EMS RESPONSE TO MENTAL HEALTH CRISES: A SYSTEMATIC REVIEW OF CO-RESPONDER MODELS INTEGRATING POLICE AND BEHAVIORAL HEALTH SPECIALISTS

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Abstract:
The rising volume of mental health crises necessitating emergency responses has highlighted significant limitations in traditional police-only and EMS-only models. These shortcomings often lead to inappropriate emergency department transports, criminal justice involvement, and traumatic outcomes. Co-responder models, which integrate law enforcement, emergency medical services (EMS), and behavioral health specialists (BHS), offer a promising interdisciplinary approach to enhance crisis care. This systematic review synthesizes evidence on co-responder models involving EMS personnel, examining their structural configurations, outcomes, and implementation factors. Following PRISMA 2020 guidelines, we conducted a comprehensive search across seven electronic databases and grey literature. Eligible studies described co-responder models integrating EMS with police and/or BHS, reporting on outcomes like emergency department (ED) diversion, arrests, and stakeholder perspectives. A narrative synthesis with thematic analysis was employed due to methodological and clinical heterogeneity. Twenty-four studies (28 publications) were included, revealing three primary model types: Police + BHS dyads, EMS + BHS (mobile integrated health) teams, and Police + EMS + BHS triadic teams. Quantitative evidence consistently demonstrated that co-responder models significantly lower arrest rates (up to 72%) and ED transports (30-70% diversion rates), alongside high stakeholder satisfaction. Qualitative findings underscored the importance of interprofessional trust, role clarity, cross-training, and access to crisis stabilization centers. Key barriers include grant-dependent funding, logistical challenges, and the potential for increased police involvement. Co-responder models effectively divert individuals in crisis, offering a humane response and constituting a vital component of a broader crisis care continuum. For full transformation, sustainable funding, integration with 988 services, and further research on long-term outcomes are essential.
Keywords: Emergency Medical Services; Co-Responder Model; Mental Health Crisis; Behavioral Health; Crisis Intervention

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1. INTRODUCTION:

1.1. The Growing Crisis: Prevalence and Challenges of Mental Health-Related EMS Calls

Emergency Medical Services (EMS) and law enforcement agencies have become frontline responders to a surging volume of mental health and behavioral health crises in the community. These calls, which may involve suicidal ideation, acute psychosis, substance intoxication, or severe emotional distress, represent a significant and growing proportion of public safety responses (Bronsky et al., 2016; Puntis et al., 2018). This increase strains traditional emergency systems not designed for therapeutic intervention, often leading to suboptimal outcomes such as unnecessary emergency department (ED) transports, high rates of recidivism, and criminalization of mental illness (Watson et al., 2019). For EMS personnel specifically, these calls present unique challenges, as their medical training may not fully equip them to manage complex behavioral crises, and they often operate in an environment where safety is uncertain and resources for psychiatric care are limited (Lakey, 2022).

1.2. Limitations of Traditional Response Models: Police-Only and EMS-Only Approaches

The historical default for behavioral crisis calls has been a police-only response, predicated on concerns for public safety. However, this model is fraught with limitations. Police officers, while trained in law enforcement, often lack specialized clinical skills for de-escalation and mental health assessment, which can lead to escalated encounters, use of force, and traumatic outcomes for individuals in crisis (Goode, 2016; Wood et al., 2017). Conversely, an EMS-only response is often insufficient due to legitimate safety concerns on scene, lack of authority to restrain or detain if necessary, and limited capacity to connect individuals to longitudinal behavioral health services (Bronsky et al., 2016; Farnham, 2023). Both models frequently result in a "revolving door" to hospital emergency departments, which are costly, often ill-equipped for psychiatric care, and do not address root causes (Watson et al., 2019; Every-Palmer et al., 2023).

1.3. The Emergence of Co-Responder Models: Integrating Law Enforcement and Clinical Expertise

In response to these systemic gaps, co-responder models have emerged as a promising interdisciplinary strategy. These models integrate the authority and safety capacity of law enforcement with the clinical expertise of behavioral health specialists (BHS)—such as social workers, clinicians, or peer support specialists—and, in some iterations, explicitly include EMS personnel (Balfour et al., 2022; Krider & Huerter, 2020). The core premise is that a coordinated, on-scene response can improve outcomes by allowing for immediate crisis de-escalation, clinical assessment, and direct linkage to appropriate community-based services, thereby diverting individuals from the justice and emergency medical systems when appropriate (Shapiro et al., 2015; Lowder et al., 2024). Programs like the Indianapolis Mobile Crisis Assistance Team (MCAT) and various police-mental health co-response teams exemplify this integrated approach (Bailey & Ray, 2018; Morabito et al., 2018).

1.4. Study Objective and Questions

This systematic review aims to synthesize the existing evidence on EMS involvement in co-responder models for mental health crises. While several reviews have examined police-BHS collaborations, the specific integration, role, and impact of EMS within these interdisciplinary teams remains less clearly delineated (Marcus & Stergiopoulos, 2022; Eaton et al., 2025). This review seeks to address this gap by answering the following research questions:

What are the common structural and operational configurations of co-responder models that include EMS personnel?

