2-19-2023

Formation of a Mental Health Co-Responder Unit

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by

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February 2023

Submitted Concordia University, St. Paul, Minnesota

College of Humanities and Social Sciences

in Partial Fulfillment of the

Requirements for the Degree of

MASTERS OF ARTS CRIMINAL JUSTICE LEADERSHIP

Abstract

The current models of treating mentally ill people with police contact are not working and have never worked. Mentally ill people, or those in crisis, often slip through gaps in the criminal justice and hospital systems. It is time for criminal justice and medical treatment systems to work together to help those with mental illnesses.

Properly implemented programs and policies will allow officers to respond better to people experiencing a crisis. These programs, and ethically implemented policies, will enable officers to better serve people by getting them the necessary services while limiting the potential for using force, jail, and hospitalization. Additionally, these programs will offer a more complete level of service, looking beyond the immediate criminal act and examining the individuals and the services they require in an effort to reduce recidivism.

Keywords: Co-Responder, Mental health Crisis, Police.

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Formation of a Mental Health Co-Responder Unit

Since its inception, police in the United States have been called upon to solve all of society's problems; this may range from a simple neighbor dispute to a homicide investigation. However, it seems no call has increased in frequency and scrutiny more than a mental health crisis call. Tragically, these calls have led to uses of force and even deaths that may have been avoidable had additional resources and training been provided to the officers.

With the increased risk of injuries, death, and litigation when dealing with people suffering a mental health crisis, some agencies are beginning to question why they even go if there was no criminal act. In fact, some police agencies have stopped sending officers to calls for service involving people experiencing mental health crises unless they pose a risk to others. Simply ignoring the issues at hand will not help the community solve the problems of people suffering from mental health crises. Instead, ignoring the issues will only further exacerbate the mental health crisis. Instead, developing a proven mental health co-responder unit will allow police officers to build de-escalation skills and help people suffering from mental health issues navigate the complicated process of seeking professional help. This issue can no longer be ignored or viewed as a task that patrol officers must navigate on their own. Resources must be designated to navigate the vast complexities of seeking mental health aid for those in crisis.

Background

Mental illness is not a new phenomenon or something that will disappear over time. However, the criminal justice system's responses to it can be changed to impact people with mental illness positively. The National Alliance on Mental Illness (2023) finds that one in five or twenty-one percent of the United States population suffers from a serious mental illness yearly. This number represents almost fifty-three million people. This is a significant amount of the

population and a number that the criminal justice system can no longer turn a blind eye towards. Instead, leaders need to focus their efforts on better serving this population and examine ways to reduce the recidivism they experience in the criminal justice system.

In addition to better serving the community by providing appropriate mental health services and allowing those suffering mental health crises to receive proper treatment, a mental health co-responder unit will have cost savings benefit to organizations. This cost savings will be accomplished by reducing the number of repeated calls for service associated with mental health crises. This reduction in repeated calls will allow officers more time to deal with more "*traditional"* roles expected of police officers. This reduction will also help the court systems and jails as they will deal less with repeat offenders who are better served through mental health services.

Statement of the Problem

Police officers are often viewed as black and white servants of the public who go out and hunt down criminals. While this may seem glorified to the public and make for compelling television and movies, it is a mere sliver of what police officers actually do in their day-to-date jobs. The reality of policing is that officers are often expected to deal with civil issues, parking issues, and many other non-criminal acts. Additionally, police officers have been expected to pick up the slack for the understaffed mental health services provided in the United States. The lack of proper mental health services available in the United States has often forced police officers to deal with those suffering from mental health crises on the streets and in public. However, the vast majority of police officers have received little to no training in dealing with the complexities associated with mental health crisis calls.

Often police officers are able to find amicable solutions to mental health crisis calls by having people talk to mental health care providers over the telephone or have them transported to a hospital emergency room to be examined by a doctor. Conversely, if a person poses a threat to themselves or threatens to use a weapon, the situation can become dangerous. In these instances, police officers often call-in significant resources to save the person's life. This addition of resources may actually increase the chances of harm to the person suffering a mental health crisis. Also, police officers may open themselves up to significant legal issues as there are court rulings outlining that the government has no duty to protect someone from private violence (Deshaney v. Winnebago County, 489 U.S. 189, n.d.). Due to this increased risk, some officers and agencies have begun walking away entirely or not even responding to these calls for service. The appropriate response to these tense and often confusing calls is an ethical dilemma that needs to be examined.

Conclusion

How can law enforcement change the response to mental health crisis calls to serve police officers, the community, and those suffering from a mental health crisis better? Does combining the efforts of police officers, mental health care providers, ambulance staff, and emergency care providers formulate a better system of initial response and follow-up to those suffering from mental health crises? This can be accomplished by creating a proper mental health care unit. This paper will examine how other agencies throughout the United States and other nations have worked to achieve this goal. It will also examine the benefits for all stakeholders, patients, agencies, emergency medical staff, and mental health care providers.

Chapter 2: Review of the Literature

Administrative lens view in creating a Mental Health Co-Responder Unit

Creating and implementing a new mental health co-responder unit will be met with pushback and challenges. It is well known that law enforcement is and has been difficult to change. Many factors contribute to this resistance to change, including the officers themselves. Another concern facing the implementation of a co-responder unit is the lack of budget and staff. All of this combined has created an environment in which police officers are often forced to spend minimal time on calls and work to develop the quickest and most efficient solution to a problem. Working to combat the root issues causing someone to suffer from mental health illness will have a more desirable, longer-lasting outcome.

The need to implement these changes far outweighs the desire to remain in the status quo. Police are dealing with mental health calls more frequently than they have in the past. A Minneapolis Police Conduct Commission notes, "Over the past decade, attention and concern has grown regarding law enforcement interactions with those displaying symptoms of mental illness" (Minneapolis Police Conduct Oversight Commission, 2016, p. 4). The same study also informs us that police fail to provide adequate services to those experiencing mental health crises. These people often end up incarcerated rather than receiving the medical or social services they more than likely need. It is estimated that seven to ten percent of all police calls involve someone suffering a mental health illness(Minneapolis Police Conduct Oversight Commission, 2016, p. 4).

