every county in Minnesota has a mobile mental health crisis team, they are almost always kept at arms-length by law enforcement agencies. Rarely are these mobile mental health crisis teams brought on-scene. The result is a separate-silo mindset where these agencies fail to work together meaningfully.

The hallmarks of true collaboration include dispatch triage with 911 call centers deflecting calls to mobile mental health crisis teams, co-location whenever possible, established mental health worker/police officer teams, and regular joint meetings and training.

III. THE POLICE-CENTERED STATUS QUO—A BRIEF HISTORY

A. The Trap

It is worth considering how police became de facto mobile mental healthcare workers. It is a role that was partially forced on them. It is also because their own culture has been slow to embrace change and collaboration.

For years people excused the status quo by pointing to the inadequacies of the mental health provider system. In fact, the perpetually underfunded provider system has used the off-budget substitution of police officers for mobile mental health workers as a crutch. With police helping fill this gap in care, the provider system is free to invest resources elsewhere. To be clear, no amount of money invested in the mental healthcare provider system (a.k.a. providers) could prevent all contacts between police and persons with mental illness. There are a huge number of these police contacts (many go undocumented) and some are unavoidable. Within this paradigm, advocacy groups and law enforcement have sought ever more funding for training to support the role of law enforcement as de facto mental health workers.

At the other end of these police contacts are the consumers of mental health services who deserve mobile responses that utilize mental health workers. Much of the public wants to move beyond the old status quo but is generally offered no alternatives to this inappropriate use of police officers.

For years no one seems satisfied with the status quo, yet it persisted.

B. Into the Soup

This trap of circumstances includes a soup of bureaucracies and opposing organizational cultures. Consumers who have contact with law enforcement often need the services of multiple public and private organizations to manage their illness and co-occurring conditions. Ideally, there would be cross-system integration and collaboration to help people stay connected and stabilized. In the past, provider system integration and collaboration with law enforcement didn't exist. The predictable result has been inefficiency, bad patient outcomes, and occasional tragedies. An important consequence of law enforcement not collaborating with providers is the missed opportunities to provide the best possible mental healthcare service when it is needed most.

Meanwhile, law enforcement has invested heavily in training. Police have purchased ever greater volumes of Crisis Intervention Team (CIT) training. Ostensibly this enables them to handle calls better and more quickly. Police came to rely on ambulances to shorten call times by transporting people to hospital emergency departments. The standard operating procedures seemed to appease some advocacy groups and the public.

Approximately five to six years ago most law enforcement agencies reported the beginning of what would become an alarmingly rapid increase in annual call totals having a mental health component. The cause of this is uncertain, but may be due in large part to CIT training expanding officers' ability to recognize signs of mental illness. Regardless of the cause, the effect was a growing prevalence of mental illness in the county jail populations. Police directed ambulances to deliver more and more people to hospital emergency departments. Law enforcement agencies saw larger portions of their budgets go toward time-consuming mental health-related calls. As criticism increased, police agencies began to value CIT training for its public relations benefit. Predictably, this benefit was undermined by embarrassing use of force incidents.[59]

To indemnify themselves and to simplify dispatch, police departments began to get more of their patrol officers CIT certified. Overwhelmed by its role as alternative mobile mental health crisis providers, law enforcement reported that it needed politicians and the underfunded mental healthcare system to provide relief. Law enforcement described a wish list within CIT Program doctrine: emergency departments that accommodate rapid drop-off; drop-off centers to replace hospital emergency departments altogether; provider volunteers to train officers; and political support of CIT programs.[60] Law enforcement used their political clout to lobby for public investment to support them in their inappropriate role.

In Minnesota and elsewhere, jails were transformed into mental health facilities while law enforcement insisted it needed support and relief in its role as de facto mobile mental crisis responders.[61] [62] The Hennepin County Health Department responded by giving law enforcement much of what it wanted. The county supplied mental health workers for the jail and built a $13.3 M secure workhouse and a drop-off center on Chicago Avenue.[63]

Various mental health advocacy groups, local politicians, and law enforcement have recently pushed for a doubling down on CIT and the paradigm of police as mobile mental health crisis workers. The Minnesota Legislature funded a $13.2 M facility that served, in great part, to house a non-governmental training organization called MN CIT that provides police CIT training.[64] The legislature also created a $12 M trust fund to

[59] What Happened to CPD CIT training? https://www.motherjones.com/politics/2016/01/chicago-police-program-was-supposed-prevent-deaths-quintonio-legrier/
[60] CIT Core Elements, op. cit.
[61] County Expands Crisis Centers. https://www.latimes.com/local/lanow/la-me-ln-mental-health-diversion-20141112-story.html
[62] Hennepin County Steps Up Plans. http://www.startribune.com/hennepin-county-aims-for-treatment-not-jail-for-mental-illness/392256331/
[63] Hennepin County Builds Drop Off Facility. http://www.startribune.com/hennepin-county-plans-to-build-its-first-secure-mental-health-facility/489066261/
[64] New Paradigm, Not New Building. https://www.minnpost.com/community-voices/2018/03/police-crisis-intervention-training-we-need-new-paradigm-not-new-building/

subsidize more of the very expensive CIT training that is now mandated for all Minnesota police officers.[65]

Meanwhile, news outlets continued to report on the growing number of police shootings of persons in mental health crisis across the state.[66] [67] [68]

The latest chapter in this story of a broken status quo was written by reporters who informed the public that Minneapolis police were directing ambulance personnel to administer Ketamine to patients, some of whom were in mental health crisis at the time.[69] Despite the bad headlines and budget problems, many of Minnesota's policy makers resisted innovation, deferring to entrenched bureaucracies and ivory tower advocates. Some of these advocates seemed to have lost their objectivity after years of partnering with police in the political sphere and in private training sessions.

C. Laboratories of Democracy Stir

A milestone was reached in 2002 with the release of the Consensus Project Report by the Council of State Governments Justice Center.[70] This document provided **47 policy statements** to improve how the criminal justice system responded to persons with mental illness. Since then the Justice Center has worked in concert with the US-DOJ to help local police implement proven reform models.[71]

The real challenges to the status quo have come in places like California, Massachusetts, Colorado, and Kansas, where police and county administrators began to explore how they might have police and mental health professionals collaborate in the field. It is an old idea given new life in an era of surging mental health-related police calls. The new expansion of collaborative response models was made possible by early efforts like the LAPD's co-response program that began in 1993 and the Ashbury, MA, co-responder program dating back to 2003.[72] [73] [74]

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[65] MN Lawmakers Police Better Training. https://www.mprnews.org/story/2016/04/11/police-mentally-ill-training-law

[66] Severe Mental Health Crises End in Fatal Encounters. https://www.mprnews.org/story/2018/11/29/several-mental-health-crises-end-in-fatal-encounters-with-mn-cops

[67] Phil Quinn Killing by St. Paul PD. http://www.startribune.com/st-paul-man-killed-in-officer-involved-shooting-is-identified/329566071/

[68] A Cry For Help Ended in His Death. https://www.mprnews.org/story/2019/11/21/a-cry-for-help-summoned-the-police-and-ended-in-his-death

[69] Ketamine at request of MPD. https://www.nytimes.com/2018/06/16/us/ketamine-minneapolis-police.html

[70] CSG Consensus Report, op. cit.

[71] Council of State Governments Justice Center. https://csgjusticecenter.org/about-jc/

[72] LAPD mental evaluation unit. http://www.lapdonline.org/detective_bureau/content_basic_view/51704

[73] LA National Model. https://www.csmonitor.com/USA/Justice/2015/0615/In-Los-Angeles-a-national-model-for-how-to-police-the-mentally-ill

[74] Regional Effort Better Equips Cops. https://www.metrowestdailynews.com/news/20181027/regional-effort-better-equips-officers-for-behavioral-health-disorders

In Colorado in 2016, the legalization of marijuana funded $7.1 M for criminal justice reforms involving behavioral health.[75] [76] In San Diego, a county-wide co-response program called San Diego County Psychiatric Emergency Response Team (PERT), flourished.[77] [78] Places like Johnson County, KS, followed the PERT example and initiated an 11-city multi-jurisdictional collaborative co-responder service.[79] [80] The LAPD and Houston PD are particularly interesting because they have multi-layered mental health units that cover dispatch triage, field triage nurses, co-responder teams, and follow-up teams. These programs are described in section VI. LAPD has assisted scores of law enforcement agencies to implement reforms for improving service on mental health-related contacts. Some agencies adopt reforms that are less transformational. Other agencies have adopted models that are more revolutionary and truly challenge the status quo. The level of public awareness and the quality of the public discussion are often deciding factors in how much the status quo is challenged.

D. Growth Without Sunshine

Most states, including Minnesota, now have cities that have adopted reform models for improving police service to persons in mental health crisis. However, growth in use of collaborative response models has been disadvantaged by the lack of a strong central organization to outline standards and best practices. While CIT International and its local partners enforce standards for CIT programs, there is nothing to prevent wide disparities in how reform response models are implemented locally. Initiatives are often created and administered with little public transparency. The public is rarely given much opportunity for input into the design and implementation of specialized police responses. Even mayors and city councilors seem uncertain of exactly what is being proposed or how it gets administered.

A key reason for this situation is the free rein given to law enforcement in choosing the scope and nature of initiatives. Politicians and advocates for persons with mental illness often reflexively ignore the origins of the status quo and allow law enforcement to proceed without public input or oversight. This is a grievous error and an abdication of responsibility by those who should be advocating for persons with mental illness. Without outside influences, law enforcement is free to concentrate on its own priorities.

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[75] Support SB17-207. https://files.constantcontact.com/812722f9001/2edf93e6-b7fb-427f-b7f0-dca19e9dabf9.pdf
[76] Policy Action Network Newsletter. https://myemail.constantcontact.com/Policy-Action-Network-Newsletter.html?soid=1102181462552&aid=ZHy6miUK0TI
[77] Escondido PERT. https://police.escondido.org/pert.aspx
[78] San Diego Blue Print for Mental Health Reform. https://www.sdcda.org/Content/Preventing/Blueprint%20for%20Mental%20Health%20Reform.pdf
[79] Eleven Johnson County Cities to Partner. https://csgjusticecenter.org/eleven-johnson-county-ks-cities-to-partner-a-mental-health-co-responder-with-law-enforcement/
[80] Overland Park PD Co-Responder Project. https://www.jocogov.org/sites/default/files/documents/CMO/Overland%20Park%20Co-responder%20Program%20Evaluation.pdf?fbclid=IwAR3gvfMuCvvsx6bs33GQFQU4WAMBXYPbczNc2DYjXnOc7lQhGXmJ8LurEds

These generally include a public relations effect, reduced call times, and reduction of expensive cyclical contacts. Initiatives must address the local police priorities to be viable—BUT they must also be effective. Any programs adopted should prioritize aiding persons with mental illness who have contact with police.

It is worth noting that other cultural institutions have failed to challenge the law enforcement dominance over reform efforts. The news media deserve criticism for scant and shallow reporting. Academia has also played a role. American researchers, especially within the field of criminology, have a long history of fashioning conclusions based simply on surveys of the opinions of officers in the field. Much of the research has focused on creating efficiency within the criminal justice system while mostly ignoring the plight of the mentally ill. Much of this work was done in an effort to refine and validate Crisis Intervention Team (CIT) training. This narrow focus by many American academics helped further entrench law enforcement in their inappropriate role of de facto mobile mental health crisis workers. Today CIT training remains a practice that is not evidence based (per outcomes) because research results rest mostly on survey responses of police officers.

Yet, some objective research was and is being conducted on real deflection, diversion, and collaborative police responses. Groundbreaking collaborative response projects going back 30+ years have flowered into well-researched best practices. Today, law enforcement is looking "beyond CIT" to implement these practices.

We should be living in a golden era of police reform with respect to contacts involving mental illness and co-occurring conditions. Much has been learned from academic research, field experience, and pilot projects. Data has solidified understandings and new technology has aided responsiveness. Some projects are applying powerful lessons and tools to improve outcomes. Others fall short of what can and should be done. We are not always applying the fruits of research and hard experience to create the best outcomes for persons with mental illness who have contact with police. This can only happen when the needs of the mentally ill are prioritized and public discourse allows objective truths to overcome subjective bureaucratic impulses.

IV. FOUNDATIONS FOR FAILURE

This section identifies practices that reflect a failure to move beyond the status quo to improve police contacts with people experiencing mental illness. These are the approaches that shun collaboration and use officers as de facto mobile mental health crisis responders. See section VI for a discussion of models and approaches that improve service via collaboration.

In April of 2018, Ronal Serpas, the former Chief of the New Orleans Police Department shared his thoughts at a mental health and criminal justice reform conference. Serpas is a Professor in Practice at the Criminology and Justice Department of Loyola University New Orleans. Serpas voiced his astonishment and frustration with the status quo and offered the following:

> *I am a fan and a believer in CIT. We've been doing de-escalation since 1980 when I first went to the police academy. Can it get better? Of course, it can get better. Can CIT be helpful? Of course, it can be helpful. But, in some ways I am very concerned that if we see that as the answer and we see that as the solution we are nowhere even scratching the surface of this problem…*
>
> *Tonight, when we go to sleep almost anywhere in America… the police officer riding by themself…will be a male or female…somewhere around 25 years old…almost unilaterally with no formal college education. In this august room of people who are trying their very best to figure out the most complex circumstances in our existence today with mental health…we are going to go to sleep tonight and hope and pray that at 2 o'clock in the morning the least educated, with the fewest alternatives, is going to make the exact right choice every time they find someone in a crisis.*
>
> *Isn't that a bit embarrassing?...*
>
> *Give officers alternatives to arrest, not CIT only, not de-escalation only. I mean an alternative where they don't even go to the door. Give them alternatives to arrest as a community and they're going to take that opportunity…*
>
> *We have limited police time, we have limited prosecution time, and we have limited prison beds. And, one of the things we have said at Law Enforcement Leaders since Oct. 15 when we launched…we are imprisoning people we are mad at versus people we are scared of.*[81]

A. Lack of Effective Dispatch Triage

Dispatch triage is one of the most straightforward ways to avoid unnecessary law enforcement contact with persons experiencing mental illness. This simply refers to deflecting calls for service to more appropriate responders. Decision-making should

[81] Serpas Urges Alternative Responses. https://youtu.be/p5JmL0fIOFU

occur at the 911 call center, ideally with the active participation of a mental health professional. When call screening shows it is appropriate, calls can be deflected to an alternative responder. The alternative service might be a county mobile mental health crisis team, a homeless outreach team, or other public and private social services. If circumstances make the police presence is unavoidable then another option would be a co-responder team.

Missing this opportunity for deflection to mental health clinicians burdens law enforcement unfairly while failing the people who need help most. Breaking the "separate silos" trap to create collaboration and deflection at 911 call centers creates efficiencies and improves service at a key upstream point.

1. The Police Obligation to Respond—Never Real and Being Withdrawn

The Duty to Protect is very limited in law and jurisprudence. In general, police officers have a general obligation to protect the populace but there is no obligation to protect or rescue any individual person. This concept is summarized as a general duty to all citizens but no duty to any one citizen.[82]

This is established common law throughout the United States. It has been solidified by court precedents, including the U.S. Supreme Court decision in DeShaney v. Winnebago County Dept. of Social Services. There are only a few exceptions where a Duty of Care can exist. These exceptions exist where a government agent has a unique relationship with an individual (e.g. as employer).

What matters here is that police are free to recognize any perceived moral obligations but are NOT bound by law to respond to 911 calls for assistance. This includes police calls for service that have a mental health component. In fact, the act of responding to a call is the main route to creating liability for officers and policing agencies. This is because a Duty of Care (i.e. potential liability) is created when police place a person in custody or utilize any police tactics that create hazard (a.k.a. state-created danger).

This logic is evident in recent news of California police departments not responding to calls for service that might involve suicidal persons.[83] The law does not require them to respond. On the other hand, responding creates risk, especially if a person attempts "suicide by cop." The stakes have been raised by a new willingness of courts and juries to make officers criminally accountable for wrongful use of force.

> *"Some police departments around the country have shifted how they respond to suicide calls," said Andy Skoogman, executive director of the Minnesota Chiefs of Police Association.*

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[82] CIF Suicide Calls Presentation. https://mcpa.memberclicks.net/assets/NEWSLETTER/CIF%202020.pdf
[83] Police Fear Suicide by Cop. https://www.latimes.com/california/story/2019-08-09/suicide-calls-california-cops-stopped-responding

> *"There are agencies across the country that are simply not showing up or they're showing up to the call, determining that the individual is not a threat to anyone other than him or herself, and they're leaving," Skoogman said. "That's a drastic departure to how law enforcement has responded to those calls in the past."*[84]

The Minnesota legislature has recognized this dynamic and in 2009 changed state statutes to permit 911 dispatch services to refer calls directly to mental health crisis teams.

> ***403.03 911 SERVICES TO BE PROVIDED.***
> ***Subdivision 1. Emergency response services.***
> *Services available through a 911 system must include police, firefighting, and emergency medical and ambulance services. Other emergency and civil defense services may be incorporated into the 911 system at the discretion of the public agency operating the public safety answering point. The 911 system may include a referral to mental health crisis teams, where available.*[85]

This evolution of thinking in Minnesota law enforcement is now happening across the nation. The deconstruction of arguments for why police respond to mental health calls is an opportunity for those who seek reform. Now is the time for communities to demand 911-based dispatch triage to prevent unnecessary police contacts with people experiencing mental health crisis.

2. Dispatch Triage at the Police Dispatcher Level (e.g. CAHOOTS)

When dispatch triage is conducted downstream of 911 call centers, within the police bureaucracies, there is a clear pattern of defaulting to the police-only response. This circumstance naturally leads to far less transparency and community oversight.

The much-publicized CAHOOTS Program in Eugene, Oregon has operated as an alternative response that is controlled at the police dispatcher level. Communities considering emulating this program should avoid this critical flaw. Having deflection happen at the 911 call center upstream of police dispatchers is essential to remove these efforts from control and management by law enforcement.

When Portland initiated Project Respond, which relied on police dispatch to deflect calls to alternative responders, they were disappointed to find that 70% of calls were not deflected but continued to be responded to with the old police and ambulance partnership approach.[86] Simply creating an alternative response option does not ensure that it will be utilized. For this reason, dispatch triage must happen at the 911 call center level.

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[84] MN Cops Rethink Suicide Calls. https://www.mprnews.org/story/2019/12/11/minnesota-cops-rethink-how-to-respond-to-suicide-calls
[85] MN Statute 403.03 https://www.revisor.mn.gov/statutes/cite/403.03
[86] Portland MH Providers Bring Cops. https://news.streetroots.org/2019/05/03/portland-mental-health-responders-alternative-police-usually-bring-cops

B. Stand-Alone CIT—Exaggerated Competencies and Separate Silos

The Crisis Intervention Team (CIT) is a program centered on training provided to police officers. The basic training lasts 8 hours but 40 hour training and advanced training are also offered. It is sensible to provide officers with some relevant training. This training is meant to help officers recognize signs of mental illness and to de-escalate. Too often the CIT programs focus solely on the training of officers and resist innovations and collaborations that break the separate silos status quo. Avoiding field collaboration with mental health clinicians is technically a misapplication of the CIT model. CIT is carefully described as an approach that promotes collaboration and community involvement. Here we must explore the hard fact that some CIT programs are less than as advertised.

There is significant variation in how CIT is taught, how fully individual officers "buy in," and in the effect it has on performance. Local media and politicians may heap praise on any CIT effort but its effectiveness should not be assumed. As described in a previous section, researchers managed to show that CIT is "evidence-based" only in terms of creating positive feedback from officers. Academia consistently reports that CIT is NOT an evidence-based practice in terms of improving outcomes for persons in mental health crisis.[87] Minnesota researchers Peterson and Densley have recently added to this chorus with their own research:

> *This study reviews 25 empirical research articles that have examined the impact of Crisis Intervention Team (CIT) training over the past 10 years. Overall, little can be said about the effectiveness of CIT training due to varying outcomes, a reliance on self-report data, lack of comparison or control groups, and inadequate follow-up data. Results of this systematic review of 25 studies demonstrated a mix of positive and negative results, and a focus on urban environments. The impact of officer characteristics and community resources on outcomes is unknown. This review indicates that additional research is necessary before CIT training can be considered an evidence-based practice that should be widely implemented. New training protocols that incorporate empirical research and are responsive to the resources in individual agencies and communities may be more effective.*[88]

Many communities have embraced the false hope that CIT training fully prepares officers to address the challenges of dealing with people in even severe mental health crisis. They might also assume individual CIT programs all rise to their billing as "more than just training" by creating community partnerships and collaboration. In actual implementation, these parts of the model are often underdeveloped or non-existent.[89]

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[87] Watson, A., Compton, M. & Draine, J. (2017). The Crisis Intervention Team (CIT) Model: An Evidence-Based Policing Practice? Behavioral Sciences & the Law. 35. 10.1002/bsl.2304. https://www.ncbi.nlm.nih.gov/pubmed/28856706

[88] Peterson, J. & Densley, J. (2018). Is Crisis Intervention Team (CIT) Training Evidence-Based Practice? A Systematic Review, Journal of Crime and Justice, 41:5, 521-534, DOI: 10.1080/0735648X.2018.1484303

[89] DOJ Investigation of Chicago PD. https://archive.org/stream/chicago_police_department_findings/chicago_police_department_findings_djvu.txt

Excellent branding has enabled local officials to use CIT training as a convenient, unassailable response to calls for reform. CIT training has become the presumptive panacea—the beginning and end of all discussions about police contacts with persons in crisis. When this happens, the CIT program becomes an abstraction which inevitably fails to deliver. In jurisdictions where CIT dominates decision-making, the response to failure is to double-down on CIT training and "buy in." This is where CIT's elevated status constrains the debate about what is possible. CIT programs very often neglect two key reforms: alternative response (deflection to non-police mental health clinicians) and on-scene co-response with mental health clinicians.

The strengths and weaknesses of CIT are not happenstance. To understand how CIT fits into the overall solution, we must accept the fundamental truth that it is a management tool for police administrators that also purports to help people in need. This admittedly stark description is necessary to understand how CIT subculture can skew the decision-making process. The CIT doctrine, as described in the CIT Core Elements, places great emphasis on improving police operations.[90]

1. Stand-Alone CIT—CIT's Core Elements Are Not Patient Centered

The Core Elements of CIT mention police call times specifically in several places and never suggest a consideration of what is best for the clients.

> *"In addition, policies should be set to ensure minimal turnaround time for the CIT Officers, so that it is less than or equivalent to the turnaround time in jail."*[91]

The importance of call time is also emphasized in the requirement that police be given a place to drop off people regardless of any clinician's assessment or the subject's finances.

> *"To ensure CIT's success, the Emergency Mental Health Receiving Facility must provide CIT Officers with minimal turnaround time and be comparable to the criminal justice system. The facility should accept all referrals regardless of diagnosis or financial status."*[92]

This disregard for the needs of people in crisis was revealed in a 2017 study by Peterson and Densley. Their study documented that 80% of individuals transferred to a psychiatric intake unit are never admitted.

> *After conducting interviews at a local psychiatric intake emergency unit, we discovered that over 80 percent of individuals were never admitted. Instead, they were turned back around into the community because they did not present a threat to self or others, thus didn't meet criteria for an emergency hold. Police send people to the hospital largely because they don't want to be held liable should something bad happen once they leave the scene. But most of the time, individuals that police*

[90] CIT Core Elements, op. cit.
[91] Ibid.
[92] Ibid.

send to the hospital are back home within hours, with a hefty ambulance bill for their troubles.

We also found that 60 percent of addresses that had one crisis call had another crisis call that same year. Several group homes in the area, designed specifically to provide mental health treatment, were calling the police on a daily basis. Police were being asked to Band-Aid a broken mental health system.

A fancy new police training center won't fix this.[93]

The Core Elements advise mental health professionals to seek roles as CIT instructors but don't mention deflecting calls to mobile mental health crisis teams.

"These professions provide treatment, education and training that result in a wide dissemination of knowledge and expertise to both individuals with a mental illness and patrol officers undergoing CIT training."[94]

2. Stand-Alone CIT—The Excuse to Avoid Co-Response or Alternative Response

The result of collaboration in training but separate silos in the field is sometimes a presumption that police officers can morph into social workers. This means police administrators and officers often choose less collaboration. A fatality at the hands of an Omaha, NE, police officer led local reporters to look into the reluctance of police to collaborate on-scene with the Douglas County Crisis Response Team. They found that officers rarely collaborated, partly because of their CIT training.

Police officers have a host of resources at their disposal when they encounter people with mental illness, but in order for them to work, officers have to use them.

Omaha Police Officer Anthony Nguyen used to call the crisis team when he had a situation that fell into a gray area: the person wasn't technically threatening himself or others enough to warrant protective custody, but Nguyen didn't feel comfortable leaving him alone.

After a few years on the force, Nguyen took the weeklong mental health training that helped him understand people in mental crisis and how to handle those situations.[95]

The reporting included statistics showing that on-scene collaboration was rare.

Omaha officers filled out 1,193 forms. Those forms indicated the crisis team was called during fewer than 30 of the 1,193 incidents – 2.4 percent during that period.[96]

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[93] Peterson, J. and Densley, J, op. cit.
[94] CIT Core Elements, op. cit.
[95] Omaha Police Have Options. https://www.omaha.com/livewellnebraska/omaha-police-have-options-on-mental-health-calls-but-available/article_676485ec-9db7-547b-aa84-d796cd33abdd.html

This seems to be a typical level of on-scene collaboration. In Salt Lake City, UT, a report by KUTV News revealed that the county Mobile Crisis Outreach Team was called to co-respond with police about 80 times per month even though police said 1 in 7 calls were mental health related. This indicates a 2–3% rate of on-scene collaboration.[97]

CIT's much touted collaborative aspect is mostly relegated to the training room by conflicts with police efficiency priorities. This conflict was obliquely described in a Police Chief Magazine article by Nick Margiotta, a veteran Phoenix Police Department member, CIT Coordinator for the Phoenix Metro Region, Board Secretary for CIT International, and NAMI Arizona Advisory Board Member. It is proven that having a mental health professional's expertise on-scene provides multiple benefits to the person in crisis and greatly reduces unnecessary transfers. Margiotta, however, explained that co-responding with a local county mobile crisis team might not have "relevance to CIT."

> *For communities with mobile behavioral crisis services or for those communities seeking to create this level of care, it is important to consider how these services can meet the needs of law enforcement when they are dealing with a behavioral health crisis. To make sure that the service has relevance to CIT, the key is for mobile community crisis response teams to be readily available to respond to a police request in a prioritized manner and free law enforcement from the scene as quickly as possible [emphasis added]. This level of responsiveness is needed to increase the likelihood that police will utilize mobile crisis services, thus increasing the opportunity to stabilize individuals safely at home, when appropriate.*[98]

Margiotta's view is conventional wisdom within law enforcement. The very reason for CIT's existence has been rooted in the fact that non-embedded county mobile mental health teams were found to have response times that were too long to be effective on-scene partners with law enforcement. For decades, CIT proponents have referenced the work by Borum (1998) and Steedman (2000), which described inadequate response times of underfunded, non-embedded clinicians.[99]

Years have passed and new officers continue to use this excuse despite the existence of innovative solutions. The Omaha situation described above provides more ready reference to field reality:

> *"...the Crisis Response Team could have been dispatched to deal with a mentally ill man who died in June after an early morning encounter with Omaha police officers.*

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[96] Ibid.
[97] Utah Police on Front Lines of Lack of MH. https://kutv.com/news/local/in-crisis-utah-police-on-the-front-lines-of-the-lack-of-mental-health-care
[98] Five Legged Stool. https://www.policechiefmagazine.org/the-five-legged-stool-a-model-for-cit-program-success/?ref=84d53c861e50b658985bf7b63f4e6d1f
[99] Police Perspectives. https://scholarcommons.usf.edu/cgi/viewcontent.cgi?article=1567&context=mhlp_facpub

'If they would have came out, it wouldn't have ended the way it did,' Lt. Colene Hinchey said. 'We missed the opportunity, and it went bad.'

'I always encourage people to call Douglas County Crisis Response Team if needed when the time is appropriate,' Hinchey said.

Alcantara said an officer's decision against bringing in the crisis team also may come down to time. … 'I think that's where a lot of times officers aren't calling out to the resources that we have because it's time-consuming.'"[100]

In the source article for this quote, Ofc. Alcantara describes a collaborative reform used elsewhere that she hopes her PD will implement. In 2018, Omaha's Police Department implemented that very reform to enable more co-response after a deadly incident in which a mentally-ill man was tased 12 times and punched in the head 13 times. Cities often implement measures to enable co-response only after preventable tragedies.

Having an incident where someone dies. This is the most frequent antecedent to change, though this is not in and of itself sufficient for change to happen. Most often, the person with mental illness is the individual who dies following police intervention.[101]

If your city is one of those that remains an enclave of CIT-only thinking, then you simply have not yet experienced the incident that forces change.

3. Stand-Alone CIT—Territorial Tendencies Result in More Investment in CIT

A precursor to tragedy might be a police department giving all its officers CIT training. This approach is a public relations win for many departments. Sam Cochran, the police major who helped create CIT, offered his explanation of how police administrators were using CIT:

Cochran and the other program leaders worry that politicians are using the name of CIT to make it look like they are taking the issue seriously without being willing to do the long-term work that it takes to make the program successful.

"Everybody wants to feel comfortable that new training is being introduced with the expectation that we're all going to live happily ever after," said Cochran. "It's a quick fix – the other things that have to take place are a little more challenging."[102]

The problems multiply when CIT becomes primarily a management tool for police administrators. Having a CIT certification in every squad car simplifies staff scheduling and aids dispatch to calls. It also means officers with less experience and less motivation for handling mental health-related calls will be thrust into situations where their

[100] Omaha Police Have Options, Op. cit.
[101] Study in Grey And Blue. https://cmha.bc.ca/wp-content/uploads/2016/07/policereport.pdf
[102] Milwaukee Training Misses Mark.
https://www.jsonline.com/story/news/investigations/2018/06/08/resentful-officers-dub-mental-health-program-hug-thug/680618002/

inexperience can lead to tragedy. Not all officers have the knowledge or interest to deal effectively with someone in a mental health crisis.

> *"'Many officers are not ready or interested or do not have the disposition,' the board of the international CIT program warns in a position paper posted in January on the organization's website.*
>
> *'For these officers, valuable training time and resources may not only be wasted on them if they are mandated to sit through the 40-hour course, but their attitudes can disrupt the class,' the experts warn. 'Even worse, an agency may send an officer who is not interested or does not have the right disposition.'"*[103]

When the Portland Police Bureau (PPB) insisted on CIT training, they required every patrol officer to get 40 hours of training. The result for the PPB was a deterioration of performance and a spate of tragedies. In fact, the results of training the wrong officers or all officers were astoundingly bad.

> *That's what happened in Portland, Ore. Many officers there considered a CIT assignment a burden, and officers tapped for duty looked at their role as nothing more than transporting people in crisis to the hospital, Watson said. Tensions between resentful officers and people with mental illness flared. Nine people with mental illness were killed in six years.*
>
> *The 2006 death of James Chasse Jr., 42, was particularly gruesome.*
>
> *Chasse, who suffered from delusions, was beaten by officers, sustaining over 20 broken bones, a punctured lung and a torn spleen. After police initially denied him medical attention, he was put in the back of a police cruiser where he died on the way to the hospital.*
>
> *"In a good faith effort to address this, they decided to train all of their officers," Watson wrote to Barrett. "It did not go well."*
>
> *In the following four years, the Portland Police Bureau used deadly force against people with mental illness 14 more times.*
>
> *In one instance, officers repeatedly tased a naked man in his own apartment for not complying with commands and reportedly running at the officers. It turned out he was not attacking them – nor was he mentally ill. He was in diabetic shock, and coming to the officers for help.*[104]

The situation in Portland came to the attention of the U.S. Department of Justice, which conducted an investigation in 2011. DOJ investigators described how CIT training had backfired within the Portland police culture.

