

Integrating Anti-Oppressive Practice into Mobile Mental Health Crisis Response

by

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Abstract

This capstone explores the integration of anti-oppressive practice (AOP) in Mobile Mental Health Crisis Response. The exploration is based on a comprehensive literature review of three crisis response models: police-led, co-response, and non-police community response. Each model is evaluated according to its effectiveness, challenges, and limitations, focusing on outcomes for marginalized populations. Findings suggest that while progress has been made in reducing harmful outcomes, significant gaps remain in the ability of each of these models to address the complex needs of individuals in mental health crises, especially those from marginalized groups. Recommendations include the integration of AOP across all models as a key way to improve service delivery and outcomes across all three models, the decreased deployment of police-led response, and the increased use of non-police community response models to address mental health crises.

Keywords: Anti-Oppressive Practice; Mobile Crisis Response; Police Involvement in Mental Health Crises

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Chapter 1: Introduction

Mental health-related emergencies represent a significant portion of 911 calls, with the Royal Canadian Mounted Police responding to an estimated 10,000 calls every month. In the United States, mental health factors are involved in one-tenth of all police callouts (Fuller et al., 2015; Tunney, 2020a, as cited in Ghelani 2021). Traditional emergency call systems, which can only dispatch firefighters, police, and paramedics, are inadequately equipped to handle the complex demands of mental health emergencies. Historically, police have attended mental health-related calls because of a real or perceived danger to first responders by the person in crisis. The use of police as primary responders to mental health-related emergencies has sparked controversy and public outcry due to ongoing incidents involving inappropriate use of force (Thyberg, 2022). Compounding the issue is a known correlation between marginalized individuals and the severity of outcomes with police encounters. Black, Indigenous, and racialized populations are statistically overrepresented in incidents involving police violence and fatal encounters and police violence represents a leading cause of death for young men of color (Singh, 2020, as cited in Ghelani, 2021; Edwards et al., 2019).

Furthermore, half of fatal police incidents in the USA have mental health problems as a factor; the risk of fatality for a person with untreated mental health issues during a police encounter is 16 times higher than the norm (Fuller et al., 2015). In Canada, 70 percent of people killed by police since the year 2000 have had mental health or substance use issues, a statistic that is on the rise (Marcoux & Nicholson, 2018). These statistics raise the question: how can emergency services provide appropriate care for those with mental health crisis that require in person intervention?

Attempts to address this complex question have resulted in the genesis of a variety of mobile mental health intervention teams across the world. The three most common approaches are: specialized police response, integrated police and mental health worker co-response, and non-police community response (Marcus & Stergiopoulos, 2022).

Overview of the Topic

The role of police as de facto first responders to mental health crises emerged during the Community Mental Health movement and the era of deinstitutionalization following World War II (George et al., 2023; Shapiro et al., 2014; Wood & Watson, 2017). Knowledge of the inhumane conditions of state-run psychiatric institutions, as well as public discomfort with the notion of sending shell-shocked veterans to these hospitals, contributed to the social movement of deinstitutionalization (George et al., 2023). During this time, antipsychotic medications became available to treat mental illnesses like schizophrenia and gradually replaced inhumane treatments like lobotomies and electro-convulsive therapy. Policymakers and mental health experts began to conceive psychiatric disorders as a public health issue and proposed a vision of community-based treatment in outpatient settings (George et al., 2023). Deinstitutionalization became the norm in North America as public programs were increasingly compelled to transition from institutionalizing individuals with mental illness towards a community-based care model. Between 1955 and 1980 state psychiatric hospital populations were reduced by 75% in the United States (Geller, 2000, as cited by George et al., 2023). While this shift aimed to provide mental health services in less restrictive and oppressive environments, lack of budget and resources led to challenges in providing effective outpatient care. For example, capacity crises emerged in psychiatric and medical emergency departments (Boyd & Kerr, 2015; George et al., 2023; Wood & Watson, 2017). Only 700 of the planned 1500 community mental health centers

were built in the United States; most of these centers were primarily focused on prevention and mild to moderate mental health care while neglecting to implement treatment options for severe and chronic mental illness (George et al., 2023). Consequently, the responsibility for responding to mental health crises began to fall heavily on first responders, who became the primary contact for de-escalating, detaining, and transporting individuals in crisis for mental health treatment (Dempsey et al., 2020; George et al., 2023; Wood & Watson, 2017). Psychiatric deinstitutionalization in the United States and Canada, coupled with insufficient community funding, has resulted in delegating mental health response primarily to police, who in turn have few resources available to them to adequately support individuals in a mental health crisis.

Incarceration of Persons with Mental Illness

Lacking adequate training and a clear mandate to attend to the care of those with mental illness, law enforcement officers were required to pivot to fill the significant gap created by the closure of psychiatric institutional facilities and the unfulfilled promise of community health centers to replace them (Dempsey et al., 2020; Wood & Watson, 2017). Legislation was shifted in many jurisdictions to allow police officers to legally detain and involuntarily transport persons with perceived serious mental health issues (Dempsey et al., 2020). Officers were left with few tools to deal with situations involving individuals with mental illness often resulting in coercive or involuntary transport to emergency departments or arrest and detainment in prison (Dempsey et al., 2020; Boyd & Kerr, 2015). Consequently, persons with mental illness began to comprise a large percentage of inmates in jails due to being seen as a disturbance to the public and lack of appropriate community supports, a trend that continues to the present day (Dempsey et al., 2020; Waters 2021). While many individuals with mental illness have ended up in the carceral system, others have become homeless or housed in single-room occupancies (SRO) where they are again

more likely to encounter police than those who have stable housing (Boyd & Kerr, 2015; Waters 2021).

Beyond criminalization, incidents of police use of excessive and lethal force have resulted in public protest and questioning of police policy. Fuller et al. (2015) estimated that 25-50% of all fatal encounters with police involve individuals with mental illness. The host of negative outcomes for individuals with mental illness encountering police—including heightened risk of death by police, involuntary detainment and transport, cyclical interactions with police and criminalization—has generated increased public scrutiny of the status quo (Dempsey et al., 2020; Fuller et al., 2015; Thyberg 2022; Waters, 2021). In response, policymakers and police agencies have implemented alternate programs to attempt to more appropriately deal with calls involving mental illness. While the landscape of police and community programs is different in every locale, the most common three types of alternatives to traditional police response to mental health are specialized police programs called Crisis Intervention Teams (CIT), programs that pair a mental health worker and a police officer (Co-response), and non-police community crisis response teams.

Racial Oppression and Persons with Mental Illness

Critics of police involvement in mental health care point to their historical role in protecting the slave trade in America and colonization in Canada, and divesting of power from Black and Indigenous populations (Lajtman, 2020; Waxman, 2017). This role of maintaining social inequities, racial oppression through segregation, and over-policing of racialized and marginalized communities continues to the present day (James-Townes, 2020). The historical and continuing relationship between law enforcement and marginalized communities has often been one that is punitive and harmful (Sato, 2020).

The murders of Breonna Taylor, George Floyd, and others have garnered further public attention on systemic racism within police and mental health services and catalyzed communities across the United States to declare racism a public health crisis (Balfour et al., 2021). Racism is increasingly being identified as being tied to negative health outcomes for racial and ethnic minorities, including creating barriers to accessing care as well as provision of inadequate or improper care (Cenat 2020; Williams, 2002). In response, stakeholders are calling for new and alternative social justice, anti-racist, and anti-oppressive approaches to mental health care (Kaufman-Mthimkhulu, 2020; Sato, 2020; Smith et al., 2022; Thyberg, 2023).

Anti-Oppressive Practice

Anti-oppressive practice (AOP) emerged as a framework in social work and mental health care in response to concerns that traditional care practices were perpetuating rather than combating oppression. AOP is influenced by several social movements and theories that gained prominence in the 1980s and 1990s, including feminism, anti-racism, social justice, and critical theory. AOP is also relevant to rethinking how mental health crisis response can be restructured to better serve marginalized communities (Fook, 2002; Thyberg, 2023). Central to AOP is understanding and resisting systems of domination that continue to influence, structure, and define mental health care systems (Ocampo & Pino, 2014). Williams (2002) suggests that addressing systemic racism and other forms of oppression is crucial for achieving social justice and combating oppressive systems of power. For these reasons, integrating anti-oppressive practice within mobile crisis response could be linked to positive outcomes for the individuals it serves. While there has been little research on mental health crisis response programs that embrace an anti-oppressive framework, a handful of real-world examples suggest AOP may

provide a promising direction (Kaufman-Mthimkhulu, 2020). These examples—such as Project LETS (2021) and M.H. First (Anti Police-Terror Project, 2023)—will be discussed in Chapter 2.

Purpose Statement

The purpose of this capstone is to explore the potential integration of anti-oppressive practice (AOP) into existing mental health crisis response models by first examining the existing research on the outcomes of mobile crisis response teams, including specialized police response, co-response and non-police response. The primary research question guiding this capstone is: How can AOP principles be incorporated into mobile crisis response models to improve outcomes for individuals experiencing mental health crises? This research is intended for mental health professionals, law enforcement agencies, policymakers, and scholars seeking alternative practices for mental health crisis interventions.

Contribution to the Field

Emergency response for individuals in mental health crises has increasingly been seen as deficient, particularly for individuals facing systemic barriers and structural oppression. Police involvement in these crises has led to poor outcomes for marginalized populations, highlighting the need for alternative approaches that incorporate anti-oppressive practices. Central to this capstone is a consideration of how AOP could be implemented in mobile crisis response as a core value system to improve outcomes. The research intends to analyze the body of literature on existing approaches to mobile crisis response and summarize the salient findings to determine the efficacy of current approaches. This analysis also seeks to identify knowledge gaps and areas for future study. Findings from this research could lend insight into the role of police in mental health response as well as ways to improve outcomes for service users.

