

# TRIAGING MENTAL HEALTH EMERGENCIES: LESSONS FROM PHILADELPHIA

JENNIFER D. WOOD\* & EVAN ANDERSON\*\*

## I

### INTRODUCTION

It is well established that police frequently encounter people experiencing mental health distress. In some instances, the same people are also experiencing other overlapping vulnerabilities like chaotic substance use and housing instability.<sup>1</sup> Because calling 911<sup>2</sup> to get assistance for mental health crises—and to manage homelessness and public disorder—has become normalized, a large portion of these encounters are initiated through emergency dispatch systems.<sup>3</sup>

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\* Jennifer D. Wood, PhD is with the Department of Criminal Justice at Temple University. This work was supported by funding from Vital Strategies Research.

\*\* Evan Anderson, JD, PhD is with the Center for Public Health Initiatives at the University of Pennsylvania.

1. See generally Amy C. Watson, Melissa Schaefer Morabito, Jeffrey Draine & Victor Ottati, *Improving Police Response to Persons with Mental Illness: A Multi-level Conceptualization of CIT*, 31 INT'L J.L. PSYCHIATRY 359, 360 (2008). Amy C. Watson, Leah G. Pope & Michael T. Compton, *Police Reform from the Perspective of Mental Health Services and Professionals: Our Role in Social Change*, 72 PSYCHIATRY SERVS. 1085, 1085 (2021) [hereinafter Watson et al., *Police Reform from the Perspective of Mental Health Services and Professionals*]. One study found that 26.2% of people using a shelter experienced a serious mental illness, and among sheltered adults who were homeless, 34.7% were affected by chronic substance use issues. See *Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN.,

[https://www.samhsa.gov/sites/default/files/programs\\_campaigns/homelessness\\_programs\\_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf) [https://perma.cc/W7J5-E58E] (last updated July 2011). The relationship between housing instability and mental illness is bidirectional. See generally Deborah K. Padgett, *Homelessness, Housing Instability and Mental Health: Making the Connections*, 44 BJPSYCH BULL. 197, 197 (2020).

2. Other articles explain the history, complexity, and function of the American 911 system. See generally REBECCA NEUSTETER, MARIS MAPOLSKI, MAWIA KHOGALI & MEGAN O'TOOLE, VERA INST. JUST., *THE 911 CALL PROCESSING SYSTEM: A REVIEW OF THE LITERATURE AS IT RELATES TO POLICING* (2019). There are over 6,000 call centers or Public Service Answer Points (PSAPs) across the country. *Id.* at 6. PSAPs process calls for a wide variety of emergencies, such as medical, fire, criminal or public safety. *Id.* Through PSAP protocols, which vary across jurisdiction, telecommunications professionals—call-takers and dispatchers—must determine which emergency service to deploy, such as Emergency Medical Services, Fire, or Police. *Id.* at 6–8.

3. See, e.g., Watson et al., *Police Reform from the Perspective of Mental Health Services and Professionals*, *supra* note 1, at 1085; MICHAEL VERMEER, DULANI WOODS & BRIAN A. JACKSON, RAND CORP., *WOULD LAW ENFORCEMENT LEADERS SUPPORT DEFUNDING THE POLICE?*

Police have been deployed as the primary response option through these systems despite reliance on formal training, skills, and tools centered on coercion and the exercise of criminal legal authority. As a result, these encounters often produce avoidable harm in the form of physical injury,<sup>4</sup> stigmatization,<sup>5</sup> and unnecessary entanglement with the criminal justice system through arrests, especially for misdemeanors.<sup>6</sup> Beyond their iatrogenic harms, overreliance on police in mental health emergencies is also likely to result in missed opportunities to connect community members with supportive services and resources.

Recognizing these problems, reform efforts have adopted two strategies. One focuses on improving police officers' knowledge of mental illness along with their self-efficacy in deescalating situations and linking people to care.<sup>7</sup> The other strategy changes the personnel who respond to mental health emergencies, either by adding civilian clinicians or social workers to police response teams<sup>8</sup> or by entirely replacing police officer teams with civilian health professionals and crisis interventionists.<sup>9</sup> The idea of co-response is premised on the assumption that officers can lend their skills and legal tools to provide for public safety, while the civilian member of the team can assess and potentially address mental health

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PROBABLY — *IF COMMUNITIES ASK POLICE TO SOLVE FEWER PROBLEMS* 3 (2020), <https://www.rand.org/pubs/perspectives/PEA108-1.html> [<https://perma.cc/C3XG-42F5>].

4. See generally Wesley Lowery et al., *Distraught People: Deadly Results*, WASH. POST (June 30, 2015), <https://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/> [<https://perma.cc/RX9Q-EUXM>]; Alexander J. Rohrer, *Law Enforcement and Persons with Mental Illness: Responding Responsibly*, 36 J. POLICE & CRIM. PSYCH. 342, 343 (2021).

5. See Amy C. Watson, Patrick W. Corrigan & Victor Ottati, *Police Officers' Attitudes Toward and Decisions About Persons with Mental Illness*, 55 PSYCHIATRIC SERVS. 49, 49 (2004) (explaining that police officers are a significant source of stigmatization and discrimination against persons with mental illness).

6. Michael T. Compton et al., *Characterizing Arrests and Charges Among Individuals with Serious Mental Illnesses in Public-Sector Treatment Settings*, 73 PSYCHIATRIC SERVS. 1102, 1103 (2022); Michael T. Compton et al., *Misdemeanor Charges Among Individuals with Serious Mental Illnesses: A Statewide Analysis of More Than Two Million Arrests*, 74 PSYCHIATRIC SERVS. 31, 31 (2023).

7. Michael T. Compton et al., *Crisis Intervention Team Training: Changes in Knowledge, Attitudes, and Stigma Related to Schizophrenia*, 57 PSYCHIATRIC SERVS. 1199, 1201 (2006); Amy C. Watson, Michael T. Compton & Jeffrey N. Draine, *The Crisis Intervention Team (CIT) Model: An Evidence-Based Policing Practice?*, 35 BEHAV. SCI. & L. 431, 436 (2017).

8. See AMY C. WATSON, MICHAEL T. COMPTON & LEAH G. POPE, VERA INST. JUST., *CRISIS RESPONSE SERVICES FOR PEOPLE WITH MENTAL ILLNESSES OR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES: A REVIEW OF THE LITERATURE ON POLICE-BASED AND OTHER FIRST RESPONSE MODELS* 14 (2019). See generally Melissa S. Morabito, Jenna Savage, Lauren Sneider & Kellie Wallace, *Police Response to People with Mental Illnesses in a Major U.S. City: The Boston Experience with the Co-Responder Model*, 13 VICTIMS & OFFENDERS 1096 (2018).

9. A well-known and longstanding example of an alternative dispatch program is the CAHOOTS model (Crisis Assistance Helping Out on the Streets) in Eugene, Oregon. In this program, which has been operating for decades, unarmed responders address calls involving mental health distress, drug use or other issues where a coercive police response is not merited. Such calls are diverted away from police through the 911 system, where in other cities, specialized behavioral health responses are enlisted through a separate crisis line. See generally JACKSON BECK, MELISSA REULAND & LEAH POPE, VERA INST. JUST., *BEHAVIORAL HEALTH CRISIS ALTERNATIVES: SHIFTING FROM POLICE TO COMMUNITY RESPONSES* (2020).

needs in the moment or through follow-up, or both. Some early co-response models operationalized this approach by enabling officers on scene to rapidly access a clinician over the telephone to help discern what might be going on with a person they have met on patrol or as the subject of a call for service. The deployment of fully civilian response teams is premised on the assumption that a large portion of mental health crises do not present public safety concerns.

Many jurisdictions have experimented with one or both strategies<sup>10</sup> necessitating the characterization of response needs or triage earlier on in the process of enlisting help, when a person initiates a call for service—in the American case, via the 911 system.<sup>11</sup> This triaging of calls aligns with the knowledge that telecommunications professionals or telecommunicators—that is, call-takers and dispatchers—serve as an early “gatekeeper”<sup>12</sup> to the criminal justice system, prior to the gatekeeping function of police,<sup>13</sup> in deciding whether or not to enlist police to a situation and how.

Telecommunicators play critical roles in interpreting the information provided by callers<sup>14</sup> and in appraising the risk of a situation.<sup>15</sup> In assessing risk, telecommunicators can potentially “prime” officers to respond with a sensibility that is attuned to the potential for danger.<sup>16</sup> Naturally, the ways in which telecommunicators construct, code, and relay information to responding officers is shaped by the information provided by callers, which is itself constructed

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10. *Alternative Dispatch Programs: A Strategy for Improving Emergency Responses and Reducing Police Violence*, EVERYTOWN FOR GUN SAFETY (Jan. 23, 2022), <https://everytownresearch.org/report/alternative-dispatch-programs/> [https://perma.cc/JR8H-73CF]; Andrea Cipriano, *Alternative Dispatch Programs for Mental Health 911 Calls Piloted in 13 Cities*, CRIME REP. (June 17, 2021), <https://thecrimereport.org/2021/06/07/alternative-dispatch-programs-for-mental-health-911-calls-piloted-in-13-cities/> [https://perma.cc/RWJ8-UV5E].

