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ORIGINAL PAPER

Social Work Student Perceptions of Co-Response: Implications for Policy

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Abstract

This article describes a study of the factors impacting social work student knowledge of co-response teams designed to divert individuals with mental illness from the criminal legal system and interest in participating in co-response teams, and provides policy and educational recommendations for social work's interaction with these teams. The data in this study was collected using convenience sampling from MSW students who were enrolled in accredited universities in the United States and Canada via an online survey in 2022 and 2023. Of 145 MSW students surveyed, roughly 75% of students had heard of co-response, over 60% agreed that they strongly supported the practice and nearly 94% believed co-response aligned with social work values. The following positively impacted student desire to join co-response teams: positive perceptions of police, knowledge of co-response, and belief that co-response aligned with social work values. Race did not impact student desire to join a co-response team. These results show support of co-response is relatively high, important given that co-response awareness for social workers is important given the different ways social workers may interact with these teams. Policy recommendations for thoughtful operationalization of co-response are discussed as a result of this research.

Keywords Co-response · Street triage · Emergency response · Crisis response team · Crisis intervention · Behavioral health emergency response · Mobile crisis team · Police social work

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Introduction

The conversation around policing in the United States was changed by the 2020 protests that occurred in response to the police killing of George Floyd and other Black Americans (Salter & Vancleave, 2023; Wilson & Wilson, 2020). Many of these deaths also highlighted the intersection between lack of community support for mental illness and violent police response (Butler & Sheriff, 2020). Social workers have a long history of collaboration with police departments (Patterson, 2022), and had historically been more reticent in critiquing police violence (Jacobs et al., 2021). However, these protests brought the scope of untreated mental illness and police brutality to the forefront of a national conversation around racial injustice and police reform and marked an opportunity for social workers to focus on alternatives to traditional policing (Subramanian & Arzy, 2022).

One local policy response to the intersection between mental illness and policing has been the creation or expansion of existing behavioral health emergency response programs in cities across the U.S., with at least 14 major cities in the U.S. spending $123 million dollars on such programs (Peltz & Bedayn, 2023). Since 2020, 15 of the largest police agencies in the U.S. have created a co-responder team and 19 have created non-police community response teams (Subramanian & Arzy, 2022).

The recent advent of a national emergency mental health hotline increased the potential for a thorough mental health emergency response system. An important aspect of the implementation of policies that divert people with mental illness from the criminal legal system is the availability of qualified, willing mental health professionals, including social workers. There is limited research on the experience of clinicians working on these teams (Stauss et al., 2023), and no prior social work research that examines the perspective of social work students regarding such policies and teams.

Mental Illness, Emergency Response, and Policing

In 2020, 52.9 million people in the United States experienced mental illness (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). Individuals with mental illness interface with the criminal legal system at many points, including the time leading to police intervention, during intervention, and once they are incarcerated. Police are often called to respond to crises involving individuals with untreated mental illness (National Alliance on Mental Illness [NAMI], n.d.), even though their training may not provide them with the skills or resources to assess or assist people with mental illness (Franz & Borum, 2011; Lamb et al., 2002). Although the scope of this article includes individuals who are not yet incarcerated, it is important to note that interactions between mental illness and the criminal legal system continues. People with mental illness make up 44% of the jail population and 37% of the prison population in the United States (Bronson & Berzofsky, 2017).

An Illinois study of hospital discharge data shows that almost 40% of people injured during law-enforcement interactions had mental health diagnoses (Holloway-Beth et al., 2016). Arrests also move individuals to the criminal legal system, and

away from treatment (Reingle et al., 2014). Death is also a real possibility. In 2021, 14% of the people killed by police suffered from mental illness (Lati et al., 2022).

Traditional emergency response poses increased risks for Black Americans compared to members of other racial and ethnic groups. In 800 jurisdictions around the U.S., Black people are five times as likely to be arrested as white people, and in 250 jurisdictions, they are 10 times as likely to be arrested (Thomas et al., 2020). Black individuals are three times as likely to be killed by police as their white counterparts (Schwartz & Jahn, 2020).