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[103] Milwaukee Training Misses Mark, Ibid.
[104] Milwaukee Training Misses Mark, Ibid.

We found that PPB officers often do not adequately consider a person's mental state before using force and that there is instead a pattern of responding inappropriately to persons in mental health crisis, resulting in a practice of excessive use of force, including deadly force, against them. Furthermore, our review of incident reports and interviews with officers and community members shows little or no indication that the officers considered, or were even aware of, the many tools available to them to resolve interactions with individuals in mental health crisis using less force.[105]

Despite the failures in Portland, police in Milwaukee and other cities went forward with expensive plans to certify their entire forces in CIT. It was a cynical reach for the easy public relations win and the aforementioned simplification of operations. Milwaukee spent $1.2M on police CIT training but failed to get "buy in" from many officers.

Meanwhile, some officers took to calling the existing program "Hug-a-Thug" and griped that it was not their jobs to be "street psychiatrists," Pasch said.

The growing resentment began to take a toll on the training with fewer classes offered.

"A lot of the momentum was lost," Pasch said.

In the days after Hamilton was killed, Flynn tried to deflect any criticism that police need to be better prepared to deal with the growing number of people with mental illness who are not properly treated.[106]

4. Stand-Alone CIT—The CIT Paradox

CIT training can be useful in those times when police do not have mental health professionals on hand to co-respond or take over the contact. CIT, ironically, has become the very reason why our mental healthcare system routinely allows the substitution of police response for a mental healthcare provider response or co-response. This paradox occasionally gets criticism. The $850M ThriveNYC Initiative is billed as an attempt to fill strategic gaps in mental health services and coordinate mental healthcare activities across agencies. A few note that it does not fill the gap in mental healthcare response that is being filled by police:

One question they might ponder is: What would it look like to have a mental health care system that didn't rely on police officers to serve as its first responders?[107]

The CIT paradox was evident with the 2016 death of John Birkeland in Minnesota. The police department should have been prepared because they had responded to his previous "mental outbursts." One of the officers even had some police training to prepare him for such mental health situations.[108] What followed was an interaction that

[105] DOJ Investigation of Portland Police. https://www.portlandoregon.gov/police/article/469399
[106] Milwaukee Training Misses Mark, op. cit.
[107] Don't Pretend Every Cop Can Play Social Worker. https://nypost.com/2019/04/03/dont-pretend-every-cop-can-play-social-worker/
[108] There Has to Be a Better Way. https://www.mikegreg.com/blog/there-has-be-better-way

apparently utilized almost none of the lessons police training is intended to imbue. There was little attempt to de-escalate with Birkeland, who suffered from untreated mental illness and was quite drunk (blood-alcohol level 0.28).[109]

The situation became deadly when they sent in a police dog that viciously attacked the man while he cowered in the back of a deep closet. Video revealed that these officers escalated their use of force and shot Mr. Birkeland without ever considering how an on-scene collaboration with a mental health professional could be helpful.[110]

De-escalation and "slowing down" are advertised to be part of CIT training for such encounters. Yet, the choice to break down the apartment door and send a police dog to attack were justified in civil court on the basis of fulfilling a "caretaker" role—"to protect the occupant from imminent injury." The Birkeland shooting was another example of relevant officer training failing to create better results. Ironically, his state senator never considered alternatives to police response but simply used his death as a reason to author (and pass) another legislative bill providing even more state funding for CIT training.[111]

Likewise, the 2014 shooting of Joe Zontelli in Duluth illustrates how police use of force training can nullify any benefits of CIT. Zontelli was a suicidal man who barricaded himself behind an interior door of his house. Officers broke down the door and had a police dog attack. A knife Zontelli intended for self-harm was turned on the attacking dog and officers then fired their weapons.[112]

> *But when officers broke down the door, saw Zontelli had a knife, shot him twice and then claimed they had feared for their lives, some say the line between public and private vanished. Advocates say any officer-involved shooting is a matter of public interest.*[113]

Police training failed Joe Zontelli on multiple occasions. He had previously been beaten by CIT-trained Officer Adam Huot in the mental health ward of St. Luke's Hospital.

> *To gain compliance, the officers began delivering strikes, with PO Huot hitting him five (5) or six (6) times with a closed fist. At that point in time, the subject's head was against the floor and it sustained injury.*[114]

Within the public files of an arbitration resolution for Ofc. Huot, an arbitrator wrote that he considered the Zontelli beating one of the "major misuses of force" by that officer. The police department attempted to terminate this officer based in part on his failure to internalize relevant training, including his CIT training.

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[109] Roseville Police Won't Be Charged. https://www.twincities.com/2016/07/07/roseville-police-no-charges-shooting-death-mentally-ill-man/

[110] Birkeland v. Jorgenson et al. https://law.justia.com/cases/federal/district-courts/minnesota/mndce/0:2017cv01149/163727/67/

[111] MN Lawmakers Police Better Training, op. cit.

[112] MN Lawmakers Police Better Training, op. cit.

[113] Body Cam Footage is New Legal Battleground. https://www.theguardian.com/us-news/2015/jan/01/duluth-police-body-camera-footage-legal-battleground

[114] Adam Huot mediation. https://mn.gov/bms/documents/BMS/134813-20180622-Duluth.pdf

> *When cross-examined, PO Huot stated, he is familiar with the department's use of force and code of conduct policies; he was well trained on same, as well as having received 40 hours of VDIIC training in 2015. Benefits derived from the latter included managing verbal abuse and bullying, defusing confrontations, de escalating violence, building cooperation and collaboration and more. (City Exhibit 13) In summary, he verbalized, the course dealt with winning subject cooperation through verbal techniques and reducing the need to use force. However, Officer Huot also remarked, with the passage of time, he could not recall many of the specific lessons taught in the CIT course he had taken and, as well, he could not recall many of provisions in the Code of Conduct.*[115]

When properly trained, CIT is supposed to provide officers with the ability to recognize symptoms and behaviors of mental illness. If true, then this recognition should lead to routine on-scene collaboration with mental health professionals. The dearth of such collaboration reveals a critical failure in stand-alone CIT implementation.

C. Refusal to Involve Alternative Responders

Whenever possible, police officers and dispatchers should not refuse requests for an alternative to a police-only response to calls involving mental illness. This is especially true when family members reach out for assistance to get help for a loved one in crisis. Expediency is a very poor excuse to avoid providing the right service, at the right place, and at the right time.

D. The Odd Effort to Misrepresent Follow-Up Services as Co-Response

The public wants co-response and alternatives to police-only response. Some officials, notably in Hennepin County, Minnesota, attempt to appease the public by pretending that follow-up services are, in fact, co-response. The problems with this are obvious. Clinicians who make follow-up contact days after police initially make contact are doing follow-up work, not co-response to a crisis call. Police officers accompanying social workers to perform follow-up work doesn't constitute co-response to crisis calls. The long-standing definition of co-response refers to real-time responses to police calls for service. Unfortunately, it is necessary to provide this clarification.

E. Follow-Up Schemes Intended to Support Entrenched Police-Only Response

Consider a scenario in which a serious auto accident yields a police response but no response by EMTs or paramedics. Most people would find this unacceptable. People want mental health professionals to respond on-scene to assist loved ones experiencing a psychiatric emergency. Academic research shows that consumers prefer deflection to mental health clinicians or co-response over a police-only first contact.[116] [117]

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[115] Adam Huot mediation. Ibid.

[116] Boscarato, Lee, Kroschel, et al., Consumer Experience of Formal Crisis-Response Services and Preferred Methods of Crisis Intervention. doi: 10.1111/inm.12059

Now consider the plight of a hiker who falls off a cliff and suffers internal injuries. It would be unthinkable for a poorly trained rescuer to tell this hiker that medically trained rescuers can visit the next day. Providing the right response at the right place and at the right time is just as important in psychiatric emergencies as in other medical emergencies. Follow-up schemes that avoid real-time co-response or deflection to an alternative responder effectively substitute police response for a mental health response. For more complicated mental health-related calls, police are woefully under qualified to stand in as substitutes for mental health professionals. Follow-up schemes are a sad betrayal of those who are experiencing the depths of a mental health crisis and need the right response.

> *Non-behavioral medical emergencies, such as heart attacks, strokes and non-vehicular accidents are often handled by the 911 system. But rather than dispatching a police officer, an ambulance is sent. A law enforcement response to a mental health crisis is almost always stigmatizing for people with mental illnesses and should be avoided when possible. Whenever possible, mental health crises should be treated using medical personnel or, even better, specialized mental health personnel.*[118]

Follow-up schemes entangle the law enforcement officers as gatekeepers to treatment and prevent first-contact community treatment by actual mental health professionals. By substituting police response for a mental health response, the mental health crisis is approached as if it were criminal. One type of follow-up scheme for mental health calls is simply an extension of a police-led diversion program for persons who have committed actual chargeable offenses.

Avoiding real-time deflection to or co-response with mental health clinicians is not excused by increased investment in downstream services like case management. Police officers should not be the gatekeepers to those needed services. Moreover, in that gatekeeping role police officers introduce real potential for harm, wasted resources, and missed opportunities. Follow-up schemes that avoid deflection or co-response maintain a key gap in care that adversely affects downstream efforts to stabilize people in need.

1. Follow-Up Schemes Supporting Police-Only Response Rule Out Cost-Saving Deflections

There is broad agreement that community-based treatment saves taxpayer money.[119] Real-time community-based clinician care via alternative response or co-response also

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[117] Evangelista, Lee, Gallagher, et al., Crisis averted: How Consumers Experienced a Police and Clinical Early Response (PACER) Unit Responding to a Mental Health Crisis. International Journal of Mental Health Nursing (2016) 25, 367–376. doi: 10.1111/inm.12218

[118] Mental Health America Position Statement 59. https://www.mentalhealthamerica.net/issues/position-statement-59-responding-behavioral-health-crises

[119] MHLN Blue Book 2018. https://mentalhealthmn.org/wp-content/uploads/2017/05/2018-MHLN-Blue-Book.pdf

results in more efficient wraparound services or intensive case management follow-up. This is lost with follow-up schemes.

Follow-up services don't address the risk of arrest and incarceration when police respond alone to mental health calls. Follow-up services don't change the fact that co-occurring substance abuse adds great complexity to calls and greater risk of incarceration. Police-only on-scene response is one key reason why 72% of jailed persons with SMI also have a co-occurring substance abuse problem.[120]

Follow-up schemes entrench police in the role of de facto mobile mental crisis workers. That allows police to continue to order transfers that are often unnecessary, unhelpful for the patient, and burdensome for multiple government systems. This is in stark contrast to the alternative of offering both a proper on-scene clinician response and follow-up services.

> *Crisis services prevent more costly hospitalizations. Over the past several years data show that for both children and adults over 80% of those served by crisis teams were able to avoid hospitalizations. Providing a mental health response also limits interactions with police.*[121]

2. Follow-Up Schemes Supporting Police-Only Response—Myth of a Clinician Labor Shortage

One of the main excuses for avoiding deflection to or co-response with mental health clinicians is the idea that there is a shortage of such professionals. This excuse is invalid. Labor market statistics show that there are ample workers for deflection or co-response. The workers needed to fill this gap in services are master's level licensed social workers, namely clinical social workers. These workers are available in greater numbers in higher population areas – the very places where deflection or co-response are most feasible. In fact, there are 800 more clinical social workers in all of Minnesota than jobs to employ them. Section IX below describes the labor market for clinical social workers.

3. Follow-Up Schemes Supporting Police-Only Response—Betray Early Episode SMI Sufferers

Those who are exhibiting significant symptoms of mental illness for the first time are being disregarded in the follow-up schemes that put police between consumers and providers. Key populations, such as those with first episode of psychosis (FEP), would benefit greatly from collaborations that create real time on-scene clinician responses. Inadequacies in the mental health systems can delay access to treatment and increase the likelihood of contact with police. For them, the police contact is just another obstacle between them and clinician care. A study in Canada put a number to the problem.

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[120] Burden of MI Behind Bars. https://www.vera.org/the-human-toll-of-jail/inside-the-massive-jail-that-doubles-as-chicagos-largest-mental-health-facility/the-burden-of-mental-illness-behind-bars

[121] MHLN Blue Book 2018, op. cit.

> *…The same study found that, in large part because of these barriers, over 30% of people with serious mental illness had contact with the police while making, or attempting to make, their first contact with the mental health system.*[122]

The problems leading to this police contact are common and exist here in Minnesota.

> *Individuals experiencing their first psychotic or manic episode are not receiving the intensive treatment they need to foster recovery. On average a person waits 74 weeks to receive treatment. Our mental health system has relied on a "fail-first" model of care that essentially requires people experiencing psychosis to be hospitalized or be committed multiple times before they can access intensive treatment and supports.*[123]

The contacts with young people in the early stages of mental illness are immensely important. These contacts are key opportunities to provide early care and reduce suffering.

> *"The earlier someone gets into care the better their outcome," says Rachel Loewy, PhD, associate professor in the department of psychiatry at the University of California, San Francisco. The symptoms of psychosis often start during the late teens or early 20s, she says. "These young adults are not only dealing with symptoms of a mental disorder but also the fact that the changes are happening at a critical time in their lives when they are developing their identities."*[124]

Well-intentioned officers can sometimes recognize early symptoms of SMI and create referrals, but that should not represent Plan A. The stakes are too high to tolerate follow-up schemes that prevent real-time on-scene co-response or deflection to alternative response by mental health crisis teams.

4. Follow-Up Schemes Supporting Police-Only Response—Delay Care and Degrade Effectiveness

On-scene clinician expertise results in a much more useful on-scene patient assessment, highly effective warm handoffs to provider facilities, and excellent coordination of follow-up services. It is hard to overstate the advantage of having a clinician do their mental health assessment on-scene at initial contact. When mental health workers attempt an assessment hours or days after initial contact, they are not seeing the patient in their crisis state. Remote and delayed assessments cannot be informed by the state of a patient's dwelling and other psychosocial considerations. Being on-scene at initial contact can mean partnering with family and friends who can offer more accurate information about the immediate situation and a history of the illness. Being on-scene at initial contact might help in the evaluation of the effect of medications. The contribution of co-occurring conditions and disorders will be more evident on-scene, in real-time. All this

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[122] Study in Grey and Blue, op. cit.
[123] MHLN Blue Book 2018, op. cit.
[124] Catching Psychosis Early. https://www.apa.org/monitor/2016/10/psychosis

insight helps well-trained mental health workers apply their expertise better to create immediate care and more appropriate follow-up services. To forgo co-response or deflection to a mobile crisis team means less efficient care or even a missed opportunity for proper care.

5. Follow-Up Schemes Supporting Police-Only Response—Are Risky

Follow-up schemes paired with a police-only response forsake all of the benefits listed above, for the old practice of a referral from the officer. Really, this is a procedure that has long existed for many urban jurisdictions. The premise is that these referrals will be more effective and that somehow this iteration of the status quo will be better. However, the risk of police use of force and the potential for arrest, even incarceration, remain with a police-only initial response. Furthermore, these follow-up schemes do not put an expert on-scene in real time. Thus, they do nothing to prevent officers from continuing to default to expensive, traumatic transfers that generally result in no immediate treatment.

Much will depend on whether mental health professionals can reconnect with the person in crisis after the initial police contact. This is not a certainty and is an unnecessary risk to the well-being of persons who needed help so badly that a 911 call was made. Follow-up contact made 1-3 days after the initial crisis might come too late to prevent harm. Persons who needed help while in crisis are often much less willing to accept help later. These represent risks and missed opportunities.

6. Follow-Up Schemes Supporting Police-Only Response—A Business Model Told Them to Do It

No management model or research paper ever concluded that persons in mental health crisis can get better on-scene care from a police officer than a mental health professional. Within public administration, some business models and researchers are promoting greater investments in upstream prevention via proactive contact with high service utilizers (see "High Utilizers" in Glossary Section). This is logical and useful. But no public administrator should proffer a false choice between investments in proactive contacts and investments that provide appropriate on-scene clinical mental health responses.

7. Follow-Up Schemes Supporting Police-Only Response—Maintain a Failed Status Quo

Follow-up schemes alone maintain the old status quo of police as de facto mobile mental health crisis workers. This is no longer acceptable. Interestingly, some of the strongest arguments against the old status quo are being voiced by law enforcement officers themselves. The following is an excerpt of a 2019 news report by KTAR News in Phoenix. Jeri Williams, the Phoenix Police Chief, is quoted.

> *"I know for a fact people call 911 when they're having the worst day of their life," Williams told KTAR News 92.3 FM's Bruce St. James and Pamela Hughes on Monday.*

> *"There are some times where we should not be responding to these mental health calls, so why not take that out of the equation," Williams said, "let the mental health professionals deal with that, give my officers time to deal with police work."*
>
> *"I'm excited about the challenge for us to create a system, not just with the police department, but with the community, the behavioral health community, other law enforcement agencies, that's going to create a response that's going to be better in the end for law enforcement and for the community."*
>
> *"What this looks like in a tangible sense to me is a mental health professional riding in the car with one of our two crisis intervention team squads," Williams said.*
>
> *"Or, take it a step further, riding in a patrol car with our patrol officers, sitting in our communication centers, diverting calls from law enforcement that can go somewhere else."*
>
> *"I'm trying to create the dynamic where I'm getting the right calls and the right people for the right reasons."*[125]

F. Dedicating Officers to Do Social Work Follow-Up Visits

Sometimes police agencies dedicate one or more law enforcement officers to do work that mimics the role of an actual social worker and/or mobile mental health professional.[126] On-scene collaboration or deflection of calls to mobile crisis response teams should be a goal, not something to be avoided.

This can evolve into an extreme example of police culture resisting collaboration and defending its old separate silo territory. Police are trained, authorized, and equipped to perform a public safety/law enforcement function. Officers can still participate in community policing and relationship building. But using police officers in follow-up work as quasi-social workers is wasteful and fraught with conflicts of interest.[127] This is especially true for follow-up work with people who have persistent mental illness and co-occurring substance abuse disorders. Involving law enforcement in follow-up services is a means of criminalizing mental illness. Law enforcement can better serve these populations by improving collaboration with actual social workers and mental health professionals rather than inserting themselves as substitute mental health workers.

G. LEAD Programs and Mental Illness

LEAD programs create care management and coordination system architecture under a philosophy that makes law enforcement contact a central and lasting component of care service delivery. Care management and coordination is discussed in section VIII. We see

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[125] Could MH Experts Prevent Phoenix OIS? https://ktar.com/story/2542809/could-mental-health-experts-prevent-phoenix-officer-involved-shootings/?show=comments
[126] MH Cops Reweave Safety Net. https://www.npr.org/sections/health-shots/2014/08/19/338895262/mental-health-cops-help-reweave-social-safety-net-in-san-antonio
[127] Cops Morphing into Social Workers Not the Solution. https://filtermag.org/cops-morphing-into-social-workers-is-not-a-solution/

the need for integration of service delivery to create efficiency and stabilize high utilizers. That is currently being attempted outside of law enforcement, primarily at the county government level. Law enforcement can and should support those existing efforts to provide care management and coordination. This would require law enforcement to collaborate well within a broader integration effort that does not center on law enforcement. Unfortunately, the LEAD approach assumes law enforcement operates in a vacuum and must be leaders in care coordination efforts. This inappropriately expands the role of police officers— particularly with respect to mental illness. Law enforcement has a key role to play in cross silo collaboration as facilitators, to get people to the primary service delivery systems whose personnel are better suited to be primary contacts.

LEAD (Law Enforcement Assisted Diversion) originated in Seattle. It was meant to divert substance abusers away from arrest and steer them to treatment. Importantly, mental illness is often involved because it so often co-occurs with SUD. Some LEAD programs are also expanding the concept beyond SUD and applying it directly where behaviors are solely the result of poverty, homelessness, and mental health. Clearly, pre-arrest diversion of people away from incarceration is a good thing. But LEAD doesn't just avoid incarceration; it also promotes a lasting and centralized role for police as gatekeepers to social services and health services. This is very different from simply enabling police to handoff vulnerable persons to service providers and case managers.

The good aspects of LEAD programs are those that do not put police into this centralized role in lieu of other alternative service givers. Pre-arrest diversion and proactive referrals by police is also commendable, but not unique to LEAD. We applaud all efforts to improve collaboration and communication between the separate siloed entities: policing agencies, prosecutor's offices, and social service providers. Tying persons to services, including intensive case management, is a worthy goal that can be pursued with or without LEAD. In fact, many local governments are working to create collaborations, integration of services, and expand case management to high utilizers without turning police into de facto social workers. (See section VIII.)

However, the unique characteristic of LEAD programs is that it puts police into a centralized role in lieu of using other types of personnel in the community. When the Seattle Police Department initiated their LEAD program, their officers became primary gatekeepers to services for some people. Proponents of this approach proudly tell stories of people in parts of Seattle going to police officers to ask for services or putting themselves in a position to be arrested to gain a police LEAD referral.[128] It's good that police can provide social services referrals, but it is strange and inappropriate for a community to utilize police as primary gatekeepers. There are alternatives that should be explored and funded. The use of community navigators is one such option.[129] [130]

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[128] Minneapolis City Council LEAD Presentation. https://youtu.be/proXKzWmpC8
[129] PCOC Minutes 3/12/19. http://www2.minneapolismn.gov/meetings/pcoc/WCMSP-217510
[130] MPD Community Navigator Program. http://www.minneapolismn.gov/police/about/WCMSP-220186

LEAD promotes problems analogous to those seen when police are used as de facto mobile mental health workers. Police are less efficient and knowledgeable than specialized social workers and other professionals trained to assist SUD sufferers. Choosing to use police as primary de facto social service gatekeepers also funnels vulnerable persons through extended contact with policing agencies and prosecutors that have conflicting obligations. LEAD has been found to suffer from predictable forms of resistance to system change:

- *resistance by rank-and-file officers*
- *competing demands and expectations*
- *an inability to measure what matters*
- *public unresponsiveness*
- *leadership transition*[131]

The efficacy of LEAD tends to suffer from the fact that only a fraction of officers support it and the number of persons granted benefits can be a vanishingly small fraction of the need. Researchers studying the touted LEAD program in Seattle noted that only 40 of 1300 officers participated.[132] The then-manager of Seattle's LEAD program said that at times there were only 40 people participating in that program despite the sizeable number of Seattle Police Department contacts.[133]

Researchers have found that police officer discretion, not expertise in SUD or mental illness, is a deciding factor in whether officers grant a person a LEAD referral.[134] The worst failure of LEAD programs is that officer discretion tends to prevent benefit to the target group of frequent fliers. It appears that officers are more reluctant to help persons who had a longer history of police contact—a trait of the group. Their reluctance to utilize the LEAD program fit with researchers' survey data showing 2/3 of the officers had reservations about the LEAD program and fully half of them held negative opinions about diversion in general.[135]

The Dirty Secrets of LEAD Programs – Presentation to Minneapolis City Council

There is an effort to expand LEAD to new cities, including Minneapolis. In 2019, local law enforcement and prosecutors had a presentation proposing the "LEAD social services model" to the Minneapolis City Council.[136] This presentation provided additional insight into the operation of LEAD programs. Some of the descriptions provided by the presenter were:

[131] Worden, R. & McLean, S. Discretion and Diversion in Albany's Lead Program. Crim Justice Policy Review, 2018, Vol. 29(6-7) 584–610. 10.1177/0887403417723960.
[132] Collins, S., Lonczak, H., & Clifasefi, S. (2015). LEAD Program Evaluation: Recidivism Report. Seattle: University of Washington.
[133] Minneapolis City Council PSEM Meeting 11/13/19. op. cit.
[134] Worden, R. & McLean, S., op. cit.
[135] Ibid.
[136] Minneapolis City Council PSEM Meeting 11/13/19. op. cit.

- **"People stay in LEAD forever." Once enrolled, a person remains in the records of law enforcement forever.** Program advocates insist on this even for persons who commit no further crimes.

- **Police comfort level determines what level of illegal substance possession qualifies a person for participation in LEAD.**
  This is highly subjective, with decisions made by officers who have no professional expertise in chemical dependency treatment. Patients are far better served if treatment experts decide who can enter programs.

- **Police apply the LEAD program to persons whose behaviors are not criminal.**
  LEAD programs initially focused on illicit drug users, but today's LEAD programs include other types of police contacts due to poverty and mental illness. Inclusion in LEAD programs depends heavily on officer discretion.

- **Social Contact Referrals, which do not involve diversion or criminal conduct, are designed to be just as important as arrest diversion referrals in the LEAD program.**
  This overreach inserts law enforcement into people's daily lives despite a lack of criminal conduct. Money and time spent expanding law enforcement's reach into the lives of people in crisis would be better spent on partnering with social services and mental health crisis responders.

- **A LEAD referral must be acted on within 30 days to avoid reapplication of the deferred criminal charges.**
  People whose criminal conduct stems from mental health crisis deserve the compassionate aid of government (see "Parens Patriae" in Glossary Section). That means facilitating deflection to mental health crisis responders or on-scene co-response. Police referral to the LEAD program is no substitute for having the right professional on-scene to offer care and assistance. By promoting this substitution, LEAD programs normalize the criminalization of homelessness and mental illness.

The presentation to the Minneapolis City Council was an attempt to sell police as a primary means of linking vulnerable persons to resources. It also suggested that the LEAD program was the only means of breaking silos. This is inaccurate in several ways. There are other ways to provide wraparound services and case management to the high utilizer population. The fact that other options have not been explored (or funded) does not necessitate a misapplication of police officers as gatekeepers to social services.

LEAD Is an Inappropriate Overreach That Criminalizes Mental Illness

Researchers studying the Albany program concluded that the failings of this model are reminders of past mistakes in police reform. CIT and LEAD suffer from the same unfortunate reflex to expand police involvement beyond what is required or appropriate. The quote below gently reminds us of this old lesson.

> *Conflicts – internal and external to police – arise over goals and the appropriate degree of coerciveness in providing services. Community expectations for crime fighting and order maintenance may, at some point, conflict with the harm reduction philosophy that underlies LEAD and programs of its ilk. Goetz and Mitchell (2006) conclude that such programs are "difficult to sustain" (p. 505). George Santayana said that "those who cannot remember the past are condemned to repeat it." We should be careful to draw lessons from experiences with the implementation of these programs. They have been characterized as "the future of policing" (Gualtieri, 2016); they are also the past of policing.*[137]

LEAD programs create conflict and waste by over-utilizing police in lieu of other, more appropriate service providers. This does not represent the future of improved collaboration and integration our communities want and need.

Leaders in Minneapolis and elsewhere should consider the potential consequences of expanding law enforcement's reach into social services delivery. LEAD has the potential to excuse surveillance of persons, their families, and their friends by police officers acting as self-appointed social workers.[138] This reality already exists in many cities where police routinely make proactive welfare contacts with persons living with mental illness.[139] [140] Local city and county leaders cannot ignore unintended consequences when local law enforcement seeks to initiate a LEAD program that inappropriately expands the reach of law enforcement in the community.

We call for common sense alternatives that truly reflect community needs and priorities. Collaboration and service systems integration can occur without LEAD programs and the conflict they bring. Social service delivery systems can provide wraparound services and case management. Cities and counties should partner with these programs and work to get them better funded. When cities and counties want to do more than simple street outreach, they can utilize social workers instead of police officers to help community members stay connected to services.

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[137] Worden, R. & McLean, S., op. cit.
[138] Cops Morphing into Social Workers Not the Solution, op. cit.
[139] Maplewood PD and Paramedics Launch MH Team. http://www.startribune.com/maplewood-police-paramedics-launch-mental-health-team/512238992
[140] Lakeville Police Team Formed to Follow Up on MH Calls. http://www.startribune.com/lakeville-police-team-formed-to-follow-up-on-mental-health-calls/307636751/

It is time for better, more appropriate solutions, rather than reflexively expanding law enforcement's role to include the provision of social services.

H. Telepsychology, Where Chosen for Convenience Only

In rural jurisdictions, law enforcement officers can have tremendous logistical obstacles to collaborating with mental health professionals. It can be common in remote areas to have no viable options for deflecting persons to alternative services. These are circumstances where electronic aids are necessary to enable a telepsychology option. This can put a patient in contact with a provider and/or inform an officer's decision-making. However, using electronic aids where not truly necessary, but for the sake of expediency, encumbers access to mental health professionals and reduces the effectiveness of the care. The priority is to provide critical care, not to make police responses more convenient for officers and police administrators.

I. Ambulances and EMTs Instead of Licensed Mobile Mental Health Crisis Workers

Alternatives to a police response are preferred if they are appropriate and adequate. Using actual mental health clinicians is most appropriate for mental health-related calls.

In some communities there is a reflexive push to use emergency medical technicians (EMTs) in ambulances as alternatives to a police response. But these are not mental health professionals; this diverts their expertise, and the ambulance asset, away from their core function.

This paper focuses on police contacts. It addresses the need for deflection to alternative response options and the need for real-time, on-scene mental health professional and police co-response. These are needs born of the reality that police should not be de facto mobile mental health care workers. Paramedics and EMTs are also not mental health professionals. Thus, they too should choose deflection to or on-scene collaboration with mental health workers when their calls involve persons in a mental health crisis. In fact, collaboration with county mobile mental health crisis teams should already be part of the standard operating procedure for ambulance services.

In urban areas, the labor market provides an adequate supply of clinical social workers to enable both deflection and on-scene collaboration (see section VII). It is time for society to recognize that mental health crises are best addressed with a mental health clinician response. This will reduce the waste of taxpayer funds and the suffering of persons who need the right response, at the right place, and at the right time.

J. Using Under-Qualified Workers for Mobile Mental Health Crisis Response

Some communities are exploring co-response options that are cheaper substitutes for using highly trained mobile mental health workers. This focus simply preserves the pattern of defaulting to unnecessary revolving door transfers. It is an example of managing, not solving a problem.

1. CAHOOTS (Crisis Assistance Helping Out On The Streets)

The well-publicized CAHOOTS Program of White Bird Clinic in Eugene, Oregon deploys mobile teams that historically mostly assisted the sizeable local homeless population. Their teams are comprised of an EMT and a crisis intervention worker. Much of the assistance is typical of what outreach teams do— tie persons to services. The teams are also expected to assist with persons affected by drug use and mental illness. Crisis intervention workers are expected to perform "mental health assessments" and "crisis counseling" on their own in the field.[141]

Postings for crisis intervention workers on the employer's webpage show the pay is $15/hour, a college degree is not required, and only two years of related experience is required.[142] This falls far short of the credentials typically required for performing mobile mental health crisis responder work.[143] [144]

In Minnesota, and in most locales, persons employed to provide "mental health mobile crisis intervention services" are required to have a Master's degree and satisfy separate statutory requirements to perform clinical mental health assessments.[145]

Communities must consider the importance of providing a true mental health care response to psychiatric emergencies using highly qualified workers. CAHOOTS does not provide this. Having highly qualified mental health professionals provide on-scene care in real time prevents unnecessary transfers, reduces system burdens, and enables better outcomes. Sending lesser-qualified individuals misses most of the long-term benefits of avoiding police-only response. In Minnesota, county mobile mental crisis response teams (e.g. COPE teams in Hennepin County) have the expertise to yield full return on the investment in an alternative response.[146] This is discussed further in sections V and VI.

K. Promises to Collaborate Without Formal Policy and Mechanisms

Time and again, a tragic use of force brings forth public pronouncements of changes, including collaboration between law enforcement and mental health providers. Too often, these are empty promises, because they don't result in concrete policies and mechanisms ensuring deflection to or co-response with mental health clinicians.