Before broadly implementing a change in policy or introducing an entirely new way of operation, agencies will need to examine how prepared they are for a change. A shift from traditional criminal justice response may seem difficult to some officers due to a co-responder

model not solely focusing on criminal matters. These criminal matters have been the conventional standard success metrics in most police departments. Instead, the co-responder model will focus on solving mental illness root issues leading to fewer crimes and calls for service for the mentally ill. As noted by the Justice System Partners, ten steps to system change, "To be truly effective, most intervention programs need to take place within a framework that supports ongoing excellence, even under varying circumstances. Sometimes this requires fundamental system change" (p.1).

The agency's leadership will need to have a clear and articulable definition of the program and explain the implementation process. To accomplish this, senior administration will have to first show the need for such a drastic change while also showing its positive effects from other studies. Once this information has been attained, the best course of action will be for the senior leadership to explain this information to all front-line supervisors and work with them to determine the most effective roll-out and training methods for all staff. Justice System Partners (2015) recommends speaking with other leaders at different agencies or peers in addition to these methods. This is often an effective method, as peers may have already laid some of the foundations for the work that will need to be done. In addition to speaking with peers, leaders should seek out community input and involvement (p. 2). Community input and involvement are the cornerstones of community policing. Also, with the current events occurring throughout the nation since 2020, having community input will be beneficial to seek proper funding and implementation of a co-responder mental health unit. An additional benefit to having community input and involvement will be opening new communication and information-sharing pathways that you may not have otherwise had.

A successful method of change may model itself using the Justice System Partners, "Ten Steps To System Change". This model notes, "If leaders in your local system are ready for change, they can take ten critical steps, …for system improvement" (Justice System Partners, 2015, p. 2). The ten-step system uses collaboration, leadership, analytics, engagement, planning, implementation, innovation, alignment, reflection, and improvement.

The first step in this system, collaboration, is what the co-responder unit implementation will be based on. For any co-responder unit to function, criminal justice leaders must work with mental health professionals and medical professionals to develop strong working relationships which will serve their communities better. The PACER model study in Australia is an excellent example of how these community partnerships and collaborations are so effective. This study examined the effectiveness of mental health care providers traveling to police calls with emergency department admittance data. "The project succeeded in developing a local partnership service based on the adaptation of overseas models. It also had a significant impact on improving the timeliness of care pathways and diversions from Eds." (Scott & Meehan, 2017, p. 522). The shared success in this program models the benefits of true collaboration and demonstrates the need to develop a wide range of stakeholders.

After the collaboration, leading is the next step in this system. Leading is a vital piece of the puzzle when implementing a new system or a prominent change agent within any organization. The leaders are the ones who will pave the path for change and express how the change will be implemented. "Leaders also act as change agents within their own agencies, establishing a vision for change; nurturing that visions through communication, education, and implementation" (Justice System Partners, 2015, p. 2). Justice System Partners explains that

leaders will continually evaluate what needs to be done to accomplish changes within an organization through this process. The goal is better service and achieving shared goals.

Analytics will be a significant factor in implementing a mental health co-responder unit. Justice System Partners (2015), notes that data will guide the most effective systematic changes. Through this process, leaders will need to continually analyze the data to determine what is and is not working. Many factors will be used to determine what is and is not successful with the implementation of the mental health co-responder unit. The first thing that must be addressed is the basic fact that the decreased use of this unit is the actual goal, unlike most metrics. This idea is counterintuitive to many measures of success. The true end goal of this unit would be to have all consumers successfully navigate their own care systems to successfully treat themselves and not call upon the police regarding any suicidal ideations or acting out in criminal ways tied to their mental health illnesses. Another matrix for success in this program is decreased use of force and/or SWAT deployments. A ten-year study on the implementation of the state of Colorado's Crisis Intervention Team concluded, "Use of force or SWAT, arrests, and injuries were infrequent. Suicide risk, psychiatric illness, and substance abuse, even in the presence of a weapon or violence threat, increased the odds of transfer to treatment, whereas suicide risk lowered the odds of transfer to jail" (Khalsa et al., 2018, p. 1).

This information is detailed in the table bel

TABLE 1. Association of factors related to incidents involving individuals who were the subject of a crisis call and disposition of the call

	Home/other[a]			Medical/psychiatric			Jail		
Factor	Exp (β)[b]	95% CI	p	Exp (β)[b]	95% CI	p	Exp (β)[b]	95% CI	p
Suicide[c]	.46	.20–1.09	.08	2.18	1.92–2.48	<.001	.69	.48–.98	.04
Mental illness[d]	1.14	.44–2.94	.79	2.54	2.12–3.03	<.001	.90	.60–1.36	.63
Violence[e]	.54	.21–1.43	.22	1.22	1.06–1.41	.006	3.46	2.55–4.69	<.001
Weapon[f]	1.20	.49–2.96	.69	1.78	1.57–2.02	<.001	1.41	1.00–1.97	.05
Drugs or alcohol[g]	.54	.22–1.30	.17	1.50	1.34–1.68	<.001	1.65	1.22–2.23	.001

[a] Incident was resolved at home, or subject of call was transferred to home
[b] Relative risk ratio for comparison with base outcome of "no transfer required." Overall model: χ^2=821.1, df=15, p≤.001
[c] Threats, attempts, any suicide risk, or original complaint
[d] Family or officer judgment, any psychiatric illness, original complaint, or mental health hold
[e] Threatened self or others, threatened police, original complaint of assault, excluding domestic violence, which by Colorado law requires arrest
[f] Includes edged weapon, overdose, firearm, asphyxiation, motor vehicle, jumper, "suicide by cop," and any or more than one weapon
[g] On the basis of officer judgment

ow.

This detailed analytic information is the critical information leaders will need to help guide the implementation process of a new unit. Through the process of analytics, they can determine the proper funding and guidance of the unit and seek additional information needed to serve the agency and the community better.

Community engagement is necessary at all levels when implementing this new complex change of a co-responder unit. The agency must incorporate all those affected by the co-responder unit. Justice System Partners describes how critical it will be to identify all affected by this system-wide change and ensure they understand the change. Implementing a mental health co-responder unit will affect more than just the officers working for the agency. The department will need to first partner with the mental health professionals who will be responding to the scene with officers to develop a mission/ goal statement.

Additionally, the department should work with local mental health care providers to develop a care pathway to serve those with mental illness better. This increased service will help eliminate hurdles those patients would receive in getting their care. Scott and Meehan (2017)

noted the importance of front-loading follow-up care from known mental health providers for patients who needed acute care in an emergency department (p.522). Through these partnerships, the co-responder units and hospitals can communicate more freely to establish better pathways to care.

