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Issues in Law Enforcement Reform: Responding to Mental Health Crises

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Issues in Law Enforcement Reform: Responding to Mental Health Crises

The manner in which police have handled mental health-related encounters has come under increased scrutiny during the last few decades, especially regarding the use of force. Through hearings and legislation, policymakers have demonstrated an interest in improving the police's response to individuals who are experiencing a mental health crisis.

When considering options for improving law enforcement's response to people experiencing a mental health crisis, policymakers have looked to specialized responses employed by local governments across the country. These responses include the following:

- Crisis Intervention Teams (CITs), in which specially trained law enforcement officers respond to calls for service involving people having a mental health crisis and liaise with mental health providers.
- Co-Responder Teams (CRTs), which pair law enforcement officers with trained clinicians who together respond to emergency calls involving individuals experiencing a mental health crisis.
- Mobile Crisis Teams (MCTs), which utilize community-based mental health professionals to respond to individuals experiencing mental health crises. These teams typically do not involve the police initially, though police can be called upon when appropriate.

Research on specialized responses to people experiencing a mental health crisis suggests that CITs, CRTs, and MCTs may improve some outcomes, such as improving police officers' perceptions of and response to people with mental illness and connecting people to mental health services. However, it remains less clear whether these changes translate into actual improved outcomes for people with mental health needs, such as fewer arrests and reduced use of force against them.

The Department of Justice (DOJ) and the Substance Abuse and Mental Health Services Administration (SAMHSA) provide funding that is intended to help improve law enforcement's response to people experiencing a mental health crisis. For example, DOJ's Justice and Mental Health Collaboration programs provide grants to help state, local, and tribal governments increase access to mental health care and other treatment services for people in need. SAMHSA's Mental Health Awareness Training grant program provides law enforcement and other first responders with training on how to recognize mental health conditions, provide initial help to those experiencing a mental health crisis, and connect individuals to appropriate care.

There are several issues policymakers might consider if Congress were to take up legislation to improve law enforcement's response to people experiencing a mental health crisis, including the following:

- aiding state and local governments with expanding their capacity to provide a continuum of mental health services, such as psychiatric emergency receiving units and inpatient mental health services;
- providing funding for preventative interventions to aid people before the onset of mental health conditions;
- providing funding for law enforcement agencies that want to provide CIT training to their officers and those that want to start CRT or MCT programs;
- collecting data on law enforcement officers' interactions with people experiencing a mental health crisis by expanding current DOJ efforts to collect data on law enforcement activities;
- providing additional funding for more staff and equipment to aid 911 call centers with handling calls for service involving people experiencing a mental health crisis;
- promoting more uniform laws and policies regarding training that law enforcement officers receive on how to respond to individuals experiencing a mental health crisis and actions officers can take to divert them from the criminal justice system; and
- supporting research on CRTs and MCTs.

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Law enforcement officers¹ are frequently the first responders to individuals experiencing a mental health crisis.² The manner in which police have handled mental health-related encounters has come under increased scrutiny during the last few decades.³ For example, people with mental illness and mental health advocacy groups have raised concerns about interactions between individuals with mental health disorders and police officers, especially those that involved the use of force.⁴ One study estimated that one in four people with a mental health condition has been arrested at some point in their lifetime and 1% of calls for service for the police involve people with a mental disorder.⁵

Law enforcement officers often have little training in mental health crisis management and response.⁶ In general, police are not formally trained to recognize, assess, and treat mental health conditions, relying instead on experiences learned on-the-job.⁷ This has led some to characterize law enforcement officers as the so-called secret social service for their largely unrecognized role in triaging individuals with mental health needs.⁸

Some research suggests that people with mental health conditions are more likely to be subjected to violence by the police. For example, one study of police-public encounters in New York City and Baltimore found that people with serious mental illness were more likely than the general population to be involved in violent incidents with the police, even after controlling for criminal behavior.⁹ Research also suggests that people with complex mental health needs are disproportionately killed during interactions with law enforcement.¹⁰ One study found that the death rate for people who had signs of a mental illness during police interactions (20 deaths per million) is nearly seven times higher than it is for people without signs of a mental illness (3 deaths per million).¹¹

¹ Throughout this report, the terms *law enforcement officer* and *police officer* or *police* will be used interchangeably.

² For the purposes of this report, a *mental health crisis* is defined as “any situation in which a person’s behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community.” Teri Brister, *Navigating a Mental Health Crisis: A NAMI Resource Guide for Those Experiencing a Mental Health Emergency*, National Alliance on Mental Illness, Arlington, VA, 2018, p. 5.

³ Jennifer D. Wood and Amy C. Watson, “Improving Police Interventions During Mental Health-Related Encounters: Past, Present, and Future,” *Policing and Society*, vol. 27, no. 3 (2017), pp. 289-299 (hereinafter, “Wood and Watson, ‘Improving Police Interventions During Mental Health-Related Encounters’”).

⁴ James D. Livingston, “Contact Between the Police and People with Mental Disorders: A Review of Rates,” *Psychiatric Services*, vol. 67, no. 8 (August 2016), p. 850 (hereinafter, “Livingston, ‘Contact Between the Police and People with Mental Disorders’”).

⁵ Livingston, “Contact Between the Police and People with Mental Disorders.”

⁶ H. Richard Lamb, Linda E. Weinberger, and Walter J. DeCuir, Jr., “The Police and Mental Health,” *Psychiatric Services*, vol. 53, no. 10 (2002), pp. 1266-1271 (hereinafter, “Lamb et al., ‘The Police and Mental Health’”).

⁷ Eddie Kane, Emily Evans, and Farhad Shokraneh, “Effectiveness of Current Policing-Related Mental Health Interventions: A Systematic Review,” *Criminal Behavior and Mental Health*, vol. 28 (2018), pp. 108-119; and Thomas M. Green, “Police As Frontline Mental Health Workers: The Decision to Arrest or Refer to Mental Health Agencies,” *International Journal of Law and Psychiatry* (1997).

⁸ Maurice Punch, “The Secret Social Service,” *The British Police* 102 (1979): 17.

⁹ Hyun-Jin Jun, Jordan E. DeVlyder, and Lisa Fedina, “Police Violence Among Adults Diagnosed with Mental Disorders,” *Health and Social Work*, vol. 45, no. 2 (May 2020), pp. 81-89.

¹⁰ Amam Z. Saleh, Paul S. Appelbaum, and Xiaoyu Liu et al., “Deaths of People with Mental Illness During Interactions with Law Enforcement,” *International Journal of Law and Psychiatry*, vol. 58 (2018), pp. 110-116 (hereinafter, “Saleh et al., ‘Deaths of People with Mental Illness During Interactions with Law Enforcement’”).

¹¹ Saleh et al., “Deaths of People with Mental Illness During Interactions with Law Enforcement,” p. 114.

This body of research, along with recent high-profile incidents in which police responses to individuals with mental health needs have had fatal outcomes, have led to a renewed interest in improving police response to mental health crises.¹² Congress has taken an interest in addressing the role of law enforcement in the mental health crisis response system.¹³ For example, Congress has supported grant programs that encourage police training or partnerships with behavioral health professionals to improve the response to persons experiencing a mental health crisis.¹⁴

Mental Health and Violence

Law enforcement officers may respond to mental health-related emergencies because of the threat of harm or violence (to the individual experiencing the crisis or to others). Most mental health crises do not involve the threat of violence and most people with mental health conditions do not pose a significant threat of violence.¹⁵ Some research suggests that a small segment of individuals with serious mental illness may be slightly more prone to violence than those without a mental health condition, though acts of violence in this population are not common.¹⁶ Data suggest that people with serious mental illness are more likely to be victims of violent crime rather than perpetrators.¹⁷ Still, some mental health-related emergencies can be volatile, and in some situations it may be most appropriate for a law enforcement officer to be present. Studies have found that law enforcement officers believe that people with mental illness are significantly more prone to violence than people without mental illness, which may result in higher levels of force being used during mental health emergencies. This suggests the importance of appropriate training for responses to these situations.¹⁸

This report discusses specialized law enforcement programs for responding to individuals experiencing mental health crises. Mental health crises can include various emergencies such as suicidal ideation, symptoms of psychosis (e.g., hallucinations, delusions), threats of harm to others, or other significant acute psychological or emotional distress. These situations can involve individuals with serious mental illness, other diagnosed mental health conditions, or no psychological disorders at all.¹⁹ The report begins by describing specialized responses that local governments have employed to improve their responses to individuals experiencing mental health crises. It briefly discusses the research on the effectiveness of these alternative responses and then turns to a review of federal programs that could provide support for these programs. Lastly, the report discusses some considerations for policymakers should Congress take up further legislation to address this issue.

¹² Minyvonne Burke, “Policing Mental Health: Recent Deaths Highlight Concerns Over Officer Response,” *NBC News*, May 16, 2021, <https://www.nbcnews.com/news/us-news/policing-mental-health-recent-deaths-highlight-concerns-over-officer-response-n1266935>; and Lamb et al., “The Police and Mental Health,” pp. 1266-1271.

¹³ See, for example, U.S. Congress, Senate Committee on the Judiciary, Subcommittee on Criminal Justice and Counterterrorism, *Behavioral Health and Policing: Interactions and Solutions*, subcommittee hearing, 117th Cong., 1st sess., April 22, 2021.

¹⁴ See, for example, the Bipartisan Safer Communities Act (P.L. 117-159).

¹⁵ Tori DeAngelis, “Mental Illness and Violence: Debunking Myths, Addressing Realities,” *Monitor on Psychology*, vol. 52, no. 3, (April/May 2021), p. 31 (hereinafter “DeAngelis, ‘Mental Illness and Violence’”).

¹⁶ See, for example, Richard Van Dorn, Jan Volavka, and Norman Johnson, “Mental Disorder and Violence: Is There a Relationship Beyond Substance Use?,” *Social Psychiatry and Psychiatric Epidemiology*, vol. 47, no. 3 (2012), pp. 487-503.

¹⁷ H. Khalifeh, S. Johnson, and L. M. Howard et al., “Violent and Non-Violent Crime Against Adults with Severe Mental Illness,” *The British Journal of Psychiatry*, vol. 206 (2015), pp. 275-282.

¹⁸ Michael T. Rossler and William Terrill, “Mental Illness, Police Use of Force, and Citizen Injury,” *Police Quarterly*, vol. 20, no. 2 (June 2017), p. 191.

¹⁹ See, for example, Deborah M. Stone, Thomas R. Simon, and Katherine A. Fowler et al., *Vital Signs: Trends in State Suicide Rates - United States, 1999-2016 and Circumstances Contributing to Suicide - 27 States, 2015*, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, vol. 67, no. 22, June 8, 2018.

Specialized Responses to Mental Health Crises

Over the past several decades, local governments have adopted specialized approaches to respond to calls involving individuals experiencing a mental health-related emergency. A survey of police agencies found that these models tend to fall into one of three categories (see **Figure 1**):

1. *Crisis Intervention Teams* (CITs), in which specially trained police officers provide initial crisis response in the field and liaise with mental health providers;
2. *Co-Responder Teams* (CRTs), in which mental health clinicians embedded in police agencies respond alongside law enforcement officers in the field; and
3. *Mobile Crisis Teams* (MCTs), in which mental health clinicians responding with or without law enforcement assistance or triage.²⁰

Each of these models provides a type of *street triage*, aiming to incorporate mental health expertise into crisis response.²¹ A primary goal of these programs is to connect individuals in crisis with community mental health services and divert them from the justice system or acute care health services (such as hospital emergency departments).²² Many observers believe that decreasing the likelihood that an individual in crisis will end up in police custody is the most appropriate way to support people with acute or chronic mental health needs and prevent reoccurrence of a crisis and repeated contact with the criminal justice system.²³

There is considerable variation in program design and heterogeneity in application of these programs—even across communities employing the same model. One review identified 19 different approaches to street triage across these three models.²⁴ For example, co-responder teams might adopt a *first* response approach in which the CRT responds initially to a perceived mental health crisis. They could also employ a *second* response (or *post*-response) approach in which other emergency personnel (e.g., traditionally trained law enforcement officers or emergency medical technicians) arrive to the scene first and call for the CRT if a mental health crisis is identified.²⁵ Some CRTs are only dispatched after a call is placed to an emergency control room (e.g., 911), some take calls directly from police officers in the field, some are dispatched in response to a call from either source, and some have their own independent line for receiving calls.²⁶

²⁰ Randy Borum, Martha Williams Deane, and Henry Steadman et al., “Police Perspectives on Responding to Mentally Ill People in Crisis: Perceptions of Program Effectiveness,” *Behavioral Sciences and the Law*, vol. 16 (1998), pp. 393-405; and Martha Williams Deane, Henry Steadman, Randy Borum et al., “Emergency Partnerships Between Mental Health and Law Enforcement,” *Psychiatric Services*, vol. 50, no. 1 (1999), pp. 99-101, as cited in Wood and Watson, “Improving Police Interventions During Mental Health-Related Encounters.”