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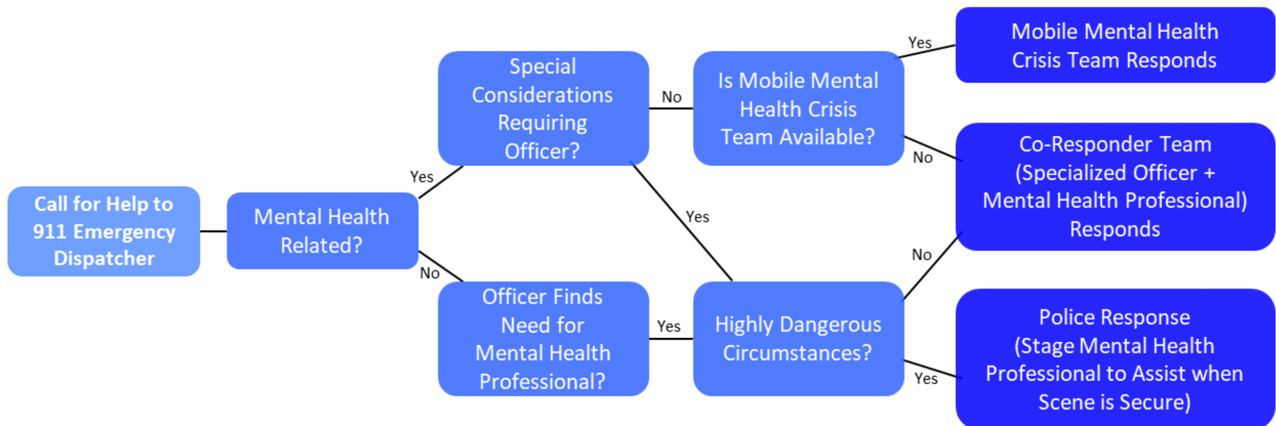
[141] Doin' the Work: Frontline Stories of Social Change, Episode 26. https://drive.google.com/file/d/1F9yNxZJoG2G4CNwIQmFZtaifwuYMgurC/view
[142] White Bird Clinic Crisis Intervention Worker Job Posting. https://whitebirdclinic.org/job-postings/
[143] HC Sr Psychiatric Social Worker Job Posting. https://agency.governmentjobs.com/hennepin/job_bulletin.cfm?jobID=2020787&sharedWindow=0
[144] Crisis Clinician Practitioner Job Posting. https://www.indeed.com/viewjob?jk=da003adc51f7a2da&q=mobile+crisis&l=Ramsey+County,+MN&tk=1e0p862lbp9p7801&from=web&vjs=3
[145] MN Statute 256B.0624, op. cit.
[146] Ibid.

V. FOUNDATIONS FOR SUCCESS

There is no single solution to reducing the use of police as de facto mobile mental health crisis workers. This section provides general concepts and a review of the limitations that exist for collaboration in rural areas. Another important consideration for decision-makers is where to access start-up information and assistance.

How 911 Calls Can Result in Mental Health Care Response



A. General Concepts

1. Multi-Layered Response Schemes That Prioritize Collaboration at First Contact

A multi-layered approach is important for decriminalizing mental illness. The LAPD created a multi-layered collaborative approach that is a national model.[147] [148] [149] Over the course of three decades, the LAPD pioneered the first stand-alone Mental Health Unit. Within that unit they created a co-responder team program (SMART teams), then a collaborative follow-up team (CAMP teams), and even a triage desk staffed by clinicians.

The Houston PD also has an impressive multi-layered system that has helped many other agencies to implement their own programs. According to the Council of State Governments, Justice Center, Houston's approach includes:

> *Crisis Intervention Response Team (CIRT) The CIRT, which started in 2008, serves as Houston's highest-level response to people in serious mental health crisis. The co-response program partners a Houston CIT officer with a masters-level licensed mental health clinician from The Harris Center. CIRT supports officers in the field, responds to CIT calls for service, is present at SWAT calls, conducts jail assessments, and performs proactive and follow-up investigations.*

[147] LAPD Unit Praised. https://www.scpr.org/news/2015/03/09/50245/police-and-the-mentally-ill-lapd-unit-praised-as-m/
[148] LAPD Mental Evaluation Unit, September 2016. https://pmhctoolkit.bja.gov/ojpasset/Documents/MEU-Program-Outline-Sept-2016.pdf
[149] LA National Model, op. cit.

Chronic Consumer Stabilization Initiative (CCSI) This program identifies people who are in frequent contact with HPD officers and pairs them with a mental health case manager.

Homeless Outreach Team (HOT) The Homeless Outreach Team has worked collaboratively since 2011 with community organizations to provide services.

Boarding Homes Enforcement Detail (BHED) Houston passed a city ordinance in July 2013 that regulated unlicensed boarding homes, many of which provide housing for people with mental illnesses.

Crisis Call Diversion Program

Senior Justice Assessment Center

Investigations Unit/Special Projects This unit analyzes every police report pertaining to mental illness and inputs these incidents into a database.[150]

Community Navigator programs at the city or county level can add a very valuable service, remove burdens from more specialized responders, and be a valuable component in the effort to tie high utilizers to services through integration. Minneapolis has a nascent program with bachelor's level social workers offering wraparound services.[151] [152]

The multi-layered approach is easier to construct in large cities, but the concept can apply anywhere. Smaller jurisdictions can create similar functionality without following the big city example with separate distinct teams and programs. It requires a high level of collaboration with the personnel available in the separate systems. The "Yellow Line Project" in Blue Earth County, MN, offers an example of a rural effort to create multiple deflection and diversion opportunities. The Yellow Line Project excels by being intentional within a framework of close collaboration.[153] [154]

2. Dispatch Triage

Governments serve their communities best when they respond to requests for service with the most appropriate resources. When a psychiatric emergency results in a call for service, the expertise of mobile mental health professionals is the most appropriate response. This maxim applies whether the call goes directly to a county mobile mental health crisis team dispatcher or goes to a 911 dispatcher. The public wants and deserves a mobile mental health care response to a mental health call for service.

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[150] CSG Law Enforcement MH Learning Site-Houston PD. https://csgjusticecenter.org/wp-content/uploads/2020/02/Law-Enforcement-Mental-Health-Learning-Sites_Houston3.26.19_508accessible.pdf
[151] PCOC Minutes 3/12/19, op. cit.
[152] MPD Community Navigator Program, op. cit.
[153] The Yellow Line Project. https://www.yellowlineproject.com/history-of-ylp/
[154] Yellow Line Project Jail Project Priorities. https://static1.squarespace.com/static/59a9b5a96f4ca376db822022/t/59c2c888197aea0c2f8207db/1505937548753/continuum+of+care.png

Dispatch Triage refers to assigning calls to the most appropriate responder. For mental health-related calls, this could mean a deflection to county mobile mental health crisis teams or to law enforcement/mental health co-responder teams. In larger cities it might even enable deflection to specialty teams for domestic disputes or homelessness.

Dispatch Triage must happen within 911 call centers prior to reaching police. The goal should be to provide real-time response and on-scene expert care—nothing less. This is an important consideration because some jurisdictions substitute a response by minimally trained workers for a police response. This betrays the community members whose crises resulted in calls for help. It is also wasteful. By deflecting to an on-scene clinician response, dispatch triage creates tremendous benefits and efficiencies.

Missing this opportunity for proper deflection is, frankly, unacceptable for systems that strive to deliver excellent service with high efficiency. This is the easiest and most efficient point to break the "separate silos" trap. Dispatch triage should be employed to prevent unnecessary police contact even in regions where there are separate call systems (e.g. 211 or crisis hotlines) dedicated to connecting the public to mental health services. But hard experience shows that deflection to alternative services is highly unlikely unless there is a formalized mechanism for dispatch triage at the 911 call center level.

Unfortunately, the U.S. 911 system has historically prevented the most appropriate response to mental health crisis. Our 911 systems do not proceed from the logical starting point that recognizes a person with mental illness in the category of a person needing medical assistance. This is analogous to someone who is injured in an automobile accident. Accident victims get emergency medical responses. In cases where persons with mental illness present a danger to others, the public safety concern can logically require a police response. Sadly, the Supreme Court has failed to require police to respond any differently than they would to a violent criminal.[155] But, the great failure of U.S. 911 systems is their inability to find middle ground when evaluating mental health-related calls. Too often the scales have been tilted to treat individual mental health-related calls as dangerous despite any and all contraindications. This is especially problematic for suicide calls, which are often treated as "imminent danger" calls requiring a police response.

Things can be different in 911 communications centers and in some places outside the U.S. they already are. In Sweden, they have chosen to decriminalize mental illness by ending police-only responses for most suicide calls. They have initiated 112 (their 911) dispatch triage that sorts suicide calls to enable alternative or co-responses where appropriate.[156] In Stockholm, a non-police rapid response team called PAM is dispatched to calls by their version of a 911 system.[157] PAM was created in response to high suicide

[155] Reasonable Accommodations, Not Unreasonable Force. http://cdrnys.org/blog/disability-dialogue/the-disability-dialogue-reasonable-accommodations-not-unreasonable-violence/
[156] PAM Follow Up. https://www.tandfonline.com/doi/full/10.1080/00207411.2016.1264040
[157] Ibid.

rates, and 53% of their calls are for severe threat or attempt of suicide.[158] (PAM is discussed in greater depth in section VI.)

Some communities in the U.S. are experimenting with dispatch triage. The proliferation of co-responder teams has helped. Dispatch triage at 911, with direct call assignment by dispatchers, is more likely to be used with 3-person co-response teams consisting of a police officer, clinician, and EMT. In Minnesota, the first locality to implement 911 dispatch triage, Ramsey County, began deflecting calls in 2018.

A Local Success Story

In Ramsey County, MN, there was almost no deflection of calls to mental health clinicians before the introduction of a dispatch triage system. The supervisor of the county crisis team reported that before the dispatch triage program, his teams "had about three assessments per month maybe" that originated from law enforcement. With dispatch triage, that number rose to more than 30 deflections a month.[159]

When this deflection occurs, it creates much better public service from all the collaborating systems.[160] [161]

Limitations will exist when the call for service includes an element of danger to responders or criminal activity is apparent. Even in those situations, such complications might not prevent the use of co-response options such as secondary response or police-embedded co-responder teams.

Dispatchers can be trained to better recognize a mental health aspect in an incoming call for service. The first dispatch triage effort in the State of Minnesota was at the Ramsey County Emergency Communications Center. At the 2018 Critical Issues Forum by the Minnesota Chiefs of Police Association, panelists from Ramsey County described their procedures. Team Supervisor, Brian Theine, described how his local 911 center determines if they can transfer a call to the county crisis team:

> *Starting Mar. 1, 2016, the emergency call center began redirecting adult crisis calls to the Ramsey County Crisis Program. … The telecom person will do an initial screening for eligibility and assessing to see that the person who needs assistance is 18, that they are not engaged in an act of suicide – so they haven't already ingested a bottle of pills or sitting with a trigger of a gun at their head – and that the caller believes that the person is not dangerous to the person on the phone or anyone else in the community, and no crime's been committed.*

[158] World's First MH Ambulance. https://www.dailyscandinavian.com/successful-launch-worlds-first-mental-health-ambulance-stockholm/
[159] Brian Theine, MPCA Critical Issues Forum. https://youtu.be/nbET9b8p80c
[160] Transferring MH Calls. https://www.governing.com/idea-center/Transferring-911-Mental-Health-Calls-Could-Reduce-Harm.html
[161] Avon and Wiltshire MH Partnership. http://www.awp.nhs.uk/services/community/street-triage-service/

> *...So, we're set up to respond to an urgent need. Paramedics and police are set up for imminence. So, dispatch's job is to decipher where does the call fall. Is it an urgent call for crisis or is it an imminent call for the police? The dispatch worker then will talk to the person on the line and see if they are comfortable with being transferred to my team, and being willing to have counseling, and a potential in-person visit by a mental health professional to their home rather than a police officer. And, are they safe and comfortable waiting for my team to respond. So, at that point, dispatch transfers the call to crisis, they announce the caller and their phone number, and they stay on the line for a short time to make sure that it's successfully has transferred. This has also proved helpful – fruitful – for us because the call is live, it's being audio-taped, so if something isn't going well between our teams we can learn from that. And, it also provides us with a safety thing in case the call gets dropped; we know who to call and what number to call back on. So then the assessment ensues, the crisis team decides is this something to offer, like information referral. Do we go out and see somebody. How do we get that set up? Sometimes it also slows down the call and we may make a decision to go out into a joint door knock, with police and crisis together in a non-emergency kind of way. The whole system has improved because of this. …Once dispatch has transferred the call, they can go and we can take over…We get to help out people in the community. We can get them help quickly – right away. And, then police are freed up to go do police work.*[162]

Abilene, TX, uses conference calling to bring a mental health professional into a 911 call with the push of a button.

> *During the three-way call between the person in a mental health crisis, a 911 dispatcher and an Avail clinician, the clinician will "triage them and determine if it's something that can be handled over the phone or if they need to dispatch our Mobile Crisis Outreach Team," Cole said. Betty Hardwick has at least one team available around the clock, Cole said.*[163] Avail is a Texas-based company that staffs crisis hotlines.

Houston's Crisis Call Diversion Program was begun in 2015 and handles thousands of calls. Their program deflects crisis calls to on-phone counseling and possible mobile team visits.[164]

In the police community, there is growing recognition of the need for 911-based dispatch triage. Phoenix Police Chief Jeri Williams described her understanding of the need for deflection and dispatch triage in a 2019 on-air KTAR interview:

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[162] Brian Theine, MPCA Critical Issues Forum, op. cit.
[163] Abilene 911 Program. https://www.reporternews.com/story/news/2019/02/01/new-abilene-program-addresses-911-mental-health-call/2747350002/
[164] Houston PD Crisis Call Diversion Program. https://perma.cc/XW5L-TCXB

There are some times where we should not be responding to these mental health calls, so why not take that out of the equation," Williams said, "let the mental health professionals deal with that, give my officers time to deal with police work.

So call 911 but perhaps in that call to 911 we can give you to a service provider, we can give you to a mental health professional...Why not give you to a crisis line, why not give you to a suicide prevention line... So we can take those calls but we want to divert those calls.[165]

Advocates for those with mental illness are also part of the rising chorus of calls for 911-based dispatch triage. NAMI Minnesota's Executive Director, Sue Abderholden, decried the lack of 911-based dispatch triage in a 2018 KSTP News report.

"Why would we have a separate mental health number that very few people know instead of making sure that our current emergency services can connect people to the right treatment?" she said.

Abderholden says lawmakers allowed 911 to link with mental health crisis response teams back in 2009. Still, nearly a decade later, few are taking advantage of it.

"We really should have the 911 operators connecting people with mental health crisis teams instead of just automatically sending out police and ambulances," said Abderholden.[166]

Dispatch triage at 911 call centers is key to making effective use of alternative response options as well as co-response options for mental health crisis calls.

3. Alternative Responders—911 Mental Health First Responders

Alternative responders are teams of professionals who are qualified to provide mobile mental health crisis interventions in the community as a substitute for a police response.

These alternative responders help to meet community expectations for quality, transparency, accountability, and cultural competence and are part of providing a patient-centered service. The kind of highly skilled personnel needed for this work are licensed master-level clinical social workers (LICSW). They offer competencies in mental health care with the social work skills to tie people with the resources they need. LICSWs make ideal primary responders as well as co-responders. Clinical social workers also have the credentials and expertise to satisfy the statutory requirements set by Minnesota for mobile mental crisis response work.[167] [168] Unlike other mental health professionals, there is a surplus of clinical social workers in many urban areas and in most of Minnesota. The labor market for clinical social workers is described in section VII.

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[165] Could MH Experts Prevent Phoenix OIS?, op. cit.
[166] MH Advocates Want 911 Linked with Crisis Response Teams. https://kstp.com/news/mental-health-advocates-want-911-linked-with-crisis-response-teams/5105208/
[167] MN Statute 256B.0624, op. cit.
[168] MN Statute 245.462. https://www.revisor.mn.gov/statutes/cite/245.462/pdf

4. Minnesota's County Crisis Response Teams: Ideal Alternative and Co-Response Option

Minnesota is blessed to have mobile mental health crisis response teams serving every county. These teams provide as an ideal foundation for building alternative response and co-response capacity. Other states should see this resource as an excellent example of how to build capacity for alternative response and co-response programs of their own.

The teams are staffed with experienced clinical social workers who can provide on-scene mental health assessment and care. They are also ideally situated to tie individuals to follow-up services and case management in increasingly integrated county care systems.

There are important benefits to funding these teams at the county level, including the potential for better response time and efficient coordination with law enforcement. Transparency and accountability are also significant considerations.

Unlike other states, Minnesota counties have key resources and organizational structure already in place. The main obstacles are capacity, the lack of 911 dispatch triage, and inadequate collaboration. More funding is needed to hire workers to handle additional calls from 911 dispatch triage and for deeper collaboration with law enforcement.

> **Ramsey County Crisis Teams are Diverting 911 Calls Away from Police**
> The Ramsey County Mental Health Crisis Response Team already benefits from 911 dispatch triage and is currently functioning as an alternative responder for mental health-related 911 calls.[169]

5. Co-Response and Mental Health Co-Responder Teams

In situations where police contact cannot be avoided, communities must provide a working mechanism to enable routine and immediate on-scene co-response by well-trained mental health professionals. This includes the ability to relieve patrol officers whose contact with someone in crisis was not foreseeable when dispatchers described the call. This is exactly what the community and consumers want. Research shows co-response is preferred over a police-only response.[170] [171]

Without a co-response option, many unforeseen or problematic mental health-related calls will be police-only contacts. The outcomes of these will be a matter of chance and police discretion instead of a clinician's expertise.

> *When the interaction between the police and the person with mental illness is initiated by the police themselves, police officers have the greatest amount of discretion. In such situations, there is considerable potential for the disposition to*

[169] Ramsey County 911 New Approach. https://www.twincities.com/2016/02/29/ramsey-county-911-will-send-mental-health-workers-to-crises/
[170] Boscarato, et al., op. cit.
[171] Evangelista, et al., op. cit.

be influenced by police officers' personal attitudes or beliefs. There may well be no one – neither citizens nor the police officers' superiors – overseeing whether a situation is handled in a standardized fashion and in a way that protects both society and the individual. In these instances, the officers act freely and solve the problem in whichever way they deem appropriate, on the basis of their particular attitudes toward, perceptions of, and assumptions about persons with mental illness.[172]

The mental health aspect of a call for service might not be understood until the first officer arrives. In other cases, the nature of the call might require a police officer to be present to verify and maintain a safe environment. Avoiding a police-only response in these circumstances requires an extremely rapid and integrated co-response option. Experience and research have shown that the best way to do this is by creating police/mental health professional co-responder teams.

COPE Partners with Minneapolis Police in Co-Responder Team Program
In Minneapolis, the county team called Community Outreach for Psychiatric Emergencies (COPE) currently provides personnel to work within the Minneapolis Police Department's Co-Responder Team Program.[173] [174]

Co-Responder Team Basics

Co-responder teams are two-person teams comprised of a dedicated specialty officer, paired with a mental health professional. These partners respond in the same vehicle exclusively to mental health-related calls. The teams exist to take the burden of mental health-related calls off the regular patrol cadre and create better outcomes for persons in crisis. Co-responder teams are far superior to the outdated model of secondary response, in which law enforcement officers may call in outside clinicians. As previously discussed, officers almost always fail to call non-embedded clinicians.

The very first use of this approach was in 1987 in Vancouver. This is the oldest police mental health crisis response initiative.

A partnership between the Vancouver Police Department and Vancouver Coastal Health, Car 87 is one of several specialized police vehicles used in the city. For a given crisis situation, one Vancouver Police constable and a psychiatric nurse will respond to conduct on-site assessments and make necessary treatment referrals. The Car 87 team also helps locate and transport individuals at the request of community mental health services. Car 87 offers the benefits of a law enforcement-

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[172] The Police and Mental Health. https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.53.10.1266
[173] Hennepin County Adult MH Crisis Response. https://www.minnesotahelp.info/Providers/Hennepin_County_Human_Services_and_Public_Health_Department/Mental_Health_Crisis_Response_Services_Adult/1?returnUrl=%2FSpecialTopics%2FYouth%2F19590%3F
[174] MPD Co-responder Teams. https://www.minnpost.com/metro/2019/01/how-co-responder-teams-are-changing-the-way-minneapolis-police-deal-with-mental-health-calls/?fbclid=IwAR1lp9HY0VyAyVH7vq93WbHeMzF4G5E3Ulf2K7E_wYxDsV442oS4LxBMJFw

> *mental health response, providing expertise in both maintaining public safety and administering psychiatric care.*[175]

The Co-Responder Team Model has been in use in the U.S. since 1992, when it was adopted by the Los Angeles Police Department. Since then it has been refined and adopted by scores of police departments in the United States, Canada, the United Kingdom, and Australia. The United States has seen a surge in the effective use of co-responder teams in the past several years. In Minnesota, the Duluth Police Department studied the Houston PD program and initiated the first such program in the state. Then Dep. Police Chief Mike Tusken welcomed the innovative approach of their co-responder program.

Co-responder teams could be asked to respond by 911 dispatchers or on-scene officers who recognize a mental health issue. In many police departments, the co-responder teams also monitor police radio traffic and can self-assign to a call. Co-responder teams can and should respond independently to most calls in which weapons are not involved.

Researchers note that by handling time-consuming mental health-related calls, co-responders are “relieving an otherwise substantial, unnecessary, and inappropriate burden on law enforcement officers.”[176] This benefit to law enforcement is not always fully appreciated by those who have no experience with this specialized police response model. However, once implemented, police officers typically recognize the improved outcomes and reduced burdens on law enforcement. In Boston, embedded co-responder Mathew Salch observed that evolution firsthand:

> *We’ve gone from not being accepted when we started, to officers in other Boston police department districts calling us for help, because they have heard of the work that we are doing. That feels good.*[177]

Rapid Growth of the Co-Responder Team Model

The Boston experience is typical in several ways. It is common for jurisdictions that implement co-responder team programs to observe tremendous immediate benefit and decide to expand their programs within a very short time. The Boston Best Program that was limited to two police districts at the time of the above quote has since expanded at the behest of multiple city councilors. The relatively new programs in Duluth and Minneapolis have both expanded.[178] [179] Countless other cities have also expanded their co-responder programs because both the community and police departments valued the

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[175] Beyond Road Runners. https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/4168-research-weekly-beyond-road-runners-insights-from-other-countries
[176] Seattle PD CRT. https://www.researchgate.net/publication/281310578_A_descriptive_evaluation_of_the_Seattle_Police_Department's_crisis_response_team_officermental_health_professional_partnership_pilot_program
[177] Boston Police Ride Along. https://stepuptogether.org/people/boston-police-ride-along-2
[178] MPD Co-Responder Teams, op. cit.
[179] Duluth Co-Responder Team Model Recognized. https://cbs3duluth.com/2019/05/22/watch-live-at-130-p-m-duluth-st-louis-co-officials-to-recognize-mental-health-unit/

improved outcomes.[180] [181] [182] [183] [184] [185] Multi-jurisdictional programs are part of this explosive growth. These programs are partnerships of two or more communities to create a co-responder team program that serves areas that could not sustain their own independent programs. This allows suburbs to benefit from the co-responder team model as a partnership that leverages economies of scale. The largest example of this is the PERT Program that provides co-responder team service to all of San Diego County.[186] [187] [188] A smaller example is the eleven-city Johnson County, Kansas program.[189]

Co-Responder Expertise Brings Highly Effective On-Scene Care and Advocacy

Police-embedded co-responder programs are important because they provide great benefit to the vulnerable persons in crisis. Community-based clinician care has been shown in research and experience to promote de-escalation, prevent unnecessary transfers, and help prevent patient entanglements in the criminal justice system.[190]

Avoiding entanglements with the criminal justice system is a key benefit. Such entanglements can have severe consequences for persons struggling to maintain a home and employment. Law enforcement consistently describes how the clinician elicits more cooperation from the patient, thus reducing the potential for use of force.[191] [192]

In Denver, this ability to gain cooperation and de-escalate situations helped the co-responders gain acceptance from patrol officers.

> *Snow says that at first, there was concern that officers might not accept clinicians riding in their cars. But that concerned quickly disappeared after officers saw how*

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[180] Boston MH Clinicians to Attend to 911 Calls. https://www.bostonherald.com/2017/02/15/city-eyes-staffing-mental-health-clinicians-to-attend-to-911-calls/
[181] St Paul PD Expanding MH Unit. https://www.mprnews.org/story/2018/12/24/st-paul-police-already-want-to-expand-new-mental-health-unit?fbclid=IwAR0doyxcYdMdecy6roJ_x39NYaJZAMXOfGnQ7wWaokM3Yuv2zYjQ5-YI6oM
[182] County Votes to Expand Mental Evaluation Teams. https://www.printfriendly.com/p/g/gkRxzr
[183] Johnson County Hiring More MH Co-responders. https://youtu.be/VlW9r0V4YqE
[184] Baltimore Police Add Crisis Response Team. https://www.baltimoresun.com/maryland/baltimore-city/bs-hs-police-crisis-response-20170727-story.html
[185] Grant to Help Tulsa's CRT. https://www.tulsaworld.com/news/crimewatch/grant-to-help-tulsa-s-community-response-team-expand-beyond/article_0f183e3e-5070-53df-a452-ca014a425f64.html?fbclid=IwAR05DFpkXKmOZCb7vZdTHhEsZVtVsETjRq1g7CVaTLZQ7AKUTziSCAbw1uo
[186] San Diego PERT. https://popcenter.asu.edu/sites/default/files/library/awards/goldstein/2005/05-12.pdf
[187] Escondido PERT, op. cit.
[188] San Diego Blueprint for Mental Health Reform, op. cit.
[189] Eleven Johnson County Cities to Partner, op. cit.
[190] Evangelista, et al., op. cit.
[191] CMPD Co-responders. https://www.wsoctv.com/news/local/cmpd-pairing-officers-with-social-workers-to-help-de-escalate-mental-health-calls/908753927/
[192] Evangelista, et al., op. cit.

effective clinicians were in de-escalating potentially volatile situations. "Then officers started competing to have clinicians," says Snow.[193]

Replacing a police-only contact with co-response can save lives and reduce trauma. A use of force can de-stabilize a patient and affect them for days or weeks.

Many victims of police violence often experience PTSD, which manifests as severe agoraphobia and paralyzing panic attacks. This creates a downward spiral of isolation, depression, and even suicide.[194]

Without co-response, officers typically default to a transfer to a brick and mortar facility where a mental health professional can make an assessment. These transfers are often unnecessary, but officers, lacking mental health expertise, naturally choose the action that will indemnify them and their agency. Researchers found that 80% of police-initiated transfers in a Minnesota jurisdiction resulted in no care.[195] This has always been a key inefficiency of the police-only response. It creates a large and unnecessary burden on hospital emergency rooms and other facilities. It adds trauma and possibly an ambulance bill to the patient's experience.[196] [197] On the west side of the continent the same dysfunction was described in Orange County, CA, where officers wait for hospitals personnel to triage patients being dropped off:

Unfortunately, Orange County relies on an obsolete, inefficient triage system that handicaps the police officer and results in an inordinate loss of time and resources. Moreover, the County jails and emergency rooms are the worst places in which to treat the severely and dangerously mentally ill.

The County's shortcomings with regard to mobile response teams and in-the-field medical clearances of the severely mentally ill, and have caused long delays in evaluating and treating the mentally ill, many wasted hours of valuable police time spent in emergency rooms and while driving the mentally ill to and from emergency treatment facilities. The County's lack of vision and leadership have resulted in a disjointed, dysfunctional system that contributes to the revolving door.[198]

Co-response eliminates wasteful inefficiency and harm caused when police act as gatekeepers. When co-responder teams were introduced in multiple jurisdictions in the United Kingdom, the result was 50% or greater reductions in transfers.[199] [200] [201] In one

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[193] DPD Co-responder Unit. https://www.westword.com/news/part-of-caring-4-denver-money-would-go-to-co-responder-unit-10935094
[194] Officers with PTSD, op. cit.
[195] New Paradigm, Not New Building, op. cit.
[196] New Paradigm, Not New Building, op. cit.
[197] Cost of MH Crisis in ED. https://www.healthcarebusinesstoday.com/true-cost-mental-health-crisis-emergency-department/
[198] MI Revolving Door, op. cit.
[199] Street Triage and Detentions. https://bmjopen.bmj.com/content/bmjopen/6/11/e011837.full.pdf
[200] Nottinghamshire Street Triage. https://www.england.nhs.uk/mental-health/case-studies/notts/
[201] Street Triage to Help the Vulnerable. https://www.bbc.com/news/health-32739451

case the reduction was by 90%.[202] A Boston researcher documented her observations in that city:

> *What clearly came across in the co-responder data and the officer interviews is that there are families who rely on police to provide a type of respite when their loved ones are in crisis. There are residents of Boston who rely on 911 and the police to address immediate problems, such as suicidal ideation, that require a quick emergency response. Traditionally, the city has filled this need through ambulance transports and emergency department evaluations, but this is not a sustainable solution both in terms of cost and outcome. It creates a revolving door of crisis services without addressing the long-term needs of these families and frustrates an already-overburdened public safety system.*[203]

In Dallas a co-responder team program and 911 dispatch triage created noticeable results after only three months of operation.

> *B.J. Wagner, senior director at the Meadows, said since the program kicked off Jan. 29, ambulance calls for mental services in southern Dallas have decreased by 23 percent [emphasis added]. When mental health emergency calls come in, clinicians and specialists use their expertise to talk a person down and free up Dallas' 42 ambulances to respond to other calls.*
>
> *…*
>
> *Wagner added that of the 709 mental health emergency calls fielded since January, just 3 percent ended in arrest. In the first three months of the program, the clinician's diversion of calls saved the police force about two weeks of salaried work [emphasis added]. "We want public safety to be our first priority, not law enforcement," Assistant Chief David Pughes said Friday. "The police officer is just there to make sure the paramedic and clinician are safe."*[204]

Having the Clinician On-Scene Immediately Is Powerful

Police co-responder teams create an immediate community-based care option that can turn a police response into a healthcare response. Being on-scene enables optimal service that begins with a more accurate assessment and immediate care. The clinician can provide counseling or evaluate co-occurring substance abuse issues.

Co-responding clinicians are well positioned to partner with family and friends to create a plan for follow-up care. This follow-up care might include wraparound services or case management. It all starts with an immediate on-scene clinician response to a psychiatric emergency. When a transfer to a brick and mortar care facility is deemed necessary, the

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[202] Operation Emblem. https://rcni.com/newsroom/nurse-awards/caring-approach-street-triage-nurses-people-mental-health-crisis-26411

[203] Boston Experience with Co-Responder Model. https://doi.org/10.1080/15564886.2018.1514340

[204] Senator Praises Program. https://www.dallasnews.com/news/2018/07/28/sen-john-cornyn-praises-dallas-police-mental-health-crisis-response-program/

clinician's expertise creates a much better handoff into the care of other mental health workers.[205]

If there is a transfer, the professional on-scene assessment and clinician-to-clinician communication is immensely important for immediate care and coordinating follow-up work.

Co-Responder Teams and Care Management

These initial contacts are extremely important opportunities to pull individuals into the care continuum. Many police-only contacts involve persons who are "off the radar" of care systems or are experiencing their first episodes. One study determined 30% of mental health contacts were early onset consumers who were not yet tied to services.[206] Stabilizing early onset individuals can prevent many from becoming "high utilizers" of social services and additional police contacts. These contacts are important windows of opportunity to help people. Very often police officers lack the expertise to identify an individual's true need for care. Researchers in Seattle noted that a co-responder team program there was creating better dispositions due to the insight of the on-scene clinicians.