Reflectivity and Positionality Statement

I approach this research as a cisgender, straight, white man and a Canadian-born settler descended from family who migrated from England, Ireland, and Scotland. I live in the unceded and traditional territories of the x^wməθk^wəy̓əm (Musqueam), Sk̓w̓x̓wú7mesh (Squamish), and səliłwətał (Tsleil-Waututh) Nations and was born and grew up in Edmonton which is located within Treaty 6 Territory and is the traditional territories of First Nations and Métis people including the Nehiyaw (Cree), Denesuliné (Dene), Nakota Sioux (Stoney), Anishinaabe (Saulteaux) and Niitsitapi (Blackfoot). My privileged position within dominant social groups has profoundly shaped my perspective and informed my commitment to examining the impact of systemic oppression in mental health crisis response. Growing up in a middle-class environment provided me with a stable home and a robust support network that saw my physical and mental health needs tended to. My experiences are contrasted with those of marginalized communities who face systemic barriers and inequalities. These communities must navigate oppressive systems in order to attempt to meet their needs often experiencing further harm in the process.

My interest in the topic of Anti-oppressive practice (AOP) and mobile mental health crisis response stems from a recognition of the disproportionate impact of current interventions on marginalized communities. As someone who has worked in the field of mental health and suicide crisis helplines, I have supported help-seekers to navigate an often-barren mental health landscape that too often relies on police or emergency departments (ED). Calling law enforcement for situations of mental health crisis became increasingly difficult as I learned of the inherent harms and possible dangers of police response. On top of stigmatizing and disempowering outcomes, instances of police officers killing individuals with mental illness – at times during mental health wellness checks – highlighted the grave ethical dilemma of calling

emergency services. The killing of queer and trans community member and activist Dani Cooper during mental health crisis by an RCMP officer in North Vancouver on November 12, 2022, a school classmate of my partner's, made this reality palpable for me (Ghoussoub, 2022). Dani's death was a tragic and shocking reminder for me that reports of police killing people with mental illness weren't happening somewhere distant, they were happening in my community, as they were in everyone's communities.

In my work in a variety of roles with a suicide crisis helpline, I have frequently encountered a lack of appropriate care for individuals needing urgent access to mental health support in Vancouver. This emergency service gap has led me to become curious about alternative ways of approaching crisis response. Vancouver does have a mental health response unit called car 87/88, which is a co-response unit pairing a police constable and a psychiatric nurse. However, through my experience as a helpline worker, I learned that this was not an emergency service. While car 87/88 may be effective in its support of the community, there is a significant gap that still needs to be filled by an emergency mobile mental health response team.

Through this research, I hope to contribute to a more inclusive and equitable model of mobile crisis response that recognizes and respects the diverse experiences and needs of all individuals. My goal is to advocate for a system that is not only effective in managing crises but is also compassionate and just in its approach. I acknowledge that my perspective is inherently shaped by my social location and positionality. In my journey through this research project, I have tried to maintain an anti-oppressive practice by regularly revisiting my assumptions and biases. I have tried to engage with the research in a way that is both critical and open to learning. Finally, I have attempted to maintain a lens grounded in cultural humility, aiming to lift the voices of those with lived and living experiences of mental illness and marginalization.

Definition of Key Terms

Anti-oppressive practice – a commitment to social justice that involves recognizing and challenging social power structures and imbalances and working towards equity. Practitioners of AOP must reflect continuously on their power and positionality in relation to others (Larsson, 2008).

Co-response Team – a team that is dispatched to respond to urgent mental health situations. Teams can be comprised of varying professions, including mental health workers (e.g., psychiatric health nurse, social worker, crisis responder) paired with police officers.

Crisis intervention – involves attending an individual or individuals in crisis to engage, assess risk, de-escalate, develop a safety plan, resolve conflict, provide referrals, and build relationships (Ghelani, 2021)

Crisis Intervention Team (CIT) – a police-based model for attending to situations involving mental health crises that features police officers with specialized training (Wood & Watson, 2017).

Mental Health Crisis – acute psychological distress where an individual's normal coping mechanisms fail (Roberts & Ottens, 2005; Iacobucci, 2014, as cited in Ghelani, 2021).

Non-police mobile response team – a mobile crisis team in which police are not primary responders. These models vary widely, variously featuring paramedics, mental health professionals, and/or peer supports.

Racism – a multifaceted form of oppression that privileges the dominant racial group while disadvantaging others (Corneau & Stergiopolous, 2012).

Service User – a person who accesses a mental health support or related service such as a mobile crisis response team.

Systemic Oppression – the structures in society that award power to individuals with dominant traits and take power away from and marginalize those with non-dominant traits. Structures of power have related oppressions, i.e. White supremacy & racism, heteronormativity & homophobia/transphobia, patriarchy and sexism, etc.

Outline of the Capstone Project Chapters

Chapter 1 outlined the historical context and current challenges in mental health crisis response and highlighted the need for integrating anti-oppressive practices. Chapter 2 reviews the literature on mobile crisis response. The chapter begins with an overview of the topic along with a discussion of the challenges inherent to researching mobile crisis response. The focus then shifts to an examination of (1) Crisis Intervention Team (police only), (2) co-response, and (3) non-police models of mobile crisis response. Research on each model is described; the effectiveness of each is considered through outcomes such as arrest rates, hospitalization, community referrals, and service user perspectives. The challenges and the efficacies of each model are also analyzed. Additionally, an anti-oppressive lens is employed to appraise and critique police and non-police crisis response models. Chapter 2 concludes with an overview of recommendations and areas for further research. Chapter 3 discusses the findings from Chapter 2 and considers anti-oppressive philosophy and its principles for use by mobile mental health crisis response teams. Principles that define and make up anti-oppressive practice are outlined and proposed as a guiding framework for crisis response.

Chapter 2: Literature Review

Police and Mental Health Crisis Response

The role of the police in mental health crisis intervention has been a subject of significant and ongoing public scrutiny and controversy. Recent incidents have highlighted the inappropriate use of force by police officers during mental health crises, sometimes resulting in injury or death (Fuller et al., 2015; Kaufman-Mthimkhulu, 2020). Police officers use higher levels of force on individuals who are perceived to have mental illness (Rossler et al., 2016). Further, these negative outcomes have disproportionately affected people of color and individuals with mental

health issues, exacerbating existing tensions between law enforcement agencies and the communities they serve (Balfour et al., 2021; Marcus & Stergiopoulos, 2022). The public has called for reform and more effective and humane approaches to crisis intervention.

While there is some consensus that current systems of crisis care do not adequately address the issues at hand, a wide divergence exists in ideas to affect change. Within this divergence, a central point of contention has been the role of police in mental health response. As a result, current mobile mental health crisis response can be seen to exist on a continuum with police-only response on one side and explicitly anti-police projects on the other (Anti-Terror Police Project, 2017). In the middle of the continuum are crisis response models like co-response teams that feature a mental health clinician paired with a police officer, or clinician-led models that will call police as backup if needed.

Two primary models of police-led mental health crisis intervention have been developed to improve outcomes of people in crisis: the Crisis Intervention Team (CIT) model and the co-response model. The CIT model, also known as the Memphis Model, involves specialized training for police officers to enhance their understanding of mental health issues and to equip them with skills for de-escalation and appropriate intervention. This model emphasizes partnerships with mental health professionals and community stakeholders to create a network of support and resources for individuals in crisis (Wood & Watson, 2017).

The co-response model takes a collaborative approach by pairing police officers with mental health clinicians during crisis calls. This partnership allows for immediate, on-scene mental health expertise, which can lead to more appropriate and effective responses to crises. Studies have shown that co-response teams can reduce the likelihood of escalation and the use of force, and they often result in better outcomes for individuals experiencing mental health crises

(Marcus & Stergiopoulos, 2022). Despite these advancements, the implementation of both models varies widely, and ongoing evaluation and refinement are necessary to ensure their effectiveness and sustainability.

Others argue that trained professionals or community-led initiatives, not police, are best positioned to respond to mental health crisis (Bosnic, 2020; James-Townes, 2020; Sato, 2020; Kaufman-Mthimkhulu, 2020). However, amidst non-policing models exists an even wider variability and little empirical research to guide best practices or demonstrate efficacy in outcomes (Marcus & Stergiopolous, 2022).

Challenges in Researching Mobile Crisis Response Teams

Since its inception, mobile mental health crisis response has been studied with efforts to evaluate and improve effectiveness and outcomes between responder and person in distress. Despite a large body of academic research and publication investigating crisis response, attempting to generalize findings has complications and limitations based on challenges resulting from numerous factors inherent to the subject (Marcus & Stergiopolous, 2022; Watson & Compton, 2019). Additionally, the research has disproportionately focused on police-led models in comparison to non-police alternatives maintaining a reliance on police systems rather than mental health systems (Watson & Compton, 2019).

Quality and design of studies is a factor to consider when analyzing the body of existing literature. Many studies that research mobile response teams are observational, lack control groups, and have a high potential for researcher bias (Marcus & Stergioupolous, 2022). There is a notable lack of randomized control trials and high-quality studies evaluating the effectiveness of mobile crisis response (Paton et al., 2016). These aspects regarding study design and research rigor obscure the applicability of the results.

Variability in implementation of and type of mental health response teams across different jurisdictions makes it difficult to compare outcomes and determine best practice (Marcus & Stergiopolous, 2022; Watson & Compton, 2019). Even when comparing two similar mobile crisis response models there are countless confounding variables when social geographical factors are considered. Many studies do not adequately control for these confounding variables making it difficult to isolate and attribute effects directly to crisis teams.