11. It is also important to note that co-deployment options are also deployed in ways other than the primary response through emergency call systems. For example, in Philadelphia, a co-deployment team works on foot patrol in a high need area and the co-deployment teams can also be summoned as a secondary response by officers already on scene. Kevin Lessard, *Improving Behavioral Health Resources and Police Response*, CITY OF PHILADELPHIA (Oct. 25, 2021), <https://www.phila.gov/2021-10-25-improving-behavioral-health-resources-and-police-response/> [https://perma.cc/6ML2-MTXD].

12. Cynthia Lum et al., *Constrained Gatekeepers of the Criminal Justice Footprint: A Systematic Social Observation Study of 9-1-1 Calltakers and Dispatchers*, 37 JUST. Q. 1176, 1177 (2020).

13. S. REBECCA NEUSTETER ET AL., VERA INST. JUST., GATEKEEPERS: THE ROLE OF POLICE IN ENDING MASS INCARCERATION 2 (2019).

14. See generally Rylan Simpson, *Calling the Police: Dispatchers as Important Interpreters and Manufacturers of Calls for Service Data*, 15 POLICING: J. POL’Y & PRAC. 1537 (2021).

15. See generally Alex Black & Karen Lumsden, *Precautionary Policing and Dispositives of Risk in a Police Force Control Room in Domestic Abuse Incidents: An Ethnography of Call Handlers, Dispatchers and Response Officers*, 30 POLICING & SOC’Y 65 (2020).

16. See generally Jessica W. Gillooly, *How 911 Callers and Call-takers Impact Police Encounters with the Public: The Case of the Henry Louis Gates Jr. Arrest*, 19 CRIMINOLOGY & PUB. POL’Y 787 (2020); Jessica W. Gillooly, “Lights and Sirens”: Variation in 911 Call-Taker Risk Appraisal and its Effects on Police Officer Perceptions at the Scene, 41 J. POL’Y ANALYSIS & MGMT. 762 (2021) [hereinafter Gillooly, “Lights and Sirens”].

through a dynamic two-way interaction between the caller and the call-taker.<sup>17</sup> Depending on the circumstances surrounding a call, such as where the call is occurring, what is going on in the background, and the emotional or psychiatric state of the caller, the ability of telecommunicators to precisely define and categorize an event can vary.<sup>18</sup>

In theory, the best response system to address acute distress in the community would involve the police as little as possible. Fully civilian and co-response teams can surely address some calls. But what would it take to figure out when police should be mobilized to address people's troubles, and when should they not? Context matters. Jurisdictions vary in the types of trouble reported to 911 call-takers. And what if a city suffers from ongoing violence? How do community member experiences with and expectations of 911 emergency responses shape norms and define possible behavior changes among all parties involved in a first response encounter? In cities plagued by violence, the challenge of determining the need for police may be more complex. The process of triage is a key part of this puzzle and the subject of this Philadelphia-based study.

## II

### POLICE MOBILIZATION AND MENTAL HEALTH DISTRESS

Police play an everyday role in responding to people with mental illnesses.<sup>19</sup> This fact is well established, but researchers still struggle to achieve precise

17. Angela Cora Garcia & Penelope Ann Parmer, *Misplaced Mistrust: The Collaborative Construction of Doubt In 911 Emergency Calls*, 22 *SYMBOLIC INTERACTION* 297, 298 (1999).

18. Marilyn R. Whalen & Don H. Zimmerman, *Describing Trouble: Practical Epistemology in Citizen Calls to the Police*, 19 *LANGUAGE SOC'Y.* 465, 485 (1990); Nils Rosenbaum, *Identification and Strategies for Diffusing 911 Abuse Caused by Psychiatric Symptoms*, 10 *J. POLICE CRISIS NEGOTS.* 182, 183 (2010). Gilsinan explains that the work of 911 telecommunicators is "interpretive work," which "involves an attempt to structure essentially ambiguous input." James F. Gilsinan, *They Is Clowning Tough: 911 and the Social Construction of Reality*, 27 *CRIMINOLOGY* 329, 339 (1989). Relatedly, Neusteter and Pollack refer to the discretion of 911 call-takers, along with variation in the operating procedures across Emergency Communities Centers (ECCs) in the United States, noting:

ECC operating procedures, together with the discretion afforded 911 call-takers and dispatchers, guide which calls are resolved without the need for a field response, whether police officers are sent to the scene and what they anticipate they will encounter upon arrival, and which calls should be diverted to alternative responders, such as mental health professionals. While standardized call-taking and triaging protocols exist to ensure that calls to 911 are neither over-triaged (sending a responder when one is not necessary) or under-triaged (underestimating the exigency and risk of the event), they are not used universally by all ECCs. This patchwork of protocols leads to uneven experiences among community members seeking emergency services.

S. REBECCA NEUSTETER & HAROLD POLLACK, *TRANSFORM 911, TRANSFORMING 911: ASSESSING THE LANDSCAPE AND IDENTIFYING NEW AREAS OF ACTION AND INQUIRY* 12 (2022), [https://bpb-us-w2.wpmucdn.com/voices.uchicago.edu/dist/e/2911/files/2022/07/Transforming-911\\_-Assessing-the-Landscape-and-Identifying-New-Areas-of-Action-and-Inquiry.pdf](https://bpb-us-w2.wpmucdn.com/voices.uchicago.edu/dist/e/2911/files/2022/07/Transforming-911_-Assessing-the-Landscape-and-Identifying-New-Areas-of-Action-and-Inquiry.pdf) [<https://perma.cc/8PTE-LDCU>].

19. Amy C. Watson & Jennifer D. Wood, *Everyday Police Work During Mental Health Encounters: A Study of Call Resolutions in Chicago and Their Implications for Diversion*, 35 *BEHAV. SCIS. & L.* 442, 443 (2017).

measures of the prevalence of mental health-related encounters. Police record-keeping systems—both at the call-taking level and at the time of disposition—were not originally designed to flag health-related concerns, but rather a behavior that violates the criminal law or threatens public order. Yet, it has long been recognized that mental health distress is a feature of some situations that officers are called upon to handle. A pioneering sociologist of police work—Egon Bittner—in his close attention to everyday police work, wrote about the handling of mental health crises and features of officer decision-making in choosing how to act, such as determining when to handle mental health issues informally rather than resorting to more coercive mental health apprehensions.<sup>20</sup>

In the ensuing years since Bittner’s observational research, a series of high-profile incidents have resulted in the deaths of people in crisis at the hands of the police. When recorded on a cellphone or a body-worn camera, these incidents provide one particularly stark embodiment of the dangerous inadequacy of police as mental health first responders.<sup>21</sup> These tragic incidents are not necessarily representative of more common harms and more widespread shortcomings of the status quo. Moreover, they sometimes focus attention too narrowly on downstream intervention.<sup>22</sup>

Researchers have sought to unpack the various dynamics contributing to harmful interactions between officers and call subjects over the course of the first response event. This knowledge informed training-focused interventions with police, equipping them with the awareness, knowledge, and skills to respond to situations safely and link people in crisis to community-based resources.<sup>23</sup> The flagship training intervention is contained in the curriculum of the Crisis Intervention Team (CIT) model.<sup>24</sup> There is strong empirical evidence<sup>25</sup> that specialized CIT training has improved officer knowledge and perceived self-

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20. See generally Egon Bittner, *Police Discretion in Emergency Apprehension of Mentally Ill Persons*, 14 SOC. PROBS. 278 (1967).

21. See *infra* note 63 and accompanying text (describing the fatal shooting of Walter Wallace Jr. in Philadelphia).

22. See, e.g., Paula M. Lantz, *The Medicalization of Population Health: Who Will Stay Upstream?*, 97 MILBANK Q. 36, 37 (2019) (noting, in a discussion of hospital programs aimed at supporting people with complex needs that, despite providing “a strong scaffolding . . . [to] support search and rescue efforts for individuals as they struggle in unhealthy currents . . . [and that] these efforts are indeed necessary and generally positive, they are also woefully insufficient if the overarching goal is improved health outcomes and health equity at the societal level”).

23. WATSON, COMPTON & POPE, *supra* note 8, at 27.

24. LAURA USHER ET AL., CRISIS INTERVENTION TEAM INT’L, CRISIS INTERVENTION TEAM (CIT) PROGRAMS: A BEST PRACTICE GUIDE FOR TRANSFORMING COMMUNITY RESPONSES TO MENTAL HEALTH CRISES (2019), [https://www.citinternational.org/resources/Best%20Practice%20Guide/CIT%20guide%20desktop%20printing%202019\\_08\\_16%20\(1\).pdf](https://www.citinternational.org/resources/Best%20Practice%20Guide/CIT%20guide%20desktop%20printing%202019_08_16%20(1).pdf) [<https://perma.cc/MQC7-ED78>].