> *The current findings show the ways in which the SPD CRT OFC/MHP team was able to provide nuanced intervention and case disposition that meaningfully addressed issues presented by frequent fliers. These individuals tend to get caught in a never-ending cycle as both victims and offenders. Without necessary resources, law enforcement officers have difficulty ascertaining the nature of the situation of individuals they come in contact with who are experiencing such severe and complex problems. Individuals with chronic and complex needs, disability, and disadvantage utilize an enormous amount of police and emergency resources. They often become targets of the police because of their unusual behavior and interaction with police tends to make them anxious which can exacerbate their problems, resistance, and contacts with police. Units such as the SPD CRT that pair law enforcement and mental health professionals provide the expertise to reduce future contacts with police and utilization of emergency and police resources by taking steps to break the cycle through appropriate case disposition that addresses the multiple and complex needs of these individuals.*[207]

The quote from the researcher in Seattle shows why failing to ensure immediate on-scene co-response is risky. When a call for help doesn't result in on-scene co-response, a window of opportunity to intercede can be lost for an unknown period of time. A follow-up worker returning through a referral by police might find a patient who is less cooperative with caregivers. An inadequate initial on-scene response might leave a vulnerable person in a decompensated state for days before follow-up is even attempted.

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[205] Evangelista, et al., op. cit.
[206] Study in Blue and Grey, op. cit.
[207] Seattle PD CRT, op. cit.

The right response, at the right place, and at the right time can reduce suffering and even prevent tragedies.

Co-response means de-criminalizing mental illness. This is common sense that also reduces waste of taxpayer funds. Most importantly, this is an approach that recognizes the needs of vulnerable citizens. Martin County Florida Sheriff, William Snyder, successfully lobbied his state legislature for the funds to initiate a co-responder program. In 2017, he explained why he thought this was important:

> *Law Enforcement officers responding to calls for service involving citizens with mental illness and/or substance abuse challenges are fraught with dangers to both citizen and officer. I intend to hire Master's Level Clinical Professionals licensed in mental illness and substance abuse intervention, who will respond alongside deputies to assist with these difficult and complex circumstances.*
>
> *It is my fervent hope that this pilot program alleviates some suffering for the most fragile among us. A compassionate community should do no less.*[208]

Co-Responder Teams Prevent Police-Only Contacts

Support for co-responder teams to prevent police-only response is growing. In Boston, a police-embedded co-responder team program (Boston BEST program) proved its merit to city leaders, police officers, and the broader community. City council leaders demanded full funding and expansion of the program.[209] This is only one example of how co-responder team use has exploded across the nation in the past several years. One clear reason is that co-responder teams put a caregiver and advocate on-scene where there would otherwise only be police officers. That creates positive consequences.

> *Mayor Usha Reddi said she can "almost guarantee" that hiring the two co-responders is the best investment that the city and county has made.*
>
> *"They're literally saving lives," she said. "Not only are they saving lives, they're doing a lot of follow-ups."*[210]

Other impressive statements of approval come from independent citizen groups focused on police reform. The community members on the 2016 Chicago Police Accountability Task Force issued a report with reform recommendations that included implementation of co-responder teams.

[208] Martin County Sheriff's Office MH Co-Responder Program. https://www.facebook.com/MartinCountySheriffsOffice/photos/a.316726388337911/1565414696802401/?type=3&theater

[209] Boston MH Clinicians to Attend 911 Calls, op. cit.

[210] RCPD Happy with Co-Responders. https://themercury.com/news/city/rcpd-happy-with-mental-health-co-responders/article_d1b9ee25-f94f-59d4-9843-0c781d64b2cd.html?fbclid=IwAR12GncQN-vGul34pueoQycFt4aNNxCH9E0TEaLGWSL0ARrcs49-3EtahFU

Recommendations: The City should create a crisis response system to support multi-layer co-responder units where behavioral health providers are working with OEMC and CPD to link individuals with mental health issues to treatment, 24 hours a day. While providing CIT training to police officers is a key tool for de-escalating responses to mental health crises, many jurisdictions recognize the value of also going beyond traditional police functions to more directly address the problem of mental illness. The President's Task Force on 21st Century Policing recommended that law enforcement agencies "engage in multidisciplinary, community team approaches for planning, implementing, and responding to crisis situations with complex causal factors." The co-responder model is one such approach. The model's primary component is intensive collaboration with mental health professionals for responding to crises and persons with mental health issues who repeatedly come to the attention of police. Police may respond in tandem with mental health professionals, allowing them to maximize their respective skills and better share information. Instead of simply arresting a person experiencing a mental health crisis, these clinicians help assess whether an alternative intervention (e.g., connecting with a social worker, getting treatment) would be more appropriate. After an incident, a clinician may follow up with the person who experienced a crisis. The crisis response system includes a crisis line that is staffed by clinicians and is well-connected to other systems (like OEMC) that can respond to mental health emergencies. Intensive training and development of this multi-layer co-responder model is necessary and relies heavily on the City and its Department of Public Health. The crisis response system should also include mobile crisis workers that can respond and provide assessments. These clinicians may also respond at the request of police officers, and request police assistance when needed. The Los Angeles Police Department's crisis response system includes co-response teams and has become nationally recognized as a best practice.[211]

Black Lives Matter also advocated for the use of co-responder teams in their original Campaign Zero plan. That draft called for reducing police use of force by using "a multi-disciplinary co-responder team that includes mental health professionals, social workers, and crisis counselors as well as specially trained police officers."[212]

6. Statutes, Medical Assistance, and Insurance Requirements

State statutes, Medical Assistance (i.e. Medicaid) rules, and private insurance rules are important considerations for both deflection to and co-response with mental health crisis teams. These statues and rules often create elevated requirements for worker education and training, supervision, government oversight, and documentation of mobile crisis care. These requirements generally exist to ensure a higher quality of mobile crisis care for vulnerable people. However, they often conflict with the priorities of law enforcement

[211] Chicago PATF Final Report, p. 124. https://chicagopatf.org/wp-content/uploads/2016/04/PATF_Final_Report_4_13_16-1.pdf
[212] Campaign Zero. https://www.joincampaignzero.org/solutions#solutionsoverview

or local government, entities that typically drive reform. Creating a cheaper alternative to using an expensive ambulance for transfers is relatively simple. But the consumer and taxpayer might be better served by deflection and co-response options that create higher-quality community-based care that qualifies for reimbursement by insurers. In fact, this is key to the success of the Yellow Line Project in Blue Earth County, Minnesota. To justify its community-based care reforms, the Yellow Line Project leverages both the expansion of Medicaid coverage under the Affordable Care Act and avoidance of hospital expenses. Effective reforms target people who are high utilizers of services with cross-system solutions that go beyond just creating a cheaper ride to the emergency room.[213] [214]

In Minnesota, statutes require those providing mobile mental health crisis care to be highly educated, for example state licensed clinical social workers (LICSW).[215]

Further requirements include appropriate documentation, proper supervision, and regulatory oversight by the county health department. Thus, in Minnesota, it is typical to see master's-level LICSWs with years of experience performing mobile crisis work. The State of Minnesota clearly defines worker roles, employer roles, the work being done, and the meaning of a "mobile crisis intervention team."[216] [217]

Only one team member must be on-site. So, mental health practitioners with the ability to readily contact a partner can satisfy the definition of a mobile crisis intervention team when performing co-responder field work with a police partner.[218] Some alternative response options used in other states are not acceptable under Minnesota statutes which prescribe higher levels of supervision and training.

B. Considerations for Rural Areas

Practical limitations exist for collaborations between police and mental health professionals in rural areas. Logistics and scarcity of resources affect most efforts. Still, there are options for promoting collaboration and avoiding the "separate silos" paradigm.

1. Dispatch Triage and Alternative Response

Dispatch triage can and should be attempted in rural areas. The benefits of collaborating are only increased where the logistics of responding to calls is more difficult.

2. Rural Co-Response

In rural areas, we recognize that lower call load, logistics, and resource limitations can prevent the use of standing co-responder teams. It is useful to have a formalized agreement for police and mental health professionals to co-respond on some calls. It is

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[213] Yellow Line Project, op. cit.
[214] Yellow Line Project Jail Project Priorities, op. cit.
[215] MN Statute 256B.0624, op. cit.
[216] Ibid.
[217] MN Statute 245.462, op. cit.
[218] MN Statute 256B.0624, op. cit.

also useful to consider co-location and, if necessary, the use of technology to facilitate collaboration.

3. Co-Location

Co-location refers to having non-police mental crisis response teams responding from the same building that houses the 911 call center and/or a policing agency. It is especially useful in rural communities where low call volumes and logistics might otherwise promote a separate silo paradigm. Co-location can enable deflection and make co-response more convenient. When law enforcement officers serve large areas, they cannot afford to respond to calls where they are not necessarily needed. Co-location can help identify opportunities for deflection to mental health clinicians at dispatch. It also allows law enforcement and mental health professionals to routinely consult and train together. Locally, one can see examples of co-location in Washington County and Scott County.[219] [220] Co-location enables more collaboration generally, but should definitely be leveraged to increase deflection of calls and co-response.

4. Telepsychology for Rural Collaboration

Jurisdictions with low population density are increasingly utilizing telepsychology (a.k.a. telemental health).

> *Key benefits to telemental health include savings in time, money and travel (Khalifa et al., 2008). These benefits may be particularly felt in rural or remote locations where the time and financial costs associated with patient transportation to facilities are typically higher than in urban areas; this was borne out in an Australian study which piloted an effective service to provide 24 hour access to mental health specialists via video-link (Saurman et al., 2011).*[221]

While in-person care by a licensed clinical social worker is more appropriate for 911 calls involving persons in mental health crisis, telepsychology can help where the alternative is a police-only response. The danger is that this tool will be abused as a rationale for unnecessarily avoiding deflection and co-response options. Telepsychology has a history in basic counseling services but not in mobile mental health crisis response. Communities should carefully evaluate how telepsychology will be applied in any local initiative.

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[219] Washington County Crisis Response Unit. https://kstp.com/medical/new-crisis-response-unit-in-washington-county-helps-answer-mental-health-crisis-calls/5249677/

[220] Scott County Mental Health Crisis Response. https://www.swnewsmedia.com/shakopee_valley_news/county-mental-health-change-exposes-large-need/article_7133a52c-b45a-5bfd-9a36-c1770fbc1bd8.html

[221] MH Interventions: What Works? https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2018/08/works-collaborative-police-health-interventions-mental-health-distress/documents/00537517-pdf/00537517-pdf/govscot%3Adocument/00537517.pdf

> *Not all clients or interventions are appropriate for teletherapy services. It is important that you identify criteria for clients who are appropriate for this kind of intervention and carefully screen clients to ensure they meet these criteria. Clients who are high risk or who need extensive support between sessions are not likely to be good candidates for teletherapy.*[222]

The American Psychological Association has developed its *Guidelines for the Practice of Telepsychology*.

> Guideline 7. Psychologists are encouraged to consider the unique issues that may arise with test instruments and assessment approaches designed for in-person implementation when providing telepsychology services.[223]

Although some studies have shown that telepsychology has similar benefits to person-to-person contact for therapy, those studies do not apply to 911 psychiatric calls.[224]

Clearly, the technology can be very useful for basic consultation and coordination of services – a triage desk function. This is certainly better than having police default to a transfer to the nearest hospital emergency room.

Thus, the decision to use telepsychology should not rest on expediency and cost savings, but rather be based on creating the best possible care under the circumstances. It should never be abused for the purpose of avoiding on-scene co-response or deflection to alternative responders when those options are appropriate.

C. Start-Up Resources for Evidence-Based Approaches

Implementing alternative responses and co-responses can be daunting. Fortunately, there are well-established resources for information-gathering and start-up planning. Using these resources saves time and money by helping communities apply proven practices and models.

Planners should seek technical assistance from objective expert sources like those listed below. This is key to steering project designs toward evidence-based approaches. When decision-makers create initiatives that are based on existing models, their communities can have more confidence in the outcomes.

Planners must also bring together stakeholders from the community, issue advocates, and professionals in partnership to ensure that plans reflect local needs and values. These

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[222] Managing Risks of Telepsychology. https://nationalpsychologist.com/2018/08/managing-risks-of-telepsychology/104807.html
[223] Guidelines for the Practice of Telepsychology. https://www.apa.org/pubs/journals/features/amp-a0035001.pdf
[224] Does Telemental Health Alter the Experience? https://psycnet.apa.org/record/2008-00950-018

partnerships can create the political momentum needed to overcome resistance and enable bold reform.

The entities listed below can assist in creating patient-centered programs for alternative response, co-response and 911 dispatch triage. They provide technical assistance in the design, planning, and start-up of collaborative projects that reduce police-only contacts.

1. Advocates Inc. of Massachusetts – Technical Assistance Center

Advocates Incorporated has been working with local law enforcement agencies since 2003 to create collaborative initiatives. This is a mental health services organization applying clinical expertise to develop highly patient-centered collaborations with law enforcement. They have a strong focus on creating alternative responses and multi-jurisdictional programs. They also have much experience with on-scene collaborative co-response teams based at police departments for rapid response. Advocates Inc. excels at assisting with program replication.[225] [226]

2. Law Enforcement Learning Sites

The United States Department of Labor, Bureau of Justice Assistance (BJA) created several Criminal Justice Mental Health Law Enforcement Learning Sites.227 At these sites, communities can study the operation of active criminal justice diversion programs. They offer direct assistance in the planning and implementation of reform initiatives at other police departments. Police administrators and supervisors often travel to learning centers to examine collaborative practices in actual use.

Arlington (MA) Police Department

The Arlington Police Department is a BJA designated learning site serving a suburban, medium-sized jurisdiction. They have several points for diversion, including a police-based mental health co-responder team option.[228]

Houston Police Department

Houston's police department has a long history of collaborating with the mental health provider system. This large agency has a fully developed multi-level structure to improve outcomes for persons with mental illness. The HPD has assisted many other agencies including the Duluth Police Dept. Typically, HPD hosts visiting officers, but HPD has actually sent their own police supervisors to other cities to assist start-ups.

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[225] Advocates Jail Diversion Program Tool Kit. https://mn.gov/dhs/assets/czech-advocates-jds-manual-12_tcm1053-256994.pdf

[226] Advocates Jail Diversion Program Impacts. https://www.advocates.org/services/jail-diversion/jail-diversion-program-impact-outcomes

[227] CSG Law Enforcement MH Learning Sites. https://csgjusticecenter.org/projects/police-mental-health-collaboration-pmhc/law-enforcement-mental-health-learning-sites/

[228] CSG Law Enforcement MH Learning Site-Arlington PD. https://csgjusticecenter.org/projects/police-mental-health-collaboration-pmhc/law-enforcement-mental-health-learning-sites/arlington-police-department/

Houston's mental health co-responder team program is called Crisis Intervention Response Teams (CIRT).[229] HPD's form of dispatch triage through the Crisis Call Diversion Program began in 2015.[230]

Los Angeles Police Department

For over 30 years, the LAPD has been at the vanguard of innovation in how police handle contacts with persons living with mental illness. It is a busy BJA learning site. It is the agency that created the first mental health co-responder team program (called SMART) in the U.S.[231] [232] [233] [234]

[229] CSG Law Enforcement MH Learning Site-Houston PD, op. cit.
[230] Harris County Crisis Call Diversion Program.
https://www.houstontx.gov/council/committees/pshs/20151119/911diversion.pdf
[231] LAPD Unit Praised, op. cit.
[232] LAPD Mental Evaluation Unit September 2016, op. cit.
[233] LAPD Mental Evaluation Unit, op. cit.
[234] In LA a National Model, op. cit.

VI. SPECIFIC APPROACHES FOR SUCCESS

Community members and decision-makers should challenge themselves to look beyond separate silos approaches. This section briefly summarizes some of the approaches for creating deeper law enforcement/mental health professional collaborations and deflections. This survey of approaches is intended to encourage the reader to further explore the means of enabling deflection to or co-response with mental health crisis teams in lieu of police-only contact. Whenever possible, communities should be provided with both alternative response options and co-response services.

A. Deflection and Prevention Before the Call to 911

While we recognize the importance of investment and reform in this area, the scope of this paper does not include these efforts.

This paper focuses on contacts made in the window from 911 call intake to the arrival of a police officer on scene. This scope does not cover the necessary and commendable efforts to prevent the use of the 911 systems for mental health crises. Those efforts are extremely important, and this discussion is not an endorsement for using the 911 system.

B. Dispatch Triage—Examples

Dispatch triage is described above and is in use in many places with little fanfare or public attention. Dispatch triage is key to preventing police only response through better use of alternative response and co-response options. This practice must be conducted within 911 call centers, rather than downstream at police dispatch. There will be significantly less deflection of calls to alternative responders if triage decision-making is pushed downstream to police dispatchers and police administrators. The merits of dispatch triage are described in section V. What follows are a few examples of dispatch triage in practice.

1. Ramsey County Deflection to County Crisis Response Team

Since starting this practice in 2017, the Ramsey County Emergency Communications Center has generated nearly ten times more deflections to alternative services than before the practice started.[235] [236] The system effectively deflects mental health-related calls to Ramsey County's mobile mental health crisis teams. As described in section V, 911 dispatchers can now immediately involve dispatchers for the county mobile crisis response team on calls involving mental illness. The crisis team dispatchers help determine if their teams can respond alone or with police backup. This is the only dispatch triage effort in Minnesota and is a national leader because it deflects calls at the highest possible level (Sequential Intercept Model, Level 0 diversion).

[235] Ramsey County 911 New Approach, op. cit.
[236] Brian Theine, MPCA Critical Issues Forum, op. cit.

2. Abilene (TX) Deflection to Crisis Response Teams

Here the 911 dispatchers can create a 3-way conference connection with crisis response team dispatchers to enable a non-police response for mental health-related calls for service. In this area, the Betty Hardwick Center can respond with a Mobile Crisis Outreach Team of clinicians if no police involvement is necessary.[237] Alternatively, they can opt for a brand new co-response option using new 3-person crisis response teams comprised of an officer, clinician, and EMT.[238] [239]

3. Harris County 911 Crisis Call Diversion Program

The goal of this program is to have dispatchers identify and refer all qualifying and eligible non-emergency mental health-related calls for immediate connection to a Harris County Public Mental Health System phone counselor. To do this, mental health counselors are physically located at the Houston 911 call center. These bachelor-level mental health workers can provide counseling on the phone, initiate a non-police care response, or verify that a co-response is appropriate. The Houston Police Department CIRT (Crisis Intervention Response Team) program includes co-responding mental health workers for such a situation. The CIRT program has in-person co-response and a virtual co-response with clinicians consulting via iPads.[240] [241] It should be noted that we do not believe telepsychology is an adequate response for more serious mental crisis calls. This call diversion effort fits within a mature multilayered response scheme that has other specialty services. Other services can be summoned from the Chronic Consumer Stabilizing Initiative (CCSI) and the local Homeless Outreach Team (HOT). In Harris County they have deflected tens of thousands of calls away from a police response.[242]

4. Mental Health Nurses in U.K. Emergency Call Centers

The U.K.'s national Street Triage effort has transformed crisis response in that country to prevent police-only responses and an urgent need to reduce Section 136 mental health holds by police.[243] [244] [245] Unlike the U.S., their evolution to a standard for deflection away from police-only response occurred relatively rapidly, benefited from high-quality on-going academic study, and has seen universal support from law enforcement. In some

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[237] Abilene 911 Program, op. cit.
[238] Behavioral Advisory Team. https://ktxs.com/news/local/behavioral-advisory-team-to-change-how-mental-health-emergencies-are-handled
[239] Abilene 911 Program, op. cit.
[240] Harris Center CIRT. https://www.theharriscenter.org/Portals/0/CIRT.pdf
[241] Harris County iPads. https://www.houstonpublicmedia.org/articles/news/in-depth/2018/07/26/297294/ipads-could-change-how-harris-county-deputies-assess-mental-health-crises/
[242] Harris County Crisis Call Diversion, op. cit.
[243] Street Triage Services in England. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6465222/pdf/S2056469418000621a.pdf
[244] Street Triage Evaluation. https://www.ucl.ac.uk/pals/sites/pals/files/street_triage_evaluation_final_report.pdf
[245] Street Triage and Detentions, op. cit.

parts of the U.K., mental health nurses are embedded in emergency communications centers and work closely with law enforcement officers.[246] [247] In the U.K., the Street Triage model has utilized both two-person officer/clinician teams, and three-person teams with a dedicated officer, mental health professional, and EMT responding in a special van.[248] [249]

5. Dallas Deflects at 911 to RIGHT Teams to Avoid Police Response

The Dallas RIGHT Teams program is noteworthy because it has deflection at the highest level of 911 call intake and utilizes personnel capable of responding to true psychiatric emergencies. A clinician is embedded in 911 call centers to manage the response to mental health-related calls.[250] RIGHT teams then respond to these calls instead of police and ambulances. Like the U.K. Street Triage model, this program has 3-person teams comprised of a dedicated officer, mental health professional, and an EMT.[251]

6. Other Examples of Dispatch Triage at 911 Emergency Call Centers

Other examples exist in the U.S. and internationally with wide variation in what calls are eligible for deflection away from police-only response and what kind of personnel are used in the alternative response. We support programs that utilize highly qualified personnel capable of handling psychiatric emergencies. This is because supplanting a police-only response is not the only consideration. The alternative response should truly address the needs of the person in mental health crisis.

Existing co-responder teams across the nation are sometimes empowered to respond to mental health-related 911 calls in lieu of a police-only response. Sometimes this is done by direct assignment from 911 dispatchers. In some cases, co-responder teams monitor police dispatch and self-assign to calls that have a mental health component.[252]

C. Alternative Responders—911 Mental Health First Responders

Communities considering alternative response models must advocate for approaches designed to provide high quality mental health services and guard against schemes that serve only to reduce budgetary stress on ambulance services, emergency rooms, and policing agencies. These stressors are often the reason the status quo breaks down to enable some 911 calls to be deflected to alternative responders. However, there are consequences for adopting the "bargain plan" by substituting outreach workers or other poorly qualified individuals for licensed clinical social workers. If people in mental

[246] Avon and Wiltshire MH Partnership, op. cit.
[247] Devon Street Triage. https://youtu.be/q2La-Hq3xB0
[248] Nottinghamshire Street Triage, op. cit.
[249] Nottinghamshire Street Triage Model. https://youtu.be/J3sJ0xMVEzQ
[250] Program Pairs Counselors with Cops. https://www.dallasnews.com/news/2018/01/24/program-pairs-counselors-with-cops-to-better-handle-mental-health-calls-in-southern-dallas/
[251] Senator Praises Dallas Program, op. cit.
[252] Baltimore County Crisis Response. https://www.thesantegroup.org/baltimore-county-crisis-services

health crisis are not given the on-scene assessment and services they need, they can fall through the cracks and become "frequent flyers."

1. Ramsey County Mental Crisis Response Teams

The number of calls deflected from police-only response increased tenfold with the initiation of dispatch triage at the local 911 call center in 2018. See section V for a detailed description of the collaborative procedure used by 911 dispatchers to hand off calls to the county team. Ramsey County has the first true application of dispatch triage in Minnesota, despite the state's well-developed system of county mobile mental crisis response teams.

In terms of quality, Minnesota mobile crisis response teams are unmatched. They are a tremendous asset and the ideal foundation for adding new dedicated 911 mental health first responder capacity. Ramsey County has proven this. The list of advantages is worth repeating:

- High prevalence of master's-level, licensed clinical social workers (LICSW) with years of education and experience in mental health care, who are capable of professional on-scene assessments.
- A team of county mental health personnel whose care and care coordination are aided by having access to public health records.
- Personnel whose credentials enable them to seek certification as Rule 25 Assessors. This means they can help indigent persons with co-occurring substance abuse disorders get access to publicly-funded treatment services.
- Better care coordination, case management, and integration. The skilled clinical social workers operating within the county health department are well placed to coordinate follow-up care, wraparound services, and case management.

Many of the benefits are a direct result of using licensed clinical social workers (LICSW) on the county crisis response teams. These professionals offer competencies in mental health care combined with the social work skills needed for persons who are high utilizers of services. A licensed clinical social worker is a professional who has earned a master's degree, spent 4000 hours in supervised clinical settings, and passed a challenging state licensing exam.[253]

To invest in this optimal approach, communities must invest in dedicated mental health crisis response teams to handle the increased workload resulting from calls deflected away from police. In Minnesota, the safest investment would be beefing up the existing county crisis response team infrastructure to meet the need.

[253] MN LICSW Licensing Requirements, op. cit.

2. Psychiatric Emergency Response Team (PAM)—Stockholm

In 2015, Sweden's care services introduced a response unit that might be a preview of what Minnesota could create by expanding its county mental health crisis team system. The Stolkholm-based Psychiatric Emergency Response Team (in Swedish: Psykiatrisk Akut Mobilitet [PAM]) is the world's first psychiatric ambulance service.[254] The unit is tasked with "responding to emergency calls regarding persons in severe mental health or behavioral distress, with suicide prevention as the main priority."[255]

> *"We help people who are suicidal and people who suffer from severe mental illness," says mental health nurse Anki Björnsdotter. And adds, "It can be someone who is manic and not aware of their own mental state, such as a person who needs to go to a hospital without realizing they need to. Also, people who are psychotic and people suffering from schizophrenia who haven't taken their medicine and are in distress."[256]*

[254] World's First MH Ambulance, op. cit.
[255] PAM Follow Up, op. cit.
[256] World's First MH Ambulance, op. cit.

Photos from PAM Follow Up.
https://www.tandfonline.com/doi/full/10.1080/00207411.2016.1264040

The PAM teams consist of two psychiatric nurses and a paramedic.[257] The paramedic is available to determine if there are any medical conditions contributing to the situation. They get direct call assignment from the Emergency Call Center (ECC) in Stockholm County.[258] Each call gets assigned a priority level by the dispatcher to indicate the level of crisis. The highest level is assigned Priority 1. Because this indicates there is a suicide attempt or serious threat, the vehicle must respond rapidly with the blue lights of their specialty ambulance on. The response times are very good. Priority 1 calls have an average response time of only 15 minutes. Priority 2 calls have medium risk of self-harm and the Priority 3 calls usually only require a transport to services.[259]

PAM was designed to respond to true psychiatric emergencies and those are the bulk of its contacts. In their first year 51% of the calls were Priority 1 calls and 46% were Priority 2 calls.[260]

It takes highly qualified mental health professionals to successfully (and ethically) serve persons in this level of crisis. The PAM psychiatric nurses have experience, specialized training, and hold master's degrees.[261] Their qualifications and experience would satisfy Minnesota standards for workers performing "mental health mobile crisis intervention

[257] Sweden Dedicated MH Ambulance. https://vt.co/news/world/sweden-unveiled-amazing-dedicated-mental-health-ambulance/
[258] PAM Follow Up, op. cit.
[259] PAM Follow Up, op. cit.
[260] PAM Follow Up, op. cit.
[261] Patient Experiences with PAM. https://onlinelibrary.wiley.com/doi/pdf/10.1111/hex.13024

services."[262] These mental health professionals are part of the larger care system and have access to patient medical records using a computer with mobile records access.

The specialty ambulance is designed as a space for counseling with a comfortable, clean space and four rotatable chairs.

> *During missions, the staff can wirelessly access the patient's journal through this identification number. All the public hospitals in Stockholm County share the same system for medical records. This enables the staff to receive medical background before seeing the patient.*
>
> *Assessment often takes place in the PAM vehicle. The staff can ask for a voluntary alcohol breath test when it seems relevant. … A patient in need of further assessment and inpatient care will be transported by PAM and admitted to the appropriate emergency department (psychiatric, somatic, or substance use ED). In Stockholm County, PED is separated from substance abuse ED, the latter traditionally handling drug induced psychosis and acute alcohol-related medical conditions like abstinence and alcohol induced delirium.*[263]

The psychiatric nurses frequently collaborate with others. They can communicate with psychiatrists in the psychiatric emergency room and sometimes request police assistance with persons who are agitated.[264]

Researchers found that service delivery is very patient centered.

> *…the PAM team created good conditions for the patients to participate in the care by being empathic, communicating in a calming way, and working to gain trust and understanding in the situation that had caused the psychiatric emergency. The PAM also invited the patients' next of kin, when present, to participate in the care. Altogether, the caring delivered by the PAM team resulted in outcomes that were attuned with the patients' needs and wants.*[265]

3. CAHOOTS Teams—Eugene, Oregon

The well-publicized CAHOOTS Program of White Bird Clinic in Eugene, Oregon has mobile teams comprised of an EMT and a crisis intervention worker. The sizeable local homeless population makes up most, but not all the contacts.[266]

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[262] MN Statute 256B.0624, op. cit.
[263] PAM Follow Up, op. cit.
[264] PAM Follow Up, op. cit.
[265] Patient Experiences with PAM, op. cit.
[266] Helping People in Crisis. https://www.registerguard.com/rg/opinion/36272835-78/helping-people-in-crisis.html.csp

The relatively large homeless populations in the area have much to do with the creation and growth of CAHOOTS. Oregon has the second-highest rate of unsheltered homelessness in the county, at 61.7%. Eugene leads the nation in the number of homeless people per capita.[267] The Eugene-Springfield area has the second-largest concentration of unsheltered homeless persons, by rate and raw numbers, among its category of urban area. The local concentration for Eugene/Springfield/Lane County is so great that Lane County, with 8.9% of the state population, has 18.4% of the state total unsheltered homeless population.[268]

The homeless population is also highly concentrated in the downtown area of Eugene. In 2016 the Eugene Police Department began a "hotspot enforcement" effort in response to aggressive panhandling, open drug use (including methamphetamine), and fights. The department also began a Community Outreach Team effort in partnership with both White Bird Clinic and Lane County Behavioral Health.

> *The recent "hot spot" enforcement and the outreach team, which started in April and was only publicly announced recently, are separate initiatives of the police department.*

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[267] Eugene Makes National Headlines. https://www.kezi.com/content/news/Eugene-makes-national-headlines-for-homeless-crisis-509933051.html

[268] HUD 2018 Report to Congress. https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf

> *For about five hours every Thursday, the team looks for and talks with downtown's most chronic offenders, those individuals whom the police department makes the most contacts with.*[269]

The Eugene Police Department was experiencing huge increases in welfare checks, such as an increase of 55.8% in 2016.[270] This was happening in a state that was ranked very low in social services and mental health services delivery.

> *A U.S. Department of Justice investigation in 2014 found Oregon institutionalized too many people with mental illness, the department alleged. The state needed to pivot to more cost-effective community-based approaches.*
>
> *Chris Bouneff, director of the Oregon chapter of the National Alliance on Mental Illness, puts it more bluntly. Too much goes to prisons and psych wards, not enough to clinics and housing.*
>
> *"There isn't a jail in this state that isn't overwhelmed by mental health issues," Bouneff says. "That's because we've failed on the healthcare side."*[271]

Then in 2017, a consultant hired by the city reported that the large, highly concentrated downtown homeless population has put the neighborhood in crisis and is the worst homelessness situation that the New York-based firm had ever seen. The consultant also reported that many local residents felt intimidated and unsafe when walking downtown.[272] [273]

The consultant's report was followed a few months later by an article in the Eugene Weekly spotlighting the effects of the police "hotspot enforcement." Their analysis of public records revealed that police were issuing many citations for trespassing, illegal camping, and parking violations. The data showed that 25% of non-traffic violations and 35% of court cases involved homeless persons.[274] The Eugene Police responded by further expanding their existing partnership with White Bird Clinic's CAHOOTS program. CAHOOTS teams began to be "dispatched in Eugene through the non-emergency police call center."[275]

Thus, the CAHOOTS program joined a relatively short list of programs that benefited from high-level dispatch triage. The CAHOOTS program has been growing and

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[269] Eugene Worst Homelessness. https://www.bendbulletin.com/nation/eugene-police-chief-says-homeless-problem-worst-he-s-seen/article_f9a1dc5f-1fb3-5ad9-a7c7-02194ee0a360.html
[270] Eugene Police Service STATS 2016. https://www.eugene-or.gov/archivecenter/viewfile/item/4801
[271] Mental Math. https://www.oregonbusiness.com/article/health-care/item/18330-mental-health
[272] Downtown Eugene in Crisis. https://www.seattletimes.com/seattle-news/downtown-eugene-in-crisis-consultant-says/
[273] Lane County Shelter Feasibility Study. https://lanecounty.org/UserFiles/Servers/Server_3585797/File/HSD/Lane%20County%20Final%20Report_1.14.19.pdf
[274] Criminalizing Homelessness. https://www.eugeneweekly.com/2017/06/01/criminalizing-homelessness/
[275] CAHOOTS FAQ. https://whitebirdclinic.org/cahoots-faq/

expanding with an offshoot in neighboring Springfield and program replication in other West Coast cities struggling with large homeless populations. Much of this growth can be attributed to news coverage by the Wall Street Journal and CBS News. The approach is generally sold on its merits as a very low-cost operation that helps avoid the use of expensive ambulance services and the costs of police response.

