Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988

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Abstract:

Lessons from history are essential to consider as policymakers reimagine a robust behavioral health crisis continuum that meets community needs. The role of law enforcement in crisis response has become fraught, with some advocates calling to defund police to prevent repetitions of tragic outcomes of police encounters, especially with Black and Brown men and individuals with mental illness. Yet, there are additional concerns that the elimination of law enforcement would have potential unintended consequences that could shift critical responses to ill-equipped mental health providers in high-risk situations. More and more, the dialogue has therefore moved to creating partnerships to enhance the community crisis response infrastructure. As 988 soon becomes operational, it is more important than ever to ensure that there is seamless connectivity between 911 and 988 for the proper response and responders for any situation. This may also reduce the use of law enforcement when not needed, while being mindful that situations will arise when risks might necessitate multiple responders on a scene. This paper aims to help shape future planning by highlighting current behavioral health crisis response services and current and historical emergency medical out-of-hospital response mechanics. It also reviews theories that help shed light on decades of racial inequities in police approaches to marginalized communities. Lastly, we offer considerations for high-risk situations to help policymakers consider some of the more challenging issues that may arise in crisis service development.

Highlights:

- Law enforcement, emergency medical services, and behavioral health will increasingly need to partner to plan and coordinate 988 and 911.
- The critical infrastructure of crisis services has become more apparent in the aftermath of COVID-19. Building adequate infrastructure will require more clarity in how communities may best execute responses.
- Mental health and law enforcement have a long and complex history of collaboration to help individuals get into treatment and keep communities safe, with important lessons to help improve outcomes in the future.

Recommendations for the post-COVID-19 future:

1. Efforts to leverage partnerships should continue across first responders of all types.
2. Training and cross-training is a critical component of maximizing the quality and dignity of crisis responses.
3. Trauma-informed crisis services should include an understanding of the traumatizing nature of being a first responder and stakeholders should make efforts to support law enforcement and other emergency personnel who serve their communities.
4. Enhancing the role of peer support specialists to work with law enforcement holds promise for achieving positive outcomes.
5. Training and policies must acknowledge and prepare for high-risk encounters in the crisis continuum.
6. Stakeholders can address racial disparities by taking stock of history and intentionally developing programs that focus on diversity and equity.
7. Empirical evidence should be pursued to help identify the effectiveness of specific partnership type behavioral health crisis response models.
There is a growing discussion advocating for reforming crisis responses in the wake of the recent killings of individuals with mental illness by law enforcement, including Black men and women. Policymakers, advocates, and scholars have called for interventions that decenter and even “defund” police, while promoting unarmed mental health or other clinicians to respond to individuals with mental illness or emotional disturbances when they are in crisis. Although some advocates consider such large-scale change in approaches to policing unrealistic, there is growing momentum to expand partnerships and the capacity of non-law enforcement clinicians from both the behavioral health system and the larger health system to respond and limit the role of law enforcement to those situations when possible. In some jurisdictions policymakers and legislators have weighed in on these partnerships. Take Connecticut for example, which passed a law enforcement “accountability” bill that puts more emphasis on oversight and review of police actions and has a section that mandates exploring the feasibility of partnering with social workers in certain responses. Even before the latest attention to these issues, mobile crisis services managed through local mental health authorities had been growing in number and availability across the United States. Parallel or integrated systems for youth mobile response and adult mobile response may exist in particular regions. Additionally, emergency medical responders may also be part of the community response to emotional crises.

Integration and coordination across behavioral health, emergency medical response, and law enforcement will be essential components for a robust crisis services system that calls for the right response and responders at the right time. These systems share a socially and politically complex past within the history of American society, with many aspects rooted in the history of American medicine. Appreciating the development of emergency medical services, community-oriented models of public services, and the role of law enforcement involvement in meeting the needs of individuals with mental health crises is essential to understanding the strengths and weaknesses of our current system and to informing improvement efforts as the promise of 988 becomes a reality.

There is an exciting dialogue happening across the United States related to the Crisis Now efforts. At the same time, history shows examples of both earlier successes of supporting disadvantaged communities to improve their health and well-being, but also the harmful effects of surveillance on marginalized communities at times in the guise of assistance. Taking stock of that history can augment future planning. This paper, Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988, as part of the NASMHPD 2021 technical assistance papers, aims to provide a historical background to community crisis responding between law enforcement and emergency medical personnel, to discuss broad structural issues that have contributed to racial inequities in the delivery of policing, and to review the current landscape regarding crisis response models in a world with the “Promise of 988” on the horizon. The Promise of 988 of the National Action Alliance and partner organizations brings the National Suicide Prevention Lifeline to a three-digit number but offers so much more in its goal of “crisis care for everyone, everywhere, every time.” Finally, this paper provides specific caveats and information regarding the management of high-risk situations where law enforcement will likely be involved, where tragedy can ensue if not considered carefully.

