Recommendation 9

Launch co-response teams to respond to 911 calls.

Introduction

In January 2021, DHS administered a public engagement feedback survey to collect input on 16 recommendations generated by the Crisis Response Stakeholder Group. In this report, the overall response numbers and a summary of respondents' comments are described. This report summarizes the feedback on Recommendation 9. Then, we provide a deeper dive into the specific suggestions and concerns respondents provided, along with quotes that help to illustrate these comments.

Recommendation Description

Recommendations were briefly described in the survey, while more detail was provided in the Recommendations PDF document. Individuals taking the survey had the ability to download the recommendations document before starting the survey but we do not know who took this step or not. Both descriptions are included below.

Recommendations Document

Launch co-response teams to respond to 911 calls. In Allegheny County, a law enforcement officer that is dispatched to a 911 call involving an individual with mental health needs has the option to call the resolve mobile crisis team to come to the scene and provide support services. Depending on resolve's capacity to respond and where the officer is located, there can be a time lag for this secondary response to arrive. In a co-responder model, a police officer and a mental health professional respond to behavioral health-related 911 calls together. Co-response teams allow for the police officer to make sure the scene is safe, and for the mental health clinician to support the individual experiencing a crisis. Ideas include:

- Leverage lessons learned from the Pittsburgh Bureau of Police and Allegheny Health Network pilot that is teaming up police officers and social workers
- Consider a peer support partner (someone with lived experience with mental health or substance use) + law enforcement officer model
- Consider a community paramedic + Crisis Intervention Team (CIT)-trained law enforcement officer model
- Consider a resolve crisis worker + police officer model
- Could also consider Emergency Medical Services + mental health co-response model
- An additional model is one where law enforcement receives telephone or video support from a clinician while they are on the scene and that clinician conducts follow-up
- Use mental health advanced directives, which is when people are able to express their preferences, when not in crisis, on where to receive care and what treatments they are willing to undergo.

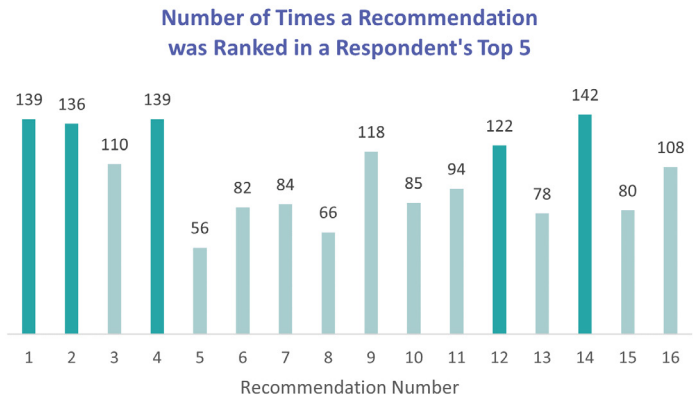
Survey

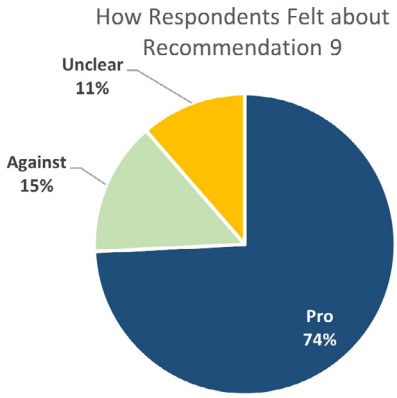
Launch co-response teams to respond to 911 calls. In Allegheny County, a law enforcement officer that is dispatched to a 911 call involving an individual with mental health needs has the option to call the resolve mobile crisis team to come to the scene and provide support services. Depending on resolve's capacity to respond and where the officer is located, there can be a time lag for this secondary response to arrive. In a co-responder model, a police officer and a mental health professional respond to behavioral health-related 911 calls together. Co-response teams allow for the police officer to make sure the scene is safe, and for the mental health clinician to support the individual experiencing a crisis.