Across crisis team models there is a lack of standardization of structure and implementation (Dempsey, 2019). Differences between urban and rural settings can influence outcomes and add a confounding element to generalizing outcomes even when there are control and experimental conditions (Kisely et al., 2010). Different settings, populations, and implementation strategies contribute to this variability (Paton et al., 2016; Yang et al., 2017). The wide variety of crisis intervention models and practices make it difficult to standardize findings and draw generalizable conclusions.

Consistency of data that is tracked and reported is also variable based on jurisdiction and police organization or mental health service (Marcus & Stergiopolous, 2022; Yang et al., 2017). Many studies rely on self-reported data from police officers which is subject to recording bias and potential for underreporting of negative outcomes such as use of force or arrest rates (Kisely et al., 2010; Marcus & Stergiopolous, 2021; Yange et al., 2017). Generally, there is lack of accurate and standardized data tracking across police organizations which results in significant underreporting of negative outcomes such as fatal encounters (Fuller et al., 2015). Lamb et al. (2014) notes that there is a discretionary element to police response to mental health crisis that results in inconsistency in practices and outcomes which makes tracking and evaluation challenging. Boyd and Kerr (2015) describe that it can be in police departments best interest to

convey data that reinforces negative discourse and stereotypes that portrays mental illness as violent and dangerous to maintain and increase police resources (Boyd & Kerr, 2015).

Accessibility of and accuracy of data is a factor that can obfuscate the research process and results. Dempsey (2019) note there can be a lack of integrated systems for data collection and reporting between police and mental health services which hinders comprehensive evaluation and comparison of outcomes. Ethical and privacy concerns are a key factor in the lack of shared systems between police and mental health services which adds barriers and complications to the research and analysis that can be conducted.

When it comes to investigating community-led or grassroots-led models of mobile crisis response, there is a significant lack of high-quality research (Marcus & Stergioupolous, 2022). In general, studies lack control conditions or comparable data with non-specialized police response, limiting interpretation and generalizability (Blais et al., 2020; Khalso et al., 2018).

While mobile mental health crisis response has been extensively studied, several challenges limit the generalizability and applicability of the findings. The disproportionate focus on police-led models and the variability in study quality and design, such as the lack of randomized control trials and high potential for researcher bias, complicate the evaluation of different crisis response models. Furthermore, the diversity in implementation and structure of mental health response teams across jurisdictions, along with inconsistent data tracking and reporting, adds layers of complexity to determining best practices. The influence of social and geographical factors, coupled with ethical and privacy concerns, further hinders comprehensive research. Notably, the paucity of high-quality research on community-led models underscores the need for more rigorous and diversified studies to better inform and improve mobile crisis

response systems. Addressing these limitations is crucial for advancing effective, equitable, and evidence-based mental health crisis interventions.

Crisis Intervention Team (CIT)

The Crisis Intervention Team (CIT) response model originated in Memphis, Tennessee, in the late 1980s following a police incident resulting in the killing of a Black man in mental health crisis (Balfour et al., 2021; Wood & Watson, 2017). This event led to the development of a specialized response model aimed at improving police interactions with individuals experiencing mental health crises. The primary goal of CIT is to enhance outcomes for individuals with mental illness by providing police officers with specialized training to handle mental health crises effectively. The aim of the model is to reduce the use of force, prevent arrests, and connect individuals with appropriate mental health services (Dempsey et al., 2019; Ghelani 2021; Wood & Watson, 2017). With estimates of over 3000 jurisdictions having implemented CIT programs, it is the most prevalent model for specialized crisis response worldwide (Ghelani 2021; Wood & Watson, 2017).

CIT training typically involves a comprehensive 40-hour training program. The training includes several key components designed to equip officers with the necessary skills and knowledge. Officers receive education on mental health conditions, substance abuse, and co-occurring disorders. The training focuses on developing de-escalation techniques, crisis intervention skills, and effective communication strategies. Participants also engage in site visits to mental health facilities, where they meet with mental health professionals and individuals with lived experiences of mental illness. Role-playing scenarios are used to simulate real-life crises, allowing officers to practice their skills in a controlled environment (Compton et al., 2014; Dempsey et al., 2019).

CIT officers are called upon to respond to mental health crises, leveraging specialized skills and knowledge that they have been provided. The CIT model emphasizes collaboration between law enforcement, mental health providers, and community organizations, which is seen as crucial for providing comprehensive care and support to individuals in crisis (Dempsey et al., 2019; Wood & Watson, 2017).

Areas for exploring effectiveness and intrusiveness of police interaction include metrics comparing specialized police response to normal police response related in the areas to use of force, number of referrals to community resources, number of arrests, number of hospitalizations. Additionally, if police are receiving specialized training, analyzing whether they are gaining knowledge and understanding is important to examine as well as if that knowledge corresponds to better outcomes or not.

Improvement in Knowledge and Attitudes

There is some evidence that CIT training has positive effects on officer knowledge about mental health and reducing stigma. CIT training seems to increase officer knowledge about mental illnesses as well as better understanding mental health crisis and confidence in how to respond to it (Compton et al., 2017). There is evidence that CIT training is tied to reduced officer's stigma and increased empathy towards individuals with mental illness and increased awareness of the complexity of mental illness, specifically regarding schizophrenia (Compton et al., 2017). CIT-trained officers coded a larger portion of encounters as involving mental illness rather than substance use compared to non-CIT trained officers suggesting that they had a greater awareness and ability to detect mental illness (Compton et al., 2014).

Use of Force

The findings on the use of force in police interactions involving individuals with mental health issues are mixed. In general, mental health-related calls seem to have higher rates of police use of force (3.9%) than non-mental health-related calls (0.2%) (Yang et al., 2018). The most common types of force used were pointing a firearm (46% of cases), takedowns (32%), use of taser (19%), and the use of officers' hands or feet (12%) (Morabito et al., 2016). Individuals with comorbid disorders were more likely to experience police use of force than those with mental illness or substance use alone (Morabito et al., 2016). This was correlated with a higher likelihood of individuals with comorbid disorders exhibiting a combination of physical and aggressive resistance (Morabito et al., 2016).

The rate of use of force by Crisis Intervention Team (CIT) trained police officers, as well as interactions resulting in civilian injury, varied significantly between jurisdictions (3.9% - 12%) (Marcus & Stergiopoulos, 2022). While CIT-trained officers were generally less likely to use force compared to non-CIT officers (Compton et al., 2017), those who volunteered for CIT training were paradoxically more likely to use force than those who were mandated to undergo the training (Compton et al., 2017).

CIT training was not consistently predictive of the level of force used by officers. No significant difference in the use of physical force was found between CIT-trained and non-CIT officers. However, CIT-trained officers were more inclined to use verbal engagement or negotiation techniques (Compton et al., 2014). Other studies did not report this outcome however, finding no significant differences in verbal engagement between CIT and non-specialized police response (Marcus & Stergiopoulos, 2022).

Woods & Watson (2017) reported some evidence suggesting that CIT may reduce the use of force, but they noted that the studies supporting this finding were dated and lacked

generalizability. In conclusion, the effectiveness of CIT training in reducing the use of force remains uncertain, influenced by a range of factors that require further investigation.

Arrests

The impact of Crisis Intervention Team (CIT) training on arrest rates remains a topic of mixed findings in the research. Some studies indicate that CIT-trained officers are less likely to arrest individuals with mental illness compared to their non-CIT counterparts (Compton et al., 2014; Compton et al., 2017). Specifically, Compton et al. (2017) found that CIT training correlated with a reduction in arrests of individuals with mental health issues.

However, the results are not uniformly consistent across all studies. While some research supports the notion that CIT training reduces arrest rates, others have found no significant effect (Wood & Watson, 2017). For instance, Khalso et al. (2018) reported that arrests occurred in less than 5% of cases where CIT officers responded to mental health-related incidents. Although this rate appears low, it does not have a direct comparison group and aligns with a general 5% arrest rate across studies for mental health calls by non-CIT officers, suggesting minimal difference (Marcus & Stergiopoulos, 2022). Factors such as threats of violence, access to weapons, and substance abuse were found to increase the likelihood of arrest (Khalso et al., 2018).

There is some evidence suggesting that CIT officers are less likely to arrest compared to non-CIT officers (Compton et al., 2017). However, the overall evidence on the effect of CIT training on arrest likelihood remains mixed and inconclusive (Marcus & Stergiopoulos, 2022; Paton et al., 2016; Seo et al., 2020). Further research is needed to clarify these findings and better understand the factors influencing arrest decisions in mental health crises.

Referrals or Transport to Mental Health Services

Referrals and transport to mental health services refer to the actions taken by officers to connect individuals in crisis with appropriate mental health resources. There is a general indication that CIT officers are more likely to provide resources, make referrals, or transport individuals to mental health services compared to non-CIT officers (Compton et al., 2014; Compton et al., 2017; Kane et al., 2017; Khalso et al., 2018; Marcus & Stergiopoulos, 2022; Seo et al., 2020; van den Brink, 2012). However, Marcus and Stergiopoulos (2022) suggest that while significant, the effect of CIT training on connecting service users with resources is relatively small.

Watson and Wood (2017) found that referrals to mental health services were provided in only 7.9% of calls. The saturation of available resources had an impact on the likelihood of referral (Watson et al., 2011). Geographic regions with higher saturation of mental health services corresponded with higher CIT referrals compared to non-CIT referrals. Conversely, in low-resource areas, there was no significant difference between CIT and non-CIT officers in terms of referrals (Watson et al., 2011).

