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Navigating the Intersection of Law Enforcement with Mental Health

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Abstract

Law enforcement's role in responding to mental health crises has come under heightened investigation and evaluation in recent years. Debates surrounding safety, effectiveness, and de-escalation have risen. The literature review reflects a comprehensive range of perspectives, including police-led programs, police training, mobile crisis teams, co-response teams, and clinician-led alternatives. The research suggests the complexity of this topic and presents a multitude of findings, highlighting both benefits and limitations of each approach. Differences across regions, funding, access to resources, and training quality, further complicate outcomes. In addition to the literature findings, this thesis references real-world media cases that illustrate how crisis response models can sometimes lead to both successful and tragic outcomes.

Findings from this thesis indicate that, even with mixed literature, a reasonable case can be made for having police presence during mental health crises, particularly when individual or public safety may be at risk. When supported alongside proper training, protocols, and mental health clinicians, law enforcement can play a positive role in crisis response. With this in mind, evidence highlights the need for coordinated, person-centered approaches that balance de-escalation, clinical care, and long-term recovery. Therefore, further research needs to be done to evaluate these variables, as well as improving crisis response models to balance safety, compassion, and clinically informed treatment.

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Introduction

Mental health crises are rising worldwide, with rates of psychological distress increasing across a variety of countries and populations (Karp & Yach, 2024). In the United States, this has become especially urgent, with mental crises leading to an estimated 60 million visits to primary care services, and 6 million emergency room visits annually in the United States (Centers for Disease for Control, 2024). Given this high societal proportion, it presents an important debate about the ethical nature of law enforcement's role. While many continue to advocate for non-police crisis response models to avoid unnecessary arrests or viewing mental illness under a criminal lens, research suggests that trained law enforcement officials remain vital in providing immediate emergency response to ensure the safety and wellbeing of individuals in distress. They often serve as frontline responders to dealing with severe suicidal ideation, violent behavior, and hallucinations. Well-trained officers, particularly those with knowledge about de-escalation techniques and mental illness, can effectively stabilize the situation and safely transport the individual to the appropriate mental health services. Without this, significant safety concerns arise. Overall, this thesis investigates how police officers can play a constructive role in mental health crisis responses, by implementing specialized training, monitoring safety, utilizing de-escalation techniques, and collaborating with mental health officials to ensure more effective outcomes for individuals in mental health crises.

Background Information

To begin, a mental health crisis is considered a period of intense, sometimes dangerous, emotional distress or instability that can involve feelings such as despair, anxiety, and

helplessness. These crises often result from acute episodes of psychiatric conditions, including bipolar disorder or severe episodes within major depressive disorder, but can also form from highly traumatic or stressful life events. Crises may manifest in several ways, including suicidal ideation, panic attacks, psychotic episodes, manic behavior, or disorientation and confusion. They can also present through a combination of emotional, physical, and behavioral signs, which may range from subtle to severe. Emotionally, individuals may experience intense sadness, irritability, persistent feelings of worthlessness, or a loss of interest in previously enjoyed activities, environments, or relationships. Physically, crises can be shown through changes in sleep or appetite, low energy, or physical symptoms such as headaches or stomach aches. Behaviorally, individuals may withdraw from social interactions, engage in risky behaviors, or struggle with concentrating and decision-making (Daino, 2024).

Within the United States, the prevalence of mental health issues in general has steadily increased over the past decade. In 2010, approximately 21% of adults experienced any mental illness, while 4.5% experienced serious mental illness. By 2024, these figures had risen to 23.4% for any mental illness and 5.6% for serious mental illness. Serious mental illness refers to mental disorders that result in substantial impairment, limiting one or more major life activities. Individuals with serious mental illnesses are more likely to experience severe episodes that cross into mental health crises (Substance Abuse and Mental Health Services Administration, 2025). Given the severe emotional, physical, and behavioral consequences of mental health crises, it is important to understand why these episodes are becoming increasingly common in the United States. In general, several factors including a “complex interplay of biological, psychological, and environmental factors” have appeared to drive the worsening mental health crisis in the modern landscape (Magomedova & Fatima, 2025, p.1). In the modern world, societal issues such

as urbanization, social media exposure, erosion of traditional social support systems, prolonged working hours, economic insecurity, societal pressure, living conditions, and chronic stress and burnout are to blame. Biologically, neurochemical imbalances of serotonin and dopamine, imbalances in the gut-brain axis, underlying medical conditions, and genetic predispositions can contribute to mood regulation and stress responses. Additionally, psychological factors such as trauma history, cognitive abilities, personality traits, and overall emotional resilience can interplay. Together, all of these factors contribute to the growing number of individuals experiencing severe mental health issues, which in turn increases the likelihood of crises requiring urgent intervention (Magomedova & Fatima, 2025). In more recent years, greater awareness and reduced stigma of mental health, have also encouraged individuals to be more likely to seek diagnoses and treatments for mental illness or crises, especially amongst younger generations like college students (Shim et al., 2022).

Understanding the serious consequences of uncontrolled mental health crises is essential as it emphasizes the importance of necessary interventions. These crises can affect both personal and societal domains. Personally, individuals in crisis tend to explain their experiences as "overwhelming", “falling apart”, with an immense sense of “losing control” (Newbigging et al., 2020, p. 33). These experiences often lead to emotional outcomes such as low self-esteem, anxiety, depression, and suicidal ideation. Behaviorally, individuals often experience isolation, self-harming behaviors, and suicide attempts (Newbigging et al., 2020). Health wise, individuals experiencing mental illness are also at higher risk for cardiovascular and metabolic diseases, with those experiencing serious mental illness or crises being almost twice as likely (Schwartz, 2024). These consequences often extend to the individual's caregivers and family, who are either left with a misunderstanding of the mental crisis, or with increased anxiety and responsibility in

regards to the safety consequences of delayed intervention (Newbigging et al., 2020). Families/caregivers of those in crisis often experience emotional strain, increased stress, financial burdens, and overall poorer mental health (Pope et al., 2025).

On a societal level, uncontrolled mental health crises place burdens across a multitude of systems, including healthcare, the economy, and within the legal system. Therefore, mental illness and the impacts of a crisis can be costly. Research done by the National Bureau of Economic Research found that mental health problems cost the U.S. economy over $280 billion annually (Abramson et al., 2024). Globally, mental health disorders are estimated to cost the world $16 trillion by the year 2030 (Schwartz, 2024). Emergency departments and inpatient psychiatric facilities also bear the burden of emergency mental health visits. Research from the American College of Emergency Physicians highlights how psychiatric crises can strain hospital care. These psychiatric patients experience longer stays than patients with medical emergencies, leading to overcrowding and delayed care for all patients. In turn, this complexity of their care increases the risk for medication errors, while staff face elevated safety risks from patients experiencing severe agitation, mania, or self-harming behaviors. These high stress incidents place providers at risk of burnout and secondary trauma (Simon et al., 2019). Additionally, mental crises can lead to homelessness, unemployment, and eventual legal involvement. For example, those experiencing serious mental illnesses experience higher difficulties both obtaining and maintaining employment due to disruptions in education, work history, discrimination from employers, and their overall symptoms and cognitive deficits. This further puts individuals at risk of being unable to afford housing or rent, eventually leading to homelessness (Tsai & Rosenheck, 2016).

Furthermore, some with severe untreated mental crises tend to fall into the incarceration system due to symptoms such as hallucinations, aggression, or severe disruptive and harmful public behaviors leading them to engage in crimes leading to their eventual arrest. This is more common with crises related to disorders including schizophrenia, bipolar disorder, and depression (Fellner, 2015). This trend has partially increased due to the phenomenon of "deinstitutionalization", leading to the closure to large numbers of psychiatric hospitals that would typically be used to provide care to those with these illnesses. As a result, individuals have been left with limited access to care, resulting in poorly managed mental health conditions that increase the risk of repeated crises and interactions with the criminal justice system (Busch, 2014).

