A PROCESSES OF CO-RESPONSE CRISIS MENTAL HEALTH MODELS: *A Scoping Review*

Thematic Findings: *Three primary themes, each with respective sub-themes were identified to address how and why crisis mental health systems have been restructured into co-response models.*

1

THEME 1: DECRIMINALIZING MENTAL HEALTH consists of two sub-themes:

1.1 Re-Evaluating the Role of Police in Crisis Mental Health Response: The criminal legal system and the field of mental health are problematically intertwined. Police have been positioned as first responders to situations involving mental health, acute distress, and/or substance-use related crises, despite these situations warranting a healthcare response. Re-evaluating police involvement in crisis response has been essential in developing and introducing care pathways that prioritize mental health expertise, reduce the criminalization of mental illness, and promote access to healthcare supports.

1.2 Reducing Reliance on Police in Crisis Mental Health Response: Interactions between police and individuals experiencing a mental health crisis are often seen as negative, particularly for those in crisis, leading to outcomes such as police use of force, violence, detention, arrest, and escalation of the crisis. Very rarely do people experiencing a mental health crisis exhibit violence, but due to the long-held belief that these individuals pose a threat perpetuates the stigma and descrimination, which influences police to respond under the assumption that violence will occur. A common finding across the literature was that police services do recognize that the integration of mental health professionals into a crisis response is more cost-effective and efficient, thereby reducing the burden on police resources and improving the outcomes for all involved.

2

THEME 2: INTERPROFESSIONAL COLLABORATION:

2.1 Partnership Between Existing Services: Rather than developing entirely new services, co-responder models have been established as an extension of police departments and health authorities, through partnerships between already operating institutions within two sectors.

2.2 Unifying Strategies: The philosophies of the criminal justice and mental health systems are fundamentally different in terms of their goals and principles; law enforcement is guided by public safety concerns and the need to maintain order, often resulting in more authoritative and immediate actions. By contrast, mental health professionals focus on therapeutic engagement and de-escalation, emphasizing the importance of establishing rapport and supporting long-term well-being. This sub-theme therefore focusses on aligning, as best possible, the two perspectives for more cohesive and collaborative partnerships. It should be noted that this hinges on law enforcement's ability to learn from and integrate the practices of mental health professionals, and not the reverse.

2.3 Establishing Multidisciplinary Teams: Nearly all of the studies from this analysis indicated the restructuring of crisis mental health response models into co-responder teams involves establishing multidisciplinary teams. While there is no universal standard as of yet, identified partnerships included police and mental health clinicians, police and nurses, police and social workers, and police, ambulatory/fire, and mental health clinicians.

3

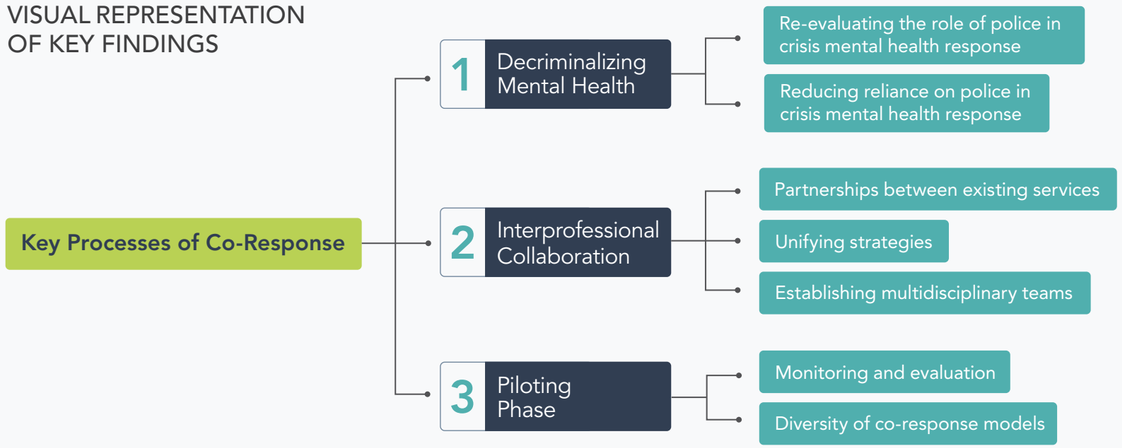
THEME 3: PILOTING PHASE

3.1 Monitoring and Evaluation
Pilot phases generally involved a preliminary period, ranging from 6 months to a year where a team is closely monitored and variables (such as number of calls, call resolution outcomes, service user outcomes) are measured and assessed, to justify the respective co-responder team's expansion, and potential increased funding for operation. For example, a year-long pilot by the Derbyshire Healthcare NHS Foundation Trust's street triage service paired mental health nurses with police officers to improve emergency responses to mental health crisis, and identified optimal practices for directing individuals to appropriate care and reducing unnecessary detentions.