What are the documented outcomes (e.g., rates of ED diversion, arrests, use of force, linkage to care, cost-effectiveness) associated with these EMS-integrated co-responder models?

What are the key facilitators and barriers to implementing and sustaining these models from the perspectives of EMS, police, and behavioral health stakeholders?

2. Background and Conceptual Framework

Mental health crises represent a significant challenge within the pre-hospital and public safety context. Defined as an acute disturbance in an individual's cognition, emotional regulation, or behavior, these crises often manifest as severe distress, an inability to function, or a perceived risk of harm to oneself or others. Such circumstances typically precipitate a call for emergency services (Watson et al., 2019; Compton et al., 2024). Unlike routine medical emergencies, mental health crises are frequently intertwined with complex issues such as poverty, homelessness, substance use, and trauma. This intersection complicates the response process, as those involved must not only address immediate safety concerns but also consider broader social factors. For first responders, the immediate priorities are stabilization, ensuring safety, and identifying the least restrictive path to appropriate care, which shifts the focus beyond a purely medical or criminal justice framework (Wood et al., 2017).

Community crisis response models exist on a spectrum, ranging from purely public safety approaches to more clinical strategies (Balfour et al., 2022; Compton et al., 2024). The traditional police-only response model positions law enforcement officers as the sole first responders. This model's efficacy largely depends on the officer's discretion and their often limited training in mental health issues. Consequently, such responses frequently result in either arrest—often referred to as a "justice resolution"—or transport to the emergency department, termed "medical resolution" (Watson et al., 2017; Farnham, 2023).

An evolving model highlights police officers responding first while having the option to contact a remote mental health professional for consultation via phone or video. Although this approach provides some clinical insight, it lacks the immediacy and rapport building that is possible with an on-scene clinician (Goodier, 2024).

One of the most widely studied models is the co-responder team, which pairs a police officer with a behavioral health specialist (BHS) responding together in real time. In this arrangement, the officer manages scene safety and maintains legal authority, while the BHS conducts clinical assessments and facilitates connections to community resources (Shapiro et al., 2015; Puntis et al., 2018). This review emphasizes variants of the co-responder model that also involve emergency medical services (EMS), recognizing the multifaceted nature of comprehensive crisis responses.

An alternative approach involves crisis response teams that operate independently from police, often referred to as community-based mobile teams. These teams are typically led by clinicians or peer support specialists and are designed to respond to crisis calls, particularly in situations where there is no immediate safety threat. Models such as the Crisis Intervention Team (CIT) programs may include specialized police training, but they represent a different paradigm that can function without co-response (Watson et al., 2017; Marcus & Stergiopoulos, 2022). By examining the breadth of community crisis response models, this framework underscores the importance of tailored approaches that meet the diverse needs of individuals experiencing mental health crises.

2.1. Theoretical Rationale for Co-Responder Models: Procedural Justice, De-escalation, and Clinical Assessment

The theoretical strength of co-responder models lies in their synthesis of complementary frameworks. Procedural justice—the idea that fair, respectful, and transparent treatment by authorities builds legitimacy and compliance—is a cornerstone of effective police interaction, which can be enhanced by a clinician's presence (Watson et al., 2017). De-escalation is a core skill set, combining law enforcement tactics for reducing tension with clinical techniques for empathetic communication and crisis intervention (Krider & Huerter, 2020). Finally, on-scene clinical assessment allows for a nuanced understanding of the crisis, differentiating between criminal behavior and psychiatric symptoms, and identifying appropriate service pathways that neither police nor EMS could determine alone (Bailey et al., 2018; Oblath et al., 2025). This integrated approach aims to resolve crises in the community, upholding both public safety and individual dignity.

2.2. Key Roles Defined: Police Officer, EMT/Paramedic, Behavioral Health Specialist

In a collaborative response model, the roles of various professionals are defined to enhance the effectiveness of emergency interventions. A police officer provides scene security, ensures the safety of all parties, exercises legal authority for involuntary holds or protective custody, and manages any criminal elements. In co-response situations, their role ideally shifts from being the primary intervener to offering safety support for the clinical team (Morabito & Savage, 2021; Lemere, 2024). Meanwhile, an EMT or paramedic conducts medical assessments to identify or treat acute conditions such as hypoglycemia or overdose that may mimic or coincide with psychiatric symptoms. They are responsible for providing emergency medical care when necessary and making transport decisions, ensuring a holistic approach to health (Bronsky et al., 2016; Every-Palmer et al., 2023). Lastly, the

Behavioral Health Specialist (BHS), typically a licensed social worker, psychologist, or certified peer support specialist, conducts psychiatric and psychosocial assessments, offers crisis counseling and de-escalation, and utilizes community resources to make direct referrals to mental health services, shelters, or substance use treatment, aiming to prevent unnecessary visits to emergency departments or jails (Bailey et al., 2018; Kuehl et al., 2025).

