



# Public health approaches to public safety in the United States: An overview of results from GLEPHA's Envisaging the Future project

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## ABSTRACT

In the summer of 2020, the Global Law Enforcement and Public Health Association (GLEPHA) launched a worldwide effort to identify and understand public safety approaches that leveraged the promise of public health frameworks and interventions. This article describes initial results from an effort to identify established and burgeoning programs applying public health approaches to meeting public safety needs in North America. It also includes an assessment of current challenges for sustainably implementing these models and ensuring equitable outcomes for all communities.

## INTRODUCTION

In May 2020, the police murder of George Floyd sparked national and global outrage and drew attention to the fundamental mismatch between the public safety needs of communities and the skills, abilities, training, and resources of the police that serve them. Though Mr. Floyd's murder activated a cultural shift in understanding this incongruity, communities disproportionately impacted by enforcement systems have long identified the limits and harms of policing as it is currently designed.

In the United States, the most common model of public safety provision relies heavily on the police. People call an emergency line for help, and police almost always are dispatched to respond, regardless of the overt or underlying needs associated with the call. While calls for service span a broad range of issues (e.g., substance use disorders, a lost pet, acute mental health crises), most police academy training is focused on force and enforcement, with minimal attention to the raft of inherently social issues implicated in calls for help (Buehler, 2021). This means police often are dispatched to address problems for which they are ill-equipped and untrained (Bailey et al., 2021).

Not only does this fail to address community needs, it contributes to overcriminalization and can lead to the inappropriate or excessive use of force. The public safety response often relies on citations, arrests, and incarceration when treatment or other social services are what is needed most.

While this mismatch between response and needs affects all of society, the costs fall disproportionately on marginalized communities and communities of colour—especially Black communities (Anderson et al., 2017; Hinton et al., 2018; United Nations, 2018).

The resulting failure to meaningfully solve community problems is exacerbated by a lack of coordination across public services, especially across public safety and public health systems. Individuals often cycle repetitively through these systems—from jails to emergency rooms and back again (Milgram et al., 2018). This results in a small number of individuals with unmet needs using an outsized proportion of public resources across systems (Baker et al., 2021; Milgram et al., 2018). For example, researchers in Camden, New Jersey, analyzed local hospital and arrest data to find that more than half of individuals arrested between 2010 and 2014 also made five or more visits to the emergency room during that same period. For many of these individuals, the presence of socio-behavioural challenges such as housing instability, substance use, or mental health issues co-occurred with a health condition or legal concern that may have been better managed in alternative settings.

But there is reason for hope. Attention to this problem is growing, and promising solutions are on the rise (Bailey et al., 2021; Lum et al., 2021). More and more, conversations about community public safety priorities often centre on social determinants of health: economic mobility, affordable housing, dependable transportation, and education. Rather

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than focusing on outcomes relevant to either a public health or public safety system, some jurisdictions are focusing on achieving community well-being through collective, coordinated efforts. This understanding, coupled with strident calls for police reform, has motivated the replication of existing models and innovation of new approaches across the continent.

In the summer of 2020, the Global Law Enforcement and Public Health Association (GLEPHA) launched a worldwide effort to identify and understand public safety approaches that leveraged the promise of public health frameworks and interventions. GLEPHA engaged research teams from regions around the world to undertake media and literature scans, conduct outreach to practitioner groups, and engage municipalities to identify current and emerging strategies. The following describes the initial results from an effort to identify, define, and categorize established and burgeoning programs applying public health approaches to meeting public safety needs in the United States. It also includes an assessment of current challenges for sustainably implementing these models and ensuring equitable outcomes for all communities. As jurisdictions continue to launch new initiatives that aim to solve public safety problems with public health strategies, and as researchers work to fill the considerable gap in evaluations of these programs, this article catalogues models currently implemented, describes promising strategies, and outlines limitations both in theory and practice.

## INITIAL RESULTS

Public safety approaches that leverage public health frameworks and concepts in the United States generally fall into the following categories. Importantly, some jurisdictions are implementing multiple approaches simultaneously across categories.

### Improved Police Response

Some jurisdictions are attempting to respond to the breadth of community needs by investing heavily in police to function as non-enforcement responders in some cases. This approach acknowledges that officers require better tools to respond appropriately to the community issues for which they are dispatched and may include increased training, such as improving police responses to individuals experiencing a mental or behavioural health crisis. Some departments also are enhancing their understanding of individual-level needs by establishing voluntary databases of individuals who are vulnerable, largely those living with specific mental health challenges.