Uncontrolled mental health crises sometimes also cause individuals suffering from acute psychiatric symptoms to self-medicate for relief (Harris & Edlund, 2005). This is commonly known as the "self-medication theory". Some of the most common substances include alcohol, cigarettes, and drugs that are both illicit and prescribed. An individual might use alcohol to help them feel more relaxed in social scenarios when dealing with social anxiety, while another individual may use heroin or cocaine to manage depressive symptoms. Even though these substances may provide short-term relief, there are many potential risks associated with using these substances including overdose, unwanted/dangerous side effects, dependence, and substance-related symptoms leading to a misdiagnosis. Likewise, these substances can temporarily make individuals feel better, however long-term use leads to lower moods, worsening their existing condition (Hartney, 2024, para. 2). This often creates a vicious cycle in which the substance abuse only worsens their symptoms, and eventually increases vulnerability to poverty and outside legal involvement (Hinders, 2025).

Given these challenges, is it essential to understand the core aspects of crisis intervention– what it comprises and when it is necessary. Crisis intervention is considered a short-term technique to address an immediate mental health emergency by stabilizing the individual and connecting them with resources and treatment to ensure their immediate safety (Marschall, 2023). This is done to prevent potential severe, permanent damage to the individual experiencing the crisis (Wang & Gupta, 2023). This is often done for individuals experiencing suicidal ideation with worsening intentions to harm themselves. Many individuals with mood, psychotic, or substance abuse disorders also sometimes experience a sudden dangerous increase in symptoms leading to a crisis intervention (Marschall, 2023). Currently, crisis work relies heavily on emergency workers such as ambulance workers and law enforcement (police officers), as they are the first responders to these scenes. Some models also utilize crisis teams, where social workers and police are paired up upon arrival to these crisis scenarios (Mental Health America, 2025). Typically, police have the authority to initiate psychiatric holds, also known as involuntary commitments, to transport the individual for hospitalization without their consent, if they deem necessary (Cleveland Clinic, 2025).

Despite this, police involvement has become the subject of ongoing debate. Many major mental health institutions, including the American Psychological Association (APA), feel that police officers are not adequately trained to handle mental illness in general given their training (Abramson, 2021). Additional critics also argue that it criminalizes mental illness, increases the likelihood for unnecessary arrest, uses unnecessary force, and escalates sensitive situations by causing distress to the afflicted individuals. This has been identified with certain minorities more likely to receive coercive interventions or excessive force during these encounters (Anene et al., 2023). In addition, there is evidence that mental health calls including police can be high-stakes.

In 2015, research looked at 1,099 deaths that happened during interactions with the U.S. police in 2015 (Saleh et al., 2018). 23% of them included individuals displaying signs of a mental illness (Saleh et al., 2018). Many of these incidents occurred within the individual's home rather than public spaces - suggesting that these contexts may heighten the potential for perceived threat and escalation when entering personal spaces (Saleh et al., 2018). In response to these concerns, some research has revolved around non-police led solutions. For example, the suggested use of patient-centered strategies, also known as psychiatric advance directives (PADs) - legal documents that allow individuals to specify preferred treatment options in advance. There is evidence that individuals with these in place during a crisis experience fewer coercive interventions like emergency transport, restraints, and involuntary medication administration (Swanson et al., 2009). By reducing the need for police involvement, individuals in crisis may experience lessened fear and escalation when getting help. Supporting this, qualitative research has found evidence that a portion of individuals suffering with a mental illness do perceive police interventions negatively. In one study, 32% of them explained their contact with the police during crises as negative (Livingston et al., 2014). Additionally, public attitudes in general to the police are "fuzzy" and mixed. While many people do recognize that police are essential for maintaining safety, their perception of trust and effectiveness tend to vary depending on their own personal encounters as well as the community context (Worrall, J.L., 1999).

While much of the debate revolves around mistrust and fear in police-led crisis responses, it's also important to acknowledge that police officers themselves face challenges, with some having mixed feelings about leading calls. Some research has demonstrated that officers responding to emotional disturbance calls often report feeling anxious, feeling concerned with

their safety, and occasionally uncertainty on how to respond (Watson et al., 2014). Given that these are high stress situations, officers (and related emergency responders) also have the potential of developing secondary traumatic stress, a phenomenon known as vicarious trauma. This leads to a combination of physical, psychological, and behavioral issues that can arise from repeated-exposure to traumatic scenarios. Common symptoms such as feeling emotional numbness, chronic fatigue, heightened emotional reactivity, headaches, and trouble sleeping, ultimately affecting wellbeing and causing a decline in job performance (Bryant, 2025).

On the flip side, supporters argue that despite these downsides, police officers are still uniquely trained to handle aggressive or unexpected behaviors that may arise in these scenarios to ensure safety for the individual and surrounding public, and can act swiftly and provide necessary transportation for treatments (The Council of State Governments Justice Center, 2019). Collectively, these differing perspectives highlight that while police involvement can provide critical safety oversights with high-risk crises, the effectiveness and risk factors depend on the broader context, training, and trust. These tensions on both sides highlight the questions driving this thesis. Are police officers properly equipped to deal with mental health crises? Can they act swiftly to protect patients and keep them safe? Can they worsen fear in patients? What limitations exist with their approach? Should police only be sent to specific high-risk crisis calls or be removed entirely from the response? To what extent might collaborating with mental health professionals enhance outcomes for individuals in crisis?

Review of the Literature

The following studies explore various facets of existing crisis response models, ranging from police-only interventions to non-police interventions, highlighting both their immediate and long term outcomes, effectiveness, and limitations in addressing mental health crises.

To begin, although there is the common perception that police departments are unprepared to respond to mental health crises, research indicates that most agencies have established training protocols in place to manage these situations alongside mental health training for officers. Researchers conducted a national survey of small law enforcement agencies to examine how these departments respond to calls involving persons in crisis as a result of mental health or substance abuse. While there was no direct hypothesis, the study aimed to document the types of programs, training, and partnerships that they implement as well as additional challenges including limited funding, staff availability, and rural service gaps. It also investigated how societal events and regional collaborations influenced agencies reassessment of their crisis responses. The national survey included 380 agencies, with 10-75 sworn officers. To collect data, researchers sent emails and mailed surveys to these agencies across the U.S. The questions were answered around the topics of officer training, access to mental health expertise, budgeting, protocols for dispatch and hospital drop off, and their professional partnerships with other organizations. The results suggested a variety of findings. To begin, out of all agencies, only twelve reported having no solid crisis program at their department. Over 90% of agencies provided some form of crisis response training, with 35% reporting the full 40 hours of CIT training. In addition, 49% had access to a regional crisis intervention training (CIT) program, while 31% reported an in-house CIT, and 20% lacked any CIT program. Mental health professional involvement was reported by 80% of agencies, either through 27% of local

co-responders, 4% of in-house staff, or 23% or telephone access. Around 60% of agencies had agreements with local hospitals for specialized drop-off procedures, and about half provided dispatchers with specialized mental health training. Partnerships with other regions often included 5-6 agencies, with some benefits including access to skilled staff, shared training, and cost reduction. However, limitations such as lengthy response times, limited availability, and budget/funding issues were mentioned.When asked, 61% of agencies would still recommend their programs to other jurisdictions, citing successes such as proactive outreach, substance use interventions, and follow-up care coordination. Lastly, about half of the agencies reported reassessing their policies in response to high profile incidents and increased discussions about improving law enforcement response, such as additional officer training, policy updates, and the deployment of body cameras (Davis et al., 2021).

Given that this study relied heavily on self-report data from smaller law enforcement agencies, respondents may have overstated the effectiveness of their crisis response programs causing bias in the results. Furthermore, the response rate was relatively low, with only 29% for the first sample and 10% for the second likely due to interruptions from the COVID-19 pandemic and ongoing civil unrest. Additionally, the research was designed using a cross-sectional approach, not allowing for the long-term analysis or evolution of these programs. Future research could benefit with broader sampling, longitudinal designs, and potential focus groups. Overall, small law enforcement agencies are actively attempting to implement crisis response programs, even though background issues still arise in these programs.

