Cities know that the way police respond to mental crisis calls must change. But how?

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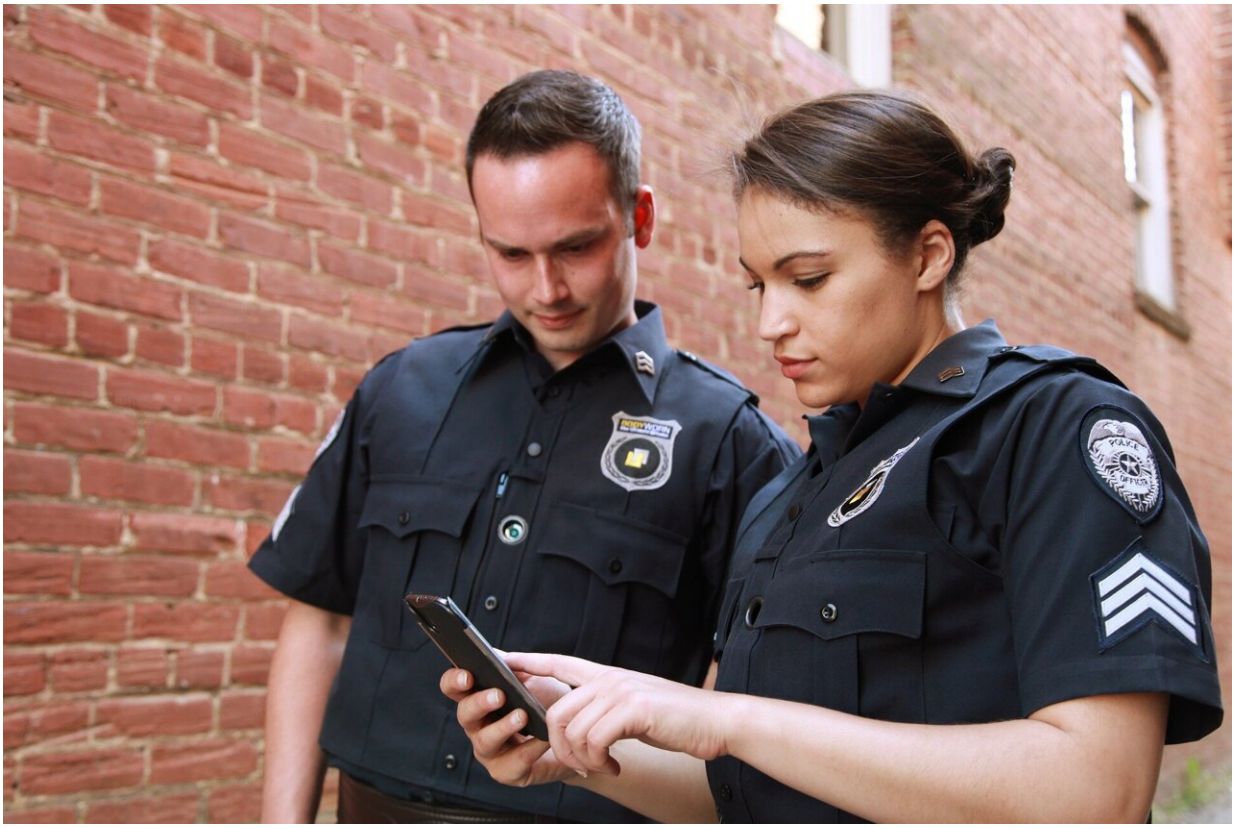

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Philadelphia police officers Kenneth Harper and Jennifer Torres were in their patrol car sitting at a red light when a call came in over the 911

radio dispatch.

"This job says 'female complaint in reference to dispute with daughter, suffers from bipolar, infant on location,'" Harper read off the computer near the front seat.

The officers got a little more information from the dispatcher: A mother needed help with her adult daughter who had become combative after drinking alcohol.

It was a Friday morning. Harper and Torres quickly drove off in the direction of the address they were given just a few miles away. They traveled in a white SUV, absent of any police markings, with a third team member in the back seat, Krystian Gardner. Gardner is not a police officer. She's a mental health clinician and social worker.