25. For a comprehensive review of evidence on CIT, see WATSON, COMPTON & POPE, *supra* note 8, at 27–33.

efficacy in the resolution of mental health encounters.<sup>26</sup> Moreover, researchers have found that CIT-trained officers are more likely to refer or transport people to mental health facilities rather than arrest them as a means of resolving the encounter.<sup>27</sup>

This first wave of police reform—centered on correcting officer behavior through mental health training—has served as a strong building block for creating mental health awareness within the police profession.<sup>28</sup> Co-response programs have also shown promise, with some evidence of decreases in detention rates and petitions for involuntary psychiatric assessment,<sup>29</sup> as well as increases in follow-up support and linkage to care.<sup>30</sup> Such programs have also shown benefits in terms of decreased time spent by officers on scene.<sup>31</sup> Non-police response alternatives are also showing promise, with a recent study finding that a “community response” pilot in Denver resulted in fewer reported instances of relatively minor crimes, such as trespassing, public disorder, and resisting arrest.<sup>32</sup>

Yet, it is important to understand that many police-citizen encounters are the result of an earlier stage of police mobilization.<sup>33</sup> In his *Dial-a-Cop* study, Shearing reminded us of the obvious, but neglected, point that “North Americans include ‘calling the cops’ as part of their repertoire of methods for dealing with trouble—that is, something wrong that something needs to be done about.”<sup>34</sup> Indeed, decades of empirical research has shown that people call for police assistance in addressing a wide variety of problems where people “sense trouble or feel threatened,”<sup>35</sup> including but not limited to situations related to mental illness, substance use or homelessness.<sup>36</sup>

The process of “reactive mobilization,” where citizens call 911 for police assistance, as opposed to “proactive mobilization,” where officers intervene in a situation at their own behest,<sup>37</sup> is a massive driver of police involvement in the

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26. Michael T. Compton et al., *The Police-Based Crisis Intervention Team (CIT) Model: I. Effects on Officers' Knowledge, Attitudes, and Skills*, 65 PSYCHIATRIC SERVS. 517, 520 (2014).

27. Michael T. Compton et al., *The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest*, 65 PSYCHIATRIC SERVS. 523, 525 (2014).

28. Watson, Compton & Draine, *supra* note 7, at 438.

29. Stephen Puntis et al., *A Systematic Review of Co-responder Models of Police Mental Health 'Street' Triage*, 18 BMC PSYCHIATRY, Aug. 2018, at 6.

30. Melissa S. Morabito & Jenna Savage, *Examining Proactive and Responsive Outcomes of a Dedicated Co-Responder Team*, 15 POLICING: J. POL'Y & PRAC. 1802, 1810 (2021).

31. Stephen Kisely et al., *A Controlled Before-and-After Evaluation of a Mobile Crisis Partnership Between Mental Health and Police Services in Nova Scotia*, 10 CANADIAN J. PSYCHIATRY 662, 664 (2010).

32. Thomas S. Dee & Jaymes Pyne, *A Community Response Approach to Mental Health and Substance Abuse Crises Reduced Crime*, 8 SCI. ADVANCES, June 2022, at 3.

33. See generally CLIFFORD D. SHEARING, *DIAL-A-COP: A STUDY OF POLICE MOBILIZATION* (1984); RICHARD V. ERICSON, *REPRODUCING ORDER: A STUDY OF POLICE PATROL WORK* (1982); A.J. REISS, *THE POLICE & THE PUBLIC* (1971).

34. SHEARING, *supra* note 33, at 1.

35. Barry Friedman, *Disaggregating the Policing Function*, 169 U. PA. L. REV. 925, 939 (2021).

36. *Id.*

37. ERICSON, *supra* note 33, at 78, 88.

lives of everyday people, including people with mental illnesses.<sup>38</sup> In Philadelphia, which has a population of 1.58 million people, there were over one million calls to 911 that resulted in police being dispatched to a scene.<sup>39</sup> Nationally, there are approximately 240 million 911 calls for service each year.<sup>40</sup> In this context, several recent studies have mined calls for police service data to distill patterns in the types of situations police are called upon to handle.<sup>41</sup> A recent multicity analysis revealed that most calls for service do not involve violent crimes and that police are regularly enlisted to address non-emergency situations.<sup>42</sup> A recent Detroit-based study found that forty-four percent of 911 calls related to crimes, while other matters related to issues such as “quality of life” concerns, traffic, and health.<sup>43</sup> Studies outside of the United States examining call center data also reveal that people routinely elicit the help of police in resolving mental health-related situations<sup>44</sup> that do not involve crimes or emergencies.<sup>45</sup> Taken together, these findings suggest that police are enlisted on a routine basis to address the needs of people in the “missing middle”<sup>46</sup>—that is, those with mental health needs that may be mild or moderate in nature but largely unaddressed by deficient health and human service systems.<sup>47</sup>

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38. NEUSTETER ET AL., *supra* note 13, at 2.

39. Jerry H. Ratcliffe, *Policing and Public Health Calls for Service in Philadelphia*, 10 CRIME SCI., Mar. 2021, at 1 (reminding us that not all calls to 911 are deemed to be dispatchable events).

40. REBECCA NEUSTETER ET AL., VERA INST. JUST., UNDERSTANDING POLICE ENFORCEMENT: A MULTICITY 911 ANALYSIS 5 (2020); *Transform 911: A Blueprint for Change*, U. CHI. HEALTH LAB, <https://www.transform911.org/blueprint/> [https://perma.cc/JQ4C-PVEK] (last accessed Nov. 29, 2022).

41. *See generally* Ratcliffe, *supra* note 39. *See also* Krystle Shore & Jennifer A. Lavoie, *Exploring Mental Health-Related Calls for Police Service: A Canadian Study of Police Officers as ‘Frontline Mental Health Workers’*, 13 POLICING: J. POL’Y & PRAC. 157, 160 (2019) (using official police data from a mid-sized Canadian city to examine the nature of mental health-related calls for service and how they were resolved by police).

42. NEUSTETER ET AL., *supra* note 40, at 241.

43. Samuel Langton et al., *Describing the Scale and Composition of Calls for Police Service: A Replication and Extension Using Open Data*, POLICE PRAC. & RSCH., Jul. 2022, at 6.

44. Judy Li, Rhiannon Newcombe, Ross Hendy & Darren Walton, *A Disproportional Increase in Lower Priority Mental Health-Related Calls to New Zealand Police Between 2009 and 2016*, 30 POLICING & SOC’Y 519, 524 (2020) (observing an increase in mental health-related calls for service over each year of the study period).

45. Ross Hendy, Judy Li, Rhiannon Newcombe & Darren Walton, *From the Street Corner to Call Centre: Changes in the Characteristics of Mental Health-Related Calls for Service Received by Police*, 32 POLICING & SOC’Y 862, 871 (2021).

46. Stuart Thomas, Chris White, Nadine Dougall & Inga Heyman, *Law Enforcement and Public Health: The Missing Middle*, in LAW ENFORCEMENT AND PUBLIC HEALTH: PARTNERS FOR COMMUNITY SAFETY AND WELLBEING 111, 111 (Isabelle Bartkowiak-Théron et al. eds., 2022).

47. *See also* Jennifer D. Wood, Amy C. Watson & Anjali J. Fulambarker, *The “Gray Zone” of Police Work During Mental Health Encounters: Findings from an Observational Study in Chicago*, 20 POLICE Q. 81, 88 (2017).

## III

## ASPECTS OF MENTAL HEALTH TRIAGE

Triage<sup>48</sup> refers generally to sorting people based on two dimensions: their need for more or less rapid intervention and their need for more or less intensive care. In emergency medicine, this process of assessment is understood to unfold across phases, starting with the summoning of assistance, proceeding to the initial assessment of clinicians on site, often emergency medical technicians (EMTs), and culminating in a more thorough examination in the hospital emergency department. Triage assessments are understood to be dynamic based both on changing health status and changing diagnostic capacity. In common colloquial and applied usage, triage presupposes scarcity: patients presenting with chest pain at the emergency department get treated first not just because of the risk of immediate harm, but because there is insufficient capacity to treat all comers rapidly. In this sense, there are often embedded and underrecognized ethical and empirical assumptions underlying triage in practice.<sup>49</sup> Triage frequently follows an implicit utilitarian orientation aimed at maximizing health at a population level while taking resource constraints as more or less fixed.<sup>50</sup>

When applied to policing, the term triage sometimes has a slightly narrower meaning more akin to assessment. In the United Kingdom, the term street triage, for example, refers to “mental health professionals supporting police officers when responding to emergency calls for cases that involve a person who may be suffering from a mental illness.”<sup>51</sup> A systematic review of “Models of Mental Health Triage for Individuals Coming to the Attention of the Police Who May Be Experiencing Mental Health Crisis” defined its inclusion criteria in exclusive reference to co-response efforts.<sup>52</sup> In more recent years, the concept of triage has

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48. Seung-Hee Lee & Chan Woong Kim, *History-Taking Questions During Triage in Emergency Medicine*, 55 RSCH. ON LANGUAGE & SOC. INTERACTION 326, 326. See also Hiroyuki Nakao, Isao Ukai & Joji Kotani, *A Review of the History of the Origin of Triage from a Disaster Medicine Perspective*, 4 ACUTE MED. & SURGERY 379 (2017) (describing the long and contested origin and evolution of triage as a concept, including conventional etymology ties to French efforts at the end of Napoleon’s conquests, and use of a similar term in Japan in the sorting of coffee beans).

49. Napoleon is believed to have valued triage for its military and not humanitarian value. He was concerned primarily with getting soldiers back to the frontlines and not saving lives per se. See Nakao, Ukai & Kotani, *supra* note 48, at 382.

50. The resort to triage due to inability to address under-resourcing has been noted as a source of inequity in the criminal justice system. L. Song Richardson, *Systemic Triage: Implicit Racial Bias in the Criminal Courtroom*, 126 YALE L.J. 862, 866 (“[P]olicies and practices burden the system with more cases than it has the capacity to handle, resulting in what I refer to as systemic triage. . . . [U]nder conditions of systemic triage, implicit racial biases are likely to thrive.”).

51. Mark Rodgers et al., *Police-Related Triage Interventions for Mental Health-Related Incidents: A Rapid Evidence Synthesis*, 7 HEALTH SERVS. & DELIVERY RSCH. 5, 16 (2019).