²¹ Stephen Puntis, Devon Perfect, and Abirami Kirumbarajan et al., “A Systematic Review of Co-Responder Models of Police Mental Health ‘Street’ Triage,” *BMC Psychiatry*, vol. 18 (2018), p. 256 (hereinafter, “Puntis et al., ‘A Systematic Review of Co-Responder Models’”).

²² G.K. Shapiro, A. Cusi, and M. Kirst et al., “Co-Responding Police-Mental Health Programs: A Review,” *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 42, no. 5 (2015), pp. 606-620 (hereinafter, “Shapiro et al., ‘Co-Responding Police-Mental Health Programs’”).

²³ Shapiro et al., “Co-Responding Police-Mental Health Programs.”

²⁴ Puntis et al., “A Systematic Review of Co-Responder Models.”

²⁵ Katie Bailey, Staci Rising Paquet, and Bradley R. Ray et al., “Barriers and Facilitators to Implementing an Urban Co-Responding Police-Mental Health Team,” *Health and Justice*, vol. 6, no. 21 (2018).

²⁶ Puntis et al., “A Systematic Review of Co-Responder Models,” p. 261.

Figure I. Common Models of Mental Health Crisis Response



Source: CRS analysis.

Notes: Some areas may employ more than one model at a time.

Crisis Intervention Teams

CITs are a first responder model in which specially trained law enforcement officers respond to calls for service involving people experiencing a mental health crisis. The CIT model is the most widely used of the three most common mental health crisis response approaches. CITs originated in Memphis, TN, in 1988 when the Memphis Police Department (MPD) partnered with the Memphis chapter of the National Alliance on Mental Illness, the University of Memphis, and the University of Tennessee to develop a specialized unit in response to public outcry over the death of a man with schizophrenia during an encounter with MPD (hence, the CIT model is sometimes referred to as the *Memphis model*).²⁷ The stated goal of the program is to reduce deaths that can occur during interactions between the police and people experiencing a mental health crisis and to divert these individuals, when appropriate, away from the criminal justice system and into treatment.²⁸

Police officers who serve on CITs typically undergo 40 hours of training, during which they learn how to recognize symptoms of major mental health conditions, interact with and gain perspective from people who have suffered mental health crises and their families, engage in role playing

²⁷ Wood and Watson, “Improving Police Interventions During Mental Health-Related Encounters,” p. 292.

²⁸ Michael S. Rogers, Dale E. McNeil, and Renee L. Bender, “Effectiveness of Police Crisis Intervention Training Programs,” *Journal of the American Academy of Psychiatry and the Law*, vol. 47, no. 4 (2019), p. 415 (hereinafter, “Rogers et al., ‘Effectiveness of CIT Programs’”).

exercises to help them develop de-escalation skills, and conduct site visits of community facilities that provide follow-up services to people with mental health needs after a treatment referral is made by law enforcement.²⁹ Police officers who serve on CITs traditionally volunteer for the team.³⁰

The Memphis model includes changes that go beyond training a portion of the agency's officers on proper responses to people experiencing a mental health crisis. The model also involves

- training dispatchers to recognize calls for service that have a high probability of being mental health-related and dispatching CITs;
- developing partnerships between law enforcement agencies, mental health services, mental health advocates, and other stakeholders; and
- establishing a centralized drop-off emergency mental health care facility that will accept all patients.³¹

According to the CIT Center at the University of Memphis, there are approximately 3,000 CIT programs in the United States.³² However, it is not clear how many of these agencies are implementing the full Memphis model (as opposed to just providing some of their officers with the 40 hours of CIT training).³³ It has been noted that the Memphis model was designed to be flexible enough to “allow communities to tailor their efforts to local needs, resources, and limitations,”³⁴ though some fidelity to the model is required for effectiveness.

Co-Responder Teams

CRTs pair law enforcement officers with clinicians who respond to emergency calls involving individuals experiencing a mental health crisis. CRTs are being implemented as a part of a larger CIT effort, part of other police-mental health collaboration programs, or on their own.³⁵ The goals of CRTs are to (1) reduce unnecessary emergency department visits, psychiatric hospitalizations, and arrests; (2) increase safety for officers and subjects; and (3) provide connections to community-based mental health treatment.³⁶ CRTs accomplish these outcomes by deescalating crises, preventing injuries to individuals in crisis and the response team, linking individuals experiencing psychiatric emergencies to appropriate care in the community, and reducing

²⁹ Charles Dempsey, Cameron Quanbeck, and Clarissa Bush et al., “Decriminalizing Mental Illness: Specialized Policing Responses,” *CNS Spectrums*, vol. 25, no. 2 (2020), p. 182, hereinafter “Dempsey et al., ‘Decriminalizing Mental Illness.’”

³⁰ Wood and Watson, “Improving Police Interventions During Mental Health-Related Encounters,” p. 292.

³¹ Amy C. Watson and Michael T. Compton, “What Research on Crisis Intervention Teams Tells Us and What We Need to Ask,” *Journal of the American Academy of Psychiatry and the Law*, vol. 47, no. 4 (2019), p. 423 (hereinafter, “Watson and Compton, ‘What Research on CITs Tells Us and What We Need to Ask’”). These drop-off emergency mental health care facilities are sometimes referred to as *psychiatric receiving units* or *crisis stabilization centers*. See “Access to Mental Health Services” later in this report.

³² University of Memphis, CIT Center, <http://www.cit.memphis.edu/>.

³³ Wood and Watson, “Improving Police Interventions During Mental Health-Related Encounters,” p. 292.

³⁴ Amy C. Watson, Michael T. Compton, and Leah G. Pope, *Crisis Response Services for People with Mental Illness or Intellectual or Developmental Disabilities: A Review of the Literature on Police-Based and Other First Response Models*, Vera Institute of Justice, New York, NY, 2019, p. 27 (hereinafter, “Watson et al., *Crisis Response Services for People with Mental Illness*”).

³⁵ Watson et al., *Crisis Response Services for People with Mental Illness*, p. 14.

³⁶ Watson et al., *Crisis Response Services for People with Mental Illness*, p. 15.

pressure on both the local justice and health care systems.³⁷ The theory underlying CRT programs is that a joint response is preferable as police are specialists in handling situations involving illegal activity while mental health professionals are specialists in providing clinical care to individuals in crisis.³⁸

As mentioned previously, there are variations in how CRTs operate and how they are deployed. Co-responding programs can differ greatly in the populations they serve, including regarding funding levels, program guidelines, hours of operation, procedures, staff expertise, equipment, and training.³⁹ In some cases, CRTs include police officers and clinicians who ride together in the same vehicle—either a squad car, unmarked police car, or ambulance.⁴⁰ In other cases, the clinician provides support to the police officer remotely, either via phone or police radio. With the exception of models that utilize remote consultation, CRTs are not available to respond 24 hours a day in most jurisdictions that have implemented them.⁴¹

Mobile Crisis Teams

MCTs utilize community-based mental health professionals to respond to mental health crises, with law enforcement deployed as needed. Unlike CITs and CRTs, MCTs typically do not involve the police initially, though police can be called upon when appropriate.⁴² Conversely, police can request that an MCT respond if the circumstances are deemed appropriate. Calls for service can be screened through a dedicated helpline or through a 911 call center.⁴³ In either case, an MCT is dispatched to respond to the call if it meets defined criteria (e.g., the subject of the call appears to be experiencing a mental health crisis and there is no evidence he or she is engaged in violent activity), as specified by the jurisdiction.⁴⁴ MCTs are usually operated by a mental health agency instead of a police department, and provide onsite crisis management through assessment, intervention, consultation, referral to services, and follow-up to help ensure that the individual connects with the recommended services.⁴⁵

Several cities have implemented MCT programs, mostly on a pilot basis (see the **Appendix** for examples). There are no comprehensive data on which cities use MCTs or the characteristics of these teams. Most available accounts indicate that pilot programs offer teams in a specific portion of the city during certain hours. Many cities take a layered approach to mental health calls by utilizing an MCT for some calls but also maintaining a CIT and/or a CRT.

The CAHOOTS Program (Eugene, OR)

The oldest and most established MCT is the Crisis Assistance Helping Out on the Streets (CAHOOTS) in Eugene, OR. The CAHOOTS program has been operating since 1989. CAHOOTS is not a part of the Eugene Police Department (EPD), but it does use City of Eugene-marked vehicles and receives funding from the city through a

³⁷ Shapiro et al., “Co-Responding Police-Mental Health Programs.”

³⁸ Shapiro et al., “Co-Responding Police-Mental Health Programs.”

³⁹ Shapiro et al., “Co-Responding Police-Mental Health Programs.”

⁴⁰ Puntis et al., “A Systematic Review of Co-Responder Models,” p. 258.

⁴¹ Puntis et al., “A Systematic Review of Co-Responder Models,” p. 261.

⁴² Watson et al., *Crisis Response Services for People with Mental Illness*, p. 39.

⁴³ Ashley Abramson, “Building mental Health into Emergency Responses,” *Monitor on Psychology*, vol. 52, no. 5, July 1, 2021, pp. 30-31 (discussing a model used in Long Island, NY, where 911 call takers can dispatch a team of clinical professionals; and a model used in Austin, TX, where callers can opt for mental health services).

⁴⁴ Watson et al., *Crisis Response Services for People with Mental Illness*, p. 39.

⁴⁵ Watson et al., *Crisis Response Services for People with Mental Illness*, p. 39.

contract with EPD.⁴⁶ CAHOOTS teams are staffed by personnel from the White Bird Clinic, a mental health services provider in the city. CAHOOTS is the primary responder in many cases involving people who are intoxicated, mentally ill, or disoriented, and they transport people for necessary nonemergency medical care. People can call the nonemergency police line or 911 and request CAHOOTS.⁴⁷ EPD triages calls for service through their call center and dispatches a CAHOOTS van (which has a paramedic and an experienced crisis worker) to the scene when it is determined that a non-law enforcement response is warranted.⁴⁸ Sometimes, CAHOOTS will be called to a scene by a police officer who initially responded to a call when that officer determines the situation would be better handled by mental health professionals.

The CAHOOTS program has served as a model for other cities exploring options for redirecting mental health calls away from the police and to mental health professionals. It was reported that since the summer of 2020, over 400 municipalities contacted CAHOOTS organizers asking for advice on how establish their own programs.⁴⁹

Other Models

In addition to the three most common mental health and law enforcement crisis response programs discussed above, other strategies have also emerged. For example, one model used in the United Kingdom embeds mental health specialists in contact control rooms (which are akin to 911 call centers in the United States) along with emergency dispatchers.⁵⁰ These mental health professionals advise call handlers and sometimes deal directly with individual callers. Other models use street triage teams that conduct outreach with people with mental illness in the community to connect them to services in hopes of preventing a mental health crisis.⁵¹

Some communities rely on emergency medical technicians (EMTs) or paramedics to provide services to individuals with mental health needs. Some public safety agencies are embracing and encouraging training for EMTs and leveraging outside resources to train EMTs to lead or support a CRT or CIT. The National Association of Emergency Medical Technicians (NAEMT) serves as a clearinghouse for training and education and provides information for first responders so they can assist in a mental health crisis.⁵² NAEMT provides links to training offered by the International Critical Incident Stress Foundation, Inc., (CISF), which trains individuals interested

⁴⁶ Eugene Police Department, “CAHOOTS,” <https://www.eugene-or.gov/4508/CAHOOTS>.

⁴⁷ Ben Adam Climer and Brenton Gicker, “CAHOOTS: A Model for Prehospital Mental Health Crisis Intervention,” *Psychiatric Times*, January 29, 2021, <https://www.psychiatristimes.com/view/cahoots-model-prehospital-mental-health-crisis-intervention>.

⁴⁸ In Eugene, 911 call takers can dispatch Eugene Police, CAHOOTS, and local fire and emergency medical services (EMS) response agencies. The decision on resources to send that a 911 call taker makes is “outlined by department policy but is informed by the knowledge, training and experience of our dispatchers. Dispatchers must consider public and responder safety, the presence of weapons, elements of criminal activity, and the needs of the citizens for every emergency.” See <https://www.eugene-or.gov/DocumentCenter/View/56581/911-Process-Infographic>.

⁴⁹ Julianne Hill, “Police Are Often the First Responders to Mental Health Crises, but Tragedies Are Prompting Change,” *ABA Journal*, April 1, 2021.

⁵⁰ Eddie Kane, Emily Evans, and Farhad Shokraneh, “Effectiveness of Current Policing-Related Mental Health Interventions: A Systematic Review,” *Criminal Behavior and Mental Health*, vol. 108 (2018).

⁵¹ Several communities have explored various approaches to responding to mental health calls before deciding on a single model. The City of Minneapolis, for example, developed and funded approaches such as sending non-police response teams, including mental health workers and emergency medical technicians (EMTs) to mental health crisis calls; training 911 dispatchers to assess mental health calls and dispatch the best response team; and embedding mental health professionals in 911 call centers to triage mental health calls and identify the best response. See League of Women Voters, “Reimagining Public Safety: Efforts to Reimagine Public Safety,” <https://lwvmpls.org/2-04-reforming-911-calls/>.