Mental Illness, Deinstitutionalization, and Policing

In the first half of the twentieth century, people with severe mental illness were cared for in state mental hospitals. However, abuse within that system led reformers to fight for de-institutionalization in the 1950s, in hopes of establishing more human treatment options for people with mental illness (Roth, 2021). The Community Mental Health Act of 1963 designated federal money for community mental health centers that would provide outpatient mental health services (SAMHSA, 2021). The closure of institutions was not followed by adequate community resources to meet the level of need (Koyanagi, 2007). In the end, less than half the number of promised community care facilities were created, leading to a gap in needed care options (Koyanagi, 2007).

At the same time, across the country, harsher sentences were imposed for drug crimes (Widra & Herring, 2021). With more behaviors criminalized, and longer sentences, the prison population grew almost 700% from 1972 to 2009 (Ghandnoosh, 2021). These laws addressing drug crimes disproportionately impact people with mental illness, who have higher rates of substance use than the general population (Roth, 2021). The lack of community mental health options and harsher laws have led to jails and prisons becoming the main providers of mental health services (Torrey et al., 2014). This means that instead of being imprisoned in mental hospitals, people with mental illness are now increasingly likely to be imprisoned by the criminal legal system (Lee & Cain, 2020).

Many programs and policies have been proposed to divert people with mental illness from the criminal legal system. The policy initiative reviewed in this study is the effort to create behavioral health crisis response teams including trained mental health professionals, such as social workers.

Behavioral Health Emergency Response

Behavioral health emergency response in an alternative that includes a variety of models ranging from co-response, where mental health workers provide emergency services alongside police, to community response, which does not involve police (Beck et al., 2020). Social workers have skills such as assessment, diagnosis, de-escalation, and communication, as well as knowledge of community resources (James-Townes, 2020). These teams are designed to interrupt the criminalization of mental illness, address immediate crises, and redirect individuals with mental illness into supportive rather than punitive systems.

Behavioral health emergency response team models vary within the U.S. and across the world. They range in composition, and may include police, EMS, peer advocates, social workers, psychiatric nurses and more (Beck et al., 2020; Helfgott et al., 2016). Some teams arrive as first responders while others come to the scene after police have been called (Helfgott et al., 2016). Mental health workers may also assist police officers by phone or telehealth (Beck et al., 2020).

Terminology also varies. Teams with different compositions may be called co-response teams, mobile crisis teams, behavioral health (emergency) response teams, crisis response teams, or street triage. For the purposes of this study, the term co-response was used to capture the most common type of behavioral health response team, and also to be able to assess how social work students' feelings about police connected with their perceptions of this type of team.

Police Social Work and Police/Social Work Collaboration

Collaboration between social workers and police officers has existed for over 100 years (Patterson, 2022) and has taken many forms over time. The term police social work was first coined by Vollmer in 1919, based on his observation about the extent to which police calls often included social work elements (Patterson, 2022). In the present day, police social work refers to social workers who work directly for a law enforcement organization, as opposed to police and social work collaboration, which involves social workers employed by a separate agency working with police officers (Patterson, 2022).

As early as the 1920s, female police officers were hired by law enforcement agencies to function as social workers (Duffin, 2010). A clear precursor to today's co-response teams is the Police-Social Work Team Model developed in Chicago in the 1970s which was a collaboration between the police force and social workers to assist with youth in need, substance misuse, family problems, non-violent offenses, and mental health emergencies (Michaels & Treger, 1973).

One challenge of police/social work collaboration is the potential for value conflicts between social workers and the police. Social workers follow the NASW Code of Ethics and must prioritize social justice, and dignity and worth of individuals, (National Association of Social Workers [NASW], 2021). These principles may be at odds with police conduct or even job requirements, which often include tactics such as surveillance, restraint, and control (James-Townes, 2020). Some social workers see opportunities for collaboration between the two professions. Others believe that policing is antithetical to social work values and that social workers should be acting to dismantle policing and prisons (Jacobs et al., 2021). This creates a divide between social workers who support behavioral health emergency response models that fall within the realm of police social work, and those that want to see these teams function independently of police.

