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POLICE-MENTAL HEALTH CO-RESPONSE VS USUAL POLICING:
Evidence from Indianapolis

BACKGROUND

This brief examines the effectiveness of a police-mental health co-response model compared to a traditional police response for behavioral health emergencies. Specifically, it summarizes findings from a randomized controlled trial conducted in Indianapolis, Indiana, to assess whether co-response teams reduce interactions with the criminal justice and emergency health systems while increasing access to behavioral health care.

Police are first responders to emergency calls for services. On these calls, they play a heavy role in dealing with people's various mental health issues. A lack of adequate mental health care services and barriers to accessing these services, including a systemic stigma against mental illness, increase how often these encounters occur,[1] and police must decide if someone should be jailed or if other options would be better.[2] This societal stigma against mental illness, substance abuse, and other behavioral problems can influence outcomes in the U.S. criminal justice system.[3, 4] In these circumstances, people with mental illnesses are overrepresented in the legal system, and police sometimes use force with disastrous results.[5, 6, 7, 8, 9]

To address this problem, police-mental health co-response is one of several alternatives to traditional police response to behavioral health emergencies. Alternative response programs are a public health approach to public safety, and they vary significantly in their staffing, assigned duties, scope of work, involved agencies, response time, and the degree of integration with broader community services, among other variables. Some programs improve police response by providing specialized crisis intervention training or by establishing databases that alert police that they are responding to calls involving at-risk individuals.

KEY FINDINGS

- Communities need specialized crisis responses, not reliance on the criminal justice system, to address gaps in mental health care.
- Alternative policing programs vary widely in design and delivery, requiring evidence-based planning and clear outcome strategies.
- Setting realistic long-term goals and measurable short-term indicators is critical for program success.
- Strong researcher-practitioner partnerships enable rigorous evaluation and guide future improvements.
- Integrated training, coordinated services, and robust infrastructure are essential for lasting impact.
- Programs linked to appropriate community and healthcare resources reduce unnecessary arrests and ensure timely help.
- Collaboration among healthcare, emergency services, and justice systems improves program effectiveness.

Some target helping the unhoused, those with substance abuse issues, or those with intellectual and developmental disabilities. Some include outreach to identify vulnerable community members and connect them to social services before crises strike. Many communities use a mix of these strategies for mental health crisis intervention.[10, 11, 12]

The Los Angeles County Sheriff's Department created the co-response model in 1991. The Federal Bureau of Investigation (FBI) identifies it as the first to establish specialized units defined as co-response teams that pair crisis-intervention-trained police officers with mental health professionals to respond to incidents involving individuals experiencing mental health crises or other behavioral health issues.[13] These teams are dispatched to de-escalate mental health crises. They intervene to provide immediate mental health support and connect individuals to appropriate services, rather than arresting or hospitalizing them. Community calls for alternative policing and deliberate federal funding for these programs have led to their expansion across the country.

The co-response model intends to connect people to get the help they need compassionately and effectively. However, little research has been done to assess program effectiveness. Studies have focused primarily on how clients and the community felt about the services, based on their descriptions of their experiences after the fact. Ultimately, they have suggested positive perceptions of this programming. Still, these studies have not evaluated specific program outcomes using scientific methods to investigate if they reduce incarceration and hospitalizations meaningfully.

So, how effective is the co-response model? Criminal justice experts from the Paul H. O'Neill School of Public and Environmental Affairs, George Mason University, the University of San Diego School of Medicine, and RTI International asked this question. They conducted the first randomized, controlled trial of a police-mental health co-response team to determine program effectiveness relative to a police-as-usual response in 1 of 6 police districts in Indianapolis, Indiana, between January 2020 and March 2021. Community stakeholders identified key outcomes for the evaluation, including emergency medical services (EMS) events, jail bookings, behavioral health outpatient encounters (BH), and emergency department (ED) visits. This brief examines the study and its results (Table 1).

Table 1. Outcome measures and hypotheses for a randomized controlled trial of a police-mental health co-response team.

OUTCOME	DESCRIPTION	HYPOTHESES
Emergency Medical Services (EMS) events	(1) Total number of EMS events in follow-up and (2) any subsquent EMS event	The co-response team group will have fewer EMS events and lower odds of any EMS events relative to the TAU group
Jail bookings	(3) Same-day jail booking, (4) any booking into the county jail, and (5) total number of jail bookings in follow-up	The co-response team will have lower odds of a same-day jail booking, lower odds of any jail booking, and fewer jail bookings relative to the TAU group.
Behavioral health (BH) outpatient encounters	(6) Same-day BH outpatient encounter, (7) any BH outpatient encounter, and (8) total number of BH outpatient encounters in follow-up.	The co-response team participants will have greater odds of same-day BH outpatient encounter, greater odds of any BH outpatient encounter, and a greater number of BH outpatient encounters relative to the TAU group.
Emergency Department (ED) visits	(9) Same-day ED visit, (10) any ED visit, and (11) total number of ED visits in follow-up	The co-response team group will have lower odds of a same-day ED visit, lower odds of any ED visit, and fewer ED visits relative to the TAU group.