⁵² National Association of Emergency Medical Technicians (NAEMT), “Awareness, Education, and Training,” <https://www.naemt.org/initiatives/wellness/ems-mental-health/awareness-education-and-training>.

in becoming a part of a crisis management team. The National Council for Mental Well Being offers a course in Mental Health First Aid, a skills-based training course that teaches participants about mental health and substance-use issues.

The International Association of Chiefs of Police (IACP) created the One Mind Campaign, which encourages training and coordination across local mental health agencies, public safety agencies, and community organizations to improve interactions between law enforcement officers and individuals with mental health conditions. The goal of the initiative is for these agencies and organizations to become “of one mind.”⁵³ To join the campaign, law enforcement agencies must pledge to implement four strategies over a 12-36 month timeframe, including (1) establishing a partnership with one or more community health organizations, (2) developing and implementing a model policy addressing law enforcement response to individuals with mental health conditions, (3) training and certifying 100% of sworn officers (and selected non-sworn staff, such as dispatchers) in mental health awareness courses by providing Mental Health First Aid training, and (4) providing CIT training to a minimum of 20% of sworn officers (and selected non-sworn staff).

988: Suicide Hotline or 911 for Mental Health?

On July 16, 2022, the *988 Suicide & Crisis Lifeline* (988 Lifeline; formerly the National Suicide Prevention Lifeline) transitioned from a 10-digit number (1-800-273-8255) to the 3-digit hotline number (988). The 988 Lifeline is a national hotline that provides immediate crisis counseling and referral services for individuals experiencing suicidal thoughts or other mental distress. Currently, the 988 Lifeline routes calls by area code to the crisis center nearest that area code. The crisis center is staffed by trained crisis workers. Call center staff are equipped to counsel callers, provide local referrals for follow-up treatment, or (in some cases) transfer callers to 911 to dispatch local emergency personnel. There is an interest in some jurisdictions for potentially expanding the 988 Lifeline from a counseling and referral hotline to a dispatching service able to deploy local crisis responders to mental health emergencies, similar to 911.⁵⁴ In 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued national guidelines for behavioral health crisis care, identifying the 988 Lifeline as a potential hub for community crisis response.⁵⁵ In this format, the 988 Lifeline would not only serve as a suicide counseling hotline—as it does currently—but as a centralized call center able to dispatch mobile crisis response and link individuals with community services. While some localities may begin piloting more comprehensive systems soon (such as coordinated 911-988 programs),⁵⁶ most communities would require significant efforts and additional resources to achieve this goal.

⁵³ International Association of Chiefs of Police (IACP), “One Mind Campaign,” <https://www.theiacp.org/projects/one-mind-campaign>.

⁵⁴ See, for example, Bipartisan Policy Center, *Answering the Call 988: A New Vision for Crisis Response*, Washington, DC, June 2022.

⁵⁵ Substance Abuse and Mental Health Services Administration (SAMHSA), *National Guidelines for Behavioral Health Crisis Care*, Best Practices Toolkit, Rockville, MD, 2020.

⁵⁶ In November 2021, a consortium of mental health providers produced a report, *Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System*. The report made several recommendations related to 911 and 988, including the need for planning “to ensure the two systems operate in a complementary fashion, not as parallel or exclusive systems,” [and] “clarity on roles and protocols for cross-system referrals.”

Research on the Mental Health Crisis Responses Models

Research suggests that CRTs and MCTs may improve some outcomes related to law enforcement interactions with people experiencing a mental health crisis.⁵⁷ For instance, CRTs and MCTs both appear particularly effective at connecting people to mental health services.⁵⁸ CRTs also appear to improve outcomes for individuals experiencing a mental health crisis.⁵⁹ Research suggests that CRTs reduced the number of people being taken into police custody and unnecessary emergency department visits.⁶⁰ An evaluation of a MCT pilot program in Denver, CO, suggests that the program not only diverted people with mental health problems from the criminal justice system by providing care to these individuals but it also decreased crime in the areas served by MCTs.⁶¹

CIT programs appear to be particularly effective at changing police officers' perceptions of and response to people with mental illness.⁶² Several studies found that CIT training has positive effects on law enforcement participants. For example, CIT training appears to improve police officers' attitudes and behaviors towards people with mental health conditions. One study found that CIT-trained officers

- demonstrate improvements in knowledge, attitudes, and self-efficacy toward interacting with people with mental illness;
- have a greater understanding of stigmas associated with mental illness;
- have beliefs about mental illness that are shaped by medical knowledge;
- demonstrate a reduced preference for using force against people with mental illness; and
- show a preference for de-escalating situations and linking people with mental illness to treatment.⁶³

While research suggests that CIT programs might be effective at changing police officers' attitudes and approaches to interacting with people experiencing a mental health crisis, it is less clear whether these changes translate into improved outcomes for people with mental health needs who have contact with the police. One study found that arrests after CIT implementation

⁵⁷ CITs are the most widely evaluated of the three models of specialized responses to people with mental illness. There is less research on the effectiveness of and outcomes related to CRTs and MCTs. In addition, a significant proportion of the CRT research comes from Canada, the United Kingdom, and Australia, where CRTs are more common and have been in existence longer.

⁵⁸ Watson et al., *Crisis Response Services for People with Mental Illness*.

⁵⁹ Puntis et al., "A Systematic Review of Co-Responder Models," pp. 256-266; and Watson et al., *Crisis Response Services for People with Mental Illness*.

⁶⁰ Puntis et al., "A Systematic Review of Co-Responder Models," pp. 256-266; and Watson et al., *Crisis Response Services for People with Mental Illness*.

⁶¹ Thomas S. Dee and Jaymes Pyne, "A Community Response Approach to Mental Health and Substance Abuse Crises Reduces Crime," *Science Advances*, vol. 8, no. 23 (2022).

⁶² Rogers et al., "Effectiveness of CIT Programs."

⁶³ Amy C. Watson, Michael T. Compton, and Jeffrey N. Draine, "The Crisis Intervention Team (CIT) Model: An Evidence-Based Policing Practice," *Behavioral Sciences and the Law*, vol. 35, no. 5-6 (September-December 2017), pp. 431-441 (hereinafter, "Watson et al., 'The Crisis Intervention Team (CIT) Model: An Evidence-Based Policing Practice'").

declined over time,⁶⁴ while a 2016 meta-analysis found that CITs do not reduce the arrest of or use of force against people with mental illness.⁶⁵

Despite the meta-analysis on CITs effects on the results of interactions between the police and people in a mental health crisis, for most of these crisis response models, research remains limited and evaluations looking at multiple outcomes of the models sometimes yield mixed results. For example, in their review of research on crisis response services, several experts concluded that

overall, the literature demonstrates that MCT services have high rates of consumer and provider satisfaction and can effectively increase community-based service use, reduce reliance on psychiatric ED [emergency departments], and link people to community-based care once discharged from an ED.⁶⁶

The authors noted that most existing studies on crisis response models have methodological limitations, hindering the ability to draw definitive conclusions for all outcomes related to these programs. Many of the studies evaluate just one program in a single city, for example, limiting the ability to generalize the results to other jurisdictions. Thus, more conclusive determinations on the effectiveness of mental health crisis response programs await a more robust body of research.

Federal Programs Related to Law Enforcement and Mental Health Crisis Response

Both the U.S. Department of Justice (DOJ) and SAMHSA⁶⁷ within the U.S. Department of Health and Human Services (HHS) provide funding to state and local governments to help improve their response to individuals experiencing a mental health crisis and those with mental health disorders.

Department of Justice Grant Programs

Justice and Mental Health Collaboration Program

Congress has appropriated funding for the Adult and Juvenile Collaboration program (34 U.S.C. §10651) since FY2006 and DOJ awards these funds through its Justice and Mental Health Collaboration program. Under the authorization for the program, grants can be awarded to state,

⁶⁴ Stephanie Franz and Randy Borum, “Crisis Intervention Teams May Prevent Arrests of People with Mental Illnesses,” *Police Practice and Research*, vol. 12, no. 3 (June), p. 2011.

⁶⁵ The meta-analysis found that CIT-trained officers were less likely than non-CIT-trained officers to arrest people with mental illness, but the result was not statistically significant. See Sema A. Taheri, “Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis,” *Criminal Justice Policy Review*, vol. 27, no. 1 (2016), pp. 76-96. The conclusions of Taheri’s meta-analysis resulted in the National Institute of Justice (NIJ) rating CITs as having “No Effects” on reducing arrests of or use of force against people with mental illness. See <https://crimesolutions.ojp.gov/ratedpractices/81#mao>. Other experts assert that due to the limitations of the research on CITs, it is too early to draw conclusions about their effectiveness in reducing arrests and use of force against people with mental illness. See, for example, Watson and Compton, “What Research on CITs Tells Us and What We Need to Ask,” pp. 422-426.

⁶⁶ Watson et al., *Crisis Response Services for People with Mental Illness*, p. 44.

⁶⁷ In addition to the two SAMHSA programs mentioned, there are a number of SAMHSA grants, such as the Community Mental Health Service Block Grants (MHBG), that offer significant flexibilities when it comes to allowable activities. Grants like the MHBG *could* be used to support activities such as response to mental health crises, but they are not specifically dedicated to that purpose. Of note, Congress included a set-aside for “evidence-based crisis systems” in the FY2021 and FY2022 annual appropriations for the MHBG.

local, and tribal governments for a variety of purposes related to improving the criminal justice system's response to people with mental health disorders.

Under the program, grants can be awarded to plan and implement programs to promote public safety by ensuring access to adequate mental health and other treatment services for adults or juveniles with mental health disorders that are overseen cooperatively by (1) a criminal or juvenile justice agency or a mental health court and (2) a mental health agency. Specifically, planning and implementation grants can be used to

- create or expand mental health courts or other court-based programs for preliminarily qualified offenders;
- offer specialized training to criminal and juvenile justice and mental health professionals on identifying the symptoms of people with mental health disorders in order to respond more effectively to these individuals;
- support programs operated cooperatively by criminal and juvenile justice and mental health agencies that provide mental health treatment, and where appropriate, substance abuse treatment; and
- support collaboration between state and local governments with respect to people with mental health disorders in the justice system.

Grants under this program can also be awarded to improve law enforcement's response to people with mental health disorders. Grants can be used to

- offer law enforcement and campus security personnel training in procedures to identify and respond to incidents involving individuals experiencing a mental health crisis;
- implement receiving centers that assess people in law enforcement custody for suicide risk and mental health and substance abuse treatment needs;
- establish new or improve existing computerized information systems to provide timely information to criminal justice system personnel so they can improve their response to individuals with mental health disorders;
- provide support for law enforcement academy, in-service, and continuing education training and other programs that instruct law enforcement personnel on how to identify and respond to people with mental health disorders or co-occurring mental health and substance use disorders; and
- establish and expand cooperative efforts to promote public safety through the use of effective intervention with individuals with mental health disorders.

Further, grants can be awarded for activities such as sequential intercept mapping, which is a process for studying how people with mental health conditions work their way through the criminal justice system. It also involves developing opportunities for the criminal justice and mental health systems to collaborate on ways to address the risks and needs of these individuals. The process includes identifying gaps in service for people with mental health conditions in the criminal justice system and developing programs to address these gaps. These programs can include emergency and crisis services; specialized police-based responses; court hearings and disposition alternatives; reentry from jails and prisons; and community supervision, treatment, and support services. Grants can also be used to implement intervention programs, which can include hiring personnel and providing support services to prevent involvement in the criminal justice system.

Community Oriented Policing Services (COPS) Office CIT Program

For FY2021 and FY2022, the COPS Office has awarded grants for CIT under its Community Policing Development program. Grants are awarded to law enforcement agencies to help them implement CITs, which can include “embedding behavioral or mental health professionals with law enforcement agencies, training for law enforcement officers and embedded behavioral or mental health professionals in crisis intervention response, or a combination of these.”⁶⁸ Grants can be used to pay law enforcement officer overtime, mental health professionals’ salaries or contracts, and personnel training costs.

Edward Byrne Memorial Justice Assistance Grant (JAG) Program

JAG is a formula grant program that provides funds to states, the District of Columbia, each territory, and local and tribal governments for a variety of criminal justice initiatives.⁶⁹ Grant recipients can use their JAG funds for state and local initiatives, technical assistance, training, personnel, equipment, supplies, contractual support, and criminal justice information systems for, among other things, mental health and related law enforcement and corrections programs, including behavioral programs and crisis intervention teams. The JAG program gives grant recipients flexibility in deciding how to spend their funds, so while state, local, and tribal governments could use JAG funding for programs to improve the criminal justice system’s response to people with mental health needs, they are not required to do so.