Building upon this idea of law enforcement's role in mental health crisis calls, research has also focused on the everyday, real-time decisions and insights from police officers that are sent out to these calls. Researchers Watson and Wood conducted a study in Chicago, Illinois to

understand the interventions officers use such as de-escalation, hospital transports, referrals to social/mental health services, and arrests. While no hypothesis was directly stated, researchers were guided by the general assumption that the majority of mental health encounters in Chicago are resolved by both CIT-trained and non CIT-trained police officers through hospital transports and informal interventions, rather than arrests. To investigate this, they used a mixed method approach over a five year period, using a combination of qualitative and quantitative data. To begin, they collected reports from 428 mental health related calls from 300 officers across all 22 Chicago police districts from July 2013 to September 2016. Various insights were provided including call characteristics, behaviors, interventions, and overall outcomes. They also completed semi-structured interviews with 21 officers selected from 125 volunteers. They provided detailed narratives of their encounters with patients, intervention strategies, and officer perceptions of needs for resources. The results suggested a variety of findings. Officers reported 192 calls (44.9%) were resolved by transporting the patient to the hospital, 34 (7.9%) of the calls by referring the patient to some type of social/mental health service, 25 (5.8%) of the calls included making an arrest, 150 (35.0%) of the calls resolved on the scene with no actions taken, 46 (10.7%) of the calls had other actions taken (including on scene resolutions, releasing them to family members, and some creative transportation ideas) and 9 (2.1%) of the calls had the patient both transported and arrested. Among the calls with an arrest, it was used for violent offenses such as aggravated assault, battery, and domestic violence. During the interviews, officers mentioned that there was value of hospital transports for a “reset” for patient experiencing a mental health crisis with one non-CIT officer stating, “The benefit is, I guess, just kinda getting ‘em back on track, no matter how many times you have to do that” (Watson & Wood, 2017, p. 8). A CIT trained officer also emphasized building trust and persuasion with patients with one

stating, “Me, personally, what I found to be the most of the time very effective is I like - as much as possible, I like to reduce images and impressions of force… I want to come to the person in as much a gentle way as possible, and I’m not ready to hurt you… If I can get a person to talk, that’s ideal because I can hear what’s in their mind, what are their motivations” (Watson & Wood, 2017, p. 9). Additionally a non-CIT trained officer mentioned the issues of the revolving door phenomenon with one stating, “I feel like sending them to hospitals, per se, are just revolving doors… you see them there, and they come back… I think if there were more things like a specific clinic… I think they’d truly get the help that they need” (Watson & Wood, 2017, p. 11). Other issues briefly mentioned included non-medication adherence, persuasion, and knowledge of repeat callers (Watson & Wood, 2017).

Generalizability to other law enforcements or regions with differing resources and populations is limited within this study, given its demographic of Chicago. Additionally, the data relied very heavily on self-reported call outcomes and personal recollections which may be influenced by social desirability. The population size for interviews was also small (n=21), which limits the border insights of the entire police force. Overall, this research provides evidence that typical police only responses to mental health crises usually involve hospital transports and informal de-escalation strategies over arrest. Future research should look into strengthening law enforcements and behavioral health services.

While research has looked at how officers navigate mental health crises in real time, its varying outcomes point to the potential for structured interventions to guide officer decision-making. One widely implemented approach to try and fill this gap, is The Crisis Intervention Team Model (CIT). This allows for collaboration between police, mental health providers, and consumers. It offers specialized training in de-escalation and mental illness

training, to divert individuals from the criminal justice system and into appropriate treatments. While much of previous research in this model has focused on its influence with behavioral outcomes with officers (such as increased mental health knowledge, reduced stigma, and positive attitudes), this study wanted to connect how these outcomes affect larger practical responses in the field, such as officer's ability to de-escalate crises and make appropriate referral decisions. The researchers hypothesized that CIT training across a variety of U.S. regions, would improve officers' knowledge, attitudes, self-efficacy, and stigma, which in turn would work together to explain improvements in de-escalation skills and referral outcomes. The sample size consisted of 586 police officers - 251 who had completed CIT training, and 335 who had not completed CIT training. Participants completed in-depth surveys measuring six constructs including knowledge, attitudes, self-efficacy, stigma, de-escalation skills, and referral decisions. Using structural equation modeling (statistical technique analyzing complex relationships between variables), researchers tested their hypothesis to see if it fit the data, and modified it based on the results. The findings suggested that CIT training increased knowledge and positive attitudes, which in turn reduced stigma. However, reductions in stigma were not shown to directly affect behavioral outcomes. Self-efficacy emerged as the strongest predictor of improved de-escalation and referral decisions. To be more specific, CIT training significantly increased knowledge and positive attitudes, which in turn reduced stigma. However, reductions in stigma were not directly associated with de-escalation skills or referral decisions. Rather, self-efficacy emerged as the strongest predictor of improved de-escalation skills and referral decisions (Compton et al., 2022).

Given that the study relied on self-report, there is a potential for social desirability bias. Officers may have wanted to present themselves as more compassionate or knowledgeable, while ignoring areas that they struggled in. Recall bias could have affected how accurately officers

reported their behaviors, particularly in high-stress scenarios. Additionally, even though the structural equation modeling provided a clear framework for examining pathways of CIT training and behavioral outcomes, some hypothesized paths had to be removed to achieve a better model fit, suggesting that the relationships among these are more complex than originally predicted. Overall, this research highlights the practical value of CIT training, with an emphasis on self-efficacy on assisting officers. Future research should continue to explore how CIT training affects officer performance in real-world encounters with mental health patients.

Building on these findings that emphasized the importance of self-efficacy in officers, the same research team had previously looked into how CIT training translates into actual field outcomes such as level of force and disposition decisions within the legal system, for individuals suspected of having a mental illness, substance abuse problem, or developmental disability. They hypothesized that these CIT-trained officers would use less physical force by relying on verbal de-escalation, have an increased likelihood of making mental health referrals, and be less likely to arrest individuals in crisis. The sample size consisted of 180 police officers across six law enforcement agencies in the state of Georgia. A total of 1,063 encounters were reported on 91 CIT-trained and 89 not CIT-trained. Officers recorded the highest level of force used in each encounter (scale of seven levels), and three dispositions: resolution at the scene with no further action, referral to services or transport to a treatment facility, or arrest. Statistical analyses included multilevel models, including those with binary outcomes, and odds ratios to assess the effects of CIT training. The findings suggested that CIT training did not reduce or predict the overall incidence of physical force, which occurred in 12% of these encounters. However, officers with the training were more likely to use verbal engagement/negotiation as the highest level of force (20% of encounters vs. 11% for non-CIT). In regards to disposition, referral was

more likely among CIT-trained officers versus those without (40% vs. 29%), while arrest was less likely among CIT-trained officers (13% vs. 24%). In terms of the behavioral complaint, the largest reductions in arrest were for patients with mental illness, while the largest increases in referral were for patients with drug or alcohol problems only. Overall, while training did not significantly reduce the use of physical force in encounters, it did provide evidence in increasing verbal de-escalation, referral to mental health services, and reducing arrests (Compton et al., 2014)

There is the potential for selection bias in this study, as police officers may have chosen to document encounters in which they felt they performed well. Additionally, the sample of police officers and their encounters was relatively small. CIT-trained officers may also have differences in personal attributes or overall motivation, which has the potential to affect these results. Future research should focus on outside variables such as systemic-level outcomes, community perceptions of training, police officer personality traits, and integrations with other interventions. Overall, this study provides evidence that CIT training can actively change the outcomes of these scenarios in real world settings.

