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BUILDING COMMUNITY- BASED EMERGENCY RESPONSE SYSTEMS

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June 2020

EXECUTIVE SUMMARY

Though police officers are neither medical professionals nor social workers, cities and counties across the country routinely send armed law enforcement officers to respond to emergency calls for help when a person is experiencing a mental or behavioral health crisis. This makes as little sense as sending a social worker into a home invasion robbery in progress. Sending law enforcement to respond to mental or behavioral health crises leads to unnecessary arrests and incarceration, and increases the risk of confrontations involving the use of force—and often deadly force.

States and local governments can redistribute funds to better manage these challenges by investing in skilled emergency response corps and crisis workers. Trained professionals, not law enforcement officers, are best positioned to respond to mental and behavioral health emergencies, including crises related to substance use, lack of housing, or inadequate health care. To be successful, these crisis response teams should operate independently of the criminal legal system, include both emergency and preventative services, and be fully funded to accomplish their mission.

In a national poll, we found broad public support for these measures:

- ▶ **68% of likely voters support** the creation of non-law enforcement emergency responders programs;
- ▶ **70% of likely voters support** a non-police response for when a family member calls 9-1-1 because of a mental health crisis; and
- ▶ **65% of likely voters support** a non-police response to a drug overdose.

BACKGROUND

The job of law enforcement officers has become so expansive in recent decades that armed police officers are now the default first responder when someone is in crisis. In some jurisdictions, police spend more time on mental-health-related calls than on burglaries or felony assaults. From 2008 to 2018, the number of 9-1-1 calls to report “emotionally disturbed persons” to the New York Police Department doubled, reaching nearly 180,000 unique calls in a year.

Because the fundamental function and training of law enforcement is to address violations of the law, their response to social, behavioral, and mental health emergencies often ends in arrest and criminal charges—rather than intervention, treatment, and care. Arrests and criminal charges also involve collateral consequences, like deportation or loss of housing, health insurance, and other benefits. On other occasions, the involvement of law enforcement needlessly escalates the situation or involves force—sometimes deadly force. There is no tracking system for how many people with mental and behavioral health disorders are killed by police each year. But studies of the available data have found that as many as half of the individuals killed by law enforcement have a disability. A 2015 study by the Treatment Advocacy Center found that people with an untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians who come into contact with law enforcement. The result is that community members often do not call for help because the response they receive is inadequate and even dangerous.

There is a better way. The default emergency first responder should be a healthcare professional or social worker, not an armed police officer. These trained professionals are able to de-escalate situations and connect the person in crisis to the resources they need to stabilize; and, importantly, they can do these things without involving the criminal legal system.

Building the appropriate crisis response requires time, personnel, and funding. These resources should be shifted away from police budgets and invested in a non-law enforcement agency filled with the trained professionals who are best equipped to create safe outcomes for everyone in these crisis situations.

Key Elements of Crisis Response Programs

Existing crisis response systems are largely community-based so they can respond rapidly to people directly in need, but a few states have proposed legislation to require expanded services statewide. (See the [appendix](#) for a list.) Successful crisis response programs should contain a few key elements.

- ▶ **Crisis response services should be separate from law enforcement.** The crisis teams, the management of those teams, and the oversight of those teams should all be independent of law enforcement. Responses to 9-1-1 calls for mental and behavioral health crises should be diverted, when appropriate, to a non-law enforcement crisis response team of trained mental and behavioral health professionals. Crisis triage by trained professionals should be available within 9-1-1 call centers to inform these decisions. For example, the Austin Expanded Mobile Crisis Outreach Team responds to 9-1-1 calls with [mental health telehealth](#) services where

certain criteria are met. Another non-9-1-1 number should be made available that goes directly to the crisis response team.

- ▶ **Crisis response should include on-site, on-demand emergency and preventative services.** Crisis response teams should include mobile units capable of meeting vulnerable populations where they are, as well as referring them to appropriate emergency services. The crisis response team should proactively engage with vulnerable populations to provide referrals for community-based treatment and services. For example, the Crisis Assistance Helping Out On The Streets ([CAHOOTS](#)) program, in Eugene, Oregon, is a mobile crisis intervention team that responds to calls related to behavioral health. Teams consist of a medic and a crisis worker and provide “immediate stabilization in case of urgent medical need or psychological crisis, assessment, information, referral, advocacy and (in some cases) transportation to the next step in treatment.” And in Dallas, Texas, the [Rapid Integrated Group Health Care Team \(RIGHT Care\)](#) is a partnership between Dallas paramedics, the Dallas Police Department, and Parkland Hospital social workers. The team responds to mental health emergency calls in South Central Dallas. The goal of the program is to divert patients with mental health disorders from area emergency rooms and jails by stabilizing them at the scene and referring them to appropriate services.
- ▶ **Funding for crisis response should be redirected from law enforcement’s budget.** According to a [2016 report by the CDC](#), nearly 1 in 5 patients (17%) don’t have a regular place to access healthcare. States and local governments can take funds previously dedicated to law enforcement and reinvest