FINDINGS

SAME-DAY AND ONE-YEAR OUTCOMES

No significant differences were found in same-day outcomes between the co-response and the treatment-as-usual (TAU) groups. Among the 435 calls in the final analysis, less than 10% of the participants were booked into jail (nearly 3% or 12 people) or had a behavioral health clinic visit (about 7% or 31 people) on the same day as the initial crisis incident. More participants had contact with EMS personnel (about 31% or 134 people) or concurrent emergency room visits (around 42% or 181 people).

During the 12-month follow-up period, participants averaged less than one jail booking (ranging from 0 to 11), about 2 EMS events (ranging from 0 to 93), 17 emergency room visits (ranging from 0 to 213), and 8 outpatient behavioral health clinic encounters (ranging from 0 to 168). In total, 18% had at least one jail booking, 35% had at least one EMS event, and 82% had at least one emergency room visit. Sixty-two percent visited a behavioral health treatment clinic at least once.

Figure 1. Predicted number of outcome events for Co-response and TAU conditions at 12 Months.

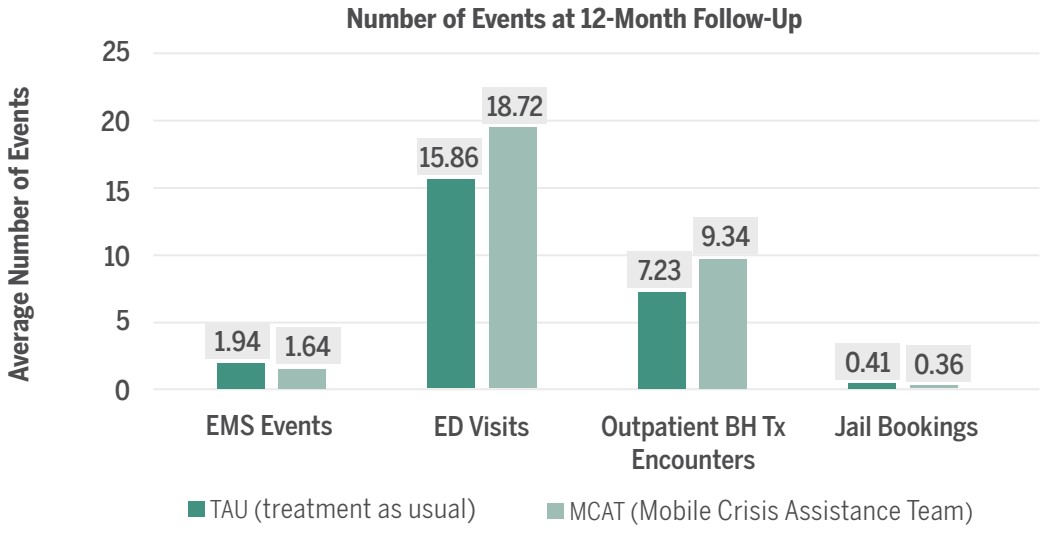
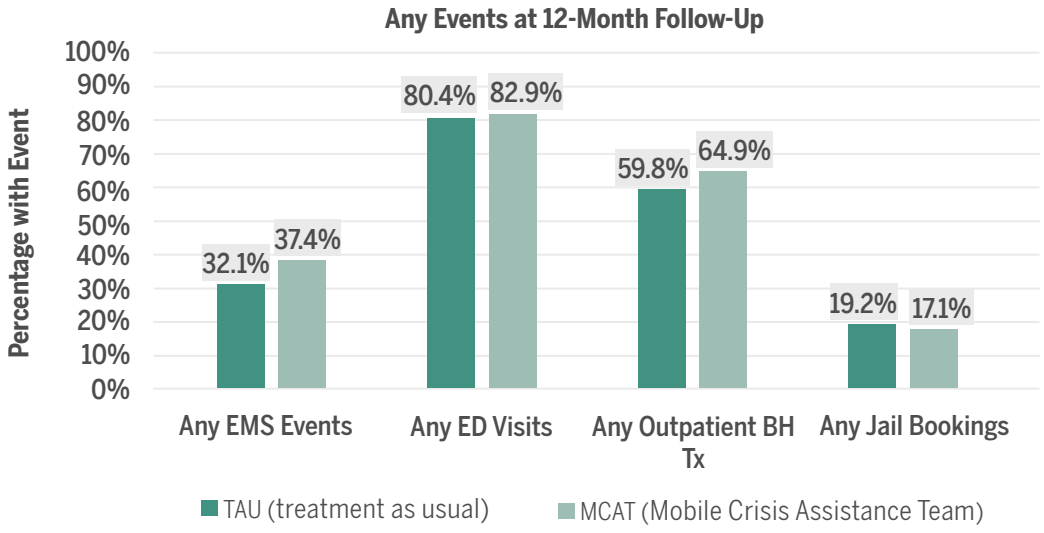


Figure 2. Predicted probability of any event for Co-response and TAU conditions at 12 Months.



