Processes of Co-Response Crisis Mental Health Models: A Scoping Review

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Abstract

Objective: Police services assume the role of first responders for mental health crisis situations. Interactions between police and individuals experiencing mental health crises are insufficiently lacking in mental health support and can result in police violence or other harm to the person in crisis. Advances in mental health and police reform has produced alternative response models such as the co-response model (i.e., crisis response teams, mobile crisis, crisis outreach). A co-response model is any crisis response model that includes both police officers and trained mental health crisis responders. This scoping review synthesizes knowledge on co-response models and presents key processes that facilitate this form of alternative crisis mental health response. **Method:** Covidence software was used by two independent reviewers to search eleven databases with terms including "co-response," "police partnerships," and "crisis response team." These reviewers screened 2690 titles and abstracts and 109 full-texts to include 76 articles. Nine independent coders employed thematic content analysis. **Results:** Three themes and seven sub-themes were determined as key processes of co-response. Decriminalizing mental health involves re-evaluating the role of police and reducing reliance on police in crisis mental health response. Interprofessional collaboration features partnerships between existing services, unifying strategies, and establishing multidisciplinary teams. A piloting phase permits monitoring and evaluation and highlights the diversity of co-response models. **Discussion:** Co-response crisis mental health models are increasingly common, heterogeneous in design and operation, and built upon existing infrastructure. Future inquiries could include trauma-informed care and the evaluation of non-police crisis mental health responses.

Keywords

Crisis Mental Health; Allied Health; Co-Response Models; Scoping Review

Introduction

Incidents of police violence toward people with mental illness or people experiencing a mental health crisis continue to rise (Haag 2022). A recent Canadian study has shown that over 70% of killings by police since 2000 have involved individuals with mental illnesses (Marcoux and Nicholson 2018), and these incidents have disproportionately impacted communities experiencing marginalization (Nicholson and Marcoux 2018). Such high-profile cases have resulted in increased scrutiny regarding the appropriateness and capacity of police to respond to mental health-related crises (Fritsch 2022), leading many to question whether police should be the first responders to mental health crisis calls. Resultantly, efforts to design and evaluate alternative approaches to mental health crisis response have emerged. The co-response model, which involves a team of police officers and trained mental health crisis responders responding to crisis calls together, is one model that has originated as an alternative approach to responding to mental health crisis calls (Koziarski 2018).

Background

North America's asylum project and subsequent deinstitutionalization movement have contributed to producing the current context of policing mental health. The inception of the asylum originated in part from the belief that people with mental illness were a "danger to be at large" (DeLottinville, 1976, p. 3) and required intensive, structured care. Institutionalization resulted in the ostracization of people with mental illness, with many scholars arguing that institutionalization's efforts were less focused on the provision of care and more concentrated on social regulation, management, and control (Cellard and Thifault 2006). Eventually, awareness regarding the harmfulness of these institutions incited a push for change (Winters *et al*. 2015).

The deinstitutionalization movement began in the 1960s and involved the rapid transfer of individuals from asylums back into the community (Sealy and Whitehead, 2004). The push for

deinstitutionalization occurred with the hope that individuals could receive treatment, have access to community mental health supports, and be socially integrated into the community (Sealy 2012). Deinstitutionalization paralleled the rise of neoliberalism as the predominant political economic system, and an appropriate allocation of funding into mental health community-based resources never occurred (Shimrat 2013). Many individuals with mental illness have been left with little support and resources (Ballard 2022). With a lack of support for mental health in communities, people with mental illnesses and substance use disorders have faced increased stigma, homelessness, criminalization, and frequent acute hospital admissions (Ballard 2022). Ultimately, the asylum project reinforced perceptions of individuals with mental illness as dangerous or unpredictable (Kalinowski and Risser 2005), while the deinstitutionalization movement failed to dismantle this stigma, and was further undermined by insufficient investment in community mental healthcare. These stigmatized views, coupled with chronic underfunding of community mental health services, have positioned the police as the default first responder to mental health crisis situations, in what is termed policing mental health (Koziarski *et al.* 2021).

In Canada, mental health crisis calls can comprise upwards of 60% of emergency calls placed to police services each year (Hoch *et al.* 2009). A Canadian study found that people with mental illnesses were 3.1 times more likely to experience police interactions relative to the general population, and are more than twice as likely to be charged and arrested (Hoch *et al.* 2009). Data from the United States and the United Kingston demonstrate similar findings (Hoch *et al.* 2009). A study conducted by the Canadian Mental Health Association, British Columbia division (CMHA-BC) found that, in a sample of individuals with mental illness, over 30%

endorsed having contact with the police while making or attempting to make their first contact with the mental healthcare system (CMHA-BC 2005).

When police are solely responsible for crisis mental health responses, the person experiencing a crisis is usually arrested, briefly detained, and released without the opportunity to access any mental health supports (Livingston 2008; Adelman 2003). Importantly, a situation where police are the sole responders to crisis mental health responses may result in adverse outcomes, including harm to a person experiencing a mental health crisis or in need of mental health supports (Macnaughton 2016). The mental impact of contact with police disproportionately affects marginalized demographics, including Black, Indigenous, unhoused, and/or mentally ill populations, who are placed at increased vulnerability to the harms of policing (Edwards *et al.* 2019). Jackson (2021) found that youth of colour report police encounters to evoke a great sense of shame, and that contact with police is experienced as highly distressing and traumatic, noting that police encounters must not be overlooked as a source of racialized trauma.

