Civilian Crisis Response Rather than Co-Responder and CIT Programs

White Paper

Resources for Human Development
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"The mere presence of a law enforcement vehicle, an officer in uniform, and/or a weapon… has the potential to escalate a situation." - International Association of Chiefs of Police

The Problem:

In the last decade, use of excessive force by police towards people during behavioral health crises has come under increasing scrutiny from the public. Police mishandling of behavioral health crises has had tragic outcomes for individuals, families, and communities. A growing body of research indicates the need for change. Behavioral health challenges are a predictor of police violence in a crisis (Rossler & Terrill, 2017). Law enforcement is more likely to use force when the person shows signs of mental illness. In the United States, people with a serious persistent mental illness (SPMI) are 16 times more likely to be killed by police than people who are not experiencing SPMI (Fuller et al., 2015). The American Public Health Association (2018) cited a 2015 estimate that 27% of police killings were of people with a mental illness. When police do use force, people with mental illness are injured a third of the time compared to people without behavioral health challenges who are only injured in a quarter of the incidents.

The American Public Health Association (2018) identifies the need to find alternative to police as the default first responders as a key public health issue. Alternative models focused on behavioral health first responders can decrease interactions with the criminal justice system, reduce involuntary hospitalizations, and increase healthcare responses to behavioral health crises. By virtue of fewer interactions with police, people are less likely to become involved in the criminal justice system when what they really need is healthcare treatment and support. This reduction in law enforcement interactions also reduces the number of excessive force allegations and police shootings because there are fewer opportunities for these tragedies to occur.

Relying on law enforcement as responders to behavioral health crises is expensive and ineffective. It results in high rates of incarceration and lack of appropriate health care for people with mental illness or substance abuse (Assey, 2021; Balfour et al., Irwin & Pearl, 2020; SAMHSA, 2020; 2022; Seo et al., 2021).

Crisis Intervention Training (CIT) & Co-response

Crisis Intervention Training (CIT) provides training to law enforcement officers on a variety of topics related to behavioral health and substance use as well as officer liability, and relevant policies and procedures. Currently, there are no uniform national standards guiding the implementation of CIT. Lack of consistency across programs makes research into the value and impact of the CIT model difficult. Despite numerous attempts, independent researchers have not been able to demonstrate clear or reliable outcomes of CIT due to the lack of uniformity across programs. While research has shown that CIT or co-response models can change officer attitudes

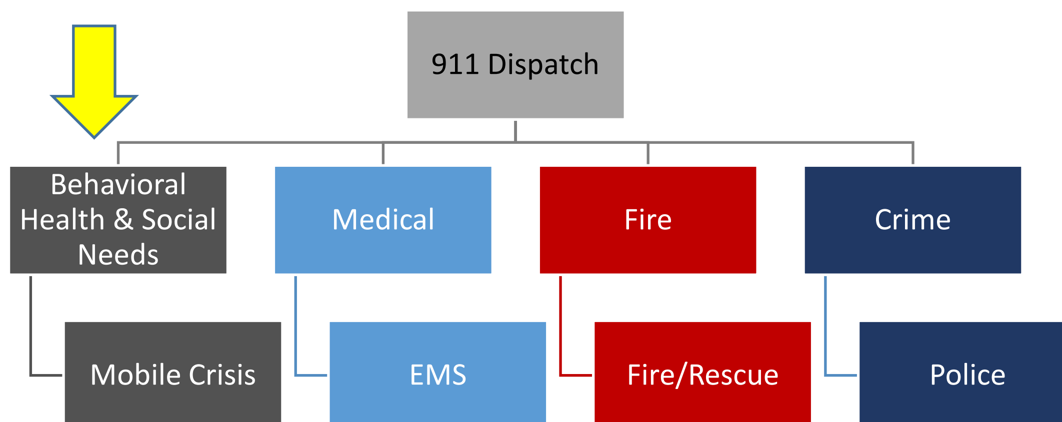
about mental illness, research does not demonstrate the same impact on officer behavior (Marcus & Stergiopoulos, 2022; Seo et al., 2021).

Co-response models pair police officers with specially trained behavioral health professionals to respond to crises in tandem. Unfortunately, co-responder teams face many of the same challenges as traditional police response. Research on the benefits of co-responder models indicates limited impact when police are part of the responding team and suggests that whenever possible, behavioral health first responders should respond without police (Bailey et al., 2018). If police are needed for safety reasons, they should respond with behavioral health first responder teams and leave the scene as soon as it is safe to allow the behavioral health first responders to manage the crisis.

Vice-President of CIT International, Ron Bruno said, “We have to challenge the belief that mental health crisis services must come in a police car,” (SAMHSA, 2020, p. 68). When police arrive, they bring lights, sirens, handcuffs, and weapons, which are a source of anxiety for many people and often escalate a behavioral health crisis. Bruno agreed, saying, “Every time a police officer goes to a crisis situation, it’s going to escalate the person’s emotional state. Yes, we can and will train officers to de-escalate situations, but often, their mere presence is stressful, and the person in crisis can become fearful and enter fight or flight. That’s when we see major problems,” (SAMHSA, 2020, p. 68). During behavioral health crises, de-escalation is key to maintaining health and safety for all those involved. If the mere presence of police has the opposite effect, we have a responsibility to explore alternatives to CIT and co-response models.