Some avid allies of this program have had to refute the veracity of estimated cost savings of the CAHOOTS program.[276] With CAHOOTS, the emphasis on cost savings has mostly obscured any consideration of whether the program is an adequate or appropriate alternative response for complicated calls involving psychiatric emergencies. The marketing appears to be getting ahead of larger questions about how to replace police response with an *appropriate* mental health crisis response.

CAHOOTS teams provide multiple levels of service. Some of their services are typical of what outreach teams would do. However, the teams are also expected to care for persons affected by drug use and mental illness. The crisis intervention worker on a CAHOOTS team is expected to perform "mental health assessments" and "crisis counseling" on their own in the field.[277] However, a posting for this job on the employer's webpage shows the pay is $15/hour, a college degree is not required, and only two years of related experience is required.[278] In essence, CAHOOTS workers have qualifications for a well-run street outreach program but are not qualified mental health professionals.[279] [280]

In Minnesota and most locales, persons employed to provide "mental health mobile crisis intervention services" are required to have a master's degree in a behavioral science and satisfy separate statutory requirements to perform clinical mental health assessments.[281] [282] [283]

Why CAHOOTS is Not the Solution for Mental Health Crises

Communities must prioritize a true mental health care response to psychiatric emergencies using highly qualified professionals over instincts to provide the cheapest possible service. CAHOOTS is that cheapest possible service–not the right person, at the right place, and at the right time to deal with true psychiatric emergencies. This goal is as important as simply preventing police-only contacts.

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[276] Eugene Budget Committee Meeting 5/23/18. https://youtu.be/wYCcYwVT6bw
[277] CAHOOTS Crisis Intervention Job Description. https://whitebirdclinic.org/job-postings/
[278] Ibid.
[279] CAHOOTS Worker Audio Interviews. https://youtu.be/kbhpjGTybK4
[280] Street Outreach Worker Job Posting.
https://www.indeed.com/viewjob?jk=73f67fc06a73335e&tk=1e0p80r3vp9p7800&from=serp&vjs=3
[281] MN Statute 256B.0624, op. cit.
[282] Crisis Clinician/Practitioner Job Posting.
https://www.indeed.com/viewjob?jk=da003adc51f7a2da&q=mobile+crisis&l=Ramsey+County,+MN&tk=1e0p862lbp9p7801&from=web&vjs=3
[283] Senior Psychiatric Social Worker Job Posting.
https://www.indeed.com/viewjob?jk=731a72b7b6411d7d&tk=1e0p83antp9p7800&from=serp&vjs=3

Having highly qualified mental health professionals respond in real time with on-scene care prevents unnecessary transfers, reduces system burdens, and enables better outcomes. Response by lesser- qualified individuals misses most of the long-term benefits of avoiding police-only response. Using CAHOOTS-style programs to respond to mental health crises puts the disposition of patients in the hands of persons who are only marginally more qualified to understand mental illness than well-trained police officers. Patients will not benefit from the improved outcomes that researchers have shown to be the result of placing highly qualified clinicians on-scene. Furthermore, services by underqualified non-professionals are not reimbursable by Medicaid and other payers.

In Minnesota, the county mobile mental crisis response teams (e.g. COPE teams in Hennepin County) have the necessary expertise to maximize the return on investment in an alternative response.[284] That return on investment can be measured in tax dollars and, more importantly, in improved outcomes for patients. In contrast, the CAHOOTS approach has not been studied by academic researchers to validate cost savings or outcomes for patients.

Despite its limitations in responding to mental health crises, CAHOOTS-style programs offer some value as part of a multi-layered response system to link people to resources in the community. But such programs cannot replace an appropriate, qualified mental health crisis response.

[284] MN Statute 256B.0624, op. cit.

COMPARING POTENTIAL 911 MENTAL HEALTH FIRST RESPONDERS

	RAMSEY COUNTY MOBILE RESPONSE TEAMS	COPE Teams (Hennepin Co)	PAM Teams (Sweden)	RIGHT Teams Program (Dallas)	CAHOOTS Teams (Eugene, OR)
Private or Public Entity	Public Entity Alternative to Police Response	Public Entity Alternative to Police Response	Public Entity Alternative to Police Response	Police/EMT/MH Professional Team (type of co-response)	Private Entity Alternative to Police Response
Dispatched by 911 to Deflect from PD Contact	YES Dispatch Triage At 911 Communications Center	NO Local Resistance to Dispatch Triage	YES	YES	NO Calls referred via "police non-emergency dispatcher"
Mental Health Workers Can Do Assessments and On-Scene Care	YES Master's-level clinicians with state licenses. Satisfy MN statutory requirements.	YES Master's-level clinicians with state licenses. Satisfy MN statutory requirements.	YES Master's-level psychiatric nurses	YES	Not by MN standards. Most workers have little relevant education and training.
Rapid Response Alternative to Police For Non-Criminal Contacts	Unknown Funding for a dedicated team serving 911 calls would be advised.	Requires new dedicated teams to ensure availability & response time	YES Ave. 15 min. response time to Priority 1 calls.	YES	YES "A mobile social service."
Can Handle Psychiatric Emergencies Including Suicides	YES Highly qualified employed licensed master's-level clinical social workers. Qualifications meet MN statutory requirements.	YES Highly qualified employed licensed master's-level clinical social workers. Qualifications meet MN statutory requirements.	YES Highly qualified psychiatric nurses – would meet MN statutory requirements	YES	Not by MN standards. Most workers do not have the education and training. Most Common Calls: 1) Public Assistance (66.3%) 2) Transport to Services (34.8%) 3) Welfare Checks (32.5%)
Expertise for Co-Occurring SUD and Getting Rule 25 Chemical Dependency Assessment.	YES Workers are experienced mobile crisis workers and clinical social workers within the county system. Have expertise to certify for Rule 25 Chemical Dependency Assessments.	YES Workers are experienced mobile crisis workers and clinical social workers within the county system. Have expertise to certify for Rule 25 Chemical Dependency Assessments.	Unknown	Unknown	Not by MN standards. Most CAHOOTS workers have minimal formal training and relevant education.

Part of Larger Care System (incl. access to records)	YES County-employed licensed master's-level clinical social workers. Part of existing care integration efforts in an established care system.	YES County-employed licensed master's-level clinical social workers. Part of any existing care integration efforts.	YES Mobile com-link access to healthcare records and also allows live consults with psychiatrists. Records are often reviewed before reaching a patient.	YES	Local system almost non-existent prior to 2018. White Bird Clinic won county funding as the only bidder to provide contract social services for Lane County. White Bird Clinic offers medical and dental services in addition to CAHOOTS.
EMT is Part of the Response Team	NO	NO, but new dedicated teams could	YES Paramedic	YES	YES. Most have only basic EMT-B level skills.
Coordinating Wraparound Services and Case Management	YES Experienced and capable. County-employed licensed master's-level clinical social workers. County employer also has established tier of workers who assist with wrap around services and do case management.	YES Experienced and capable. County-employed licensed master's-level clinical social workers. County employer also has established tier of workers who assist with wrap around services and do case management.	NO	Unknown	YES Workers generally have experience with outreach work and good knowledge of how to tie persons to services. Some case management is done through White Bird Clinic.
Spends Time Needed Per Call to Create True Community-Based Care for Mental Health Crisis	YES	YES	YES Calls typically take more than 1 hour and teams average 3.4 calls per day. Expertise prevented unnecessary transfers; 78% of patients transferred were admitted for inpatient psychiatric care. Local psychiatric ER reported significant drop in visits after PAM.	YES Has created a 23% drop in ambulance transfers.	"The two-person teams that staff each van respond to an average of about 15 to 16 calls in a 12-hour shift in Eugene, although it can be as many as 25 calls per shift" Counseling provided in 15% of calls.
Reviewed by Independent and Academic Researchers	YES	YES	YES	YES The model is very well-researched in the UK where it is in common use.	NO Only data is the contract private operator's estimates of cost savings for local government. Accuracy has been refuted by program allies.

1. Program Pairs Counselors with Cops Dallas. https://www.dallasnews.com/news/2018/01/24/program-pairs-counselors-with-cops-to-better-handle-mental-health-calls-in-southern-dallas/
2. CAHOOTS FAQ. https://whitebirdclinic.org/cahoots-faq/
3. Senior Psychiatric Social Worker Job Posting. https://agency.governmentjobs.com/hennepin/job_bulletin.cfm?jobID=2020787&sharedWindow=0
4. CAHOOTS Crisis Intervention Worker Job Posting. https://web.archive.org/web/20161111172544/http://whitebirdclinic.org/job/cahoots-crisis-intervention-worker
5. Mobile Crisis Intervention - Brenton Gicker and Chelsea Swift. https://dointhework.podbean.com/e/mobile-crisis-intervention-brenton-gicker-and-chelsea-swift/?fbclid=IwAR25J66GT1sdeLn79M1HMe_6CBiNkLHSNxJY5nTDOnJfhg69EoWedjh1ses
6. First-year follow-up of the Psychiatric Emergency Response Team (PAM) in Stockholm County, Sweden: A descriptive study. https://www.tandfonline.com/doi/full/10.1080/00207411.2016.1264040
7. Crisis Assistance Helping Out on the Streets. http://www.mentalhealthportland.org/wp-content/uploads/2019/05/2018CAHOOTSBROCHURE.pdf
8. Lane County Mental Health Services Agenda. https://www.lanecounty.org/UserFiles/Servers/Server_3585797/File/Government/BCC/2019/2019_AGENDAS/070919agenda/T.5.C.2.pdf
9. CAHOOTS Medic Job Posting. https://web.archive.org/web/20160915221941/http://whitebirdclinic.org/job/cahoots-medic/
10. Helping People in Crisis. https://www.registerguard.com/rg/opinion/36272835-78/helping-people-in-crisis.html.csp
11. Rule 25 Assessments. https://www.northstarbehavioralhealthmn.com/what-is-a-rule-25-assessment
12. Mental Health Legislative Network Blue Book 2018. https://mentalhealthmn.org/wp-content/uploads/2017/05/2018-MHLN-Blue-Book.pdf
13. Eugene Budget Committee Meeting May 23, 2018 (at 03:12:00). https://www.youtube.com/watch?v=FM3PpOP9Np0

D. Post-Booking Diversion

The scope of this paper is limited to field contacts with persons living with mental illness. However, this is a promising area of exploration.

E. Co-Location

Co-location—placing members of mental health crisis response teams in the same physical space as law enforcement officers—is especially useful in rural jurisdictions. Co-location was adopted in Scott County to overcome the immense difficulties in collaborating with existing crisis response teams that served two counties and were based on the opposite side of the Minnesota River.[285] Washington County, Minnesota has also co-located their county mobile mental crisis responders with law enforcement.[286]

F. Co-Response Options

When police contact cannot be avoided, co-response with mental health workers offers a stark improvement over a police-only response. Co-response puts a mental health worker on-scene to advocate and care for a vulnerable person. Co-response has long been an option in places which have county mobile mental health crisis response teams. But routine co-response will not occur organically. This elevated level of collaboration is best promoted through dispatch triage at the 911 call centers.

1. New to the U.S.: Three-Person Officer/Clinician/EMT Co-Response Teams

When 911 emergency call centers deflect calls to a co-response option in the U.S., the odds are that it will be a new three-person officer/clinician/EMT team. This approach also seems more likely to get direct call assignments from 911 call centers than the traditional police officer and clinician teams. Although new to the U.S., this approach is a national model in the U.K. (a.k.a. Street Triage). The U.K. experience was very positive, as described in section VI.

2. LAPD and Houston: Very Large City Programs

The Los Angeles Police Department was a vanguard agency for co-response in the early 1990s. Their work refined the model and showed how it fit into a larger multi-level response serving persons having mental illness. The LAPD and Houston PD are two of the very largest programs and routinely offer other police agencies start-up assistance.[287]

3. St. Paul, Gainesville, and Other Mid-Sized Programs

St. Paul police created a program that incorporates many of the lessons from the LAPD model. They separated the co-responder teams from the patrol function by creating a

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[285] Scott County MH Change, op. cit.
[286] Washington County Crisis Response Unit, op. cit.
[287] LAPD Mental Evaluation Unit September 2016, op. cit.

Mental Health Unit.[288] Like most programs, their teams have highly qualified mental health workers supervised by a mental health provider. In Minnesota, state statutes require that those performing mobile crisis work satisfy strict qualifications for education, experience, and supervision.[289] The St. Paul program uses master's-level, state licensed clinical social workers (LCSW) who can be certified to perform Rule 25 assessments.[290] These clinical assessments determine appropriate chemical dependency treatment and ensure that indigent people qualify for public funding of the treatment.[291] [292] This is only one example of how well-qualified workers can create better, lasting outcomes.

Gainesville and other cities have also partnered with local mental health service providers to create co-responder teams.[293] [294] [295] [296] [297] The use of co-responders is also common in Colorado.[298]

4. Multi-Jurisdictional Programs Enable Suburbs and Smaller Cities to Share Teams

Multi-jurisdictional programs bring economies of scale and staffing flexibility to smaller jurisdictions that would otherwise be unable to support a standing co-responder team service. Suburbs of bigger cities are especially suited to this approach. One example is found in Johnson County, KS. This partnership brings together 11 cities and the sheriff's office to serve almost the entire county.[299] The county provides and supervises the Licensed Mental Health Professionals (LMHP) and provides additional services like case management. Partnerships like these are created by having individual jurisdictions sign onto a common Memorandum of Understanding which lists participant responsibilities and monetary contribution to the program. The Johnson County program memorandum can be found and reviewed online.[300]

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[288] Embedded Social Worker SPPD. https://www.twincities.com/2018/08/01/embedded-social-worker-working-with-st-paul-police-mental-health-unit-with-a-second-starting-soon/
[289] MN Board of Social Work LICSW Requirements, op. cit.
[290] MN Rule 9530.6615, op. cit.
[291] HC Sr Psychiatric Social Worker Job Posting, op. cit.
[292] Rule 25 Assessments. https://www.northstarbehavioralhealthmn.com/what-is-a-rule-25-assessment
[293] Gainesville MH Co-Responder Team. https://www.wuft.org/news/2019/04/26/gainesvilles-mental-health-co-responder-team-diverts-arrests-and-saves-taxpayers-money/
[294] Civilized Approach to MI Duluth. https://blogs.mprnews.org/newscut/2019/05/a-civilized-approach-to-mental-illness-pays-off-in-duluth/
[295] Overland Park PD Co-Responder Program, op. cit.
[296] Sending Social Workers to Answer 911 Calls. https://www.economist.com/united-states/2019/05/11/why-american-departments-are-sending-social-workers-to-answer-911-calls
[297] Program Pairs CMPD and MH Experts. https://www.charlotteobserver.com/news/local/crime/article224956705.html
[298] Colorado Co-Responder Program. https://www.colorado.gov/pacific/cdhs/co-responder-programs
[299] Co-Responder National Conference. https://shawneemissionpost.com/2020/03/12/mental-health-professionals-discuss-client-confidentiality-uniform-choice-funding-issues-at-first-national-co-responder-conference-88360/
[300] Johnson County MOU (p. 11). https://drive.google.com/drive/folders/0B28l5JpCZgBfYTVMWnJLckRHT1U

The largest multi-jurisdictional co-responder program is undoubtedly the Psychiatric Emergency Response Team (PERT) that serves all of San Diego County. This program has operated for 23 years without any harm befalling a co-responding clinician. It has also grown rapidly in size over the last several years and currently employs 70 clinicians.[301] [302]

Massachusetts has many jurisdictions with co-responder programs including multi-jurisdictional efforts. Many of these programs were assisted by the provider, Advocates Inc., which has helped police departments implement co-responder programs in Massachusetts since 2003.[303]

5. Co-Response with Officers, EMTs, and Mental Health Workers

There is growing use of three-person responses utilizing a police officer, emergency medical technician, and mental health worker. These teams are more likely to get direct call assignments from 911 centers because they can handle a wide variety of calls. They can reduce burdens on ambulance services, police, and hospital emergency rooms. By adding an EMT to the mix, the response can include an evaluation for medical issues. By using EMTs and special vehicles, the teams can transfer individuals.

This approach became part of the national model in the U.K. following pilot trials in 2011.[304] [305] [306] The U.K .programs are broadly grouped under the term “street triage.” They quickly proved that having mental health workers on-scene prevented a huge number of unnecessary transfers to U.K. care facilities. Transfers were often reduced by 50% or more.[307]

The Dallas RIGHT Team program began in 2018 and quickly impressed. Like its U.K. cousin, this program was able to utilize on-scene clinician expertise to drastically cut transfers by ambulances.[308] Dallas reported a 23% reduction in the use of ambulance transfers within the first three months of the RIGHT Teams program even though the teams only served a fraction of the city.[309]

These three U.S. cities are known to use the three-person co-response model:

- Dallas RIGHT Teams
- Abilene (TX) Crisis Response Teams
- Tulsa Crisis Response Teams

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[301] Escondito PERT, op. cit.
[302] San Diego Blueprint for MH Reform, op. cit.
[303] Abbott Presents Research on Jail Diversion. https://www.advocates.org/news/sarah-abbott-presents-research-about-jail-diversion-program
[304] Street Triage Services in England, op. cit.
[305] Street Triage Evaluation, op. cit.
[306] Street Triage and Detentions, op. cit.
[307] Avon and Wiltshire MH Partnership, op. cit.
[308] Houston PD Crisis Call Diversion Program, op. cit.
[309] Senator Praises Dallas MH Crisis Response Program, op. cit.

6. A-PACER in Victoria, AU

This is a co-response initiative that has been very well studied by researchers. The researchers provided tremendous value to their work by including data about the immediate outcomes for patients and their own perceptions of the collaborative response. In comparison, researchers in the U.S. have spent much time evaluating police officer perceptions of initiatives and relatively little time assessing patient outcomes and perceptions of value. The Australian researchers found that having clinicians respond in tandem with police was much preferred over a police-only response.[310] Consumers also noticed that there was much more cooperation and healthy teamwork between the clinicians and officers when they responded together versus separately.[311] When clinicians were allowed to co-respond, researchers found that they were able to create much more effective warm handoffs of patients to care facilities.[312] Some patients noted how the clinicians were effective in de-escalating situations and helping promote cooperation with police.[313]

7. Co-Response by Non-Embedded Clinicians (a.k.a. Separate Response)

This type of response has always been available and exists without formalized agreements. The on-scene collaboration can result when either policing agencies or the local provider of mobile mental health crisis services determines they need the other entity to co-respond. This is the old status quo that has mostly failed. It is often the only option in rural locations.

However, even when available, this option has been severely underutilized by law enforcement.[314] Even in urban areas, law enforcement has historically viewed non-embedded clinician teams as poor co-response partners due to inadequate availability and unacceptably long response times.[315] Adequate availability and response time can be engineered with the creation of mobile crisis response teams dedicated to filling a co-response role with police in high-density areas. Section IV has more information on the separate response form of co-response.

[310] Consumer Experience of CR Services, op. cit.
[311] Ibid.
[312] Ibid.
[313] Ibid.
[314] Omaha Police Have Options, op. cit.
[315] Police Perspectives, op. cit.

VII. THE LABOR MARKET FOR KEY MENTAL HEALTH PROFESSIONALS

The highly skilled workers needed to staff alternative responses are in greater supply than other types of mental health workers. It is common knowledge that there are shortages in some kinds of mental health workers (e.g. psychiatrists), especially in rural areas. However, many communities currently have a surplus of the types of workers needed to create alternative responses or co-response teams for mental health-related calls. The primary type of worker needed for on-scene responses are licensed clinical social workers (LICSW).

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) workforce study released in 2018 has provided state-by-state statistics per worker type.[316]

HRSA data shows that, in 2016, Minnesota had 800 more such workers than jobs to employ them. Interestingly, the study indicated that the future supply of licensed clinical social workers would keep up with or exceed demands in almost all states through 2030. This supply of workers can be further deepened and improved with programs that provide tuition assistance and opportunities to gain early career experience.

The labor supply is available if communities are willing to fund alternatives to a police-only response to mental health-related calls.

[316] Behavioral Health Occupation Projections. https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/state-level-estimates-report-2018.pdf

Table 19: Social Worker Supply and Demand, 2016 by State

Region and State	Supply	Demand: Scenario One (assumes equilibrium)	Demand: Scenario Two (Unmet needs)	Adequacy of Supply: Scenario One (assumes equilibrium)	Adequacy of Supply: Scenario Two (Unmet needs)
Northeast	**65,070**	**41,330**	**49,610**	**23,740**	**15,460**
Connecticut	4,760	2,590	3,110	2,170	1,650
Maine	1,330	1,000	1,200	330	130
Massachusetts	9,270	5,050	6,060	4,220	3,210
New Hampshire	1,080	970	1,160	110	(80)
New Jersey	9,050	6,270	7,530	2,780	1,520
New York	26,900	14,040	16,850	12,860	10,050
Pennsylvania	10,490	10,100	12,120	390	(1,630)
Rhode Island	1,330	830	1,000	500	330
Vermont	860	480	580	380	280
Midwest	**52,290**	**51,130**	**61,360**	**1,160**	**(9,070)**
Illinois	12,950	9,360	11,230	3,590	1,720
Indiana	3,580	5,030	6,030	(1,450)	(2,450)
Iowa	1,540	2,340	2,810	(800)	(1,270)
Kansas	2,120	2,150	2,580	(30)	(460)
Michigan	10,280	7,680	9,210	2,600	1,070
Minnesota	4,860	4,060	4,870	800	(10)
Missouri	3,890	4,640	5,570	(750)	(1,680)
Nebraska	1,040	1,380	1,660	(340)	(620)
North Dakota	150	560	670	(410)	(520)
Ohio	7,760	8,940	10,730	(1,180)	(2,970)
South Dakota	320	650	790	(330)	(470)
Wisconsin	3,800	4,340	5,210	(540)	(1,410)

Table 20: Social Worker Supply and Demand, 2030 by State

Region and State	Supply	Demand: Scenario One (assumes equilibrium)	Demand: Scenario Two (Unmet needs)	Adequacy of Supply: Scenario One (assumes equilibrium)	Adequacy of Supply: Scenario Two (Unmet needs)
Northeast	**127,880**	**43,910**	**52,710**	**83,970**	**75,170**
Connecticut	9,000	2,710	3,250	6,290	5,750
Maine	2,060	960	1,160	1,100	900
Massachusetts	17,170	5,430	6,510	11,740	10,660
New Hampshire	2,130	1,040	1,250	1,090	880
New Jersey	21,280	7,010	8,420	14,270	12,860
New York	50,670	14,640	17,570	36,030	33,100
Pennsylvania	21,660	10,780	12,940	10,880	8,720
Rhode Island	2,650	860	1,030	1,790	1,620
Vermont	1,260	480	580	780	680
Midwest	**105,610**	**53,600**	**64,310**	**52,010**	**41,300**
Illinois	27,460	9,970	11,970	17,490	15,490
Indiana	7,610	5,320	6,390	2,290	1,220
Iowa	2,740	2,240	2,680	500	60
Kansas	3,950	2,300	2,760	1,650	1,190
Michigan	18,590	7,810	9,370	10,780	9,220
Minnesota	8,350	4,430	5,320	3,920	3,030
Missouri	7,750	5,060	6,080	2,690	1,670
Nebraska	1,950	1,420	1,700	530	250
North Dakota	1,130	590	700	540	430
Ohio	16,910	8,890	10,660	8,020	6,250
South Dakota	1,290	730	870	560	420
Wisconsin	7,880	4,840	5,810	3,040	2,070

Source: https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/state-level-estimates-report-2018.pdf

VIII. CO-OCCURRING CONDITIONS, INTEGRATION, AND THE NEED FOR QUALITY MOBILE RESPONSE

A. Co-Occurring Conditions and Factors

People experiencing mental illness often have co-occurring conditions and socioeconomic factors. Substance use disorder is a commonly discussed example and is typically termed a "co-occurring disorder."[317] However, when considering the topic of law enforcement contacts, it is important to recognize a wider spectrum of co-occurring conditions and factors. Other examples are homelessness, autism, chronic medical diseases (e.g. hypertension, diabetes, or asthma), domestic abuse, poverty, and unemployment. Broader co-occurring psychosocial factors might include age and subculture.

All this added complexity can challenge emergency responders. When police respond to persons with a complex palette of needs, there is a much greater risk of harmful outcomes for the vulnerable community members and society as a whole. However, it is imperative that any alternative response schemes employ professionals capable of addressing the complex demands of co-occurring conditions and factors.

Local governments are rapidly embracing the reality that they must do a better job of serving persons who are "high utilizers" of healthcare and behavioral health services:

> *High utilizers are typically vulnerable populations with complex social components, high behavioral health needs, and multiple chronic conditions. The top 5% of individual utilizers account for about 50% of overall health care expenditures. Due to their complicated medical needs, these patients tend to heavily rely on ED facilities and are difficult to engage in ongoing care with primary care providers. ED use is more expensive to the health care system than going to a primary care physician.*[318]

Decision-makers can create dollar savings by focusing on correcting the "disjointed system that perpetuates inefficiencies, such as overreliance on emergency departments (EDs)."[319] Yet, one under-appreciated contribution to the overall inefficiency is the use of police as de facto mobile mental healthcare workers. The same high utilizers in other systems are well-known as "mental health frequent fliers" to law enforcement.[320] [321]

When the problem of co-occurring conditions was studied by state mental health and substance abuse directors and the National Council for Community Behavioral

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[317] Co-Occurring Disorders. https://www.psychologytoday.com/us/conditions/co-occurring-disorders
[318] Targeting High Utilizers. https://ldi.upenn.edu/sumr-blog/targeting-high-utilizers-health-care
[319] Ibid.
[320] Integrating Public Health and Public Safety Data. https://www.policeone.com/crime/articles/research-analysis-why-integration-of-public-health-and-public-safety-data-makes-sense-gUVAkLS5kWUVrfXD/
[321] LAPD ME Unit Named Learning Site. http://www.lapdonline.org/newsroom/news_view/46481

Healthcare (NCCBH), the conclusion was that separate silos thinking and planning was thwarting effective care.

> *Increased integration of behavioral health and healthcare services is a priority at the national, state, local and person levels. Good public policy will work to sustain, support and require integration of services between the two "safety net" systems of CHCs [community health centers] and SMHA [state mental health agency] providers with integration ranging from coordination of care to full integration of medical and behavioral services.*[322] [323]

The NCCBH recommendation for integration of behavioral health and healthcare services has been embraced nationally. It is recognition of the need for improvement by breaking down silos.

> *Between now and 2020, the system of funding and management that we have worked under for years will be transformed. Rather than treat substance use disorders and mental illness as separate conditions, with separate providers and funding sources, the trend is to offer comprehensive care that encompasses both conditions, as well as physical healthcare. This will provide our clients with more effective, integrated care. But it also means that every aspect of how we deliver services, and how we are funded, will change.*[324]

Yet, this high stakes integration trend has not overcome the silo around law enforcement, a sector that has many critical contacts with persons in crisis and/or poorly tied to services. Catherine R. Counts, a researcher at the University of Washington, spelled out the problem with pursuing integration without including law enforcement:

> *Until silos around the healthcare and criminal justice systems are broken, it will be impossible to fully understand the driving forces behind individuals frequenting both systems.*[325]

B. Care Integration Versus the Law Enforcement Silo

The integration of system services to serve those with co-occurring conditions and factors has been enabled by the Medicaid expansion available through the Affordable Care Act

[322] Integrating Behavioral Health and Primary Care. https://www.integration.samhsa.gov/workforce/Final_Technical_Report_on_Primary_Care_-_Behavioral_Health_Integration.final.pdf

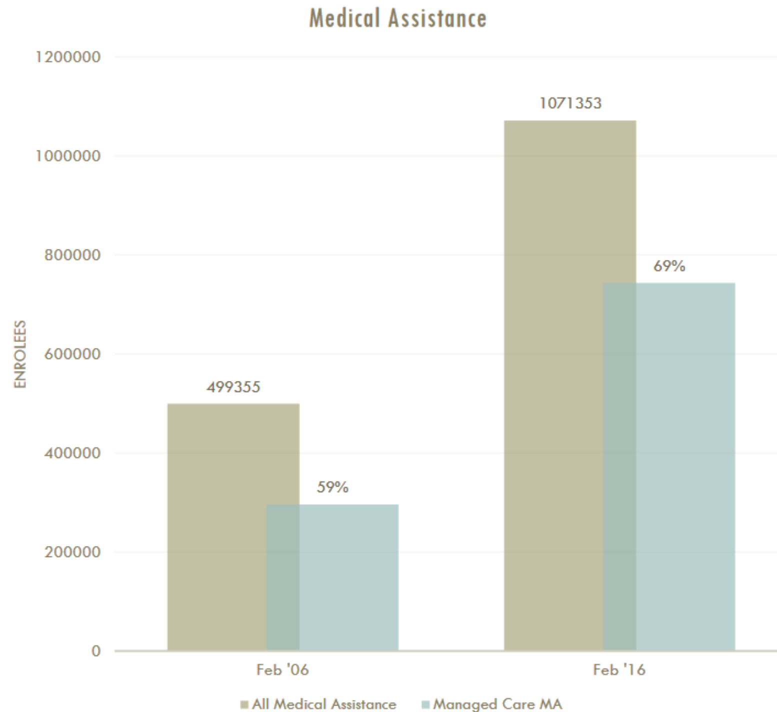
[323] Rule 25 Assessments, op. cit.

[324] Building Hope One By One. https://www.glmhc.org/wp-content/uploads/2016/11/Greater_Lakes_Connections_2016.pdf

[325] Integrating Public Health and Public Safety Data, op. cit.

(ACA) of 2010.[326] The ACA created insurance coverage for large numbers of poor people, including many high utilizers.[327] The bar graph below illustrates this effect in Minnesota.

Increase In MA/Medicaid Coverage In Minnesota[328]



The influx of Medicaid expansion funds creates a tremendous opportunity to fund integrated programs aimed at stabilizing the lives of these high utilizers.[329]

County-level administrators are busy quantifying their high utilizer challenges and studying integration options.[330] [331] [332] Administrators are also steering these changes with

[326] Moving Beyond Parity. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359059/pdf/nihms375613.pdf
[327] Effects of Medicaid Expansion. http://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf
[328] Reforming Mental Health in Minnesota. https://static1.squarespace.com/static/5a32b14bccc5c5b7c9b19622/t/5a9c44e4e2c48369e043cfec/1520190697410/Overview-Mental-Health-Prese.pdf
[329] CHCS High Utilizer Report. https://www.chcs.org/media/HighUtilizerReport_102413_Final3.pdf
[330] Integrated Care Affects Health Care Use. https://twin-cities.umn.edu/study-shows-integrated-care-affects-health-care-use-among-vulnerable-adults
[331] Care Delivery for New Medicaid Beneficiaries. https://www.commonwealthfund.org/publications/case-study/2016/oct/hennepin-health-care-delivery-paradigm-new-medicaid-beneficiaries
[332] Cross-Sector Service Use. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0991?rfr_dat=cr_pub%3Dpubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&journalCode=hlthaff

a host of new public sector business models like the Harvard University Human Services Value Curve.[333]

Locally, a Hennepin County research study of more than 70,000 new Medicaid enrollees confirmed that high utilizers of services also had a great deal of contact with the criminal justice system.