In some circumstances, police responses to mental health crises result in shootings by police (i.e., officer involved shootings) causing civilian death (Hoch *et al.* 2009, Livingston 2018 and Macnaughton 2016). During a 15-year period in British Columbia, 87% of shootings by police resulted in the death of people who either had prior experience in the mental health system or who exhibiting noticeable symptoms of mental illness (Macnaughton 2016). Data from the United States have recently confirmed contact with police to be the sixth leading cause of death amongst Black men (Edwards *et al.* 2019), and police are more likely to use lethal force toward individuals with the intersecting identities of experiencing mental illness and being Black and/or Indigenous (Gillezeau *et al*. 2022). Officer-involved shootings and continued reports of police

use of lethal force have heightened public concern of the roles and responsibilities of police, and have called into question police appropriateness of responding to mental health calls (Saleh *et al.* 2018), urging the exploration of possible alternatives to policing mental health (Wood and Watson 2017).

Reform and the Development of the Co-Response Model

Acts of police violence in the media (e.g., the tragic murder of Mr. George Floyd) have motivated a push for change within policing and calls for reform (Pasternak *et al*. 2023). The first wave of efforts, originating in Memphis following the tragic shooting of a local man by police, took form in sensitivity training for police (Rogers *et al.* 2019). This involved what has been coined as the "Memphis Model" or Crisis Intervention Training (CIT), which requires officers on the CIT team to complete a training program developed by mental health professionals (Compton *et al.* 2008). These CIT officers undergo both in-class and practice-based education to learn how to de-escalate and manage a crisis (Compton *et al.* 2008). CITs quickly gained government support (Kane *et al*. 2017). Despite seeking to improve mental health crisis response, research on the CIT model's capability of de-escalating crisis and reducing the use of force has been conflicting (Compton *et al*. 2014; Taheri 2016; Watson *et al*. 2011). Importantly, however, CIT training has consistently been found to be largely ineffective in mitigating mental health stigma and racial biases among officers (Chaplain 2023; Rogers *et al.* 2019; Yang *et al.* 2015).

The second wave of reform led to the development of the co-response model, which involves a paired team of police and mental health professional(s). The co-response model emerged in the United States in 1993 and is now being used by hundreds of jurisdictions across the United States, Canada, the United Kingdom, Australia, and elsewhere (Dempsey 2017). The goals of the model include preventing incarceration and violence against people with mental

illnesses, providing alternate care in a less restrictive environment, and reducing the burden on police services, allowing officers focus on their other duties (Dempsey 2017). Although this model has existed for roughly 30 years, there has been a lack of research evaluating the ways in which the model has been structured and implemented, as well research measuring the program outcomes.

Although there is variation among co-response models, they all involve collaboration between police and mental health practitioners when responding to mental health crisis calls (Yang *et al*. 2024). Other variables include the number of responders involved, the responders' backgrounds and training, as well as the model's response mechanism. For example, in Ontario, Canada, the city of Hamilton has implemented an emergency co-response model called The Mobile Crisis Rapid Response Team (MCRRT) as well the Crisis Outreach Support Team (COAST). These teams pair CIT-trained police officers with an experienced mental health crisis worker who respond to mental health crisis calls together. The MCRRT will respond to immediate and life-threatening calls, COAST will respond to less urgent crisis calls (Koziarski *et al.* 2021). Other programs employ a tri-response model, which involve including EMS or fire department personnel to respond to crisis calls alongside the co-response team of mental health clinician and police. A co-response team in Indianapolis follows this model, and involves a CIT-trained police officer, a master's-level mental health clinician from a community mental health network, as well as a local EMS paramedic (Bailey *et al*. 2022).

For the purposes of this study, the co–response model is defined as any crisis response model that includes, at minimum, police officers and trained mental health crisis responders that respond to mental health situations. Trained mental health crisis responders can include mental health practitioners, nurses and other trained civilians, however, our definition excludes

paramedics as mental health crisis responders. Models that include police, mental health crisis responders, and other professionals (i.e., fire personnel, paramedics) may also be included, so long as a trained mental health crisis responder is part of the team. Our rationale for excluding paramedics as a professional who, when paired with police, would compose a co-responder model, is theoretically grounded in the power dynamics that arise from institutional care. For example, when it comes to care for those with mental illnesses, hospitals are often insufficient at meeting the needs for mental health treatment and supports: they do not offer the same continuum of supports found in the community and can often perpetuate similar power dynamic as incarceration (Wahbi and Beletsky 2022). Accordingly, because of these problematic institutional power structures, mental health professionals included within the co-response teams must be separate from these systems and paramedics are too closely involved within the carceral health system.

Objective

In this paper, we aim to synthesize information to analyze how and why crisis mental health response has been restructured into co-responder models to identify the key processes that led to this restructuring and that sustain implementation of the co-response model.

Theoretical Frameworks

This review is guided by Restorative Justice and Institutional Theory. Restorative justice places a jurisdiction's community—which may include victims and offenders of crime alongside the general public—as the center and driving force of criminal justice policy and practice (Asadullah, 2020; Dickson-Gilmore & LaPrairie, 2005). Through decades of applied research using this theory, firm recommendations have emerged suggesting that the criminal justice system should be one that is comprehensive and holistic, participatory, and focused on taking

responsibility which may better align with mental health response than a police presence (Llewellyn & Morrison, 2018). Given how harmful the criminal justice system can be for those going through mental health crises, restorative justice explores alternative approaches (Muhammad and Gray, 2021). It also refers to practices where there is reform that diverges from the ideas of punishment and focuses more on healing and repairing the community (Drennan, 2018).