Early Models of Successful Community Engagement in Emergency Responding: Pittsburgh’s Freedom House Example

History provides examples of successful models of community engagement that enabled communities of color and others to reimagine health, safety, and well-being.
Freedom House emerged during the 1960s and 1970s spurred by persistent social inequality and the need for improved systems of emergency care. Pittsburgh’s Freedom House Ambulance Service was a novel, socio-medical program that not only displaced police officers from emergency medical response roles in which they were not effective but simultaneously set national standards for emergency medical services. Before Freedom House, most pre-hospital emergency care was provided by police officers and morticians without medical training that utilized a model that emphasized transportation without medical treatment.

President Lyndon B. Johnson’s Great Society initiatives, and specifically the War on Poverty’s Office of Economic Opportunity (OEO), supported programs “promoting public welfare, education, urban development and public health programs.” As police performed a large proportion of pre-hospital transport, Black citizens relied on them for transportation to local hospitals for medical care. Because of the historical discrimination against Black citizens at the hands of police, having Black community members provide prehospital transport held promise for better outcomes. Ultimately, the OEO recruited Black men and women from low-income neighborhoods in Pittsburgh and partnered with physicians from the University of Pittsburgh Medical Center. A concerned group of Black and White citizens approached Peter Safar, MD, perhaps best known for developing the principles of cardiopulmonary resuscitation, for counsel on equipping vehicles for medical transport. Safar agreed to train Black community members to provide prehospital transport, and the Freedom House ambulance service thus partnered with Safar and the University of Pittsburgh Medical Center. Through this partnership, Safar and his colleague Nancy Caroline, MD, trained a group of Black citizens from marginalized communities in Pittsburgh to become paramedics and pioneer the training and delivery of emergency medical services.

Freedom House proved enormously successful. It provided superior medical care compared to earlier models, and it advanced the development of a new cadre of emergency medical technicians as health care professionals. Freedom House improved the community morale for paramedics and Black and White citizens throughout Pittsburgh as a form of social enterprise. Despite these successes, however, racial discrimination and prejudice plagued the program. The program’s reliance on local, state, and federal funding made it susceptible to local challenges from predominantly White suburban police and fire departments. And the city government sponsored the creation of a majority White “superambulance” service. Although the city administration cited Freedom House’s cost as its rationale for deprioritizing the program, it simultaneously supported the more expensive “superambulance” program. As Edwards (2021) argues, with the shift to the “superambulance” program, the pre-hospital functions shifted to primarily white male professionals who came from neighborhoods outside their service areas. The history of Freedom House illustrates how community health programs can serve as better alternatives to policing and the ongoing dangers of racial inequities that can evolve in service delivery. As current crisis services expand, stakeholders cannot overlook the importance of the history of local citizens helping each other and of cultural competence in caring for community crisis needs.

The “Out-of-Hospital” or “Prehospital” Medical Response and growing “Out-of-Hospital” Behavioral Health Crisis Responses

The Freedom House initiative demonstrated the importance of delivering care early and where needed outside of hospital contexts. This approach is parallel to the idea of mobile crisis services that go to the scene of the behavioral health crisis to meet the needs of the individuals and avoid unnecessary hospitalization by taking steps to resolve the crisis in the most effective and least restrictive way possible. Whether providing emergency stabilization in trauma situations, administering life-saving
medications, or intubating on a scene, first responders employ a host of responses to care for individuals
in crisis. Local medical authorities dictate protocols used in a particular region. And the on-scene
responders—such as paramedics or emergency medical technicians—provide the local response under
that medical authority. With the expanded partnerships with behavioral health, more interventions
become possible.

Advances in behavioral health services are expanding this idea of behavioral health “out-of-hospital
approaches.” For example, for youth mobile crisis services in many jurisdictions, the delivery of in-home
supports and some post-crisis follow-up has advanced the continuum of crisis care delivery in behavioral
health. Massachusetts, spurred in part by the Rosie D litigation, and Connecticut with its youth Mobile
Crisis Intervention Services, are leading examples of such in-home and “out-of-hospital” interventions.