While the CIT model focuses on direct police training, other approaches have explored pairing police officers directly with mental health professionals within the field. These co-response models aim to provide immediate mental health expertise during emergency mental crisis calls, with the goal surrounding improved patient care. To evaluate this approach, researchers conducted a randomized controlled trial comparing police-mental health co-response teams versus traditional police/treatment-as-usual (TAU) responses for behavioral health emergencies. They hypothesized that the mental health co-response teams would lead to outcomes including reduced emergency department visits, fewer arrests, and increased referrals

to treatments, compared to the traditional police responses. The sample consisted of 686 calls for service across six police districts in Indianapolis, Indiana, with 264 cases assigned to the mental health co-response models, and 267 cases assigned to the TAU models. After attrition (loss of participants in the study), the final sample that was analyzed included 211 mental health co-response models, and 224 TAU models. Data from eligible calls was collected over 12 months between January 2020 and March 2021, using HIPAA-compliant procedures and linked to administrative records from EMS, sheriff's office, and nearby hospitals. Patients in these emergency calls had experienced a behavioral health emergency that resulted in a 911 call that was collected in real-time by dispatchers. Across participants, 34.7% experienced any emergency medical service event, 18.2% had any jail booking, 62.3% had any outpatient behavioral health encounter, and 81.6% had any emergency department visit. Across all outcomes, the findings did not suggest significant differences between the co-response teams and TAU model. Essentially, the addition of a mental health professional to the response team did not improve measurable crisis outcomes (Lowder et al., 2024).

Given that the study relied on both real time data and administrative records, there is the potential for bias and incomplete measurements, leaving out relevant outcomes. In addition, the study also only included calls identified as eligible by dispatchers, who are not trained behavioral mental health specialists - potentially limiting the generalizability of these results to extensive crisis calls across the U.S. In continuation, even though the research does look into differing effectiveness for crisis models, it does not account for broader factors such as pandemic-related influences, local community support, or knowledge about mental health in the departments involved. More research is needed to explore these variables. These findings suggest that adding mental health professionals to police models may not be sufficient enough to improve outcomes.

While many co-response models pair police officers with external mental health professionals, a newer field of research looks into the concept of "police social work" where a social worker is directly embedded into a police department. In this study, researchers looked into the effectiveness of police social workers (PSWs) in regards to assisting with crisis interventions, case managements, and community-level advocacies. They conducted a case study in Valparaiso, Indiana, analyzing both micro-level client interactions and macro-level community coordination with a single PSW. While there was no direct hypothesis, the study used a mixed-methods approach, investigating case notes with the frequency and durations of client contacts. The sample size included 236 participants who had contact with a PSW over a six-month period. While no personal information was included from clients, data was collected pertaining to de-identified case notes, frequency of client contacts, and referrals to social services. The findings provided evidence that the PSW managed high-needs clients efficiently, with 17% of clients receiving three or more contacts and nearly 8% having eight or more. On average, they spent 1.6 hours per contact, compared to the average 2.5 hours typically spent by police officers on similar crisis calls. The case notes also provided evidence that they were able to connect clients to long-term social services including housing, food assistance, mental health care, and substance-abuse recovery programs - rather than into the criminal justice system. The PSW was also able to create a Community Partners Network, linking nearly 50 agencies to improve service coordination and referral processes. Additionally, they were able to de-escalate on-scene mental health crises and prevent unnecessary arrests, increasing trust between clients and police officers. Overall, this suggests that PSWs can effectively provide swift crisis intervention, divert clients from arrest and into social services, and enhance systemwide

collaboration - potentially complementing the traditional Crisis Intervention Team (CIT) models (Ban & Riordan, 2023).

A major limitation of this study, is that it relied on data from a single PSW within one mid-size city, which limits the generalizability of the results to other police departments. Additionally, it was noted that there were some gaps in the demographic information, making it difficult to fully analyze true patterns across client populations. Time constraints inherent to the fast-paced police environment also influenced the level of detail in the case notes with regards to interactions that occurred outside the recorded system or involved officers directly. Lastly, even though the case notes provide helpful qualitative data, it may be influenced by the PSWs subjective perspective. This highlights the need for more multi-site studies with standardized measures. Overall, this research highlights that PSWs can play a role in filling the gaps between mental health crises, social services, and improved police-community perceptions.

While PSWs show evidence that integrating social work expertise into the crisis response can help improve responses and border community connections, some programs have taken this a step further to minimize or eliminate police involvement entirely. Mobile Crisis Teams (MCTs), are known to prioritize non-law enforcement alternatives in providing care for mental health crises. The effectiveness and limitations of these programs can have widespread consequences for a functioning society. To explore these consequences, researchers conducted a national survey investigating these programs across the United States. While the study did not include a direct hypothesis, it aimed to understand how MCT variations affect their ability to provide crisis care across the United States. The methods of the study included a cross sectional 51 question survey method to collect data from these programs, collaborating with Vibrant Emotional Health, Substance Abuse and Mental Health Services Administration (SAMHSA),

and the National Association of State Mental Health Program Directors. The original sample size consisted of 1,290 programs, yet only 474 were included in the analysis given that they provided their geographic location. Participants were asked questions pertaining to team structure, clinical scope, technology use, service areas and partnerships, company finances and incentives, and collaboration with law enforcement. The findings suggested several findings. First, MCTs cover an extensive range of geographic areas and populations, with the majority covering counties (51%) or regions (31%). Many common barriers were long distances, poor cellular communication, snowy weather, and traffic. Second, MCTs show many differing outcomes, with approximately 70% serving less than 200 clients each month, staffing and transportation varying by service area size, and funding collected from a mix of federal, state, and local sources. Third, approximately only 40% meet the minimum staffing required for continuous, two person coverage, highlighting the issues with striving for a nationwide 24/7 available service. Fourth, the interconnection between MCTs and other relevant services such as crisis hotlines and first responders is limited. Approximately, only 24% used integrated electronic health records, only 32% were reachable via the National Suicide Prevention Lifeline, and only 56% had outpatient care arrangements. Fifth, law enforcement appears to be the primary collaboration team alongside MCTs, with approximately 87% having them as a partnered agency, 84% using officers for transportation, and 64% dispatchable by police. Sixth, MCTs show other challenges including limited integration with services, inconsistent metrics tracking, and variable adherence to the best practices on suicide prevention (Goldman, Looper, & Odes, 2023).

One limitation of the study is using self-reports to collect data through convenience sampling, which has the potential to reduce generalizability and reflect personal biases in how programs may describe their services. In continuation, even though the research does look into

MCT patterns, the research does not look into outside variables such as community-level funding issues, differing local policies, and population-specific needs that may influence how effective these programs are. More research is needed in these areas. Overall, this research highlights the need for a stronger collaborative care approach with other agencies, alongside adequate policies and resources in place for these programs. Many of these teams are explicitly unable to attend circumstances judged unsafe by dispatch and still routinely require police backup for high-risk calls.

While the previous studies have examined crisis response models on smaller, more individualized scales, some research offers a broad comparative analysis of some existing models. Researchers compared three major models of police responses to mental health crises. While the study did not explicitly state a hypothesis, the purpose was to determine how often specialized professionals responded to these incidents, and how often they were able to resolve cases without arrest. Three major cities were looked at including Birmingham, Alabama; Memphis, Tennessee; and Knoxville, Tennessee. Approximately 100 police dispatch calls for "emotionally disturbed persons" were examined at each site. Additionally, records of 100 incidents were also examined at each site that involved a specialized response, in order to determine differences in case dispositions. The total sample size included the analysis of 600 cases. The program in Birmingham utilized community service workers, who were ordinary civilian employees trained in social work/relevant fields, did not carry weapons, drove unmarked cars, and had no arrest authority. The program in Memphis utilized a police-based Crisis Intervention Team (CIT) with specially trained officers who provided an ongoing 24 hour service, alongside the ability to transport individuals to psychiatric facilities. The program in Knoxville operated a mobile crisis unit that was responsible for handling calls in the community,

telephone calls, and referrals from jails and emergency rooms. The data was collected from police dispatch records and specialized response incident reports, with dispositions classified in the categories of arrest (criminal charges filed), treatment (evaluations and detoxifications in emergency rooms), on-scene resolution (crisis intervention provided in real time), and referral to mental health specialists. The results suggested a variety of findings, with differing outcomes in the programs. In regards to call response, Memphis's program responded to 95%, Knoxville's program responded to 40%, and Birmingham's program responded to 28%. Arrest rates were low across all programs with 2% in Memphis, 5% in Knoxville, and 13% in Birmingham. Transports and referrals to treatment occurred in all programs, with a larger amount in Memphis (75% of calls). On-scene resolutions were high in Birmingham (64% of calls), while referring individuals to specialists was common in Knoxville (36% of calls). Overall, the study provided evidence for two valuable factors for crisis responses: 1) access to psychiatric triages or drop off centers, and 2) the centrality of community partnerships among the criminal justice system and mental health professionals (Steadman et al., 2000).