Institutional theory is a complementary framework based on the tenet that systems, like mental health crisis responses, are informed by the interconnection of individual factors, social environment, organizational contexts, and regulatory policies (Andresen and Shen 2019). Applications of institutional theory have found policing to be harmful to marginalized communities in its goal to maintain existing power structures. Harms include a distrust of police and an assaulted sense of self, which are at odds with recovery and the goals of community-based mental health care (Andresen and Shen 2019 and DeValve 2020).

Methods

A scoping review was employed to synthesize knowledge on co-response crisis models. Scoping reviews are designed to synthesize knowledge by identifying key concepts and gaps in research, thus creating a model of extant knowledge that can inform policy and practice (Pham *et al.* 2014). A scoping review was determined to be the most suitable knowledge synthesis method for this paper as the topic is broad, includes more than one research question, and explores an area that has been reported in both empirical and grey literature (Munn *et al.* 2018). Restructuring mental health crisis response systems away from police is not densely discussed in scholarly literature (Munn *et al.* 2018). Further, police forces have distinct internal cultures and external community relations that affect their attitudes and behaviours (Munn *et al.* 2018).

Therefore, modifying police services requires focusing on the unique context of specific jurisdictions.

Search Procedure

Following scoping review guidelines (Pham *et al.* 2014 and Munn *et al.* 2018) we registered the review with Open Science Framework and conducted scholarly database searches alongside searching relevant professional networks and works in progress. We identified relevant studies by completing 11 database searches that included APA PsychInfo, APA PsycArticles, CINAHL & MEDLINE Combined Search, Criminal Justice Database (collection and abstracts), CQ Researcher, ProQuest Health & Medical Collection, ProQuest Nursing & Allied Health Database, SAGE Journals, Sociological Collection (Sociological Abstracts), Social Work Abstracts, and ProQuest Dissertations and Theses. We also included grey literature and reports of co-response and civilian models. Key terms used to conduct the searches included "police" AND ["defunding" or "reallocating" or "reorganizing"] AND ["mental health" OR "distress"]. In addition, we used keywords to target specific response models such as "co-response," "police partnerships," and "crisis response team." Complete search syntax is available on Borealis (Eaton and Rowe 2024).

Inclusion Criteria

Literature was included if it examined a co-response model involving, at minimum, both police officers and trained mental health crisis responders (i.e., mental health practitioner, nurse), and if the focus of the literature was on mental health-specific crisis intervention. The literature had to recognize or explore one of the following: the need for non-police crisis response models; the potential of non-police crisis response models; the development of non-police crisis response models; the implementation of non-police crisis response models; the outcome of non-police

crisis response models; the impact of non-police crisis response models; or the efficacy of non-police crisis response models. The literature also needed to include programs that work with and are available to the public and to consider how the first point of contact takes place. We included international studies but restricted grey literature to Canada and the United States. We also included criteria that the literature was available in English, and published from the year 2000 onward.

Screening

Once our searches were complete, two reviewers independently performed the title and abstract screening of all articles using Covidence software and the inclusion and exclusion criteria established prior to the screen. The two reviewers met to discuss their reviews and consulted a third reviewer to resolve disagreements as necessary. After the title and abstract screening were complete, each reviewer was assigned articles to complete a full-text screen. The completion of this screening resulted in a total of 76 eligible articles. Refer to Figure 1 for the PRISMA flow chart.