What do you think of this recommendation?

Number of Responses and Rankings

299 respondents wrote in comments about Recommendation 9. Responses were organized into three categories: Pro, Against and Unclear.[1] Additionally, 118 respondents ranked Recommendation 9 as one of their top 5 recommendations. See rankings and descriptions for all recommendations in the chart and table below. The top 5 most-ranked recommendations are highlighted in the chart.





16 Recommendations for Improving Crisis Prevention and Response

Rec	Description
1	Improve the quality and increase the availability of crisis walk-in centers and other services that are available 24 hours a day, 7 days a week to receive a person experiencing a crisis.
2	Improve mobile crisis options and functioning.
3	Support first responders across the county to receive needed, ongoing training.
4	Improve discharge planning from jails, hospitals and emergency departments.
5	Enhance designated phone line(s) for connecting individuals to human services so that healthcare systems, providers and discharge planners have one place to call when patients need immediate human services and supports.
6	Establish a structure and set of protocols that is responsible for overseeing and holding accountable the full crisis system.
7	Develop a system or resource with real time information on service availability (e.g., eligibility criteria, area or population served, appointment availability).
8	Increase availability of easy access, low-barrier respite centers and similar models.
9	Launch co-response teams to respond to 911 calls.
10	Develop awareness around an alternative number to 911 that people can call when someone is experiencing a behavioral health crisis and explore strategies to provide a behavioral health response to 911 calls involving individuals in crisis.
11	Increase the availability of preventative and proactive outreach supports to prevent a crisis before it occurs.
12	Address basic housing needs.
13	Establish and fund more community-led and operated crisis response models.
14	Make sure qualified, trained frontline staff are available 24/7 for individuals experiencing crisis and that these staff have the appropriate compensation, support and caseloads to provide the best services possible, no matter the time of day.
15	Develop a process to address mistrust and hurt between communities and government, including law enforcement.
16	Increase the number of Black, Indigenous and People of Color (BIPOC) behavioral health providers.

The highlighted recommendations were most often ranked in the top 5 by survey respondents.

[1] For responses were in favor of the recommendation. Against responses were against the recommendation. Unclear responses left it unclear what the respondent thought and included individuals whose comments made it seem likely that they misunderstood the recommendation as well as those who wrote comments responding to something other than the recommendation.

Summary of Comments on Recommendation 9

Most respondents were in support of co-response teams, though often support was expressed in the "best case scenario," and many questions and concerns about implementation - especially around training capacity, and funding, - remain. Those that were not supportive of the recommendation cited concerns about the presence of police and the potential for escalation, or other uncertainties about implementation that could lead to harm.

Responses to this recommendation were grouped into the following categories, which are described in more detail on the following pages: [2]

- Opportunity to increase safety, efficiency, collaboration and accountability
- Concern about police presence at response site
- Need for extensive training for police officers and others and to clearly define roles in co-response team
- Implementation questions, concerns or suggestions (capacity, skill and funding)
- Other ideas/concerns

[2] In addition to identifying whether respondents were in favor of or against the recommendation, each response was also assessed for themes. Responses were grouped and counted according to those themes. Some comments were assigned multiple themes and some responses didn't fit into a theme. For example, some comments were simply "Yes!" or "Good idea!" These comments were counted as "Pro" votes, but not assigned any theme.

Opportunity to increase safety, efficiency, collaboration and accountability

Respondents noted different ways this recommendation could be preventative, lead to individuals getting treatment that fits their needs and build trust in the community.

1. This recommendation could increase preventative action such as
    - Saving lives
    - Reducing violence against community members
    - Preventing incarceration or hospitalization
2. This recommendation could allow individuals to get care specific to their needs
    - Individual receives treatment instead of arrest
    - Opportunity to de-escalate, give individual someone to talk to
3. Respondents noted collaboration could be an opportunity to build trust with communities and increase accountability if something does go wrong
4. Respondents also noted having a co-response model could be more efficient than first responders needing to wait for a resolve response team

What respondents said about the opportunity to increase safety, efficiency, collaboration, and accountability

"Absolutely agree with this recommendation. That initial interaction is crucial in ensuring a safe, favorable outcome for all parties involved."