Relevant Policies and Programs

Crisis response programs exist in cities across the country, including Denver, Albuquerque, New York City, Salt Lake City, Washington DC, and Houston (Beck et al.,

2020; Subramanian & Arzy, 2022). A prime example is the CAHOOTS program in Eugene, Oregon. Started in 1989, it includes a nurse and a mental health worker (White Bird Clinic, 2020). A 2019 program evaluation reported the program caused 5–8% of all 911 calls to be diverted from the police (Eugene Police Department Crime Analysis Unit, 2020). These programs tend to be developed at the municipal level and the policies implementing them vary by location. Below, we discuss relevant state and federal policies.

American Rescue Plan Act of, 2021

The American Rescue Plan Act of, 2021 (ARPA) provided relief from the impact of COVID-19 and includes funding for mental health resources. ARPA funding includes emergency crisis response, providing a three-year 85% matching rate for states that cover crisis intervention services through Medicaid, and increased dollars for community-based services and community mental health block grants (ARPA, 2021). The policy requires that at least one member of any crisis team be trained in behavioral health and the team have relationships with community partners and providers.

Emergency Mental Health Line

The National Suicide Hotline Designation Act, authorized 988 for suicide, mental health crisis, and substance use crises in all 50 states and five U.S. territories, with $432 million in funding (NAMI, n.d.; SAMHSA, 2021). In 2021, the hotline fielded 3.6 million calls, chats, and texts (SAMSHA, 2021). Successful implementation of this policy requires qualified mental health response (NAMI, n.d.). The US Department of Health and Human Services has advocated for policy additions such as future in-person emergency crisis response and encourages localities to build capacity in this area (SAMSHA, 2021). The rollout of this hotline brings increased public attention to the mental health crises occurring across the U.S. and the need for accompanying crisis response teams.

State Policy

Marcus David-Peters Act (HB 5043) in Virginia

While limited funding may be provided by the federal government, states and municipalities may create policies to implement relevant programming, including behavioral health emergency response teams. An example is the Marcus David-Peters Act (HB 5043) which created a state-wide system connecting people in crisis to mental health workers and providing mental health referrals to those in need (Marcus David-Peters Act, 2020). It is a multi-part framework involving everything from a mental health call center to a new approach to 911 dispatch. The program rolled out as a pilot in December 2021and is expected to be fully operational by July, 2026.

Model Legislation for States and Municipalities

Advocates of emergency response reform have proposed model legislation such as the Model Behavioral Health Response Team Act (El-Sabawi & Caroll, 2021). The sample law is based on empirical evidence and a case study of the political fallout after police killed a man having a mental health crisis (El-Sabawi & Caroll, 2021). The legislation includes the creation of crisis call centers and a behavioral health team located outside the police department. This sample law includes provisions for an advisory board made up of community members, focusing on people from groups who have been societally marginalized. The model law also calls for a team that includes an EMT, a mental health provider such as a social worker, and a mental health consumer (El-Sabawi & Caroll, 2021).

Review of Literature

As a growing field, co-response has prompted researchers to investigate its implementation, practice, and effectiveness. Literature reviewed here includes research from Australia, New Zealand, Canada, the United Kingdom, and the United States, and examines outcome data as well as the perception of co-response.

Co-Response Outcomes Data

Morabito et al. (2018) used data from the Boston Emergency Services Team to determine short-term co-response outcomes. Of 1,127 calls, only 0.8% resulted in an arrest, 8.4% resulted in emergency department psychiatric evaluations, and 36%were resolved on-scene. Blais et al.'s (2020) quasi-experimental study found co-response was associated with a decrease in police use of force, transport to hospital against individual's desires, and hospital transport overall. Co-response was associated with a higher likelihood of referral to community resources or being assisted by one's own social network. Every-Palmer et al. (2022) compared the outcomes of New Zealand's first co-response team to traditional emergency response in immediate dispositions and one-month outcomes for 1,273 cases. Co-response reduced use of emergency room services (32% compared to 45%), yielded fewer return visits, and shortened wait for services by 32.5 min.

