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REDESIGNING PUBLIC SAFETY

Mental Health Emergency Response

Authors

Charlotte Resing, J.D.
Center for Policing Equity

Scarlet Neath, M.P.P.
Center for Policing Equity

Hilary Rau, J.D.
Center for Policing Equity

Andrew Eslich, M.Phil.
Center for Policing Equity

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Introduction

It is estimated that 7% to 10%[1] of all police encounters involve a person who has mental illness.* Most of these encounters do not involve any violence, and some don't involve a crime at all.[2] People with mental illness are no more likely than anyone else to act violently.[3] Despite this, police arrest,[4] injure,[5] and kill[6] people with mental illness at higher rates than people without mental illness. And because of systemic inequities in health care access as well as rates of police contact, Black and Brown people—as well as LGBTQ+ people, young people, and those living in poverty—are particularly at risk of these harms when living with mental illness. People experiencing mental health emergencies are less safe when law enforcement are the primary responders. A public safety approach to mental health emergencies requires creating accessible and equitable systems to accommodate the needs of people who experience them, without unnecessary criminalization, institutionalization, or violence.

Law enforcement officers are often the default responders to mental health emergencies—or situations in which a person's safety and health or the safety and health of others—are at immediate risk due to their mental health symptoms. This has been the case since the 1960s, when government policies significantly scaled back the use of state mental health institutions and mental health hospitalization for outpatient treatment.[7] This was followed by a successful effort by President Ronald Reagan to repeal most of a bill that would have funded community-based mental health services,[8] along with an expansion of incarceration and policing of low-level offenses.[9] Today approximately 14.2 million adults live with a serious mental illness.[10] In 2020, only 64.5% of those people received treatment,[11] a failure driven by barriers to treatment such as insurers denying care, high out-of-pocket costs, lack of access to psychiatric medications, and mental health providers not being adequately reimbursed by insurance companies.[12]

The shift to a law enforcement response for mental health emergencies means that officers are now responsible for responding to situations they are not equipped to handle appropriately. When a person experiences a mental health emergency, their loved ones or bystanders may have no option other than to call 911 for help, at which point a dispatcher then makes a decision of whether to send police, EMT, or both. Officers are not trained or qualified to identify a mental health crisis; it can be difficult to distinguish symptoms of a mental health emergency from symptoms of other health crises such as drug overdose, hypoglycemic shock, or epileptic seizure, which require distinct kinds of care.[13] This insufficient and inappropriate system for handling mental health emergencies is worsened by stigma surrounding mental illness,[14] barriers to treatment, lack of culturally competent care, and the mental health impact of racism.[15] As a result of these and other factors, including lack of treatment, housing, and other social services, people who experience mental health emergencies are routinely arrested.[16]

SINCE 2015, 21% OF PEOPLE KILLED BY THE POLICE IN THE UNITED STATES HAD A KNOWN MENTAL ILLNESS

The routine criminalization of people with mental illness by police has serious consequences. Nearly 37% of people in state and federal prisons, and 44% of people in local jails, have been diagnosed with mental illness.[17] In most states, police have the power not only to arrest people with mental illness but also to institutionalize people against their will.[18] This can lead to people being subjected to inappropriate institutionalization: In 2016, a study in Alameda County, California, found that at least 75% of people who were subjected to an involuntary emergency psychiatric hold did not meet the medical criteria for such a response.[19] Local governments' reliance on police to respond to calls related to mental health issues—which includes emergencies as well as common public disturbance issues—can unnecessarily escalate a situation that wasn't dangerous. Sending police to respond to mental health crises, or simply behavior that falls out of societal norms, can lead to preventable arrest, use of force, institutionalization, injury, or death:[20] Since 2015, 21% of people killed by the police in the United States had a known mental illness.[21]

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* This paper lays out recommendations for policymakers and communities on how to improve responses to mental health emergencies. Many of these recommendations could improve emergency responses for people with intellectual or developmental disabilities, but additional and different responses may be necessary.