> *High healthcare utilizers, approximately 7 percent of our sample, were disproportionately American Indian, younger, and significantly more likely than other expansion enrollees to have mental health (88.1 percent versus 48.0 percent) or substance use diagnoses (79.2 percent versus 29.6 percent). Total cross-sector public spending was nearly four times higher for high health care users ($25,337 versus $6,786), and their non–health care expenses were 2.4 times higher ($7,476 versus $3,108). High levels of cross-sector service use suggest that there are opportunities for collaboration that may result in cost savings across sectors.*
>
> *…Almost eight out of ten Medicaid expansion high utilizers had an interaction with the criminal justice sector during the study period (70.6 percent versus 35.9 percent of other enrollees).*
>
> *…Overall, Medicaid expansion high utilizers accounted for 8.1 percent of all jail days in Hennepin County during the study period.*
>
> *…Criminal justice involvement includes non-traffic, non-petty misdemeanor offenses.*
>
> *…Over three quarters of high utilizers were diagnosed at least once with either mental illness (88.1 percent), a substance abuse disorder (72.2 percent), or both (74.5 percent versus 22.9 percent of other enrollees).*[334]

We currently have the most favorable environment to date for finally addressing the inefficiencies and issues created by police-only contacts. This empirically-driven understanding should result in more dispatch triage, police-mental health worker co-response, and deflection to alternative response options.

Despite the demonstrated value of integrated systems, many police agencies are reluctant to utilize dispatch triage, deflection, and co-response with mental health professionals. They cling to old patterns of response that make police de facto mental health workers or social workers.

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[333] Human Services Value Curve.
https://aphsa.org/OE/organizational_effectiveness/OE_Consulting_Practice/OE_Framework.aspx
[334] Cross-Sector Service Use, op. cit.

> *"We try to understand what their situation is and what supports they have in place already. We see where those supports and care are falling short," said Maplewood police Sgt. Mike Dugas. "For those not served, we help connect them with services."*
>
> *Some people are skeptical of police and paramedics taking on this expanded role.*
>
> *…"If someone is calling us about it, it's a police issue," (Maplewood Police Officer) Burt-McGregor said.*
>
> *[Sue] Abderholden [executive director of NAMI-MN] said she hopes community leaders, seeing the benefit of the work now being done by first responders, employ social workers and mental health workers to carry out this work in the future.*[335]

The separate silos and territorial reflexes of law enforcement must evolve to catch up with other parts of local government and the undeniable realities of system integration. The problem is evident when CIT training is the excuse to avoid collaborating with mental health workers on-scene. Likewise, the problem is evident when the idea of collaboration becomes the excuse to embed police officers in the actual delivery of social services (e.g. LEAD programs). We challenge decision makers, and community members in general, to recognize this problem and address it directly.

C. The Community-Based Approach to Care Management and Coordination

How care is delivered is an important consideration for integrating law enforcement. The evolving consensus approach to high utilizers is to invest heavily in care management/coordination with wraparound social and behavioral health support. One can believe this will be a successful approach because it directly addresses two old public policy lessons—the Million Dollar Murrays and the Pareto Principle.[336] [337]

The most applicable aphorism is probably the child of the Million Dollar Murray story: *Some problems are cheaper to solve than to manage*. This is evident in statistics showing the high costs of simply managing the crises of high utilizers. But if the decision is made to solve this problem with intensive care management and coordination, that approach can take several forms. One researcher broadly categorized them:

> 1. ***Health Plan Model.*** *The health plan employs a care management team that operates from the health plan; usually the care management is mostly telephonic.*
>
> 2. ***Primary Care Model****. The care management team is embedded in one or more primary care practices. The team could be employed by a health plan or a provider organization, but its location is a primary care site.*

[335] Maplewood PD and Paramedics Launch MH Team, op. cit.
[336] Million Dollar Murray. http://dpbh.nv.gov/uploadedFiles/A%20MillionDollarMurray.pdf
[337] Pareto Principle in Healthcare. https://www.valueinhealthjournal.com/article/S1098-3015(16)32929-1/fulltext#s0380

*3. **aICU (ambulatory intensive caring unit) Model**. High-utilizing, complex patients receive all their care from a separate high-risk clinic or a high-risk team within a clinic. They no longer receive care from a primary care provider who sees both complex and non-complex patients. The entire attention of the high-risk clinic/team is focused on a small panel of high-utilizing patients.*

*4. **Hospital Discharge Model.** This model focuses on intensive care management during the transition from inpatient to home and to primary care. Ideally, patients in this model continue care management in one of the other models once the transition from inpatient is completed.*

*5. **Emergency Department-Based Model.** Patients are recruited in the emergency department (ED) and an ED-related team provides care management.*

*6. **Home-Based Model.** This model is for patients unable to leave the home, or for whom leaving the home is difficult. Care management takes place entirely in the patient's home. For homeless or precariously housed patients the care goes to wherever the patient is.*

*7. **Housing First Model**. High-utilizing patients who are homeless or precariously housed are provided with stable housing, without a medical care component. In some cases, case managers are available at the housing sites to assist with social services.*

*8. **Community-Based Model.** The care management team engages patients wherever the patients are located.*[338]

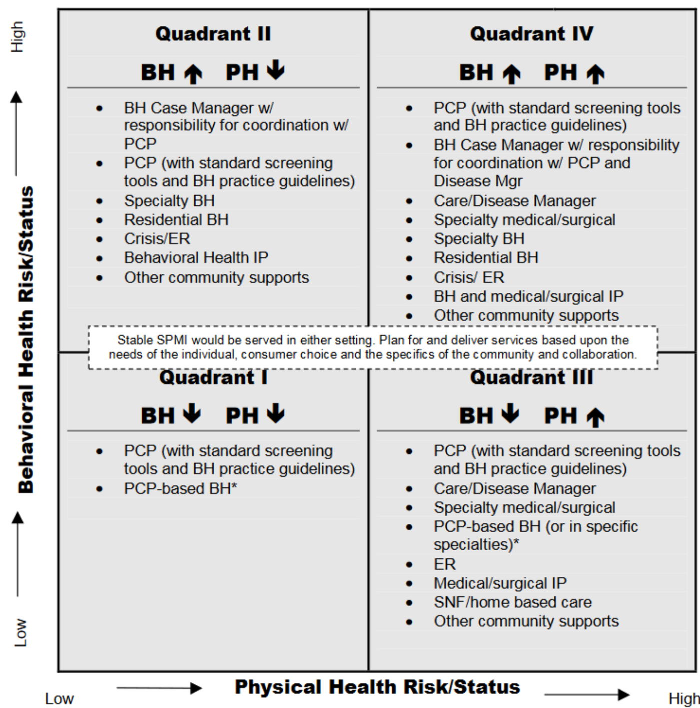
Only the Community-Based Model offers a true path for law enforcement to partner with other systems to properly address the needs presented in complex cases. If policy makers truly intend to move from managing the high utilizer problem to solving it, then they must partner on-scene with law enforcement. Community members and advocates for vulnerable populations are encouraged to support a community-based model that includes integration of police contacts. That integration model, not others, would minimize police-only contacts by enabling co-response and alternative response options.

D. High Quality Initial Co-Response and Alternative Response

In response to the push for integration, the National Council for Community Behavioral Healthcare (NCCBH) created a tool called the Four Quadrant Clinical Integration Model. It doesn't address police directly but illustrates how co-occurring conditions and factors build layers of complexity for dealing with patients who are high utilizers.

[338] CHCS High Utilizer Report, op. cit.

FOUR QUADRANT MODEL ILLUSTRATES COMPLEXITY WITH CO-OCCURRING SUD[339]



Policy makers are now willing to make significant investments in broad integration initiatives to address complex patient needs, all based on the expectation of savings. It is a welcome rejection of the old disjointed, inefficient systems that too often failed persons who needed the right service, at the right place, and at the right time.

Yet, these initiatives often fail to create a true, silo-breaking on-scene partnership with law enforcement. Law enforcement contacts are guaranteed to include high utilizers of services, persons with co-occurring conditions, and persons who are newly symptomatic. The stakes are too high to allow initial field contacts to go to under-qualified responders such as police officers. True integration includes dispatch triage at 911 call centers that ensures deflection to high-quality alternative responders or co-response when police contact is unavoidable.

Communities across the nation are being presented with initiatives for improving service to persons having mental illness. Many of these new initiatives will target high utilizers of services but fail to address the problems created by avoidable police-only contacts. Concerned community members should look for this deficiency and demand fully integrated services.

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[339] Integrating Behavioral Health and Primary Care, op. cit.

IX. FUNDING INNOVATION

The services this paper advocates for are really just part of the broader ongoing national desire for an expansion of community-based mental health services. The niche topics of this paper are dispatch triage to ensure deflection to alternative responders and, if deflection is not possible, then real time collaborative co-response to avoid police-only responses to mental health crisis calls. In many communities, these are either non-existent or tremendously underfunded needs. Interested community members can expect strong public support for funding these alternatives to the police-only responses.

To be successful, change agents must understand government funding mechanisms and how to influence populations and decision-makers in order to make the machinery of government move. Positive change will not guarantee funding, even when it creates parallel cost savings and mitigates human suffering.

In some cases the fight for funding is easier because key local government and law enforcement leaders champion the change. Such was the case in Duluth, Minnesota. Minnesota's first collaborative mental health co-responder program was funded in 2015 by unanimous vote of St. Louis County commissioners.[340] Support from key leaders and the culture of local government organizations was key to implementing a program that became an award-winning example for the rest of the state.[341] [342]

Every government body has forward-thinking individuals who can be convinced to support better approaches. Sometimes, as in Duluth, there is already a critical mass of progressive thinkers willing to make change happen. In other cases, that critical mass must be created through the efforts of concerned community members.

Funding can be a significant obstacle. Community members sometimes overcome resistance to change with an information campaign. Creating or supporting allies within government can drive results similar to those in Duluth. Police officials, politicians, and even local government managers can become important players. The operational and policy changes central to our topics are typically treated as the exclusive purview of such insiders. Insiders can be swayed by community members who offer reasoned arguments showing the humanitarian need, the cost savings, and the demonstrated feasibility of reform initiatives. The inside game of persuasion must be paired with a concerted effort to create community support and political pressure for change.

Budgets are, essentially, policy statements. Most would agree that state and local budgets should efficiently apply limited resources to the important goal of caring for persons experiencing mental health crises. Oddly, this sentiment is usually not effectively applied

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[340] Duluth Police Sharpen Social Work Endeavor. https://www.duluthnewstribune.com/lifestyle/4289177-breaking-never-ending-cycle-duluth-police-sharpen-social-work-endeavor
[341] Duluth PD Award Nomination. https://mcpa.memberclicks.net/assets/ETI2016/duluth_mantal%20health%20services.pdf
[342] Duluth PD Teams with Social Workers. https://www.duluthnewstribune.com/opinion/4021484-police-team-social-workers

when persons experiencing mental health crises have contact with police. This can be changed by concerned community members willing to invest the energy to create political momentum for change.

A. Acknowledging Obstacles to Success—An Essential Starting Point

No matter how far you have gone on the wrong road, turn back.
-Turkish proverb

There is great opportunity to implement new approaches for handling and preventing police-only contacts with persons living with mental illness. However, the returns on investment in reforms will suffer if bureaucracies preserve old ideas and practices relating to the use of police. Much of this paper is dedicated to identifying the engrained failure modes that entrench police as de facto mobile mental health crisis workers. The reader is encouraged to review this in previous sections. Below is a summary of the harm created by old thinking and failed practices. We must remove this poison from the system and maximize return on investment at the initiation of any reform.

PRESERVING OLD APPROACHES CAN REDUCE ROI

APPROACH	HOW IT REDUCES RETURN ON INVESTMENT	SECTION REFERENCE
CIT officers as de facto mobile mental health crisis workers	• Absence of clinical expertise • Criminalizes mental illness • Missed opportunities to utilize broader care integration investments • Elevates costs of policing and incarceration • Destabilizes and traumatizes patients despite other investments • Harmful to key target populations like high utilizers and early symptomatic persons • Increases the likelihood of physical harm and tragedies for vulnerable people • Further criminalizes dual diagnosis sufferers who are key targets of other investments	I III IV
Fail to accurately assess the local labor supply of licensed clinical social workers. *These are the key workers for creating expert mobile mental health crisis response. There is often a surplus of these workers in urban areas, despite shortages of psychiatrists.*	• Prompts utilization of unqualified mental health crisis workers • Initiatives can be limited or abandoned based on an incorrect assumption that there is a shortage of qualified workers, despite good availability in Minnesota • Communities desire alternatives to police and police-only response to mental health crisis calls for help. Local government decision-makers who acknowledge an availability of workers can expect community support for additional revenue for alternative response and co-response initiatives. Failing here means lost revenue.	IV VII

Lack of dispatch triage at 911 call centers	• Absence of clinical expertise • Criminalizing mental illness • Inefficiencies and waste from using police as primary gatekeepers • Missed opportunities to fully utilize broader care integration funding • Duplicate funding of police in social worker roles in parallel with existing county social services programs	IV V
Failure to require police to collaborate on-scene in real time with mobile crisis teams or co-responder teams *Getting mental health clinicians on-scene in real time creates an 85% diversion rate from in-patient care. [Reforming Mental Health in MN, op. cit.]*	• Creates unnecessary burdens on emergency rooms and care facilities • Increases costly incarceration of persons with mental illness • Reduces care system effectiveness by preventing on-scene counseling and delaying care to people in crisis • Reduces care system effectiveness by preventing clinical assessment from being performed immediately, on-scene • Precludes a highly effective warm handoff from on-scene clinician to care facility workers	I III IV V
Territorial thinking focused on preserving monies for existing siloed budget items	• Promotes the idea that any new initiative must have zero budget impact regardless of potential savings & efficiencies—comparison to zero • Inhibits on-scene collaborations between law enforcement and county service providers • Encourages county administrators to off-load their budgetary responsibilities to local police departments by using officers as de facto mobile mental crisis workers • Preserves inefficiencies, waste, and human suffering that collaboration could mitigate • Limits the scope of collaborative work since funding will primarily rely on outside grants	IV

B. Simultaneous Funding of Both Alternative Response and Co-Response Options

The siloed status quo has resulted in separate paths: one funding alternative responses, and another funding on-scene real time co-response. This is a problem that must be overcome. These modalities are both necessary and work in tandem to improve outcomes by minimizing police-only contacts. In Minnesota, increasing the use of dispatch triage will deflect mental health calls to the existing county mobile mental crisis team system. When deflection is not possible there needs to be a real time co-response option. These two options sometimes get funded separately through the health and criminal justice systems. The result is that the synergistic response options get uneven attention or are even treated as conflicting approaches.

Change agents and communities are urged to address this problem. Funding for mental health professionals for both response options can be provided solely through the

healthcare system. Funding for both response options should flow through the same dedicated budget.

C. Getting City and County Political Support and Funding

City and county governments can be the best policy laboratories of our democracy. So it should be no surprise that most projects relevant to this writing are funded as budget items at the city or county level. Unfortunately, funding created as year-to-year local budget items are not ideal for projects that create safety net emergency services for vulnerable populations. Political change or a souring economy can result in slashes in funding. A secure source of funding is critical for retaining key personnel such as highly skilled mental health crisis responders. The League of Minnesota Cities has online resources for understanding how your city creates its budget.[343] [344] [345]
Still, city and county funding may allow a local community to initiate a pilot project for introducing change and proving concepts. These pilot projects can create the impetus for more stable funding from county or state government.

City and county funding is often supplemented by grant money in later budgets. Outside funding sources can replace city funding or be a means of expanding an existing project. Projects can be endangered when they do not get increases in funding or see their funding stream become overly dependent upon outside grants. Projects that demonstrate efficacy and value should become part of the government services structure. Sometimes that only happens when engaged community members lobby for expanded funding or the use of new dedicated funding streams.[346]

Access to city council members and county commissioners is far easier than reaching state and federal politicians. Information campaigns targeting voter constituencies are also more manageable at this level. This access enables community members to partner with local politicians and other decision-makers on efforts to develop and fund innovative projects. The support of an open-minded local police chief or sheriff is also helpful. Like any organization, law enforcement agencies have distinct cultures. Community members interested in reform initiatives are encouraged to reach out to law enforcement and create partnerships whenever possible.

Even at the local level, significant time and effort will be required to create the needed momentum for change. Some of that time should be invested in fostering coalitions among local social justice and advocacy groups. All counties in Minnesota have community mental health advisory boards that identify unmet needs, including mobile crisis responses.

[343] Paying for City Services. https://www.lmc.org/resources/paying-for-city-services/
[344] Sources of Revenue. https://www.lmc.org/wp-content/uploads/documents/Sources-of-Revenue.pdf
[345] Property Taxation 101. https://www.lmc.org/resources/property-taxation-101/
[346] Boston MH Clinicians to Attend 911 Calls, op. cit.

D. Dedicated Revenue Streams

A dedicated revenue stream promotes the long-term success and stability of reform initiatives but is often assumed to be a political non-starter. In truth, the community will support new taxation or fees that create positive change. The public looks favorably on investments that help vulnerable people and there is broad interest in reducing unnecessary police contacts. In recent years, communities have been turning to more local dedicated funding of community mental health and drug addiction services. This is a reflection of greater community needs and insufficient and erratic funding mechanisms at the state and federal level.

County governments typically take the lead in regulating local health care services and providing or contracting for emergency health care services. Counties can fund collaborative or diversion programs using state funding support for health care or by dedicating revenue from local property tax and fees.

Lasting change is more likely when communities can dedicate funds from special fees or tax increments.

1. Special Sales Taxes

There are many examples of cities and counties around the nation using special sales taxes to fund needed community mental health services. In Washington State in 2012, the Tacoma City Council passed Ordinance 28057, which created a special 0.1% sales tax to fund mental healthcare services. Many other Washington cities and counties now do this, too.[347] [348]

In 2018, Denver voters approved the Caring for Denver Initiative by a 67.96% vote. It created a 0.25% dedicated sales tax yielding $45M annually for addiction, mental health services, and associated housing.[349] Social justice groups, unions, mental health groups, and provider organizations collaborated in the successful political effort. Denver voters wanted to take the problem out of the hands of police and jails. Mental Health America Vice President, Debbie Plotnick, welcomed the surge in local initiatives:

> *For years there had been such discrimination; it was treated as a safety crisis, not a health problem. "Can you think of any other medical emergency where they send the police? So localities had to take charge and develop services where there hadn't been any before.*[350]

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[347] WA State Bill 82.14.460. https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460
[348] Cowlitz County MH Sales Tax. https://www.co.cowlitz.wa.us/2399/110th-of-1-Mental-Health-Sales-Tax
[349] Voters Approve MH Tax. https://www.denverpost.com/2018/11/06/denver-ballot-issues-results/
[350] Why Denver Voted to Fund MH Treatment. https://www.citylab.com/equity/2018/11/treatment-centers-addiction-mental-health-caring-4-denver/576202/

Another example is found in Eagle County, CO, where voters easily approved a new sales tax on recreational marijuana. It passed with 72% approval. The resulting $1.2M per year of funding is dedicated to mental health and addiction services. Voters were partly swayed by problems at the Eagle County Jail. In that jail, 73% of inmates were prescribed psychotropic drugs.[351]

> *It's a lot less expensive and a lot more humane and smarter to treat mental illness than to ignore it or criminalize it. Turning our jails into mental hospitals is indefensible, immoral and idiotic.*
>
> *– Andrew Romanoff, CEO of Mental Health Colorado*

In Minnesota, state legislative action would be required to utilize a special sales tax approach.

2. Special Tax Levies and Local Mental Health Board Systems

Property tax levies funding mental health services are a common approach at the county government level. Like the sales tax examples above, these tax levies also enjoy popular support. In Ohio, 76 of 88 counties have a mental health services levy and all have been renewed by voters.[352]

Cities also get some funding through property taxes collected by counties.[353] Where permitted by state statute, a city can create a dedicated property tax increment to support added services or a reform initiative.

Chicago, in 2008, provides an inspirational example of community members overcoming politics and bureaucracy. A coalition of community members got a referendum to the voters in a bid to save community mental health services which were desperately underfunded and shrinking. Their referendum for a mere 0.004% increase in property taxes passed with 71% voter approval. However, this Chicago referendum was non-binding and city leaders refused to act on it. The steadfast community activists convinced the Illinois legislature to draft a law allowing Chicago communities to pass *binding* referenda to raise property taxes to fund mental health services. This law, the Community Expanded Mental Health Services Act, was passed into state law.[354] In 2012, the community coalition reintroduced their referendum, now binding, and voters approved it by a 74% vote.[355]

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[351] Eagle County Voters Approve Tax. https://www.mentalhealthcolorado.org/eagle-county-marijuana-tax/
[352] How Communities Can Fund MH Services. https://careforyourmind.org/how-communities-can-fund-mental-health-services/
[353] Property Taxes Climbing But Needs Are Many. https://www.startribune.com/property-taxes-climbing-but-needs-are-many-activists-say/502275201/
[354] IGA 405 ILCS 22. http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=3300&ChapterID=34
[355] Why One Community Voted to Tax Itself.
http://inthesetimes.com/article/17636/community_funded_mental_health_clinis

Very recently, the bi-county Mental Health and Recovery Board of Erie and Sandusky Counties in Ohio got their voters to renew a 0.5 mill, 10-year property tax levy. (A 0.5 mill levy is the equivalent of a 0.05% tax on assessed value.) This levy results in $1.9M from both counties to fund mental health and addiction recovery services.[356]

In 1988, the Ohio legislature required county governments to set up local mental health boards that oversee the management and financing of county safety net services. The goal was more local control in developing, planning, managing, and funding community-based services. This illustrates how government structure can be altered to increase local control of mental health services, putting decision-making into the hands of community members.[357] [358] [359]

These local boards were created at a time when federal government control of mental health services was being devolved to states and counties. Ohio and other states chose systems that emphasized local control.[360] It was these local boards that determined the need for funding and pushed for the referenda to secure that funding.
By contrast, states like Minnesota did not create local mental health boards as the sole entities to manage mental health services policy. In places like Minnesota, the delivery of community-based mental healthcare services is driven by state funding and tightly managed within the county government. The resulting policy choices are made behind closed doors by county department managers and administrators. Minnesota would be well-served to adopt a local county-based mental health board system.

Minnesota taxpayers pay out much money for these services, but do they have as much say in the design and delivery of these services as taxpayers in other states?

> *In Ohio, devolution was overlaid with a long tradition of "home rule," in which county authority is vested with and exercises significant political influence. A similar context exists for North Carolina counties. Devolution in Ohio spawned an increased emphasis on the state's consultation and collaboration with the core mental health system constituencies: consumers and families, providers of services, and county authorities.*[361]

Recent financial missteps at the Minnesota Department of Human Services have triggered discussions about how to restructure that sector of our government. Minnesota

[356] MH Board Seeks Levy Renewal. https://sanduskyregister.com/news/3031/mental-health-board-plans-to-seek-renewal-of-levy/
[357] Monroe County Community Services Board. https://www2.monroecounty.gov/mh-csboard.php
[358] Community Boards Community Benefits.
https://www.mhrbeo.org/Downloads/Community%20Boards%20Community%20Benefits2.pdf
[359] Ohio Behavioral Healthcare System. https://www.mhrbeo.org/Downloads/Overview_Ohio_System2.pdf
[360] Haves and Have Nots. https://www.communitysolutions.com/wp-content/uploads/2019/11/112519-Levy-Paper.pdf
[361] MH Services in Ohio. https://www.purdue.edu/hhs/hdfs/fii/wp-content/uploads/2015/07/s_ncfis02c03.pdf

voters and issue advocates could take this opportunity to push for independent local mental health boards.

E. State Government Funding

Sometimes state funds can be tapped directly through existing grant programs or by funding authorized in new legislation. State legislators may be particularly willing to pass legislation for start-up funding of deflection efforts or law enforcement/mental health collaborative projects. Consider the example from Martin County, Florida, where a sheriff successfully lobbied the state legislature for funding to support a new mental health co-responder team program.

> *When Governor Scott recently signed the state's 2017/2018 budget, he approved funding for a Martin County Sheriff's Office Mental Health Co-Responder initiative. I am profoundly grateful to the Governor, Senate President Joseph Negron, Majority Leader Senator Simpson, and State Representative Gayle Harrell, who supported our request and made this funding possible.*
> *...It is my fervent hope that this pilot program alleviates some suffering for the most fragile among us. A compassionate community should do no less.*
> *– Martin County Sheriff William D. Snyder*[362]

This sheriff's success can be replicated and energetic community groups can play an important role. This can be done by defining specific program goals, creating community awareness, and getting a state legislator to sponsor the necessary legislation. This basic function within our democracy is surprisingly amenable to community groups that invest the necessary time and energy.

Another example is S.F. 2892 passed by Washington State in 2018. This created grant funding for police/mental health worker co-response projects in the state to reduce police-only contacts.[363] Broad support helped it pass without a single nay vote in the state senate and house.[364] The funding created the Mental Health Field Response Teams Program that awards grants of $100,000 with stipulations on data collection and reporting.[365] The requirement for data collection and analysis of outcomes is a common and beneficial requirement in grant programs.

State level funding in Colorado for collaborative diversion and deflection programs came through the 2012 legalization of recreational marijuana use. In 2017, state legislators approved a bill to apply marijuana use tax revenue toward a grant program that would

[362] Martin County Sheriff Facebook Post, op. cit.
[363] WA State Legislature Passes HB2892. https://www.youtube.com/watch?v=6xUI8hLNq_w
[364] WA State Bill HB2892. https://apps.leg.wa.gov/billsummary/?BillNumber=2892&Year=2018&Initiative=false
[365] Text of WA State Bill HB2892. http://lawfilesext.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/House/2892.SL.pdf

fund collaborative co-response projects.[366] This law, *SB 17-207: Strengthen Colorado Behavioral Health Crisis System*, was part of a push to decriminalize mental illness.

> *SB 17-207 aims to improve coordination and response for behavioral health crises, forbids the use of jails for 72-hour holds and identifies psychiatric emergencies as a healthcare issue that allows the individual to adequately receive necessary services.*[367]

SB 17-207 directed millions of dollars into treatment and diversion activities for justice-involved individuals.[368] Part of this went to the creation of a Co-Responder Program that issued 5-year funding grants to programs which prevent police-only response to calls involving mental illness.[369]

In Massachusetts, the state Department of Mental Health offers grants through the Jail/Arrest Diversion Grant Program. This program shows that state-level funding is useful in creating cost-effective multi-jurisdictional programs serving several cities or a region.

> *The Co-Response Model has been a popular request of grant applicants and has even been adapted to use as a shared resource among several contiguous towns and regions. This model is a mental-health based diversion model that pairs clinician, often a clinician affiliated with the local Emergency Services Program (ESP) with police to co-respond to calls with mental health elements. The clinician in this model can be embedded into the police department during their work hours. Calls in which clinicians participate deliberately involve individuals experiencing emotional distress and/or psychiatric symptoms and may also have co-occurring substance use issues.*[370]

Locally, Minnesota has a relevant grant program that has yet to be utilized to directly prevent police-only contacts on mental health calls. So far the Minnesota Mental Health Innovation Grant Program has helped justice-involved individuals through improved follow-up services and drop-off points for officers to take persons they contact.[371] This grant program could be utilized to directly support dispatch triage at 911 centers, more robust alternative on-scene response capabilities, or more co-response capacity in urban

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[366] CO Marijuana Tax Cash Fund. https://footprintstorecovery.com/addiction-treatment-locations/colorado/marijuana-tax-cash-fund/
[367] CO Behavioral Health Crisis System. https://cha.com/wp-content/uploads/2017/08/CHA.074-Leg_SB-17-207-1.pdf
[368] Treatment for Patients in Crisis. https://www.bizjournals.com/denver/feature/mental-health-matters/2017/giving-patients-in-crisis-the-treatment-they.html
[369] Colorado Co-Responder Program, op. cit.
[370] Jail/Arrest Diversion Grant Program. https://www.mass.gov/files/documents/2018/01/19/2018-01-02%20DMH%20JDP%20mid-year%20report-%20FY18.pdf
[371] MH Innovation Grant Program. https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/mh-innovation-grant-program/

areas. These are community-based, high-efficiency services the Minnesota grant program seems to be intended for, based on the stated goals:

> *[The] Mental Health Innovation Grant Program is a new grant program intended to improve access to and the quality of community-based, outpatient mental health services and reduce the number of people admitted to regional treatment centers and community behavioral health hospitals.*[372]

The way the Minnesota grant has been used thus far illustrates how decriminalization of mental illness can be thwarted by CIT-centric thinking. Minnesotans should be funding collaborative reform approaches at the point of police contact. Witness states like Colorado, Massachusetts, and Washington which put patient needs first with reforms that go beyond follow-up services and drop-off centers.

There have been halting efforts to get state funding for deflection and co-response options. Recently, bills were introduced to the state legislature to fund co-response pilot projects in Hennepin and Dakota counties.[373] [374] Both of these unsuccessful bills were spurred by recommendation from the 2016 Governor's State Task Force on Mental Health for more real time co-response.[375]

Minnesota counties now have mobile mental health crisis response teams staffed with excellent mental health professionals. They are the foundation for what could be ideal alternative response or co-response options. What's missing is dispatch triage to enable deflection to or co-response with mental health clinicians to minimize police-only contacts for mental health-related calls. Unfortunately, there have been no efforts at the state legislature to study, fund, or mandate dispatch triage of mental health-related calls received by 911 centers.

F. Federal Government Funding

The most common federal-level source of funding is the Criminal Justice Mental Health Collaboration Grant provided through the U.S. Department of Justice, Bureau of Justice Assistance.[376] [377] The grants are typically $100,000–$250,000 over a two-year period for

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[372] Ibid.
[373] Minnesota SF 2787. https://www.revisor.mn.gov/bills/text.php?number=SF2787&version=latest&session=ls91&session_year=2019&session_number=0
[374] Minnesota SF 1632. https://www.revisor.mn.gov/bills/text.php?version=latest&session=ls90&number=SF1632&session_year=2017&session_number=0
[375] Governor's Task Force on MH. https://mn.gov/dhs/assets/mental-health-task-force-report-2016_tcm1053-263148.pdf
[376] Justice and MH Grant Announcement. https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/BJA-2019-15099.PDF

projects in the start-up phase. The funding is available through a competitive application process for each of three tiers of a project: a planning phase, an implementation phase, and an expansion phase. The Council of State Governments–Justice Center is a source of information and direct support for prospective applicants and awardees.[378] The grant support is not intended to be on-going and grant recipients must secure other funding sources after the grants expire.

G. Private Funding and Support

There are a few sources for private funding of these programs. The MacArthur Foundation has helped some communities through its Safety and Justice Challenge grants.[379] Milwaukee was able to partially fund their collaborative Crisis Assessment Response Team with one of these grants.[380] The MacArthur Foundation funded criminal justice reform for 20 communities.[381]

In 2017, Dallas County, TX, was able to fund its RIGHT Program with many millions of dollars in private funding. That program included collaborative mobile mental health crisis response.[382] [383]

H. Savings and Efficiencies

It is very common for new practices, policies, and programs to be justified by expected cost savings. Often it is part of the justification for changes targeting high utilizers of emergency services. Yet most plans for changes in services ignore the savings from avoiding police-only contacts with persons in mental health crisis. For example, money spent on police training will not prevent the waste and inefficiency created by not having a clinician on-scene in real time to de-escalate, prevent incarceration, and provide evaluations. County governments are making large investments in service integration and case management without working to prevent police-only contacts with the target populations.