Service User Perspective

Service users and caregivers of individuals in mental health crisis generally report negative experiences with police whether CIT-trained or not (Marcus & Stergiopolous, 2022). Service users reported interactions with police were often traumatic and felt they were treated as criminals (Daggenvoorde et al., 2017; Puntis et al., 2018). Police uniforms, weapons, and marked cars were experienced as intimidating and service users expressed a desire for unmarked cars and officers in plain clothes (Boscarato et al., 2014; Lamana et al., 2018; Puntis et al., 2018). Participants were distressed in instances of excessive force such as use of tasers, handcuffs, and being put in police custody (Boscarato et al., 2014; Daggenvoorde et al., 2017; Lamana et al.,

2018). Service users expressed that support from family, friends, or general practitioners was preferable to police intervention (Boscarato et al., 2014). Service users and their caregivers tended to feel that police officers lacked sufficient training in mental health awareness resulting in poor crisis de-escalation and communication (Boscarato et al., 2014; Brennan et al., 2016). Caregivers reported feeling excluded from decision-making and perceive a lack of collaboration from officers (Brennan et al., 2016).

Challenges and Limitations

Determining whether CIT training directly influences outcomes is challenging, especially since many officers who undergo the training volunteer, potentially skewing results (Kane et al., 2017; van den Brink et al., 2021). The general lack of comparative data between CIT and non-CIT officers complicates the tracking and interpretation of outcomes (Blais et al., 2020; Khalso et al., 2018; Marcus & Stergiopoulos, 2022).

In Chicago, researchers discovered significant differences in outcomes across districts, attributing resource availability as a primary factor influencing CIT outcomes (Watson et al., 2011). Such discrepancies within a single city underscore the complexity and difficulty of generalizing outcomes to other locales. Hypotheses for the diversity of results may be due to discrepancies in the outcomes examined across studies or third-variable effects across geographical borders (Seo et al., 2020). Watson and Compton (2019) note that there is variability in the implementation of CITs in part due to a lack of a standardized appraisal tool to ensure consistency across programs.

Marcus and Stergiopoulos (2022) define "contact only" as calls resolved on the scene with no further intervention, such as emergency department (ED) visits, justice system diversion, or provision of resources or referrals. Their literature review revealed no significant difference in

contact-only rates between CIT and non-CIT officers generally. Combining all these outcomes into a single category rather than tracking each individually can conflate all interventions as positive. Resolving incidents on the scene may be preferable for clients rather than ED transport (Daggenvoorde et al., 2022), while others may feel their requests for help are not taken seriously if there is no intervention (Daggenvoorde et al., 2017). The variability of individual experience and interpretation of interventions makes it difficult to make positive or negative assumptions about outcomes when user experience isn't recorded.

Police officers often view psychiatric hospitalization as an ideal or preferred outcome for mental health crises (Daggenvoorde et al., 2022). Many CIT studies refer to hospitalization as a referral or preferred outcome, citing higher transport rates to the ED among CIT-trained officers (Compton et al., 2014; Compton et al., 2017; Kane et al., 2017; Khalso et al., 2018; Marcus & Stergiopoulos, 2019; Seo et al., 2020; van den Brink, 2012). While hospital transport may be a more appropriate outcome than criminalization and arrest, resolving mental health crises without either intervention appears to be a preferred outcome among individuals in mental health crises (Daggenvoorde et al., 2022; Marcus & Stergiopolous, 2022).

While CIT models focus on equipping police officers with mental health training, co-response models seek to address crises through a collaborative approach involving both law enforcement and mental health professionals.

Co-Response Crisis Response Model

The co-response model typically involves a partnership between law enforcement officers and mental health professionals who respond together to mental health crisis incidents (Blais et al., 2020; Dempsey et al., 2019; Shapiro et al. 2014). In theory, this model is designed to leverage the skills and expertise of both disciplines to provide a more comprehensive and

effective response to individuals in crisis. Co-response teams operate from the assumption that police are experts in handling circumstances where there is possibility of violence or threat to personal safety, whereas mental health practitioners have most competence in providing mental health care to individuals in crisis (Blais et al., 2020; Shapiro et al., 2014). The primary goal of the co-response model is to de-escalate crises, reduce the need for police use of force, avoid unnecessary hospitalizations or incarcerations, connect individuals with appropriate mental health services, and generally divert cases from the already overstressed judicial and healthcare systems (Shapiro et al., 2014).

Co-response teams are typically composed of police officers and mental health professionals. The police officers on these teams have usually received specialized training in crisis intervention (Blais et al., 2020; Fahim et al., 2016). The mental health professionals may include psychiatric nurses, social workers, or other mental health crisis workers who provide on-scene mental health assessments, crisis intervention, and referrals to appropriate services (Fahim et al., 2016; Ghelani, 2021; Shapiro et al., 2014). There can be considerable variation between the types of co-response teams across programs based on the populations they encounter, funding, type of response and mandate, operating hours, type of mental health practitioner enlisted, and training received (Ghelani, 2021; Shapiro et al., 2014). The key aspect of the co-response model is the collaboration between law enforcement and mental health services, allowing each professional to perform their roles effectively while ensuring the safety and well-being of the individual in crisis (Wood et al., 2011).

The co-response model features a joint response where both police officers and mental health professionals respond to crises together. While this varies across models, it can allow for immediate on-scene assessment and intervention. Mental health professionals can provide

immediate support, conduct risk assessments, and determine the best course of action for the individual, whether it's hospitalization, referral to community services, or other interventions. The presence of mental health professionals is designed to lead to better de-escalation of potentially volatile situations and reduce the likelihood of the use of force by police (Ghelani, 2021; Shapiro et al., 2014).

Effectiveness

According to Shapiro et al. (2014), co-response teams have four primary goals: reduce the need for police use of force and resulting injury, avoid unnecessary hospitalizations or incarcerations, connect individuals with appropriate mental health services, and reduce pressure from the judicial and health care systems. Effectiveness can be investigated by examining outcome data with respect to these criteria (Blais et al., 2020).

Use of Force

Co-responder models tend to report lower rates of use of force and resulting injury compared to police-led models. However, the evidence is mixed and sometimes lacks robust comparators (Marcus & Stergiopoulos, 2019). A study examining outcomes of the co-responding police-mental health team in Toronto (Ontario, Canada) found that injury to person in crisis was reported in 1.9% of interactions and these injuries were primarily self-inflicted (Lamanna et al., 2018). Another study in Sherbrooke (Quebec, Canada) found that the co-response team was less likely to use force when compared to police officers alone (Blais et al., 2020).

There is minimal data on whether co-response teams reduce the use of force during police interactions with individuals (Ghelani, 2023). While few studies have explored use of force outcomes and the current data is inconclusive (Ghelani, 2023; Marcus & Stergiopoulos, 2022),

there is a general belief that combining mental health staff with police officers can reduce crisis escalation and injury (Shapiro et al., 2014).

Arrests

Co-responder mental health teams generally report lower rates of arrest comparatively to police-led models (Ghelani, 2023; Marcus & Stergiopoulos, 2022; Shapiro et al., 2014). There is some evidence that co-response leads to reduced arrests when compared to police only response (Lamb et al., 2002). This reduction of arrests was seen for Black individuals encountering a co-response team compared to police response (Bailey et al., 2022). Comparing outcomes with a co-response team versus police response in Indianapolis (Indiana, USA), individuals in mental health crisis were less likely to be arrested (Bailey et al., 2022). In another study, arrest was an uncommon outcome reported in co-response team interactions (1.9%) (Lamanna et al. 2018). Semple et al., (2016) reported the Community-Based Mobile Crisis Intervention Team (COAST) apprehended individuals less often than general patrol. On the other hand, Scott (2000) found no significant difference in arrest rates between the mobile crisis team and regular police intervention. While short-term arrests seem to be reduced when co-responder teams are dispatched to scene, there is evidence that longer term reduction in criminalization isn't necessarily achieved given higher arrest rates associated with follow-up (Shapiro et al., 2014).

Difference in arrest rates tend to be lowered with co-response teams when compared to traditional police response, however the data is mixed. While studies do point to a reduction in arrests, not all studies are able to claim cause and effect relationships because of study design (Marcus & Stergiopoulos, 2022; Shapiro et al., 2014).

Hospitalization

When examining hospitalization rates there is dissonance within and across articles in whether it is coded as a positive or negative outcome. CIT literature typically lumped ER visits and hospitalization as transport to mental health services (Compton et al., 2017; Wood & Watson 2017). Factors that seem to lead to higher levels of care including voluntary and involuntary hospitalization are individuals with homicidal ideation, heightened suicide risk, injury towards self, inability to care for self, and psychotic symptoms (Muesham et al., 2018).

Co-response research often differentiates hospitalization from other mental health services referral and more typically codes hospitalization as a less desirable outcome as it is associated with a strain on the hospital system as well as negative client feedback (Marcus & Stergiopolous, 2022; Shapiro et al., 2014). Typically, involuntary admission is seen as less desirable than voluntary because of the disregard for the individual's autonomy and consent. Despite this, involuntary admissions rates in BC have grown 70% and surpassed voluntary admissions rates which stayed consistent during the same time (Columbia et al., 2019). Legal safeguards are in place with the intention to protect the liberties of individuals facing involuntary admission; however, they are not always appropriately adhered to. In BC, the Ombudsperson's investigation into involuntary hospital admissions found widespread non-compliance with procedural requirements, routine failure to inform individuals of their rights, and often inadequate or missing documentation (Columbia et al., 2019). Further complicating this matter is the blurred distinction between voluntary and involuntary hospitalization, especially when considering evidence suggesting that a significant number of voluntarily hospitalized individuals felt coerced into providing their consent at the time of admission (Ward-Ciesielski & Rizvi, 2020).