Systemic inequities make Black people more at risk of police violence in mental health emergency response. Because of racial disparities in rates of police contact,[22] Black people, including those with mental illness, are more likely to interact with police. Additionally, nearly two out of every three Black people who need mental health care services do not receive them.[23] Because of inequitable mental health care access and quality, Black people may be more likely to experience mental health emergencies that are handled with a police response.[24] These inequities are compounded by the toll of police interactions themselves and societal racism, both of which have been shown to adversely impact mental health.[25]

All people who experience—or are at risk of experiencing—mental health emergencies deserve appropriate, accessible, and high-quality mental health diagnoses, treatment, and services. They deserve to be treated equitably, with dignity and compassion, in the least coercive and intrusive manner possible, and without having to fear violence or criminalization for seeking help or for exhibiting behavior that falls outside of social norms.

The recommendations in this report guide communities and policymakers on how to achieve this vision of mental health emergency response and prevention. They acknowledge and aim to remedy the deep racism in the criminal legal system, mental health care systems, and social services that has made Black people who experience mental health emergencies more likely to be arrested, harmed by police, jailed, and denied access to appropriate health care. They also recognize the pervasive racism, sexism, and ableism that contribute to police and broader society perceiving certain behaviors as "disruptive" or threatening.[26] They are grounded in the reality that police and criminal legal systems were not designed to—and should not—handle mental health emergencies.

Invest in Alternative Response Programs

People who experience mental health emergencies deserve a nonviolent and non-carceral response that provides treatment and services. Because police often incorrectly view people with mental illness as especially dangerous, the armed law enforcement response to mental health emergencies makes the situation more dangerous for the people they are responding to than for officers.[27] Research also shows that officers are often not equipped with the knowledge or resources to determine the services someone needs, which prevents people experiencing mental health emergencies from receiving appropriate care that may prevent future crises.[28] Relying on a law enforcement response to mental health emergencies instead of equipping public health systems to effectively meet the needs of people living with mental health issues perpetuates the issues that drive police contact.

Police should not be the default responders to mental health calls that do not involve any threat of violence to first responders or others. Instead, communities should develop alternative responses to increase public safety and reduce contact with the police that leads to the disproportionate harm faced by people with mental illness.[29]

Several communities have demonstrated the effectiveness of investing in unarmed, alternative response programs that aim to better support the health and well-being of people experiencing mental health emergencies. Many of these programs respond to people experiencing either mental health or substance use emergencies in light of the fact that an estimated 40% of adults with serious mental illness also have a substance use disorder.[30] *

POLICE SHOULD NOT BE THE DEFAULT RESPONDERS TO MENTAL HEALTH CALLS THAT DO NOT INVOLVE ANY THREAT OF VIOLENCE

* A forthcoming report in this series will provide specific recommendations on responding to substance use emergencies.

These community-based first response models, such as CAHOOTS (Eugene, Oregon), STAR (Denver), B-HEARD (New York City), and Portland Street Response (Portland), have generated early evidence showing that unarmed crisis services can effectively divert people experiencing mental health emergencies away from arrest and hospitalization, decrease the repeated use of crisis services, and improve the health of people who need emergency mental health care.[31] The following strategies can help communities expand or launch their own alternative response programs.

1. **Invest in and study community-based mental health first response models.**

Community-based crisis response programs* aim to transform mental health emergency response. These programs provide an alternative to police response for people experiencing mental health emergencies and can offer services, medication, and basic necessities that a typical police response does not provide. Several U.S. cities have established community-based crisis response teams to meet the needs of people in their communities.[32]

Examples of community-based crisis response teams nationwide

- Rapid Integrated Group Healthcare Team (RIGHT CARE) in Dallas

- Street Crisis Response Teams (SCRT) in San Francisco

- Holistic Assistance Response Teams (HART) in Houston

- Policing Alternatives & Diversion Initiative (PAD) in Atlanta

- Psychiatric Mobile Response Teams in Los Angeles

- Person in Crisis Team in Rochester, NY

- Baltimore Crisis Response, Inc. (BCRI) in Baltimore

- Crisis Response Network (CRN) in Phoenix

- Mobile Crisis Team in Cuyahoga County, OH

Early evidence on community response teams is very promising. Individual crisis teams have been associated with fewer hospital admissions and reduced incarceration of people experiencing mental health emergencies.[33] They have also been shown to reduce unnecessary police contact and rarely require police engagement related to safety concerns.[34] A recent study on Denver's STAR program estimated that in a six-month period, the program prevented nearly 1,400 criminal offenses. The study concluded that the program reduced the number of instances when mental health emergencies were classified as low-level crimes. It also found that STAR led to an overall reduction in such offenses, even during the program's off-hours, suggesting that connecting people to services had an effect on recidivism.[35]

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* These are also referred to as mobile crisis units, emergency response teams, and other names.