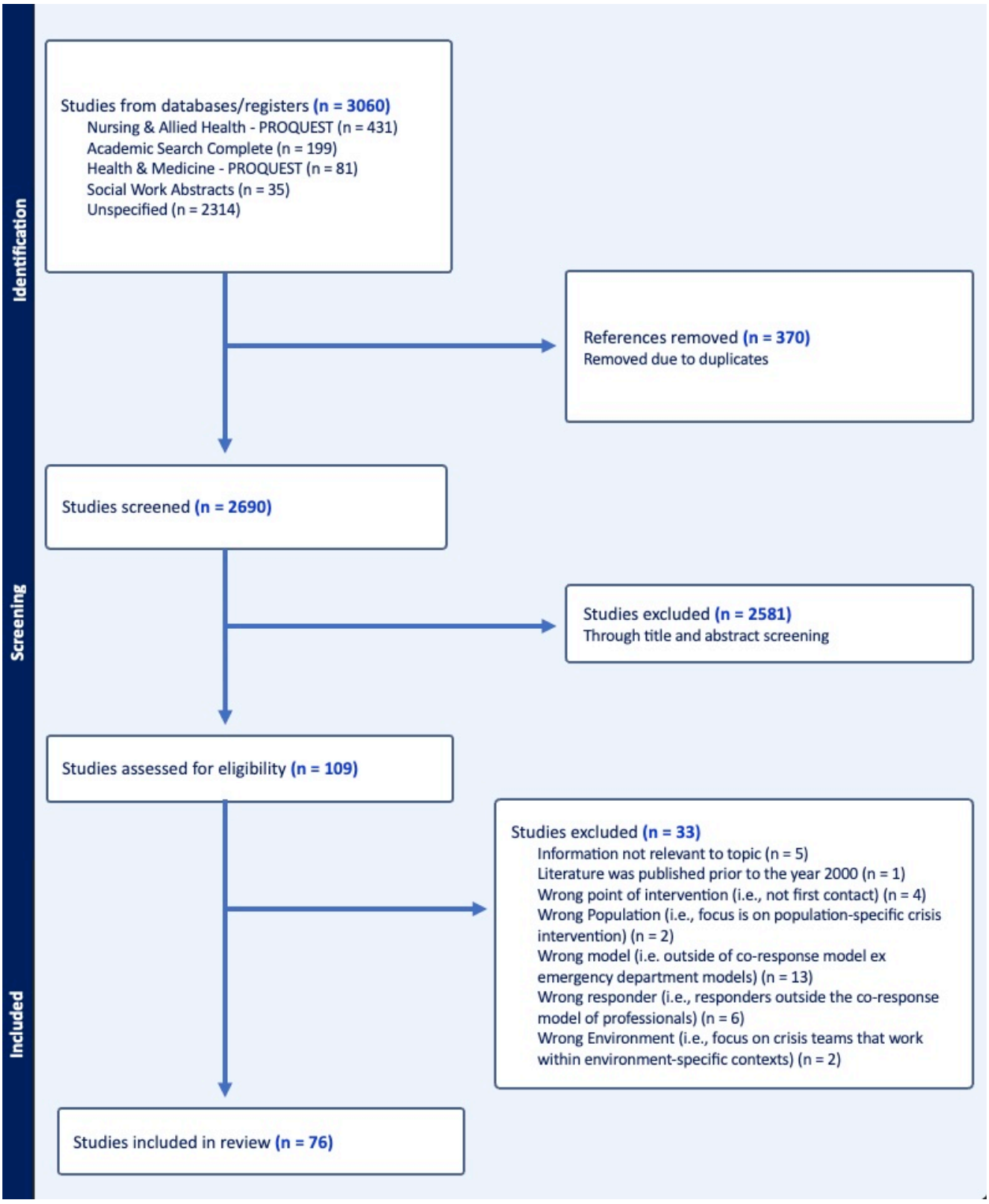

Figure 1: PRISMA flowchart

Data Extraction and Analysis

In order to extract data from the articles, trained research assistants documented information from the articles, inputting details into set categories such as modes of data analysis, aims/purpose, outcomes and more. This extraction allowed us to better synthesize the data needed for our research. The extraction spreadsheet is available on Borealis (Eaton and Rowe 2024). We then had a total of nine independent coders conduct thematic content analysis. Coders included people working within crisis mental health responses, people with lived experience of mental illness, mental health advocates, and policy analysts. Each of the coders were assigned eight-to-ten articles and was provided with a set of guiding questions (see supplementary file) to utilize in synthesizing information. Through independent review and reviewer meetings, themes and subthemes were identified and reported from the extracted literature. NVIVO 12 software was used to organize and analyze the data. Specifically, it was used to assign descriptive codes to the data, identify patterns among the codes, categorize codes into similar areas, and group such categories into major themes and subthemes. Quantitative data from studies were analyzed using numerical counts and tables.

Quality

The Mixed Methods Appraisal Tool (MMAT) Version 2018 (Hong *et al*. 2018) was used to assess the quality of evidence and risk of bias in the included studies. Only studies that met the criteria for MMAT appraisal were appraised (i.e., primary research based on experiment, observation or simulation). Each article was assessed using seven criteria. The first two items serve as screening questions ("Are there clear research questions?" and "Do the collected data address the research questions?") and are consistent for all articles. The MMAT suggests that further appraisal may not be appropriate or possible when the answer is "No" or "Can't Tell" to

one or both screening questions. Accordingly, articles that did not have a “Yes” for both screening questions were not appraised. The remaining five items are based on the study design (qualitative, quantitative randomized control trial, quantitative non-randomized, quantitative descriptive, or mixed methods). Each item was dummy-coded; the article was given a 1 if the response to the criteria was a “Yes” or a 0 if the response was a “No” or “Can’t Tell.” Articles were given ratings from 0% (low quality) to 100% (high quality) in 20-percentage point increments as five unique items were used for each study design (e.g., if an article received a “Yes” for each of the five items, it would receive a score of 100%, indicating the highest quality score).

Appraisal was conducted independently by one reviewer. A second reviewer cross-checked their work, making appropriate changes where necessary, such as altering literature categorization (i.e., from Qualitative to Mixed Methods Design) and/or changing responses to items (“can’t tell”, “yes”, “no”) where applicable. The appraisal results are posted on Borealis (Eaton and Rowe 2024).

Results

There were 76 articles included in this scoping review. Literature included qualitative studies (n = 22, 28.94%), quantitative studies (n = 15, 19.73%), mixed-methods studies (n = 15, 19.73%), and grey literature (n = 24, 32.89%). Zero studies were randomized controlled trials. The MMAT was used to appraise the quality of evidence of each article. Forty-six articles received a score of 100% and four studies received a score of 80%. Of the remaining articles, 23 articles were grey literature which cannot be appraised using the MMAT tool, and three articles did not pass the MMAT screening questions. Accordingly, these articles were not appraised. Of

the 15 quantitative studies, 13 scored 100% and two scored 80%. The 13 mixed methods studies scored 100%. Lastly, of the total 21 qualitative designs, 20 scored 100% and one scored 80%.