The co-response team in Toronto reported a higher percentage of crisis interactions resulting in transport to hospital emergency department (38-45%) when compared to typical police response (27%) (Lamanna et al., 2015; Lamanna et al., 2018). This contrasts with other studies which found that co-response teams typically corresponded with lower transports to ER when compared with police-only response (Blais et al., 2020; Ghelani 2021; Lamb et al., 2002). A mental health co-response team in Hamilton reported a 49% reduction of hospital transport for individuals in mental health crises compared to a police-only model (Fahim et al., 2016). Additionally, police surveys indicated that without a mental health worker present, they would have transported a far greater number of individuals to hospital, representing a 52% reduction in ED visits (Fahim et al., 2016). Victoria's Integrated Mobile Crisis Response Team (IMCRT) found a reduction of 7.8% in hospital use compared to police-led response (Baess et al., 2002).

Evidence on the reduction of hospitalization admissions is mixed for interactions with co-response teams (Marcus & Stergiopolous 2022; Shapiro et al. 2014). Marcus & Stergiopolous (2022) suggest that these varied findings could be due to an increased knowledge and ability to assess need for hospitalization in co-responder teams compared to police only. While there is discrepancy in general hospitalization rates, the literature suggests that co-response teams typically have lower rates of involuntary transport to the ER when compared to police only (Lamanna et al., 2015; Lamanna et al., 2018, Ghelani 2023; Marcus & Stergiopolous 2022).

Emergency Department (ED) wait times is a factor when considering hospital admission for individuals who are in mental health crisis. Long wait times in ED can be a significant challenge given the delay in transferring the person in crisis to the appropriate place as well as tying up the responding team and preventing them from responding to other situations (Kirst et al., 2015). There is evidence that co-responding teams have consistently shorter wait times than

police response (Baess et al., 2005; Fahim et al., 2016; Lamanna et al., 2015; Lamanna et al., 2018; Marcus & Stergiopolous 2019; Semple et al., 2016). Average wait times for co-response teams ranged from 45-60 minutes while police only wait times were reported to be from 75 – 121 minutes (Baess et al., 2005; Fahim et al., 2016; Lamanna et al., 2015; Lamanna et al., 2018; Semple et al., 2016). Furthermore, there is evidence that co-response team presence increased the likelihood of an individual seeing a psychiatrist as well as a higher rate of hospital admission (Fahim et al., 2016; Ghelani 2023).

In summary, the literature presents a complex and often inconsistent picture regarding the outcomes of hospitalization rates in mental health crisis responses, particularly when comparing co-response teams to police-led response. While some studies suggest that co-response teams may lead to higher hospital transport rates due to their enhanced ability to assess the need for hospitalization, other research indicates a reduction in emergency department visits when mental health professionals are involved. The differentiation between voluntary and involuntary admissions further complicates the analysis, as voluntary admissions often involve perceived coercion. Additionally, co-response teams typically report shorter emergency department wait times compared to police-only responses, which can significantly impact the efficiency and effectiveness of crisis interventions. Overall, factors such as the severity of the crisis, the individual's symptoms, and the team's ability to provide immediate mental health assessment play crucial roles in determining the level of care required, highlighting the need for more standardized and rigorous research to draw definitive conclusions.

Referrals or Transport to Mental Health Services

Co-responder models seem to be effective at connecting individuals in crisis to community mental health services and resources when compared to police-led response (Ghelani

2023; Marcus & Stergiopoulos, 2019; Shapiro et al., 2014). Referral rates differed across studies ranging from 17%-42% (Marcus & Stergiopoulos, 2019; Semple et al., 2016). Type of referral varied across jurisdictions though often had some form of accompanied follow-up (Marcus & Stergiopoulos, 2019). Age and gender were factors that that predicted level of care recommendations and type of referral offered (Muesham et al., 2018). Older individuals were more likely to be suggested for higher levels of care while females were less likely to be recommended for voluntary transport to hospital. Recent substance-use significantly increased probability of referral to community mental health service (Muesham et al., 2018).

Service User Perspective

Police involvement often was associated with evoking negative feelings from services users. Being placed in custody or being handcuffed was reported to have left individuals feeling criminalized (Daggenvoorde et al., 2017; Lamanna et al., 2018). The presence of police alone as well as marked police vehicles evoked similar feelings and was experienced as intrusive with individuals reporting feelings of lack of control, humiliation, and generally stigmatized (Daggenvoorde et al., 2017; Lamanna et al., 2018). Qualitative responses from service users in the Netherlands reported feeling confusion about the role of the mental health practitioner on the co-response team which resulted in lack of trust (Daggenvoorde et al., 2017). Additionally, there were feelings described about loss of control and powerlessness from lack of communication from the co-response team. However, individuals also reported feeling reassured and heard when the mental health co-responder communicated calmly and empathetically (Daggenvoorde et al., 2017).

There is evidence that co-responder models are generally perceived favorably compared to police only response to mental health crisis by service users (Fahim et al., 2016, Ghelani et al.,

2023; Lamanna et al., 2015; Marcus & Stergiopolous, 2022; Shapiro et al., 2014). Service users that had experienced both co-responder model and police only intervention expressed a preference for co-response (Lamanna et al., 2018). These differences in preference seem related primarily to the mental health practitioner on the co-response team. Service users report appreciation of being treated respectfully and in a supportive manner, highlighting that they felt listened to and were given options during crisis (Kirst et al., 2015; Lamanna et al., 2018). Specifically, service user feedback suggests that non-police co-responders' knowledge of mental health, crisis de-escalation skills, and empathetic and empowering approach were key factors in positive experiences (Lamanna et al., 2018). Co-responding teams were also less likely to be perceived as treating individuals as criminals (Lamanna et al., 2018). Survey data collected from service users of a co-response model reported on average relatively high satisfaction ratings (27.4 out of 32) (Scott, 2000). Kisely et al., (2010) reported that not only were in the moment interactions tied to feelings of service user satisfaction with support but also a resulting increase in outpatient contacts suggesting an increase in client engagement with treatment.

Responder Perspectives

At its best, the partnerships between mental health practitioner and police officer were experienced as offering improved outcomes for service users compared to CIT response (Marcus & Stergiopolous, 2022). However, differing roles, culture, and expectations resulted in challenges for both mental health practitioner and police in their respective role as well as in collaboration with the other (Daggenvoorde et al., 2022; Kirst et al., 2015). Police defined their role as primarily maintaining order and public safety and not providing care (Daggenvoorde et al., 2022; Kirst et al., 2015). On the other hand, a mental health practitioners' definition of their role was focused on the individual's wellbeing ranging from crisis de-escalation, linking clients

to community resources, brief addition counseling, challenging systemic racism, and relationship building (Ghelani, 2023; Kirst et al., 2015). Having clear role distinction was identified as an important factor in fostering effective teamwork and service delivery (Kirst et al., 2015).

Both respective members of co-responder teams felt a need for more cross-sector training to improve understanding of roles and improve user experience (Kirst et al., 2015). Team building and training was associated with establishing cohesion between police and mental health practitioner partnership (Bailey et al., 2018). Mutual acceptance of shared responsibilities was seen as critical to effective collaboration between police officer and mental health practitioner (Daggenvoorde et al., 2022). Examples of where expectations could differ and create challenges in working relationship were related to differing perceptions of urgency, differing response times, and information sharing (Daggenvoorde et al., 2022, Bailey et al., 2018). Comprehensive access to service user information was seen as an important factor in understanding and responding to individual situations (Bailey et al., 2018). Police reported a willingness to openly share information whereas mental health practitioners were often more concerned about protecting service user confidentiality and balancing these legal constraints with crisis resolution (Daggenvoorde et al., 2022).

Some factors that inhibited the perceived effectiveness of co-response by stakeholders were tied to larger organizational or systemic limitations. Factors like limited staffing, restricted hours of operation, role clarity, and confusion about mandate were identified as challenges to co-response programs (Ghelani, 2013; Lamanna et al., 2015). More availability of local treatment resources and external agency awareness and partnership with co-response teams could increase program efficacy and create better service user outcomes (Bailey et al., 2022).

Cross-sector collaboration across police services and the health system in co-response teams was valued by team members. Co-response teams were felt to be most effective when mutual understanding and collaboration was present particularly in deciding who would take the lead based on the type of situation (Kirst et al., 2015). Police officers who received training and participated on co-response teams were seen to improve their own awareness and understanding of mental illness as well as increase non-violent de-escalation ability (Shapiro et al., 2014). Mental health staff report feeling safer with officers' present when attending crisis situations (Shapiro et al., 2015). Overall, there is evidence that the distinctions between roles was difficult to navigate at times but in other instances was useful in improving outcomes.

Anti-Oppressive Perspective on Co-Response

Despite some evidence of lower arrest rates, use of force, and mental health act apprehensions (Marcus & Stergiopolous, 2022), social justice advocates have voiced concerns about co-response models of crisis care. The National Association of Social Workers' (NASW) endorsement of co-response has been met with backlash from social workers who have viewed a partnership with police as harmful to themselves and their clients due to a perpetuation of systemic oppression (James-Townes, 2020; Sato, 2020; Social Service Workers United-Chicago, 2020; Vakaria, 2024). Vakaria (2024) suggests that integrating social workers into police response doesn't mitigate the fundamental harms caused on communities. Concerns call attention to the precarious line that social workers already walk in their own history of systemic oppression on marginalized communities. Working collaboratively with police could further entrench social workers in not only being complicit in systemic oppression but being agents of control and coercion themselves (Vakaria, 2024). James-Townes (2020) suggests it is a social

workers' moral imperative to avoid being participants in systemic oppression and punitive policing systems.