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[377] JMHCP Overview. https://bja.ojp.gov/program/justice-and-mental-health-collaboration-program-jmhcp/overview
[378] JMHCP Orientation. https://www.youtube.com/watch?v=8O53r7a0Zg4&feature=youtu.be
[379] Criminalizing Homelessness, op. cit.
[380] Safety and Justice Challenge. https://www.macfound.org/press/press-releases/safety-and-justice-challenge-expands-52-cities-counties/
[381] MacArthur Foundation Press Release. https://www.macfound.org/press/press-releases/20-diverse-communities-receive-macarthur-support-reduce-jail-populations-improve-local-systems-and-model-reforms-nation/
[382] Dallas RIGHT Program. https://www.dallasjustice.com/2017-dallas-right-program-mentally-ill-avoid-bail-jail/
[383] Dallas Co-Responder Program. https://www.dallasnews.com/news/2018/01/24/program-pairs-counselors-with-cops-to-better-handle-mental-health-calls-in-southern-dallas/

1. Costs of Police-Only Crisis Response—Table

It is common knowledge that a system that puts a clinician on-scene for crisis response will create efficiencies and better outcomes. The following table summarizes these consequences and costs of police-only response.

CONSEQUENCES AND COSTS OF THE POLICE-ONLY RESPONSE

INEFFICIENT AND HARMFUL PRACTICES	CONSEQUENCES	COSTS
Wasting Money: Police-only responses instead of co-response or deflection to a mobile mental health crisis response team	Increased costs for the criminal justice system, mental health facilities, and the persons who need care.	• Minnesota's county mobile mental health crisis teams have a return on investment (ROI) of about $4.10 for every dollar invested.(1) • These ROI do not fully account for the savings created by reducing entanglements with the criminal justice system.(2) • Collaboration helps prevent entanglements with the criminal justice system; ROI can be as high as $10 per dollar invested.(3)
Police-only response creates staffing burden on police departments See discussions in Sections: III, IV	• Calls for service with a mental health component are time-consuming for patrol officers. • Many are hidden in unrelated call descriptors like "domestic disturbance." • The number of mental health-related police calls has been growing rapidly.	• Police department budgets are typically 35% of a city's budget. Increased time spent on mental health calls takes away from other duties and increases police budgets.(4) • 95% of MN law enforcement agencies report mental health calls have increased over the last 5 years, with 20% reporting these calls have more than doubled.(5) • Albuquerque police report that mental health was the primary factor in 33% of calls.(6) • "Calls for assistance, welfare checks, disturbances, domestics, run-aways, medicals and other like service calls, places a front-line officer on over 50% of the calls in direct contact with drug impaired, mentally unstable, mentally ill, psychotic, suicidal, and others in crisis."(7)
Police-only response results in unnecessary transfers by ambulance See discussions in Sections: I, III, IV	• Police default to transferring people, forcing them to pay for ambulance bills that often lead to no real care.(8) (9) • UK co-response (street triage) results in reduction of transfers by 50-75%.(10) • Dallas reported a 23% reduction in ambulance transfers within the first 3 months of the RIGHT Teams program.(11)	Ambulance care is expensive. • Costs depend on qualifications of the ambulance staff, procedures used, miles traveled, if the trip is covered by Medicare, if the ambulance goes to an in-network hospital, and if the service is contracted by a local municipality. • One patient was billed $3,660 for a 4-mile ride but would have cost $1,490 if he was picked up blocks away in a neighboring city.(12)

Delay of care resulting from police-only contact and police referral See discussions in Sections: III, IV	Delaying care with a police-only response is a risky choice with serious consequences.	• When police-only response is the only option, suicidal persons are less likely to call and more likely to attempt or commit suicide.(13) • There is no guarantee a referral from police will result in a successful reconnection with the individual. Sometimes people can’t be found, or they decide not to accept help when contacted days later.
Avoiding on-scene collaboration because emergency rooms and drop-off centers are more convenient for police operations See discussions in Sections: I, III, IV	• Police transfers create burdens for emergency rooms. 80% of transfers to ERs result in no care.(14) • CIT doctrine promotes investment in emergency rooms and drop-off centers to make transfers more convenient for police operations.(15) • People are harmed by transfers: “Hours of waiting in mental misery may only confirm the patient's feelings of hopelessness and abandonment, thereby increasing suicide risk.(16)”	Police transfers to ERs cost a lot. • From 2010 to 2017, ER visits for mental health and substance abuse greatly increased. “As a subset of the 75.1 percent increase, substance abuse ER visits increased 145.6 percent and mental health ER visits increased 51.4 percent.”(17) • “The average boarding time for a psychiatric patient ranges between 8 and 34 hours, with an average cost of $2,264.”(18) • “Eliminating unnecessary ED use for mental illness could save about $4.6 billion annually."(19)
Police-Only responses elevate risk of arrest and incarceration See discussions in Sections: I, III, IV	• There are more mentally ill persons in jails than in hospitals.(20) • The prevalence rates of serious mental illnesses in jails are three to six times higher than for the general population.(21) • Revolving door contact with the criminal justice system traps “frequent fliers” and incurs cost for the system.(22) • Jailing of mentally ill people leads to decompensation (worsening).(23) • The family of a man with schizophrenia in Alexandria, MN, hoped police would assist in transporting him to a care facility. Instead, police interpreted the situation as a domestic dispute, arrested him, and put him in jail for 5 days.(24)	• Jails spend 2-3 times more to house and treat the mentally ill. Jails aren’t set up to assure that mentally-ill persons receive psychiatric care upon release.(25) • Inmates with major psychiatric disorders in Texas state prisons were 2.4 times more likely to have four or more repeat incarcerations in 2007 than those without mental illness.(26) • In Miami-Dade County, FL, 97 high service utilizers with SMI cost taxpayers $13 million in criminal justice costs over 2005-2010.(27) The “decompensation cycle” wastes money. • Courts require treatment to make people competent to stand trial but returning them to jail to await trial often results in decompensation. • Upon return to jail “inmates usually decompensate quickly and require intensive psychiatric care and/or readmission to inpatient care.”(28)

Missed Opportunity: Failure to reconnect after referral from police-only contacts See discussions in Sections: III, IV	• Over 30% of persons with serious mental illness had contact with police while making, or trying to make their first contact with the mental health system.(29) • Many find it difficult to connect with mental health treatment after police-only contact.	Delay is inhumane and has cost implications. • Prolonged suffering and expense are predictable outcomes from inadequate initial responses to calls for help from high utilizers and early symptomatic individuals. • Mental illness increases the odds of homelessness and costs the U.S. $193.2 billion every year in lost wages.(30)
Missed Opportunity: Police-only response creates harm despite any focused follow-up See discussions in Sections: I, III, IV	• Police-only contacts create a tremendous risk for missed opportunity to help the people. • Some people who have repeat contact with police are also high utilizers or even "super utilizers" of social services and emergency medical services. • Many individuals cycle in and out of the group defined as high utilizers. Thus, all persons in crisis are potentially on track to become a high utilizer of services.(31)	Research by Denver Health found: • 3% of adult patients consistently met super-utilizer criteria and accounted for 30% of healthcare costs. However, fewer than half of the super-utilizers were in the category seven months later, and only 28 percent were in the category at the end of a year. And at the end of two years, only 14% were in the category. • A one-size-fits-all program isn't the answer to reducing the healthcare cost impact of super-utilizers.(32)
Missed Opportunity: Rule 25 SUD Assessments See discussions in Sections: IV, V, VI	• It is important to get a clinician on-scene with the qualifications to do a Rule 25 chemical dependency assessment. These assessments help poor people qualify for publicly-funded chemical dependency treatment.(33) • Only 1 in 10 people with a substance use disorder receive any type of specialty treatment.(34) • 72% of jailed persons with serious mental illness have a co-occurring substance abuse problem.(35)	• Every dollar invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft.(36) • When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1.(37) • The average cost for 1 full year of methadone maintenance treatment is approximately $4,700 per patient, whereas 1 full year of imprisonment costs approximately $24,000 per person.(38) • "It is vital to integrate treatment of mental illness and accompanying substance abuse. This is an especially high priority because the combination of untreated mental illness and addiction is the best predictor of violence, suicide, and other poor outcomes."(39)

Decompensation of Patients Due to Police Contact See discussions in Sections: I, III, IV	Police-only contact can traumatize people who need a mental health professional's expertise.	• Many victims of police violence experience PTSD, which manifests as severe agoraphobia and paralyzing panic attacks. This creates a downward spiral of isolation, depression, and even suicide.(40)
Use of Force (Monetary settlements and increased needs of patient) See discussions in Sections: I, III	• Untreated mental illness can lead people to behave erratically or disruptively. Some may have difficulty responding to directions.(41) • People in mental health crisis are 16 times more likely to be killed by police and can experience excessive force and civil rights violations, resulting in settlements with taxpayer funds.(42)	In Minnesota, the cases of David Smith and Dominic Felder stand out. • Smith died after multiple taser shocks and positional asphyxia.(43) His family was paid $3 million in settlement.(44) • Felder was unarmed and having a nervous breakdown when he was shot to death.(45) His family was paid $2.19M in settlement.(46) • Most mental health-related calls with bad outcomes don't make the news. Between 2006 and 2012 Minneapolis paid out $14M in settlements for police misconduct, most in unpublicized cases.(47) • There are numerous cash settlements nationally for police mishandling of people in mental health crisis. Many more incidents result in no settlements or publicity.(48)

1. MHLN Blue Book 2018, op. cit.
2. Revolving Door Serious Mental Illness in Super Utilizers, op. cit.
3. New Paradigm Not New Building, op. cit.
4. How Much Do Cities Spend on Police? https://www.forbes.com/sites/niallmccarthy/2017/08/07/how-much-do-u-s-cities-spend-every-year-on-policing-infographic/#34d121bbe7b7
5. MCPA Legislative Update, op. cit.
6. Police Perceptions Albuquerque, op. cit.
7. St. Anthony PD 2015 Annual Report, op. cit.
8. New Paradigm Not New Building, op. cit.
9. Senator Praises MH Crisis Response Program, op. cit.
10. Avon and Wiltshire MH Partnership, op. cit.
11. Senator Praises MH Crisis Response Program, op. cit.
12. Ambulance Bill Surprise. https://www.presspubs.com/white_bear/news/ambulance-ride-bill-may-be-a-surprise/article_deeee8b6-2c0c-11ea-8a89-8f3317f5a6a7.html
13. Is it a True Emergency? https://www.psychiatrictimes.com/suicide/it-true-emergency-suicidal-patients-access-their-psychiatrists
14. New Paradigm, Not New Building, op. cit.
15. CIT Core Elements, op. cit.
16. Is it a True Emergency? op. cit.
17. True Cost of MH in ED. https://www.healthcarebusinesstoday.com/true-cost-mental-health-crisis-emergency-department/
18. Preventable ED Use. https://www.hfma.org/topics/news/2019/02/63247.html
19. Mental and Behavioral Health Priorities. https://www.mnhospitals.org/newsroom/news/id/2144/mental-and-behavioral-health-priorities

20. MI Revolving Door, op. cit.
21. Revolving Door Serious MI in Super Utilizers, op. cit.
22. Ibid.
23. Ibid.
24. Jailed Amid MH Crisis. https://www.sctimes.com/story/news/local/2018/12/01/alexandria-couple-rebuilds-mental-health-care-jailed-schizophrenia/555155002/
25. MI Revolving Door, op. cit.
26. Revolving Door Serious MI in Super Utilizers, op. cit.
27. Ibid.
28. Restore, Revert, Repeat. https://cdn.vanderbilt.edu/vu-wp0/wp-content/uploads/sites/278/2018/01/18175600/Restore-Revert-Repeat.pdf
29. Police MI Interactions. https://cmha.bc.ca/wp-content/uploads/2016/07/policesheets_all.pdf
30. Treating America's MH Crisis, op. cit.
31. Super Utilizer Beliefs. http://www.healthcarebusinesstech.com/super-utilizers/
32. Ibid.
33. Rule 25 Assessments, op. cit.
34. Facing Addiction in America (Ch. 4). https://www.ncbi.nlm.nih.gov/books/NBK424859/
35. Burden of MI Behind Bars, op. cit.
36. Is Drug Addiction Treatment Worth its Cost? https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost
37. Ibid.
38. Ibid.
39. Repairing Our Broken MH Care System. https://www.psychiatrictimes.com/mental-health/repairing-our-broken-mental-health-care-system-advice-policymakers/page/0/1?utm_source=bibblio_recommendation
40. Officers with PTSD, op. cit.
41. Police Use of Force, US Commission on Civil Rights (p. 49-52). https://www.usccr.gov/pubs/2018/11-15-Police-Force.pdf
42. Ibid.
43. David Smith Verdict, op. cit.
44. $3 Million Payout in Smith Case. http://www.startribune.com/may-25-minneapolis-pays-3-million-in-police-misconduct-case/208912661/
45. Dominic Felder Verdict, op. cit.
46. $2.1 Million Payout in Felder Case. http://www.citypages.com/news/dominic-felders-family-awarded-21m-by-minneapolis-in-wake-of-police-shooting-6563768
47. Largest Police Misconduct Payouts in MN. https://www.newsmax.com/FastFeatures/police-misconduct-lawsuits-payouts-Minnesota/2015/08/21/id/671210/
48. Police Use of Force, US Commission on Civil Rights (p. 49-52), op. cit.

2. Hidden Benefits and Savings

Some savings are difficult to measure. Avoidable costs results from the cascade of consequences created by police-only responses. Destabilizing a patient might result in the loss of employment or housing. Mental illness increases the odds of homelessness and costs the U.S. $193.2 billion every year in lost wages.[384]

Decompensation can mean physical health is affected, an insidious hidden cost. Mental illness is even tied to decreased life expectancy—10 years lower than the general population.[385] Destabilization creates other costs by exacerbating co-occurring conditions like SUD. These hidden costs should be part of the consideration to avoid police-only response to mental health crisis. These larger social costs of policy decisions are real and other countries actually make them part of decision-making.[386]

Local governments that fail to evaluate their performance beyond superficial effects to their own budgets are camouflaging harm. Taxpayers should demand deeper analysis and the use of Social Return on Investment (SROI) analysis in this age of data-driven decision-making.[387] [388]

[384] Treating America's MH Crisis. https://www.thewellnessnetwork.net/health-news-and-insights/mental-health-crisis/
[385] Right to Treatment. https://www.samhsa.gov/sites/default/files/the_right_to_treatment.pdf
[386] Social Cost Considerations. https://nrc-publications.canada.ca/eng/view/fulltext/?id=e0a1d165-abe5-4aed-89c8-ef27d8d88e28
[387] Valuing SROI. http://ppidb.iu.edu/Uploads/PublicationFiles/Valuing%20SROI-Noaber%20Final%20Report-FINAL.pdf
[388] Prospective SROI. https://www.wilder.org/sites/default/files/imports/MICC_SROI_Report_3-19.pdf

X. MORAL AND ETHICAL CONSIDERATIONS

Our communities demand that law enforcement stop being primary responders to mental health calls in place of a proper health care response. For the reasons already outlined, defaulting to a law enforcement response to mental health crisis is neither rational nor necessary. Yet this status quo has survived legal and legislative challenges and has become accepted, despite our better angels.

A. Legal is Not Always Ethical or Moral

> *In matters of conscience the law of majority has no place.*[389]
>
> *– Mahatma Gandhi*

The de-institutionalization of the mental health provider system in the 1960s and 1970s was supposed to harken a great expansion of community mental health services.[390] That did not happen.[391] Since then, legislatures and courts have been largely ineffective in regulating police contacts with persons in crisis. The 1990 passage of the Americans with Disabilities Act (ADA) sought to create equity and protect the civil rights of disabled people, including those with mental illness.[392] Later, the U.S. Supreme Court's Olmstead v. LC decision offered hope for further decriminalizing mental illness.[393] Still, police continue to be primary responders and jails continue to be de facto mental health holding facilities. Expectations of reasonable accommodation have not prevented police-only responses or even altered use of force requirements by police.[394]

In the 2015 Sheehan ruling, the U.S. Supreme Court refused to bind law enforcement by the ADA requirements for reasonable modifications. It included a nod to the legal standard of objective reasonableness that gives officers almost unlimited discretion in their use of force.[395] [396] [397]

In this incident, officers knew Sheehan was in mental health crisis, confronted her, retreated after an initial confrontation, and then immediately re-entered the dwelling instead of de-escalating. They entered with guns drawn and shot Sheehan at least five times. These choices were in direct conflict with their police department's policies and

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[389] Essence of Democracy. https://www.mkgandhi.org/momgandhi/chap72.htm
[390] Deinstitutionalization of People with MI. https://journalofethics.ama-assn.org/article/deinstitutionalization-people-mental-illness-causes-and-consequences/2013-10
[391] To Stop Police Shootings of People with MH Disabilities, op. cit.
[392] What is the ADA? https://adata.org/learn-about-ada
[393] About Olmstead. https://www.olmsteadrights.org/about-olmstead/
[394] San Francisco v Sheehan. https://www.scotusblog.com/case-files/cases/city-and-county-of-san-francisco-california-v-sheehan/
[395] From Garner to Graham and Beyond. https://scholarship.kentlaw.iit.edu/cgi/viewcontent.cgi?article=4109&context=cklawreview
[396] Bad Apple Myth of Policing. https://www.theatlantic.com/politics/archive/2019/08/how-courts-judge-police-use-force/594832/
[397] Excessive Reasonableness. https://mckinneylaw.iu.edu/ilr/pdf/vol43p117.pdf

training. Because she lived, Theresa Sheehan was charged with two felony counts for threatening the officers with a knife.[398]

The Sheehan case exemplifies why the law and the courts cannot be relied upon to create ethical and moral boundaries for society. In Sheehan, the court system flatly rejected the common sense notion that police officers should alter their tactics when they know that they are interacting with people in mental health crises.

> *In court, she argued that the police violated the "reasonable modifications" protections under the ADA. The Federal Appeals Court of San Francisco agreed with her; however, the San Francisco Police Department has filed an appeal [successfully] with the United States Supreme Court to exclude the police from following the ADA.*[399]

The idea that the ADA requires police to make accommodations for people with mental illness continues to be routinely defeated in court.[400] The expression of police power on mental health calls greatly obscures the competing principle of *parens patriae*—protecting disabled persons who cannot protect themselves.[401]

B. Allowing Fear to Overcome Compassion

Despite the fact that mentally ill people are far more likely to be victims of violence than perpetrators, common media themes portray the mentally ill as violent, unpredictable, and untreatable.[402] This widely held misconception creates fear of people with mental illness that justifies the substitution of law enforcement officers for mental health professionals in responding to people in mental health crisis.

Criminalization of mental illness-induced behavior leads to damaging and unnecessary trauma for the person in crisis.[403] Such encounters can also trigger an officer's own unresolved trauma.[404] [405] [406] [407] The officer's response can then escalate trauma in the

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[398] No New Limit on Police Use of Force. https://www.scotusblog.com/2015/05/opinion-analysis-no-new-limit-on-police-use-of-force/
[399] Reasonable Accommodations Not Unreasonable Violence. http://cdrnys.org/blog/disability-dialogue/the-disability-dialogue-reasonable-accommodations-not-unreasonable-violence/
[400] Police Didn't Discriminate. https://www.startribune.com/minnesota-agency-says-police-didn-t-discriminate-in-hauling-mentally-ill-man-to-jail/410321985/?fbclid=IwAR1IVWCFVwWDFueOW57xLNVRUtG7pn6aQIqXvheb66-2EbXFXYuBRbdFenc
[401] Police as Streetcorner Psychiatrist, op. cit.
[402] Media's Damaging Depictions of MI. https://psychcentral.com/lib/medias-damaging-depictions-of-mental-illness/2/
[403] Police MI Interactions, op. cit.
[404] Friends Under Fire. https://psycnet.apa.org/doiLanding?doi=10.1037%2Fh0099403
[405] Childhood Trauma in Police Recruits. https://www.sciencedirect.com/science/article/abs/pii/S0006322304010728
[406] Childhood Trauma and Police Cadets. https://psycnet.apa.org/record/2007-06673-012
[407] MH Stigma Among Police Officers. https://link.springer.com/article/10.1007/s11896-018-9285-x

patient. Because trauma is not solely or even primarily a mental health condition, but actually lives in the body, [408] [409] [410] the mind may not perceive what is happening. As the person in crisis moves into "fight or flight" mode in reaction to their own fears, the situation can reach a dangerous high and the officer may resort to use of force to regain control of the situation. The officer may say he feared for his life as an explanation for his reaction.

Law enforcement officers and many others fail to recognize or understand the signs of a traumatic reaction, treating the person as if they should just stop or get the reaction under control on their own. If a person has a heart attack, they're provided with treatment with no expectation that they can voluntarily stop the heart attack. The same understanding should apply to mental health crisis.

C. Beyond Control—Valuing Autonomy

There is a strange disconnect between the rights of patients and the actions of police that must be considered and confronted.

Every human being needs autonomy, competence, and interconnection. This set is referred to as Basic Psychological Needs.[411] If it is immoral to forcibly prevent a person from accessing water, it is equally immoral to forcibly prevent someone from exercising their autonomy.

Research consistently shows that creating more space for these needs empowers people to be more independent, healthier, and more caring towards others.[412] [413] This strongly suggests that a police-only response to mental health crisis, with its inherent veneer of state authority and potential for use of force, will make the person less capable, healthy, and independent.

D. Acting on a Moral and Ethical Imperative

There is a moral and ethical crisis in the status quo that promotes unnecessary police-only contacts with people experiencing mental health crisis. It is demonstrably unjust

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[408] Complex Trauma. https://www.healio.com/psychiatry/journals/psycann/2005-5-35-5/%7B4b9f8030-1eba-442f-8b32-8504c01a0000%7D/complex-trauma-in-children-and-adolescents#

[409] The Body Keeps the Score; Van der Kolk, B. A. (2014). https://books.google.com/books?hl=en&lr=&id=vHnZCwAAQBAJ&oi=fnd&pg=PA1&dq=dr+van+der+kolk+trauma&ots=THsvj-kPmw&sig=eUgp7ohrSKwLqjmMS2BXukuqia8#v=onepage&q=dr%20van%20der%20kolk%20trauma&f=false

[410] Polyvagal Theory of Trauma. http://www.complextrauma.uk/uploads/2/3/9/4/23949705/stephen_porges_interview.pdf

[411] Brick by Brick. https://www.sciencedirect.com/science/article/pii/S221509191930001X?via%3Dihub

[412] Brick by Brick, op. cit.

[413] SDT Applied to Health Contexts. https://journals.sagepub.com/doi/abs/10.1177/1745691612447309

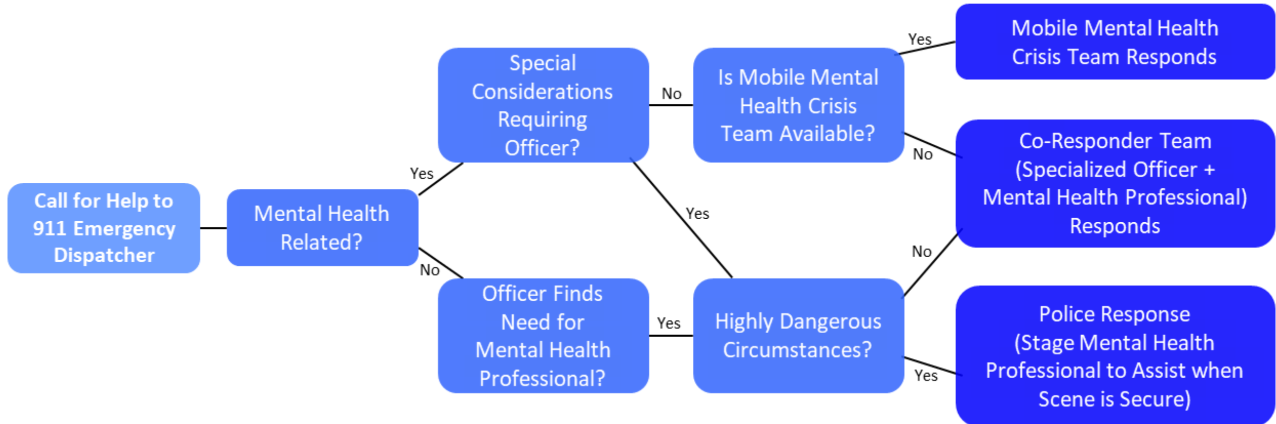
and inhumane to have police officers simultaneously act as law enforcers and de facto mobile mental health crisis responders. The fact that our legislation and our courts permit this does not make it ethical or moral.

In truth, the use of police for mental crisis calls in lieu of mental health professionals is simply bad policy born of fear. It is a policy decision that has been made for our communities by multiple generations of civil servants and politicians. This paper has offered all the criticisms. We have shown that this is an avoidable ill. It is inappropriate, unjust, and inhumane. It is wasteful and stems from a profound failure of leadership. Most importantly, it persists in defiance of the values and priorities we share as a society.

The time has come for communities to move beyond the inadequate standards set by the law and the courts and to do the right thing for vulnerable members of the community. Recognizing this, we must finally choose to move the thin blue line aside and permit collaboration and direct crisis response by professionals with the appropriate expertise.

XI. CONCLUDING STATEMENTS AND RECOMMENDATIONS

We offer three clear recommendations.



- **IMPLEMENT DISPATCH TRIAGE AT 911 CALL CENTERS.** Assigning calls for help to the appropriate responders is a necessity. It is imperative to triage 911 calls and deflect mental health-related calls away from police-only contact whenever possible. Some calls can be deflected to alternative responders like county mobile mental health crisis teams. When calls have a public safety consideration that requires a police presence, dispatch triage can lead to a co-response option.

- **UTILIZE ALTERNATIVE RESPONDERS.** There must be routine deflection to non-police alternative responders when 911 centers receive mental health-related calls. Communities must avoid unnecessary police contacts by creating and utilizing mobile response teams of highly qualified mental health professionals. Availability and fast response are key and might require the use of mobile crisis teams that are dedicated to responding to 911 calls. Minnesota has the ideal foundation for this response with its existing county mobile mental crisis response teams.

- **ENABLE REAL TIME CO-RESPONSE TO PREVENT POLICE-ONLY CONTACTS.** A police-mental health professional co-response option is needed for some cases where considerations such as safety require an officer to be present. This puts mental health professionals on-scene in real time as part of a co-responder team. Real time co-response is distinctly different from simple follow-up contact. The strong collaboration within co-responder teams makes them the ideal form of co-response. These co-responder teams are also excellent for assisting on calls where a mental health aspect is determined only after police arrive. In other cases, county mobile crisis teams can be staged nearby for co-response after a scene is confirmed to be safe—just as is done with ambulance services.

It is time for our government to respond to calls for help with the appropriate resources. Faithfully serving vulnerable community members means enabling real time mobile mental healthcare responses to 911 calls involving mental illness. Law enforcement-only responses must be minimized because they criminalize mental illness, waste resources, and create inferior outcomes for patients.

- We call for law enforcement officers to prioritize the needs of persons with mental illness. Actively promoting and enabling on-scene clinician response is the best way for law enforcement agencies to serve and protect persons with mental illness.

- We call for county health department administrators to fully accept the responsibility for mobile crisis response and work to minimize police-only contacts with persons in mental health crisis.

- We call for city and county leaders to create the funding and the binding policy changes needed. Cities and counties must work together to ensure that mental health crisis calls will be deflected to alternative or co-response options.

- We call for state politicians to frame legislation that funds and obligates local dispatch triage, rapid alternative response, and co-response options. This gap in care requires the attention of state government.

Most of all, we urge community members to become actively engaged in the issues presented here. It is far too easy for government actors to maintain the status quo in the absence of community pressure. You can start by raising awareness and spurring discussion with your neighbors. The topics of this paper are being discussed by your city, county, and state officials. Community members can drive change by attending public meetings and engaging politicians at all levels. We wish you every success.

GLOSSARY

211 CRISIS LINES: The Federal Communications Commission (FCC) reserved the 211 dialing code for community information and referral services. The FCC intended the 211 code as an easy-to-remember and universally recognizable number that would enable a critical connection between individuals and families in need and the appropriate community-based organizations and government agencies. The existence of a 211 system or similar dedicated number cannot prevent police contacts with persons in mental health crisis. Dispatch triage and 911 centers and co-response options will continue to be needed to prevent police-only contacts.[414]

911 CALL CENTER/EMERGENCY COMMUNICATIONS CENTER: Call centers operated by cities and counties to receive 911 emergency calls for assistance. 911 operators coordinate the emergency response by responders such as the fire department and police department. Dispatch triage in this writing refers to an added capacity at 911 call centers to deflect mental health-related calls away from the police and to alternative responders such as mobile mental health crisis teams.[415]

ACA (Affordable Care Act): A federal statute that was signed into law in March 2010 under the title of the Patient Protection and Affordable Care Act (PPACA) to ensure that Americans have access to affordable and quality health insurance. The Act includes several provisions to increase health insurance coverage by expanding Medicaid coverage, developing state health insurance exchanges, and prohibiting insurers from denying coverage due to pre-existing medical conditions.[416]

ADA (Americans with Disabilities Act): A 1990 federal law that prohibits discrimination in areas such as access to programs, services, and activities provided by a public agency. The ADA is one of America's most comprehensive pieces of civil rights legislation that prohibits discrimination and guarantees the rights of people with disabilities.[417]

ALTERNATIVE RESPONSE: Response by entities other than law enforcement. Occurs when mental health-related calls are deflected to mobile mental health crisis teams in lieu of the customary police response. This refers to the initial response, not follow-up contact.

AUTONOMY: Functioning independently without control by others.

CAD: See Dispatch, CAD

CAHOOTS (Crisis Assistance Helping Out On The Streets): Program started in Eugene, Oregon to provide mobile outreach and crisis services. The City of Eugene has one of the worst unsheltered homeless crises in the nation and utilizes CAHOOTS mobile services to take pressure off police and thin social services infrastructure. CAHOOTS mobile teams provide valuable outreach services including basic medical care. The teams get

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[414] What is 211? https://www.helplinecenter.org/2-1-1-community-resources/what-is-211/
[415] What is 911? https://www.nena.org/page/911GeneralInfo
[416] NASMHPD Glossary. http://www.nasmhpd.org/node/1394
[417] Introduction to the ADA. https://www.ada.gov/ada_intro.htm

many calls deflected directly to them from the police dispatch level. National media organizations have elevated awareness of these teams with stories. Although they provide much needed outreach services, these teams utilize people who are unqualified by most standards (including Minnesota law) to perform mobile mental health crisis care.

CASE MANAGEMENT: Management of an individual's mental health, rehabilitation, and social support needs over an indefinite period of time by a team of people with fairly small client loads (less than 20). The aim is to help develop skills to access medical, behavioral health, housing, employment, social, and educational services. Case management teams can offer 24-hour help and see clients in a non-clinical setting. Case management is already offered as a county health department service. It need not be recreated within a parallel faux social services initiative based at law enforcement agencies.[418] [419]

CASE MANAGEMENT SERVICES – MN STATUTORY DEFINITION: "'Case management services' means activities that are coordinated with the community support services program as defined in subdivision 6 and are designed to help adults with serious and persistent mental illness in gaining access to needed medical, social, educational, vocational, and other necessary services as they relate to the client's mental health needs. Case management services include developing a functional assessment, an individual community support plan, referring and assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services."[420]

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS (CCBHC): Facilities designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. CCBHCs are responsible for directly providing (or contracting with partner organizations to provide) nine types of services, with an emphasis on the provision of 24-hour crisis care.[421]

CIT (Crisis Intervention Training): CIT is a police-based, pre-booking approach with specially trained officers who provide first-line response to calls involving a person with mental illness and who act as liaisons to the mental health system. CIT is not considered

[418] Glossary of LE and MH Terms. https://pmhctoolkit.bja.gov/ojpasset/Documents/Glossary%20of%20Law%20Enforcement%20and%20Mental%20Health%20Terms.pdf

[419] ICM for Severe MI. https://www.cochrane.org/CD007906/SCHIZ_intensive-case-management-people-severe-mental-illness

[420] MN Statute 245.462, op. cit.

[421] What is a CCBHC? https://www.thenationalcouncil.org/wp-content/uploads/2017/11/What-is-a-CCBHC-11.7.17.pdf?daf=375ateTbd56

evidence-based in terms of outcomes, but is proven to garner positive feedback from police officers.[422] [423]

CIT PARADOX: CIT training grew in usage because police believed they could not count on an on-scene response from mobile mental health professionals. Paradoxically, the fact that police officers get CIT training has now become a rationale for not bothering to collaborate with clinicians on-scene or deflecting mental health-related calls for service to mobile mental health crisis teams.