Across much of the prior research, co-response yields low rates of arrest, use of force and hospitalization (Blais et al., 2020; Helfgott et al., 2016; Lamanna et al., 2018). More specifically, co-response has promise to reduce arrest rates for Black people (Bailey et al., 2021) who normally have the highest rates of arrest (Thomas et al., 2020). If initial police contact is considered a risk factor for further criminal legal involvement, co-response has the possibility of transforming that experience from arrest to referral (Munetz & Griffen, 2006).

Perceptions of Co-Response

Co-response team members report primarily positive experiences. Horspool et al. (2016) conducted a cross-sectional qualitative study of police officers and mental

health workers participating in street triage teams (analogous to co-response teams) in the United Kingdom. Interviewees believed street triage led to understanding one another's roles better, to inter-agency collaboration, and information sharing. It was agreed that mental health workers gave police officers the confidence to refer people to community services rather than relying on involuntary holds. In Cleveland, England, Dyer et al. (2015) found service users, police and associated agencies had positive feedback. Stakeholders said that that these teams referred fewer people for psychiatric holds and provided more support for police officers, leading to better client outcomes. Concerns included lack of funding, lack of collaboration between teams and community organizations, and the problem of repeat referrals. Boscarato et al. (2014) conducted 11 interviews with Australian consumers of mental health services. Interviewed mental health consumers preferred friends or family members to assist them in crisis. If a formal response was necessary, participants wanted mental health workers or their primary care physicians to intervene. None of the participants wanted only police to assist. Participants were open to having a collaborative response.

Overall, clients reported a desire to be treated well by first responders instead of being criminalized. Clients showed a preference against having police-only emergency response teams (Boscarato et al., 2014; Lamanna et al., 2018). For the co-responders and stakeholders, co-response teams bring up worries about privacy issues, staffing shortages, limited funding and hours of operation (Iacoboni, 2015; Koziarski et al., 2021; Lee et al., 2015; Morabito et al., 2018). They also express the benefits yielded by co-response teams of collaboration, data-sharing, and more efficient use of time and resources (Horspool et al., 2016; McKenna et al., 2015).

Co-Response and Social Workers

No peer-reviewed social work research looks at social worker perception of co-response. One recent article in the social work literature (Stauss et al., 2023) focuses on police attitudes towards the social workers on their co-response team but does not interview social workersSupport for behavioral health emergency response The perspective of social workers about readiness and willingness to engage with co-response as team members or community partners can help inform both social work education and social policy related to these teams and social work participation.

Research Aims

Prior studies of mental health workers focused on implementation and effectiveness of co-response programs already in operation, and there very limited social work literature on the topic (Stauss et al., 2023). The present study attempted to fill this gap to determine whether MSW students' knowledge of co-response, perception of police, race, and beliefs about alignment with social work values impact student desire to work on co-response teams.

Methods

The data in this study was collected from MSW students via an online survey in 2022 and 2023. The study was approved by the Institutional Review Board of the authors' university and participants were eligible for a drawing for a $30 gift card.

Sample

The sampling frame included current students in accredited MSW programs in the United States or Canada, who were at least 18 years old, and able to read and respond to the survey in English. Convenience sampling was used to distribute this survey via professional networks and social work listservs.

A priori power analysis was performed using STATA (version 17) to determine the ideal sample size of the current study. R-Squared was set for minimal value of 0.1 for two dependent variables and 0.2 for 3 independent variables including controlled variables (e.g., demographic information). To achieve $\alpha = 0.5$ with power of 0.8, the estimated required sample size is 71.

Data Collection

Participants accessed an online survey via a Qualtrics link with a description of the purpose of the survey, and informed consent. The survey included 39 close-ended questions and four open-ended questions, in addition to seven demographic questions.

Data Cleaning

One common threat to online surveys is internet "bots" who may be particularly likely to respond to a survey that has a financial incentive (Simone, 2019). While it is not possible to be sure if a bot has gained access to one's survey, Simone suggests some key signs that a respondents may not be legitimate such as a large influx of responses in a short period of time or illogical answers to open-ended questions. Any response that fell into one of Simone's categories resulted in a review of all that participant's answers. If a second flag was detected, that respondent was excluded.