The CAHOOTS model (Crisis Assistance Helping Out on the Streets) has also received national attention
as the conversation about non-law enforcement responses has become louder. This program runs out of
Eugene and Springfield, Oregon, and was designed and implemented in the late 1980s as an alternative
to community police intervention to help persons in a mental health crisis, with substance use disorders
or facing homelessness. Two-person teams—often a nurse and a paramedic type responder trained to
deal with behavioral health crises—are sent to the scene of the crisis, where they provide trauma-
informed responses to attempt to resolve the situation. They only rarely must call the police.

New tools, technologies, and treatments, from telehealth to naloxone and buprenorphine induction for
opioid use disorder, dramatically reconfigure the types of care and aid individuals can receive
outside hospital settings. Perhaps nowhere is the capacity for the democratization of health care and
the expansion of access to life-saving treatments in mental health and substance use crisis response
more evident than in naloxone administration and efforts to help individuals with opioid use disorders
be linked to treatment from the emergency response. This opportunity has been aided in part by Good
Samaritan laws, which aim to reduce barriers to seeking emergency care. With the rise in opioid deaths
nationally, most states adopted some form of these Good Samaritan laws to all individuals aware of
someone’s opioid overdose to call for emergency assistance without fear of prosecution. The application
of life-saving technologies, aided in part by progressive laws meant to decriminalize substance use, in
some ways highlight a tension between the medical goals of emergency response and treatment and the
public safety goals of deterrence. These approaches, however, also further exemplify the promise of a
mobile response to a behavioral health crisis that can deliver immediate access to care—and eliminate
the necessity of a justice system response with the help of policies that align these practices.

Current and Emerging approaches to Crisis Calls: Taking Stock of 9-1-1 in
Envisioning 9-8-8

The task of aligning response systems highlights the organizational structures, interconnections and
jurisdictional variations between crisis services for individuals receiving public mental health supports,
emergency medical services, and law enforcement responses. These differences may be more apparent
when systems respond to catastrophic disasters or community behavioral crises. Across emergency
services as they exist today, all jurisdictions have identified “Public Safety Answering Points” or PSAPs,
which serve as a central hub where 911 calls are routed directly from the control center in each state.
There are primary PSAPs that get direct calls and secondary PSAPs to which calls are further routed. A
PSAP registry was started in 2003 by the FCC in December 2003 to gather data regarding the readiness
of the 911 system to respond to needs. When 911 is dialed, there is a triage decision in which the
caller is generally asked what type of emergency is taking place, with a determination made at that level.
as to whether to dispatch an EMS response, fire department, or law enforcement. For example, in the city of Rochester, when someone calls 911, a telecommunicator is considered the first link in what can be referred to as a medical survival chain. The telecommunicator is trained to ask questions and provide instructions to the caller, including talking the caller through situations ranging from CPR to childbirth while the caller waits for the proper assistance to arrive on the scene. The telecommunicator dispatches a responder to the scene using computerized systems.

As it has become clear that mental health situations require their own most appropriate, least restrictive available responses, some communities have been examining this triage process and determining how best to forge partnerships so that the law enforcement response is shifted from the default response to one that is there when needed. As such, some jurisdictions have opted to add a fourth option to the 911 call to determine if there is a mental health emergency. For example, the city of Austin in February 2021, implemented that fourth option for dispatch to ask emergency callers if their call was related to a need for mental health services. Moreover, many communities have developed mental health crisis access lines, which people (especially in the public behavioral health system) are given to call in case of a crisis. These behavioral health crisis lines may mobilize an alternative response of a mobile crisis intervention team of various designs that also intersect with police responses (Figure 1).

As noted in Crisis Services: Meeting Needs, Saving Lives, this growing development of mobile crisis responses across communities and partnerships with law enforcement is not a new area. In the last 20 years, one of the impetuses for this growth has been the national dialogue related to the Sequential Intercept Model, which added Intercept 0 as part of its framework to help communities specifically target the development of community crisis responses both as part of jail diversion and law enforcement deflection efforts. Studies have shown positive results related to jail diversion and reducing the likelihood of individuals with mental illness being routed to jail. These may include specialized responses such as those that involve a police-friendly crisis drop off point or police referral of an individual to a mental health specialist. Primers are available to illustrate examples of how these relationships between police and mental health systems have been operationalized and enacted around the country over several years. Many communities show tremendous growth in this area of mobile crisis response, and SAMHSA’s National...
Guidelines for Behavioral Health Crisis Care Best Practice Toolkit calls for ongoing efforts as part of advancing a crisis services continuum. Thus, in many communities, mobile crisis supports and stabilization services are becoming well-recognized and widespread.