The co-response and TAU groups had a similar number of EMS events. Moreover, no significant differences were observed between groups across other measured outcomes. Although slight variations in average rates appeared, the results were not substantial enough to indicate meaningful distinctions. The likelihood of events occurring remained similar for both groups. Where discrepancies did arise, they lacked the reliability necessary for researchers to consider them noteworthy.

STUDY LIMITATIONS

Several factors may explain why the study found no significant difference between MCAT and standard police response in reducing jail bookings, ER visits, or EMS use. These include the short 15-month timeframe, MCAT's limited hours, and mental health training for all officers. COVID-19 disruptions reduced calls and bookings, while data gaps and lack of demographic details limited analysis. Community perceptions also were not measured, limiting broader insights

CONCLUSIONS AND IMPLICATIONS

People with mental health or substance-use challenges often require specialized responses during crises. For this reason, communities are trying new ways to respond to these situations. These alternative response programs differ significantly in their design and delivery, including who is involved, the roles they play, which agencies participate, when and how they respond, and the extent to which they are connected to other community services. The range and variation in these programs are significant and should not be overlooked.

This study's major strength was the successful collaboration with community partners across multiple agencies to conduct a randomized controlled trial in a real-world setting—the first to evaluate a police-mental health co-response team. Such researcher-practitioner partnerships are essential for assessing policy innovations as they unfold and guiding future efforts to meet community needs.

As communities design alternative response programs, it is essential to establish realistic long-term objectives for them and measurable short-term indicators of progress. These initiatives should be grounded in evidence-based theories, with solid planning and a clear understanding of how desired outcomes will be achieved and measured.

More than 1 in 10 calls in this study involved someone who had used the service before. This finding gives some credence to the opinion of experts who worry that co-response teams might lead people to wait until they are experiencing a severe crisis before getting help. Following implementation, communities must investigate any suspected undesirable program side effects like this and periodically assess alternative response programs to learn what is working and what is not, so that adjustments can be made.

Although it did not show statistically significant results, this study represents a major step forward in understanding how police and mental health teams can work together. Enhancing coordination among healthcare, emergency services, and the justice system can increase the effectiveness of these programs. In this study, special co-response (MCAT) teams responded to certain crisis calls based on cues they heard on police radio. Despite the researchers' randomization of calls to help make selection fair, dispatchers lacked specialized behavioral health training. The research team had to assist in identifying eligible calls. To improve alternative responses to crises, some U.S. cities have established training for 9-1-1 call dispatchers to recognize when a call involves a mental health issue and to send the most appropriate type of help.[13] To create a meaningful and lasting impact, alternative response programs must incorporate integrated training, coordinated efforts between different services, and solid infrastructure support systems. These key elements will make these programs effective and help ensure they can serve their communities long term.

As alternative policing response programs continue to grow across the United States, evaluating whether these models lead to meaningful and clinically significant outcomes is critical. Communities should not rely on the criminal justice system to fill the gaps left by an underfunded mental health system. Instead, they should assess whether crisis response efforts are connected to the right community

and healthcare resources. This approach can help reduce unnecessary arrests and ensure that people in crisis get the support they need when they need it.

METHODOLOGY

The Mobile Crisis Assistance Team (MCAT), launched in 2017, pairs a specially trained Indianapolis police officer with a mental health clinician from Eskenazi Health. These teams monitor 9-1-1 calls for mental health crises, overdoses, and similar emergencies, responding together in a police vehicle. MCAT operates in all six city districts on weekdays from 10 a.m. to 5 p.m.

To understand how MCAT compares to a standard police response, researchers conducted a randomized study in the Northwest District. To measure MCAT's impact, researchers conducted a randomized study—meaning calls were assigned by chance to either MCAT or standard police response. This ensures the comparison is fair and not influenced by factors like time of day or call type. Between January 2020 and March 2021, 686 calls were randomly assigned; 435 were analyzed (211 MCAT responses, 224 standard responses). Researchers tracked outcomes for a year, including EMS use, jail bookings, ER visits, and behavioral health clinic visits. The goal was to see if MCAT could reduce criminal justice and emergency service involvement while increasing access to behavioral health care.

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FURTHER READING

To read more, see the results of a process evaluation of the Indianapolis Mobile Crisis Assistance Team (MCAT) and an early outcome evaluation of the program.

For the full study results, see Lowder, E.M., Grommon, E., Bailey, K., & Ray, B. (2024). Police-mental health co-response versus police-as-usual response to behavioral health emergencies: A pragmatic randomized effectiveness trial. *Social Science & Medicine, 345*, 116723. https://doi.org/10.1016/j.socscimed.2024.116723

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