The fifth step is the detailed plan which will help navigate the implementation of the co-responder mental health unit. Of course, ensuring the agency has a comprehensive overall plan and strategy which will engage all partners is essential. Justice System Partners, however, note the importance of having a day-to-day plan, "equally important are the supporting tactical plans, which detail the day-to-day steps of implementation" (Justice System Partners, 2015, p. 3). These tactical plans or day-to-day operations detail how the co-responder unit will function. It is essential to get operational input from the front-line supervisors and staff of all agencies working in the new co-responder unit.

One of the critical factors in any system is the implementation of the change. With the implementation of the co-responder model, leaders will need to review existing policies and laws to ensure they are setting up programs for long-term success. Stojkovic et al. (2014), also describes the importance of improving criminal justice decisions, with one of the key factors being that decisions should always contribute to future decisions (pp. 373-374). The decisions made during this implementation phase of the co-responder model must benefit the department now and in the future. One way a department can be improved now and, in the future, will be to increase crisis intervention training for all officers. This training will benefit all staff and the public. There have been noted reductions in the use of force and injuries to officers and subjects when officers trained in crisis intervention deal with people in crisis (Khalsa et al., 2018). An additional benefit is how "CIT has been shown to have some measurable positive effects mainly

in the area of officer level outcome. These include increased officer satisfaction and self-perception in the reduction in the use of force" (Rogers et al., 2019, p. 5). The crisis unit's implementation must consist of collaborative cross-training between police and mental health professionals. This training may be coordinated in daily or weekly training until both sides are brought up to an operational level. Once this has been completed, the remainder of the department should continue to train with at least the minimum licensing standards for crisis intervention; however, this can be supplemented via in-house crisis training led by the department crisis unit.

The seventh step of innovation will help define the problem and how we will work to solve the problem of mental illness and its impacts on the criminal justice system. Justice System Partners (2015) notes leaders will need to explore what information already exists and develop creative approaches to garner implementation support and evaluate the impact of changes. With abundant information about the best strategies to treat those suffering from mental illness, police leaders will not need to invent a new treatment method. Instead, leaders must examine at how they can improve the use of police and mental health services to those in need in innovative ways. The agency will establish a clear operating policy by implementing a co-responder unit. However, agencies will also need to create a matrix to determine how the unit's innovations are functioning and working. The evaluation will be accomplished by examining how often those who have a mental illness call the police for services or how often others call on them to receive police services. As previously noted, the goal is to reduce the need for people with mental illness to require police interventions. In evaluating a co-responder model out of Australia by Scott and Meehan (2017), it was noted there was relatively good success in reducing repeating clients. They noted 171 calls for service during this trial, with only 21 secondary calls and only 5 total

calls requiring three or more service visits. See table 1 below for a further breakdown of information from this study (Huppert & Griffiths p. 522).

Table 1. Demographics and response data

Total jobs (235)	
Attended jobs	171
Phone advice	64
Requests	279
Average requests per day	3.1
Time PACER spent from initial call to cleared time	
<0.5 h	34%
0.5-1h	27%
1-1.5h	16%
> 1.5h	22%
Demographics	
Male	58%
Female	42%
<18 years	13%
18–29 years	26%
30–39 years	20%
40–49 years	15%
50–59 years	10%
60+ years	11%
Previous contact with:	
Police	16%
Mental health	10%
Police and mental health	38%
Not specified	36%
Contact during PACER trial	
Two occasions	21 people
Three occasions	4 people
Four occasions	1 person
Diagnoses identified	
Mental illness	28%,
Dual diagnosis	19%
Drug affected/poly-substance use	10%
Alcohol affected	8%
Intellectual disability	8%
Dual disability	5%
Location	
Residence	63%
Public place	20%
Police station	9%
Outcomes	
Admitted (ED)	27%
No action	23%
Referred	17%
Intervention strategy developed	17%
Taken into custody	8%

PACER: Police Ambulance Crisis Emergency Response; ED: Emergency Department.

The eighth step for implementing the co-responder unit will be alignment. The department will work to get the appropriate staffing levels to support the unit. Justice System Partners (2015), notes, "all business practices need to support system goals" (p. 4). For this to happen in an agency, the agency will first need to acquire the staff and training required to start the unit then get the staff trained to fulfill the goals established by the department leaders for the co-responder unit.

Once the co-responder unit has been established and working, leadership must complete step nine by reflecting on how the program is operating and if the unit is working towards achieving its goals. As noted in Justice System Partners (2015), departments will also check to see what opportunities are available to improve or enhance. Suppose the agency is not seeing any impact on repeated calls for service or a decrease in the use of force related to mentally ill

clients. In that case, the agency must seek further input from related literature. Additionally, leaders must be open to tweaking policies and procedures to improve this unit.

The final step in the process for any agency is to improve. When using this step in the extent of a co-responder unit, agencies will have to ensure they are continually looking to implement the most up-to-date practices. This is something officers may struggle with as they are comfortable doing things "*the way they have always done them*." While the program will be new today, eventually, it will become standard practice in the department. For this reason, leadership must continually evaluate these practices. "Systems must continue to refine their strategies and tactics as new challenges emerge, innovations are evaluated, and the body of research grows" (Justice System Partners, 2015, p. 5).

Setbacks that hinder the proper implementation of a co-responder unit must also be acknowledged. Any government agency seeking funding to start a new unit is an enormous task. Political capital may need to be expended; however, this is a reasonable idea to move the agency's goals forward. "Leaders need to develop a high level of sophistication about the organization's political and task environments to be successful change agents. Potential stakeholders, allies, threats, and opportunities must be recognized" (Stojkovic et al., 2014, p. 443). We will raise funding to create the co-responder unit and properly implement it using this philosophy.

Ethical Considerations in Creating a Mental Health Co-Responder Unit

Creating a new mental health co-responder unit for a law enforcement agency will face many challenges. This will come from both internal and external factors for the agency. Internal challenges will arise at many levels throughout the organization. First, officers may resist change in their work style and the culture of their policing. This resistance can result from several

factors, including not wanting to learn new methods for handling calls. For years, officers have been forced to handle calls for service in a manner that focused on safety for them and the public while ensuring they could resolve the issue quickly. This is due to many police agencies often having limited staff and resources. Another internal stressor to creating a new unit will be the limited number of officers available to the agency. To combat this, leaders should plan to expend political capital to focus on securing additional staff and resources to be directed to the new unit.