Substance Abuse and Mental Health Services Administration Grant Programs

Law Enforcement and Behavioral Health Partnerships for Early Diversion Grants

SAMHSA administers the Law Enforcement and Behavioral Health Partnerships for Early Diversion (or Early Diversion) grant program as part of its criminal and juvenile justice programming. The purpose of this program is to establish or expand programs that divert adults with a serious mental illness from the criminal justice system to community-based services prior to arrest and booking.⁷⁰ SAMHSA’s Early Diversion grant program supports three programs in Colorado, Connecticut, and Tennessee.⁷¹

Mental Health Awareness Training

SAMHSA’S Mental Health Awareness Training (MHAT) grant program provides resources for training law enforcement and other first responders on how to recognize a mental health condition, provide initial help in a mental health crisis, and connect individuals to appropriate care. The MHAT program—also known as Mental Health First Aid—is structured similarly to

⁶⁸ U.S. Department of Justice (DOJ), Community Oriented Policing Services Office (COPS), *FY2022 Crisis Intervention Teams Program, Community Policing Development*, fact sheet, May 2022, p. 1.

⁶⁹ For more information on the JAG program, see CRS In Focus IF10691, *The Edward Byrne Memorial Justice Assistance Grant (JAG) Program*.

⁷⁰ U.S. Department of Health and Human Services (HHS), SAMHSA, *Fiscal Year 2023 Justification of Estimates for Appropriations Committees*, <https://www.samhsa.gov/sites/default/files/samhsa-fy-2023-cj.pdf>.

⁷¹ SAMHSA, *Law Enforcement and Behavioral Health Partnerships for Early Diversion*, <https://www.samhsa.gov/criminal-juvenile-justice/grants-grantees/early-diversion>.

standard first aid training: an eight-hour course that instructs participants in how to identify, understand, and respond to the signs of a mental health crisis. SAMHSA partners with the National Council for Mental Wellbeing to administer MHAT grants. Originally part of Project AWARE, the MHAT program received its own authorization in Section 9010 of the 21st Century Cures Act (P.L. 114-255).

Considerations for Congress

If policymakers choose to take steps related to supporting specialized law enforcement responses to mental health crises, there are several issues Congress could consider, including the following:

- further aiding state and local governments with expanding their capacity to provide mental health services,
- providing funding for preventative interventions to aid people before the onset of mental health conditions,
- promoting more training for law enforcement officers on how to respond to people experiencing a mental health crisis,
- promoting responses that utilize mental health professionals,
- collecting data on law enforcement officers' interactions with people experiencing a mental health crisis,
- providing additional funding to aid 911 call centers with handling calls for service involving people experiencing a mental health crisis,
- promoting more uniform laws and policies regarding how law enforcement agencies respond to mental health crises, and
- supporting research on alternative law enforcement responses.

Access to Mental Health Services

There is a growing sentiment that diverting individuals to mental health services during a crisis would reduce burdens on both the criminal justice and local health care systems.⁷² Cities that have implemented specialized law enforcement mental health crisis response programs have found the availability of adequate community mental health resources to be essential to program effectiveness.⁷³ However, research suggests that police officers have perceived the mental health resources in their area as “inadequate, cumbersome, or absent altogether.”⁷⁴ Improving law enforcement’s response to individuals experiencing a mental health crisis depends on the availability of appropriate mental health services. As one study noted, even if appropriate police intervention occurs, without adequate supportive housing programs, short and long-term mental health bed availability, and sufficient mental health and substance use disorder treatment

⁷² See, for example, Katie Bailey, Staci Rising Paquet, and Bradley R. Ray et al., “Barriers and Facilitators to Implementing an Urban Co-Responding Police-Mental Health Team,” *Health and Justice*, vol. 6, no. 21 (2018).

⁷³ See, for example, William Wells and Joseph A. Schafer, “Officer Perceptions of Police Responses to Persons with a Mental Illness,” *Policing: An International Journal of Police Strategies & Management*, vol. 29, no. 4 (2006), pp. 578-601 (hereinafter, “Wells and Schafer, ‘Officer Perceptions of Police Responses to Persons with a Mental Illness’”).

⁷⁴ Wells and Schafer, “Officer Perceptions of Police Responses to Persons with a Mental Illness,” p. 581.

programs, many individuals will likely continue to experience crises that require police response.⁷⁵

For individuals needing mental health services, acute care medical facilities such as hospital emergency departments or incarceration in jails are often the only options in many communities.⁷⁶ In areas with few psychiatric inpatient beds or limited mental health services, treatment may actually be more accessible in jail than in the community.⁷⁷ With limited options for custodial care of individuals with mental health needs, law enforcement and other first responders are often left with few resources when encountering people experiencing a mental health crisis.⁷⁸

Inpatient Bed Availability

Effective treatment for individuals experiencing a mental health crisis typically involves a spectrum of services provided at continuum of care facilities. For many individuals, mental health needs can be met through community-based outpatient services. For those with complex mental health conditions or a serious mental illness, or those in an acute crisis, inpatient care may be the most effective care.⁷⁹ Most estimates suggest that the supply of psychiatric inpatient beds in hospitals in the United States is not adequate to meet the demand for institutional care. While there is no agreed-upon number for system adequacy, experts have recommended 40-60 psychiatric inpatient beds per 100,000 people.⁸⁰ According to a Pew Charitable Trusts study, the national average for states is 11.7 beds per 100,000.⁸¹ A 2015 study conducted by the National Association of State Mental Health Program Directors found that most states (35 of the 46 with available data) were experiencing shortages of psychiatric hospital beds.⁸² The psychiatric bed

⁷⁵ Jacqueline B. Helfgott, Matthew J. Hickman, and Andre P. Labossiere, “A Descriptive Evaluation of the Seattle Police Department’s Crisis Response Team Officer/Mental Health Professional Partnership Pilot Program,” *International Journal of Law and Psychiatry*, vol. 44 (2016), pp. 109-122.

⁷⁶ Emergency department (ED) care must be provided regardless of a patient’s ability to pay under the Emergency Medical Treatment and Labor Act (EMTALA) requirements. Thus, local EDs often become a safety net when other alternatives are unavailable. See David Bender, Nalini Pande, and Michael Ludwig, *A Literature Review: Psychiatric Boarding*, HHS, Assistant Secretary for Planning and Evaluation (ASPE), Office of Disability, Aging and Long-Term Care Policy, October 29, 2008, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/43101/PsyBdLR.pdf; and Wood and Watson, “Improving Police Interventions During Mental Health-Related Encounters.”

⁷⁷ One report described a practice referred to as *mercy booking*, in which law enforcement officers perceived detention in jail as the only available access point to psychiatric treatment, even when officers recognize that it would likely not serve the person in need as well as other services. See Lamb et al., “The Police and Mental Health,” pp. 1266-1271.

⁷⁸ Walid Fakhoury and Stefan Priebe, “Deinstitutionalization and Reinstitutionalization: Major Changes in the Provision of Mental Healthcare,” *Psychiatry*, vol. 6, no. 8 (August 2007), pp. 313-316.

⁷⁹ See, for example, National Association of State Mental Health Program Directors, *Beyond Beds: A Series of Working Papers, 2017-2021*, <https://nasmhpd.org/content/tac-assessment-papers>.

⁸⁰ California Hospital Association, *California’s Acute Psychiatric Bed Loss*, Sacramento, CA, February 2019, <https://calhospital.org/wp-content/uploads/2021/04/psychbeddata2017.pdf>; and The Pew Charitable Trusts, *Amid Shortage of Psychiatric Beds, Mentally Ill Face Long Waits for Treatment*, Stateline Article, August, 2, 2019, <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/02/amid-shortage-of-psychiatric-beds-mentally-ill-face-long-waits-for-treatment> (hereinafter, “Pew, *Amid Shortage of Psychiatric Beds, Mentally Ill Face Long Waits for Treatment*”).

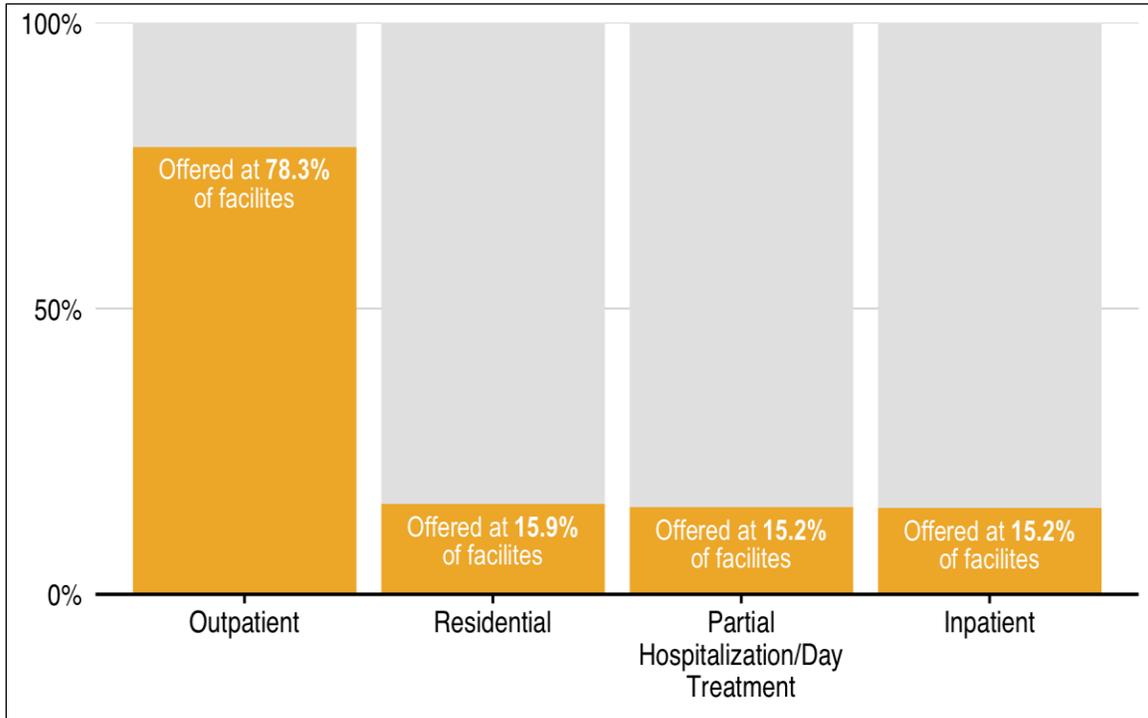
⁸¹ Pew, *Amid Shortage of Psychiatric Beds, Mentally Ill Face Long Waits for Treatment*. The Treatment Advocacy Center—a nonprofit advocacy organization—has estimated that the country needs an additional 123,300 state psychiatric beds to meet current demand. See Doris A. Fuller and Elizabeth Sinclair, Treatment Advocacy Center, *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds, 2016*,

⁸² Ted Lutterman, Robert Shaw, and William Fisher et al., *Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014*, National Association of State Mental Health Program Directors, Beyond Beds Assessment

shortage is due, in part, to a lack of mental health treatment facilities offering inpatient care. According to SAMHSA’s National Mental Health Services Survey (N-MHSS), approximately 15% of mental health treatment facilities offered inpatient care in 2018 (**Figure 2**).

Figure 2. Mental Health Service Settings in the United States, 2018

Percentage of Mental Health Treatment Facilities that Offer Certain Treatment Formats



Source: Substance Abuse and Mental Health Services Administration (SAMHSA), *National Mental Health Services Survey (N-MHSS): 2018, Data on Mental Health Treatment Facilities*, Rockville, MD, 2019, available at <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NMHSS-2018.pdf>

Notes: *Outpatient mental health facilities* provide only outpatient mental health services to ambulatory clients (i.e., <3 hours daily), *residential treatment centers* provide treatment in residential care settings, *partial hospitalization/day treatment facilities* provide partial day services to ambulatory clients (i.e., >3 hours daily), and *inpatient facilities* are hospitals that primarily provide 24-hour inpatient care to persons with mental illness. See the source cited above for more information.

Experts and other stakeholders debate whether to add more psychiatric beds to meet demand or enhance community-based care to reduce demand for psychiatric beds by preventing mental health crises.⁸³ While lawmakers have pursued both paths, current federal policies primarily support community-based outpatient care, with states responsible for most inpatient psychiatric care.⁸⁴ SAMHSA has noted that the core structural elements of an optimal crisis response system

#2, Alexandria, VA, August 2017, https://nasmhpd.org/sites/default/files/TACPaper.2.Psychiatric-Inpatient-Capacity_508C.pdf.

⁸³ See CRS In Focus IF10870, *Psychiatric Institutionalization and Deinstitutionalization*.