Measures

Because no existing measurement instruments addressed the study question, questions and scales were adapted from previous research in other areas of social work education, and values. The Social Work Education in Suicide Survey (SWESS) examines social work students' perceptions of education in suicide prevention (Feldman & Freedenthal, 2006). The questions were adapted to measure knowledge, skills, and education related to co-response. The research question also requires knowledge of students' beliefs about social work values. Here, Reamer's Ethical Decision-Making Framework (Reamer, 2018) was used as the foundation for creating questions about students' perception of the alignment of co-response with social work values. Because co-response typically requires social workers to partner with police, social

work students' perceptions of police may impact their views on co-response. The study used Nadal et al.'s (2017) Perceptions of Police Survey (POPS), which includes twelve statements about police that participants rate using a Likert scale Table 1.

Data Analysis

Data analysis used STATA (Version 17). For descriptive analysis, data was analyzed by location, age, race, and full or part-time student status. The data was further analyzed to generate descriptive statistics of the sample, and standardized scores of each measurement, including the measure of frequency, tendency, and dispersion. For inferential analysis, ordered logistic regression was used. The dependent variable was students' desire to work with co-response team while independent variables included race, age, gender, student status, perception of police, knowledge, and values.

Internal Consistency

Scales were validated using Cronbach's alpha to measure internal consistency. For perception of police, Cronbach's $\alpha = 0.96$. For alignment with NASW values, Cronbach's α-=0.89. For social work knowledge, Cronbach's α-=0.88.

Table 1 Demographics of same ($N = 145$)

	M (SD)	*n* (%)
Gender		
Male		28 (22.40)
Female		92 (73.60)
Other		5(4.0)
Age	31.90 (8.79)	
Race		
White		102 (83.61)
Black		8 (6.56)
Hispanic/Latinx		3 (2.46)
Asian		3 (2.46)
Mixed ethnicity		4 (3.28)
Native American/Alaska Native		2 (1.64)
Census Region		
New England		5 (4.07)
Middle Atlantic		29 (23.58)
South Atlantic		28 (22.76)
East North Central		3 (2.44)
East South Central		14 (11.38)
West South Central		5 (4.07)
Mountain		17 (13.82)
Pacific		8 (6.50)
Canada		2 (1.63)
Student status		
Fulltime		83 (70.94)
Parttime		34 (29.06)

Missing Data Analysis

Some respondents did not answer all survey questions. Missing data was explored to determine how many answers were missing and if questions were skipped at random. Analysis revealed that 90% of values across 33 items of interest were present. Because missingness was at random, estimates reported for the regression analyses were generated using Full Information Maximum estimation on missing data (Soley-Bori, 2013).

Results

Data was collected from 228 respondents. However, one did not consent, and six did not meet the criteria of being current MSW students. An additional 76 responses were removed due to concerns about bot interference, leaving a total of 145 responses for analysis.

Demographics

Nearly three quarters (73.60%) of participants identified as female, with a mean age of 30.90. Most respondents were white (83.61%) and from the Middle Atlantic (23.58%) and South Atlantic (22.76%) regions.

The sample diverged from the general population of MSW students primarily in gender and racial composition. The sample population had more male students than the general population and fewer students of color (Council on Social Work Education [CSWE], 2021).

Co-Response Support and Preferences

Table 2 shows student knowledge and prior education relating to co-response, support for the practice, beliefs about co-response alignment with NASW values, and interest in participating. Before completing this survey, 74.81% of students had previously heard of co-response. A total of 60.74% of students strongly agreed that they supported the use of co-response teams. Similarly, 93.89% believed that co-response aligned with social work values. However, only 13.08% said that they were extremely likely to join a co-response team. Regarding co-response knowledge, 15.5% strongly agreed they felt confident regarding their current knowledge and skillsets pertaining to co-response and 13.95% strongly agreed they received enough training in their MSW program to participate on a team.