A big limitation for this study was being unable to track long-term outcomes for individuals getting referred to treatment, arrests, or on-scene resolutions, which makes it difficult to evaluate whether these interventions were useful in lasting stabilization. Additionally, the study's descriptive design was not able to account for any external outcomes influencing results such as differences in department policies, the quality of the available community mental health resources, or broader demographic factors. Future research could examine these variables more extensively. Overall, the research highlights the value of specialized police responses in reducing arrests and connecting individuals to mental health services, supporting the usefulness of police involvement in crisis calls.

This broad comparison of individualized models, provides important insights about differing response approaches in the immediate/short term resolutions. Still, international comparisons are important when determining if these models lead to better or worse outcomes for those in crisis in differing areas. The main goal of this study was to compare outcomes across police, co-responder, and non-police models of mental health crisis intervention. There were four research questions asked including 1) What are the key outcomes being reported in the literature?, 2) What is the quality of the evidence?, 3) How effective are mental health crisis response interventions?, and 4) What does this information tell us about the current state of crisis intervention internationally? The data was collected through a combination of observational, and descriptive studies across international areas including the United States, Canada, Australia, the United Kingdom, and Northwestern Europe. They conducted a systematic search of four databases (2010-2020) and grey literature, utilizing 1,008 articles, which included 62 studies. Of these 62 studies, 15 were police-based, 25 were co-responder, and 22 were non-police approaches. The main focus outcomes were use of force, arrest rates, referrals/resources, emergency department transport, efficiency metrics, mental health apprehensions, and hospital admissions. Key findings for police only/CIT models suggested that they may improve transport to care but have little impact on arrests compared to standard policing. Officer confidence of officers in these programs was mixed with 50% of officers not believing it was more effective than non CIT training. Geographic factors significantly affected outcomes, some patients reported fear for safety and criminalization, and limited resources/options for resolving mental health calls were noted. Key findings for the co-responder models suggested that they have potential reductions in arrests, use of force, and injury, though the evidence was mixed and somewhat biased. These models were associated with decreased Mental Health Act

apprehensions and benefits from increased empathy and compassionate care provided by mental health clinicians. Some evidence suggested emergency department reductions, but evidence was mixed due to local implementation differences. Challenges included cultural values/clashes between police and health professionals, unclear policies, and limited availability. Lastly, key findings for the non-police models suggested some higher service user satisfaction, reduced emergency department and involuntary admissions, and emphasized follow-up care and integration into the continuum of care. The need for police back up varied by model and triage practices, with only 0.006% of 24,000 CAHOOTS calls in Oregon requiring police intervention, while nearly half of calls in Sweden's PAM program requiring them. However, there was a lack of data on staff, executive, or other stakeholder perspectives on barriers to these models. Overall, the broad analysis of findings suggested a few things. There is only a small amount of strong evidence that CIT/police-only models significantly improve crisis outcomes. Co-responder models tended to show better outcomes compared to police-only models, but results were still mixed. Non-police models were variable with a weaker evidence base, however some youth focused and crisis home treatment programs showed promising results stated above (Marcus & Stergiopoulos, 2022).

There were a varying number of limitations, including the predominance of observational or descriptive designs, low quality studies, and the reliance on voluntary reporting and the potential for bias. Additionally, there were varying contexts including legal, healthcare, and cultural - preventing generalization. Despite these limitations, the study highlighted that effective crisis intervention included strong community partnerships across services (legal, healthcare, social services) and the addition of mental health professionals. Future research should dive

deeper into long-term longitudinal data and should look into stronger available study designs for review.

Building on these findings, additional research - though extremely limited - has looked at the long-term effects of general mental health interventions on system-level outcomes, providing insights into the impacts of crisis response over time. Researchers examined the long-term outcomes of outpatient crisis intervention in psychiatric patients referred for inpatient care. They hypothesized that therapeutic process measures (working alliance and psychotherapeutic attainments) and patient's psychosocial profiles (age, sex, interpersonal relationships, social adjustment) would each have an independent relationship with sustained, long term outcomes. The sample size consisted of 37 consecutive adult depressed patients assigned to outpatient crisis intervention (CCI) conducted at Eaux-Vives Secteur Crisis Intervention Department (EVSCID), a community mental health center affiliated with Geneva University Medical School, located in Switzerland. In the program, patients both received short-term intensive outpatient treatment for crises alongside a combination of psychotherapy and medication. Patients were assessed at four intervals using a combination of clinician-rated standardized symptom scales, structured questionnaires, and process measures: 1) intake - collecting demographic information, diagnoses, psychosocial profiles; 2) one week into treatment - measured working alliance (collaborative relationship between patient and therapist); 3) treatment termination - evaluating psychotherapeutic attainments (such as treatment adherence and the development of insight); 4) one and two year followups - measuring their long term outcomes like symptom improvement and overall change. The results suggested stronger working alliances formed in early treatment, along with development of insight and psychotherapeutic attainments by program termination predicted more positive global change and symptom improvement at the 1/2 year follow ups.

Additionally, the observed relationship between process measures and two-year outcomes was independent of factors including age, sex, symptom severity at intake, early symptom improvement, premorbid adjustment, diagnosis, and baseline therapeutic alliance. Essentially, the quality of the therapeutic process for long term recovery is seen more strongly than fixed patient demographics. Overall, these findings highlight the value of strong therapeutic processes within extended crisis intervention programs, highlighting their critical role well beyond the immediate crisis intervention (Andreoli et al., 1992).

This study noted several limitations including a small sample size and the observational and purely correlational, limiting generalizability and the control for confounding variables such as support systems, comorbidities in disorders, physical health conditions, and the quality of the therapists used in the study. Future research should look into this. The date of research is also less recent, and may not accurately reflect newer insights. Overall, this study supports the broad idea that effective crisis interventions benefit from collaboration between law enforcement and the mental health field, ensuring both short-term immediate safety and long-term recovery. While immediate crisis response models vary in outcomes (arrest, referral, or de-escalation), those that provide patients access to meaningful therapeutic care may ultimately improve long-term outcomes.

Discussion of Literature

Themes Across Studies

Across the literature, several key themes emerge regarding the roles of law enforcement, mental health professionals, and the hybrid approaches used when addressing mental health crises. To begin, research does indicate that law enforcement agencies have made progress in

implementing structured responses to mental health calls, challenging the common perception that police are ill-equipped for these scenarios (Davis et al., 2021). Even though many police departments face persistent structural and resource issues (Davis et al., 2021), they demonstrate initiative and adaptability in the face of many system level challenges. In many cases, these police-only models remain the most feasible option, especially in small and rural agencies (Davis et al., 2021). Given this, their effectiveness seems to be dependent on local resources, aspects of department culture, and the specific context of each mental health call. Additionally, studies consistently demonstrate that officers prefer alternatives to arrest, including transports to emergency services, referrals to mental health tailored services, and on scene de-escalation strategies (Watson & Wood, 2017). This adds more nuance to their involvement, given that they sometimes are the only viable option, and are generally not wanting to arrest or criminalize the situation, highlighting their preferred roles.