CLINICAL (DIAGNOSTIC) ASSESSMENT: A psychological assessment performed by a mental health professional to diagnose mental illness and determine appropriate care. This assessment must be performed by a skilled and credentialed clinician and apply the standards of the DSM-5 for evaluation of symptoms. In Minnesota and most states, this evaluation qualifies persons for insurance and public funding only when conducted through an in-person interview. MN law outlines qualifications for professionals performing these assessments and defines the assessment.[424] [425] [426]

CO-LOCATION: Used here to describe the practice of physically basing local mobile mental health crisis response teams in the same facilities that house law enforcement agencies (e.g. sheriff's offices) and/or local 911 emergency call centers. This practice is especially beneficial in rural settings where it promotes collaboration between local mobile mental health response personnel, law enforcement, and 911 dispatchers.

COMMUNITY MENTAL HEALTH ACT OF 1963: A milestone in the process of de-institutionalization. This act was meant to initiate a transition to more community-based treatment. However, the resources to make that happen were not provided. The result is a greater likelihood of police contact with persons living with severe mental illness and experiencing a mental health crisis.[427]

COMPASSION: Sympathy; to feel pity, accompanied by an urge to help.

CONSENSUS PROJECT REPORT: A 2002 report that examined the criminal justice system's response to people with mental illness. The Criminal Justice/Mental Health Consensus Project brought together leaders in corrections, law enforcement, government mental health services, and the judicial system. The report presents policy statements for

[422] San Diego Blueprint for MH Reform, op. cit.
[423] Eleven Johnson County Cities to Partner, op. cit.
[424] MN Statute 245.462, op. cit.
[425] MDH Diagnostic Assessment. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_058048#standard
[426] Mayo Diagnostic Assessment. https://www.mayoclinic.org/diseases-conditions/mental-illness/diagnosis-treatment/drc-20374974
[427] Kennedy's Vision. https://www.usatoday.com/story/news/nation/2013/10/20/kennedys-vision-mental-health/3100001/

improvement based on the existing knowledge base. It became a touchstone resource for studies and reforms that occurred in subsequent years.[428]

CONSUMER: A person with a mental illness receiving mental health services. Consumer advocacy groups and many professionals prefer "people first" language so as not to label a person as diseased. For example, one should say "a person with mental illness" and not a "mentally ill person."[429]

CO-OCCURRING CONDITIONS: Mental illness occurring in combination with substance use disorder (SUD), homelessness, poverty, medical ailments, and/or other social-psychological factors.

CO-OCCURRING DISORDERS (COD): Refers to having both a mental health and substance use disorder.[430]

CO-RESPONDER TEAM MODEL: The Co-Responder model pairs law enforcement and behavioral health specialists to respond to behavioral health-related calls for police service. These teams utilize the combined expertise of the officer and the behavioral health specialist to de-escalate situations and help link people with appropriate services.[431] [432]

COUNTY ADULT MENTAL HEALTH ADVISORY COUNCILS (MN): Boards required by MN state law and are comprised of community members appointed by county commissioners. They provide community oversight of local mental health systems and are obligated by law to create an annual public report of the unmet community needs.[433]

COUNTY JUVENILE MENTAL HEALTH ADVISORY COUNCILS (MN): These boards are analogous to the County Adult Mental Health Advisory Councils and provide community oversight of local mental health systems that serve juveniles.[434]

COUNTY MENTAL HEALTH BOARDS: As discussed in section IX, Subsection D2, in some states (e.g. Ohio, North Carolina, but not Minnesota), state legislatures empowered counties to create boards of experts tasked with planning and funding local mental healthcare services. These boards represent local control of resources to meet the community's needs and have the power to fund services by implementing local tax levies.[435]

CRISIS STABILIZATION CENTERS: A facility that provides care to persons in crisis. These facilities are often built to relieve burdens on hospital emergency rooms and police, and become drop-off centers that enable a police-only mental health crisis response.

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[428] CSG Consensus Report, op. cit.
[429] Glossary of LE and MH Terms, op. cit.
[430] Ibid.
[431] Colorado Co-Responder Program, op. cit.
[432] LAPD Unit Praised, op. cit.
[433] Adult MH Advisory Council. https://mn.gov/dhs/assets/lac-guidebook_tcm1053-386047.pdf
[434] Ibid.
[435] MH Services in Ohio, op. cit.

CRISIS STABILIZATION UNITS: Crisis Stabilization Units (CSU) are small inpatient facilities of less than 16 beds for people in mental health crisis whose needs cannot be met safely in residential service settings. CSUs may be designed to admit on a voluntary or involuntary basis when the person needs a secure environment that is less restrictive than a hospital. CSUs try to stabilize the person and get him or her back into the community quickly.

DECOMPENSATION: Deterioration of a person's mental health and/or return to a lower level of psychological adaptation or functioning, often occurring when an individual is under considerable stress or has discontinued psychiatric medication against medical advice.[436]

DECRIMINALIZATION OF MENTAL ILLNESS: This phrase refers to efforts to reduce the high percentage of persons in jails with untreated mental illness. Criminalization of mental illness is a result of defaulting to a law enforcement response to mental health calls. Criminalization can take the form of avoidable incarceration or the harm (stigma, trauma, and lack of clinical care) that comes with unnecessary police contacts with persons in mental health crisis.

DECRIMINALIZE: To eliminate or reduce legal penalties.

DE-ESCALATE: To reverse the effect of escalation; reduce or lessen in scope or magnitude.

DE-ESCALATION: Verbal and nonverbal interpersonal skills that enable a law enforcement officer to recognize and defuse violent behavior, preferably without force, preserving the suspect's safety and dignity.[437]

DE FACTO: Existing or being such in actual fact, though not by legal establishment; official recognition; by default.

DEFLECTION: Moving a person *away* from any contact with the criminal justice system and *toward* community mental health and social services, avoiding arrest and/or processing into the criminal justice system. Deflection refers to complete avoidance of police contact. This is in contrast to the more ambiguous term, diversion. Deflection is used in this paper for absolute clarity. "Pre-booking diversion" could be considered synonymous in some circumstances.[438]

DE-INSTITUTIONALIZATION: The process of replacing long-stay psychiatric hospitals with community mental health services for those diagnosed with a mental disorder or developmental disability.

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[436] Glossary of LE and MH Terms, op. cit.
[437] Ibid.
[438] Deflection Surge. https://thecrimereport.org/2017/03/21/the-deflection-surge-key-to-reducing-re-arrests/#

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-V): The standard reference handbook used by behavioral health professionals in the United States to classify mental health conditions. The current edition is denoted V.[439]

DISPATCH, CAD (Computer-Aided Dispatch): Computer systems at 911 emergency calls centers use advanced software and hardware to help dispatchers gather and share information. CAD systems enable rapid communications with police and fire departments. Minnesota law allows these systems to also be used for communication with county-run mobile mental health crisis response teams. CAD systems are mostly separate from RMS systems used by police agencies for managing information about calls for service.[440] [441]

DISPATCH, FLAGGING RECORDS: Calls for service are given call descriptors that reflect the nature of the call as originally understood by 911 call takers. Responding officers find that many calls for service have a mental health component despite being assigned unrelated call descriptors (e.g. "domestic disturbance"). CAD and RMS computer systems are typically not designed to allow dispatchers or officers to flag such calls to assist data searches if the original call descriptor does not reflect a mental health component. This is part of the reason why mental health-related calls for service are significantly undercounted.[442] [443]

DISPATCH, IMMINENCE: Imminence is a term used in 911 emergency call centers while also referring to the legal doctrine of Imminent Peril. Calls are categorized based on the immediacy of the danger involved. Imminent danger is certain, immediate, and impending. When danger is imminent or, more rarely, active, then the call always requires a police response. In many cities (including Minneapolis) 911 calls describing suicide attempts are almost always considered to have imminent danger and get a police-only response. The Imminent Peril Doctrine indemnifies responders from liability. Mobile mental crisis response teams routinely respond to calls that would get a police-only response from 911 dispatchers. When mobile mental crisis response teams get a call that includes the possibility of danger to the responder, they request a police co-response. Few 911 emergency communications centers utilize a co-response option.[444] [445] [446]

DISPATCH, POLICE: Police dispatch exists separately from 911 call centers. Call centers relay calls for service to police dispatchers who manage police response directly. Dispatch triage should be a function performed at 911 centers, not at police dispatch.

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[439] NASMHPD Glossary, op. cit.
[440] Computer-Aided Dispatch. https://en.wikipedia.org/wiki/Computer-aided_dispatch
[441] MN Statute 403.03, op. cit.
[442] Fulton County PD Tracking. https://www.ajc.com/news/local-govt--politics/fulton-police-consider-special-crisis-teams-for-mental-health-calls/nYJzO3QkdMw9mDMzomte2M/
[443] Survey of Police Officers. https://www.cabq.gov/mental-health-response-advisory-committee/documents/survey-of-police-officers-for-calls-for-services-as-mental-illness.pdf
[444] Imminent. https://law.jrank.org/pages/7485/Imminent.html
[445] Imminent Peril Doctrine. https://definitions.uslegal.com/i/imminent-peril-doctrine/
[446] MPD Policy 7-100. http://www.ci.minneapolis.mn.us/police/policy/mpdpolicy_7-100_7-100

DISPATCH, RMS (Record Management Systems): Law enforcement agencies use RMS software to communicate and store information related to calls for service. These are often purchased as packaged systems and rarely allow patrol officers to flag call records that were found to have a mental health component. Thus a large number of mental health-related contacts are hidden under unrelated call descriptors (e.g. "domestic disturbance"). The inability to document the true nature of contacts reduces the ability of dispatchers or law enforcement to see patterns when calls come in for the same person and location. Furthermore, statistical summaries are inaccurate, hindering the ability of police administrators to measure and manage patrol officer workloads.

DISPATCH TRIAGE: The practice of triaging mental health-related calls at 911 centers and, when appropriate, diverting them to responders other than police services. This practice has seen significant use as part of the Street Triage programs in the U.K. beginning in 2011 and is becoming common in the U.S.[447] [448]

DISPATCH, URGENCY: Urgency is a term used in 911 call centers where calls are categorized based on the immediacy of the danger involved. Calls categorized as urgent involve danger that is impending but not immediate or even certain. This is a lower category of 911 call than those having imminent danger. In many cities, including Minneapolis, calls having a high level of urgency get a police-only response. Some of these calls can involve persons in mental health crisis. In the past, welfare checks for persons with mental health issues have been categorized as urgent calls and given police-only responses. Mobile mental health crisis response teams could routinely respond to many calls that would get a police-only response from 911 dispatchers.[449]

DIVERSION: Removing someone from the traditional track or expected process of the criminal justice system; police diversion (or pre-booking diversion) means that the person is not taken into custody but either taken home, to some treatment or support system, or simply released in lieu of charging the person with a crime. Jail diversion involves a judicial decision that pretrial release or probation is more appropriate than incarceration. This contrasts with deflection, which refers to alternate response that avoids contact with law enforcement.[450]

DSM-5, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL HEALTH DISORDERS (Rev. 5): See Diagnostic and Statistical Manual of Mental Disorders (DSM-V).

DUAL DIAGNOSIS: "Dual diagnosis describes a practice that treats people who suffer from both an addiction and a psychiatric disorder."[451]

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[447] Abilene 911 Program, op. cit.
[448] Dallas Dispatching Social Workers. https://www.dallasobserver.com/news/dallas-has-been-dispatching-social-workers-to-some-911-calls-its-working-11810019
[449] MPD Policy 7-100, op. cit.
[450] Glossary of LE and MH Terms, op. cit.
[451] Dual Diagnosis. https://www.psychologytoday.com/us/blog/the-anatomy-addiction/201110/what-is-dual-diagnosis

DUTY OF CARE: A duty of care is the legal responsibility to avoid actions or omissions that could reasonably be foreseen to cause harm to others. This is relevant to whether police must modify their procedures or take added care in interactions with persons in mental health crises. The U.S. Supreme Court's Sheehan ruling sidestepped a potential opportunity to create a duty of care in police interactions with persons in crises.[452]

DUTY TO PROTECT: Law enforcement officers have only a general obligation to protect the populace. There is no legal obligation to protect or rescue any individual person. This established common law has been solidified by the U.S. Supreme Court decision in DeShaney v. Winnebago County Dept. of Social Services. Thus, there is no legal requirement for law enforcement officers to respond to 911 calls, including calls that have a mental health component.[453]

ETHICAL: Conforming to the standards of conduct expected or legally required of a profession or group.

FIRST EPISODE PSYCHOSIS (FEP): Psychosis is a disconnect from reality and it can be very distressing for young persons. Persons experiencing FEP deserve on-scene clinical response if it is at all possible.

> *Early psychosis, also known as first-episode psychosis (FEP), is often frightening, confusing and distressing for the person experiencing it and difficult for his or her family to understand. During early psychosis or a first episode is the most important time to connect with the right treatment. Doing so can be life-changing and radically alter a person's future.*[454]

FOLLOW-UP SERVICES: After initial police contact, law enforcement may refer an individual experiencing mental illness to a social services agency. This is an inefficient and often unsuccessful process that ensures some people needing assistance will fall through the cracks. Instead, an initial interaction should be a useful clinical intervention followed by referrals for services coordinated by mental health professionals to stabilize the individual. Follow-up helps to reduce negative outcomes and benefits individuals with co-occurring substance use disorder. For high utilizers of services with complex needs, mental health follow-up services should be part of a broader case management effort.

FREQUENT PRESENTERS: Persons with mental illness who have repeated, cyclical contact with law enforcement. Often co-occurring conditions like substance use disorder promote this cyclical contact. Whom law enforcement perceives as frequent presenters might also be observed as high utilizers in local health care systems. Integration of service systems and multi-layered responses can help break the cycle. See also High Utilizers.

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[452] CIF Suicide Calls Presentation, op. cit.
[453] Ibid.
[454] MHLN Blue Book 2018, op. cit.

GATEKEEPERS TO CARE, POLICE AS: As the first, and sometimes only, option for mobile response, police are thrust into a position of providing a type of triage service to the mentally ill that they are neither trained to deliver nor prepared to perform.[455] Many scholars argue that this forces the police into a precarious position of being "primary gatekeepers" to care.

HIGH UTILIZERS: High utilizers are a small group of patients who have multiple, sometimes complex, problems that place a disproportionately high burden on the healthcare system due to their elevated resource use. Many high utilizers have mental health problems and are also "frequent presenters" to law enforcement.[456] [457]

HUMAN SERVICES VALUE CURVE: A model of social service delivery that outlines four levels of delivery from the perspective of the consumer of those services. Used with imagination, this model offers public sector planners a pathway toward meeting community needs. However, because of long-standing use of police as primary responders, planners using this model often fail to recognize the need to deflect calls for mental health services away from police.[458]

INTEGRATION, CARE: Care integration combines primary care and mental health services in one setting. This approach improves overall wellness and saves money by preventing relapses of medical, mental health, or socio-economic crises and reducing reliance on hospital emergency departments. Integration is especially beneficial for persons deemed "high utilizers" of services.[459] [460]

LAW ENFORCEMENT LEARNING SITES: These are police departments that help other enforcement agencies interested in collaborative approaches to handling mental health-related calls. Officially called Criminal Justice Mental Health Law Enforcement Learning Sites, they were chosen by the U.S. Department of Justice–Bureau of Justice Assistance. The LAPD, Houston PD, and Arlington (MA) PD are examples.[461]

LAW ENFORCEMENT MENTAL HEALTH COLLABORATION GRANT: This program funds innovative collaborative programs. Grant periods are typically three years and can be used for program planning, initiation, and expansion. Contact the U.S. Department of Justice's Bureau of Justice Assistance (BJA).[462]

LEAD PROGRAMS: The **L**aw **E**nforcement **A**ssisted **D**iversion program. This program funnels persons to social services through contact with police, with or without criminal

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455 Cross-Disciplinary Partnerships, op. cit.
456 Behavioral Health Occupation Projections, op. cit.
457 Targeting High Utilizers, op. cit.
458 CHCS High Utilizer Report, op. cit.
459 Integrating Behavioral Health and Primary Care, op. cit.
460 Integrating Health Care and Social Services. https://www.shvs.org/wp-content/uploads/2016/11/SHVS-Bailit-Integrating-Health-Care-and-Social-Services-November-2016.pdf
461 CSG Law Enforcement MH Learning Sites, op. cit.
462 Justice and MH Collaboration Program. https://bja.ojp.gov/funding/opportunities/bja-2020-17114

conduct. While the premise is to provide police with referral resources for frequent presenters, the emphasis is on the use of police as gatekeepers for these services. Instead of funding a parallel social services (LEAD) structure, cities could utilize their funds to create a healthy collaboration with the existing county social services delivery system. **The State of Minnesota notes on its website that:** *"Contacting the county mobile crisis team can be an entry point for accessing case management and other county services."*[463]

LICSW: See Social Worker-Licensed, Clinical.

MEDICAID EXPANSION. Authorized by the Affordable Care Act, the Medicaid Expansion program provides health coverage to individuals between the ages of 19 and 64 with incomes 138% below the federal poverty level, regardless of disability, assets, and other factors that are usually taken into account in Medicaid eligibility decisions. This expansion of health insurance coverage is key to funding innovations and system integration efforts aimed at helping high utilizers of services.[464]

MEDICAL ASSISTANCE (Minnesota): Medical Assistance is Minnesota's name for Medicaid, a joint federal/state program that provides healthcare coverage for low-income individuals as defined by federal law. Mobile mental health responses can be covered by Medicaid if the response teams include a Mental Health Professional as defined under Minnesota Law.[465]

MENTAL HEALTH PRACTITIONER—MN STATUTORY DEFINITION: Under Minnesota Statute 245.462, a mental health practitioner provides services to adults with mental illness or children with emotional disturbance. To qualify, the practitioner must complete at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and have at least 2000 hours of supervised experience in the delivery of services to adults or children.[466]

MENTAL HEALTH PROFESSIONAL—MN STATUTORY DEFINITION: Under Minnesota Statute 245.462, a mental health professional provides clinical services in the treatment of mental illness and who is qualified through at least a master's degree or as a psychiatric nurse. The most relevant qualification for staffing mobile mental crisis response teams is a Licensed Clinical Social Worker (LICSW). A LICSW can perform diagnostic assessments and provide on-scene clinical care.[467] [468]

MOBILE MENTAL HEALTH CRISIS RESPONSE TEAMS: Teams composed of mental health service professionals who provide on-scene responses in mental health emergencies.[469]

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[463] Mobile Crisis MH Services. https://mn.gov/dhs/people-we-serve/adults/health-care/mental-health/programs-services/mobile-crisis.jsp
[464] Medicaid Matters. https://www.leg.state.mn.us/docs/2018/other/180391.pdf
[465] Ibid.
[466] MN Statute 245.462, op. cit.
[467] Ibid.
[468] MN Board of Social Work LICSW Requirements, op. cit.
[469] Glossary of LE and MH Terms, op. cit.

MOBILE MENTAL HEALTH CRISIS RESPONSE TEAMS—MN STATUTORY DEFINITION: Under Minnesota Statute 256B.0624, these teams provide "face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning. The services, including screening and treatment plan recommendations, must be culturally and linguistically appropriate." Teams in Minnesota are supervised by county health departments.[470]

MOBILE MENTAL HEALTH CRISIS RESPONSE TEAMS—MINNESOTA COUNTIES: Minnesota state government funds a system of county-based mobile mental health crisis teams staffed by licensed mental health professionals. These teams should be given the opportunity to respond to all mental health calls including those that happen to come through 911 systems. At the time of this writing, only Ramsey County deflects mental health-related 911 calls to the county mobile crisis response team using a dispatch triage process.[471]

MOBILE MENTAL HEALTH CRISIS RESPONSE TEAMS—STREET TRIAGE: In the United Kingdom, the National Health Service has adopted a collaborative crisis response called street triage. This takes different forms depending upon the local circumstances but is generally implemented with a response team comprised of a mental health professional paired with a police officer and an EMT. This team responds directly to mental health-related calls for service in a special van. These programs greatly reduce transfers and holds, improving services and saving money.[472]

MORAL: Relating to, dealing with, or capable of making the distinction between right and wrong in conduct.

MULTI-LAYERED RESPONSE: Utilizing several types and levels of response to enable integrated systems to serve patients at their current level of need. The LAPD created the first multi-layered response structures involving law enforcement. Their program exemplifies collaboration with mental health professionals to keep high utilizers/frequent presenters out of crisis.[473]

NAVIGATOR PROGRAMS: Programs that put workers in the community to maintain contact with persons in need and keep them tied to services. They can be an important avenue for helping persons with mental illness and complex co-occurring conditions receive health services, mental health care, employment assistance, housing assistance, and other social services. As with other social service functions, this role should be based in the county health departments, not police departments.[474] [475]

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[470] MN Statute 256B.0624, op. cit.
[471] Mobile Crisis Mental Health Services, op. cit.
[472] Nottinghamshire Street Triage, op. cit.
[473] LAPD Mental Evaluation Unit, op. cit.
[474] Community Navigators Reduce Hospital Utilization. https://www.ajmc.com/journals/issue/2018/2018-vol24-n2/community-navigators-reduce-hospital-utilization-in-superutilizers

NO HESITATION TRAINING: Training to law enforcement officers encouraging them not to hesitate to use force on members of the community. Trainers share pseudo-science about reaction time and pre-attack indicators and provide summations of how state and federal law minimizes the likelihood of prosecution or discipline for almost any use of force. Because mental illness can cause a person to have difficulty understanding instructions, be argumentative, or move about unpredictably, this training creates risk of injury for people in mental health crisis.[476] [477]

OLMSTEAD U.S. SUPREME COURT DECISION: This 1999 decision, based on the Americans with Disabilities Act, held that people with disabilities have a right to receive state-funded supports and services in the community (i.e. "least restrictive environment") rather than institutions. This ruling can be interpreted to mean that the government has an obligation to provide mobile mental health crisis services in the community by clinicians rather than police officers.[478]

PARENS PATRIAE: An obligation of government to serve and protect vulnerable persons who cannot help themselves.

PEER SUPPORT SPECIALIST: Occupational title for a person with lived-experience providing services. These individuals might not have the credentials required under state law to perform mobile mental health crisis work but they can be a valuable resource for creating a multi-layered response system.[479]

POST-TRAUMATIC STRESS DISORDER (PTSD): A psychological reaction that occurs after experiencing a highly stressing event, such as wartime combat, physical violence or a natural disaster. PTSD is usually characterized by depression, anxiety, flashbacks, recurrent nightmares and avoidance of reminders of the event. Also called delayed-stress disorder or posttraumatic stress syndrome.[480]

PSMI (PERSISTENT SERIOUS MENTAL ILLNESS): See SMI.

PSYCHIATRIC EMERGENCY SERVICES—MN STATUATORY DEFINITION: Psychiatric emergency services are immediate responses by mental health professionals available 24 hours, seven days a week for people experiencing a psychiatric crisis.[481]

REASONABLE: Using or showing reason, or sound judgment; sensible; not extreme or excessive.

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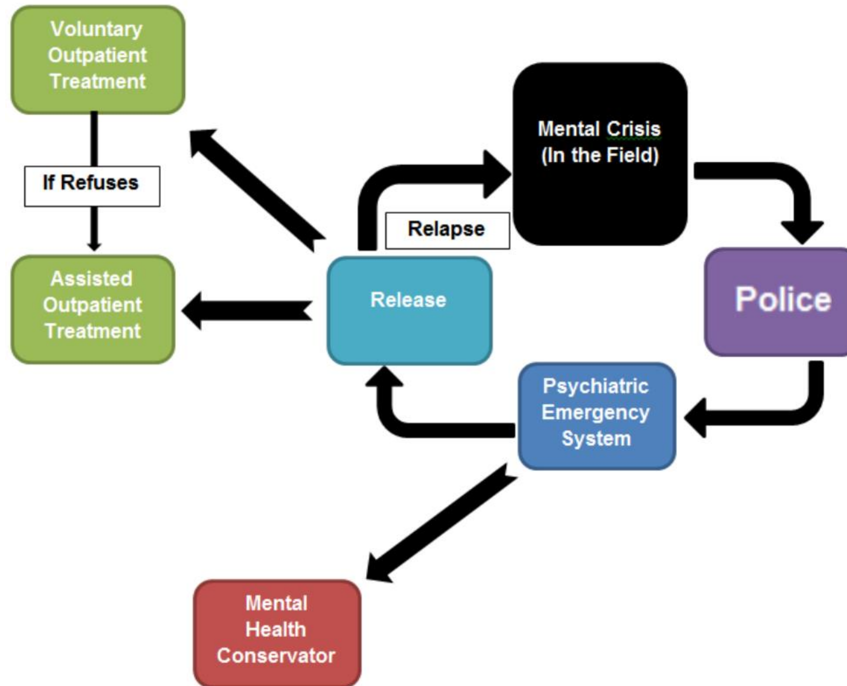
[475] Community Navigation as a Field of Practice. http://floodlight.denverfoundation.org/Portals/0/Uploads/Documents/Community%20Navigation%20as%20a%20Field%20of%20Practice_%20Reframing%20Service%20De.pdf
[476] How Police Training Contributes to Avoidable Deaths. https://www.theatlantic.com/national/archive/2014/12/police-gun-shooting-training-ferguson/383681/
[477] Lewinski Defends Excessive Force. http://www.citypages.com/news/bill-lewinski-defends-cops-accused-of-excessive-force-6725973
[478] About Olmstead, op. cit.
[479] Human Services Glossary. https://www.nd.gov/dhs/info/pubs/docs/dhs-glossary-of-terms-acronyms.pdf
[480] What is PTSD? https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd
[481] MN Statute 245.462, op. cit.

REVOLVING DOOR: The cycle of police contact and potential incarceration that afflicts some persons with mental illness. Co-occurring conditions can greatly contribute to individuals falling into this trap.[482]



RMS (Record Management Systems): See Dispatch, RMS.

RULE 25 ASSESSMENT: This is a chemical dependency assessment, performed by a qualified person with state assessor certification. It is very beneficial for mobile mental health crisis response workers to have this certification. To receive public funding for chemical dependency treatment, an individual needs to have a chemical use assessment conducted by a Rule 25 assessor.[483] [484]

SECONDARY TRAUMATIC STRESS (STS): Secondary traumatic stress refers to the presence of PTSD symptoms caused by indirect exposure to traumatic events. Nurses, police officers, and social workers providing mobile mental health crisis response work are susceptible to STS.[485] [486] [487]

SEPARATE RESPONSE: Researchers use this term to describe the practice of police and mental health crisis response teams arriving in separate vehicles from separate locations.

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482 MI Revolving Door, op. cit.
483 MN Rule 9530.6615, op. cit.
484 Rule 25 Assessments, op. cit.
485 Social Worker Burnout, op. cit.
486 Officers with PTSD, op. cit.
487 Work Environment and Officer PTSD, op. cit.

Persons in need of mental health crisis response liked this type of co-response less because police typically arrive first and these separate responders do not collaborate as well compared to when they co-respond in the same vehicle.[488]

SEPARATE SILOS: This refers to the problem of separate organizations not communicating and collaborating well. The problem of separate silos hinders integration of systems and collaborations between police and social service agencies.

SEQUENTIAL INTERCEPT MODE: A tool for shaping reform in the criminal justice system created by the Policy Research Associates. This model divides the system into levels (e.g. Level 0 is prior to police contact) and promotes brainstorming of services to assist people with problems like substance abuse or mental illness to avoid law enforcement entanglements.[489]

SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI): A diagnosable mental, behavioral, or emotional disorder that meets the criteria of DSM and has resulted in functional impairment which substantially interferes with or limits one or more major life activities of an adult. Specific diagnoses that often meet the criteria for SMI are: schizophrenia, schizoaffective disorder, bipolar or manic depressive disorder, severe forms of major depression or anxiety disorders and some personality disorders and are used to determine eligibility for state-supported mental health services.[490]

SHEEHAN U.S. SUPREME COURT DECISION: In the 2015 ruling in City and County of San Francisco v. Sheehan, the court refused to apply ADA requirements to law enforcement. This weakened arguments for a duty of care and allows law enforcement officers to base their use of force decisions on Graham v. Connor, even for individuals whose behaviors are a result of mental illness.[491] [492] [493] [494]

SOCIAL WORKER, LICENSED: See Social Worker, Licensed, Clinical, LICSW.

SOCIAL WORKER, LICENSED, CLINICAL (LICSW): This is a master's degree-prepared social worker who has 4000 hours of supervised experience in a clinical setting and has earned state certification. LICSW is the highest level of social worker in Minnesota. LISW is a lower classification that can only work in clinical settings if supervised by an LICSW. Minnesota recognizes those with LICSW licensure as mental health professionals, qualified to perform diagnostic assessments and work on mobile mental health crisis response teams. These professionals are very well suited to provide crisis response,

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[488] Consumer Experience of CR Services, op. cit.
[489] Sequential Intercept Model. https://www.prainc.com/wp-content/uploads/2017/08/SIM-Brochure-Redesign0824.pdf
[490] Glossary of LE and MH Terms, op. cit.
[491] San Francisco v Sheehan, op. cit.
[492] Excessive Reasonableness, op. cit.
[493] From Garner to Graham and Beyond, op. cit.
[494] Bad Apple Myth of Policing, op. cit.

ensure system integration, and tie patients to wider services or case management. Minnesota's labor market has an abundance of LICSWs.[495] [496] [497]

STREET TRIAGE: See Mobile Mental Crisis Response Teams, Street Triage.

SUBSTANCE USE DISORDER (SUD): Substance Use Disorder is a complex brain disease that occurs when a person has a dependence on alcohol and or other drugs that is accompanied by intense and sometimes uncontrollable cravings and compulsive behaviors to obtain the substance.[498]

TELEHEALTH: See Telepsychiatry.

TELEMENTAL HEALTH: See Telepsychiatry.

TELEPSYCHIATRY: Telepsychiatry, a subset of telemedicine, uses video technology to provide a range of services including psychiatric evaluations, therapy (individual therapy, group therapy, family therapy), patient education, and medication management. Mental health care can be delivered in a live, interactive communication.[499]

TRIAGE DESK: This is a practice of placing a mental health professional within a 911 call center or police dispatch to assist in dispatch triage or to be available for immediate consultation with police officers on the scene. This practice was innovated by the Los Angeles Police Department.[500]

TRAUMA: Harm or damage caused by a deeply distressing or disturbing experience.

WARRIOR TRAINING: Law enforcement training that encourages a paramilitary culture and promotes the image of officers as warriors. Trainers emphasize the dangers of contact with the public and promote paranoia among officers. This training is shown to cause officers to quickly default to serious use of force that leads to death or serious injury for persons in crisis.[501] [502] [503]

WRAPAROUND SERVICES: An individually designed set of services and supports provided to people who have multiple needs due to serious mental illness. Wraparound services include diagnostic and treatment services, personal support services, and other supports needed to maintain the person in their home and community-based settings. This is a particularly effective approach in assisting people who are being served by multiple systems.

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[495] MN Board of Social Work LICSW Requirements, op. cit.
[496] Social Work Licensure in Minnesota. https://www.humanservicesedu.org/minnesota-social-work-requirements.html
[497] MN Statute 245.462, op. cit.
[498] Human Services Glossary, op. cit.
[499] What is Telepsychiatry? https://www.psychiatry.org/patients-families/what-is-telepsychiatry
[500] LAPD Unit Praised, op. cit.
[501] Professor Carnage. https://newrepublic.com/article/141675/professor-carnage-dave-grossman-police-warrior-philosophy
[502] Law Enforcement's Warrior Problem, op. cit.
[503] The Truth About the Philando Castile Verdict. https://www.youtube.com/watch?v=wqgz7kRGVxg

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Section VI

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