⁸⁴ For example, the Medicaid Institutions for Mental Disease (IMD) rule limits the use of Medicaid payment for psychiatric inpatient care in hospitals for much of the adult population; see CRS In Focus IF10222, *Medicaid’s Institutions for Mental Disease (IMD) Exclusion* for more information. Also, federal statute prohibits use of Mental Health Block Grant (MHBG) funds for inpatient services in any setting; see CRS Report R46426, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs* for more

include a regional call center, crisis mobile response teams, *and* crisis receiving and stabilization facilities with inpatient capacities or referral options.⁸⁵ Crisis response programs that train law enforcement officers to respond to people with mental health needs—or partner officers with a mental health provider—may only be as effective as the community mental health services available to individuals in need after crisis response triage occurs. The role of the federal government in psychiatric inpatient care remains up for debate: some believe more federal resources are necessary to promote adequate care while others believe this is the responsibility of the states, citing increased costs to the federal government, among other reasons.⁸⁶

Identifying Available Bedspace in Treatment Facilities

In addition to an inadequate number of beds, identifying available beds in mental health treatment facilities can also be a challenge. The mental health treatment system is largely a patchwork of independently operated public and private facilities that rely primarily on limited informal communication networks. Some states have begun to create psychiatric bed registries or bed tracking systems as tools for providers, patients, and caregivers to identify open hospital beds more efficiently.⁸⁷ In 2016, Section 9007 of the 21st Century Cures Act (P.L. 114-255) required the HHS Secretary to award competitive grants to states to, among other things, develop and maintain a database of beds at inpatient behavioral health treatment facilities. In 2019, SAMHSA announced a pilot initiative to help select states establish or expand psychiatric crisis bed registry programs.⁸⁸ A study by HHS’s Office of the Assistant Secretary for Planning and Evaluation found that while state bed registries experience significant challenges—such as the reluctance of hospitals to update information frequently enough to be useful—states report that the registries can be helpful in locating open beds and identifying the need for additional psychiatric beds.⁸⁹

Expanding Capacity for Mental Health Services

For law enforcement agencies to effectively divert certain people with mental health conditions from the criminal justice system, most jurisdictions would need to increase the capacity of their community mental health services. An effective crisis response system requires access to a spectrum of available services across a continuum of providers. Trained law enforcement officers may be able to effectively respond to certain situations involving persons experiencing a mental health crisis, but officers may be limited in their response without access to adequate follow-up

information. Other public policies also play a role, such as regulations related to implementation of the Supreme Court’s 1999 decision in *Olmstead v. L.C.*; see CRS In Focus IF10870, *Psychiatric Institutionalization and Deinstitutionalization* for more information.

⁸⁵ SAMHSA, *National Guidelines for Behavioral Health Crisis Care*, Best Practice Toolkit, Rockville, MD, 2020.

⁸⁶ See, for example, U.S. Government Accountability Office (GAO), *Medicaid: States Fund Services for Adults in Institutions for Mental Diseases Using a Variety of Strategies*, GAO-17-652, September 8, 2017, <https://www.gao.gov/products/gao-17-652>; Jennifer Mathis, “Medicaid’s Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate—Argument to Retain the IMD Rule,” *Psychiatric Services*, vol. 70, no. 1 (January 1, 2019), pp. 4-6; and Aaron Glickman and Dominic Sisti, “Medicaid’s Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate—Argument to Repeal the IMD Rule,” *Psychiatric Services*, vol. 70, no. 1 (January 1, 2019), pp. 7-10.

⁸⁷ Laurel Fuller, Tami Mark, and Shilpi Misra et al., *Inpatient Bed Tracking: State Responses to Need for Inpatient Care*, HHS, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Final Report, Washington, DC, August 2019, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//190716/IPBedTrack.pdf.

⁸⁸ SAMHSA, “Crisis Bed Registries to Assist People with Urgent Mental Health Needs,” press release, January 24, 2019, <https://www.samhsa.gov/newsroom/press-announcements/201901240130> (hereinafter, “SAMHSA, ‘Crisis Bed Registries to Assist People with Urgent Mental Health Needs’”).

⁸⁹ SAMHSA, “Crisis Bed Registries to Assist People with Urgent Mental Health Needs.”

care for those persons. Without mental health receiving facilities, individuals with further mental health needs are more likely to end up in emergency departments or jails. Increasing acute inpatient beds or establishing psychiatric crisis stabilization centers, for example, may improve outcomes for individuals in crisis, reduce the burden on health care or justice facilities, and reduce overall costs.⁹⁰

Mental health services have historically been the responsibility of states. The federal government, primarily through Medicaid and discretionary grants administered by HHS, provides financial support to states for mental health treatment. Both Medicaid and discretionary grant programs have limits on funding inpatient mental health care. For example, SAMHSA's Community Mental Health Services Block Grant (MHBG) is the largest federal grant provided to states for mental health services. Each state may distribute MHBG funds to provide community mental health services and has flexibility in the use of funds within the framework of a state plan and federal requirements. The authorization for MHBG prohibits the use of block grant funds "to provide inpatient services."⁹¹ Similarly, Medicaid, the single largest payer of mental health treatment services in the United States,⁹² has a long-standing policy that prohibits the federal government from providing federal Medicaid funds to states for services rendered to patients in health care facilities (of more than 16 beds) that primarily provide treatment for mental health disorders. Known as the *IMD exclusion*, this policy prevents the federal government from providing federal Medicaid funds to states for any service delivered to individuals aged 21 through 64 in an "institution for mental diseases (IMD)."⁹³ States can provide Medicaid coverage for services rendered in facilities that do not meet the definition of an IMD, such as facilities with 16 or fewer beds and facilities that are not primarily engaged in providing care to individuals with mental diseases.⁹⁴ Options to enhance mental health crisis response and treatment services could involve Congress amending the MHBG authorization or changing Medicaid rules to expand support for crisis response services and psychiatric inpatient care.⁹⁵ Tradeoffs to this approach, however, would include higher costs for inpatient care incurred by the federal government.⁹⁶

Congress has recently increased federal support for crisis response programs. For example, Congress included a set-aside for "evidence-based crisis systems" in the FY2021 and FY2022 annual appropriations for the MHBG.⁹⁷ Similarly, the American Rescue Plan Act of 2021 (ARPA,

⁹⁰ Wells and Schafer, "Officer Perceptions of Police Responses to Persons with a Mental Illness."

⁹¹ Public Health Service Act (PHSA) §1916 (42 U.S.C. §300x-5).

⁹² Medicaid.gov, Centers for Medicare and Medicaid Services, *Behavioral Health Services*, Baltimore, MD, <https://www.medicare.gov/medicaid/benefits/behavioral-health-services/index.html>.

⁹³ The term *institution for mental diseases* means a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services" (SSA §1905(i)).

⁹⁴ States may also request waivers to receive federal Medicaid funds for services provided to individuals who are patients in IMDs or make monthly payments to managed care organizations for enrollees aged 21 through 64 who are patients in an IMD under Medicaid managed care coverage. For more information, see CRS In Focus IF10222, *Medicaid's Institutions for Mental Disease (IMD) Exclusion*.

⁹⁵ Of note, the MHBG represents a small percentage of state spending on behavioral health activities. The MHBG funds an average of 1% of the expenses for state mental health agencies. See SAMHSA, *Funding and Characteristics of Single State Agencies*, 2017.

⁹⁶ See, for example, U.S. Government Accountability Office (GAO), *Medicaid: States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, GAO-17-652, August 2017, <https://www.gao.gov/assets/gao-17-652.pdf>.

⁹⁷ Rep. Rosa DeLauro, "Explanatory Statement Submitted by Ms. DeLauro, Chair of the House Committee on Appropriations, Regarding the House Amendment to the Senate Amendment to H.R. 2471, Consolidated Appropriations Act, 2022," Proceedings and Debates of the 117th Congress, Second Session, *Congressional Record*,

P.L. 117-2) provided flexibilities related to Medicaid coverage of community-based mobile crisis intervention services and appropriated \$15 million for these efforts.⁹⁸ Other options for Congress to enhance crisis response systems could include direct funding for these activities or further flexibilities for use of existing funds. Congress made use of both of these approaches when it appropriated \$340 million for emergency substance use or mental health needs in COVID-19 supplemental appropriations measures, for instance.⁹⁹ Some states are using ARPA funds to bolster the continuum of mental health services as well. Massachusetts, for example, used \$31 million of ARPA funds to support inpatient psychiatric acute facilities.¹⁰⁰

California's Psychiatric Health Facilities

To create receiving facilities for individuals experiencing a mental health crisis—other than jails or emergency departments—California established alternative nonhospital 24-hour acute treatment facilities beginning in the 1980s. This strategy was designed to meet the need for inpatient services while also controlling costs.¹⁰¹ California's *psychiatric health facilities* (PHFs) provide short-term mental health treatment to individuals in crisis or those with acute mental health needs. Similar to other short-term residential settings, psychiatric acute care facilities, or crisis stabilization units, PHFs provide short-term mental health treatment in less medically intensive, nonhospital settings.¹⁰² PHF services utilize an interdisciplinary team that includes psychiatry, clinical psychology, psychiatric nursing, and social work personnel who provide crisis services, medication management, psychotherapy and other counseling, rehabilitation, drug administration, and pharmacy and basic support services, among others.¹⁰³ Initial estimates suggested that PHFs were associated with reduced costs compared to emergency department or other acute hospital admissions.¹⁰⁴ As of 2021, California had over 20 PHFs in operation throughout the state.

Preventing Mental Illness and Mental Health Crises

Some experts have argued that an emphasis on psychiatric service expansion would be an insufficient way to address mental health crisis response, and would perpetuate an already inadequate “standard, reactive psychiatric consultation model.”¹⁰⁵ A more *upstream* approach to addressing mental health crises would invest in prevention interventions prior to the onset of a mental health condition. Some proponents of this model note that prevention efforts, and more targeted programming, are more efficient uses of finite criminal justice and mental health

vol. 168, part No. 42, Book IV (March 9, 2022), pp. H2477-H3215.

⁹⁸ For more information, see CRS Report R46777, *American Rescue Plan Act of 2021 (P.L. 117-2): Private Health Insurance, Medicaid, CHIP, and Medicare Provisions*.

⁹⁹ For more information, see CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

¹⁰⁰ National Academy for State Health Policy, *How States Are Spending American Rescue Plan Funds*, October 8, 2021, <https://www.nashp.org/how-states-are-spending-american-rescue-plan-state-fiscal-recovery-funds/>.

¹⁰¹ Sally Moltzen, Howard Gurevitz, and Maurice Rappaport et al., “The Psychiatric Health Facility: An Alternative for Acute Inpatient Treatment in Nonhospital Setting,” *Hospital and Community Psychiatry*, vol. 37, no. 11 (November 1986) (hereinafter, “Moltzen et al., ‘The Psychiatric Health Facility’”).

¹⁰² HHS, ASPE, Office of Disability, Aging, and Long-Term Care Policy, *Inpatient Bed Tracking: State Responses to Need for Inpatient Care*, Washington, DC, August 2019, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/190716/IPBedTrack.pdf.

¹⁰³ California State Department of Health Care Services, *Psychiatric Health Facilities*, May 4, 2021, <https://www.dhcs.ca.gov/psychiatric-health-facilities>.

¹⁰⁴ Moltzen et al., “The Psychiatric Health Facility.”

¹⁰⁵ Mara Laderman, Amrita Dasgupta, and Robin Henderson et al., “Tackling the Mental Health Crisis in Emergency Departments: Look Upstream for Solutions,” *Health Affairs Blog*, January 26, 2018, <https://www.healthaffairs.org/doi/10.1377/forefront.20180123.22248/full/>.

resources.¹⁰⁶ An upstream approach to preventing mental health crises could focus efforts on economic initiatives,¹⁰⁷ education and school-based programs,¹⁰⁸ interventions addressing social determinants of mental health,¹⁰⁹ community development,¹¹⁰ or medical care earlier in life (i.e., prenatal care, early childhood interventions).¹¹¹ Given the dearth of mental health providers, generating enough treatment services might not be feasible, suggesting an opportunity for investments in prevention.¹¹² Additionally, outcome research on law enforcement crisis response models is nascent. If future research suggests ineffectiveness, resources to address mental illness and mental health crises may be better used elsewhere.

Training for Law Enforcement Personnel

Jurisdictions that want to establish a specialized response for individuals experiencing a mental health crises face potential challenges with developing that capacity, including finding the time and resources necessary to provide initial and then ongoing training for selected officers. For example, the CIT model requires 40 hours of training for law enforcement officers to be certified. The core elements of the model state that 20%-25% of patrol officers be CIT-certified to fully implement a CIT program.¹¹³ For smaller law enforcement agencies, extended training sessions and continuing education can pose significant burdens. Data from the Bureau of Justice Statistics indicates that three-quarters of police departments in 2016 employed 24 or fewer officers and about half employed 9 or fewer officers.¹¹⁴ In addition to staffing challenges, the cost of travel, per diem, and training might not be easily accommodated given limited budgetary resources. The Council of State Governments Justice Center and International Association of Directors of Law Enforcement Standards and Training noted that “for law enforcement agencies, there is also a concern with how to meet minimum deployment needs while officers are in training and how to cover any associated overtime costs, particularly for specialized training courses.”¹¹⁵

¹⁰⁶ Jennifer D. Wood and Laura Beierschmitt, “Beyond Police Crisis Intervention: Moving ‘Upstream’ to Manage Cases and Places of Behavioral Health Vulnerability,” *Psychiatry*, vol. 37, no. 5 (September-October 2014), pp. 439-447.

¹⁰⁷ Anna Macintyre, Daniel Ferris, and Briana Concalves et al., “What has Economics Got to Do with It? The Impact of Socioeconomic Factors on Mental Health and the Case for Collective Action,” *Palgrave Communications*, vol. 4, article no. 10 (2018).