Police and social workers have roles and objectives that are conflicting. The presence of armed police officers can escalate crisis situations and can retraumatize service users who have previously experienced negative encounters with law enforcement (Kaufman-Mthimkhulu, 2020; James-Townes, 2020). The goals of social workers are to build trust, provide care, and offer options which contrasts with police whose focus is one of control and suppression (James-Townes, 2020).

The concept of resistance is central to anti-oppressive practice. In their discursive analysis of violence, Coates & Wade (2007) suggest that resistance to oppression is ubiquitous whether it is overt or covert. Resistance is a way that social groups withstand oppression (Smith et al., 2022). Police by nature are expected to be agents of control who have access to punitive actions of violence or criminalization – one that has a propensity to threaten or encroach on an individual's autonomy. Within police discourse, citizen resistance is seen as a threat. In fact, citizen resistance is the strongest predictor of the level of force used by police officers (Rossler et al., 2016). On the other hand, anti-oppressive social work would see resistance as an expression of encountering oppression. Instead of violence or restriction of freedoms, the focus would be on prioritizing informed consent and providing a variety of options to the person in crisis rather than taking them away (Kaufman-Mthimkhulu, 2022).

For these reasons, police officers responding to mental health crises can undermine the goals of social workers (James-Townes, 2020; Social Service Workers United-Chicago, 2020; Vakaria, 2024). An anti-oppressive framework argues for the removal of police from mental health crisis response, advocating instead for approaches that dismantle the entrenched structures

of power and oppression inherent in law enforcement. For instance, programs like Project LETS demonstrate how peer-led initiatives can effectively support individuals in crisis without police involvement (Kaufman-Mthimkhulu, 2022).

Non-Police Crisis Response Models

Non-police crisis response models are designed to provide support during mental health crises through de-escalation, mental health support, and community-based interventions, and intentionally avoiding the involvement of law enforcement to reduce the potential for escalation and harm. Despite their potential, non-police models remain under-researched compared to police-involved crisis responses (Marcus & Stergiopolous, 2022). The quality of research on non-police models is primarily observational and lacks robust, high-quality experimental designs, which are subject to challenges in comparing outcomes or drawing meaningful conclusions (Marcus & Stergiopolous, 2022). Of the existing research on non-police crisis response models, the most studied teams feature a mental health professional paired with a medical professional, often a paramedic (Marcus & Stergiopolous, 2022).

This model can be found across the world in different variations. Examples include Denver's Support Team Assisted Response (STAR) program, Crisis Assistance Helping Out On The Streets (CAHOOTS) located in Eugene (USA), Mobile Health and Social Care Unit (MHSCU) in Copenhagen (Denmark), the Mental Health Acute Assessment Team (MHAAT) in Western Sydney (Australia), and the Psychiatric Emergency Response Team (PAM) in Stockholm (Sweden) (Enos et al., 2020; Lindstrom et al. 2020; Ostergaard & Lyngby, 2019; Waters, 2021). Other researched models were designed for children and youth response only (Alvarado et al., 2020; Cordell et al., 2016; Faddy et al., 2017; Fendrich et al., 2017; Vanderploeg et al., 2016). Models with an anti-oppressive lens, such as Project LETS based in

New York and M.H. First, based in Oakland and Sacramento, that feature peer-led and community response have not been subject to academic study. A primary mission for all these projects is intercepting cases before the individual is admitted to an ED as well as creating more appropriate pathways to crisis stabilization and community mental health services without police involvement.

Police Involvement

While non-police models differentiate themselves from CIT and co-response models by not including a police officer on the team that attends in every situation, police still typically function as a backup option for situations where public safety is a concern (Enos et al., 2020). Some studies reported police involvement in as many as half of all interactions like PAM (49%) and MHAAT (50.8%) (Bouveng et al., 2017; Faddy et al., 2017). Other studies report much lower police involvement. In the first months of the pilot project STAR, Enos et al., (2020) reported responding to over 400 calls without a need for police backup. Similarly, in 2019 CAHOOTS handled 18,583 calls and police backup was requested only 311 times, accounting for less than 2% of situations (Waters, 2021). Out of 2,976 calls between 2016-2017, the MHSCU in Copenhagen referred only .4% to police (Ostergarard & Lyngby, 2019). High variance in the frequency of police involvement seems to be due to differences in how crisis calls are triaged with other emergency resources (Marcus & Stergiopolous; 2022).

Use of force and arrest data is a metric that was rarely tracked in police-led response and even less so for non-police models (Marcus & Stergiopolous, 2022). In their meta-analysis, Marcus and Stergiopolous (2022) found only one non-police led crisis intervention team study that reported on use of force. Faddy et al. (2017) found that individuals were restrained in 4.5% of interactions. Restraint was not only from the police (handcuffing: 2.3%), but also from the

ambulance responder (chemical sedation: 1.7%; mechanical restraint: 1.3%) (Faddy et al., 2017). Arrest data wasn't reported in any non-police crisis response studies (Marcus & Stergiopolous, 2022).

Hospitalization

A primary objective for non-police-led crisis response models is reducing unneeded transport to EDs and subsequent hospitalization. There is some evidence that non-police models can contribute to a reduction in hospital admissions though it is difficult to make claims of these types because of a lack of comparison data (Marcus & Stergiopolous, 2022). As with police-led models, hospitalization is a complex subject and subsequently it is difficult to interpret the data. Generally, with hospitalization, the consensus seems to be that the majority of mental health crises can be resolved on the phone or in the field without the need for additional escalation to an ED (Balfour et al., 2021). However, there is a fraction of calls where an individual is experiencing a mental health crisis that is not able to be stabilized without further intervention. This subgroup is further divided into individuals who understand a need for further intervention and consent to transport to the hospital voluntarily. A final group of individuals are thought to need greater care by a clinician, generally because of a danger to themselves or others, and who are not consenting to treatment themselves.

Voluntary treatment is the preferred outcome though clinicians must be aware that clients may feel coerced into giving their consent. There can be a fear among individuals that divulging their symptoms to a mental health professional could result in coercion into hospital treatment (Bosnic, 2020). While it may seem that hospital is a beneficial place for those who are mentally unwell, Bosnic (2020) describes that psychiatric institutions can resemble prisons in the service user's loss of autonomy and high levels of surveillance and control over patients' freedom

(Kaufman-Mthinmkhulu, 2020). Such environments can be experienced as dehumanizing and traumatic which can result in individuals avoiding seeking support in the future (Bosnic, 2020; Kaufman-Mthimkhulu, 2020).

Transport to hospital varied greatly across studies and, like variance in police involvement data, this seems to be related in part to differences in structure, approach, socio geographic setting, and population. In a pilot project with school-aged children, Alvarardo et al., (2020) reported a 44% decrease in ED referrals during the operating hours of the crisis team. They also saw an increase in admission rates suggesting that cases that were being sent to ED by crisis team were more likely to be appropriate. Faddy et al. (2017) found that the MHAAT model helped to avoid ED environments for most service users with 70% being treated outside of ED. Similarly, in Denmark, with the MHSCU, 21.5% of service users were taken to ED (Ostergaard & Lyngby, 2019). The non-police crisis response team model in Sweden found a correlation between the implementation of the team with a reduction in average ED visits of about 2.4 patients per day (Bouveng et al., 2017). In contrast, mental health care initiative in rural Australia saw an initial 55% increase in hospital admissions after launch though these numbers decreased 28% over the consecutive two years (Saurman et al., 2014).

Of studies that reported involuntary hospital transport, Muesham et al., (2019) reported a rate of 9.2% and Bouveng et al., (2017) found one third of service users were involuntarily transported to hospital. It is unknown how this range between 9% - 33% is comparable to involuntary hospital transport rates across other non-police models.

There is some evidence that there were long term effects of non-police crisis intervention in reducing future ED visits with children and youth. After receiving mobile crisis intervention, youth had lower likelihood of future ED visits than comparison group (Fendrich et al., 2017).

Despite higher initial rates of ED service usage, after mobile intervention children had lower usage compared to children in standard care (Cordell et al., 2016).

Referrals or Transport to Mental Health Services

Some studies reported on referrals and transport to mental health services besides ED. Two-thirds of serviced users were transported to a mental health facility directly with the majority gaining admission and the remainder receiving community services care (Faddy et al., 2017). Another outcome was service users being left to self-care after initial intervention which ranged from 11.9-56.5% across studies (Ostergaard & Lyngby, 2019; Marcus & Stergiopolous, 2022; Muesham et al., 2019). While it seems to be a generally favorable outcome for a crisis response team to be able to resolve a situation on the scene, it is difficult to interpret this data without knowing the service user's perspective on whether the intervention was helpful.

Person in Crisis Perspective

Service users generally report positive experiences with non-police crisis response teams (Marcus & Stergiopolous, 2022). Positive outcomes are reported frequently though often with only anecdotal evidence (Bouveng et al., 2017; Enos et al., 2020; Waters, 2021). There is some qualitative data to back this up (Lidstrom et al., 2020). Notably, service users of Psychiatric Emergency response team (PAM) appreciated a non-judgement and empathetic response. An emphasis was placed by service users on their ability to be participants in decision making. Additionally, some service users reported a sense of relief when PAM responded rather than police. On the other hand, service users reported a wish that the clearly marked, brightly yellow colored, and equipped with lights and siren PAM vehicles were less conspicuous due to attention and stigmatization from their neighbors (Lidstrom et al., 2020). In another study regarding a non-police mobile response unit for children and youth reported high levels of service user

satisfaction with the service in survey (Braganza et al., 2020). Service users accounts of non-police response is generally favorable though there is limited data. Given the wide variety of non-police response models it is unclear if service user perspective is shared, though general evidence would point to positive perceptions.