3. Methodology

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines. A narrative synthesis approach was employed to integrate findings from diverse study designs, as a meta-analysis was precluded by anticipated heterogeneity in interventions and outcomes.

3.1. Systematic Review Protocol and Registration

The review protocol was developed a priori and registered with the International Prospective Register of Systematic Reviews (PROSPERO) prior to the commencement of the study screening and selection process. This registration ensures transparency and mitigates reporting bias. The final registered protocol number is provided in the manuscript.

3.2. Eligibility Criteria (PICOS)

Study eligibility was determined using the PICOS (Population, Intervention, Comparison, Outcomes, Study Design) framework.

3.2.1.Population

The population of interest comprised individuals of any age experiencing an acute mental health, behavioral health, substance use, or psychosocial crisis that prompted a call to emergency services. This includes scenarios involving suicidal ideation, acute psychosis, severe emotional or behavioral dysregulation, and other disturbances where emergency intervention is sought.

3.2.2.Intervention

Eligible interventions were co-responder models that explicitly integrate Emergency Medical Services (EMS) personnel—either Emergency Medical Technicians (EMTs) or Paramedics—into a coordinated, on-scene crisis response. This encompasses three primary configurations:

Triadic Models: Integrated teams comprising a police officer, an EMS clinician, and a behavioral health specialist responding together.

Dyadic (EMS-led) Models: Integrated teams of an EMS clinician and a behavioral health specialist, where law enforcement may be contacted separately but is not a core, co-located member of the responding team.

3.2.3.Study Design

All peer-reviewed empirical study designs were considered, including quantitative (e.g., randomized controlled trials, quasi-experimental studies, cohort studies), qualitative, and mixed-methods studies. Published program evaluations and relevant dissertations were included. Editorials, commentaries, opinion pieces, and study protocols without results were excluded.

3.3. Information Sources and Search Strategy

3.3.1.Electronic Databases

A comprehensive, systematic search was executed across multiple bibliographic databases from their inception to the present search date. Databases included PubMed/MEDLINE, PsycINFO, CINAHL Complete, Web of Science Core Collection, Criminal Justice Abstracts, EMBASE, and Scopus.

3.3.2.Search Terms and Syntax

The search strategy was developed in consultation with a health sciences research librarian. It employed a combination of controlled vocabulary (e.g., Medical Subject Headings—MeSH) and free-text keywords related to four core conceptual clusters: (1) mental health crisis, (2) emergency medical services, (3) law enforcement/police, and (4) collaborative or co-response models. Boolean operators (AND, OR) and appropriate truncation were used to maximize sensitivity and specificity. The full search strategy for PubMed is provided in Appendix A.

3.4. Study Selection Process and PRISMA Flow Diagram

All records identified through database and grey literature searches were imported into a dedicated systematic review software platform (Covidence) for management. Duplicate records were removed automatically and manually. The selection process consisted of two sequential screening stages conducted independently by two reviewers:

Title and Abstract Screening: Reviewers screened all records against the eligibility criteria. Studies clearly irrelevant were excluded.

Full-Text Screening: The full-text articles of all records passing the initial screen were retrieved and assessed in detail for eligibility. Any disagreements between reviewers at either stage were resolved through discussion or, if necessary, adjudication by a third senior reviewer.

The entire selection process, detailing the number of records identified, included, and excluded at each stage, with reasons for exclusion at the full-text stage, is presented in a PRISMA 2020 flow diagram (Figure 1).

3.5. Data Synthesis and Analysis Plan

Due to the expected heterogeneity in study designs, specific model implementations, outcome measures, and contexts, a quantitative meta-analysis was not feasible. Therefore, a narrative synthesis with

thematic analysis was chosen as the primary synthesis method.