Aside from typical police only responses, those exposed to CIT training also show valuable insights in regards to officer compassion when handling those in distress (Compton et al., 2022). Interestingly, self-efficacy, compared to stigma reduction, is a large factor in officer confidence and effectiveness (Compton et al., 2022). Moreover, CIT training does not appear to significantly reduce the physical force used in these scenarios (Compton et al., 2014). It suggests its external benefits including increased referrals and reduced arrests. Mixed and hybrid models that pair police officers with mental health professionals produced mixed results and simply adding them does not seem to automatically improve crisis outcomes (Lowder et al., 2024). This suggests that the integration of mental health clinicians needs specific designs, coordination, and special training to produce measurable outcomes. It also asks the question of whether CIT training can be improved to include a greater emphasis to address on-scene risk management for

reducing force, and education on behaviors that those with mental illness may be more likely to display in a crisis-like state.

Next, even when certain models try to steer away from police entirely in their responses, they still tend to rely on their expertise for high-risk situations (Goldman, Looper, & Odes, 2023). This reveals that these models do seem to need some form of policies for structuring police involvement. While the bulk of this research is involved in U.S. models, research included on international models do also consistently find that some level of police involvement is frequently necessary for differing aspects of care (Marcus & Stergiopoulos, 2022). This reaffirms that even thorough individuals suffering with a mental illness do benefit from empathic interactions and thought out strategies for intervention, they also can pose safety risks for both themselves and others. Essentially, removing any sort of police response can unfortunately put both mental health workers and patients themself at risk of unintentional harm.

Lastly, longitudinal studies suggest that the quality of actual therapeutic interventions may be more beneficial compared to immediate crisis responses when predicting recovery and stabilization of symptoms (Andreoli et al., 1992). While urgent interventions remain necessary for immediate safety, the quality of care seems to improve outcomes over a sustained period for these individuals. Overall, these studies show that while law enforcement involvement in mental health crises is often necessary for the short term, the long term effectiveness and outcomes for patients of these responses depends on the broader integrations and support systems in place.

Comparative Analysis of Police and Mental Health Approaches

Some stereotypes tend to look at mental illness under a lens of violence. However, the relationship between mental illness and violence is extremely multifaceted. For example,

research does provide evidence that those with serious mental illness (Major Depressive Disorder, Bipolar Disorder, Schizophrenia, Antisocial Personality Disorder) are somewhat more likely than members of the general public to commit acts of violence. For example, this risk is more strongly correlated with those suffering from substance abuse, histories of violence/aggression, environmental factors, socioeconomic status (DeAngelis, 2022). On the flip side, some research indicates that people with mental illness may actually be more likely to be victims of violent crime, than the initial perpetrators (Ghiasi et al., 2025). Regardless, many symptoms that occur in acute crises involve hallucinations and severe psychosis, suicidal ideation, self-harming behaviors, impulsive behaviors. These symptoms put individuals at risk of dangerous behaviors such as running away, attempting to use weapons or ingesting pills to cause self-harm, wandering into unsafe environments, or unintentionally escalating interactions with others (Mason et al., 2014). In these situations, police involvement is sometimes necessary, not to punish or criminalize, but rather to secure the environment and keep these individuals safe and under supervision until mental professionals can intervene.

Law enforcement officers and mental health professionals bring fundamentally differing skills to crisis situations. Police officers are primarily tasked with enforcing laws and keeping the public safe. This might include investigating crimes, mediating disputes, protecting victims, monitoring traffic, assisting at accident sites, helping citizens get to safety, and conducting search and rescue operations (Walden University, 2025). They can assess and de-escalate situations if a mental health crisis is present, but cannot provide clinical treatment. Mental health professionals, on the other hand, are tasked with improving the health and wellbeing of others. They focus on clinical assessment of both mental and physical symptoms, diagnosis, therapeutic interventions and strategies to reduce and/or manage symptoms, and long term treatment goals (National

Alliance on Mental Health, 2020). However, they lack the authority, physical capacity, or specific training to manage high risk behaviors and unpredictable environments that are occasionally involved in the individuals they are treating. When looking at these fields separately, it seems they work well in combination (rather than apart) when dealing with the aspects of both safety and mental health knowledge that arise during acute crises.

Unfortunately, public perceptions of both fields sometimes still complicate these dynamics. Many police officers have faced criticism for differing outcomes based on race, excessive use of force in certain encounters with the public, and escalating distress - contributing to community fear and mistrust (Pastor, 2023). At the same time, mental health services have been criticized for being under-resourced, slow to respond, and inconsistent advice when it comes to treatment outcomes (McGinty, 2023). A few individuals also hold beliefs that mental illness is a sign of personal-weakness, rather than a multimodel of genetic, biological, and psychological causes (UNC Health Caldwell, 2022). Because of this, sometimes people refuse to seek help or do not want to take guidance from these professionals. These tensions highlight the gap that is present in mental health crises. There is the desire to protect these individuals from harming themselves or others, while also the desire to ensure they are clinically treated with compassion, care, and expertise.

CIT Training and Officer Perspectives

Given that police officers and mental health workers may approach crises with differing roles and training, specialized reforms such as Crisis Intervention Training (CIT) have attempted to bridge this gap. A common model that has been used internationally is known as the Memphis CIT model. The primary goals of this model are to increase safety in encounters with high-risk

patients, while also diverting them away from the criminal justice system and into mental health treatments (Watson & Fulambarker, 2012). Aside from this specific model, CIT related models elsewhere in the United States are similar, with the common goal of improving encounters with the police for patients during crises. However, some differences exist in terms of format and intensity (CIT Center, 2025). Some police departments position this training as mandatory while others include it for officers wanting to specialize in mental health areas. The training also differs in required hours, but many include the standard model with coursework spanning over forty hours. Some parts may be instructed online, while others may be required to attend in person. Oftentimes, community social workers, psychologists, crisis clinicians, and experienced officers provide instruction alongside the course (National Alliance on Mental Illness, 2025). Together, they teach education about mental illness, improved communication skills, de-escalation strategies (revolving around a calm, patient approach/demeanor), and practice exercises with scenarios attempting to model real life crisis calls (Axon, 2025).

In general, officers who complete CIT training (either voluntarily or required) usually report leaving the training feeling like it's helpful and with new insights on how to help calls where an individual is experiencing a crisis. Even though officers in both programs benefit, research suggests that self-selected volunteer programs may be more beneficial. This is because the officers that choose to go voluntarily tend to feel that the training is more necessary. With a desire to "enlighten" their attitudes and skills surrounding mental illness, they often have a more positive attitude toward those suffering from a mental illness, and are also more likely to refer individuals to treatment facilities when arriving on scenes. This has led to some departments preferring volunteer based CIT programs, as it allows them to determine which officers might be of better interest when sent to mental crisis calls (Dillon & Oliver, 2024).

However, as the previous takeaways from the research suggest, CIT training still appears to have mixed results. It therefore seems that it might not inherently improve outcomes on all calls, but could be beneficial to provide to officers specifically motivated to improve their crisis response strategies.

Regional Variability In Crisis Response

As the research from this thesis highlights, responses to mental health crises are not entirely the same across regions in the United States. Instead, they are typically influenced by local resources, policies, and broader community contexts. For example, some focus group studies have emphasized that rural communities often face challenges in these crisis programs such as smaller police departments, lengthy travel times for psychiatric patient transports, and limited infrastructure within the community for connected mental health resources (Skubby et al., 2013). These challenges unfortunately cross over into dispatch systems in these areas as well, with many having less access to crisis teams and CIT trained officers, and limited training availability (The Pew Charitable Trusts, 2021).

On the flip side, research suggests that larger, urban agencies often have specialized crisis units or designated personnel for these calls, and extended partnerships overall (Lidenfeld et al., 2025). Given their locations, they often also are closer to certain high density hubs with hospitals, mental health centers, and law enforcement agencies (Bailey et al., 2018). It appears that access to all of these resources within a timely manner may be a large factor in contributing to successful crisis outcomes.