### Training

Likely the most established specialized training to improve law enforcement's ability to respond to individuals experiencing a mental or behavioural health crisis is Crisis Intervention Team (CIT) training (or the "Memphis Model," named for the department in which it originated). It has been implemented in over 2,700 sites across the country for over two decades (Pelfrey & Young, 2019; Hassell, 2020). This 40-hour, specialized curriculum is designed to improve law enforcement response to individuals living with mental illness and substance abuse disorders, with a particular focus on reducing the risk of serious injury or death. Crisis Intervention Team

training is a widely replicated program, though departments frequently modify the model to fit their local needs (e.g., integrating it as a mandatory part of officer training vs. permitting officers to voluntarily self-select). It is supported somewhat in the scientific literature. Studies generally show positive officer-level outcomes (e.g., self-perception of a reduction in use of force), as well as an increase in pre-arrest diversion (Pelfrey & Young, 2019; Hassell, 2020). However, there is limited evidence supporting CIT's impact on measures such as arrests, officer or citizen injury, and officer use of force (Rogers et al., 2019).

### Officer Notifications and Flagging Systems

In Fort Smith, Arkansas, the police department has established a vulnerable persons database to assist police officers in responding to mentally impaired and other at-risk individuals (Fort Smith Police Department, 2020). Participation is voluntary—individuals or their guardians submit a picture of the individual and a form detailing the individual's at-risk status and their address. When an officer runs an individual's background during an encounter in the field, the system will flag for vulnerable persons and prompt an officer to call a specialist. This allows officers to benefit from support from other experts and better respond to individuals' immediate needs. Early research indicates that such flagging systems may make arrests less likely. Similar databases exist in other jurisdictions, generally focusing on mental health conditions or developmental disabilities, such as individuals living with autism (Watson et al., 2019).

### Co-Responder Models

Co-responder models couple a non-police practitioner, usually a social worker or a mental or behavioural health specialist, with a police responder. These models vary widely across jurisdictions, though they usually involve at least one law enforcement officer and one social worker or mental health professional jointly responding to incidents. Usually, these teams are mobile and ride together for a shift, during which they're either jointly dispatched to respond immediately to relevant incidents or are called in as backup after the initial police response. The social services provider may take the lead in engaging with the individual in crisis at the scene. The provider may also follow up to connect the individual to treatment or help them access other needed resources. Unlike alternative response models that operate without the presence of a police officer, co-responder teams may respond to incidents involving threats or the presence of a weapon. Some jurisdictions are also experimenting with virtual co-response models, where officers are given iPads to connect with behavioural health specialists for assessments and referrals in real time (Krider et al., 2020). Though they are being increasingly adopted by municipalities across the region, these models lack rigorous evaluation and require further research.

### In-Person Co-Response

The Denver, Colorado, Police Department has operated its Co-Responder Program since 2016. The model pairs a behavioural health professional with an officer to respond directly to 911 calls for service that involves a mental health component. These calls may or may not include the presence of a weapon and are dispatched day and night, 7 days a week. The Colorado

Department of Human Services funds some 28 similarly designed co-responder programs throughout the state and, in a recent evaluation, found that 98% of the 25,900 calls for service managed by co-responder teams between 2020 and 2021 did not result in an arrest (Colorado Office of Behavioral Health, 2021).

### Remote Co-Response

Harris County, Texas's tele-psychiatry program virtually connects individuals experiencing a mental health crisis with licensed professionals in the field (Harris County Sheriff's Office, n.d.). Deputies use iPads to connect individuals with clinicians in real time, 24 hours a day, 7 days a week. In addition to assisting with stabilization, these clinicians connect individuals with necessary follow-up services, such as counseling or access to treatment.

### Alternative Response

Alternative response models replace a traditional police response with a non-enforcement practitioner response. These responders generally are social workers or behavioural/mental health clinicians or specialists, with a particular focus on stabilizing individuals in crisis. Usually, these responders monitor police radios and are dispatched in response to very specific call types clearly identified as involving mental or behavioural health needs that do not involve the presence of a weapon at the time of dispatch (Baker et al., 2021; Blais & Brisebois, 2021; Lum et al., 2021). These teams are also dispatched for issues related to substance use and homelessness. When a call for service meets pre-defined criteria, the non-police practitioner is dispatched as the primary response, and police are called for backup only if necessary. The responders stabilize the situation and connect the individual with necessary services when appropriate, including transport.