While each program differs to best address the needs and constraints of their communities, crisis teams share many basic features. The programs are typically staffed by non-sworn community members (sometimes in street clothes) who have mental health, physical health, or crisis response training, or who have personally experienced one or many of the crises frequently faced by the clients they serve.[36] Crisis teams respond to certain categories of mental health emergencies, service needs, or victimless crimes.[37] They provide a variety of services that police do not frequently have the resources or mandate to provide. Depending on the jurisdiction, crisis teams can offer de-escalation; medication and first aid; peer support; crisis care; basic living necessities such as food, water, and clothing; and referral to any number of services and supports. Calls to these programs either come through their direct lines, if available, or are diverted to the team by dispatchers of 911, 988 (the new national suicide and crisis hotline), or nonemergency lines such as 311.[38]

To maximize effectiveness, crisis response systems should be available 24 hours a day, seven days a week. These response systems should be able to receive calls redirected from 911, 988, and nonemergency lines, as well as calls from a direct number that does not have to be dispatched through traditional lines (for more on how dispatch systems can redirect these calls, see page 8).

CRISIS RESPONSE SYSTEMS SHOULD BE AVAILABLE 24 HOURS A DAY, SEVEN DAYS A WEEK

Successfully designing, funding, and maintaining crisis response systems requires active partnerships among many stakeholders. This includes local municipal leaders; community members; mental health and substance use service providers; emergency services, including police; and dispatch centers. When designing these programs, stakeholders should actively consult people who would currently be served by this programming and those with lived experience of police contact.

Funding a crisis response team is often a challenge. Jurisdictions have successfully funded their programs (described below as case studies) using a variety of approaches. Denver's STAR program, for example, is funded by a ballot initiative passed in 2018 that increased sales tax to generate funding for mental health and substance use response.[39] Eugene's CAHOOTS, like many other crisis teams, is funded primarily out of the city's budget.[40] City officials view it as an overall savings since it would cost an additional $6.4 million to have the police department respond to the calls CAHOOTS currently covers.[41] Other jurisdictions have used multiple funding streams including Medicaid funding,[42] private funding, money reallocated from local police departments, and American Rescue Plan funding, as well as state grants and Center for Disease Control and Prevention money.[43] In addition to operating individual programs, policymakers should dedicate funding to evaluate the successes and failures of new crisis services across the country and in individual communities.

TO HAVE THE POLICE DEPARTMENT RESPOND TO THE CALLS CAHOOTS CURRENTLY COVERS, IT WOULD COST AN ADDITIONAL

$6.4M

- **Eugene, Oregon: Crisis Assistance Helping Out On The Streets (CAHOOTS)**
  CAHOOTS is a mobile crisis intervention program in Eugene, Oregon, staffed by employees from a local clinic.[44] The program, which has operated for more than 30 years, responded to 16,479 calls for service in 2021, and on average diverts 3% to 8% of calls that would have otherwise been handled by police.[45] The majority of CAHOOTS responses serve people with housing instability.[46] CAHOOTS dispatches teams of medical professionals and crisis workers when called, and can provide crisis intervention, basic medical care, and mediation, as well as referral and transportation to social services.[47] CAHOOTS responders can be dispatched through Eugene's 911 call center, either alone or with police. The program's responders can also be called in by police or emergency medical personnel if it is determined that CAHOOTS would provide better services for the situation.[48]