The Vera Institute describes the police and community responders arranged on a continuum, with either a police-only response, a combined type of response, or a community-based non-law enforcement response to the crisis. These conceptualizations of a continuum present an interesting premise and one that can help a community conceptualize an infrastructure they are hoping to build. In a recent Open Minds executive briefing on “Building New Bridges,” author Monica Oss described several examples of innovative and hybrid approaches to behavioral health and law enforcement emerging across the country.

Because persons with disabilities warrant support rather than criminalization for the manifestations of their conditions, and the Americans with Disabilities Act and Olmstead v. L.C. dictate responses that provide reasonable accommodations and community-based alternatives, it is more critical than ever to ensure the most robust behavioral health response possible in communities around the country while intentionally planning how stakeholders might best construct a response and what roles each of the responders might play. To that end, there may be several aspects of the work that can help improve outcomes as partnerships are formed discussed below. Before one can get to these areas, however, it is important to review critical areas related to race and equity and high-risk encounters that crisis services will need the tools to tackle at this interface.

Mental Illness, Surveillance, and Policing in History and Addressing Race/Equity Challenges

When considering moving toward community-based interventions that may limit the role of the police, stakeholders can glean helpful lessons by understanding how historical efforts to address public safety needs have furthered structural inequities across communities. As historian Nic John Ramos writes in his history of racial liberalism in policing in California, many scholars and advocates viewed the community mental health movement as a “benevolent movement,” one that simultaneously paved the way for “new surveillance and policing strategies” such as broken windows theory. This theory of policing conferred a necessity to address even minor crimes such as vandalism to prevent a more serious crime. The broken windows theory was popularized in New York City during the 1970s and 1980s and it resulted in heavier policing in disadvantaged communities. On the other coast, psychiatrists at the University of California at Los Angeles similarly developed racially liberal approaches to policing. These approaches considered Black and White communities similar to each other regardless of what was happening in their respective communities. Despite these ostensibly progressive ideologies, scrutiny and surveillance for people of color continued to increase across the country, resulting in more “forms of incarceration, segregation and discrimination.” In arguing for racial sameness, these approaches showed the pitfalls of racial liberalism by enabling – and intentionally deprioritizing – the social structures and systems that reproduced poverty, health and socio-economic inequity in Black communities.

Partially in response to some of the civil unrest of the late 1960s, as Ramos argues, psychiatrists and social scientists pursued a unified agenda to “align anti-poverty policies with the community mental health movement and the movement for psychiatric deinstitutionalization.”
As large urban centers increased aggressive policing and surveillance efforts in underserved neighborhoods, however, the net effect of this change was that “rioting, crime, drug use, domestic abuse, and family dysfunction” were seen more as “race problems”\textsuperscript{39} than consequences of structural racism and discrimination.\textsuperscript{40} To this day, these critical infrastructure conceptualizations create disparate education, housing, employment, and mental health outcomes. As crisis services evolve to provide more just and equitable care for all who need it, these forms of structural problems will continue to create parallel systems if not attended to in a more intentional way moving forward.

Contemporary discourses on crisis services, law enforcement, and the potentials of the 988 federal mandate must consider issues of race, structural racism, justice, diversity, equity, and inclusion. Such a consideration highlights the importance of partnerships, policies and protocols. To be sure, there have been general disparities in police activity across multiple axes of difference, including race, gender, and mental health status. Individuals with a mental illness involved in police interactions are 16 times more likely to die during such interactions than individuals without mental illness.\textsuperscript{41,42} Even more devastating, Black people with mental illness are 2.8 times more likely to die than their White counterparts.\textsuperscript{43,44}

Structural racism explains not only why racially and ethnically oppressed groups have poorer health access, opportunities, and outcomes than their White counterparts,\textsuperscript{45} but also explains how racialized violence by police and others lead to lower rates of sanctions, penalties, and criminalization for law enforcement officer-related deaths.\textsuperscript{46} Racialized legal status, the legal classifications such as criminalization and immigration status that have a disproportionate effect on minority persons further reduce access to care, determine health outcomes, and shape the legal circumstances and life trajectories that many individuals with mental illness navigate each day.\textsuperscript{47,48}

Social inequality is behind much of these disparities, shaped by a longstanding history of structural racism. White Americans, for example, have a net worth nearly 10 times greater than their Black American counterparts.\textsuperscript{49} Historical practices of structural racism have reduced financial, residential, and occupational opportunities for minoritized persons in the United States. Exclusion from social and safety net programs,\textsuperscript{50} neoliberal contractions of social programs during the 1970s and 1980s,\textsuperscript{51} residential segregation driven partly by the Federal Housing Administration,\textsuperscript{52,53} and other forms of racial discrimination have contributed to the disparities in wealth accumulation in the United States.\textsuperscript{54} Residential segregation, a social determinant of health that impacts downstream factors including neighborhood quality and safety, access to food and resources, education,\textsuperscript{55} and the climate of police officer interactions, has been one of the strongest drivers of health inequities among African American populations.