Variables Impacting Social Work Students' Desire to Work on Co-Response Teams

An ordinal logistic regression examined the relationship between the dependent variable (desire to work in co-response) and the following independent variables: values, knowledge, perception of police, race, gender, age, and student status. The analysis showed that the odds of being interested in joining the co-response team were

Table 2 Student support and knowledge of co-response frequencies

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
I support the use of co-response teams	82 (60.74)	40 (29.63)	8 (5.93)	5 (3.70)	0 (0.00)
I feel confident regarding my current knowledge and skillset pertaining to co-response work	20 (15.50)	35 (27.13)	32 (22.81)	21 (16.28)	21 (16.28)
	Extremely likely	Somewhat likely	Neither likely nor unlikely	Somewhat unlikely	Extremely unlikely
How likely would you be to join a co-response team?	17 (13.08)	45 (34.62)	19 (14.62)	31 (23.85)	18 (13.85)
		Yes		No	
Before reading this definition, had you heard of co-response?		101 (74.81)		34 (25.19)	
Do you believe co-response aligns with social work ethics?		123 (93.89)		8 (6.11)	
Did your MSW offer any formal training-courses, seminars, field placement, etc- that included topics related to co-response?		41 (31.78)		88 (68.22)	

Table 3 Student interest in joining co-response team[1]

	Estimate	95% CI	OR	OR 95% CI
Joining Co-response Team *ON*				
Knowledge of co-response	0.08*	0.00, 0.15	1.08	1.00, 1.17
Race- nonwhite	−0.15	-1.13, 0.83	0.86	0.32, 2.30
NASW values alignment	0.14*	0.05, 0.23	1.15	1.05, 1.26
Perception of police	−0.04*	−0.08, −0.00	0.96	0.93, 1.00
Age	−0.02		0.98	0.94, 1.02
Gender	0.68	−0.06, 0.02	1.98	0.84, 4.66
Fulltime	−0.33	−0.17, 1.54 -1.13, 0.47	0.72	0.32, 1.60

Note * $p<.05$; ** $p<.01$

[1]Adjusted R-squared=0.06

higher as knowledge level increased, holding other independent variables constant (OR=1.08, 95% CI, 1.00 to 1.17; $p=.04$). The analysis showed no significant relationship between student race and desire to join a co-response team (OR=0.86, 95% CI, 0.32 to 2.30; $p=.77$). The odds of being interested in joining the co-response team were higher for students who more strongly believed that co-response aligned with NASW values, holding other independent variables constant (OR=1.08, 95% CI, 1.00 to 1.26; $p=.03$). An increase in perception of police led to an increased chance of wanting to join a co-response team, holding other independent variables constant (OR=0.96, 95% CI, 0.92 to 0.99; $p=.04$).

Table 3 shows the coefficients, odds ratios, and confidence intervals for all the independent variables that were included in the ordinal logistic regressions that were used to test the four hypotheses above.

Discussion

This research adds to the growing literature on behavioral health emergency response teams to examine initial social work perspectives on such teams.

Knowledge of co-response and beliefs about its alignment with social work values were found to be important predictors of interest in team participation. This is important given that nearly 94% of students believe that co-response aligns with social work ethics. Fewer than 16% of MSW students strongly agreed that they were confident about their knowledge and skills relating to co-response. This study also found that desire to participate did not mirror support. While 60.74% of students strongly supported the use of co-response, only 13.08% would be extremely likely to participate.

Implications for Policy and Social Work Education

Behavioral health emergency response is an opportunity for social workers to contribute to the effort to divert people with mental illness away from the criminal legal system. Increased discussion of crisis response and the potential alignment or conflict with social work values provides opportunities for social workers who may interact with co-response team members through their work with community agencies, work on such teams, or advocacy efforts to learn more about relevant policies and practices. One particular finding of previous literature was that community partners did not have updated, accurate knowledge about behavioral health emergency response (Bailey et al., 2018; Kirst et al., 2015). Social workers leading agencies and working in policy should be well-versed in co-response as they may be able to advocate for the increased use of crisis response teams and contribute to decisions about how they are operationalized in congruence with social work values.