- **New York City: Behavioral Health Emergency Assistance Response Division (B-HEARD)**
  B-HEARD is New York City's pilot for mental health crisis response. The ongoing pilot, which began in spring 2021, sends teams of mental health professionals and medical personnel to respond to mental health and substance use calls that do not pose an imminent risk of harm.[49] The medical personnel on the team can include emergency medical technicians (EMT) or paramedics. The program is dispatched by 911 operators and the pilot was initially limited to parts of Harlem; it has since expanded to Manhattan's West Harlem, Washington Heights, and Inwood communities; the South Bronx; and Brooklyn's East New York and Brownsville neighborhoods.[50] The dispatched teams can conduct physical and mental health assessments, connect community members with providers, provide crisis counseling, and refer community members to follow-up services.[51] During its first six months, B-HEARD operated 16 hours a day, seven days a week, and responded to approximately 17 mental health calls per day in the pilot area.[52] B-HEARD transported about half as many people to a hospital compared to a typical police response, instead offering on-site care and, when needed, transportation to community-based care and services.[53]

- **Denver: Support Team Assisted Response (STAR) Program**
  STAR is a mobile crisis response program that serves members of the Denver community who are experiencing emergencies related to mental health, substance use, poverty, and/or housing instability.[54] When responding to a call, STAR sends a mental health clinician and a paramedic or EMT in plain clothes to the scene to provide medical assessments, crisis intervention, de-escalation, transportation, or connection to additional resources and services, as needed.[55] The STAR teams are also equipped with water, food, clothing, and other basic supplies for clients.[56] The program is being expanded citywide, but during its pilot phase it has served a specific geographic area and operated from 10 a.m. to 6 p.m.[57] STAR is dispatched through Denver's 911 call center or can be called directly through a separate line.[58] Dispatchers determine whether STAR is a more appropriate response than emergency police or paramedic services and direct appropriate calls to the program.[59] STAR responded to 748 calls for service in the first six months of operation.[60] The city estimates that the program could reduce police calls by about 2.8%.[61] For the duration of the pilot, police were never called for backup[62] and responses never ended in arrests or injury.[63]

2. **Use mental health co-response teams if a call cannot be diverted to community-based systems.**

Community-based crisis response systems are the best option for mental health emergencies because they prevent unnecessary police contact and do not reinforce the role of law enforcement as first responders for behaviors that fall outside of societal norms.[64] But if they are unavailable then traditional mental health co-responder teams, which include police as well as mental health professionals, can be used as a harm reduction measure. Mental health co-responder teams typically partner a mental health professional and a police officer who specializes in mental health, and are a type of Police–Mental Health Collaboration program.[65]

Although more research is needed to evaluate and better understand the various components of co-responder models,[66] including their effectiveness in areas with limited social service resources,[67] the emerging body of evidence is promising. Studies show that co-responder models have the potential to be effective at de-escalation,[68] reducing the number of people arrested or detained,[69] limiting arrests and jail time,[70] and alleviating a burden on police departments.[71] Furthermore, a systematic review found some evidence that co-responder models improve police officers' perception and understanding of people with mental illness.[72]

Police who participate in co-responder teams are often trained in crisis response through the widespread Crisis Intervention Team (CIT) model, which typically involves, at minimum, 40 hours of training for officers. But not all CIT training specializes in mental health. And while CIT is commonly used without a co-response program, research on the effectiveness of such a response is lacking.

3. **Use dispatch to divert calls to alternative response programs and mental health service providers.**

Police officers heavily rely on the information given to them by 911 dispatch when responding to calls, and many calls[73] for service to 911 dispatch do not need armed response.[74] 911 dispatch is typically well positioned to screen those calls for mental health situations that do not require police and divert them to alternative crisis response teams or mental health professionals. Dispatchers can improve their ability to determine an appropriate response by asking open-ended questions that allow and encourage callers to describe the behavior being exhibited, rather than a specific diagnosis they might not be aware of. Properly funding and training 911 dispatch, as well as pairing dispatch staff with embedded clinicians who work alongside them, can greatly reduce unnecessary contact with police and directly connect people to mental health services.[75] To maximize the potential of 911 dispatch:

- **Fund dispatch diversion programs and specialized training for 911 dispatchers.** Dispatch diversion programs vary across jurisdictions but have two basic structures: diverting calls to mental health professionals who can provide mental health services over the phone; or diverting calls to alternative crisis response programs. Some jurisdictions, like the city of Tucson, have decided to adopt both dispatch diversion models. Tucson resolves 80% of the calls diverted to their crisis line by phone, and dispatches a mobile crisis team to address the remaining 20%.[76]