People who are racially and ethnically oppressed have higher rates of chronic disease; experience earlier onset and increased severity of disease; are less likely to have access to medical care; receive poorer quality medical care than their White counterparts, are more likely to die prematurely from disease, and experience racism as a psychosocial stressor.\textsuperscript{56} The fact that nearly one-third, one-fifth, and one-fourth of Black, Latinx, and indigenous peoples, respectively, report not seeking medical care due to experiences of discrimination\textsuperscript{57} also raises concerns about associations between race, policing, and mental health. Consider a recent study that found that police killings of unarmed Black Americans have “spillover effects” by increasing the number of poor mental health days. Black Americans who have faced discrimination in medical care may be less likely to seek care and are at greater risk of the deleterious mental health effects of police killings of unarmed Black Americans.\textsuperscript{58}
Disparities in mental health care go beyond experiences of interpersonal racism, extending into mental health care outcomes, policies, tools, and diagnostics. The overdiagnosis of schizophrenia among African American populations is well-documented. Research suggests that African Americans and other minority groups are more likely to present with different illness scripts, which likely increases the rate of misdiagnosis of schizophrenia. Moreover, mental health clinicians are less likely to elicit affective symptoms when evaluating patients, leading to twice the rate of misdiagnosis. Even when particular symptom pools are observed (i.e., psychosis), clinicians may over-value positive and negative symptoms in affective psychosis, leading to beliefs that mental illness among Black populations is more chronic and persistent. The perception of more severe mental disease leads to higher prescribed doses of antipsychotic medication and higher rates of medication-related adverse effects such as tardive dyskinesia. Therefore, it is not surprising that non-White patients have a greater incidence of restraints despite no difference in violence risk, and are more likely to be placed in restraints or seclusion when admitted to psychiatric emergency services.

Racial and mental health inequities help drive the penetration of African Americans and other racially and ethnically oppressed groups deeper into the forensic and criminal justice systems. Mental illness generally, and drug use and addiction in particular, are criminalized in the United States. This increased criminalization is more prevalent in communities of color vis-à-vis the compounding effects of structural racism and residential segregation. Consider the “two-tiered system” of substance use disorder treatment in the United States. Whereas office-based buprenorphine maintenance by monthly prescriptions is more heavily concentrated in higher-income predominantly White areas, DEA-regulated methadone clinics require daily observed dosing and is heavily concentrated in Black, Latinx, and low-income neighborhoods. Such disparities are enabled by the very logic of policymakers and advocates for mental health policy: In supporting the Drug Addiction and Treatment Act of 1999, one scientist testified that “[methadone]... tends to be concentrated in urban areas, [and] is a poor fit for the suburban spread of narcotic addiction.”

The history of mental health treatment in the United States helps explain the role that policing plays in considering how intersecting identities of being Black and having a mental illness shape outcomes for individuals. The deinstitutionalization of the 1970s that increased transitions of men and women from state psychiatric hospitals coincided temporally with the popularization of “tough-on-crime policing [that] began to drive up incarceration rates,” though, the relationship between these policies is more complicated than one might read in popular media. Nevertheless, for many different reasons, police have become increasingly more likely to engage with persons with mental illness as first-responders. Often referred to as “quasi-mental health professionals...street corner psychiatrists... and frontline mental health workers,” police officers have become an indispensable link in the community mental health system. It has been postulated that police would continue to serve in this role as long as the mental health system remained fragmented. Police frequently arrest homeless persons and individuals discharged from psychiatric treatment facilities, and most officers report responding to mental health crises on a weekly to monthly basis. Yet, police continually note a lack of adequate mental health training despite this vital function of their role.

Addressing longstanding and pervasive forms of structural violence and institutional racism will require active antiracist policies and programs that center the experiences and perspectives of marginalized populations. This includes an intentional focus on how stigma and mental illness further these disparities. Policies and practices should involve these communities as agents as was seen in the Freedom House initiative. There must be sufficient workforce diversity to ensure the healthcare system meets the needs of the communities it serves, such as a workforce that challenges the use of
race-neutral and racially liberal perspectives in diagnosis, treatment, policing, and research that fail to address the persistence of structural racism.  