External factors limiting the push to create a new mental health co-responder unit include various stakeholders with competing interests. Some stakeholders believe that police should not be a part of these mental health response units for various reasons. Turner (2022) considers the mere presence of police officers can have a detrimental impact on the outcome of mental health calls. While other stakeholders, such as doctors, may want to avoid working with the police for various moral or ethical reasons they subscribe to. This is undoubtedly related to the harm they have seen occur from police to the patients they would be trying to serve. However, this is a flawed methodology, which will most certainly lead to additional calls for service as the person suffering the crisis will not receive proper care. Additionally, this will create more patient service calls, leading to increased police contact. However, if the police are able to work with a well-rounded co-responder team, there will be a high level of service, leading to decreased recidivism, as found in Huppert and Griffiths (2015) PACER study.

So why should law enforcement officers work to improve our response when we already know we will face pushback from both internal and external forces? Because police officers are bound by an ethical duty to care for all they serve. In recent years there has been a nationwide push to reduce law enforcement interactions with those experiencing a mental health crisis. This response has varied from managing these incidents via the phone or crisis call centers to simply

refusing to respond if the situation poses no immediate risk to others. Both approaches pose several real-life challenges to the ethical and moral duty imposed on law enforcement officers. This is because police officers are obligated to protect people and make efforts to save lives while ensuring they work to de-escalate people in crisis.

All law enforcement agencies need to develop and fund a proper mental health co-responder unit to better serve the community. This unit will need to consist of police officers trained to work with people experiencing mental health crises, a social worker, and a medical professional trained in mental health related issues. Knowing these calls account for many calls for service, police leaders have an ethical obligation to develop ways to deal with them appropriately. The next section will further explore the ethical duty imposed on law enforcement leaders to work to create these units.

The career of law enforcement has changed since its inception. Many of the changes have been beneficial to both the public and officers. The invention of body armor, the shift to community-based policing, and many more changes have helped to create a better profession for officers. However, taking on additional public issues, such as mental health, has created significant problems for the law enforcement community. Shortly after losing five officers in a shooting rampage Chief David Brown stated, "We're asking cops to do too much in this country. We are. Every societal failure, we put it off on the cops to solve. Not enough mental health funding, let the cops handle it. Here in Dallas, we got a loose dog problem; let's have the cops chase the loose dogs. Schools fail, let's give it to the cops. That's too much to ask. Policing was never meant to solve all those problems (Dennis et al., 2016, para. 3).

Chief Brown is correct in his assessment that police are not equipped to tackle the mental health crisis plaguing our nation. For years, the task of dealing with mentally ill people has fallen

on patrol officers, who have received little to no training in mental health calls. This task must be aided by adequately trained mental health officers and mental health co-responder units comprised of mental health care professionals and doctors. These units have a proven track record of reducing physical harm to the person experiencing a mental health crisis. Officers who have received even minimal training in dealing with mental health crisis calls have shown a reduction in the use of force or reliance of SWAT teams on armed barricaded individuals (Khalsa et al., 2018). Another study out of Australia applied similar tactics when responding to mental health crisis calls. This study not only showed a reduction of harm risk to mental health patients but also revealed a reduced workload for officers and medical staff. This study also revealed a reduced demand for emergency room services required by mentally ill patients (Huppet & Griffiths, 2015).

Without the assistance of trained mental health care providers and officers, many departments face a moral and ethical dilemma when handling mental health calls. This ethical dilemma is especially true when the person threatens to kill themselves. In years past, departments would respond to calls of suicidal people who may be armed with a knife or a gun. These incidents often turned into long, drawn-out events that sadly often ended with the officers shooting the suicidal person. In recent years, many police departments have shifted away from this response, especially when the suicidal person is alone in their home. This precedent has been set forward as the Supreme Court has found that the government has no duty to protect a private citizen from private violence (Deshaney v. Winnebago County, 489 U.S. 189, n.d.). This decision would be especially true when this private violence is self-inflicted.

This new moral and ethical dilemma has created a situation in which officers may be working to protect a life that does not desire to be protected. Additionally, these officers may be

open to civil liabilities for the actions taken when dealing with a suicidal person. For these reasons, many criminal justice leaders believe officers should not act in these situations if officers have no legal requirement. However, this logic and way of thinking are ethically flawed and contradict law enforcement's mission of helping people. The justification for this way of thinking has been identified by Pollock (2021) as bounded ethicality. This concept allows for cognitive structuring (justification) to make decisions using variables that do not include ethics (p. 77). In this instance of mental health crisis calls, many police leaders would only consider the liability of action versus inaction in dealing with someone in crisis. While a situation may often resolve itself, for the time being, the base cause of the issue has not been dealt with, and the problems will arise later.

To truly consider the moral and ethical risks or implications, leaders must consider all the risks associated with their decisions and actions or their inaction. When examining the risk associated with mental health calls, , it is often believed all of the risks are linked to the person in crisis. However, there are times when the person in crisis may turn their ideations to another person or persons. This risk could include shooting indiscriminately in public or setting a home on fire. While no person can predict the future to know if the officers should stay at the scene or back away, it is important to have good guiding policies about responding to mental health calls. These policies will also help guide law enforcement officers to make better ethical decisions considering the liability of a decision and its ethical soundness.

When responding to mental health crisis calls, criminal justice leaders should ensure they make every reasonable effort to help the person in crisis. Additionally, leaders should look for innovative ways to solve the crisis calls, including providing a co-responder response and officers trained in de-escalation. This response style has been shown to reduce the risk of injury,

as found in the Khalsa et al. (2018) study of mental health response and in Rogers et al. (2019). Furthermore, criminal justice leaders should seek the public's input about how they wish to see these situations handled and their expectations from the criminal justice agency.

Criminal justice leaders must ensure that others within the organization are provided with clear guiding principles and ethics codes to help guide staff when dealing with complex legal situations. Providing and fostering an ethically sound policy manual will help shape the minds of employees and ease the internal tension they may feel while determining the best courses of action. Ethically sound policies should continually be reviewed and updated to reflect the current moral fabric of the community.

With a clearly defined ethical dilemma, criminal justice leaders must develop and implement a plan of action to account for the ethical situations surrounding mental health crisis calls. This plan must account for community expectations and the legality of officers' actions. This plan will be accomplished through continued education and training, which are imperative to ensure employees understand the complexities of ethically defensible and sound actions. These policies should be at the forefront of the decision and actions of all employees, and violations of these moral codes will need to be addressed no matter the position or history of the employee.