52. Alice Park et al., *Models of Mental Health Triage for Individuals Coming to the Attention of the Police Who May Be Experiencing Mental Health Crisis: A Scoping Review*, 15 POLICING: J. POL’Y & PRAC. 859, 861 (2021) (“Interventions were schemes, where collaboration between the police and mental health professional(s) involved the mental health professional advising the police and supporting them to manage individuals perceived to be experiencing a mental health crisis.”).



emerged in advocacy and research focused on the deployment of mental health emergency response personnel. In principle, triaging for mental health concerns helps to allocate scarce mental health resources to people in need as well as potentially divert people away from harmful criminal justice involvement. Previous research suggests that calls coded as mental health-related are more likely to result in linkage to services versus arrest or informal resolutions.<sup>53</sup> However, there is a paucity of theory underlying mental health triage,<sup>54</sup> and the term is used imprecisely, both of which complicate broad generalizations about its implementation and effects.<sup>55</sup>

Theoretically, alternative response models that decenter the police—or remove police altogether from mental health emergency response—are assumed to interrupt the harmful processes that can occur when a conventional, police-only response is deployed. The presumptive logic is that police-only responses can worsen a person’s health and social conditions. This is analogous to iatrogenesis, which refers to harms that result from medical intervention.<sup>56</sup> The iatrogenic harms of police result from intervening in ways that are emotionally, psychiatrically, or physically injurious—either directly through the interaction itself or indirectly by extending criminal justice system involvement through arrest. By introducing a process for triaging mental health emergencies, it is assumed that the right type of first response will be deployed to avoid injury, link call subjects to needed supports and services, and reduce their chances of acute distress in the future. With the implementation of such models, the triage process has two main aspects: first, identifying a mental health emergency, and second, determining which type of first response deployment, if any, would be the most helpful and least harmful to the call subject and others in the situation. The second aspect is in essence the treatment decision that is made based on the necessarily limited information provided by the caller to the call-taker. It is the hope with such response models that call-takers can predict with specificity the need for police, co-response, or no police at all, while avoiding—with a high level of probability—the harmful errors of sending the wrong type of response.

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53. Amy C. Watson, Linda K. Owens, Jennifer Wood & Michael T. Compton, *The Impact of Crisis Intervention Team Response, Dispatch Coding, and Location on the Outcomes of Police Encounters with Individuals with Mental Illnesses in Chicago*, 15 POLICING: J. POL’Y & PRAC. 1948, 1956 (2021).

54. Park et al., *supra* note 52, at 892 (“None of the reports in this review referred to any underlying programme theory for the scheme. Additionally, owing to the numerous outcomes resulting from a mental health triage ‘referral’, it is important to consider mental health triage as a complex intervention, embedded in criminal justice and mental health pathways, rather than a distinct service.”).

55. See generally Marc Broadbent, Anne Creaton, Lorna Moxham & Trudy Dwyer, *Review of Triage Reform: The Case for National Consensus on a Single Triage Scale for Clients with a Mental Illness in Australian Emergency Departments*, 19 J. CLINICAL NURSING 712 (2010).

56. Evan D. Anderson & Scott Burris, *Policing and Public Health: Not Quite the Right Analogy*, 27 J. POLICING & SOC’Y 300, 302 (2017) (discussing the iatrogenic potential of policing). See generally Gerald N. Grob, *The Rise and Decline of Tonsillectomy in Twentieth-Century America*, 62 J. HIST. MED. & ALLIED SCIS. 383, 407 (2007) (describing how such harms are still common in medicine and explaining that the tonsillectomy, the most common medical procedure in the 20<sup>th</sup> century, provided minimal benefit while carrying substantial risks like all surgical interventions).

The challenge of this triage process can be illuminated through scenarios that illustrate the typical range of mental health emergencies that are the subject of 911 calls for service. Consider three following scenarios discussed in a workshop by an interdisciplinary group of experts on frontline responses to mental health emergencies at the Sixth Global Law Enforcement and Public Health Conference.<sup>57</sup> The first scenario involves a mother who calls 911 claiming that her daughter with schizoaffective disorder stopped taking her medication, yelling and being destructive as a result. At the workshop, it was the consensus among participants that there was no need to send the police at all in such a situation. Moreover, alternative first responders, such as licensed therapists or peers, could readily assess the needs of the individual, the needs of the family, trauma, and other medical events that may be taking place, such as drug-drug interactions. In essence, participants agreed that if there were no signs of danger, then there would be no need for police.

In the workshop, this scenario was altered slightly by the introduction of a new piece of information. In this new scenario, the mother reported the daughter to have said “you just want me dead, but I will kill you first;” there was no information conveyed on the call, at that point, to suggest the presence of a weapon on scene. Based on this new information, participants slightly modified their views about the appropriate type of first responder. Overall, there was still a preference to decenter the police in the response, but it was recommended that police should perhaps be on standby. There was a concern that police involvement could potentially make matters worse, even if only by their uniformed presence, which could potentially cause fear, upset, or discomfort. When this scenario was modified a second time, this time by noting the caller reported the daughter as having a knife and threatened to use it if the mother entered the room, participants agreed that a police response was needed, as safety was now a central concern. However, there was a concern expressed by a police participant that sending the police could potentially escalate the situation, even if their intention was to do no harm. A different participant added that it is possible the caller may not have shared all relevant information to the call-taker, such as the daughter having hypothetically threatened her earlier. Participants agreed that in this situation, the family of the call subject should be provided with a follow-up response that equips them with the knowledge and resources to help them be proactive with their loved one and forestall mental health crises in the future.

In contrast to the first scenario involving a call from a family member, a second scenario involves a person calling 911 in relation to a stranger who is yelling Bible verses in public. The caller expresses concern for the individual, indicating a desire to get him help. Workshop participants agreed that this call

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57. See GLOB. L. ENF'T & PUB. HEALTH, *MoI 14: Workshop: Who Should Respond to Behavioral Health Crises? Imagining a New Behavioral Health Crisis Response Professional*, YOUTUBE (June 12, 2021), <https://www.youtube.com/watch?v=HQUw1EyGS4s> [<https://perma.cc/6YLT-ZNSL>] (discussing the skills and strategies best suited to responding to different types of mental health crises).

did not merit a police response, and it was even suggested that this situation reflects a wider cultural view that this type of behavior is aberrant. Another participant suggested that this situation did not constitute a mental health emergency. The scenario was changed, whereby the caller reported the person swinging a stick when people came near him. For participants, this scenario represented a clear public safety issue, and warranted a police presence. At the same time, however, there was concern about what would happen if the person did not want help because it was clear that arrest would not be appropriate.

In the third scenario, a woman calls 911 because she is contemplating committing suicide by ingesting a full bottle of pills that are at her disposal. There is no indication from the call that the woman has access to weapons. In this scenario, participants did not mention the need for police, but rather focused on the value of crisis hotline workers in building a relationship with the caller and deescalating the crisis. When the scenario was changed to include a man sitting on a couch with a gun to his head, participants readily agreed on the need for an in-person response involving a police presence. In this modified scenario, the fact that a gun was present changed the meaning of this situation to a public safety threat—akin to a barricade situation—where primary importance is placed not only on protecting the call subject, but also his neighbors and the larger community. In this scenario, it was noted that the public would expect a police response, and that there would be concern about putting non-police responders into harm's way.

All these scenarios reveal the holistic and contextual nature of mental health emergency triage and the ways in which assessments of public safety and risk can unfold dynamically over time and with the uptake of new pieces of information. Overall, the multidisciplinary participants who discussed these scenarios took it as their premise that police presence is generally unresponsive to events involving mental illness symptomology or distress, yet the extent to which police presence can be decentered or removed altogether hinges on a careful and situational weighing of the potential harms of iatrogenesis versus the potential harms of not having officers there at all.

## IV

### THE CURRENT STUDY

#### A. Problems And Policy Initiatives in Philadelphia

The implementation and effects of police reform efforts are context-dependent.<sup>58</sup> Philadelphia presents unique challenges and opportunities in efforts

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58. Park et al., *supra* note 52, at 892 (“Realist evaluation, which is a form of theory-driven enquiry, is particularly appropriate when looking at complex interventions . . . . Theory-driven evaluations may help to understand specifically what it is about mental health triage that works in its local setting, why, and for whom . . . which would be invaluable for future commissioning.”).

to realize a healthier response to acute mental distress in the community. It is the poorest large city in the United States, with large areas of deep intergenerational poverty. It has the highest rate of fatal overdose among large cities, with over 1,000 annual deaths in each of the last five years. The city also has sizable areas of concentrated public disorder, including one neighborhood that is often described as the largest open-air drug market on the east coast.<sup>59</sup> That area features many people injecting drugs in public, a subject of consistent concern both for its effect on public disorder—intoxication, minor crime, and trash—and on preventable suffering. The response to these social and health problems has historically relied on policing, which has resulted in the city having the highest rates of incarceration and supervision among similarly sized cities, with enormous racial disparities.<sup>60</sup> This reliance on policing has not resulted in a broad sense of public safety. On the contrary, in the most recent citywide polling, less than fifty percent of residents reported feeling safe in their neighborhood at night, and seventy percent viewed crime, drugs, and public safety as the biggest local issues.<sup>61</sup>

When the city received an infusion of funding from the MacArthur Foundation in 2017, it began implementing a series of initiatives focused on criminal justice policies. Among the more important efforts, for our purposes here, was the establishment of a pre-booking diversion program called Police Assisted Diversion (PAD). PAD launched in two large pilot areas. To better operationalize that effort in one of the areas—the one with the large area of public drug use—the city created a co-responder team whose mission was to provide outreach to people struggling with substance use. That co-responder team included one behavioral health provider and two officers assigned to a foot patrol from a specialized public service detail with experience in managing homeless, mental illness, and other vulnerabilities. The PAD program grew rapidly with over 2,000 social and stop referrals each between December of 2017 and May of 2021.<sup>62</sup>

A number of initiatives aimed at improving the response to mental health distress in the community were also well underway by the middle of 2020. By early October, the city had embedded a clinically trained behavioral health provider in the 911 radio room to help identify calls that involve mental health distress. In addition, the Police Department was in the final stages of creating a

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59. Jerry H. Ratcliffe & Hayley Wight, *Policing the Largest Drug Market on the Eastern Seaboard: Officer Perspectives on Enforcement and Community Safety*, 45 POLICING: AN INT'L J. 727, 727 (2022).