**High-risk Situations**

Fragmentation across responders arriving on the scene of a crisis can contribute to chaos on the scene. There may be a deployment of any number of people and professional types that arrive at a scene including blue uniforms, white coats, and plain-clothed community responders. When law enforcement, emergency medical response, and mental health work together for situation resolution, even in high-risk situations, positive outcomes can be seen. For example, during the pandemic in Washtenaw County, Michigan, an armed man was reported to be having mental health challenges. The embedded community mental health clinicians and other responders assisted a local emergency law enforcement SWAT team in bringing all parties to safety after a 36-hour standoff. The heroic and coordinated response included leadership, patience and strategic planning.

Yet, first responders coming to a mental health crisis often come from siloed places and may be disconnected from each other, making such positive outcomes less likely. There are many lessons that can be learned from high-risk encounters between law enforcement and people with mental illness including those that have resulted in fatal shootings. At best, if well-coordinated and thoughtfully executed, there can be a calming effect on the situation. At worst, a situation can escalate with potentially avoidable dire consequences in the heat of the moment.

Most police officers will encounter an individual with mental illness, with estimates that one in ten police encounters involve someone with a mental illness. Yet, even with crisis services expanding, many police departments still lack a specialized system to handle issues specifically related to mental health situations. However, without specialized training, policies, or coordinated responses, police may not adequately adjust their techniques to appropriately address individuals' special behavioral considerations and capacities in mental health crises. Moreover, individuals with mental illness may not respond effectively to police commands, which may lead police to justify the escalation of force. Training typically focuses on awareness of mental illness, verbal skills, and crisis intervention and de-escalation strategies. Still, there are numerous challenges in the field, including working with psychiatric hospitalization involuntary commitment laws and navigating complex and high-risk situations. Despite advances in many areas, it is important to recognize situations that can arise that are too dangerous for anyone else. Preparation and acknowledgment that these situations can arise in communities are critical.

One example of a high-risk situation includes “suicide by cop” in addition to firearms or other serious weapon-related threats. “Suicide by cop” may also be referred to as “victim-precipitated homicide,” “law enforcement forced-assisted suicide,” and “law enforcement officer-assisted suicide.” This phenomenon occurs when a suicidal individual provokes deadly force from a law enforcement officer who is then compelled to act in self-defense or to protect public safety. Police officers may not be aware of their instrumental role in assisting an individual’s suicide at the time of an incident. One study found that psychiatric and medical illness and substance use accounted for 56% of victim-precipitated homicide involving police. Low socioeconomic background, criminal history, prior suicide attempts, and many other factors are strongly associated with these incidents.

Dewey and colleagues parsed suicide-by-cop cases into three subtypes: those involving mental illness, criminality, and those that were not otherwise specified. Each subtype showed differences in the levels
of substance use, symptoms of mental illness, or involvement of criminal behavior. The study further found that decreasing fragmentation between mental health and law enforcement might be one way to help with prevention.

In situations where police tragically shoot an individual, subsequent psychological autopsies may reveal more details about the police actions and the victim’s intent leading up to the incident. As emotional and political as it may be, it is critical to review and learn from high-risk encounters in “after-action reviews.” Litigation in this area is common, with one San Francisco case recently heard by the U.S. Supreme Court examining aspects of the Americans with Disabilities Act (ADA) concerning a police encounter with an individual with mental illness. Ultimately, the U.S. Supreme Court did not settle a dispute among the circuit courts regarding whether individuals could pursue a lawsuit under the ADA for an arrest that failed to provide accommodations for persons with disabilities. In the aftermath of the Court’s review, however, one author suggested a “sliding scale” of accommodations that increase as threats are diminished and a scene is more secured. This model presents an interesting way to consider reviewing incidents and training prospectively. By reviewing both positive and poor outcomes, crisis responders may improve the quality of responses and improve understanding of the role of mediation skills, emotional regulation, verbal de-escalation, and educating police about mental illness to reduce stigma.

Another example of high-risk situations includes hostage and barricade situations, which may also benefit from partnerships with mental health professionals. These partnerships already span decades, with one study dating back to 1993 showing that 39% of surveyed law enforcement hostage negotiation teams worked with mental health professionals and found improved results when doing so. In these settings, psychiatrists, psychologists, social workers, and other mental health clinicians may help assist in crisis negotiation, which typically involves verbal de-escalation to reduce emotional tension and acuity aimed at safe resolution of these situations. Psychiatrists and other mental health professionals consulting in crisis negotiations often serve in advisory capacities rather than negotiators. They may also participate in training, assessments, and debriefings. When mental health professionals are brought into these roles, it is important for them to receive training and to continue to practice within their ethical frames and avoid taking on quasi-law enforcement roles. Nonetheless, strengthening the crisis care continuum involves considering situations that can present high-risk scenarios where law enforcement will be instrumental in helping safety be realized.