Figure 2 illustrates the thematic findings. Three primary themes, each with respective subthemes, were identified within the literature to address this research question: How and why have crisis mental health response systems been restructured into co-response models? The first theme, Decriminalizing Mental Health, included the subthemes of re-evaluating the role of police in crisis mental health response and reducing reliance on police in crisis mental health response. This theme speaks to various key components that have led to divesting from police-as-sole-response to mental health crisis calls. The second theme, Interprofessional Collaboration, included the subthemes of partnerships between existing services, unifying strategies, and establishing multidisciplinary teams. Each subtheme discuss various processes involved in the successful adoption and operation of co-responder teams. The final theme was identified as Piloting Phase, with subthemes of monitoring and evaluation, and diversity of co-response models, explains a critical preliminary process of co-responder teams that informs their broader uptake and expansion.

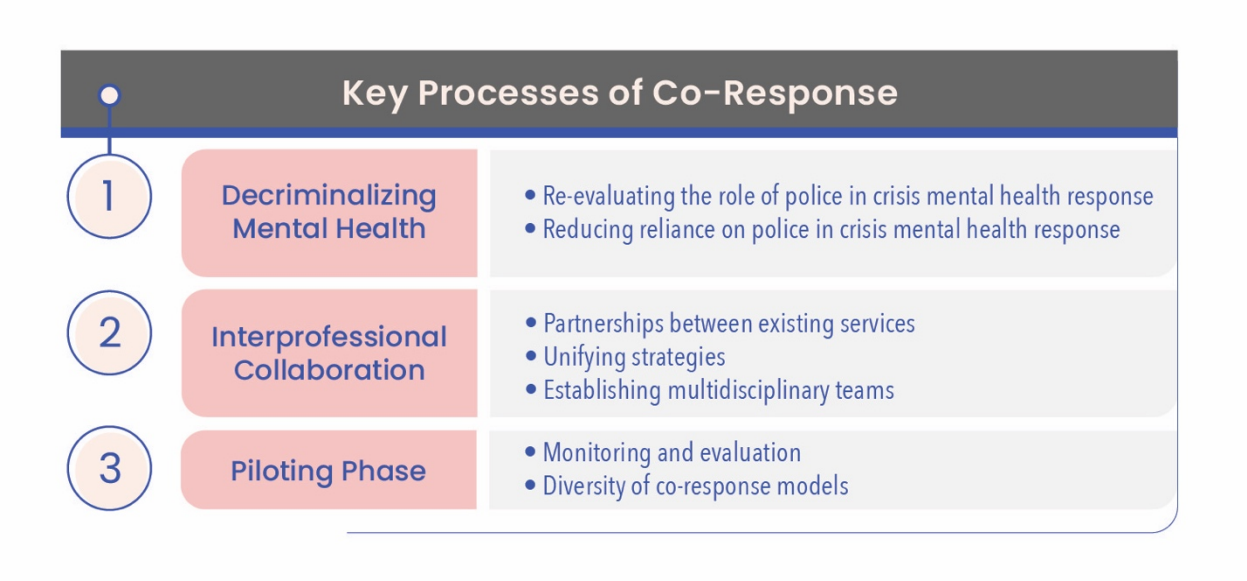

Figure 2: Key processes of co-response crisis mental health models

Theme 1: Decriminalizing Mental Illness

Sixty-eight articles discussed the importance of decriminalizing mental illness to prioritize mental health care over punitive interventions. Decriminalizing mental illness consists of two subthemes: challenging the role of police in crisis mental health response and reducing the reliance on police in mental health intervention.

Sub-Theme 1.1: Re-Evaluating the Role of Police in Crisis Mental Health Response

Fifty articles discussed the need to re-evaluate the involvement, scope, and power of police within crisis mental health response (e.g., Wood and Anderson 2023; Tatem *et al*. 2021; Seo *et al*. 2021a; Robertson *et al*. 2019). Re-evaluating the role of police in crisis mental health response pulls from a theoretical lens grounded within the intersections of public health, criminal justice, and social justice (Seo *et al.* 2021b). This lens emphasizes the importance of addressing the systemic factors that have led to the over-reliance on law enforcement in situations where mental health professionals may be better equipped to respond.

Semple and colleagues (2021), Shapiro and colleagues (2014), and Ghelani and colleagues (2023), amongst others (e.g., Dempsey *et al*. 2019; Yang *et al.* 2015; Ramasamy *et al*. 2021) discuss the deinstitutionalization movement's unfulfilled aspirations as a contributing factor to police being placed at the forefront of crisis mental health response. Specifically, police have been increasingly ascribed responsibility for acting as primary first responders for crisis mental health situations despite their inadequate positioning to do so (Cotton and Coleman 2006; Livingston 2008).