60. Over 90% of the local jail population remain people of color, and Black residents are still detained at nine times the rate of white residents. Samantha Melamed, *Inventing Solitary*, PHILA. INQUIRER (June 8, 2022), <https://www.inquirer.com/news/inq2/more-perfect-union-philadelphia-solitary-prison-population-incarceration-20220608.html> [<https://perma.cc/27XB-AQ3A>].

61. Harrison Cann, *New Pew Poll Shows 30% Increase in Philly Residents Concerned About Crime*, PA. CAP.-STAR (April 10, 2022), <https://www.penncapital-star.com/criminal-justice/new-pew-poll-shows-30-increase-in-philly-residents-concerned-about-crime/> [<https://perma.cc/4HRM-V9PF>].

62. Evan Anderson et al., *Experiences with the Philadelphia Police Assisted Diversion Program: A Qualitative Study*, 100 INT'L J. DRUG POL'Y, Feb. 2022, at 3.

co-response initiative. The importance of these efforts was apparent in late October when two police officers responded to a West Philadelphia residence following several 911 calls reporting a person screaming and a man assaulting an elderly female. Police had responded to two other calls at the same location earlier that day relating to the same ongoing incident. In the audio from the 911 calls, neither did the dispatchers ask nor did the callers offer that the individual—Walter Wallace Jr.—suffered from mental illness. When police arrived, Mr. Wallace walked out the front door of his house carrying a knife. The officers instructed Mr. Wallace to “put the knife down” more than ten times before fatally shooting him as he continued to move forward. The family’s lawyer blamed the incident on both a lack of training and of tasers.<sup>63</sup> The criticism was not the use of tasers—which some offer—but the fact that the officers were not equipped with them in this instance.

Philadelphia launched its 911 triage and co-response pilot program soon after in the early months of 2021. One of the first steps was changing the 911 radio room script.<sup>64</sup> The co-response team is called the “Crisis Intervention Response Team” (CIRT).<sup>65</sup> The purpose of a CIRT is to address the behavioral health needs of people in crises, link such people to community-based care, and end their involvement with the criminal justice system. At the time of writing, the CIRT model involves a first-response team consisting of a Philadelphia Police Officer with CIT training and a behavioral health clinician, funded by the Department of Behavioral Health and Intellectual Disability Services (DBHIDS) through a contract with a behavioral health provider. The CIRT rides together, responding to events identified as mental health crisis situations. Theoretically, the CIRT response can be deployed by police dispatch based on responses to questions on the mental health script. CIRTs can also be enlisted secondarily by officers deployed as a first response and who subsequently discern a mental health crisis component.

The 911 Triage and CIRT program also includes a follow-up outreach component. Peer Specialists and Outreach Specialists help provide links to community-based services for people previously aided by CIRTs. City officials are working to refine and expand the program so that it eventually addresses the needs of citizens from across Philadelphia.

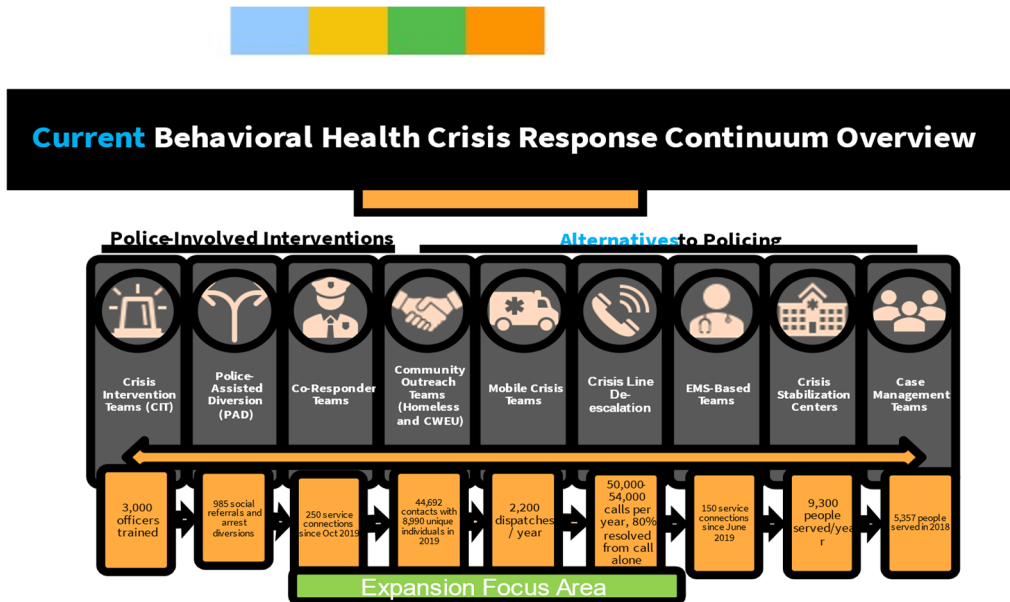
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63. The police department has since committed to providing CIT training and a taser to every officer working out in the community. *Philadelphia to Equip Patrol Officers with TASERs*, POLICE MAG. (Oct. 27, 2021), <https://www.policemag.com/621892/philadelphia-to-equip-patrol-officers-with-tasers> [<https://perma.cc/8WJU-3QPW>].

64. Michaela Winberg, *Policing and Mental Health: Experts Call Philly’s New 911 Script a Good Idea, But Too Long*, BILLY PENN (Apr. 21, 2021), <https://billypenn.com/2021/04/21/philadelphia-police-mental-health-911-script-walter-wallace/> [<https://perma.cc/83KG-2SSY>].

65. Anna Orso, *Following Other Cities, Philly Will Soon Send Specialists Alongside Cops to Some Mental Health Calls*, PHILA. INQUIRER (May 4, 2021), <https://www.inquirer.com/news/philadelphia-police-mental-health-specialists-co-responder-unit-20210504.html> [<https://perma.cc/7T4V-CDMG>].

**Figure 1. Philadelphia Behavioral Health Continuum**



CIRTs are designed to supplement and enhance the Philadelphia Police Department's (PPD) existing CIT Program involving officers with specialized mental health training and the crisis-related services provided by DBHIDS. CIRTs are supervised in two of Philadelphia's six police divisions. In theory, calls that come into 911 dispatch and are flagged as having a behavioral health component may result in the mobilization of a CIRT response. A DBHIDS Crisis Navigator has been stationed at the 911 Radio Room. There are plans to permanently expand the Crisis Navigators 24/7/365, with intentions to provide additional capability across shifts and enhance their role to include direct involvement with callers who have reported behavioral health crises that could appropriately receive a non-law enforcement behavioral health response. Figure 1 depicts the spectrum of response options available at least in some form in some parts of the city.

## B. Methods

This article draws from qualitative data produced as part of an assessment of Philadelphia's 911 Triage and CIRT program as well as survey findings on people's experiences of police response to mental health distress and their preferences for mental health first response options. The survey findings are the

focus of a separate article,<sup>66</sup> and some of its highlights are reported here to complement and add a breadth of understanding to the focus group insights.

The qualitative data is derived from ten focus groups with members of the PPD. One of the authors—Anderson—moderated the focus groups between August and October of 2021. Six focus groups were composed of patrol officers representing each of the six divisions. Four of these groups included officers working on a daytime shift, and two of the groups included officers assigned to the last out night shift. A seventh focus group included officers from specialized public service details, which operate in two divisions. The eighth and ninth focus groups each included sergeants and lieutenants. Finally, there was one focus group with senior leaders from the Inspector and Commander ranks. All groups were diverse in years of service, race, and gender. For narrative simplicity and to preserve anonymity, all respondents are usually described as Officers, despite including participants with a wide range of ranks. In some limited instances, perspectives are attributed to patrol officers or supervisors, with the latter including all ranks of lieutenant and above.

The initial focus group question guide was developed through reviews of relevant literature and discussions with stakeholders. The guide begins with general questions and ends with specific inquiries. To build rapport and explore potentially important contextual differences across divisions, shifts, and assignments, all officers were first asked to describe a normal shift in terms of the volume, type, origin, and priority of jobs. Officers always noted a significant number of jobs involving mental health distress; if they had not, the moderator would have asked whether mental health distress was common among these jobs.