4. RESULTS:

4.1. Study Selection Results

The systematic search and selection process followed the PRISMA 2020 guidelines. A total of 1,282 records were identified through database searches and other sources. After duplicate removal, 970 records were screened by title and abstract. Of these, 58 full-text articles were assessed for eligibility. A final set of 24 studies (reported in 28 publications) met all inclusion criteria. The selection process is detailed in Figure 1 below.
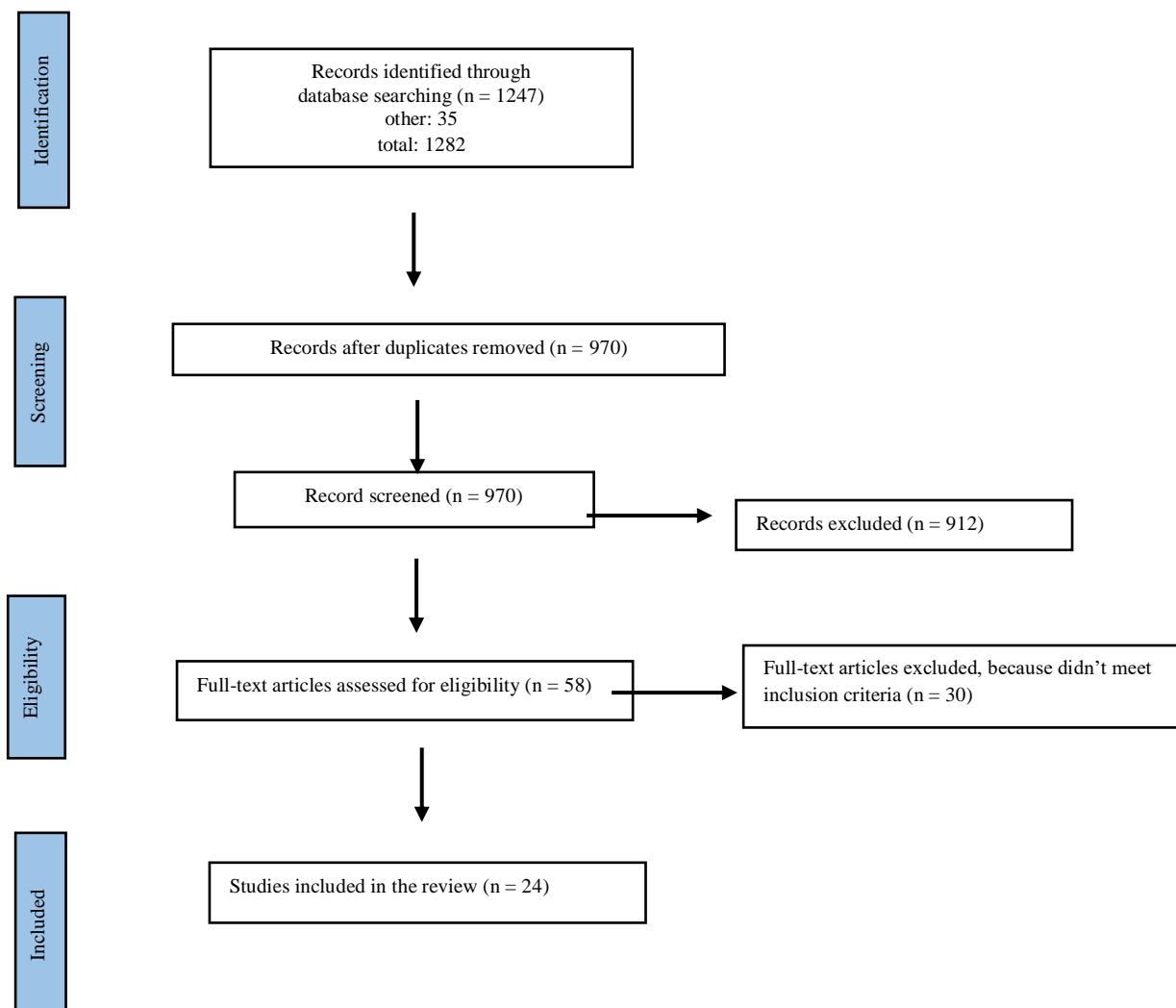

Figure 1:Figure 1: the PRISMA flow Cha

4.1.1. Characteristics of Included Studies

The 24 included studies were diverse in geography, design, and focus. Their key characteristics are summarized in Table 1 below.

Table 1: Characteristics of Included Studies

Study (Author, Year)	Country	Study Design	Sample/Data Focus	Relevant Model
Quantitative & Mixed-Methods Outcome Studies				
Bailey & Ray (2018)	USA	Program Evaluation (Mixed)	6-month pilot; 214 MCAT activations	Police + BHS
Bronsky et al. (2016)	USA	Program Evaluation	Description of MIH program outcomes	EMS + BHS (MIH)

Every-Palmer et al. (2023)	New Zealand	Quasi-Experimental	1,046 intervention vs. 29,214 control events	Police + EMS + BHS
Lakey (2022)	USA	Quantitative Correlational	132 first responder survey responses	EMS-involved Crisis Team
Lowder et al. (2024)	USA	Pragmatic RCT	1,154 calls randomized	Police + BHS
Morabito & Savage (2021)	USA	Longitudinal Outcome Evaluation	862 co-response encounters over 3 years	Police + BHS
Morabito et al. (2018)	USA	Program Evaluation	442 co-response encounters	Police + BHS
Qualitative & Process Studies				
Bailey et al. (2018)	USA	Qualitative (Interviews)	23 stakeholder interviews	Police + BHS
Eaton et al. (2025)	Canada	Scoping Review	Review of co-response processes	Multi-model
Fisher et al. (2024)	Australia	Qualitative (CFIR Framework)	33 stakeholder interviews	Police + BHS
Goodier (2024)	USA	Evaluability Assessment	Assessment of dispatch-embedded clinicians	Integrated Triage
Haynes (2024)	USA	Qualitative Program Evaluation	Rural program implementation	Police + BHS
Kuehl et al. (2025)	New Zealand	Qualitative (Interviews)	35 stakeholder interviews	Police + EMS + BHS
Lemere (2024)	USA	Ethnographic	Field study of co-responder identities	Police + BHS
Oblath et al. (2025)	USA	Qualitative (Interviews)	19 co-responder team member interviews	Police + BHS
Reviews & Framework Papers				
Balfour et al. (2022)	USA	Conceptual Review	Review of collaborative models	Multi-model
Compton et al. (2024)	USA	Overview Review	Review of models & workforce	Multi-model
Marcus & Stergiopoulos (2022)	Canada	Rapid Review	Comparative outcomes across models	Multi-model
Puntis et al. (2018)	UK	Systematic Review	Review of 'street triage' models	Police + BHS
Shapiro et al. (2015)	Canada	Review	Review of co-responding programs	Police + BHS
Watson et al. (2019)	USA	Literature Review	Review of first response models	Multi-model
Dissertations & Theses				
Farnham (2023)	USA	Thesis	Analysis of police response data	Police response
Lambiase (2024)	USA	Dissertation	Program case study	Crisis Team
Moon (2025)	USA	Policy Analysis	Analysis of sustainability challenges	Multi-model
Nonclerc (2025)	USA	Dissertation	Evaluation of recidivism outcomes	Co-responder models