Challenges and Limitations

An overarching challenge in evaluating non-police crisis response models is a high degree of variance in models and a lack of robust and high-quality research. These factors make comparison across non-police models and police-led models challenging at best and futile at worst. Common threats to research methods included lack of long-term data sets, usage of third-party administrative data which does not capture all relevant details and could introduce bias, and lack of pretrial or control groups (Alvarado et al., 2020; Bouveng et al., 2017; Enos et al., 2020; Fenrich et al., 2017; Hayford, 2022; Marcus & Stergiopolous, 2022; Vanderploeg et al., 2016; Waters, 2021). High variance in which non-police mental health response requested police accompaniment further obscures conclusions regarding the outcomes of non-police models. Marcus and Stergiopolous (2022) suggest that the framework in which non-police crisis response teams are contacted and dispatched is likely a significant factor in which calls they are sent to. Teams that are dispatched through 911 like STAR and CAHOOTS on the surface seem to have less police accompaniment, perhaps because they have already been triaged by operators to not need police response, though there could be many other variables of significance (Enos et al., 2020; Waters, 2021). Clearly defining roles of crisis responders, when to deploy police, and the role of police when deployed have been identified as important factors (Hayford, 2022; Marcus & Stergiopolous, 2022).

Despite the promising outcomes associated with non-police crisis response models, like co-response models, their implementation and maintenance are limited by hours of operation, staffing, and lack of funding (Alvarado et al., 2020; Bouveng et al., 2017; Enos et al., 2020; Hayford, 2022; Waters, 2021). Of all the challenges faced by non-police models, the most cited were related to staffing and underlying structural and social factors such as racism, poverty, lack of affordable housing, and lack of mental health services (Hayford, 2022).

Anti-Oppressive Perspective on Non-Police Crisis Response

Like CIT and co-response models, non-police models must navigate underlying structural issues such as systemic racism and social inequities, which complicate the implementation and effectiveness of mobile crisis response teams (Hayford, 2022). While police have been identified as agents of oppression, social workers, medical professionals, and mental health clinicians are also capable of perpetuating social control and violence on marginalized individuals (Bosnic, 2020; James-Townes, 2020; Kaufman-Mthimkhulu, 2020; Sato, 2020; Vakaria, 2020).

The issue of mental health act apprehensions is of critical importance. Some researchers suggest that in the absence of police, involuntary transport to ED would need to continue to exist in some capacity within non-police models and suggest that legislation would need to be amended to give clinicians this power (Bouveng et al., 2017; Marcus & Stergiopolous, 2021; Muesham et al., 2019). This sort of power to control individuals and deprive them of their autonomy goes against anti-oppressive philosophy. AOP posits that true care is incompatible with threat, force, or coercion and prioritizing consent even in dire situations is critical (Kaufman-Mthimkhulu, 2020).

Some caution that historically the profession of social work has upheld social control and marginalization of communities through jails, probation, foster care, and child protective services

which has disproportionately harmed families of Colour (Vakaria, 2020; James-Townes, 2020; Kaufman-Mthimkhulu, 2020; Sato, 2020; Social Service Workers United-Chicago, 2020). The medical and mental health system has been similarly situated as a White and western-philosophy dominated institution that has caused similar harms to BIPOC especially those who are mentally ill, disabled, neurodivergent, or Deaf (Cenat, 2020; Corneau & Stergiopolous, 2012; Kaufman-Mthimkhulu, 2020; Larson, 2008; Ocampo & Pino, 2014). Simply relocating social workers or other mental health professionals into situations currently held by police without taking measures to address underlying systems of oppression has potential to create new systems that are just as coercive and punitive (Bosnic, 2020).

A way forward for mobile crisis response is far from clear. While there is no consensus, many suggest that a paradigm shift may be necessary in order reform the current landscape (Balfour et al., 2021; Marcus & Stergiopolous; Vakharria, 2020; Kaufman-Mmthimkhulu, 2020; Sato, 2020; Social Service Workers United-Chicago, 2020). Some social workers propose an abolitionist framework that seeks to dismantle oppressive systems, targeting punitive aspects of policing and social work to avoid trading one system of policing for another (Vakharria, 2020; Kaufman-Mmthimkhulu, 2020; Sato, 2020; Social Service Workers United-Chicago, 2020). Others suggest a framework that exists parallel to current systems but introduces new pathways for mental illness (Balfour et al., 2021). Such a system proposes crisis lines instead of 911 dispatch, mobile crisis response instead of police, and community services and post crisis centres rather than jail and ED admissions (Balfour et al., 2021). James-Townes (2020) suggests that regardless of the reform or changes to mental health crisis response, it is necessary to have a profound investment in social services such as public health, housing, education, employment, and poverty reduction. While acute mental health crisis is often seen as the symptom that needs

to be treated, these larger structural issues are often the root causes. Addressing only the surface level symptoms of crisis is unlikely to have lasting or truly beneficial outcomes.

Recommendations

In general, there is a lack of quality research and evidence on the outcomes of mobile mental health crisis regardless of police-led, co-response, or non-police models (Bailey et al., 2021; Blais et al., 2021; Ghelani et al., 2023; Marcus & Stergiopolous; 2021). More evidence is required to better understand the impacts of crisis response teams particularly stemming from experimental and quasi-experimental studies as well as collecting data on domains that are often unreported like use of force (Blais et al., 2020; Ghelani et al., 2023). Most evaluative research has been conducted on police models of crisis response yet there is little evidence that supports police involvement (Marcus & Stergiopolous, 2022). There is a need for more research to better understand alternative models than police response and co-response (Puntis et al., 2018; Marcus & Stergiopolous, 2022). Additionally, there is a gap in research on types of mobile crisis response and culturally appropriate care for these marginalized communities (Marcus & Stergiopolous, 2022). It is recommended in future studies that data on race, gender identity, and sexual orientation could be collected to examine effects and outcomes (Marcus & Stergiopolous, 2022).

There is a need for culturally competency and cultural humility in mobile crisis response to mitigate the disproportionate harm done to marginalized communities particularly BIPOC and 2SLGBTQ+ individuals (Balfour et al., 2021; Ghelani et al., 2023). There is a gap in research on types of mobile crisis response and culturally appropriate care for these marginalized communities (Marcus & Stergiopolous, 2022). Community and service user involvement in all levels of crisis response including higher level decision making related to crisis response

strategies and oversight was cited as a crucial element in creating a successful system (Balfour et al., 2021; Kaufman-Mthimkhulu 2020; Hayford et al., 2022; Marcus & Stergiopolous, 2022).

Furthermore, marginalized individuals such as BIPOC, disability, neurodivergent, or with lived and living experience of mental illness should be centered as stakeholders and decision makers (Balfour et al., 2021; Kaufman- Mthimkhulu, 2020).

There is a need to rethink the current paradigm of crisis response (Balfour et al., 2021; Kaufman-Mthimkhulu, 2021; Marcus & Stergiopolous, 2022). Removing police from crisis response is seen as a prudent course of action to increase support and mitigate harm to service users (Kaufman-Mthimkhulu, 2021; Sato, 2020; Vakharia, 2020). Ensuring the alternative to police-based crisis response is anti-oppressive in nature is fundamental to prevent trading one oppressive system for another (Kaufman-Mthimkhulu, 2021; Sato, 2020; Vakharia, 2020).

Chapter 3: Discussion and Application

Discussion

Research on mobile mental health crisis response teams is hindered by several significant challenges, including an overemphasis on police-led models, variability in study quality and design, and inconsistencies in data tracking and reporting (Bailey et al., 2021; Blais et al., 2021; Blais et al., 2020; Dempsey et al., 2019; Ghelani et al., 2023; Khalso et al., 2018; Marcus & Stergiopolous; 2021; Watson & Compton, 2019). Addressing these challenges is crucial for developing more effective and equitable mental health crisis interventions.

The Crisis Intervention Team (CIT) model seeks to improve police-led response to mental health crises by training officers in de-escalation and mental health awareness (Compton et al., 2017; Wood & Watson, 2017). While CIT is widely implemented, its effectiveness in achieving better outcomes compared to traditional police responses is mixed (Ghelani, 2021; Marcus & Stergiopoloulos, 2022). Service users report negative interactions with CIT officers, feeling criminalized or intimidated, which suggests that CIT may not fully address the systemic issues inherent in police-only crisis responses (Daggenvoorde et al., 2017; Lamana et al., 2018; Puntis et al., 2018). The variability in outcomes, along with the reported negative experiences of service users, complicates the assessment of CIT's overall effectiveness and highlights a potential need for alternative approaches to mobile crisis response.

The co-response model, involving partnerships between law enforcement officers and mental health professionals, is designed to provide a more comprehensive and effective response to mental health crises by leveraging the expertise of both fields (Blais et al., 2020; Dempsey et al., 2019; Shapiro et al., 2014). Some evidence suggests that co-response teams may result in lower rates of force and arrest compared to police-only responses (Ghelani et al., 2023; Marcus

& Stergiopoulos, 2022; Shapiro et al., 2014). However, the data on these outcomes is mixed, with some studies indicating minimal differences in arrest rates and use of force is often not reported on (Ghelani et al., 2023; Marcus & Stergiopoulos, 2022; Shapiro et al., 2014). The presence of mental health professionals appears to mitigate some negative impacts typically associated with police-only interventions, such as feelings of criminalization and intimidation reported by service users (Lamana et al., 2018; Marcus & Stergiopoulos, 2022). While the co-response model offers potential benefits, such as shorter emergency department wait times and improved user satisfaction, challenges remain, including role clarity and systemic issues (Baess et al., 2005; Fahim et al., 2016; Lamanna et al., 2015; Lamanna et al., 2018; Marcus & Stergiopolous 2022; Semple et al., 2016).