The moderator then directed officers to reflect on their experiences responding to people experiencing a mental health crisis and to describe what resources—broadly defined—would help them respond more safely and effectively in those instances. At the end of this discussion, the moderator asked respondents for their experiences and perspectives with co-deployment generally and CIRTs specifically. Some officers had direct experience with CIRTs and

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66. HELENA ADDISON ET AL., RESIDENT PERSPECTIVES ON POLICE INVOLVEMENT IN THE RESPONSE TO MENTAL HEALTH CRISES (under review). The survey was designed as part of a larger study of people's perspectives on the Philadelphia Police Assisted Diversion Program. The survey items of relevance in this article were designed to gauge the views of community members on police responses to mental health distress and people's preferences for different types of front-line responses ranging from police-only responses to alternative, non-police responses involving mental health professionals. Three additional questions related to the theme of police mobilization. One such question elicited people's perceptions of how quick the police responded to calls for service, and the other two questions sought to understand whether people's familiarity with the practice of reporting the presence of a gun or a weapon to elicit a faster police response. All these additional survey items were inspired by the findings from the above police focus groups. The survey was administered by the Institute for Survey Research at Temple University (ISR) which has a panel of over 10,000 Philadelphia residents who agree to participate in surveys and who are representative of the city in terms of demographic characteristics. ISR invited the 1,443 panel members living in four police districts with some demographic differences, but comparable rates of serious crime, including homicide rates five times the national average. The study closed with 292 participants, representing a 20% response rate. The data were compiled in May 2022.

offered views on the model in practice. Others were only able to offer perspectives on the possible strengths and weaknesses of CIRTs in theory after the moderator explained basic operational features. Officers were always asked—if they did not volunteer it otherwise—for which types of jobs, if any, would a CIRT response be appropriate. In these answers, participants in early groups frequently brought up and initiated broader conversations about voluntary and involuntary commitments—known colloquially as “201s”<sup>67</sup> and “302s”<sup>68</sup> by their location in the state mental health code—and domestic disturbance calls—known colloquially as “domestics.” In later groups, the moderator asked about these jobs both generally and specifically concerning the potential CIRT response.

The focus groups were conducted in private conference rooms in district offices. The discussions were audio-recorded and transcribed. In total, the transcripts covered close to four hundred pages. The study team developed a codebook through a line-by-line reading of a subsample of transcripts and an analysis of relevant scientific literature. Each code was given an explicit definition to ensure coding accuracy and each transcript was coded independently by two members of the study team. The research team resolved coding inconsistencies before the resulting codes were organized into thematic categories.<sup>69</sup> Other findings from the focus groups relating to issues other than 911 triage are under review elsewhere.<sup>70</sup> The institutional review board at the University of Pennsylvania approved this activity.

### C. Results

Overall, officers’ perspectives and experiences related to frontline mental health response and the triage process reveal two central and connected problems. The first is the challenge of predicting, with a high level of specificity, the types of situations to which a CIRT would serve as an effective response. High levels of predictability could be characterized as true positives. Without such specificity, there is the potential for false positives. The second, interrelated problem relates to the challenge of identifying, with a high level of specificity, situations where a CIRT should *not* be deployed. Knowing precisely when a CIRT response is not appropriate reflects a true negative situation. Without such specificity, the problem of false negatives presents itself. In interpreting the data below, the unique context of Philadelphia—with its high levels of violence, drug

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67. See generally 50 PA. STAT. AND CONS. STAT. § 7201.

68. *Id.* § 7301.

69. For this article, one of the authors reviewed excerpts relating to codes that were germane to the theme of triage, jotted analytic notes, and selected quotations from across the groups that are emblematic of the findings discussed below.

70. Ruth Shefner, Rebecca Koppel, Jennifer Wood & Evan Anderson, *Co-Deployment is an Answer. But What Are the Questions?*, POLICE PRAC. & RSCH., Feb. 2023 (noting general consensus that conventional police-centered responses to mental health concerns are often problematic but reducing police involvement is difficult).



use, overdose, poverty, and disadvantage — provides an important background to officers' lived experiences as well as claims about what is possible.

### 1. False Positives

The problem of false positives reflects widespread notions that violence is possible if not probable when interacting with people in distress. As one officer put it, “[T]here is a small amount of jobs that we really don’t have to go to, but the thing is when you put civilians in harm’s way and they can go right nine out of ten times, but that one time it can get ugly.” Officers noted the potential for violence in situations where police or callers are choosing to petition for an involuntary psychiatric assessment—that is, a 302. As one police supervisor put it, “Everybody thinks they just want to go. They don’t. They will fight you. They’re violent. They’re being 302’d for a reason.”

The general concern with violence is amplified by a widespread perception that people embellish the element of danger when they call 911. The problem of call embellishment was understood by officers within the wider context of crime and violence in the city as well as their experience that police are stretched too thin in responding to the broad spectrum of troubles they are enlisted to handle. If telecommunicators appraise a call as having an element of risk, it will be classified as “high priority,”<sup>71</sup> and officers expressed the view that callers know full well that an embellished call will elicit a faster police response. As one officer put it, “[P]eople in the city know you’re short, and they know there is violence everywhere, so you get a neighbor dispute, somebody calls in with a gun, whatever will come to that, and you get there is no gun.” In the following exchange, officers explain this point in reference to a hypothetical person screaming in a call:

Speaker 1: Person screaming is—

Speaker 2: Could be anything.

Speaker 1: Could be anything. Could be a rape, it could be a murder, it could be someone getting beat.

Speaker 2: It could be someone that wants us to come there faster.

Speaker 1: Yeah.

Speaker 3: It could be anything. That’s the problem. We don’t know what it is.

The view that people know that police are short and may embellish a situation to get a faster response has some support in the community survey of Philadelphia residents, where Addison and colleagues report that over sixty-five

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71. “Unlike cut-and-dry calls about barking dogs, vehicle crashes, or burglar alarms, situations about mental health, intimate partner violence, and assault require call-takers to *select from among multiple potentially relevant call categories that trigger different priority level responses*. It is in situations like these that a call-taker’s judgment can most impact the trajectory of an incident. For example, call-takers often have seconds to decide between coding a mental health call as a ‘suicidal subject’ (high priority), ‘welfare check’ (lower priority), or ‘emotionally disturbed person’ (even lower priority). How they triage the call will shape the nature of the response.” Gillooly, “*Lights and Sirens*”, *supra* note 16, at 6–7 (emphasis in original).

percent of respondents believe the PPD does not provide a quick response to calls for service.<sup>72</sup> Additionally, the majority of respondents perceive call embellishment to take place in their communities. Notably, some specific patterns emerge in a more granular analysis of this data. Respondents with no more than five self-reported 911 calls perceive that community members mention there is a gun or other weapon to get a faster response, and among those with more than twenty self-reported 911 calls, this perception is highly prevalent at ninety percent.<sup>73</sup>

Concerning triaging for mental health distress, some officers suggested that this process is best performed on scene, and if the police detect a mental health-related situation, they can summon a CIRT as a secondary response. As one officer stated, “I think if we’re on location and now we assessed the situation: ‘Okay. Radio, is there any way you can raise a CIRT unit to then come over?’” In a different focus group, an officer echoes the point about not knowing all dimensions of a situation at the call-taking level, stating that “[W]e can’t put it on our dispatchers because they only get what the callers takers give.” This officer’s colleague expanded on this point, referencing a purported 302 situation:

Speaker 1: And the job can change when you’re in the middle of it. When I was in the 22nd my partner and I would like to a call because mother wants to 302 her daughter. Looks like on the outside, caring mother wants to 302 her kid because the kid is exhibiting signs of suicidal behavior. We go in, mother is trash drunk. There’s a guy in the house who is the boyfriend, not even the father. Mother wants to start screaming at the kid, then wants to swing on the kid while we’re standing there. So it goes from a hands off talking situation to very hands on situation in point five seconds. Radio can’t tell you exactly what you’ve got. You can’t assess it on the outside before you get there. You’re dealing with it as it evolves.

Speaker 2: Like they’re saying being able to judge if it’s safe or not is impossible. Scenario changes, it’s fluid.

Based on the assumption that you do not know key details until you get there, coupled with the concern about the potential for violence, an officer raised concerns about protecting the civilian member of a co-response team:

I think my main concern with that though would be how have you successfully triage over the phone the potential for violence and exposing the social worker to that potential for physical harm, without having the accompanying police officer that would concern me somewhat.

In a different focus group, an officer raised the same concern, framing it as a liability issue:

[O]ur CIRT units are responding to, they’re listening to radio. And this is more recently, they’re starting to respond to jobs as they’re going on with other officers, at least make their way over to that. And they might even get there first or whatnot, but you still have a liability in your car. That’s what it comes down to ultimately. Because God forbid something goes south, all I got is a vest and they got to sit in a car that has no bulletproof glass or anything else.

Another officer raised the same issue, suggesting that one cannot fully predict where a person in crisis has access to a weapon:

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72. ADDISON ET AL., *supra* note 66, at 4.

73. *Id.*

[H]ow about a person whose mental crisis, like barricaded in the back bedroom? You don't know if he has any weapons. Do you send the therapist to go to try to talk him down? That's a good question.

One officer even suggested that all calls should be handled by two officers: "Every job, you need two officers to handle any kind of job because it can always escalate." This overall concern with protecting public safety during mental health-related encounters was echoed by Philadelphia citizens in the community survey.<sup>74</sup>

## 2. False Negatives

False negatives represent missed opportunities to deploy co-response units. False negatives can result from unspecific and monolithic notions of what constitutes a mental health-related incident. The potential for distress to coincide with other challenges or issues, such as substance use, further complicates identification of false negatives.