- **Provide dispatchers with clear dispatch and diversion criteria to prevent bias from influencing decisions about which response is needed.** Research has documented racial bias in diversion decisions among prosecutors[77] and police.[78] Clear dispatch and diversion criteria can guard against the effects of bias and ensure that calls receive alternative responses when possible. For example, Virginia has developed a four-tier framework to assess the risk level of a call and deploy the appropriate response.[79] In addition, 911 call centers should be funded to address the chronic issues of inadequate training[80] and low pay.[81] As dispatchers are increasingly asked to play a new role in diverting calls to alternative crisis response and mental services, it is essential that 911 call centers are funded to support every part of their job, including specialized mental health training. Funding should also extend to salaries so that centers can retain experienced staff who might otherwise leave for higher paying jobs.

PROPERLY FUNDING AND TRAINING 911 DISPATCH CAN GREATLY REDUCE UNNECESSARY CONTACT WITH POLICE AND DIRECTLY CONNECT PEOPLE TO MENTAL HEALTH SERVICES

- **Inform 911 callers that emergency mental health services are available.** If a jurisdiction has mental services available over the phone, the caller should be able to immediately indicate their need for those services. For example, Austin, TX, has added a new option to the 911 call script to allow a dispatcher to quickly transfer the person reporting a mental health emergency to an appropriate provider.[82] Dispatchers ask 911 callers: "Do you need police, fire, EMS, or mental health services?"[83]

- **Embed mental health clinicians with 911 dispatchers.** Embedded clinicians can significantly improve efficiency in dispatch centers by working alongside dispatchers to determine the most appropriate response for mental health calls.[84] They can also resolve some mental health emergencies by phone without a need for dispatching clinicians, special teams, or police.[85]

Maximizing the potential of 988

In July 2022, 988 was launched nationally as a universal 24/7 hotline, replacing the previous 10-digit National Suicide Prevention Lifeline. Any call to 988 will be answered by someone trained in mental health crisis response who can either resolve the situation over the phone or dispatch crisis services. By separating mental health calls from 911 dispatch, which typically ends in a law enforcement response, 988 offers a significant opportunity for states to redesign their emergency mental health response systems without having to redesign their dispatch system. But this potential will be fulfilled only if people who call 988 are met with appropriate, noncoercive responses that connect them to care which in many places requires significant funding for scaling or building unarmed, community-based crisis response systems. Without these supports, there is a risk that calls to 988 could lead to unintended punitive outcomes, including forced institutionalization. State policymakers can maximize the potential of 988 by funding community-based crisis services—including through American Rescue Plan funding,[86] by assessing a fee on cell phone bills,[87] or by appropriating budgetary funding.[88] Jurisdictions can also support effective rollout by creating clear criteria for assessing the response needed for 988 calls.[89]

Regulate Police Response

Mental health emergencies are medical emergencies and should be treated as such. Recent high-profile fatal police shootings of people experiencing mental health emergencies, including Walter Wallace Jr.,[90] have drawn attention to the danger of relying on armed officers to respond to these events. Research has shown that people with serious mental illness are 12 times more likely to experience use of force by police than other people.[91] People with mental illness are not inherently more dangerous than anyone else[92] and behavior that stems from a mental health crisis or condition should not be treated as a crime. People experiencing mental health emergencies should not live with heightened risk of violence, involuntary confinement, or arrest by police.