¹⁰⁸ Amanda Sanchez, Danielle Cornacchio, and Bridget Poznanski et al., “The Effectiveness of School-Based Mental Health Services for Elementary-Aged Children: A Meta-Analysis,” *Child & Adolescent Psychiatry*, vol. 57, no. 3 (March 2018), pp. 153-165.

¹⁰⁹ Deidre M. Anglin, Sandro Galea, and Peter Bachman, “Going Upstream to Advance Psychosis Prevention and Improve Public Health,” *JAMA Psychiatry*, vol. 77, no. 7 (April 1, 2020).

¹¹⁰ Laura Choi, *Moving Upstream to Promote Mental Health: The Role of Community Development*, Center for Behavioral Health Statistics and Quality, 2018, <https://www.frbsf.org/community-development/wp-content/uploads/sites/3/moving-upstream-choi-mental-health-and-community-development-cdir-13-1.pdf>.

¹¹¹ Celso Arango, Covadongo Diaz-Caneja, and Patrick McGorry et al., “Preventive Strategies for Mental Health,” *The Lancet Psychiatry*, vol. 5, no. 7 (July 2018), pp. 591-604.

¹¹² Corey L. M. Keyes, Satvinder S. Dhingra, and Eduardo J. Simoes, “Change in Level of Positive Mental Health as a Predictor of Future Risk of Mental Illness,” *American Journal of Public Health*, vol. 100, no. 12 (2010), pp. 2366-2371.

¹¹³ Randolph Dupont, Sam Cochran, and Sarah Pillsbury, *Crisis Intervention Team Core Elements*, University of Memphis, Memphis, TN, September 2007, p. 10, <http://cit.memphis.edu/CoreElements.pdf>.

¹¹⁴ Shelley S. Hyland and Elizabeth Davis, *Local Police Departments, 2016: Personnel*, DOJ, Office of Justice Programs, Bureau of Justice Statistics, NCJ 252835, Washington, DC, October 2019, p. 3.

¹¹⁵ Martha Plotkin and Talia Peckerman, *The Variability in Law Enforcement State Standards: A 42 State Survey on Mental Health and Crisis De-Escalation Training*, Council of State Governments Justice Center, New York, NY,

In addition to training law enforcement officers to provide specialized responses to people with mental illness, there is also a need to train civilian staff at 911 call centers to appropriately navigate mental health emergencies. Call center operators are frequently the first point of contact for people who are suffering a mental health crisis. The 911 system is decentralized, with over 5,000 call centers across the country, each with their own standards regarding training, how calls are handled, dispatch protocols, and data management and reporting systems.¹¹⁶ A “key insight” presented in a Pew study of call center capacity to handle mental health emergencies was that about two-thirds of respondents reported that their call center operators have not received any specialized mental health crisis training.¹¹⁷ Even though the findings of this study cannot be generalized to all call centers, due to a small sample size and low response rate, it does reveal some potentially important insights. Barriers to accessing training included high staff turnover, staffing shortfalls resulting from the amount of time that a call taker is unavailable while he or she is in training and lack of funding or staff for backfilling call center shifts, budgetary constraints preventing staff from going to training that requires travel, and lack of awareness that training is available.¹¹⁸ Given the lack of widespread specialized training in some jurisdictions, having access to mental health professionals who could assist call center operators with handling calls involving people with mental illness could be a valuable resource, though it may be prohibitively costly and cumbersome for some areas and centers, and lead to increased response times if additional mental health screening questions are added to 911 scripts.¹¹⁹ Federal agencies involved in the transition to the new three-digit 988 Suicide & Crisis Lifeline have expressed ambitions to situate that crisis hotline in the center of a robust crisis response system.¹²⁰ However, building such a system would require substantial effort and considerable resources, and few areas are currently well positioned to establish this network.

Supporting Co-Responder and Mobile Crisis Teams

While CIT is the most widely used model, anecdotal evidence suggests that more jurisdictions are adopting CRTs and MRTs in order to improve their response to people with mental illness. As discussed previously, CRTs and MCTs employ mental health professionals in some capacity, while CITs consist entirely of law enforcement officers, albeit specially trained officers. Policymakers might consider whether the federal government could support jurisdictions that want to start new or expand the capacity of existing CRTs or MCTs.

A key question might be whether funds under DOJ’s Justice and Mental Health Collaboration and JAG programs could be used to support CRTs and MCTs. The authorization for the Justice and Mental Health Collaboration program specifically authorizes funds to be used for CIT programs, though the authorization states that the “appropriate use” of funds also includes “law enforcement

January 2017, p. 7 (hereinafter, “Plotkin and Peckerman, 42 State Survey on Mental Health and Crisis De-Escalation Training”).

¹¹⁶ Pew Charitable Trusts, *New Research Suggests 911 Call Centers Lack Resources to Handle Behavioral Health Crises*, online issue brief, October 26, 2021, <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/10/new-research-suggests-911-call-centers-lack-resources-to-handle-behavioral-health-crises> (hereinafter, “Pew, 911 Call Centers Lack Resources”).

¹¹⁷ Pew noted that the results of the survey are not representative of call centers nationally (Pew sent their questionnaire to 233 call centers, only 37 responded), but it asserts that the results provide “key insights” into the mental health crisis system resources of 911 call centers. Pew, 911 Call Centers Lack Resources.

¹¹⁸ Pew, 911 Call Centers Lack Resources.

¹¹⁹ Jonathan Levinson, “Dying on hold: How new software is creating a logjam at Portland’s 911,” Oregon Public Broadcasting News, May 6, 2022, <https://www.opb.org/article/2022/05/06/portland-911-calls-hold-times-multnomah-county-emergency-response-system-issues/>.

¹²⁰ SAMHSA, *988 Appropriations Report*, Rockville, MD, December 2021.

diversion” (34 U.S.C. §10651(a)(4)(B)). The authorization for the program defines *diversion* as “the appropriate use of effective mental health treatment alternatives to juvenile justice or criminal justice system institutional placements for preliminarily qualified offenders” (34 U.S.C. §10651(a)(4)(A)). In addition, the authorization for the JAG program allows funds to be used for “mental health programs and related law enforcement and corrections programs, including behavioral programs and crisis intervention teams” (34 U.S.C. §10152(a)(1)(H)).

Congress might consider whether to amend the authorizations for the Justice and Mental Health Collaboration and JAG programs to make it explicit that funds under both programs can be used for CRTs and MCTs. However, some might question whether MCTs should be funded with grants from DOJ, which largely focus on law enforcement-based programs and responses. Supporters of MCTs argue that law enforcement does not need to be or should not be involved in responding to calls for service that involve people with mental health problems who are not engaging in violent behavior. There also might be a question about whether supporting MCTs through grants from DOJ, a prominent law enforcement agency, could harm their legitimacy in communities that want to separate responses to people with mental health problems from law enforcement. Policymakers might consider whether MCTs should be supported through grants from SAMHSA rather than DOJ.

Other questions regarding financial support for crisis response services surround the shared commitment between federal, state, and local governments and the private sector. If the responsibility for mental health emergency response shifts from law enforcement to health services, then it may be prudent to utilize the existing systems of health care financing—such as private health insurance and public programs like Medicaid and Medicare—rather than annual discretionary funding and competitive grants to fund such a system. A substantial share of behavioral health costs have historically been borne by states—an anomalous arrangement relative to other health conditions. Congress may consider options to incorporate payment for crisis response services into mainstream health care financing systems, and determine the appropriate balance between mandatory and discretionary funding streams.

Data Collection

Policymakers might consider whether there is a need for a requirement for DOJ to collect and report data on a broader range of contacts between law enforcement officers and people in mental health crises. DOJ currently collects data on some interactions between law enforcement officers and people experiencing mental health crises through its National Incident Based Reporting System (NIBRS) and its Use-of-Force Data Collection program, but the data collected through these systems are limited, and in the case of the Use-of-Force Data Collection program, the data are hampered by limited participation on the part of law enforcement agencies. More complete data (e.g., collecting data on the situation surrounding the contact between the police and a person in a mental health crisis and the outcome of that interaction) could aid federal, state, and local policymakers with decisions about how to respond to people with mental illness. For example, policymakers could examine whether people in mental health crises in cities with CRTs or MCTs are less likely to be arrested or injured while they are experiencing a mental health crisis.

A potential mandate for DOJ to collect and report data on a wider variety of law enforcement interactions with people experiencing mental health emergencies does not mean that state and local law enforcement agencies will participate in a data collection program absent an incentive, and even then, that the incentive would be enough to induce law enforcement agencies to submit

the required data.¹²¹ Potential incentives could include making participation a condition of accessing grant funds from DOJ, requiring states to collect and report data from their law enforcement agencies or face reduced funding under the JAG program, giving preferential consideration for competitive grants to law enforcement agencies who can demonstrate that they submit the required data, or awarding bonus allocations under the JAG program to states that participate in the data collection program.

Increasing the Capabilities of 911 Call Centers

A Pew study of 911 call centers suggested that these centers might require additional resources to increase their capacity to respond to mental health-related calls.¹²² Many of the call centers that responded to the survey reported that their operators did not have training on how to handle mental health-related calls and lacked access to mental health professionals to aid in handling these calls.

To address these issues, policymakers may consider whether to authorize funding for research on how to improve 911 response to mental health calls, and to identify options and best practices that could be shared with 911 centers.¹²³ Policymakers may choose to authorize funding that would support hiring of mental health professionals to handle mental health-related 911 calls or to assist 911 call takers with those calls. While Congress has established programs to fund certain positions (e.g., police, firefighters), traditionally it has not funded 911 positions (state and local governments typically fund these). Further, it does not typically fund positions in perpetuity. For example, for the Department of Homeland Security Staffing for Adequate Firefighter Emergency Response (SAFER) program, federal funding is limited to three years, with localities assuming a higher percentage of the salaries each year. Policymakers may consider supporting the development of and providing funding for training programs, including train-the-trainer programs and other training to assist 911 operators responding to mental health calls.¹²⁴

Call centers have also reported several logistical issues preventing effective response, such as inconsistencies in software used to manage 911 calls. These technological barriers prevent centers from collecting consistent data on the number of mental health-related calls they receive and the outcomes of these calls. Policymakers may consider authorizing funding to help upgrade local 911 systems to assist them in collecting data on the number of, responses to, and outcomes of mental health related calls. If Congress were to authorize a grant program to assist jurisdictions with data collection, policymakers may also consider the merits of requiring a federal agency to coordinate with industry stakeholders or lead a public-private effort to develop data collection standards for 911 call centers regarding mental health-related calls (and require any jurisdiction that receives funding to report data based on these standards). A challenge with this approach is that only 911 centers that have standardized software and receive grant funding would likely

¹²¹ For a more in-depth discussion of the issues involved with crafting incentives for law enforcement agencies to submit data on their activities to the federal government, see CRS Report R46443, *Programs to Collect Data on Law Enforcement Activities: Overview and Issues*.

¹²² Pew, 911 Call Centers Lack Resources.

¹²³ The National 911 Program office in the National Highway Traffic Safety Administration at the U.S. Department of Transportation used this approach to improve survivor rates for those experiencing heart attacks. Based on research from the National Academies, the National 911 Program office created “CPR Lifelinks”—a national initiative to train 911 call takers to help others administer CPR before professional help arrives.

¹²⁴ The National 911 Program Office lists several (non-governmental) organizations that provide training for 911 call takers including the 911 Training Institute, which offers training for managing calls from those experiencing a mental health crisis, available at <https://www.911training.net/>.

report, meaning that any collected data would be incomplete. Even if funding is not tied to implementing data collection standards, requiring a federal agency to encourage such standards, even as advisory guidance, might help promote more consistent data on mental health-related calls.

A final issue for consideration is coordination between 911 call centers and 988 calling services. Currently, the two systems are separate.¹²⁵ Industry stakeholders have encouraged greater planning, coordination, and shared protocols between 911 and 988 systems and have called for increased definition of roles, responsibilities, and procedures for managing and referring calls between the two systems.

Promoting Consistency in Law and Policies

States have a range of laws and policies regarding the training law enforcement officers receive on how to respond to people with mental illness.¹²⁶ States also have varying laws regarding what actions law enforcement officers can take when they encounter someone experiencing a mental health crisis, such as who can initiate a temporary hold so someone can be evaluated by a mental health professional or whether officers can issue a citation in lieu of an arrest, thereby diverting someone experiencing a mental health crisis from potential incarceration.¹²⁷

Policymakers might consider whether the federal government should take any steps to promote more consistency in these laws and policies among states. One possible step might be for Congress to require DOJ to publish recommended standards regarding the type and amount of academy and in-service training law enforcement officers should receive. Policymakers might consider whether to authorize a new grant program to help support efforts to provide more academy-based and in-service mental health training to law enforcement officers for state or local governments that agree to meet the requirements of the recommended training standards. Federal agencies such as DOJ and HHS could issue model laws that states could adopt to improve how people with mental illness interact with the criminal justice and mental health systems. Due to the federalized system of government in the United States, it is unlikely that Congress could directly require states to adopt any recommended changes to their laws or policies, so Congress might consider providing an incentive for states to do so.¹²⁸ Policymakers might also consider whether to make adoption of any proposed changes to policies regarding mental health training for law enforcement officers or actions law enforcement officers can take when they encounter a person with mental illness a condition of receiving federal funding.