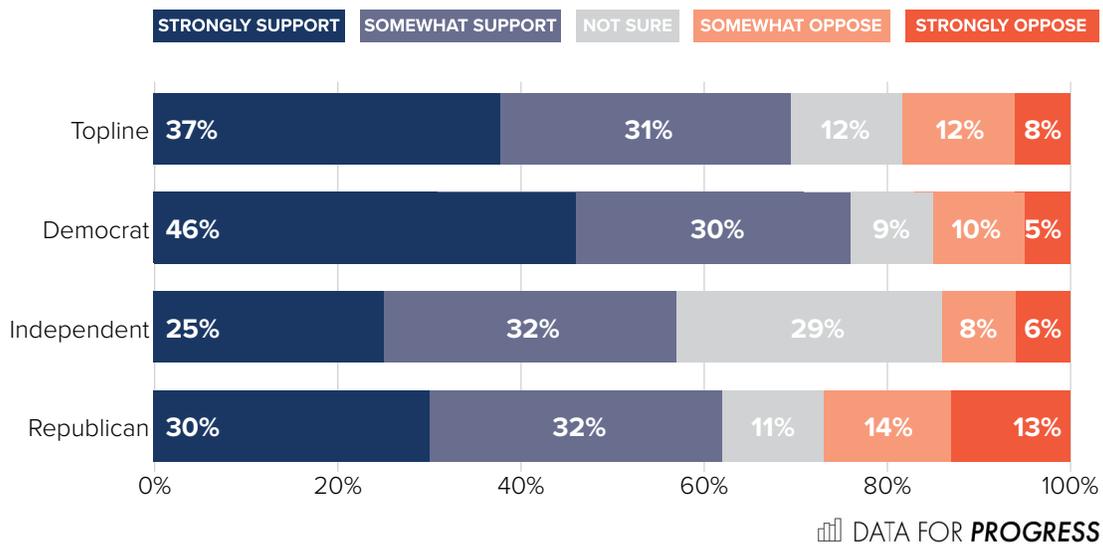
in healthcare resources, including mobile crisis response teams, to identify and prevent healthcare crises for vulnerable populations.

Public Support

Our national survey of 1,352 likely voters shows strong support for non-law enforcement emergency responders.

- ▶ **68% supported** the creation of non-law enforcement emergency response programs.

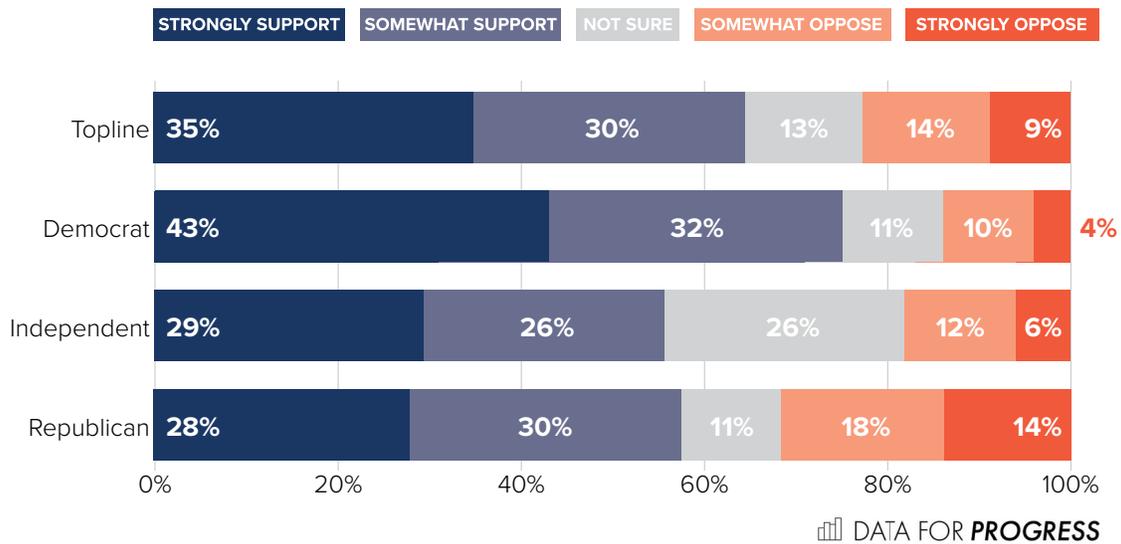
Do you support or oppose creating a new agency of first responders, like emergency medical services or firefighters, to deal with issues related to substance use or mental illness that need to be remedied but do not need police?