"Do we know the age of the daughter?" Gardner asked the officers. She was preparing a list of possible services and treatment options.

As the team pulled up to a row house in North Philadelphia, the mother was waiting for them outside, on the front stoop. They spent 40 minutes with the family, working to de-escalate the immediate tension, provide the mom with support, and connect her daughter to treatment services.

The trio returned to the patrol car and got to work documenting what had happened and recording the visit in an electronic database.

Officer Torres commented on the adult daughter: "In regards to her mental health, she is taking care of herself, she's taking her medication, and she's going to therapy, so we don't need to help her too much on that aspect."

"She's actually sleeping right now, so I gave her my card and she'll call us

whenever she wakes up," Torres added.

Soon, the radio crackled with their next call, to a home across town where an older woman with a history of mental disorders had wandered outside naked.

This visit took longer, over an hour, but had a similar outcome—help with the immediate mental health crisis, a connection to follow-up services with a case manager, and no arrest or use of force by police.

New ways to respond to behavioral health needs

Emergency dispatchers in Philadelphia are increasingly assigning 911 calls involving people in mental health crises to the city's Crisis Intervention Response Team, which pairs police officers with civilian mental health professionals. This model is called a "co-responder program."

Cities are experimenting with new ways to meet the rapidly increasing demand for behavioral health crisis intervention, at a time when incidents of police shooting and killing people in mental health crisis have become painfully familiar.

Big questions persist: What role should law enforcement play in mental crisis response, if any? How can leaders make sure the right kind of response is dispatched to meet the needs of a person in crisis? And what kind of ongoing support is necessary after a crisis response call?

City officials and behavioral health professionals often don't have easy answers, in part because the programs are new and hard data on their effectiveness is scarce. Without a single, definitive model for how to improve crisis response, cities are trying to learn from one another's successes and mistakes as they build and adjust their programs.

The Philadelphia Police Department established its Behavioral Health Unit in November 2022 and officially launched the co-responder crisis teams as a main feature.

The department said its goal is to meet people's immediate behavioral health needs, avoiding arrests or use of force, if possible. Philadelphia's program has answered about 600 calls since December 2022—and only one case resulted in an arrest as of November 2023, according to city data.

In about 85% of cases, people experienced one of four major outcomes: They were connected to outpatient mental health and social services, voluntarily entered psychiatric treatment, were involuntarily committed to treatment, or were taken to a hospital for medical care.

"I think the practical experiences that people have had has really opened up a lot of people's eyes to what the work does, how it's actually reducing harm to the community," said Kurt August, director of Philadelphia's Office of Criminal Justice.

Give a social worker a dispatch radio

City officials in Philadelphia looked to such cities as Los Angeles, Houston, and Denver, which have developed their own models over the years. They contacted people like Chris Richardson.

Richardson in 2016 helped found Denver's co-responder program, which pairs police officers with mental health professionals, like Philadelphia's CIRT program.

Denver residents had been unhappy with the status quo, Richardson recalled. At the time, rank-and-file police officers were the only ones responding to 911 calls involving people in crisis.

"We just heard a lot of those communities saying, "We wish there was something better,'" he said. "That's what kind of gave us that ability to start those conversations and start a partnership."

Getting buy-in from law enforcement and other emergency response teams took time, Richardson said. Eventually, the co-responder program grew to include all police precincts and several fire departments.

Then, Denver city and county park rangers began requesting the aid of mental health professionals to accompany them while on patrol in public spaces, and during emergency calls.

"And then, somewhere in the middle there, we were like, you know, give a social worker a radio. We're like, why are we sending police to this, in general?" he said. "How do we take police out of things that don't need policing?"

Denver then launched a second model, its civilian response program, in 2019. It brings together paramedics and mental health professionals to respond to crisis calls—no police officers involved.

Now, Denver uses both models—the co-responder program with police, and the all-civilian response program—to cover Denver's crisis needs. Richardson said both programs are necessary, at least in Denver.

"It's a spectrum of care with behavioral health crises," he said. "Some of it is really low-level. No threats, no safety concerns, no legal issues."

But sometimes responders or community members may face serious safety concerns, and that's when a co-response team that includes police officers is needed, Richardson said.