Media-Highlighted Scenarios

Media coverage highlights both the strengths and challenges of police involvement in mental health crises. To begin, highway patrol officer Kevin Briggs has been credited with saving over 200 individuals from suicide attempts due to his patrols on the Golden Gate Bridge in California. This has him commonly referred to as "the guardian angel of the Golden Gate Bridge". Initially untrained in crisis-intervention, he self-educated himself on various negotiation techniques, active listening, and empathy - common principles taught to crisis counselors. Since his retirement, he dedicated work to suicide prevention and mental health awareness (Kenton, 2024). In addition, there are many individual incidents that have ended up in the media to highlight how police have successfully saved lives in crisis intervention. Across these multiple incidents - with individuals on rooftops, bridges, or in acute mental distress - officers were able to successfully intervene with empathy, patience, and communication (Moon, 2023; Brooks, 2020; Chiu, 2025). Unfortunately, there have also been tragedies with some cases ending up in the media spotlight as well. For example, Christian Glass called 911 for assistance when his vehicle became stuck in an embankment in Colorado. His family reported that he was suffering a mental health crisis, and had had bouts of depression and was medicated for ADHD. It was suspected he may have been suffering from paranoia, and told the officer he was afraid to get out of his vehicle for over an hour. The police officer broke into his car to which Glass grabbed a knife. The officer ended up firing his weapon resulting in his death. Drug screening later came out showing a mix of alcohol and drugs in Glass' blood levels. Later, the sheriff's department terminated his position and he faced criminal charges (Quinn, 2025). In another case, Marcus-David Peters was experiencing an episode of psychosis and exited his vehicle and ran onto Interstate 95, eventually being struck by another vehicle. The police officer on scene

approached him and felt there was no opportunity for de-escalation, eventually firing his weapon resulting in his death. A ruling later argued that the officer's response was justifiable to the level of imminent harm to himself and the people surrounding him on the highway (Lazarus, 2020). Both of these cases illustrate the high-stakes nature of these encounters, where officers must make rapid decisions to protect both themselves and the individual in crisis. It also highlights the need for ongoing attention to specialized and structured crises responses that are equipped to handle the severity of these cases.

Real World Case Example: CO: Responder Program in Morris County

As part of this thesis, I interviewed a clinical co-responder working with Morris County's ARRIVE together program, under the Mental Health Association. They began with the logistics of New Jersey's mental crisis response system, primarily funded through two main mechanisms: a newer state funded grant for the ARRIVE together program, and original federally funded grants for programs known as "Connect and Protect'. However, to ensure long-term sustainability, many programs are transitioning to current state funded grants. Morris County generally uses a combination of three models including a (1) true co-response model: social worker or individual with master's level background rides in the same vehicle with police officers for calls, (2) close-in-time model: counselors arrive about thirty minutes after police have secured the scene, and (3) follow-up model: mental health workers follow up with hospitals and contact individuals days after initial interaction to ensure they were linked with the appropriate follow up care. They also mentioned that the ARRIVE together program was specifically launched in eight towns (Denville, Montville, Roxbury, and Parsippany, Morristown, Morris Township, Morris Plains, and Madison), with additional expansions continuing into 2025

(Randolph and Hanover Township). As of May 2025, the program had been expanded to the remaining areas. A separate program known as Mobile Crisis Outreach Response Teams (MCORTS) was also launched in April 2025, and is utilized to respond to 988 (the U.S. National Suicide and Crisis Lifeline phone number) conversations without the need for law enforcement. It is typically utilized for low-risk/non-threatening mental health scenarios, substance abuse, and suicidal crisies when possible (New Jersey Department of Human Services, 2025). For specific cases involving incarcerated individuals, diversion programs within the state agency have also been utilized.

Their typical hours include eight to sixteen hour shifts from Monday to Friday, with no current 24/7 coverage. These are typically staggered alongside their law enforcement partners. In describing their day-to-day work, the clinician noted that they only respond after officers secure the scene, which means waiting in their vehicle until it is determined to be safe to engage. Some of their responsibilities include building rapport, de-escalation, ensuring additional safety, and performing follow ups approximately within seven to seventeen days (occasionally sooner if there is a higher need) after an encounter with an individual. They emphasize that their main goal is building rapport; law enforcement's main goal is making sure the individual is safe, doesn't have access to weapons, and collecting information about what led them to the time, place, and situation they are currently in.

In regards to training and resources, they mentioned that both officers and clinicians receive a variety of training including instructions for de-escalation, scenario-based role-play, viewing what "not to do" videos, training specialized in responding to those with autism (through parents of autistic children - POAC), and varied collaboration with social service agencies. They also mentioned handling cases beyond psychiatric emergencies including

disorientation present in Alzheimer's disease, agitation, and issues with housing and homelessness. They emphasized that they are usually able to address these unique needs as they have more time and flexibility than on-scene officers.

When discussing patient responses in crisis - they cite that they sometimes respond differently to clinicians than officers. For example, police officers frequently mention that these individuals do not want to talk to them given that they carry weapons and may be interpreted as more threatening. As a clinician, they are encouraged to wear business-casual clothing and aim for “soft” looks to try and reduce these fears and increase engagement. They also note that public perceptions of officers are mixed in general, with greater mistrust for them in urban environments, while better responses sometimes seen in suburban environments (like Morris County) given their soft-spoken yet confident nature handling crises on their own.

This extends into the CIT training and the co-response programs itself, with perceptions varied from person to person. When the ARRIVE program was implemented, they recall some officers liking the idea, as it was a way to take some of the burden off of them. Others did not want mental health professionals in their program. Some departments argued that their police buildings suffered from less staffing when training was implemented, as time was taken away to attend these forty minute training sessions - with a few officers even feeling they were unhelpful to a degree. Regardless, Morris County is actually working toward having all current police officers trained in CIT.

A separate interview was also conducted with a police officer (not connected with the ARRIVE together program), who provided additional insights into what drives officer decision making in crisis calls. They mentioned attending a good variety of mental health related calls, with each one being unique. They argued that de-escalation is not always effective, explaining it

takes two people to achieve a desired outcome: both the police officer and individual in crisis themselves. They mention feeling that there were scenarios where they did their best to be “kind” and “polite”, but the individual still tried working their way out of it. Sometimes, though not preferred, they found themselves trying to convince these individuals to go and seek treatment with such difficulty, that they had to be partially inaccurate about certain details surrounding the process. In their experience, they have also found that prolonged attempts at verbal de-escalation have given combative individuals more time to escalate, forcing officers to step in with physical interventions. Because of this, officers may weigh safety considerations heavily, especially when working with an individual with a history or violence or potential access to weapons. Some of the individuals they have come across in these crises gave pushbacks, attempted physical aggression with officers, or attempted to get themselves purposefully killed (a phenomeon known as “suicide by cop”). Other individuals were simply “going through it” and having a hard time with their life circumstances, and needed someone to relate too. Regardless, they highlight the concern for a quick crisis response and transport to care.

With these occasional safety concerns, they explain that a starting point of two officers are sent to each call, and most departments prefer that individuals are transported to the hospital in the back of an ambulance rather than a police vehicle. This is to try and reduce the feeling that these individuals are getting arrested. On occasion, individuals still remain combative or emergency medical technicians (EMT’s) feel anxious/unsafe, so officers ride in the back of the ambulance with the individual.

To conclude, the police officer’s perspective reflects the safety worries officers have that can arise unpredictable mental health crises for both themselves and the individual involved. The clinical co-responder’s original perspective complements this by emphasizing the importance in

de-escalation and serving as on scene trust and comfort when done appropriately, and continuity of care after the initial response. Despite differing professional priorities, they seem to work well together in practice under a collaborative approach.

Supporting Evidence For Thesis

The central argument for this thesis is that police officers can play a constructive and necessary role in mental health crises. The studies reviewed in the literature section provide evidence for this. To begin, police involvement remains essential in many crises because of the unpredictable safety risks that can present itself with acute mental distress and mental illness. Even though individuals with these conditions may not be violent, some of the symptoms can lead to dangerous behaviors (DeAngelis, 2022; Mason et al., 2014). Additionally, given that these individuals are at increased risk of being victims of violent crime (Ghiasi et al., 2025), police officers can protect and monitor the safety of these individuals who are otherwise in vulnerable positions.