Implementing a new mental health co-responder policy will be essential for any criminal justice leader. One may think this is a simple task, and you will need to create a policy that ensures employees do not break any law. However, as Fugate (2015) has informed readers that having legally defensible policies is the lowest bar one can set. Instead, criminal justice leaders need to examine all aspects of policies and the considerations that go into ethical decisions. In doing this, leaders must implement a policy that guides the ethical decision-making for staff and

addresses the fact that time and available information will dictate how they may make more ethical choices.

To develop and implement an ethically sound policy for a mental health co-responder unit, the agency will need to formulate a workgroup to help implement the action plan. This workgroup will need people of varied backgrounds and community members who may be affected by the unit's implementation, such as emergency medical services, mental health providers, and the department's legal counsel.

This working group should meet twice a month to review tasks and policy implementations. As staff and community work toward creating and fostering ethical sound actions and principles, the bounds in which policies have been created may need to shift. In these scenarios, it will be essential to ensure the policy is morally defensible while also working to stay within the bounds of the procedural justice values, as stated by Pollock (2021).

Once the group has been established, the leader of the criminal justice agency will have to approve the implementation of a policy that would address all the following factors; the proper initial response to mental health calls, specifically those threatening suicide, determine the appropriate risk mitigation for all involved, when and how to involve mental health responders or other community groups trained in mental health care. The criminal justice leader will also need to address proper ethical ideals that factor all lives in the decisions making process. Finally, the leader and group will need to develop an appropriate training program to establish the mental health co-responder unit. These policies should also establish mental health training for all staff, including de-escalation and crisis intervention.

Implementing any new unit will significantly impact a criminal justice agency and the community. The creation of a new unit can occur in a few ways. First, the criminal justice

organization will have to take bodies from one unit and move them to another. Another way this can occur would be by adding staff. When examining these options, the criminal justice leader must consider many factors and how they will affect their staff, peers, and the community.

When considering moving staff, a criminal justice leader will need to examine the impact this could have on services provided to the community and weigh that against the new or preconceived benefits of adding a co-responder mental health unit. While many would immediately see this staff shifting as an issue that could reduce other police services. However, the PACER study by Huppert and Griffiths (2015) found that when these mental health calls are properly handled, there is a reduction in repeat calls for services. Applying this information, one could argue that while the short-term loss of service may occur, the long-term benefit of an overall reduction of calls could be more beneficial. This teleological application of staff movement may be the best option for departments struggling with budgets or staff shortages (Bourgon, 2013, p. 77).

The second way the new co-responder unit could be created would be by adding staff. While this may be hard for some departments to justify due to the upfront investment, criminal justice leaders should evaluate the overall cost analysis, not just the employment costs. When adding additional staff for a mental health co-responder unit, criminal justice leaders will also need to consider the costs of reduced litigation for decreased uses of force, reduction in repeat calls for service, and lowered incarceration rates for those suffering a mental health crisis. The study by Khalsa et al. (2018) found the "use of force or SWAT, arrests and injuries were infrequent. Suicide risk, psychiatric illness, and substance abuse, even in the presence of a weapon or violence threat, increased the odds of transfer to treatment, whereas suicide risk lowered the odds of transfer to jail" (p. 1).

While the initial investment may be significant for an agency, the overall implementation may have financial benefits. This investment will also provide the best ethically sound option for criminal justice organizations as it can help reduce costs, and provide the best care.

After careful review and extensive training, implementing this policy and action plan will have to be phased in over time. The goal will be to create an environment and culture using the "consensus paradigm", in which Pollock (2021) explains the community and department members "have similar beliefs, values, goals and societal laws that reflect the majority view (p. 181).

While the law clearly states that the government has no legal duty to protect suicidal people, officers have taken an oath to protect and serve the public. By these, officers are morally bound to try to help individuals experiencing a mental health crisis. While the approach may vary from agency to agency, officers do need to make an effort to provide some care. This care could be as simple as trying to talk to the person on the phone. The most successful option; however, is implementing a co-responder unit of trained officers, medical and mental health professionals, and training officers in mental health de-escalation.

Opposition to the formation of such a unit will occur due to the polarizing belief in police involvement in mental health calls for service. The resistance to forming such a unit will come from all stakeholders, police officers, police administration, community members, and mental health care providers. This hesitation can be due to the above-described budgetary issues or the notion by police officers that they should not be taking on additional tasks. However, one of the major resistors to the formation and implementation of a mental health co-responder unit may be from the public and some mental health care providers who believe that the mere presence of a police officer will only worsen the chance of rapport. In his reporting, Nicholas Turner discusses

the formation of a similar style unit; however, it does not include any police officers. "Even in situations in which police officers have completed relevant training, the mere presence of armed, uniformed officers can exacerbate the feelings of distress for people with behavioral health conditions" (Turner, 2022, para. 5). Turner goes on to discuss how a recent study of 911 calls for service in eight (undefined) cities found between twenty-one and thirty-eight percent of 911 calls were related to mental health, substance abuse, homelessness and other quality of life issues. With a large percentage of these calls seeming to relate to untraditional or non-criminal matters, some also believe the police have no role in the response to these calls for service. Turner also discusses the successes of these programs in places like Eugene, Oregon; San Francisco, California; Denver, Colorado and Olympia, Washington. All of these units consist of people who have some level of knowledge in dealing with people experiencing mental health crises, homelessness, or drug-related issues. Some of these units also include people who have past experiences with these issues (Turner, 2022).

While these services are helpful and can lead to successful outcomes for those who accept them, Turner fails to acknowledge the important role police may play as a stakeholder in these calls for service. While one specific 911 call may relate to homelessness, drug issues, or a mental health crisis, police officers will often get called to have interactions with the same people for differing issues, some civil and some criminal. As a stakeholder in the community, police officers need to be kept abreast of information regarding someone's mental health whenever possible. Simply excluding police will only exacerbate the issues when untrained police officers knowingly or unknowingly encounter someone who is experiencing a mental health crisis. Additionally, there are many safety concerns surrounding a response team with no police response. These safety concerns arise as there are times when someone experiencing a

mental health crisis may exhibit unpredictable and violent behavior toward others. While the primary goal of a co-responder mental health unit is to provide a better and more complete level of service to those experiencing a mental health crisis, there is certainly a level of safety that police officers must uphold. To fail to provide this level of service and safety would not be an ethical action as it may lead to placing innocent people at risk of being harmed.