The most well-known and established alternative response model is Eugene, Oregon's Crisis Assistance Helping Out on the Streets (CAHOOTS), founded in 1989 (Beck, 2020). In CAHOOTS, an experienced crisis worker and a paramedic (usually a nurse or EMT) are dispatched to calls for service that have a strong behavioural health component and clearly do not involve a legal issue or an extreme threat of violence. CAHOOTS teams may also self-initiate contact with individuals who appear in need of services or may be directly requested by officers on the scene during an encounter. These first responders stabilize the situation and provide transport for non-emergency medical care if needed. Estimates of the number of the Eugene Police Department's overall call volume that the CAHOOTS team answered range from 5% to 17% (Eugene Police Department, 2020.; White Bird Clinic Eugene, 2020)

Another growing alternative response model involves embedding clinicians within 911 call centres. These social workers, nurses, and other specialized health professionals interact directly with callers to understand the acuity of their needs and triage residents to appropriate levels of care. The Right Care, Right Now Triage Line in Washington, D.C., transfers 911 callers with non-threatening medical issues to a nurse who can assess individuals virtually and connect them with community clinics and in-person care. In its 4 years of operation, Right Care, Right Now has processed some 47,000 911 calls and diverted 17,000 from an emergency

room response (Segraves, 2022). The triage line is undergoing an evaluation through a randomized control trial to better understand how co-locating practitioners in 911 impacts emergency department usage.

### Non-Enforcement Police-Led Outreach

The goal of these programs is to identify proactively vulnerable community members and connect them with social services. These efforts are police-led and usually are part of a broader crime prevention strategy. Their success depends on police officer access to and relationship with communities, and they generally involve robust partnerships with other public agencies and social services, who either conduct outreach alongside the police officer, are standing by to provide necessary services, or both. Some programs target specific social issues such as homelessness, while others provide generalist responses to community needs.

For example, the Long Beach Police Department in California established a Quality of Life Unit. It was founded in 2007 with the goal of reducing vagrancy-related crimes and calls for service associated with homelessness by proactively encountering unhoused persons and connecting them with resources (Long Beach Police Foundation, 2019). This unit includes police officers and mental health clinicians who conduct outreach to individuals experiencing homelessness. The team members connect individuals with housing, transportation, mental health services, and community support groups. Similarly, in Sarasota, the Police Department partners with other service entities to operate its Homeless Outreach Teams (HOT), which consist of case managers, officers, and a supervising sergeant. Homeless Outreach Teams conduct outreach to persons experiencing homelessness throughout the week, connecting individuals to essential social services with a focus on improving long-term outcomes (Sarasota Police Department, 2022). These models have not undergone rigorous evaluation to understand their impact on public safety.

### Pre-Arrest Diversion/Deflection

In pre-arrest diversion (also known as police deflection), a police officer has the discretion to connect an individual to necessary treatment or services in lieu of arrest. The individual must meet pre-defined criteria, and this model usually is used only with non-violent, misdemeanor offenses. This spares the individual from having an arrest record, diverting them away from the criminal justice system and into services more likely to address their underlying and overt needs. Usually, participation in a pre-arrest diversion program is voluntary, and an individual may choose to go through the criminal justice system rather than receive services or treatment. If an individual is diverted but fails to comply with the terms of treatment, they may be arrested for their original offense as a result. These approaches are increasingly used to respond to the opioid epidemic and connect individuals with substance use disorders to treatment, but they are also used for individuals experiencing mental or behavioural health crises and people experiencing homelessness.

One of the most well-known and replicated diversion programs is the Law Enforcement Assisted Diversion (LEAD) program. This is a community-based program that focuses on treatment and services in lieu of arrest for individuals whose criminal activity is linked to an underlying mental health

or substance use issue. Low-level offenders are diverted to harm-reduction-based, individualized case management. The individual receives a variety of support services, often including transitional housing and drug treatment. The case manager coordinates with law enforcement and prosecution to ensure that criminal justice contacts with LEAD participants—including new criminal offenses—are coordinated with the service plan (Clifasefi et al., 2016).

Research on the unique value of LEAD is promising, especially for low-level drug and prostitution offenses. A recent evaluation of Seattle's LEAD program found that participation in LEAD was associated with a statistically significant reduction in criminal justice and legal system involvement. Specifically, LEAD participants had 1.4 fewer jail bookings and spent approximately 41 fewer days in jail per year. Participants also saw a decrease in legal costs, while comparison participants saw significant cost increases (Collins et al., 2019). Another evaluation found that participants in LEAD were significantly more likely to obtain employment and a legitimate income after their LEAD referral compared with the month prior to their referral, and participants were 89% more likely to obtain permanent housing during their follow-up engagement with the program (Clifasefi et al., 2016). Together, these findings indicate a reduction in the use of multiple public systems resulting from implementing the LEAD model—carceral, government aid, housing, legal, and public health.