"This has the potential to really make an impact for the community at large and also the trust that the community has in law enforcement if it is done well."

"Yes I think this is a wonderful collaboration and true demonstration of team work, sensitive to the mental health needs of the individual."

Concern about police presence at response site

Respondents against this recommendation cited concern about having police presence at mental health calls at all. Others thought the recommendation had potential but also expressed concerns about the presence of firearms and/or use of violence.

1. Concern about police presence at mental health calls
    - Potential to escalate those in crisis
    - Police cause violence
    - Will not change pattern of behavior we have seen
    - If an officer is present, a mental health professional will have no power in the situation
    - Preference for creating a separate response that does not involve police
    - Concern that if mental health calls become associated with police response, people will be less likely to reach out for help
2. Respondents expressed it would be better to work toward a model without police
    - Better to prioritize a model that sends only mental health professionals
    - Ideally not embedded together
    - More social workers, less police

What respondents said related to concerns about police presence at response site

"Absolutely NOT. The only tool police have is force. Force is never a way to help people. The very fact that you automatically consider a mental health patient to be dangerous is the very problem."

"I think this is one of the most important ones. Police do not need to respond to everything. They cause more fear and worry and don't help people feel 'protected.'"

"Ideally, police and behavioral health would not be embedded together. I would prefer to see a model where nearly all behavioral health calls are referred to a separate process where police are not involved."

"Absolutely do not do this. Police will always escalate a situation. Police have an inability to defer to the expertise of social workers, especially when we do not use power and control and coercion to force people into things. Police are a tool of force. Introducing force into a mental health crisis is never appropriate."

Need for extensive training for police officers and others and to clearly define roles in co-response team

Respondents expressed the need for specific and rigorous training for police officers, mental health providers serving on crisis response teams and operators

1. Training needed for police
    - Must ensure violence is not the default and responders are trained in de-escalation
    - Need specialized and specifically trained officers to avoid bias
    - Officers and mental health professionals must be trained together
2. Training needed for mental health providers and operators
    - Mental health professionals must be trained to help to ensure safety of all involved
    - Mental health professionals should be trained to provide physical support
    - Operators must be trained to evaluate which calls require a mental health response
3. Clear roles for officers and mental health professional are necessary to ensure everyone's safety
    - Respondents stated it may be a challenge to build collaboration between officers and mental health professionals
    - Respondents believed a mental health professional will always take a backseat to law enforcement in crisis situations because de-escalation often will not work in crisis situations
    - Respondents stated the need for officers to act in a support role only, in order to not escalate the situation

What respondents said about the need for extensive training for police officers and others and clearly defined roles in co-response team

> *"I think this will only work if officers are trained appropriately on how to operate on a crisis call but I do not feel confident in the effectiveness of such training."*

> *"Absolutely necessary to ensure that violence is not the default response and that trained professionals are trying to deescalate or help people in a crisis situation."*

> *"I believe having a call where by a mental health professional and law enforcement respond at the same time to an individual experiencing a crisis will be helpful whereby trust can be built between all involved to ensure a desired outcome"*

> *"I think there'd need to be clear roles about the officers acting in a support capacity so they do not end up escalating the situation."*

Implementation questions, concerns or suggestions (capacity, skill and funding)

A number of responses included questions, concerns or suggestions related to the implementation of this recommendation. Respondents' comments suggested the recommendation could work if certain aspects of implementation - especially around capacity, skill and funding - were properly addressed.