There may not be a perfect method to handle every call for service, especially those as complex as a mental health crisis, there are certainly ways that we can increase the level of service while also increasing the odds of a safe outcome for all involved in the process. To accomplish this, law enforcement leaders need to continually work to seek better outcomes and resources concerning mental health crises. This plan should include community input on what is expected of the agencies operating the co-responder units. The plan should also address the concerns stakeholders may have when opposing the creation of a new unit or the involvement of police in mental health services. The plan should also include using political capital to push the need for funding to add more resources to a problem that has been thrust onto untrained police officers. The time for continuing business as normal or burying your head in the sand to ignore the issue is over. Leaders must ensure they are providing their staff with ethical resources and training to deal with the many complexities surrounding these often-difficult calls for service.

Implementing Change

With so many calls for service related to people experiencing mental health crises, there has been a significant increase in mentally ill, court, jail, and prison populations. This increase in calls for service not only raises the chances for violent police confrontations but also hinders the availability of courts, jails, and prisons to focus on criminal matters and treat those who have violated criminal laws.

Currently, police, courts, and prisons cannot serve people who are suffering from mental illnesses adequately. Additionally, this should not be a task that the criminal justice system should handle. However, there is a significant shortage of mental health care providers available to treat those suffering from mental illnesses properly. This shortage often leaves people unable to care for themselves properly, resulting in higher rates of interactions in the criminal justice system.

For too long, the failure of both the criminal justice system and the mental health service industries have created strategies that do not reduce harm to mentally ill people. Instead, each has only considered self-serving interests related to their perspective industries. This failure to work together to develop amicable solutions has been to the detriment of the people both groups are working to protect.

These continued failures have caused significant harm to the criminal justice system's reputation for its poor treatment of people suffering a mental health crisis. This continued failure has led some activist groups to call for the police to be eradicated from the mental health aspect of criminal justice. They have also called for a reduction in police funding and training. While the emotional aspect of killing a person suffering a mental health crisis is heartbreaking, the reality is that those suffering a mental health crisis in a public place may pose a significant risk of harm to others. Therefore, the idea of eradicating police is a false reality. Instead of focusing on unrealistic expectations, an in-depth analysis of mental health treatment and pathways to treatment needs to occur.

The criminal justice and mental health systems have worked independently with the same customer/ patient populations for far too long. To prevent continued failures, both systems need

to focus on root cause analysis of their customer/ patient populations and how they can work together to resolve these issues and reduce recidivism.

The criminal justice system has worked independently to develop techniques to foster better community relations when dealing with those experiencing a mental health crisis. Police Departments throughout the country have worked to develop crisis intervention training or de-escalation. Some court systems have worked to create a mental health court similar to a drug court, providing a pathway forward without incarceration. Jails and prisons have tried to implement mental health counseling for incarcerated people. While all of these are important ideas, none examine the more significant issue of lack of follow-up treatment and guidance through the often-complicated mental health treatment system. Instead, each has been focused on the immediate problem that brought the patient before the criminal justice system, acting like a band-aid rather than a medical team looking for the root cause of an illness.

Mental health care providers are vested in ensuring their patients receive the best care possible. However, they alone do not have the resources to provide this care as the demand is too high. This has created a system in which those experiencing mental health-related issues may be forced into a police encounter. This encounter can then place the subject into the criminal justice system. During their time in the criminal justice system, many mentally ill people will experience more trauma and more significant issues related to their untreated mental illness while also preventing the patient from receiving proper mental health care.

Both systems will need to work together for the criminal justice and mental health systems to treat the mental health epidemic in the United States successfully. This partnership should not only be information sharing, and transport holds with the idea of the patient following up with a primary care doctor at a later date. Instead, this partnership needs to be transformative.

New care systems and pathways to treatment must be implemented for both the criminal justice and mental health treatment systems.

While neither the criminal justice system nor the mental health system will independently be able to resolve the mental health crisis that reaches every part of our country, they can certainly work together to reduce harm to patients. Additionally, while working together, the two systems can develop better approaches to dealing with the influx of demand regarding proper mental health treatment that does not result in additional harm to the patients.

Police Officers in the United States have been tasked with fixing systemic societal problems since the early days of policing. Included in these social issues are the increasing calls for mental health services. Many issues surround the problem of police response to mental health calls. Heath (2019) notes that one in four people experience a mental illness each year. While many try to seek help for their mental health issues, they face roadblocks. The limitations in mental health care can include the shortage of mental health clinicians, as "the nation needs just over seven thousand more mental health clinicians to fill the provider shortage" (Heath, 2019, para. 7). Additional barriers include the fragmented mental and physical health services among care providers, limited access to care providers via insurance, and the social stigmas associated with mental health care (Heath, 2019).

With the challenges associated with mental health care, many people are forced to leave their mental health issues untreated. When these issues are left untreated, people may slip into an episode that other members of society deem to be problematic. When these seeming violations of social contracts are broken, people have been forced to turn to the police as there is no other option due to the fractured system of mental health care providers. Unfortunately for society, the police, and those suffering a mental health episode, the police are not equipped to deal with these

systemic societal failures. Some of the issues that arise when the police are contacted for mental health calls include the lack of criminal activity, the lack of training to respond to a mental health crisis call, and the lack of resources to get patients the proper care they need. This lack of resources and skills for police to help mentally ill people has aided in creating a system where people are forced to face criminal actions repeatedly rather than obtain treatment. This approach has not worked and is not a new issue.

Creating a system in which police and mental health services can work together will help create a better system of care, which will lower the demand for both services. To accomplish this, many community stakeholders will have to work together. The police and mental health care providers, either through governmental services or care providers, will have to establish mutually beneficial goals and methods of response and care. However, before this occurs, the legislature will need to take action to adequately fund these endeavors and create policies and laws to support more mental health services. Through these partnerships, department leaders will need to create new policies and a new unit for the response to mental health crisis calls.

Creating and implementing a new mental health co-responder unit will be met with pushback through budgetary and policy-related challenges on a state level. It is well known that law enforcement is and has been challenging to change. Many factors contribute to this resistance to change, including the officers themselves. Another concern facing the implementation of a co-responder unit is the lack of budget and staff for the respective departments. These local budget issues often leave minimal staffing levels to respond to emergency calls. Additionally, discretionary time is often directed at patrols to locate criminal offenders.