Opportunities exist to increase content about crisis teams within social work curricula. Social work programs may choose to partner with their local crisis response teams to offer internships and placements like the current program in Fayetteville, Arkansas (Stauss et al., 2023). A limited number of social work programs have courses about police social work, or available internship placements in the field (Patterson, 2022), which may present opportunities as well. Behavioral health response overlaps with police social work but also with multiple other areas of the curriculum, from direct practice to policy to mental health content. The opportunities for social work students to interact with crisis response can occur as soon as their internships or upon graduation, suggesting the need for information to be included in the curriculum.

Policy Advocacy Implications

Local government needs input from social workers in decisions about behavioral health emergency response team presence and structure in their communities to ensure that resulting policies are evidence-based, equitable, socially just, and built on social work values. Given the gap between the number of social work students who support co-response (nearly 61%) and the number who say that they are extremely

like to participate in it (about 13%), policy responses can include social work voices in creating opportunities that will be congruent with social work values and attractive to social workers. The positive relationship between knowledge of co-response and desire to work in the field is a good sign. In addition, the positive relationship between belief that co-response aligns with social work values and desire to join should be a catalyst for advocates and policymakers to ensure that policies are developed in congruence with social work values.

The current policy environment, where money from the American Rescue Plan Act of, 2021 (ARPA) has been set aside for states that choose to cover crisis intervention through Medicaid, provides a unique opportunity for social work advocacy, particularly given that this policy requires that the crisis teams have a behavioral health worker. Although ARPA was created to solve a temporary problem, it may allow the creation and expansion of long-term programs. If states use ARPA's increased Medicaid funding to create and finance crisis response teams with positive results, policy advocates may be able to request funding for them in the future.

The 988 suicide and crisis lifeline opens up the need to operationalize the service provision that 988 requires for responders, which can include behavioral health emergency response teams. Municipalities and states should include social work advocates in discussions of new policy development to ensure that the positions are attractive to social workers. Not every social worker wants to work in crisis response, but a qualified workforce is essential for the successful implementation of these policies.

At the same time, state legislators who are attempting to pass bills to create robust mental health legislation that centers around emergency response diversion programs can lean on social workers and social work students as allies. For example, in New York, Assemblyman Harry Bronson, and state Senator Samra Brouk, co-sponsored a bill called Daniel's Law (S.2398/A.2210) in 2021 (Lekhtman, 2023) after Daniel Prude was killed by police while experiencing a mental health crisis. The law would create a state-wide program that would send mental health response units instead of police to people in distress. Teams would include a mental health worker, an EMT and a peer, similar to the proposed draft legislation discussed earlier (Lekhtman, 2023). This bill has been stagnant so far and is a potential opportunity for social work advocacy. Social workers in other states can and should engage in advocacy to pass similar bills on the state level.

Limitations

One limitation of the study is the potential that exists for confusion given the multiple terms used for co-response and related teams. We recommend that policymakers and researchers standardize their terminology to address this issue. Response bias may have resulted in a group of respondents who were more familiar with co-response than the general population of social work students. Potential sampling bias is one reason it would be valuable to try to replicate these results with future studies.

Additionally, this study accesses a small percentage of existing social work students. It is not possible to capture the diversity of student opinions in one survey. The sample was also not generalizable due to convenience, rather than random sampling.

Conclusion

This study brings a new perspective to behavioral health emergency response research. While previous studies focused on outcome data, and participant perceptions about the implementation and effectiveness of existing teams, this research focused on social work students' perception and knowledge of response teams at large.

Support for behavioral health emergency response teams is strong, and nearly all students believe in the alignment between social work values and these teams. However, there is a large gap between the number of students who support co-response teams as a part of the solution to existing problems and the number who want to participate. To continue to grow the field, there must be action on the part of social work practitioners, educators, and legislators. Policymakers looking to pass and implement policies to expand crisis response teams should be engaging with social workers to address the common goal of better policy that decreases the overrepresentation of people with mental illness in the criminal legal system and increases the likelihood that proposed policies will strongly represent social work's core values.

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Declarations

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Competing Interests The authors have no competing interests to declare that are relevant to the content of this article.

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