¹²⁵ In some areas, the 911 and 988 systems may have formal relationships, but the infrastructure and routing systems remain separate.

¹²⁶ For an overview of mental health and de-escalation training provided to law enforcement officers, see Plotkin and Peckerman, 42 State Survey on Mental Health and Crisis De-Escalation Training.

¹²⁷ For an overview of state laws that might affect law enforcement officers' ability to respond to people experiencing a mental health crisis, see Lars Trautman and Jonathan Haggarty, *Statewide Policies Relating to Pre-Arrest Diversion and Crisis Response*, R Street Policy Study #187, November 2019. The R Street Institute is described as a "nonprofit, nonpartisan, public policy research organization that promotes center-right solutions to public policy problems." MacArthur Foundation, R Street Institute, <https://www.macfound.org/grantee/r-street-institute-10097751/>.

¹²⁸ For a review of federalism and congressional influence over state and local law enforcement policy, see CRS Report R43904, *Public Trust and Law Enforcement—A Discussion for Policymakers*.

Supporting Research on Crisis Response Models

There is a dearth of high-quality research on the effectiveness of MCTs and CRTs, and to some extent CITs (though studies on CITs are more numerous than studies on the other two approaches). Concerns about how law enforcement officers handle calls for service involving people with mental health problems have led many jurisdictions to consider alternatives to traditional law enforcement responses.¹²⁹ This might provide an opportunity for the federal government to support more research on MCTs and CRTs. Policymakers could consider authorizing a new grant program that would help jurisdictions either start MCTs or CRTs or expand them beyond the pilot stage with the condition that jurisdictions evaluate their programs and make the results available to the granting agency. Congress could also provide funding for evaluation research on MCTs and CRTs through the National Institute of Justice (NIJ) or the National Institutes of Health (NIH).

¹²⁹ David A. Graham, “The Stumbling Block to One of the Most Promising Police Reforms,” *The Atlantic*, February 22, 2022.

Appendix. Examples of Mobile Crisis Teams

Members of Congress who want to learn more about responses to people in a mental health crisis that do not involve law enforcement might be interested in which jurisdictions have MCTs. While there is no comprehensive accounting of cities that utilize MCTs, this appendix provides examples of cities that are using them on either a permanent or pilot basis.

Albuquerque, NM

In September 2021, Albuquerque launched the Albuquerque Community Safety Department (ACS) to respond to emergency nonmedical calls that are not believed to involve violence or the threat of violence.¹³⁰ Unlike some of the other pilot programs highlighted below, ACS is now a cabinet-level city department, acting as a third public safety agency alongside the Albuquerque police and fire departments.¹³¹ 911 dispatchers route calls for disturbances, issues involving mental health or homelessness, possible suicides, welfare checks, and other calls believed to be nonviolent and nonmedical to ACS.¹³² ACS responses to 911 calls for service are in lieu of a response from firefighters, EMTs, or law enforcement, preserving these first responders for other emergency calls.¹³³ ACS has several different types of responders. MCT clinicians are dispatched in joint responses with law enforcement and respond exclusively to ACS' 911 calls. Behavioral Health Responders (BHR) and Community Responders (CR) resemble traditional MCTs, and are dispatched in teams of two to respond to nonviolent 911 calls and tickets created by the city's nonemergency request line, 311.¹³⁴ Street Outreach and Resource Coordinators (SO) respond to 311 tickets, and do not respond to 911 dispatches. BHR, CR, and SO teams may also proactively aid individuals in need, resulting in a *self-dispatch*.¹³⁵ As of July 2022, the department has received nearly 14,000 calls for service from 911 dispatch, 311 tickets, and self-dispatch, and estimates that over 7,000 calls have been diverted from the Albuquerque Police Department to ACS. The majority of calls for service are taken by BHR teams, which are also the largest group of ACS responders.¹³⁶

Denver, CO

The Supported Team Assistance Response (STAR) Program is a collaborative effort between the Caring for Denver Foundation, Denver Police Department, WellPower (Mental Health Center of Denver), Denver Health Paramedic Division, Denver 911, and other organizations offering community supports and resources. 911 dispatchers redirect certain calls related to individuals

¹³⁰ Colleen Heild, "ABQ's Community Safety Department Launches Patrols," *Albuquerque Journal*, September 11, 2021.

¹³¹ City of Albuquerque, *Albuquerque Community Safety Department FY2022 Organizational Plan*, Albuquerque Community Safety Department, December 2021, p. 9 (hereinafter, "Albuquerque Community Safety Department FY2022 Organizational Plan").

¹³² "Albuquerque Community Safety Department FY2022 Organizational Plan," p. 24.

¹³³ City of Albuquerque Mayor Tim Keller, "Albuquerque Community Safety Responders Hit the Street," press release, October 13, 2021.

¹³⁴ 311 is a specialized phone number supported by many cities in the United States that provides access to nonemergency municipal services and is intended to divert calls from 911.

¹³⁵ "Albuquerque Community Safety Department FY2022 Organizational Plan," p. 17-23.

¹³⁶ City of Albuquerque, *Albuquerque Community Safety Monthly Informational Report: July 2022*, Albuquerque Community Safety Department.

experiencing problems with mental health, poverty, homelessness, and/or substance abuse issues to STAR.¹³⁷ A STAR mobile crisis response team (e.g., a social worker and paramedic) can provide medical assessment, crisis intervention, de-escalation, transportation, and connections to community resources.¹³⁸ STAR only responds to incidents in which there is no evidence of criminal activity or violence, weapons, threats, injuries, or serious medical needs. The STAR pilot program operated from June 1 to November 30, 2020. During the pilot phase, STAR operated one van staffed with a paramedic and a clinician that offered services from 10:00 a.m. to 6:00 p.m. on weekdays in high-demand neighborhoods. An evaluation of the STAR pilot found that the program reduced reports of less serious crimes in covered neighborhoods by 34% overall, and it found evidence of reduced crime levels outside of STAR operating hours.¹³⁹ Denver continued to operate STAR after the pilot phase and the program has secured additional funding to expand service. STAR currently operates from 6:00 a.m. to 10:00 p.m., and is in the process of trying to secure several new vans and expand service citywide.¹⁴⁰

Anchorage, AK

The municipality of Anchorage launched an MCT program in the summer of 2021. MCT teams comprised of a mental health clinician and a paramedic from the Anchorage Fire Department (AFD) respond to 911 or 311 calls involving a mental health crisis that are believed not to involve a weapon, an active suicide attempt, or any other threat of violence toward the patient or responders. The program is housed in AFD, and initially received calls exclusively through the fire department's dispatch center. Police dispatchers have since been trained on how to use and dispatch MCTs, increasing dispatch volume for the teams. 911 callers may request an MCT response, and dispatchers screen and connect appropriate requests. The MCT program currently operates from 10:00 a.m. to 8:00 p.m., seven days a week, and responds to calls citywide. However, in May 2022 the city assembly approved additional funding for the program with the intent to expand service to 24 hours a day.¹⁴¹

Olympia, WA

The Crisis Response Unit (CRU) in Olympia, WA, was started in 2019 as a unit within the Olympia Police Department and is staffed by six behavioral health specialists who work in pairs. The Olympia Police Department works with the Thurston County 911 Communications Center to identify calls where CRU might be an appropriate response. However, rather than dispatching

¹³⁷ STAR Program Evaluation; Li Cohen, "Health Care Workers Replaced Denver Cops in Handling Hundreds of Mental Health and Substance Abuse Cases—And Officials Say it Saved Lives," *CBS News*, February 6, 2021; David Sachs, "In the First Six Months of Health Care Professionals Replacing Police Officers, No One They Encountered was Arrested," *Denverite*, February 2, 2021.

¹³⁸ City of Denver, "Support Team Assisted Response (STAR) Program," <https://www.denvergov.org/Government/Agencies-Departments-Offices/Agencies-Departments-Offices-Directory/Public-Health-Environment/Community-Behavioral-Health/Behavioral-Health-Strategies/Support-Team-Assisted-Response-STAR-Program> (hereinafter, "Support Team Assisted Response (STAR) Program").

¹³⁹ Thomas S. Dee and Jaymes Pyne, "A community response approach to mental health and substance abuse crises reduced crime," *Science Advances*, vol. 8, no. 23 (June 8, 2022).

¹⁴⁰ "Support Team Assisted Response (STAR) Program."

¹⁴¹ Municipality of Anchorage, Anchorage Fire Department, "What is the Mobile Crisis Team (MCT)?," <https://www.muni.org/Departments/Fire/Pages/Mobile-Crisis-Team.aspx>; Tess Williams, "A new team of Anchorage first responders focuses on mental health crises. Officials say it frees up hospital beds and public safety resources," *Anchorage Daily News*, November 6, 2021; and Wesley Early, "Anchorage's Mobile Crisis Team hopes funding to operate 24/7 will expand ability to address mental health crises," *Alaska Public Media*, August 15, 2022.

CRU directly to calls based on certain criteria, the 911 call center shares all potentially eligible calls over the police radio frequency and CRU decides whether to respond. Alternatively, police officers can refer the call to CRU if they determine that a non-law enforcement based response would be better and the threat to first responders is minimal. CRU also provides a secondary response at the request of the first responding police officer. As CRU has become more established, some callers have started asking for CRU to respond. In addition to responding to calls for service, CRU also does proactive outreach to develop trust with the community, such as having a presence at the city-sanctioned encampment for people who are homeless.¹⁴² With increased funding, Olympia expanded CRU operations to 24 hours a day, seven days a week. As of 2021, the program was working on hiring additional crisis response specialists and medical staff.¹⁴³

Stockton, CA

In July 2022, the Stockton City Council approved the pilot of the Care Link Response Program. The program is to create a behavioral health first responder system to divert mental health crises calls to 911 that are believed to be nonviolent from the city's police and fire departments. Created by a partnership between the city and a local nonprofit, Community Medical Centers, the pilot program is to begin in late 2022 with one team, comprised of a licensed mental health clinician, an outreach worker, and a case manager. Programs goals include decreasing recidivism, decreasing repeat callers on emergency lines, increasing community trust, decreasing costs related to emergency calls, decreasing fears of calling the police, and diverting people from the criminal justice system.¹⁴⁴

Austin, TX

The Expanded Mobile Crisis Outreach Team (EMCOT) in Austin, TX, is staffed with mental health providers from Integral Health, the mental health authority for Travis County (the county in which Austin is located). EMCOT started in 2013 and EMTs and law enforcement agencies in Travis County can request EMCOT assistance with calls through the county's 911 call center. EMCOT connects people with treatment appropriate for psychiatric crises with the intent of diverting people from emergency rooms or jail.¹⁴⁵ The city increased the budget for EMCOT in 2020 with the intention of increasing staffing, thereby allowing all mental health-related 911 calls that do not involve a threat to public safety to be diverted to EMCOT. (EMCOT is not involved in cases where there is evidence that a crime has been committed, a weapon is present, someone is in need of medical assistance due to use of drugs or alcohol, someone is at risk of hurting themselves or someone else, or someone's life or property are under threat.) Law enforcement officers still have to be involved in some mental health calls because under Texas law only law enforcement officers can initiate an involuntary commitment of someone at risk of harming

¹⁴² Jackson Beck, Melissa Reuland, and Leah Pope, *Case Study: CRU and Familiar Faces*, Vera Institute of Justice, November 2020, <https://www.vera.org/behavioral-health-crisis-alternatives/cru-and-familiar-faces>.

¹⁴³ Elizabeth Fleming, "Staffing Community Responder Programs: Q&A with the Olympia (WA) Crisis Response Unit," The Council of State Governments Justice Center, October 7, 2021, <https://csgjusticecenter.org/2021/10/07/staffing-community-responder-programs-qa-with-the-olympia-wa-crisis-response-unit/>.

¹⁴⁴ Gabriel Porras, "Stockton City Council approves pilot program to send crisis intervention team to some police calls," *ABC 10 News (Stockton)*, July 28, 2022.