Non-police crisis response models aim to provide support during mental health crises without involving law enforcement, focusing instead on de-escalation, mental health support, and community-based interventions. These models vary widely in structure, often pairing mental health professionals with medical personnel, such as paramedics, and have been implemented in various forms globally (Hayford, 2022; Lindstrom et al. 2020; Ostergaard & Lyngby, 2019). Research on these models is less extensive compared to police-involved responses, and existing studies are often observational and lack robust experimental designs, making it challenging to draw definitive conclusions (Marcus & Stergiopolous, 2022). While these models generally aim to avoid police involvement, they often serve as a backup in situations deemed potentially dangerous (Bouveng et al., 2017; Enos et al., 2020; Faddy et al., 2017; Lindstrom et al., 2020; Ostergaard & Lyngby, 2019; Waters 2021). The data on the use of force and arrests in non-police models is limited, though some studies suggest lower rates of restraint and hospitalization compared to police-led responses (Marcus & Stergiopolous, 2022). Service users generally

report positive experiences with non-police interventions, appreciating the non-judgmental and supportive approach (Lidstrom et al., 2020; Marcus & Stergiopolous, 2022). An AOP perspective highlights that non-police models can perpetuate systemic oppression by way of involuntary treatment and control, particularly if underlying social inequalities are not addressed (Bosnic, 2020; James-Townes, 2020; Kaufman-Mthimkhulu, 2020; Sato, 2020; Vakaria, 2020).

Co-response models appear to yield moderately improved outcomes than police-only interventions, particularly in terms of reducing criminalization, violence, and unnecessary hospitalization. Marcus & Stergiopolous (2022) suggest that these differences are likely attributable to the mental health responder involvement, mitigating the negative outcomes of police officers. This lends support to the idea that co-response models offer advantages over police-only responses. Furthermore, while there is not yet evidence to back this claim, non-police crisis response models, which emphasize mental health support without involving law enforcement altogether, may be able to further negate harms that are attributable to police response.

Further research is needed to determine the validity of the assertion that non-police models yield preferable outcomes. However, for now, non-police crisis response models seem to hold promising potential for the future of mobile crisis response (Balfour et al., 2021). Nonetheless, it is crucial to exercise caution when implementing non-police models, as clinicians can also perpetuate systemic oppression, particularly if they are granted the power of involuntary detainment (Bosnic, 2020; James-Townes, 2020; Kaufman-Mthimkhulu, 2020; Sato, 2020; Vakaria, 2020). There needs to be a fundamental awareness of power structures and systemic oppression within clinicians to mitigate the perpetuation of systemic harm (Corneau & Stergiopolous 2012; Larson, 2008). Incorporating anti-oppressive practice as a guiding

philosophy in mobile mental health crisis response could contribute to more equitable and just interventions.

Application

Anti-Oppressive Practice (AOP) has emerged as a critical framework within social work and mental health care, emphasizing the need to address systemic inequities and empower marginalized communities. The approach is designed to dismantle intersecting systemic inequalities such as racism, sexism, ableism, and classism which individually and collectively impact individuals' mental health and wellness. Systemic issues seem to be central to those faced by service users of mental health crisis response given marginalized individuals are disproportionately affected by negative outcomes. Advocates of this AOP suggest that mental health services could benefit from the integration of AOP which could improve outcomes for service users (Larson, 2008; Thyberg, 2012).

Principles of Anti-Oppressive Practice

Important principles of AOP that could be used to ground a non-police mobile crisis response include empowerment, embracing a holistic healing model, fostering reflexivity, and social justice promotion (Corneau & Stergiopolous 2012; Larson, 2008).

Empowerment of individuals is a central goal of anti-oppressive practice. Empowerment can be achieved through collaboration with a focus on power-sharing and invitation into decision making (Corneau & Stergioplous, 2012; Kaufman-Mthimkhulu. 2020; Larson 2008). AOP values suggest that service users should be full participants in all aspects of mental health services from decision-making in the provision of care to policy development and agency governance (Corneau & Stergiopolous, 2012; Larson, 2008). Lending credence to this idea, community input and leadership in all aspects and phases of programs is among most frequently

cited reasons for success in non-police models such as STAR, CAHOOTS, and SCRT (Hayford, 2022). AOP dictates that the role of experts should be shared and not given to mental health practitioners alone, conversely service users are seen as the experts of their own experience. In mobile crisis response, practitioners should facilitate an environment that allows service users to have control of their circumstances (Larson, 2008). Founder and director of a non-police crisis response model based on anti-oppressive practice called Project LETS suggests that offering choices and emphasizing consent to service users is essential for effective crisis response (Kaufman-Mthimkhulu, 2022). In practice, power sharing can be achieved in ways such as avoiding formal titles that reinforce hierarchy, sharing clinical records with service user, reminding service users that they can ask questions, and using appropriate self-disclosures (Corneau & Stergiopolous, 2012; Larson, 2008).

The use of egalitarian language is also an important aspect of fostering service user empowerment by intentionally using language that is non-stigmatizing, non-pathologizing and respectful (Corneau & Stergiopolous, 2012; Larson, 2008). Corneau & Stergiopolous (2012) emphasize the importance of practitioners who speak the same preferred language as service users or having interpreters as options if service users choose.

Anti-oppressive practice embraces a holistic model of care which examines the mental, physical, social, emotional and spiritual contexts of symptoms (Corneau & Stergiopolous, 2012; Larson, 2008; Ocampo & Pino, 2014). This contrasts the standard approaches to mental health which is dominated by a western medical model of care which emphasizes pathology (Corneau & Stergiopolous, 2012; Larson, 2008). Rather than illness and pathology, anti-oppressive practice favors strength-based discourses of service users (Larson, 2008). AOP leans into service user diversity and strength by integrating cultural and spiritual perspectives into mental health

practice. This requires an understanding and valuing of the diversity of service users' worldviews and life experience (Larson, 2008). Alternate holistic approaches to mental well-being such as Indigenous practices, Chinese traditional medicine, Indian Ayurveda, African approaches, yoga, as well as others could be integrated into care (Corneau & Stergiopolous, 2012; Kaufman-Mthimkhulu, 2022). Critically examining the medical model and challenging its deficiencies while introducing holistic, strength-based, and culturally appropriate approaches is an important facet of AOP.

Maintaining practitioner reflexivity is an integral aspect of AOP. For a practitioner to be anti-oppressive they need to have an awareness of structural imbalances of power and an ongoing understanding of their relationship with power and oppression (Cenat, 2020; Corneau & Stergiopolous, 2012; Kaufman-Mthimkhulu, 2022; Larson, 2008; Smith et al., 2022).

Practitioners need to reflect on their own social location and be aware of their biases and how they may be contributing to oppression such as racism, sexism, classism, ableism, heterosexism, and other marginalizing structures (Corneau & Stergiopolous, 2012; & Larson, 2008). Ongoing self-reflection is a crucial and required aspect of practitioner cultural competency within AOP.

Finally, social justice promotion is key feature of AOP. Promoting social justice as a mental health practitioner takes many forms including education, advocacy, and alliance building (Cenat, 2020; Corneau & Stergiopolous, 2012; Larson, 2008; Thyberg; 2023). As a practitioner it is necessary to engage in ongoing education relating to history of oppressive forces like racism. There should also be ongoing learning about diversity and developing tools for challenging dominant discourse. It is the role of the practitioner to not only develop one's own growth but to also promote the education of service users and community (Corneau & Stergiopolous, 2012; Larson, 2008). To address racism in treatment, for example, it is necessary to be able to explain

the effects that discrimination have on mental health (Cenat, 2020). AOP requires practitioners to take a political stance against discriminatory policies and practices. AOP practitioners are advocates for policy change to promote the rights and freedoms of marginalized community members where unjust legislation exists (Corneau & Stergiopolous, 2012; Larson, 2008). As a result, an AOP informed program can build the trust of marginalized communities that work toward dismantling oppressive forces.

Conclusions

Current mental health crisis response systems are fundamentally insufficient, often failing to provide culturally appropriate and equitable care to service users. To address these shortcomings, there is a pressing need to integrate AOP into crisis response models, moving away from police-led interventions toward community-centred, non-coercive approaches. Despite ongoing negative outcomes such as criminalization, coercion, and use of force resulting in injury and death, police continue to be dispatched as the usual responders to mental health crises. Efforts to improve mobile mental health crisis response have focused primarily on improving police response through specialized training (CIT) or pairing police officers with a mental health practitioner. While fewer non police models have been implemented or studied there is an increasing demand for implementation. Non-police crisis response, while intended to escape the contraindications of police response, is not immune to the harms that can be perpetuated on marginalized communities. At the heart of many criticisms of mobile crisis response are the disproportionate harms to these marginalized communities.

Anti-oppressive practice is a pedagogy based in social work that is focused on dismantling systemic oppression such as racism, sexism, ableism, heterosexism, and classism. From an anti-oppressive lens, structures of power undermine not only the interactions between

mobile crisis responder and service user but are in fact root cause of the symptoms intrinsic to mental health crisis itself. From this premise, only a framework that accounts for systemic oppression and structures of power can effectively respond to the complexity of mental health crises. Anti-oppressive practice offers one possible approach.

The role of police officers is inherently incompatible with AOP (Leland & Stockwell, 2022). Thus, a mobile mental health crisis response project that is based on AOP principles would aim for the removal of police in mental health response (Kaufman-Mthimkhulu, 2020). Future research should evaluate the effectiveness of AOP-informed crisis response models, particularly in diverse communities. For example, studies could examine current mobile crisis response models guided by the tenets of AOP, such as Project LETS and M.H. First, including their scalability and long-term outcomes. Such studies are essential for developing equitable and responsive crisis response systems that meet all individuals' needs.

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