These factors have combined to create an environment where police officers are often forced to spend minimal time on calls and work to develop the quickest and most efficient solution to a problem. However, spending more time on a call working to combat the root issues causing someone to suffer from mental health illness will have a more desirable, longer-lasting outcome leading to fewer repeat calls for service (Huppert & Griffiths, 2015).

Others who may be opposed to creating a police mental health co-responder unit are seeking and or backing a defunding of the police movement. Or any other activists who are seeking legislative attention. A new concept has been the mass protest of police budgets and the impacts of the budgets relative to underfunded community needs. From these claims, activists allege reallocating the funds from a police budget will allow better access to community members for school, after-school care, and possible mental health services. Thus far, this research has not been able to locate established literature showing how these plans have been successful.

A way to combat these groups' ideas would be to show the shared goals of a co-responder unit to decrease police use of force when dealing with those suffering from a mental health crisis. Khalsa et al. (2018), research examining a ten-year period of Colorado police officers trained in mental health response, had promising results in decreasing jailing of those with mental illness and reducing occurrences when the police are using force. This study notes "use of force or SWAT, arrests, and injuries were infrequent. Suicide risk, psychiatric illness, and substance abuse, even in the presence of a weapon or violence threat, increased the odds of transfer to treatment, whereas suicide risk lowered the odds of transfer to jail" (Khalsa et al., 2018, conclusions section). Implementing these fundamental shifts in how police officers operate will allow more officers to experience an effective method of policing, creating better outcomes for

all. Furthermore, this change in policing style will help make new training to allow for a cognitive shift in how police officers view their jobs and the *"mission"* of policing.

Creating this shift in the thought behavior link of the criminal justice system only serving to combat criminal-related issues will have a far-reaching impact. The adaptation of the co-responder unit must extend beyond just how police officers respond to calls for service. Khalsa et al. (2018) notes how co-responder programs will succeed when they seek out creative partnerships for streamlined mental health transport, custodial transfers, community mental health centers, hospital care providers, and post-crisis case management. For this to happen, there will need to be a focus on how police officers understand their response to mental health crisis calls for service and how the community partners respond to the issues.

Implementing a co-responder mental health unit will impact all involved in the criminal justice system by helping reduce calls for service and allowing criminal justice practitioners to focus on non-mental health-related issues. A prime example of the success of how proper treatment of mental health issues can be better served with treatment rather than jail has been the introduction of mental health courts. These courts were created to help find a better path for those who have committed crimes, primarily due to untreated mental health issues. These courts will then work to seek mental health treatment for an offender. So long as the offender is working on completing their treatment, their sentence will be deferred until the treatment is completed. Pending successful completion of treatment, the charges would be dismissed. See Figure 1 below for how the case may flow through a mental health court (Snedker et al., 2017, p.

6).

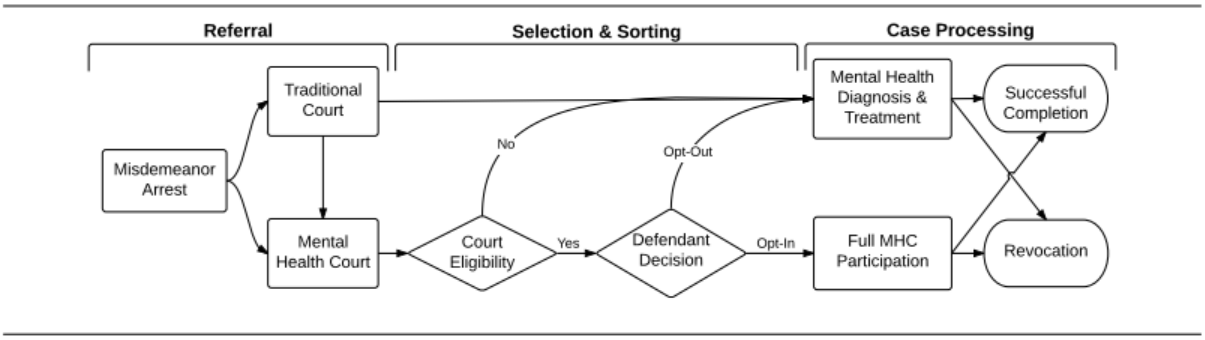

Figure 1: Defendant Selection Process in a Municipal Mental Health Court

This focus on treatment and shift in the criminal court proceedings allows for a behavior shift in criminal justice and those suffering from a mental health-related arrest. The offender can use the skills learned in mental health treatments to learn better coping skills and how to implement cognitive changes into their decision-making processes properly. These cognitive behavior skills learned in treatment have helped lower recidivism amongst those who have completed their treatment (Snedker et al., 2017).

A critical community stakeholder required for the creation of mental health services would be the care providers. This includes the individual doctors and nurses who comprise the care providers and the respective companies providing the resources for care. The benefits for these stakeholders would be a decrease in demand for emergency services that could be treated with a different care pathway. Those suffering from mental health issues are often forcibly transported by police to an emergency department for mental health evaluation. Those patients are then typically evaluated by an emergency room doctor who may not have the time or skill to conduct an overlapping physical and mental health evaluation. The patient will then be released back into the community, creating a systemic mental health issue. Huppert and Griffiths (2015) PACER model study showed how using a co-responder mental health unit can stop this systemic issue and get people set on a better path of care by utilizing the in-depth knowledge of mental

health care provided by the co-responder model. This method will also result in repeated calls for service and trips to emergency departments.

Before broadly implementing a change in policy or introducing an entirely new way of operation, one must examine and determine how prepared the agency is for change. A shift from traditional criminal justice response may seem difficult to some officers due to a co-responder model not solely focusing on criminal matters. These criminal matters have been the conventional standard success metrics in most police departments. Instead, a co-responder model will focus on solving mental illness root issues leading to fewer crimes and calls for service for the mentally ill. Justice System Partners (2015) noted, "To be truly effective, most intervention programs need to occur within a framework that supports ongoing excellence, even under varying circumstances" (p. 2). Sometimes this requires fundamental system change. By creating this shift in how police respond to calls and evaluate their success, we will work to create a change in police officers through behavior links hoping to create a system where the value of success will be placed on the successful resolution of an incident as well as post-incident follow up to prevent re-occurring calls for mental health emergency calls for service.