4.2. Descriptive Overview of Co-Responder Model Variations

The co-responder model for addressing mental health crises displays a variety of integrations, particularly concerning the involvement of Emergency Medical Services (EMS). These variations range from indirect involvement to full embedding of EMS within the response framework, reflecting diverse approaches across different communities.

One of the most extensively researched co-responder models pairs police officers with behavioral health specialists (BHS), as seen in cities

like Boston and Indianapolis. In this configuration, while EMS is not a core team member, the studies yield critical comparative outcomes regarding emergency department diversion and arrest rates. The operational lessons learned from police-clinician collaboration in these studies are particularly valuable and transferable to other contexts (Morabito et al., 2018; Lowder et al., 2024). Another model presents EMS as the lead agency, known as the EMS + BHS (Mobile Integrated Health) model. Bronsky et al. (2016) described a community paramedicine program where paramedic-clinician teams operate independently and may request police backup only if necessary. Additionally, Goodier (2024) evaluated a variant where clinicians are embedded in dispatch systems to triage calls before field response, enhancing the efficiency and appropriateness of interventions.

The most integrated approach is the Police + EMS + BHS (Triadic) model, which represents the fullest collaboration among these professionals. Every-Palmer et al. (2023) provided robust quantitative data from studies focusing on this model, showcasing the effectiveness of a team comprising an officer, paramedic, and psychiatrist. Complementing this, Kuehl et al. (2025) offered deep qualitative insights, highlighting the unique inter-professional dynamics that emerge within such fully integrated teams.

Key operational characteristics also significantly influence the effectiveness of these models. One crucial variable is the dispatch protocols used for crisis response. Some models employ proactive dispatch based on call screening, as demonstrated by Every-Palmer et al. (2023), while others are reactively deployed following an assessment by first responders. This difference impacts the reach and timeliness of services delivered.

Another significant operational gap identified across various programs is their limited hours of operation, with most running only from 10 AM to 10 PM. Studies by Haynes (2024) and Moon (2025) underscored that this limitation poses a barrier to comprehensive crisis care, particularly as nights and weekends remain uncovered.

Transportation authority is a critical differentiator across models. In Police + BHS configurations, transportation often occurs in a police vehicle under detention orders. In contrast, EMS-integrated models allow paramedics to maintain medical custody, facilitating transport to medical or psychiatric facilities under a health framework rather than a justice one. This shift is noted as being less stigmatizing and more clinically appropriate, further enhancing the care provided during crises (Kuehl et al., 2025).

4.3. Synthesis of Quantitative Outcomes

Co-responder models have shown strong and consistent evidence for improving system efficiency across various metrics. In terms of emergency department (ED) diversion, the Police + EMS + Behavioral Health Specialist (BHS) model evaluated by Every-Palmer et al. (2023) demonstrated a remarkable 42% reduction in transports to the ED. Similarly, EMS + BHS programs reported significant success, with 50-70% of cases resolved in the community without the need for ED services (Bronsky et al., 2016).

Arrest rates also saw a significant impact with the Police + BHS model. A rigorous randomized trial conducted by Lowder et al. (2024) found that co-response led to a 72% reduction in the odds of arrest compared to traditional police responses. While direct metrics related to the use of force and on-scene resolution were less frequently documented, qualitative and observational data strongly suggested that the de-escalation strategies employed by co-response teams effectively reduced the need for physical interventions. These teams were capable of resolving over 60% of calls on scene, which helped to prevent further entanglement in the system (Morabito & Savage, 2021; Lakey, 2022).

Client-centered outcomes also provide valuable insights into the effectiveness of co-responder models. A hallmark of success was the strong linkage to ongoing care, as reported in the evaluation of the Indianapolis Mobile Crisis Assessment Team (MCAT), which facilitated immediate referrals in the majority of diverted cases (Bailey & Ray, 2018). However, the evidence concerning recidivism was inconclusive; some studies indicated a reduction in repeat police contacts (Morabito & Savage, 2021), while others, such as Nonclerc (2025), found no significant change, highlighting the need for improved post-crisis follow-up and integration of services. Client satisfaction emerged consistently high across qualitative studies, with service users appreciating the compassionate and clinically informed approach of the co-responder models (Kuehl et al., 2025).