Officers' accounts of their own encounter experiences, or their scenarios of typical experiences with a perceived mental health component, revealed that there are different types of mental health distress, varying contexts in which they arise, such as domestic settings, and the possible existence of co-occurring factors, such as the involvement of a juvenile, an intimate partner dispute, or substance use. Across the focus groups, officers spoke of domestic situations involving unhealthy dynamics or unresolved conflicts within a family, in which police were enlisted to provide a remedy.

According to officers' accounts, in other family situations, a caller expects that the police will arrive on scene to provide the information the caller needs to effectuate a petition for an involuntary psychiatric assessment. In this scenario, the officers are expected to serve, in Ericson's terms, as "knowledge brokers."<sup>75</sup> As one officer described it:

Sometimes we get there though, it's a call from a lady, her son acting up and we get there and she says, 'I just want to know how to 302 him.' And that's the only information she wants, 'How do I 302 him?' And I said, 'Well, is that all . . . ' 'That's all I need. I just want to know because he's not acting up now, but in the future how can I—'

In addition to serving as knowledge brokers—helping people navigate the informational requirements of other institutions—officers also bring to bear their craft-based, experiential knowledge<sup>76</sup> in figuring out how to address the needs of

74. ADDISON ET AL., *supra* note 66, at 4.

75. Richard V. Ericson, *The Division of Expert Knowledge in Policing and Security*, 45 BRIT. J. SOCIO. 149, 151 (1994).

76. See Jenny Fleming & Rod Rhodes, *Can Experience be Evidence? Craft Knowledge and Evidence-Based Policing*, 46 POL'Y & POL., no. 1, 2018; James J. Willis & Stephen D. Mastrofski, *Improving Policing by Integrating Craft and Science: What Can Patrol Officers Teach Us About Good Police Work?*, 28 POLICING & SOC'Y 27, 27 (2018) (providing a critique of the "evidence-based policing" movement based on the argument that it "undervalues" the "craft" which they define as "the knowledge, skill and judgment patrol officers acquire through their daily experiences"); David Thacher, *Research for the Front Lines*, 18 POLICING & SOC'Y 46, 52 (2018) ("We have a primitive understanding of what is involved in the kind of context-specific, situated knowledge that officers value. As a result, the very fact that it is knowledge is easily missed.") (emphasis in original).

callers. Officers' nuanced views of mental distress were especially pronounced in stories they told about repeat callers or repeat call subjects. As one officer claimed, "[T]here's probably five people I can name on top of my head that we probably 302'd well over fifty times." In a different focus group, an officer elaborates on the following example of a scenario involving a person with complex needs:

I think that the resources we have are for right now, not for the future because even if someone gets 302'd, they're going to come back and we already know who they are and then they're like, "We got the paper work again." And it's the same thing. So, depending on the area that we're at, depending on how the call comes out, we already know. "It's Carol, it's this person." We already know who that person is, because they're only being held for a certain amount of days, and then they're back up on the street. Then they're getting into these abandoned properties and then they're starting to squat and live there. Then the neighbors are complaining and everyone is complaining, so it's not enough.

Family situations—where a person enlists the police to help with a mental health crisis—were a common reference point for officers when they discussed examples of mental health-related calls. In these examples, callers had specific instrumental goals in mind when asking the police for help, such as wanting some respite from intensifying arguments among intimate partners and family members. However, these callers were also resigned to the absence of response alternatives other than involuntary or voluntary psychiatric commitment. This can lead to a vicious circle of psychiatric petitioning, a return to the home, and a recurrent mental health crisis. An officer referred to an example of a mother yearning for a long term solution to her daughter's mental health needs: "I guess the mom was like 'This is ongoing. So yes, she's calming down now, but what can I do for this to not continuously happen?'" A fellow officer added, "[W]hat other resources do they have aside from 302'ing their children." Some officers perceived that lack of adherence to psychiatric medication as an issue that triggers repeat calls for police assistance by family members,<sup>77</sup> resulting in the cycle of repeat involuntary commitments:

[T]here are times when you go to a house . . . . You speak to the person who's their caretaker, why are they not on medicine? Why are they not taking their medication? They're prescribed medication that you are fully aware that if they don't take, this is going to become a problem. I went to this one house probably nine times in six months and had to 302 the same exact guy.

Certain calls may have some type of mental health component, even if secondary to the primary concern, such as behavioral changes due to drug use:

A lot of times when we went to the CRC [designated crisis response center], the nurses they would say, "This person is just high, they're not mentally ill, they're just going through an episode." And, so they tell us to take them to the hospital across the street or whatever. So, how are we going to determine who is mentally is and who is not

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77. This finding also emerged in Chicago-based research. See Jennifer D. Wood, Amy C. Watson & Christine Barber, *What Can We Expect of Police in the Face of Deficient Mental Health Systems?*, 28 J. PSYCHIATRIC & MENTAL HEALTH NURSING 28, 31 (2020) (reporting officers' claims about "going off meds").

because obviously they're acting erratic, so that to me shows they're mentally unstable. So, I think it's mostly due to I would say drugs and drug use.

In hypothetical true positive situations—calls that would benefit from a CIRT response—one assumes that the CIRT is surrounded by resources in the mental health “ecosystem”<sup>78</sup> that it can mobilize in responding to the needs of the call subject. Previous Chicago-based research on officers' experiences with this ecosystem revealed an overarching concern with system deficits.<sup>79</sup> Having ready access to resources that can address a person's complex needs is vital for police because the tools they have at their disposal, such as arrests or involuntary commitments, are tools simply for handling crises. As one officer put it, “[I]f somebody's presenting an issue, a danger to themselves or to another person, obviously, we want to 302 them. But for those instances where the person just may be suffering mental illness, homelessness, or something like that, then we're handcuffed.”

### 3. False Dichotomy?

Two issues arise from our study that merit further exploration. One is the lack of definition for a true positive and true negative. This seems to result in part from a total lack of theoretical grounding for how alternate response approaches aim to work. There is high face validity for bringing expertise, such as clinical training, to issues that are technically complex, such as mental health crises. Guns and badges are not therapeutic, and many people have long traumatic histories with coercion, which police embody. But still, in a review of co-deployment initiatives, “None of the reports . . . referred to any underlying programme theory for the [program].”<sup>80</sup> They also suggest that “[M]ental health triage [is] a complex intervention, embedded in criminal justice and mental health pathways, rather than a distinct service.”<sup>81</sup>

Second, the prospective and retrospective risks are probably confounded and endogenous. As the officers told us, their presence is sometimes a stimulus for violence. That further complicates triage assessment. It points to the difficulty of advancing knowledge without trying and carefully observing alternate responses in much wider use. Defining a typology of calls and quantifying false positivity and negativity are important next steps.

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78. Erin Falconer et al., *Integrated Multisystem Analysis in a Mental Health and Criminal Justice Ecosystem*, 5 HEALTH & JUST., Mar. 2017, at 2.

79. See Wood, Watson & Barber, *supra* note 77, at 34–36 (discussing variability in officers' experiences with the hospital drop-off process and the quality of hospital services, the “never ending cycle” of hospital transport”, and lack of services for co-occurring needs).

80. Park et al., *supra* note 52, at 892.

81. *Id.*

## VI

## SUMMARY AND IMPLICATIONS

Expansion and sustainability of CIRTs seemingly depends on a call screening system that is highly predictive of both true positives—that is, where a CIRT is appropriately deployed to calls—and true negatives—that is, where a CIRT is appropriately *not* deployed to calls. Yet, our findings to date document difficulty avoiding false positives and false negatives. The problem of false positives reflects widespread notions that violence is possible if not probable when interacting with people in distress. In any situation appraised as high risk by telecommunications professionals, officers will arrive at a scene attuned to the potential for violence, and once they arrive, they will need to reassess. This speaks to the dynamic nature of triage. Risk appraisal is shaped initially by the provision of information by a caller, then by the processing and conveying of information by call-takers and dispatchers, and then again by the reappraisals that happen in real-time throughout a police-citizen encounter. Given the dynamic and ongoing risk appraisal process, the ability to specify whether a police response is merited can be time-bound. Based on his analysis of calls-for-service data in Philadelphia, Ratcliffe has suggested that it is likely hard to know for sure whether a police response is merited until the police arrive first and assess the situation that is before them.<sup>82</sup>

Our findings reveal a logic of risk aversion in the handling of 911 calls for service, a type of “precautionary logic” that has been observed elsewhere.<sup>83</sup> Yet, there is empirical evidence that challenges the concern of danger associated with mental health-related encounters.<sup>84</sup> Data from the Crisis Assistance Helping Out On The Streets (CAHOOTS) program—which has been operating for decades—reveals that the police are simply not required to address mental health crises, except in rare cases.<sup>85</sup> With respect to the wider universe of calls to police, a recent Seattle-based study found that almost half of 911 calls could be handled by a non-police first responder.<sup>86</sup> It is difficult to determine how local context

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82. Ratcliffe, *supra* note 39, at 3–5.

83. Black & Lumsden, *supra* note 15, at 69.

84. See Melissa Schaefer Morabito & Kelly M. Socia, *Is Dangerousness a Myth? Injuries and Police Encounters with People with Mental Illnesses* *Police Encounters with People with Mental Illness*, 14 *CRIMINOLOGY & PUB. POL'Y* 253, 266 (2015) (describing a “use-of-force” study with results that showed that “subjects with perceived mental illness do not represent an increased danger to officers in terms of injury”).