**Bringing Lessons Forward: Importance of partnerships, policies, peers, and trauma-informed practices**

One of the most recognized law enforcement approaches to mental health crises involves the Crisis Intervention Team (CIT) model. Although originally seen more as a police-based specialized police response model, CIT International’s evolving protocols look to improve systems across multiple dimensions, including:

- increasing safety,
- increasing connections to mental health services for those who need them,
- only using law enforcement “strategically” in higher-risk or criminal encounters,
- increasing the roles of mental health professionals and peers,
- reducing trauma for individuals in crisis to help support their recovery.
CIT International recently issued its own “Best Practice Guide” to help foster communities attempting to meet these goals. Although formal CIT may not be suitable for every department and new models are emerging recognizing that CIT has its advantages and limits, there are many lessons that CIT can teach about building specialized services and establishing partnerships and community problem-solving. Furthermore, stakeholders, policymakers, and behavioral health specialists need more data about the effectiveness of CIT in reducing use-of-force outcomes.

Policies for emerging 988 response models will also need to be developed and can leverage lessons learned from CIT and other practices. Medical control authorities have very rigorous protocols for what types of interventions might warrant particular responses, such as medication administration, and these protocols for out of hospital responses can make life and death differences. Similarly, because crisis responses can involve managing exacerbations of serious mental illness or manifestations of behavioral dysregulation by individuals with other complex and co-occurring conditions, 988 responses will need to have sound clinical leadership to guide aspects of responses. Additionally, there will need to be protocols and policies that maximize safety, provide proper assessments, and help resolve crises in the least restrictive manner possible and are guided by mental health laws and general legal and regulatory provisions.

To implement effective responses, partnerships will be key. As described throughout this paper, partnerships have been evolving in numerous innovative ways. As noted by Oss, reports of law enforcement responding daily to overdoses and behavioral health crisis are creating an impetus for working together. Models of Law Enforcement Assisted Diversion, such as the program started in Seattle, Washington, and the Police Assisted Recovery and Addiction Initiative and the Angel Program originating in Gloucester, Massachusetts, both demonstrated how police can assist individuals with substance use disorders rather than arresting them. They both are excellent examples of law enforcement working at the substance use/crisis interface. Other examples highlighted by Oss and worth repeating include the District of Columbia’s Department of Behavioral Health’s pilot of sending an unarmed community response team to respond to behavioral health crises. This came as part of a recommendation from a police reform commission that examined practices in the District that realized that approximately 90 calls per day to police related to behavioral health crises. And New York released data showing that consumers were more likely to accept help from their Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot in Harlem, where emergency medical personnel and social workers responded to specific mental health emergency calls. This is a reminder of the importance of community interventions being culturally competent with the particular communities rather than over-relying on police just like the Freedom House ideas 50 years ago.

As these models emerge, staff development, recruitment, and retention are other critical issues facing law enforcement, emergency medical responders, and behavioral health. Priorities should include ensuring diversity and equity in the workforce while enhancing training and quality of services. Many of the populations of individuals encountering the crisis system, especially those at substance use, mental health, and criminal-legal system interface, may be challenging to engage. This may be especially true in communities with longstanding mistrust of the medical system. In those areas, there is a need to rebuild broken ties. These communities must enhance engagement strategies—learning in some ways from the Freedom House example or NAMI’s framework for engagement—to help attract people to services rather than inadvertently turning them off from the very supports they may need most.
Training can be a crucial area to help give law enforcement and first responders greater confidence and tools to help manage crises that they do encounter. It is critical that all parties receive sufficient training to be able to provide proper responses to behavioral health crises. Inadequate training in policing individuals with mental health is an ongoing issue, with one study going back over 15 years calling for training in topics including dangerousness, suicide by cop, decreasing suicide risk, mental health law, and liability [risk] management. Since the time of that survey, much has been done to enhance officer knowledge and skills. The International Association of Chiefs of Police OneMind Campaign aims to assist police in better preparedness for managing crises involving persons with mental illness or developmental disabilities. The Bureau of Justice Assistance has put forth a police mental health collaboration online toolkit. Law enforcement training is a cornerstone of the Crisis Intervention Team (CIT) model, which includes a robust 40-hour training curriculum that has shown effectiveness in several domains, including officers’ cognitive and attitudinal outcomes. Training may also help address compassion fatigue for law enforcement faced with recurring behavioral health issues in their communities, such as overdoses due to opioids. Training and protocols to answer crisis calls have also helped address suicide risk among crisis callers.