"We want to make sure that that person in crisis is still getting taken care

of," he said.

Getting the right responders to the right call

Officials in Philadelphia want the police co-responder program to work in parallel with the city's existing network of civilian-only mental health response teams. The co-responder program is dispatched by 911, while the all-civilian program is activated when residents call 988.

The 988 system launched in July 2022, providing a three-digit number that can be dialed from any phone by people who are suicidal or experiencing a behavioral emergency. Calls are routed to a network of over 200 local and state-funded crisis centers.

"A large percentage of Philadelphians are not aware of 988," said Jill Bowen, commissioner of the Philadelphia Department of Behavioral Health and Intellectual disAbility Services. "I like to say that people are born knowing to call 911, kind of come out of the womb and they know to call 911. And we really are trying to reach that kind of level of awareness."

To help sort incoming calls, 911 dispatch centers in Philadelphia have been hiring mental health professionals. They can screen calls from people in crisis who don't need a police response, and forward them to 988.

Other cities and states are also struggling with confusion over how to handle the overlap between 911 and 988 calls.

Although 988 is a national network, calls are taken by regional call centers, which are overseen and managed by local governments. The federal Substance Abuse and Mental Health Services Administration said it is working on "building strong coordination between the two

services," but it's currently up to states and counties themselves to figure out how 911 and 988 work together.

National data collected one year after 988's implementation showed that most calls to the service can be handled with conversation and referrals to other services. But 2% of calls to 988 require rapid in-person intervention. In most states, the responding agency is 911, which deploys traditional law enforcement, or co-response teams, if they're available.

Next steps: A safe place to go

In states where awareness of 988 is higher, some behavioral health leaders are focused on a lack of continuing care resources for people in crisis.

During a July press conference marking one year since 988, Shari Sinwelski, the head of California's biggest crisis call center, described the ideal crisis response as a three-legged stool: "someone to talk to, someone to respond, a safe place to go." The idea was introduced by SAMHSA in 2020.

In California, 44 out of its 58 counties have some form of mobile crisis response, meaning a team that can travel to someone in need, according to a 2021 survey conducted in partnership with the County Behavioral Health Directors Association of California.

However, the preparedness of these teams varies significantly. The survey identified that many of them don't operate 24/7, have long wait times (up to a day), and aren't equipped to handle children in crisis.

The same survey found that around 43% of the state's counties didn't have any physical place for people to go and stabilize during and after a crisis. WellSpace Health is California's second-biggest 988 center, by

call volume, and is located in Sacramento County. A few years ago, WellSpace leaders decided it was time to open a crisis stabilization unit.

In summer 2020, WellSpace unveiled the Crisis Receiving for Behavioral Health center, known as "Crib," in downtown Sacramento. The center receives people experiencing a mental health crisis or drug intoxication and allows them to stay for 24 hours and be connected to other services. The group says it has served more than 7,500 people since opening.

Physical locations linked to services, like Crib, are a crucial part of a well-functioning 988 system, said Jennifer Snow, national director of government relations and policy for the National Alliance on Mental Illness.

"Those crisis stabilization programs are really key to helping somebody not languish in the ER or unnecessarily get caught up in the criminal justice system," she said.

Snow said it's too early to know how the nation is progressing overall on building up these kinds of centers.

"This is something I am dying to know, and we just don't," she said.

Snow explained that the crisis care system has roots in law enforcement, so it tends to replicate law enforcement's decentralized and locally led structure.

"It makes it harder to look at it from a national perspective and, you know, be able to identify exactly where are these services and where are the gaps in services," she said.

Building additional crisis centers, and hiring enough response teams to

respond quickly, at all hours, in more areas of the U.S., would require significant investment. The current system relies heavily on state and local government funding, and more federal support is needed, Snow said.

In 2022, a group of legislators introduced the 988 Implementation Act in the House of Representatives. They were able to pass several provisions, including securing $385 million for certified community behavioral health clinics, which operate 24/7 crisis care, and $20 million for mobile crisis response pilot programs.

The bill was reintroduced in 2023, with the goal of passing the remaining sections. A significant provision would force Medicare and Medicaid, as well as private health insurance, to reimburse providers for crisis services.