85. See Jennifer J. Carroll et al., *The Workforce for Non-Police Behavioral Health Crisis Response Doesn't Exist – We Need to Create it*, *HEALTH AFFS.* (Sept. 8, 2021), <https://www.healthaffairs.org/doi/10.1377/forefront.20210903.856934/full/> [<https://perma.cc/S6QH-HBR3>] (finding that police officers were “not needed on scene at 99 percent of [CAHOOTS] crisis calls”).

86. See JENNY A. DURKAN, OFF. OF THE MAYOR, CITY OF SEATTLE REPORT 7–8 (2021), <https://publicola.com/wp-content/uploads/2021/07/IDT-Report-on-Reimagining-Policing-and-Community-Safety-in-Seattle3361.pdf> [<https://perma.cc/9DPV-4CPZ>] (finding that 49% of 911 calls could have most likely been handled “by an unarmed/community response”).

shapes the development and scale of experimentation with non-police options. Brave leadership is definitely one of multiple factors that can define and ultimately influence this precautionary logic.

The problem of false negatives represents missed opportunities to deploy co-response. It is a natural result of coarse and monolithic notions of what constitutes a mental health-related incident or mental health distress. Based on their lived experiences, officers conveyed examples in the focus groups of situations where a mental health component seemed apparent to them, but in the wider context of family or other groups dynamics. Officers' accounts of such situations revealed that it is hard to approach the problem of mental health in dichotomous terms—yes or no—because mental health distress is coupled with other forms of “trouble” in one’s immediate familial or community environment. Other scholars have noted that officers observe the intersections of “severe and multiple disadvantages”<sup>87</sup>—that is, the many intersections between different forms of disadvantage, such as housing insecurity, mental illness, substance use, and criminal legal involvement.

From a research and policy perspective, the challenge remains in building systems of measurement that can reliably predict true positives and true negatives. To date, there have been multiple studies that identify the frequency of mental health calls using computer-aided dispatch (CAD) data, but they tend to dichotomize calls as having a mental health component or not. This crude categorization may miss calls that have some type of mental health component, even if secondary to the primary concern. In other words, there are no studies that describe the prevalence of different types of mental health distress, the contexts in which they arise, such as domestic settings, and the existence of co-occurring factors, such as the involvement of a juvenile, an intimate partner dispute, or substance use. Future research should use CAD data and associated incident reports to develop a typology of mental health calls, and moreover, to point to spatial patterns in repeat calls. This is especially important in Philadelphia where, sadly, there are profound geographic differences in levels of unmet basic needs and in community trauma. It is well established in the literature on crime and place that calls to police can and do cluster in time and space,<sup>88</sup> which speaks to the social and ecological determinants of community mental health.

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87. Francesca Menichelli, *Preventing Crises in the Midst of a Global Pandemic: Responsiveness, Participation and Equity in Policing and Public Health Partnerships During COVID-19*, 31 POLICING & SOC'Y 530, 531 (2021).

88. See, e.g., Langton et al., *supra* note 43, at 5–11 (identifying both the time of day that calls to police are made and the spatial patterning of time spent on the scene); Tarah Hodgkinson & Martin A. Andresen, *Understanding the Spatial Patterns of Police Activity and Mental Health in a Canadian City*, 35 J. CONTEMP. CRIM. JUST. 221 (2019) (showing hot spots of police activity around low-income residences); Adam D. Vaughan et al., *Exploring the Role of the Environmental Context in the Spatial Distribution of Calls-for-Service Associated with Emotionally Disturbed Persons*, 10 POLICING 121, 127 (2015) (finding a “high degree of spatial concentration” for calls from “emotionally disturbed persons”); Clair White &

Additionally, more research needs to be done on what people expect when they call 911 for help. One reason for this is that expectations may need to be better managed within conditions of resource scarcity. It could be that given alternative—and arguably cheaper—options, people’s expectations could be reshaped towards non-police first responders. Yet, with a few exceptions, there is limited research on people’s experiences with alternative mental health first response programs, as well as what they prefer as an optimal first responder response.<sup>89</sup> This knowledge is especially limited when it comes to people living in cities plagued by structural inequality, institutional racism, persistent street violence, and community trauma, like Philadelphia.<sup>90</sup> For instance, findings from the Philadelphia community survey make clear that racial differences and dynamics must be more fully understood when it comes to mobilizing the police for help. During the focus groups, officers spoke commonly of family situations where people call 911 in the hopes that police will address their loved one’s mental health crisis.

Public use of 911 as a key vehicle of police mobilization, therefore, merits greater attention as the subject of reform. Future research should seek to better measure the many dimensions of police mobilization, providing data-driven understandings of who, how, when, why, and where people mobilize the police.<sup>91</sup> Members of the public place demands on the police, and these demands vary by place, situation, and who has a stake in how certain situations are resolved. More research is needed that better understands these demand conditions. It is vital to understand the expectations of citizens because, as Lum and colleagues point out, “Citizens and their expectations, therefore, play a significant role in generating the criminal justice footprint through their use of 911.”<sup>92</sup> Managing citizens’

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Victoria Goldberg, *Hot Spots of Mental Health Crises*, 41 POLICING: INT’L J. 401, 406 (2018) (finding that “over 50 percent of mental health calls are concentrated on 3 percent of street segments”).

89. For exceptions, see Kara Boscarato et al., *Consumer Experience of Formal Crisis-Response Services and Preferred Methods of Crisis Intervention*, 23 INT’L J. MENTAL HEALTH NURSING 287, 287 (2014) (investigating experiences of mental health consumers who had experiences with alternative response models); Leah Pope et al., *Preferences for Crisis Response Models Among Mental Health Consumers with Prior Criminal Legal Contact and their Family Members and Friends* (forthcoming 2023).

90. See generally Sara F. Jacoby, Charles C. Branas, Daniel N. Holena & Elinore J. Kaufman, *Beyond Survival: The Broader Consequences of Prehospital Transport by Police for Penetrating Trauma*, 5 TRAUMA SURGERY & ACUTE CARE OPEN, no. 1, 2020 (discussing the importance of examining issues of equity as well as considering a variety of stakeholder perspectives on the advantages and disadvantages of police versus EMS transport of people with penetrating injuries to trauma centers).

91. See Jacek Kozierski, Lorna Ferguson & Laura Huey, *Shedding Light on the Dark Figure of Police Mental Health Calls for Service*, 16 POLICING: J. POL’Y & PRAC., no. 4, 2022, at 5–6 (observing that persons with perceived mental illness are involved in more calls for police service than what is captured under calls classified as mental health calls, thereby revealing the larger problem of misspecification in the classification of calls for police service); Renèe J. Mitchell, Sean Wire & Alan Balog, *The ‘Criminalization’ of the Cop: How Incremental, Systematic Flaws Lead to Misunderstanding Police Calls for Service Involving Persons with Mental Illness*, 16 POLICING: J. POL’Y & PRAC. 370 (2022); Jeremy Pearce & Rylan Simpson, *The Role of Police in Conducting Wellness Checks: Insight from a Study of Police Data*, 23 POLICE PRAC. & RSCH. 400 (2022).

92. Lum et al., *supra* note 12, at 1178.



expectations are also important in addressing 911 misuse or abuse,<sup>93</sup> which includes calling 911 to report situations that are either embellished or fictitious.

A data-driven approach to the dynamic process of call-taking, mental health triage, and police response is critically important because officers' experiences of calls with mental health elements do not align with how dispatch and incident data is constructed.<sup>94</sup> A recent study by Pew Charitable Trusts found that behavioral health training for telecommunicators is important, but for mental health-related calls to be appropriately and sustainably diverted away from traditional police response, there must be a well-resourced system to support such dispatch efforts.<sup>95</sup> As noted in the Pew study:

The lack of consistent coding and data sharing suggests many administrators and policymakers do not have the information necessary to understand the scope of behavioral health crises in their communities, how they are being addressed, potential disparities based on race or location, and where opportunities might exist for improvements and needed investment. It also highlights the difficulty in painting a national picture of the scope of emergency calls related to mental health and substance use.<sup>96</sup>

## VII

### CONCLUSION

In recent years, models have emerged that replace police or co-deploy police alongside behavioral health specialists. In many places, including Philadelphia, both strategies are implemented as part of a continuum of crisis response options involving varying levels of police involvement. Underlying these crisis response alternatives is the assumption that police are sometimes needed to address ongoing public safety threats, but that the least police-centered model is otherwise preferable. For this approach to work, telecommunications professionals on 911 and crisis lines must accurately identify and convey safety risks. Our article elaborates on the problems of false positives and false negatives as issues that—if unaddressed—may forestall wider efforts to decenter the police as first responders to acute mental distress.

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93. See Peter C. Moskos, *911 and the Failure of Police Rapid Response*, 7 L. ENF'T EXEC. F. 137 (2007) (finding that the number of false or embellished 911 calls makes it more challenging for police to respond to citizens' needs).

94. See generally LAURA HUEY ET AL., *POLICING MENTAL HEALTH: PUBLIC SAFETY AND CRIME PREVENTION IN CANADA* (2022); Laura Huey et al., *The Limits of our Knowledge: Tracking the Size and Scope of Police Involvement with Persons with Mental Illness*, 6 FACETS 424 (2021).

95. *New Research Suggests 911 Call Centers Lack Resources to Handle Behavioral Health Crises*, PEW CHARITABLE TRS. (Oct. 26, 2021), <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/10/new-research-suggests-911-call-centers-lack-resources-to-handle-behavioral-health-crises> [<https://perma.cc/64UT-6ULB>].

96. *Id.*