Training can also address issues of stigma. Police see skewed samples of the population because they are generally only involved when things are not going well. Despite data showing that only 3-5% of violence towards others is attributable to people with mental disorders, stigma persists about persons with mental illness and beliefs that they are more dangerous than the general population. This can impact how law enforcement officers might respond to an individual with mental illness in crisis. It is therefore critical that training involves education about the role of stigma in perceptions of violence and mental illness. Given the role of police in protecting all individuals, it is also essential for training to include information that individuals with mental illness are more likely to be victims of violent crime, theft, assault, and rape than be a perpetrator.

Lastly, training can also enhance community partnerships, especially when different disciplines train together. Michigan, for example, through its Mental Health Diversion Council, has been working with partners in behavioral health, law enforcement, and emergency medical responses to build out more recently updated cross-training for all three systems together.

Other specific approaches may also help improve outcomes in overall crisis service delivery. Trauma-informed services are recognized as increasingly important given the recognition of the high proportion of behavioral health- and justice systems-involved persons who have trauma histories both as victims of and witnesses to violence. Studies demonstrate that histories of childhood trauma contribute to more behavioral health challenges. SAMHSA has defined trauma by understanding the three “E’s” of events, experiences of the event(s), and the effect of those experiences on an individual. It has noted how people can recover and adapt with the right supports despite their traumatic experiences. In its guiding documents, SAMHSA further recommends that a system is trauma-informed through a framework of four “R’s,” which means that the system realizes the impact of trauma and the potential for recovery when it recognizes signs of trauma and responds by developing policies and practices to help avoid and resist retraumatization. For law enforcement working with emergency medical responders and behavioral health crisis response systems, these partnerships should aim to be trauma-informed.

Stakeholders must also address exposure to trauma among the workforce to provide the most responsive crisis services. First responders are at increased risk of mental health challenges related to their work, with high levels of exposure to traumatic events, challenges with their work schedules, and
general work-related stressors unique to their roles. Similarly, first responders and response teams have raised concerns about the impact of exposure to suicides in crisis work on their personal lives. Law enforcement officers are not immune from these experiences. Studies have shown them to be at increased risk of cardiovascular disease, psychological stress, and even suicide.

Several law enforcement programs around the country have recognized that their own risk of trauma can impact their well-being and have begun to implement peer support programs. For example, police in Miami-Dade, Florida, surveyed its police and fire departments to better understand how their workforce is dealing with post-traumatic stress disorder. As part of their efforts to expand CIT training, they have begun developing and delivering models to better support officer mental health. These models should be considered a basic necessity for all crisis responders—from call center employees to those out in the field delivering direct services. The experience of COVID-19 has further highlighted these needs.

Finally, there has been increasing attention to peer support engagement in the crisis response at the interface of law enforcement, mobile crisis teams, and emergency responders. The Boston Medical Center Emergency Services Program (BMC ESP) provides robust and integrated crisis services in several communities, including Boston, Cambridge, Somerville, and Fall River, and actively engages health professionals, mental health staff, and peer specialists to provide crisis services that “respect the dignity” of those served. A learning community to enhance and help train peer support professionals in crisis services is offered by C4 Innovations. Roles of “forensic peers”—those with criminal legal and behavioral health system personal experience has also been shown to have a role for individuals with co-occurring disorders in the justice system. Peer-led warmlines at the call center interface have also been promulgated, and NAMI has actively promoted these lines and disseminated information about them. History illustrates that peers can play a vital role in helping individuals in crisis and can assist at the law enforcement interface to extend the types of supports for individuals being served.

Conclusion

The promise of 988 reimagines an alternative pathway for individuals in crisis related to mental health, substance use, or other emotional challenges that will result in decreased suicides, safe crisis resolution, and linkage to needed treatments. In such a system, the role of law enforcement is de-emphasized in favor of utilizing responders through call centers and mobile teams along with emergency medical supports that can arrive on the scene as best equipped to manage mental health and substance use challenges in the community. This change is a critical step forward in reducing the numbers of individuals with behavioral health challenges from being arrested and needlessly criminalized and hopefully lowering the disproportionate numbers of individuals with mental illness whose lives end with encounters with law enforcement that have gone awry. In those situations, there are no winners, and the traumatic impact on communities of these incidents continues for generations. At the same time, law enforcement responders will always be needed for situations that are high-risk or where criminal conduct is an issue. As such, it is critical to enhance partnerships, develop policies, and plan for and support crisis services that acknowledge and coordinate roles of all responders. By taking these steps, the promise of 988 has greater potential to maximize safety while shaping improved outcomes that recognize the vulnerability of all humans to emotional crises and meet the unique needs of any individual in crisis, anywhere, at any time.
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