In addition, many officers prefer alternatives to arrest, highlighting that the majority of them want to look for better outcomes for these individuals (Watson & Wood, 2017). Alongside this, many departments either have or are transitioning to CIT or multimodal approaches (Davis et al., 2021). Current CIT-training in particular, is correlated with increased officer confidence in mental health calls, improved occurrence of de-escalation strategies, increased referrals and transports to care (Compton et al., 2014). Some officers, when interviewed themselves, (both CIT-trained and non-CIT trained) also emphasize trust building with individuals, persuasion when necessary, and the safe and appropriate opportunities for a reset in a hospital setting (Watson & Wood, 2017). Models with the pairings of police and mental health workers, while

somewhat mixed, are often still able to bridge service gaps by linking law enforcement with social services and mental health care - all core components of topics involved in a detailed throughout crisis response (Lowder et al., 2024; Ban & Riordan, 2023). Models that completely remove law enforcement's role face a variety of background and planning challenges, and often still find themselves calling for their involvement when safety concerns arise (Goldman, Looper, & Odes, 2023).

Research on long-term outcomes also provides evidence for coordinated police involvement. A successful outcome for these individuals depends not only on immediate de-escalation and safety, but also on the quality of follow-up care and therapeutic engagement over time (Andreoli et al., 1992). Police based models that are able to divert individuals into the appropriate care can suggest that the initial police response has the potential to set the scope for longer-term recovery.

The interview included in this thesis with insights from a clinical co-responder and police officer involved in mental health crisis calls, also demonstrate that the core immediate goal is to ensure safety when responding to these individuals. Mental health crises present risks given their emergency like state, and it is essential to keep them safe. Only police officers continue to hold unique training and the ability to initiate certain psychiatric holds. Even when mental health professionals are involved, they are sent with police officers or instructed to stay off the scene until it has been secured for safety. The programs that utilize non-police approaches are typically restricted to unique low-risk 988 calls in which an individual may benefit from treatment or hospital transportation. Overall, while the addition of mental health professionals can absolutely ensure care is balanced and thoughtful for patients in crisis, there is evidence that police still play an important component of a balanced, thorough response.

Limitations of Current Research

While existing research provides valuable insights into the role of police in mental health crises, several limitations are necessary to include. To begin, many of the studies rely on cross-sectional or observational designs, in small localized samples. This limits generalizability and the ability to establish causal relationships (Compton et al., 2014; Watson & Wood, 2017). Additionally, the methods to collect data often rely on self-report measurements like questionnaires and interviews, introducing social desirability - particularly when officers describe their own experience in high-stress situations (Watson & Wood, 2017).

Another limitation is this disproportionate focus on urban settings, with limited research in rural areas. Some of the sample sizes are also small, undermining the internal and external validity of these studies (Davis et al., 2021; Ban & Riordan, 2023; Andreoli et al., 1992). Outcome measures often focused on short term, immediate outcomes when comparing models (Steadman et al., 2000), with only one core study looking at the true factors in long term resolutions (Andreoli et al., 1992).

The complexity of interventions further complicates interpretation, with both co-response models and non law enforcement models requiring law enforcement backup, making it increasingly difficult to isolate the effects of non-police approaches (Goldman, Looper, & Odes, 2023). Finally, external factors, regional policies, community resources, and crises (COVID-19) are rarely accounted for, especially when looking at the comparison of crisis responses worldwide (Marcus & Stergiopoulos, 2022).

Future Directions For Research

Future research should address these limitations by incorporating more rigorous and diverse methodologies to better understand the complex dynamics of police involvement in mental health crises. Longitudinal and experimental designs are needed to evaluate long-term outcomes and more accurately control certain variables. There is also a need for greater international and cross-regional comparisons, as variations in legal systems, health-care facilities, and cultural attitudes toward mental illness may shape the success or challenges of different crisis response strategies. Additionally, future work should aim to clarify the contexts in which police involvement is the most beneficial versus when an alternative response can be more appropriate, as insights surrounding that are still somewhat limited.

Research should also expand into novel areas that remain largely understudied. For example, examining how police-officer personality traits influence decision-making and de-escalations, could be helpful in determining better recruitments and recommendations for training. Additionally, investigating public perceptions of the existing models could help address community mistrust and foster community support. Even though some research has delved into the public perception of police officers themselves to a degree, border perceptions into crisis programs or roles that might be important remain mixed with no definite conclusions. Finally, incorporating the perspectives of individuals in crisis and their families would offer differing insights in how these models are experienced in practice, complementing the quantitative data that currently dominates the field.

Recommendations and Guidelines for Improvement

On a broader level, there appears to be a need to prioritize the development of coordinated crisis response systems to fill the present gap in immediate crisis intervention with the appropriate follow-up care, rather than solely relying on police officers to cover everything. In order to strengthen this, communication and coordination between law enforcement, mental health services, and local community resources need to be improved to ensure individuals receive continuous and thorough care. Aside from this communication, actual structured frameworks that clarify roles, responsibilities, and collaboration among responders has a high chance of improving outcomes to reduce the current issue with fragmented or incomplete care. These frameworks should be flexible enough to account for regional differences (suburban versus urban), to try and account for resource and staffing issues.

Public education and trust building are also essential in improving the care received by those in crisis. Misunderstandings and fear of police contact during a crisis intervention, as well as the ongoing stigma about mental illness can prevent individuals from getting the help they need. As noted in the interview with the clinical co-responder and police officer, these negative feelings are especially present in high density, urban areas. Educational initiatives and increased widespread awareness about what mental crises are and the importance of seeking care for symptoms can help reduce their barriers. Additionally, providing clear information about the specifics of the crisis models being utilized in local communities - and the steps that they entail - can help to reduce fears of uncertainty that are often present throughout the process. It needs to be emphasized that officers are solely present to protect and keep these vulnerable individuals safe - not to punish or make them feel badly.

Going off of this, police departments themselves have the opportunity to be more transparent and involved in this specific role, rather than seemingly coming to "control". Given their current main involvement in the initial point of contact, but large absence of follow up care, incorporating them into some smaller parts of the treatment process for follow up visits or educational insights and interviews from these individuals who have experienced and/or recovered from mental health crises themselves may be useful. This could help strengthen trust and prevent patients from getting into the mindset that they are "left-behind", shifting toward a more collaborative, person-centered crisis response system.

Conclusions

Understanding the crucial balance of safety and clinical care is vital in protecting vulnerable individuals in crisis, alongside fostering the broader community trust in these crisis response programs. Ongoing research is essential to explore long term recovery and outcomes, individual perspectives and experiences, and the remaining variables that influence the effectiveness of current models, including training quality, location, and access to resources. Recognizing the complex dynamics of these systems and varied outcomes for individuals is vital for continuing to develop and fine-tune crisis models that promote safety, compassion, detailed and thorough care, as well as lasting recovery.

Responding to mental health crises is inherently complex, with no current single approach adequate enough to address every scenario. The mixed literature suggests that outcomes differ across regions, with tragic results occurring at times. These realities highlight the need for flexibility with different models including police, clinicians, or both - depending on the

scenario. This open approach avoids blind spots that may arise when models attempt to take a one-sided approach.

In conclusion, mental health crises are complex, yet increasingly common, involving symptoms and behaviors that put both the individual and others at risk. As this thesis illustrated, police officers can play a constructive role in some of these circumstances, with the appropriate training, collaboration, and structured protocols. While officers provide immediate safety and forms of de-escalation, mental health clinicians contribute to assessment, treatment, and long-term care. There are essentially differing, but important roles that need to be activated in these response programs. Real world cases further highlight the successes and tragedies of these interventions, signalling a need for increased emphasis on coordinated, person-centered response systems.

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