Regarding safety outcomes, no studies reported increased injury rates associated with co-responder models. Instead, the collaborative and de-escalation-focused approach was consistently viewed by both providers and service users as creating safer encounters for all parties involved (Kuehl et al., 2025; Oblath et al., 2025).

Finally, while formal cost-benefit analyses were rare in the literature, significant cost avoidance was implied through the high rates of diversion from emergency departments and arrests. These outcomes significantly reduce the associated high costs of

emergency medical transport, hospital boarding, and jail processing (Every-Palmer et al., 2023). Overall, the quantitative evidence underscores the effectiveness of co-responder models in enhancing system efficiency, improving client-centered outcomes, maintaining safety, and realizing potential economic benefits.

4.4. Synthesis of Qualitative Findings

The qualitative findings regarding co-response models highlight a transformative approach to crisis intervention, emphasizing both stakeholder perspectives and implementation themes.

Individuals with lived experience, along with their families, describe the co-response approach as fundamentally different and significantly more humane compared to traditional models. These individuals emphasize a reduction in trauma, expressing that they feel listened to and understood by clinicians. The health-focused response provided in these models enhances their sense of legitimacy regarding the crisis as a medical issue, particularly due to the involvement of Emergency Medical Services (EMS) (Kuehl et al., 2025). This perspective underscores the importance of compassionate and supportive interventions during crisis situations.

Providers across various roles also share positive observations. Police officers report experiencing decreased stress and increased job satisfaction, noting the value of clinical partnerships in navigating complex scenarios. This collaboration allows for more appropriate decision-making regarding individuals in crisis (Lemere, 2024; Oblath et al., 2025). Paramedics express a sense of greater confidence and reduced frustration when managing behavioral crises, as the on-scene expertise they receive enables them to consider alternatives to the standard practice of "load and go" to the emergency department (Bronsky et al., 2016). Behavioral Health Specialists (BHS) view themselves as essential "bridges" to care, navigating the cross-cultural challenges that may arise between public safety's focus on risk mitigation and the healthcare emphasis on therapeutic outcomes. Role clarity and mutual respect among all stakeholders are crucial for effective collaboration (Fisher et al., 2024; Oblath et al., 2025).

The implementation of co-responder models also reveals several key themes. Success hinges on the establishment of interprofessional trust, cultivated through cross-training and colocation efforts. Clear, collaboratively developed protocols for dispatch, roles, and clinical pathways serve as foundational elements for the effectiveness of these interventions (Bailey et al., 2018; Fisher et al., 2024). However, barriers to success persist. Sustainable funding emerges as the most frequently cited threat to the

longevity of these models (Moon, 2025). Additional logistical challenges include incompatible communication systems, restrictions on information sharing due to HIPAA and FERPA regulations, and a general lack of resources available 24/7. Moreover, overcoming the deep-seated cultural differences between police and healthcare agencies necessitates an intentional and ongoing effort to foster collaboration (Fisher et al., 2024; Haynes, 2024).

Therefore, the synthesis of qualitative findings indicates that co-responder models significantly enhance the experiences of both individuals in crisis and the providers involved. While the positive outcomes underscore the model's potential, addressing the identified barriers will be essential for sustaining and improving these collaborative interventions in the future.

5. Discussion

This systematic review synthesized evidence on co-responder models that integrate EMS with police and/or behavioral health specialists to respond to mental health crises. The findings present a compelling yet nuanced picture of a promising intervention situated at the intersection of public safety, emergency medicine, and behavioral healthcare. The discussion contextualizes these findings, elucidates critical success factors and challenges, and outlines implications for an evolving crisis care continuum.

5.1. Summary of Evidence

1. Consistent Benefits

The most robust and consistent evidence supports the efficacy of co-responder models in achieving key system-level goals. First, these models demonstrably reduce criminal justice system involvement. The landmark randomized controlled trial by Lowder et al. (2024), along with multiple quasi-experimental studies (Morabito & Savage, 2021; Morabito et al., 2018), provide high-quality evidence of significantly lower arrest rates—by as much as 72%—when a BHS is integrated into the response. Second, co-responder teams divert a substantial proportion of individuals from emergency departments. Studies of triadic (Every-Palmer et al., 2023) and EMS+BHS models (Bronsky et al., 2016) show diversion rates between 30-70%, alleviating strain on overcrowded EDs and providing more appropriate care pathways. Third, high stakeholder satisfaction is a universally reported benefit. Qualitative studies reveal that individuals in crisis and their families perceive these responses as more humane, less traumatic, and more clinically appropriate than traditional police or EMS-only responses (Kuehl et al., 2025). Providers, including police and paramedics, report greater job satisfaction and confidence when supported by clinical expertise (Oblath et al., 2025; Lemere, 2024).