PEOPLE WITH SERIOUS MENTAL ILLNESS ARE 12 TIMES MORE LIKELY TO EXPERIENCE USE OF FORCE BY POLICE THAN OTHER PEOPLE

Lawmakers and police departments should implement policies to prevent the disproportionate and serious harms that police contact routinely causes to people experiencing mental health emergencies, and ensure that they receive prompt, safe, and appropriate treatment. Department policies should aim to counteract myths about the relationship between mental illness and violence and affirm that officers should strive to direct people experiencing a mental health emergency to community-based health care. Policies should also note that police departments are required by the Americans with Disabilities Act (ADA) to provide accommodations for people with mental health disabilities, which can include using de-escalation tactics and calling for assistance from a specialized mental health team.[93]

Without adequate regulation, the myriad harms that police contact causes to people with mental illness can stem from not only the response to mental health emergencies, but also to any number of behaviors perceived to be public disturbances. Officers should therefore be encouraged to not make arrests for crimes such as disorderly conduct, public disturbance, noncompliance, or other misdemeanors when the behavior stems from a mental health condition, intellectual disability, developmental disability, or substance use emergency.

DEPARTMENT POLICIES SHOULD AIM TO COUNTERACT MYTHS ABOUT THE RELATIONSHIP BETWEEN MENTAL ILLNESS AND VIOLENCE

4. **Require police officers to call for assistance from a specialty mental health team when they encounter a person experiencing a mental health emergency.**

Officers should be trained on how to identify and stabilize people who may be experiencing a mental health emergency and the environment around them until a specialized mental health team arrives. Such teams can include crisis intervention trained officers who have been designated as primary responders to calls involving people in crisis; mobile crisis units; mental health professionals who are embedded or designated within a police department; or mental health co-response teams.

Officers should know which specialized response teams and other mental health resources (if there are multiple) are available in their community. Departments should set criteria for which emergency situations are appropriate for which team. Police should obtain and follow guidance from available mental health responders as soon as they get in contact by phone, radio, or in person. Unless police are needed due to a threat of violence, police should transfer control of the situation to mental health responders whenever possible.

Departments should also adopt policies clarifying when officers should call EMS or refer a person to community mental health resources.

5. **Officers should be trained on de-escalation and calming tactics for interacting with a person who is having a mental health emergency.**

In 2014, Dontre Hamilton, who lived with schizophrenia, was killed by police after being woken up on a park bench by an officer.[94] Following a common pattern of escalation of a routine encounter between police and someone with a mental health condition, the officer initiated an out-of-policy pat-down, which led to a scuffle in which Hamilton gained control of the officer's baton and struck him with it.

De-escalation tactics can help prevent such situations by limiting known factors that contribute to perceptions of danger and slowing down encounters to add time to safely resolve a situation. De-escalation tactics can include, for example, not using sirens or lights; employing a calming, quiet, nonthreatening tone; avoiding physical contact or threats of arrest; and using slow movements.[95] Support for de-escalation is broad, including among diverse groups such as the NAACP[96] and the International Association of Chiefs of Police.[97]

Evidence on the effects of de-escalation training is limited[98] but promising: A recent randomized control trial found that use of a new de-escalation training was correlated with statistically significant reductions in use of force incidents and injuries, including officer injuries.[99] De-escalation has also been found to be effective in managing violence and aggression in settings other than policing.[100]

Officers should be required to use de-escalation and calming tactics while awaiting any available and appropriate alternative emergency response. If a specialty mental health team or a designated mental health professional within a department is available, officers should defer to their directions or guidance whether in person, by phone, or by radio. Officers should listen to relatives, friends, or bystanders who may know if a person is experiencing a mental health crisis, what the person needs, and particular de-escalation tactics that might be effective or to avoid.

If at any point a person is no longer or was never a threat to themselves or others, policies should mandate that officers leave the scene unless they are providing referrals for other services to someone who has consented to such continued interaction. If at any point an officer perceives that continuing an interaction would escalate the situation—given that the mere presence of an officer in uniform can be stressful to a person in crisis and thus escalate the situation—they should disengage or seek approval from a supervisor to disengage.

De-escalation tactics should be grounded by specific officer training for de-escalation when interacting with a person who is having a mental health emergency, and officers should be held accountable if de-escalation tactics are not employed as required by department policy. Lawmakers, police departments, and other stakeholders should monitor new research on the effectiveness of de-escalation and adjust training, policies, and practices accordingly.