Cotton and Coleman (2006) and Abella and colleagues (2022), among others (e.g., Puntis *et al*. 2018; Morabito *et al.* 2018; Lopez 2016), discuss the need to critically evaluate and challenge the appropriateness of police-as-sole-responders to crisis mental health situations. Findings highlight that police often serve as the initial access point to mental healthcare services, obliging individuals seeking mental health support to first engage with the criminal justice system (Parker *et al.* 2018; Yang *et al.* 2015). The outcomes of deinstitutionalization, as well as the co-occurrence of mental illness and substance use, and/or the co-occurrence of mental illness and experiencing houselessness, were equally identified as factors that contribute to the criminalization of mental health and increased contact with police (Koziarski *et al.* 2021, Morabito *et al.* 2021). Ultimately, individuals with mental illness(es) are overrepresented in the criminal justice system and face disproportionate and often unwarranted contact with police (Koziarski *et al.* 2021), highlighting the concerning overlap between the mental health and criminal justice systems (Shapiro *et al.* 2014). The literature suggests that separating these systems is pivotal in preventing the criminalization of a healthcare matter such as a mental health crisis. Consequently, as identified across the majority of included studies (e.g. Allen 2019; Bailey *et al.* 2021; Bailey 2022; Blais and Brisebois 2021), re-evaluating the role of police and their

appropriateness within crisis mental health response has been an instrumental component in the restructuring of crisis mental health services. This re-evaluation 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.

Sub-Theme 1.2 Reducing Reliance on Police in Crisis Mental Health Response

Most of the included studies (*n*=45) explore the theme of reducing reliance on police in crisis mental health response. Studies indicate that co-responder models have been structured to support this objective by integrating mental health professionals into crisis response intervention to mitigate the scope and power of police that result from police-only intervention (Abella *et al.* 2022; Bailey, 2022; Bouveng *et al*. 2017; Brezowski 2022). 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.

Police officers, who are trained to enforce the law and criminal justice protocols, often lack the specialized skills required to handle mental health crises appropriately (Johnson, 2020). For example, police are commonly conditioned to adopt a "force first" mentality which involves asserting control through authoritative measures (Ruelas 2024). Johnson (2020) indicates that 'when you rely on law enforcement to respond to a situation, they're looking at the situation through a safety lens and interpreting behaviours as potential threats, and then they respond accordingly' (p. 1). Very rarely, however, do people experiencing mental health crises exhibit violence (Coleman and Cotton 2010). Yet, the inaccurate but long-held belief that people with mental illnesses are dangerous and unpredictable, which perpetuates stigma and discrimination,

coupled with the general mentality police officers are trained under, influences police to respond to these calls under the assumption that violence will occur (Johnson 2020).

While there is broad support for reducing police involvement in crisis mental health responses, the lens taken to champion this shift varies among key players, as evidenced across the articles included in this analysis. Specifically, while the literature suggests overall support for reducing reliance on police-only models, the underlying reasons for this support varies across key players. Mental health professionals and advocates within the field often discuss the importance of reducing reliance on police-only intervention to ensure that individuals in crisis receive appropriate mental health care without the risk of criminalization that many believe to be inherent to police response and/or presence (Lamanna *et al*. 2017; Semple *et al*. 2021; Shapiro *et al*. 2014; Young *et al*. 2008). Additionally, there is often a strong emphasis on the importance of offering specialized support that directly addresses the needs of those in crisis, rather than relying on inappropriate responses from the criminal justice system.

Professionals within law enforcement predominantly recognize the limitations of police-only models from a resource-based or fiscally-motivated standpoint, while some echo the aforementioned perspectives of mental health field personnel (Hellfgott *et al.* 2015; Lamanna *et al.* 2017). Commonly across the literature, police services see the integration of mental health professionals into crisis response as a more cost-effective and efficient approach, which can reduce the burden on police resources and improve outcomes for all involved (Hellfgott *et al.* 2015; Iacobini 2015; Reuland 2010). Alleviating patrol resources, reducing costs, providing better continuity of care, and promoting better use of police resources were mentioned as key factors in driving the restructuring of crisis response into co-responder models (Hellfgott *et al.* 2015; Iacobini 2015; Reuland 2010).

The restructuring of crisis response models into co-responder models, which reduces the reliance on police-only response, has allowed mental health crisis systems to intervene in situations more effectively and reach more supportive outcomes for those who need services. For example, the Mobile Crisis Rapid Response Team (MCRRT), formed through partnership between the Hamilton Police Service and St. Joseph's Healthcare Hamilton, has led to reduced hospital admissions, immediate on-scene care, and more appropriate diversions to community services compared to police-only crisis response models (Fahim *et al*. 2016). Similarly, the Boston Police Department's co-responder program, in partnership with the Boston Emergency Services Team (BEST), has been effective in reducing hospitalizations and arrests (Morabito *et al*. 2018). By providing on-scene mental health crisis support from a mental health professional rather than police, the program has improved crisis stabilization and diverted individuals from the criminal justice system to appropriate mental health services (Morabito *et al.* 2018). This approach has also enhanced the relationship between the community and law enforcement, fostering greater trust and cooperation (Morabito *et al*. 2018). Ultimately, restructuring police-only models into co-response models ensures that mental health professionals can provide specialized care during crises, which has been instrumental in improving the overall effectiveness of crisis response and reducing the strain on emergency services (Morabito *et al.* 2018; Fahim *et al.* 2016; Ghelani *et al.* 2023; Heffernan *et al*. 2021).

Theme 2: Interprofessional Collaboration

Seventy-five of the total seventy-six articles indicated interprofessional collaboration as a critical component of reconceptualizing and restructuring crisis mental health response services. The theme of interprofessional collaboration consists of three subthemes: *partnerships between existing services*, *unifying strategies* and *establishing multidisciplinary teams*.