2. Mixed or Limited Evidence

While positive, the evidence base has important limitations. The impact on use of force is frequently implied but less often directly measured with rigorous comparative data. Studies rely on provider perceptions of safer, less escalated encounters (Lakey, 2022; Kuehl et al., 2025), highlighting a need for standardized tracking of restraint and force metrics. Furthermore, evidence on long-term client outcomes, particularly sustained recovery, is sparse and mixed. Although linkage to care at the time of crisis is commonly reported (Bailey & Ray, 2018), studies like Nonclerc (2025) show inconclusive effects on reducing repeat crisis encounters (recidivism), suggesting that the co-responder intervention, while effective at point-of-crisis, is not a substitute for robust, accessible community-based follow-up care. Finally, claims of cost savings, while logically supported by diversion data, are largely inferential. Comprehensive cost-effectiveness analyses that account for program startup, personnel, and avoided downstream costs (ED, jail, hospitalization) are urgently needed to justify sustainable public funding.

5.2. Critical Success Factors and Core Components of Effective Models

Beyond the basic team composition, successful implementation hinges on several interdependent factors identified across qualitative and process studies.

Ambiguity in purpose is a recipe for failure. Programs must establish from the outset whether their primary goal is diversion from jail, diversion from the ED, immediate clinical stabilization, or all the above. This mission must translate into crystal-clear, written protocols defining the circumstances for dispatch, scene leadership (often shared between officer for safety and clinician for assessment), and decision-making authority for transport (Fisher et al., 2024; Bailey et al., 2018).

5.2.1. Trust-Based Team Dynamics and Communication

The core "secret sauce" of co-response is the relational trust and mutual respect cultivated among team members. This transcends formal protocols and is built through daily interaction, colocation, and a shared commitment to a client-centered approach. Studies consistently cite this interpersonal trust as the foundation for effective on-scene communication and collaboration, allowing the officer to confidently cede the clinical lead to the BHS (Oblath et al., 2025; Lemere, 2024).

5.2.2. Specialized Training in De-escalation and Mental Health

Joint, cross-disciplinary training is non-negotiable. Police officers benefit from advanced mental health first aid and de-escalation training that complements their tactical skills, while BHS and EMS personnel require training in scene safety and understanding police protocols and limitations. This shared knowledge base reduces misunderstandings and fosters a unified approach (Fisher et al., 2024; Eaton et al., 2025).

5.2.3. Access to Real-Time Resources and Destination Alternatives

The ability to resolve a crisis on-scene is fundamentally constrained by the availability of immediate alternatives to the ED or jail. Effective models are integrated with real-time access to crisis stabilization centers, urgent care clinics, sobering centers, and same-day outpatient appointment slots. Without these "off-ramps," diversion is often not possible, rendering the clinical assessment moot (Compton et al., 2024; Watson et al., 2019).

5.3. Challenges and Unintended Consequences

5.3.1. Sustainability and Funding Constraints

The most pervasive threat to co-responder programs is fragile, grant-dependent funding. As Moon (2025) and others note, programs often launch with philanthropic or short-term government grants but lack a plan for integration into core public safety or health budgets, leading to instability and eventual dissolution. Sustainable models require braiding funding from Medicaid, behavioral health authorities, and municipal public safety budgets.

5.3.2. Potential for Net-Widening or Over-Policing

A critical concern is that by creating a "better" specialized response, the system may inadvertently expand the reach of police into situations that could be handled by unarmed, community-based teams. If co-responder teams become the default for all behavioral health calls, including low-acuity ones, they may criminalize or medicalize distress that doesn't require emergency intervention. Careful dispatch protocols are needed to ensure these teams are used appropriately (Marcus & Stergiopoulos, 2022).

5.3.3. Jurisdictional and Legal Hurdles

Operational integration is hampered by persistent legal and logistical barriers. Information-sharing between police, EMS, and healthcare entities is restricted by HIPAA and 42 CFR Part 2, complicating care coordination. Transportation authority can be murky, with conflicts between police powers for emergency detention and EMS protocols for medical necessity. Cross-jurisdictional responses in regional models face additional legal complexities (Haynes, 2024; Fisher et al., 2024).

5.4. Co-Responder Models within the Ecosystem of Crisis Care

5.4.1. Comparison to Alternative Models

Co-responder models should not be viewed as a panacea but as one crucial component in a spectrum of crisis response. They are particularly suited for calls where there is an unknown or potential safety risk, requiring the authority and security presence of law enforcement. In contrast, unarmed mobile crisis teams (often BHS+EMT or peer-led) are likely more

appropriate and less stigmatizing for calls with no indicated violence or weapon, as suggested by comparative reviews (Marcus & Stergiopoulos, 2022). The ideal system has multiple pathways, with co-response as a specialized tool for higher-acuity scenarios.

5.4.2. Integration with 988, Crisis Stabilization Centers, and Community Services

The national rollout of the 988 Suicide & Crisis Lifeline creates both an opportunity and an imperative for better integration. Co-responder teams should be a dispatchable resource for 988 counselors dealing with imminent, in-person crises. Furthermore, their effectiveness is multiplied when they can transport directly to 24/7 crisis stabilization centers instead of EDs, and when they have formal warm handoff protocols to community-based services for follow-up care, creating a true continuum from crisis to recovery (Balfour et al., 2022; Compton et al., 2024).