3.2 Diversity of Co-Response Models
The rationale, approach, and implementation for piloting should be consistent, however there is considerable diversity in the composition of the team members involved (consisting of any combination of paramedics, mental health nurses, mental health practitioners, and police). Despite these variations in team composition, all teams which underwent a pilot phase successfully expanded their operations.

Pre-defining the pilot period can help establish concrete goals, ensure the program's impact is measurable, and that there is a clear plan for progressing beyond the pilot stage. A structured timeline also prevents programs from remaining indefinitely in an experimental loop, as this could impede efforts to secure funding, and erode stakeholder commitment and public trust.

VISUAL REPRESENTATION OF KEY FINDINGS



B RESTRUCTURING CRISIS RESPONSE PROGRAMS AS CIVILIAN-LED: *A Scoping Review*

Thematic Findings: *Three primary themes were identified regarding key processes involved in restructuring crisis response models into civilian-led teams, each with corresponding sub-themes:*

1

THEME 1: DECENTERING POLICE: explores the growing collective awareness of the harms associated with policing mental health and the corresponding need for alternative approaches, alongside efforts to establish a team composition that is intentionally distinct.

1.1 Collective Awareness: A key component in the shift towards establishing civilian-led crisis response teams was the collective awareness of the harms of policing mental health—noting that police involvement in crisis intervention often escalates situations, and disproportionately harms radicalized communities. This is largely due to law enforcement not being adequately trained or equipped to handle crisis interventions appropriately. The tragic murder of George Floyd by police officer Derick Chauvin in May 2020 was a catalyst event that precipitated calls for police reform and abolition, especially in regards to crisis intervention. A second example is the death of Regis Korchinski-Paquet, which highlighted the specific dangers of police involvement in crisis response, thus directly leading to the development of the Toronto Community Crisis Service.

1.2 Establishing a Distinct Team Composition
A consistent defining feature across models is the deliberate exclusion of police from team staffing, as civilian-led models recognize the inherent harm introduced by law enforcement in any form and have thus responded by eliminating police from team composition. It's been documented that police involvement often escalates emotional distress, resulting in harm towards the individual in crisis, and is particularly true for Black and other non-white individuals. Within this scoping review's included literature, civilian-led teams were often consisting of some combination of: nurses, mental health workers (including clinicians and/or peers), behavioural health crisis workers, and trained crisis responder volunteers.

2

THEME 2: OPERATIONAL FRAMEWORK explores the sub-themes of dispatch logistics and defining criteria for response.

2.1 Dispatch Logistics: While there is no universal standard for the point of access and the hours of operation for a team, the phone numbers 911, 211, and 988 were the most common, with a dispatch procedure consistently including initial calls for service, subsequent screening by the dispatch receiver, and finally dispatching the team. There remains debate about 911 being the most optimal option, as some communities do not associate 911 with safety. Allowing 911 operators to dispatch civilian-led teams alongside traditional emergency responders, or having multiple access points, including a dedicated crisis team number, could ensure broader accessibility and choice for this in crisis. Regarding hours of operation, 24/7/365 is the most desirable model, but barriers such as inadequate funding and challenges securing staff place limitations on programs. Ultimately, the goal is "to offer rapid assessment with 24/7 availability" (Karlsson et al., 2012, p. 3). While there is no universal standard as of yet, identified partnerships included police and mental health clinicians, police and nurses, police and social workers, and police, ambulatory/fire, and mental health clinicians.

2.2 Defining Criteria for a Response: Operators are trained to assess incoming emergency calls and determine when to dispatch a civilian-led team depending on if the call meets established criteria. Typically, these teams are dispatched when a caller uses certain keywords or phrases that match the team's predefined criteria for intervention. Across the literature, the most common keywords used to describe the types of situations these teams respond to include "mental health crisis", "substance use crisis", "non-emergency crisis", and "non-violent incidences". However, there is a lack of clear and consistent definitions for the these terms.

3

THEME 3: TEAM SUSTAINABILITY explores how social and political will to introduce how alternative crisis response teams shape the uptake and long-term sustainability of civilian-led crisis programs, as well as efforts to resource these teams.

3.1 Social and Political Will
Social will refers to the support and perceptions of community (Chalabi, 2019), while political will pertains to the commitment of elected officials and government bodies (Post et al., 2010). This relationship was identified as reciprocal, with community advocacy influencing political action, and political decisions in turn, shaping public engagement.

3.2 Resourcing
There are varying perspectives regarding the source and allocation of funding for civilian-led programs; some sources indicate it should come directly from cuts to policing budgets, while others suggest a dedicated funding stream through private funding sources.

VISUAL REPRESENTATION OF KEY FINDINGS