¹⁴⁵ Jennifer Kendall, "Crisis Counselors Responding to More Mental Health Calls in Austin," *Fox 7 (Austin) News*, November 2, 2020.

himself/herself or others.¹⁴⁶ The increased funding allowed for EMCOT mental health clinicians to be added to local 911 call centers. All callers now have the option to choose from police, fire, EMS, or mental health services when they begin a 911 call. If callers request mental health services, the 911 call taker screens the call to try to ensure that police, EMS, or fire department responses are not needed, and then transfers the caller to an onsite health clinician for additional screening.¹⁴⁷ EMCOT services are currently available 24 hours a day, seven days a week.¹⁴⁸

New York, NY

New York City piloted an MCT program in three police precincts in Harlem starting in February 2021.¹⁴⁹ The program, called the Behavioral Health Emergency Assistance Response Division (B-HEARD), has since been expanded to include additional areas of Harlem, Washington Heights, Inwood, and parts of the South Bronx, with plans to expand to central Brooklyn and eastern Queens in New York City’s FY2023. Under the program, teams comprised of two paramedics from the fire department’s Emergency Medical Services and one mental health professional from NYC Health + Hospitals respond to mental health emergencies. Teams respond to 911 calls involving a range of behavioral health issues, such as suicide attempts, substance use, and serious mental illness. However, if the subject is known to be armed or presents a danger, a police officer responds with or in place of the B-HEARD team. B-HEARD operates 16 hours a day, seven days a week.¹⁵⁰ Between January 1, 2022, and March 31, 2022, approximately 2,400 mental health calls to 911 were diverted to B-HEARD. Of those calls, 23% were routed to B-HEARD teams, and B-HEARD responded to 68% of calls routed to them. Of the calls routed to B-HEARD that B-HEARD was not able to respond to, it was typically because the B-HEARD teams were responding to another call or otherwise unavailable. Although most mental health calls in the B-HEARD operating area still receive a law enforcement response, of the calls that B-HEARD teams responded to, assisted individuals were more likely to accept help and less likely to be transported to a hospital than individuals assisted by traditional first responders.¹⁵¹

Portland, OR

Portland Street Response (PSR) launched in February 2021 as a pilot program that dispatches a paramedic, a mental health clinician, and, if necessary, one or more community health workers to

¹⁴⁶ Ryan Thorton, “Integral Care Set to Address Most Mental Health Emergency Calls Without Involving APD,” *Austin Chronicle*, August 18, 2020; and Integral Care, *Expanded Mobile Crisis Outreach Team*, <https://www.austintexas.gov/edims/document.cfm?id=302634>.

¹⁴⁷ Amanda Ruiz, “Austin 911 adds fourth option for mental health services,” *Fox 7 (Austin) News*, February 10, 2021; and The Council of State Governments Justice Center, “Integral Care’s Expanded Mobile Crisis Outreach Team – Austin, TX,” <https://integralcare.org/program/mobile-crisis-outreach-team-mcot/>.

¹⁴⁸ Integral Care, “Mobile Crisis Outreach Team (MCOT),” <https://integralcare.org/program/mobile-crisis-outreach-team-mcot/>

¹⁴⁹ Associated Press, “Mental Health Workers to Take the Lead in Some NYC 911 Calls,” November 10, 2020; City of New York, “New York City Announces New Mental Health Teams to Respond to Mental Health Crises,” press release, November 10, 2020; and Lauren Cook, Nicole Johnson, and the Associated Press, “Social Workers, EMS—Not NYPD—to Respond to Non-Violent Mental Health Calls Citywide,” *Pix 11 (New York) News*, updated April 30, 2021.

¹⁵⁰ New York City Mayor’s Office of Community Mental Health, “Re-Imagining New York City’s Mental Health Emergency Response: FAQ,” <https://mentalhealth.cityofnewyork.us/b-heard>.

¹⁵¹ New York City Mayor’s Office of Community Mental Health, *B-HEARD: Transforming NYC’s Response to Mental Health Emergencies, January-March 2022 (FY22 Q3)*, <https://mentalhealth.cityofnewyork.us/wp-content/uploads/2022/06/FINAL-DATA-BRIEF-B-HEARD-FY22-Q3.pdf>.

911 calls involving people who are homeless or have serious mental health issues. The paramedic and mental health clinician are dispatched first for mental health calls or when a wellness check is needed. Community health workers are dispatched if the individual expresses need for additional services such as shelter or housing.¹⁵² PSR is dispatched only if the individual in crisis is believed to be in a publicly accessible space, not obstructing traffic, is nonviolent, does not have a weapon, and is not suicidal. PSR is coordinated through Portland Fire and Rescue because the program needs a connection to the current 911 system. Portland Fire and Rescue's Community Health Division focuses on preventive healthcare intervention, and the arrangement aligns with the intent to keep the program separate from the police department. The program was expanded citywide in March 2022. PRS currently operates 10 to 14 hours a day, seven days a week, but hopes by fall of 2022 to operate 24 hours a day with a staff of 58 full-time employees.¹⁵³ An evaluation of the first year of the PSR pilot found that the calls responded to by PSR represented a 4% reduction in total calls that police would have traditionally responded to in the PSR operating area and service hours, despite PSR operating with a single team for two-thirds of the first year. The reduction in nonemergency calls was larger, representing a 27% decline in police responses to nonemergency welfare checks and unwanted persons calls,¹⁵⁴ and a 12.4% decline in fire department responses to behavioral health and illegal burn calls.¹⁵⁵

San Francisco, CA

San Francisco launched its Street Crisis Response Team (SCRT) as a pilot program in November 2020.¹⁵⁶ The program is a joint effort between the San Francisco Fire Department and the San Francisco Department of Public Health, in collaboration with the Department of Emergency Management. SCRT started by exclusively serving the Tenderloin neighborhood, but it became a citywide 24-hour, seven days a week service by July 2021. Five teams are assigned to each respond to a specific neighborhood, and two teams provide overnight coverage and dispatch citywide as needed. SCRT teams are dispatched to 911 calls involving “mentally disturbed persons” experiencing behavioral health crises that are believed not to involve weapons or violence. Each team is staffed with a community paramedic, a behavioral health clinician, and a peer specialist. Teams are supported by the newly created Office of Coordinated Care, which staffs a special team of care coordinators that follows up with all SCRT contacts within 24 hours to help ensure connections to mental health care and substance use services.¹⁵⁷ In June 2022, Phase 2 of the SCRT program began with transitioning from police dispatch to Emergency Medical Dispatch. This change further separates behavioral health crisis response from law enforcement, allows an EMS rather than a police response if SCRT is unable to respond to a call,

¹⁵² Nicole Hayden, “Portland Street Response Launches, Pairing Medics with Clinicians on Mental Health Calls,” *The Oregonian*, February 17, 2021.

¹⁵³ City of Portland, “Portland Street Response Frequently Asked Questions,” <https://www.portland.gov/streetresponse/psr-faq>; and KATU 2 (Portland) News, “Portland Street Response sees surge in call volume with citywide expansion,” June 22, 2022.

¹⁵⁴ An unwanted persons call involves an individual refusing to leave a location when asked. City of Portland, “Police Dispatched Calls Dashboard,” <https://www.portland.gov/police/open-data/police-dispatched-calls>.

¹⁵⁵ Greg Townley and Emily Leickly, *Portland Street Response: Year One Evaluation*, Portland State University, April 2022.

¹⁵⁶ City of San Francisco, Mayor's Office, “Mayor London Breed Announces Plan to Create Street Wellness Response Team To Expand Services For Those In Need,” press release, May 10, 2021.

¹⁵⁷ Harder+Company Community Research, *Street Crisis Response Team Pilot: Final Report*, May 2022.

and expands the range of calls for SCRT response. As of July 2022, SCRT has responded to 11,324 calls, with 5,508 client engagements on-scene.¹⁵⁸

Minneapolis, MN

In December 2021, the City of Minneapolis launched the Behavioral Crisis Response (BCR) program to divert mental health crisis calls from law enforcement. The city contracted with Canopy Roots, a local private mental health services organization, to staff the BCR teams. Teams of mental health practitioners respond to mental health crisis calls to 911 in which there are believed to be no firearms involved and the person in need appears nonviolent. Two teams are available to respond citywide, 24 hours a day, Monday through Friday. If both BCR units are unavailable, then 911 dispatch sends a traditional police response to the mental health crisis call.¹⁵⁹ In the first six months of operation, BCR diverted an estimated 1,400 calls from the Minneapolis Police Department.¹⁶⁰

Chicago, IL

The City of Chicago first launched its Crisis Assistance Response and Engagement (CARE) Program in September 2021 as a co-responder program with a Chicago Fire Department community paramedic, a Chicago Department of Public Health (CDPH) mental health practitioner, and a Chicago Police Department CIT officer on each team. CARE teams receive and respond to mental health crisis calls placed to 911 that are believed to be nonviolent. In May 2022, Mayor Lori E. Lightfoot announced that, with the approval of a new 911 routing and response protocol by the Illinois Department of Public Health, CARE teams of paramedics and mental health clinicians can respond to nonviolent mental health calls without involving police officers. As part of the CARE initiative, mental health professionals from CDPH are embedded in the 911 emergency communications center to provide support and mental health consultation to dispatchers. CARE teams operate in the Lakeview, Uptown, Auburn Gresham, Chatham, Chicago Lawn, Gage Park, West Elsdon, and West Lawn neighborhoods between 10:30 a.m. and 4:00 p.m., Monday through Friday.¹⁶¹

Baltimore, MD

In partnership with Baltimore Crisis Response, Inc. (BCRI), the City of Baltimore launched the Behavioral Health 9-1-1 Diversion Pilot Program in June 2021. The program diverts certain behavioral health related calls to 911 to the Here2Help hotline operated by BCRI. The mental health professionals staffing the BCRI line either resolve calls over the phone or dispatch a team of mental health clinicians to respond. MCTs are available 24 hours a day, seven days a week. The city collects data on 911 calls and mental health related diversions and displays it on a

¹⁵⁸ City and County of San Francisco, *Street Crisis Response Team (SCRT): July 2022 Update*.

¹⁵⁹ City of Minneapolis, “Behavioral crisis response,” <https://www.minneapolismn.gov/resident-services/public-safety/unarmed-public-safety/behavioral-crisis-response>; and City of Minneapolis, “Behavioral health crisis,” <https://www.minneapolismn.gov/report-an-issue/behavioral-health-crisis>.

¹⁶⁰ CBS News Minnesota “Behavioral Crisis Response Team Diverted 1,400 Calls from MPD In The Last 3 Months,” *CBS News*, May 4, 2022.

¹⁶¹ City of Chicago, Office of the Mayor, “Mayor Lightfoot and the City of Chicago Announce Expansion of 911 Alternate Crisis Response and Engagement Program,” press release, May 26, 2022; Chip Mitchell, “A glimpse inside mental health crisis response teams as Chicago creates versions without cops,” *WBEZ Chicago*, April 6, 2022

frequently updated, interactive dashboard.¹⁶² Currently, the program is only able to provide mobile crisis response for adults; however, the city has announced an upcoming expansion that will create youth-focused MCTs. The expansion is also expected to place mental health clinicians in the 911 call center to assist dispatchers with de-escalation and screening.¹⁶³

Washington, DC

In May 2021, Mayor Muriel Bowser announced the pilot launch of a Mental Health Emergency Dispatch Program in Washington, DC. The program is a partnership between the Office of the Deputy Mayor for Public Safety and Justice, the Office of the Deputy Mayor for Health and Human Services, the Office of the City Administrator, the Office of Unified Communications, and the Department of Behavioral Health (DBH). The pilot builds on city resources by dispatching existing Community Response Teams from DBH to mental health crisis calls received by 911 that are not believed to involve drug use, alcohol use, or any perceived threat to patient or responder safety.¹⁶⁴ The mental health response program also complements the city's existing Right Care, Right Now program, which triages nonemergency medical calls received by 911 to registered nurses who advise on treatment options or dispatch resources.¹⁶⁵ In November 2021, the city announced additional pilot phases of the Mental Health Emergency Dispatch Program. The second and third pilot phases aim to increase the number of available responders, increase service hours from 12 hours a day to 24 hours a day, and allow teams to respond to a wider range of calls, including those involving substance use. In phase one of the pilot, teams responded to an estimated 2% of all behavioral health calls placed to 911. By phase three, the program hopes to respond to one-third of all behavioral health calls.¹⁶⁶

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¹⁶² City of Baltimore, Mayor's Office, "Behavioral Health 9-1-1 Diversion," <https://mayor.baltimorecity.gov/behavioral-health-and-consent-decree/9-1-1-diversion>.

¹⁶³ Kevin Kinally, "Baltimore City Expanding Behavioral Health 9-1-1 Diversion Program," *Conduit Street*, July 1, 2022.

¹⁶⁴ Rachel Weiner, "D.C. to divert some mental health calls away from police," *The Washington Post*, May 17, 2021; City of Washington, DC, Office of Unified Communications (OUC), "DBH and OUC Mental Health Emergency Dispatch Program," <https://ouc.dc.gov/page/dbh-and-ouc-mental-health-emergency-dispatch-program>; and Sarah Holder, "D.C. Extends Program Diverting Mental Health Calls From Police," *Bloomberg CityLab*, November 12, 2021, (hereinafter, "Holder, 'D.C. Extends Program Diverting Mental Health Calls From Police'").

¹⁶⁵ City of Washington, DC, Fire and EMS Department, "Frequently Asked Questions Right Care, Right Now," <https://fems.dc.gov/page/frequently-asked-questions-right-care-right-now>.

¹⁶⁶ Holder, "D.C. Extends Program Diverting Mental Health Calls From Police."

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