Sub-Theme 2.1: Partnerships Between Existing Services

Fifty articles included in this analysis noted the importance of interagency collaboration in developing and operating co-responder teams. Specifically, findings indicate that many of the co-responder teams were established through the partnership and integration of existing services (Abella *et al.* 2022; Bailey *et al.* 2018; Cook 2019; Dyer *et al.* 2015; Kisely *et al*. 2010; Morabito *et al*. 2018; Mulder and Meckler 2014; Yang *et al*. 2015; Zuckerman *et al*. 2023). A number of co-responder teams identified across the literature (e.g., The Boston Emergency Services Team. The Mobile Crisis Rapid Response Team. The West Moreton Mental Health Co-Responder Program) were formed through the collaboration between pre-existing services (Kisely *et al*. 2010; Morabito *et al.* 2018; Mulder and Meckler 2014). Rather than being developed as entirely new services from the ground up, co-responder models have been established as an extension of police departments and health authorities, made possible through the partnerships between already operating institutions within two sectors (Huppert and Griffiths 2015; Morabito *et al.* 2018). Thus, despite the novelty of the respective co-responder teams themselves as a new form of response and service, the teams are supported by and created through the joint operations already existing systems (Kisely *et al.* 2010).

Sub-Theme 2.2: Unifying Strategies

Unifying strategies between the criminal justice system and the mental health field within the context of crisis mental health response was identified across forty-one included articles (e.g., Abella *et al*. 2022; Allen 2019; ANMF 2015; Bailey *et al.* 2018; Bonfire and Barrenger 2022; Dubey 2006; Erich 2021) as an integral step in creating co-responder teams. The criminal justice and mental health systems have fundamentally different goals and underlying principles that guide their practices. Consequently, the fundamental philosophies of each influence how their

personnel approach and handle crisis mental health situations. Police responses are typically guided by public safety concerns and the need to maintain order, often resulting in more authoritative and immediate actions (Johnson 2020). In contrast, mental health clinicians prioritize therapeutic engagement and de-escalation, emphasizing the importance of establishing rapport and supporting long-term well-being (Allen 2019). Therefore, the initial restructuring of crisis mental health models into co-responder models involves aligning, as best possible, the perspectives of mental health clinicians and law enforcement to ensure tailored responses and cohesive partnerships.

While unifying strategies could be perceived as aligning perspectives, it is important to make the distinction between these two ideas. The term 'unifying strategies' reflects a deliberate and positioned use of language, highlighting the importance of achieving a collaborative response effort between mental health professionals and law enforcement, without implying a merger of the underlying philosophies of each field. Where unifying strategies emerged as a key element for fostering a successful partnership between police officers and mental health personnel during crisis response, aligning perspectives did not. Instead, the restructuring of crisis response models into co-responder teams hinges on law enforcement's ability to learn from and integrate the practices of mental health professionals. This implies that it is, in fact, law enforcement that aligns with mental health best practices, rather than the reverse. Ultimately, the goal is not to achieve a balanced alignment of perspectives between mental health practices and law enforcement strategies, but rather for co-response approaches to enable police to adopt and/or permit the best practice strategies promoted by the mental health field.

Sub-Theme 2.3: Establishing Multidisciplinary Teams

Almost all the studies (*n*=71) included in this analysis indicated that the restructuring of crisis mental health response models into co-responder teams involves establishing multidisciplinary teams. Currently, however, there is no universal standard for which professionals should comprise a multidisciplinary team. The articles included here (e.g., Abella *et al.* 2022; Allen 2019; Barros 2023; De Caire 2015; Every-Palmer *et al.* 2022; Heyman and McGeough 2018; Isselbacher 2020; Kirst *et al*. 2015) showcase this diversity; they identified partnerships between police and mental health clinicians (*n* = 53), police and nurses (*n* = 9), police and social workers (*n* = 6), and police, ambulatory/fire, and mental health clinicians (*n* = 5).

Theme 3: Piloting Phase

Twenty-three studies discussed how the co-response teams implemented an initial pilot phase as a critical preliminary step. Pilot phases generally involve testing new interventions in a specific environment or area to identify potential challenges, refine protocols, and gather preliminary data. This phase is essential for ensuring that the intervention is feasible, acceptable, and effective before expanding implementation.

Sub-Theme 3.1: Monitoring and Evaluation

Across the included articles that discuss co-responder team pilot phases (*n* = 23), the main purpose of undertaking piloting was to monitor and evaluate the team's implementation and operation. Specifically, the pilot phases generally involved a preliminary period, ranging from six months to a year, where a team is closely monitored and outcome variables (e.g., number of calls, call resolution outcomes, service user outcomes) are measured and assessed (Allen 2019; Bailey *et al*. 2022; Bouveng *et al.* 2017; Brezowski 2022; Morabito and Savage 2021, Nursing

Standard 2013). These data are subsequently used to justify the respective co-responder team's expansion, as well as the acquisition of increased funding for the teams' operation. Each team that underwent a pilot phase was eventually expanded to offer a broader scope of service. For example, Brezowski (2022) explains that the Dallas-based RIGHT Care co-response team started as a pilot project in 2018 prior to its formal expansion in 2021. Both the Boston Co-Response Team (Morabito and Savage 2021) and the Dallas-based Mental Health Triage Hub (Allen 2019) followed a similar trajectory. The pilot phase also played a crucial role in the Derbyshire Healthcare NHS Foundation Trust's street triage service, which paired mental health nurses with police officers to improve emergency responses to mental health crises. This year-long pilot helped identify the most effective practices for directing individuals to appropriate care and reducing unnecessary detentions (Nursing Standard 2014). Finally, pilot schemes in Leicestershire, Cleveland and Scarborough involved preliminarily introducing teams of nurses and police officers to respond to mental health crisis calls (Nursing Standard 2013).