1. Respondents suggested the following capacity issues would need to be addressed
    - There would need to be sufficient response team members trained and available (this would be a significant number)
    - Response times could be affected if there are insufficient mental health professionals on-call or if the procedure for co-response is unclear
    - An increase of crisis centers and treatment beds would be needed to support this recommendation
    - Crisis team would need to be located nearby in order to respond quickly
    - Robust satellites sites in different zones could improve mental health professional response time
2. Respondents provided the following suggestions for necessary skills
    - There could be a safety risk in having a mental health professional on the scene of a high-risk situation
    - Cultural competency would need to be addressed and people on the scene would need to understand the communities they were responding to
    - resolve responders do not always have a mental health background and there are challenges to communication and documentation of important information
    - Police need increased empathy training
    - It could be more effective to increase police behavioral health training
    - There are many decision points that could cause things to go wrong
3. Respondents expressed the need for sufficient funding and questions about where it would come from

What respondents said about implementation questions related to capacity, skill and funding

> *"I could see this being a barrier if there are not enough resources. While this is valuable, I think having officers trained is [a] quicker win while resources are expanded to allow for this type of capability"*

> *"Co-response teams are an excellent idea but where will all the funding come from to accomplish this?"*

> *"Again, in theory, this seems like a great idea, but I have many questions about the logistics. How many mental health professionals are available to respond throughout the County? How would response times be affected? Policies and procedures could be difficult to finalize as each municipality must consider liability issues as well as the safety of patients, residents as well as all involved co-responders. I anticipate this will be a big part of discussions as we move forward with this project."*

"This is a good idea. And speaking with officers now in 2021, [resolve] responders have told them there are 'no beds' for follow up so again, they cannot connect people to nonexistent help. Push back on the state to provide $$$ for treatment beds, step down houses, intensive/assisted outpatient. These technical connecting pieces (phone numbers, bodies, IT systems) will be empty of resources if they come to be in 2021."

"I think this would be a great idea if they are able to respond in a timely manner. The hard part from a law enforcement perspective is we normally cannot wait at calls for an extended period due to additional calls coming in to 911. If the team is able to be prompt, it is a great idea!"

"This is needed, but need to make sure that there isn't a capacity issue and clinicians are available immediately and on call 24-7"

Other Ideas and Concerns

There were some ideas mentioned that didn't fall into an overarching category. These ideas are outlined below:

Respondents expressed the following ideas and concerns in their comments:

1. Police should have a designated department to respond to mental health calls
    - Train police in behavioral health and Mental Health First Aid (dually certified)
    - Use trained police instead of co-responder model
    - Opportunity to hire mental health clinicians and have dual-role officers
2. Develop resolve to create a response option that does not include police
    - Hire additional supports
3. Embed mental health professionals in the police department
    - Not officers but present so they can respond in real time
4. The need for diverse teams
5. The need to develop the advance directive process (it is lengthy and not all are familiar)
6. Co-response puts social worker and police officer in danger
7. Social workers should attend non-mental health calls to inform de-escalation tactics

What Respondents Said about other ideas and concerns

"Police officers should be trained in Mental Health First Aid. I'm sure the cost in mandating this training will be considerably less than have to 2 people show up, Additionally, two-model response may work if a client is unreceptive to law enforcement."

"This would be helpful. As I said in an early response, though, it might be better to grow the resolve program so it is [one] program that is offering this support. It would reduce confusion, and people would be able to get familiar with the program being offered."

"Would it be possible to have a special unit of the law enforcement that is dually certified to meet immediate mental health crisis such as de-escalation and then knowledgeable in where to make a referral for that individual? They could be called onto a scene or travel with another officer if their is a high chance of mental health issues. If someone had to be immediately incarcerated maybe there could be on call therapists who could make a visit to the jail and do a screening/evaluation right there."

"This is utterly ridiculous! Do not sent social workers out to respond instead of police! Yes, it's a team, but it consists of one cop and one social worker. This is putting social workers in serious unnecessary danger. and the police as well for not having proper back up! Instead of putting citizens in danger, how about trying to train police officers."

"Sounds fantastic. Can clinicians also go on non-behavioral health calls and coach police officers on how to de-escalate situations?"

"It would be beneficial to have health care providers already available at the police department as a separate housed program that can respond to calls real time vs. having to call another provider to tag along. This would also improve relationships between mental health providers and police departments by integrating the two."