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How to Get Cops Out of the Mental-Health Business

In Denver, a program to reduce police involvement in nonviolent 911 calls also reduced minor crime.

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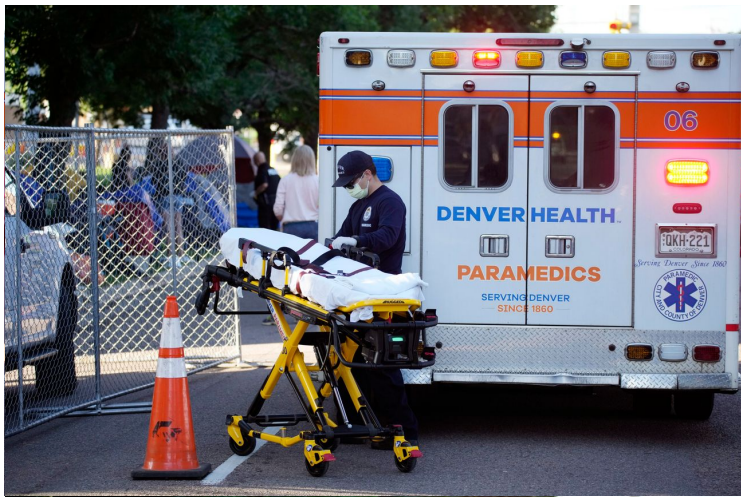
July 8, 2022 5:45 pm ET



A paramedic in Denver, July 7, 2021.

PHOTO: DAVID ZALUBOWSKI/ASSOCIATED PRESS

The police in St. Petersburg, Fla., knew well that Jeffrey Haarsma had mental-health issues. Officers had been to the 55-year-old's home at least 25 times in the year prior to an emergency call on Aug. 7, 2020. But the lone responding officer shot and killed Haarsma, who was unarmed, as he attacked her during an attempted arrest over a minor offense. While Pinellas County officials later decided the shooting was justified, they also concluded the call should have been handled as a mental-health issue rather than a criminal investigation.

Since that day, there have been nearly 2,000 fatal shootings by police officers in the line of duty. Roughly 1 in 5 involved a police response to someone showing signs of mental illness. It doesn't have to be this way.

Both the 2020 murder of George Floyd by a Minneapolis police officer responding to a 911 call over an alleged counterfeit bill and the school shooting in Uvalde, Texas, have drawn appropriate attention to police behavior. But what about when they are called to deal with nonviolent emergencies? How we design our first-response systems to deal with urgent events involving mental health

and substance abuse merits similarly careful scrutiny.

At least a third of the emergency calls to which police respond could instead be safely directed to health-focused emergency responders such as mental-health professionals, paramedics and social workers. Doing so is clearly humane because it provides people in distress with appropriate healthcare rather than an arrest (or worse). Mental-health first responders can reduce the risk of tragic and violent escalation and attenuate the substantial financial costs of shunting mentally ill citizens into the criminal-justice system.

Redesigning first-responder systems to incorporate mental-health expertise should also have the enthusiastic support of a broad political coalition. Surveys of police officers indicate that they feel overwhelmed and frustrated by mental-illness calls, for which they have inadequate training. Similarly, voices for police reform don't want armed officers responding to nonviolent calls for assistance. The reallocation of existing police resources to fund mental-health first responders will allow police departments to focus on their core mission of law enforcement.

A small but growing number of cities have introduced innovative programs that screen emergency calls by the type of incident or with the guidance of a specially trained dispatcher. The goal is to identify calls where trained healthcare professionals can support police or directly serve as first responders. Boston, Pittsburgh and Seattle have adopted "co-response" models that allow police officers to query mental-health specialists for guidance or to have their in-person collaboration on field calls.

More ambitious but less common "community response" models forgo police involvement altogether on carefully screened calls. The seminal program, which began in Eugene, Ore., more than 30 years ago, has 911 dispatchers direct nonviolent incidents involving behavioral health to a two-person team consisting of a medic and a mental-health crisis specialist. New York City and Washington began piloting similar community response initiatives last year and more recently have expanded the scale of these operations.

We know far too little about the effectiveness of these programs, the relevance of their design details, and how to meet the challenges of implementing these programs well. Nonetheless, our recent study of a community response initiative in Denver suggests their promise is compelling and extraordinary.

In June 2020, Denver piloted a community response program in the city's central

downtown neighborhoods, dispatching a mental-health clinician and a paramedic in an equipped van to nonviolent emergency calls related to mental health, substance abuse and homelessness. These teams responded most frequently to incidents involving trespassing, welfare checks and requests for assistance. Over its first six months, Denver's community responders handled 748 calls for service, none of which resulted in an arrest.

Our independent analysis found that in the eight police precincts where the pilot was active, Denver's initiative reduced targeted, lower-level crimes such as disorderly conduct, trespassing and substance abuse by 34%. These reductions also occurred during hours when the community responders were unavailable, a finding consistent with the evidence that people in untreated mental-health crises are likely to offend repeatedly. We also found the program's corresponding reduction in police involvement didn't lead to an unintended increase in more serious crimes.

These results illustrate that the direct cost savings of a community response program can be considerable. We estimate that Denver's community response program cost only $151 per criminal offense avoided. That amount is only a quarter of the estimated cost of processing lower-level offenses through the criminal-justice system.

We'll never know for sure whether Jeffrey Haarsma would still be alive if his serial engagements with the police had included mental-health supports. But the available evidence on the exceptional promise and simple common sense of community response programs is a strong argument for studying this innovation throughout the country.

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Appeared in the July 9, 2022, print edition as 'How to Get Cops Out of the Mental-Health Business'.