Sub-Theme 3.2: Diversity of Co-Response Models

Across the teams discussed in the included articles (n = 23), there is a consistent approach to implementing and justifying a pilot phase. However, it is noteworthy that while the rationale, approach, and implementation for piloting are consistent, there is considerable diversity in the composition of the team members involved in the piloted co-responder teams themselves. Specifically, teams consisting of paramedics, mental health practitioners, and police (e.g., Allen 2019; Brezowski 2022), mental health nurse and police (e.g., Nursing Standard 2013; Nursing Standard 2014), mental health nurses and paramedics (e.g., Bouveng *et al.* 2017), well as mental health practitioner with police (e.g., Morabito and Savage 2021). Importantly, despite the variation in team composition, all teams that underwent a pilot phase were reported to have

successfully expanded their operations following the completion of piloting. One other commonality is that none of the reviewed models specified 24/7 round-the-clock co-response.

Discussion

The findings from this scoping review, derived from thematic content analysis of 76 articles involving nine independent coders, illuminate the key processes for co-response crisis mental health models. Although there is growing recognition that police institutions are inadequate at responding to mental health concerns, the responsibility for mental health crisis response continues to fall chiefly to the police (Laing *et al.* 2009). The scrutiny of police and activism to decrease their role in mental health crisis response has, in part, led to better health outcomes for those in crisis or needing mental health supports as well as interprofessional collaborations via co-response models. Such alternatives fall within the principles of Restorative Justice, as the third theme demonstrates that these co-response programs are also scrutinized for safety and effectiveness (Scott and Meehan, 2017). There is no 'gold standard' to co-response as these models may often be developed due to the context (e.g., resources, partnerships, political will) of a particular area or jurisdiction. The key processes identified represent common elements that facilitate the creation, implementation, and evaluation of co-response crisis mental health programs. Critiques of the co-response model include that the criminal justice sector and the mental health field may ultimately be incompatible and attempts to merge them, such as through co-response, may prove unsustainable (Pepler and Barber 2021). From the lens of restorative justice, co-response may offer better care pathways for people struggling from mental illness (Lancaster 2016). Yet other criminology theories, such as transformative justice, suggest that co-response models do not address the systemic issues oppressing people experiencing mental health crises and concerns (Meehan *et al.* 2019).

Notably, there was a lack of detail on trauma-informed care (TIC) within the included articles. This is surprising since co-response models, per Theme 1, frequently develop due re-evaluation and reduction of police services which often result from community advocacy in response to traumatic events (e.g., officer-involved shootings). Further, TIC has been recommended within crisis and emergency mental health care (Saunders *et al.* 2023) as traumatic experiences have been associated with psychological distress (Chen *et al.* 2010; Hughes *et al.* 2017). While co-response models may inherently offer a less stressful interaction than a police-only response (Lee *et al.* 2015), intentional incorporation of TIC would provide further assurance that these alternative crisis mental health response models are providing safe community care (Evangelisa *et al.* 2016).

Implications for Policy and Practice

While there is no one way to develop a co-response model, this review found that the co-response models are fairly widespread and are reporting better outcomes compared to a police-only response. Given the diversity of professionals on co-response teams (e.g., social worker, nurse, psychologist, peer) and differences among them in how the models are put into practice, there is a good evidence base for co-response. From the evidence presented here, we suggest that police departments and community agencies interested in establishing and implementing a co-response team would benefit from having guidelines on how to do so, including how to establish community partnerships, leverage existing services, and evaluate the program outcomes. At the practice level, reviewed studies highlighted how the 24/7 nature of policing may conflict with limited hours for co-response programs. Considering round-the-clock co-response would greatly decrease the likelihood of police alone interacting with a person experiencing a mental health crisis, aligning with community preferences (Boscarato *et al.* 2014). Finally, pre-determining a

set pilot period prior to launch may be beneficial for revision, expansion, and sustainability (Helfgott *et al.* 2016).

Implications for Research

Based on the number of co-response models reviewed and, it may be possible to conduct long-term outcome evaluations of these models. Research that examines multi-year data on rates of arrest, hospitalizations, linkage to care, and other health outcomes could provide more definitive data on the efficacy of co-response models. While co-response models may be widely developed and utilized, they still include police at the site of mental health crisis response. An emergency mental health crisis response staffed solely by civilians (e.g., peers, social workers, nurses, psychologists) is another form of alternative response that does not involve police at all. Designing and evaluating civilian crisis mental health responses would provide a wider evidence base to inform how crisis response services are designed and how they respond to mental health.

Limitations

A systematic review and meta-analysis were not possible due to the great differences in model design and outcome evaluation (Cumpston *et al.,* 2019). Restricting the review to English reports limited the search scope. Due to the diverse language used to describe co-response, some articles may have been missed despite our multifaceted search strategy.

Conclusion

This review demonstrates that co-response mental health models are widely utilized as alternatives to police-only responses to mental health. Literature is heterogenous, meaning that model designs and outcomes are diverse, and has developed over the past three decades. Overall, co-response crisis mental health models are a promising alternative to better support people experiencing mental health crises.

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