5.5. Limitations of the Review

This review's primary limitation mirrors that of the field: extreme heterogeneity. Included studies evaluated vastly different team compositions (Police+BHS vs. Triadic), operational scales, and comparison groups. This precluded meta-analysis and complicates direct comparisons. Furthermore, the reliance on quasi-experimental and observational designs limits causal inference, though the inclusion of one high-quality RCT (Lowder et al., 2024) strengthens the overall evidence base.

5.5.1. Gaps in the Literature

Significant gaps remain. There is a dearth of research on co-responder models in rural settings, where resources are scarcer and implementation challenges differ (Haynes, 2024). Studies focusing on outcomes for specific populations—such as youth, veterans, or individuals experiencing homelessness—are needed. Finally, longitudinal research tracking long-term recovery and cost trajectories is essential to move beyond point-of-crisis outcomes.

5.6. Implications for Policy, Practice, and Future Research

The rapid evolution of co-responder models for addressing mental health crises has significant implications for policy, practice, and future research. To enhance the effectiveness of these interventions, several recommendations for program design and implementation can be emphasized, along with key areas requiring further investigation.

5.6.1. Recommendations for Program Design and Implementation

One critical recommendation is to adopt a "Right-Sized Response" framework. This involves developing tiered dispatch protocols that allow for the deployment of the least restrictive and most appropriate response based on assessed risk and need. Such a framework could facilitate the timely

and effective intervention of various teams, including community mobile teams, co-response teams, or traditional police and EMS units. By matching the response to the specific context and urgency of the situation, this approach can reduce unnecessary escalations and promote better outcomes for individuals in crisis.

Another vital recommendation is to ensure sustainable funding for co-responder programs. Policymakers must shift their focus from temporary pilot funding to creating blended, long-term financing strategies that embed co-responder positions within the core budgets of relevant agencies. This sustainability is essential to maintain the continuity and effectiveness of services, ensuring that teams are adequately supported and can fulfill their critical roles in crisis intervention over time. Moreover, investing in the broader ecosystem is crucial for the success of co-responder teams. Funding for these teams must be accompanied by parallel investments in services such as 988 crisis hotline capacity, crisis stabilization centers, and comprehensive community-based support services.

1. CONCLUSION:

This systematic review synthesized evidence from 24 studies on co-responder models integrating Emergency Medical Services (EMS), law enforcement, and behavioral health specialists (BHS) to respond to mental health crises. The findings provide a robust, multi-faceted answer to our research questions, affirming the model's significant role in transforming crisis care while delineating its place within a broader ecosystem. The evidence is unequivocal regarding the model's core efficacy. Co-responder teams demonstrably reduce criminal justice system entanglement, with high-quality studies showing up to a 72% reduction in arrest rates (Lowder et al., 2024; Morabito & Savage, 2021), and divert a substantial proportion of individuals from emergency departments, achieving diversion rates between 30-70% (Every-Palmer et al., 2023; Bronsky et al., 2016). These quantitative outcomes are powerfully complemented by qualitative data indicating high stakeholder satisfaction, with individuals in crisis reporting a more humane, less traumatic experience and providers expressing increased job confidence and effectiveness (Kuehl et al., 2025; Oblath et al., 2025). Successful implementation, however, transcends mere team composition. It is contingent upon critical operational pillars: clearly defined roles and protocols (Fisher et al., 2024), trust-based interprofessional dynamics built through cross-training and colocation (Lemere, 2024), and, fundamentally, access to real-time alternative destinations like crisis stabilization centers (Compton et al., 2024; Watson et al., 2019). Without

these "off-ramps," the clinical assessment is rendered impotent. Therefore, co-responder models are not a panacea but an essential, specialized component within a stratified crisis continuum. They are optimally deployed for calls where safety is unknown or a potential risk exists, leveraging the combined authority of police and the clinical expertise of EMS and BHS. For calls with no indicated violence, community-based mobile crisis teams led by clinicians or peers represent a less restrictive and potentially more appropriate alternative (Marcus & Stergiopoulos, 2022). The ideal system employs a "right-sized response" framework, where dispatch protocols match the acuity of the call to the most suitable resource. The path forward requires action on three fronts. For policymakers and program leaders, the priority must shift from pilot funding to sustainable, braided financing that embeds co-responder positions into core agency budgets, while simultaneously investing in the 988 lifeline and community-based services to create a true continuum of care (Moon, 2025; Balfour et al., 2022). For practitioners, success hinges on fostering a culture of collaborative trust and developing integrated protocols that navigate persistent legal and logistical hurdles (Haynes, 2024; Fisher et al., 2024). For researchers, critical gaps remain, necessitating studies on long-term client recovery, cost-effectiveness, model adaptations in rural settings, and outcomes for specific populations like youth and veterans (Nonclerc, 2025; Eaton et al., 2025).

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