The Solution: Civilian Crisis Response

Municipalities looking to reduce unnecessary hospitalizations and incarceration while also reducing costs and improving efficiency have a solution at their fingertips: civilian-only crisis response teams as the fourth branch of the emergency response system. These teams, often referred to as civilian crisis response, mobile crisis outreach teams, alternative dispatch teams, or community responder models, are dispatched by 911 to behavioral health crises in the community. Civilian-only response teams are composed of highly specialized behavioral health crises workers, under the supervision of licensed clinicians. Cities that have adopted these models have seen multiple benefits beyond appropriate treatment, including reduced costs for police overtime, reduction in arrests, and even reduction in crime (Dee & Pyne, 2022).



Parity with Physical Health

Another benefit of civilian response over co-response teams is the opportunity provided for cities, counties, and campuses to offer parity between physical health and behavioral health in their public safety and emergency response systems. A current court case brought suit against the District of Columbia for offering medical-specific first responders while sending police to behavioral health emergencies. The suit identifies this as discrimination against people with mental illness, which is in violation of the Americans with Disabilities Act (American Civil Liberties Union, 2023). Adding a fourth branch of the emergency response system allows for behavioral health first responders to respond with or without police as the crisis calls for.

The last evolution of the emergency response system occurred approximately 50 years ago with the addition of what we now know as the Emergency Medical Service (EMS). EMTs report over 7,770 injuries each year, with one-third attributed to patient violence (Maguire & Amiry, 2023). Reasonable concern over the potential for similar injuries to behavioral health workers has led to support for the co-response model. However, evidence shows that properly trained crisis response workers, skilled in de-escalation, are actually safer without police present. When a scene is known to have higher risks of violence, police and EMS respond together. Behavioral Health First Responders and police can do the same.

Faster Response Time with the Mutual Response Model

There are practical reasons for municipalities to invest in mobile crisis teams who can "mutually respond" over co-responding teams. In mutual response models, two branches of the emergency system send the first available personnel to the scene, rather than wait for the availability of a dedicated behavioral health co-response team. Mutual response can arrive on scene faster because any behavioral health first responder team and any police officers can respond rather than waiting for the co-response team to be available and arrive. This means the closest responders can be dispatched, minimizing response time, which minimizes the chance that the crisis will escalate while waiting for help. Mutual response also allows officers to leave once they secure the scene, so they are free to respond to other calls. In a co-responder model, the officer is tied up with the behavioral health worker, even if they are not needed. This is an inefficient use of officer time.

Example Civilian Crisis Response Program

The New Orleans Mobile Crisis Intervention Unit (MCIU) is an example of a successful adoption of the fourth branch of the emergency response system. Implemented in June 2023, MCIU is staffed by behavioral health first responders who are dispatched from 911 to behavioral health crises to manage the scene, facilitate referrals to treatment, and provide transport if needed. They are able to mutually respond with fire/rescue, EMS, or police but usually respond without one of the other branches.

The average MCIU response time is 15 minutes. New Orleans' average EMS and police response time is over an hour. The program projects saving 5000 police hours a year. Involuntary hospitalizations account for only 15% of calls, the lowest of any mobile crisis team in the state;

according to data from the New Orleans Police Department, 60% of 911 calls with a mental health signal ended in involuntary hospitalization in 2020 (Chrastil, 2023). There have been zero instances of harm to first responders, individuals in crisis, or bystanders. MCIU has been able to divert situations away from SWAT, saving the city tens of thousands of dollars.

Regarding the success of the MCIU team, New Orleans Police Department CIT Coordinator, Desi Broussard says, “The feedback from the field is amazing. Every time one of my officers encounters someone from the MCIU team, I get nothing but amazing feedback. They are so grateful to have partners in the field with such in depth clinical knowledge to help us make those decisions whenever we just aren’t quite sure what to do. They are so grateful for that partnership and the people you have in place in these green shirts, they are truly heroes.”

Recommendations

A separate team that can provide a mutual response rather than a co-responder model in which an officer is always present is more aligned with the SAMHSA recommendations, which state that mobile crisis should be the sole responder unless there is a specific need for police involvement (SAMHSA, 2020). While CIT and co-responding models provided an improvement from patrol or police-only responders to behavioral health crises, the research has not shown that they are consistently successful. The practical barriers of these models further reduce their efficacy as a resolution to the current gap in the emergency response system. Continuing to send officers, no matter how well trained, to behavioral health crises when we know officer presence escalates these situations will continue to cause harm. Replacing police response to behavioral health crises with specialized mental health response, as we do for physical health, will lead to the best public service by first responders.

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