## LIMITATIONS AND CONSIDERATIONS

While these models of public safety are promising, and some program evaluations indicate great potential for improving public safety outcomes, additional research is needed. Minimal research has been conducted beyond simple outcome evaluations, and long-term, cross-system studies are necessary to better understand the different models' efficacy. It is presently unclear whether these programs sufficiently realign community need with response. In addition to more in-depth program evaluations, the following issues must be sufficiently addressed to support broadscale adoption.

### Systemic Racism

The driving force behind current calls for police reform is the historic and pervasive systemic racism in criminal justice systems and resulting disparate impacts on communities of colour, especially Black communities. The same systemic racism exists in other public institutions, including public health. Simply shifting aspects of police response to public health systems or adding a public health lens to a public safety challenge will not solve the underlying racial inequity inherent in public systems.

### Risk Determination

Many of the models above involve modifications to current dispatch and response models. Understanding the risk associated with a call for service is critical when determining whether a police response or an alternative response is needed. Both failing to send the police when they are needed and sending them when they are not carry inherent risks. Research on risk and dispatch is extremely limited (though preliminary research on CAHOOTS indicates that this type

of risk determination is possible).<sup>1</sup> Jurisdictions should establish clear guidelines regarding when various response types should be sent. Otherwise, overly subjective decisions could perpetuate disparate impacts (e.g., where police response is dispatched to Black communities and other communities of colour, while white neighborhoods receive the alternative models) (Gillooly, 2020).

### Time Bound of Response

One advantage of police response is that they can be dispatched around the clock. Many alternative response models only respond during certain times of day in certain neighborhoods or geographic regions, and not necessarily the times where those services are most needed. If an alternative model is truly to replace the police response, it must be staffed and available for dispatch at all hours, every day, everywhere. In addition, there are many community issues beyond mental/behavioural health, substance use, and homelessness that may be good candidates for alternative or co-response models, such as noise complaints, general disturbances or assaults. Funding fully staffed responders available 24 hours a day, 7 days a week, and uniquely equipped to respond to variable community needs is costly and could require an infusion of newly dedicated resources.

### Practitioner Implications

Many discussions about alternative models—especially alternative response models—take for granted that practitioners such as mental health or behavioural health specialists are willing to assume responsibility for first response at all hours, and in conditions that carry inherent risks. Additionally, discussions ignore the fact that the quasi-social work aspects of policing may be what drives many practitioners to the field. If these activities are removed from the police profession, the nature of the profession changes consequentially in a way that may negatively impact the ability of agencies to recruit service-oriented individuals. If certain police responsibilities are reduced or eliminated, there must be consideration for what police could and should do with freed capacity and how those changes might positively or negatively impact public safety outcomes.

### Need for Downstream Resources

In order for these models to result in improved community outcomes, there must be a wide range of local resources available to meet community public health needs, such as mental and behavioural health services, housing, substance abuse treatment, and other support systems. Otherwise, the “revolving door” nature of the public safety and public health systems will continue.

### Narrow Scope of Responses

Most of these solutions target mental/behavioural health, persons experiencing homelessness, and substance abuse. While these are serious societal problems that police are indeed often ill-equipped to handle, they represent a small portion of calls for service that result in a police response

<sup>1</sup>For example, in 2019, CAHOOTS practitioners responded to approximately 24,000 calls, and only required police backup in 311 instances (Beck et al., 2020).

and are therefore unlikely to significantly impact the role that police play in first response.

### Gravitational Pull of the Status Quo

Support for some of these models seems to be declining in the face of increases in violent crime across the United States (Rosenfeld & Lopez, 2022). Communities that were previously focused on narrowing the police function and expanding the role of social services in public safety systems seem to be shifting focus back to previous models with a focus on force and enforcement (New York Times, 2021; Goodman, 2021). From New York City to Los Angeles and Baltimore, cities across the country opted to restore and/or increase funding to police departments in 2021. For example, Portland restored \$5.2 million to its police budget after cutting \$15 million in June 2020. Despite there being no documented causation between the “defund movement” and rising crime rates, this public perception is difficult to combat. It is important to note, however, that simply because jurisdictions are putting funds back into police departments and expanding support for things like officers on patrol, it does not necessarily mean that they simultaneously are disinvesting from alternatives.

### CONCLUSION

Across the continent, jurisdictions are exploring and implementing novel approaches to public safety that recognize the value and relevance of public health approaches to improving community outcomes. Communities and the government agencies meant to serve them—including police—seem to agree that we simply ask the police to do too much, and much of what we ask goes beyond their skills and resources. Many alternative models designed to address this mismatch show great promise, and several well-established programs are being replicated widely. However, more research is critically needed, and significant social, logistical, and political challenges must be navigated for these programs to be maximally impactful.

### CONFLICT OF INTEREST DISCLOSURES

The author declares that there are no conflicts of interest.

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