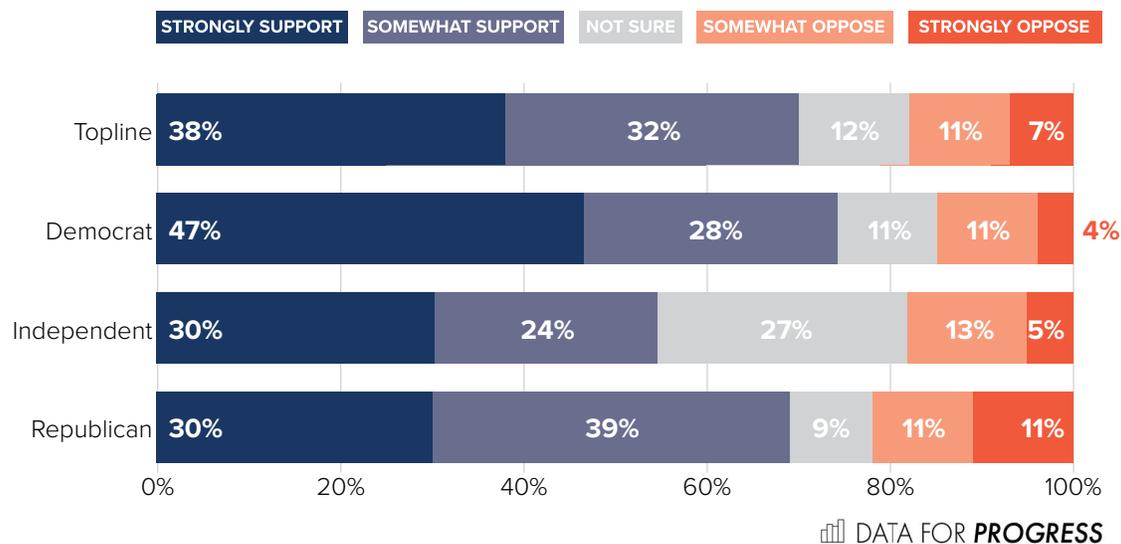
▶ **70% supported** a non-police response for when a family member calls 9-1-1 because of a mental health crisis;

▶ **65% supported** a non-police response to an overdose.

Do you support or oppose a new agency of treatment professionals and experts responding to a call instead of a police officer when a person has overdosed?



Do you support or oppose a new agency of treatment professionals and experts responding instead of police when a person calls 911 to get help for a family member who is having a mental health crisis?



CONCLUSION

Community-based crisis response systems, not law enforcement, should be the first points of contact for people in distress. Trained medical and behavioral health professionals are best positioned to provide on-site, on-demand emergency services, as well as referrals for community-based services and treatment plans. Moving the responsibilities for crisis response to

social workers and medical personnel will connect people with the care they need at the time they need it most. Community-based systems can also provide preventative care by proactively engaging with vulnerable communities and referring individuals to community-based treatment and services, diminishing the need for emergency relief and improving overall health and safety. To provide effective crisis response, states and local governments must fully fund these programs, divesting resources allocated to law enforcement and redirecting into community-based solutions.

ACKNOWLEDGEMENTS

This report was written with consultation from:

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METHODOLOGY

From 6/4/2020 to 6/6/2020 Data for Progress conducted a survey of 1,352 likely voters nationally using web panel respondents. The sample was weighted to be representative of likely voters by age, gender, education, race, and voting history. The survey was conducted in English. The margin of error is ± 2.7 percent

From 6/7/2020 to 6/8/2020 Data for Progress conducted a survey of 1,291 likely voters nationally using web panel respondents. The sample was weighted to be representative of likely voters by age, gender, education, race, and voting history. The survey was conducted in English. The margin of error is ± 2.7 percent

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