In addition to the policy and legal issues regarding developing a mental health co-responder unit, the department leader will have to work to secure staff and funding to support the staff needs. Of course, this will be one of the biggest hurdles for any department looking to implement a new co-responder unit. Much like any other local governmental agency, police budgets, while significant in scale, are often already maxed out in allocations. To make the necessary changes in funding, the leadership of police agencies will need to seek funding through grants and partnerships with public and private stakeholders. Additionally, leaders should be willing to expend political capital to create a co-responder unit; however, this is a

reasonable ideal to move agency goals forward. "Leaders need to develop a high level of sophistication about the organization's political and task environments to be successful change agents. Potential stakeholders, allies, threats, and opportunities must be recognized" (Stojkovic et al., 2014, p. 443).

Despite potential community pushback surrounding the increased budget requests during a politically charged time, leaders must be willing to expend the political capital needed to implement these policies and law changes appropriately. Additionally, leaders and change agents of agencies are responsible for fully explaining these fundamental changes in responding to mental health calls. Implementing additional resources can only accomplish this change for officers and mental health professionals by creating new policies and units to support a co-responder method. This change will also help lower the increased call load for mental health crisis calls. When properly implemented, it will, in fact, eventually reduce the call load allowing officers to focus on traditional criminal police matters. With more officers adequately trained in mental health crisis response and allocating more discretionary time for other officers, the community will receive better service from the police.

Chapter 3: Implications, Recommendations, and Conclusions

Law enforcement leaders must focus on making changes to how the profession handles calls for service in relation to mental health crisis incidents. The literature has made it clear that the community needs more advanced methods of care than in the past. Additionally, the officers responding to these calls for service want a more impactful reach to those seeking help. Law enforcement currently knows better ways to handle these complex mental health calls, which will reduce the use of force and increase positive outcomes for all involved. For these reasons, the law enforcement community must be committed to creating change by implementing better mental health responses through a mental health co-responder unit.

Practical Application

The formation of new mental health co-responder units is essential for law enforcement agencies. The timing and need for these units have become more apparent in recent years with the high levels of scrutiny in use of force and use of deadly force in high-profile incidents. The community has expressed the desire to have better outcomes regarding mental health crisis calls for service. With the increased contact between police and those experiencing a mental health crisis, police leaders must accept these calls for service are not going away. A better plan must be developed to resolve mental health crisis calls with less risk to the patients. To achieve this, law enforcement administrators must seek new and innovative solutions to these complex problems. As the literature in this paper has shown, the way to complete this is by seeking community partnerships with mental health providers, emergency medical services, and clinicians. Additionally, further training must be conducted for all officers working in the agency regarding best practices when encountering someone suffering from a mental health crisis.

In reviewing the PACER program for Australia's regional police response to mental health crisis calls, research has shown great success in reducing the use of force and repeated calls for service for those experiencing mental health-related crises. In this study, Huppert and Griffiths (2015) found the combination of a police and emergency medical response reduced repeated calls for police response resulting in fewer chances of uses of force. However, it also reduced the demand for emergency room handling of people who are experiencing a mental health crisis. This reduction in repeated demand will be useful to police and medical services, both of which have experienced higher demand with less staffing availability in recent years.

In focusing on a more localized benefit to mental health co-responder units and their benefits to the organization, we can turn to Khalsa et al. (2018) examination of the reduction in uses of force and SWAT deployments in calls regarding mental health crisis events. Khalsa et al. (2018) study reveals the benefits in the reductions of uses of force and SWAT in relation to mental health crisis calls. With SWAT being used around one percent of the time and force having to be used around five percent of the time. The practical benefits for organizations are far-reaching with these results. Administrators will see the benefits of reduced litigation with less force applied, and reductions in operational costs, as SWAT events can result in prolonged calls consuming significant resources. Additionally, we will see fewer injuries to officers resulting in less time missed at work. However, the best result in this practical application will be better community relations, and trust as less force will occur with those experiencing a mental health crisis.

Recommendations for Further Research

Further research is required regarding partnering private medical practices with public entities like police and ambulance services to improve the treatment of those experiencing

mental health crisis events. This research should focus on the mutual benefits of full information sharing and follow-up after-care programs established via the first contact with emergency services. This research aims to improve patients' treatment methods with the ultimate goal of reducing emergency services required for people who experience acute mental health issues.

Additional research should also focus on the amount of police follow-up involvement in after-care related to the post-crisis event. As it currently stands, police and emergency medical services typically only handle the immediate involvement of the initial crisis response with no follow-up care. The current models need to allow for rapport-building in relation to mental health clients who experience acute mental health crises. This research should examine the legal and ethical issues surrounding law enforcement involvement during post-crisis event follow-up.

Conclusion

Law enforcement has been the de facto end-all-be-all for any problem that society sees as unfit. No matter the issues, whether they are civil or criminal in nature or merely a call for assistance, people have been conditioned to pick up a phone and call 911 for help. Society has also come to expect police officers to be trained to handle most situations acting as a jack of all trades. However, this expectation is failing to be met. Instead of being the jack of all trades, the law enforcement profession has lived up to the second half of that famous quote in being a master of none in relation to handling mental health-related crisis calls.

Law enforcement leaders know the expectations of the community are for police officers to be able to respond to mental health crisis-related calls and work toward peaceful resolutions. However, throughout the years, law enforcement leaders have realized there is a need for specified training on how to come to these resolutions. The time of ask, tell, and make is no longer a valid option when handling complex mental health crisis calls.

Law enforcement leaders need to take action in developing mental health co-responder units to meet community expectations and reduce litigation risks and any propensity of injury to officers or those experiencing a mental health crisis.

The literature is clear in the fact that officers trained in crisis interventions will have more positive outcomes in dealing with those experiencing a mental health crisis. These positive outcomes will be measured in the context of reduced uses of force and reduced prolonged standoffs. However, when the training stops at crisis intervention, there is a large void in follow-up care resulting in recidivism and increased contact with people in crisis.

To better serve the community and their employees, law enforcement leaders must invest their efforts in the formation of mental health co-responder units. With the proven benefits in the reduction of harm and recidivism, there is an ethical duty to provide a level of service that offers the best opportunity for those experiencing a mental health crisis to not only live through the event but be offered follow-up care to reduce continued risk of law enforcement interaction during a crisis event.

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