OFFICERS SHOULD BE REQUIRED TO USE DE-ESCALATION AND CALMING TACTICS WHILE AWAITING ANY AVAILABLE AND APPROPRIATE ALTERNATIVE EMERGENCY RESPONSE

6. **Pre-arrest diversion policies should identify criteria for presumptive or mandatory diversion in order to remove bias in discretionary diversion decisions.**

Pre-arrest diversion refers to a process in which a person is offered an option to participate in a program or get referred to services as an alternative to criminal repercussions.[101] Unlike 911 diversion, pre-arrest diversion happens when police officers are already engaged with a person they intend to arrest or give a citation to for an offense. These programs give officers the discretion to offer diversion to people who fit particular criteria, such as if the individual would otherwise be arrested for a certain low-level offense.[102] Diversion programs can include substance use and mental health treatment and other social service programing like housing, employment, or case management. *To be successful, pre-arrest diversion programs should be built collaboratively with directly impacted community members; mental health, substance use, and social service providers; criminal legal agencies; and community stakeholders.*

Although there is not a large base of evidence on the effectiveness of pre-arrest diversion,[103] available research suggests that pre-arrest diversion reduces the risk of reoffending.[104]

Pre-arrest diversion programs frequently have disqualifying criteria, which are factors that prevent someone from being eligible for diversion, such as being on probation or having committed certain types of crimes.[105] Mandatory, or presumptive, inclusion criteria instead are factors that automatically qualify someone for diversion (or would at least require the consideration of diversion). For example, mandatory inclusion criteria would require officers to consider diversion for someone who is perceived to have committed a crime connected to a substance use issue.

Using mandatory rather than exclusionary diversion criteria gives more people the opportunity to participate in diversion. This approach also has the potential to remove some officer discretion in diversion decisions, which may reduce racial or other biases that can influence the decision-making process. Traditional diversion programs have been shown to have biased outcomes: Black children are less likely to be offered pre-arrest diversion by police than their peers[106] and in pretrial diversion, prosecutors are more likely to grant diversion to White defendants than defendants of other racial groups.[107]

Stakeholders should ensure that diversion programs have mandatory criteria in order to address factors that commonly lead to unnecessary criminalization and reinforce that arrest is an inappropriate response to issues stemming from mental illness. For example, criteria could include categories of public order crimes such as low-level drug possession, vagrancy, or loitering. The criteria should also aim to include people who demonstrate signs of a mental health or substance use issue (even when they have committed more serious offenses).

7. Provide officers with names, contact information, and addresses for community-based mental health and social service resources.

This information is necessary for officers to make appropriate referrals when interacting with community members. Information about community-based mental health and social service providers should be regularly updated, be readily accessible when officers are responding to calls, and should include which situations each resource should be used or contacted for, as well as their hours of operation. Departments should have open and ongoing relationships with outside or contracted mental health providers to streamline handoffs and emphasize the importance of referrals.

8. Prohibit the use of ketamine and other "chemical restraints" by first responders, except for use by emergency medical services when necessary for the patient's benefit due to a medical emergency.

Ketamine is an anesthetic that has a sedative effect and reduces pain sensations.[108] While ketamine has legitimate medical uses in some circumstances, it can be dangerous for people with high blood pressure and when it interacts with drugs such as cocaine and alcohol.[109] The tragic death of 23-year-old Elijah Mcclain in 2019 heightened public awareness and outrage over the use of ketamine and other sedatives as "chemical restraints" in police responses.[110] Elijah Mcclain was injected with an inappropriately large dose of ketamine by paramedics in Aurora, Colorado, after being stopped by police who were responding to a call about a "suspicious man"[111] who "looked sketchy."[112] Although the autopsy could not definitively determine the cause of death, a grand jury indicted three police officers and two paramedics with Mcclain's death.[113] In 2021, Colorado passed a bill curtailing the use of ketamine outside of a hospital,[114] and the Aurora City Council banned the use of ketamine by emergency responders entirely until an independent investigation was completed.[115]

Paramedics routinely use ketamine for a variety of purposes.[116] But inappropriate use of ketamine to subdue and restrain people can be very dangerous.[117] Officials in St. Paul, Minnesota, conducted an audit that determined that EMS use of ketamine had increased significantly in just a few years[118] and that officers, who are not medically trained, assisted in the administration of ketamine in the majority of cases.[119]

Law enforcement commonly justifies the administration of ketamine and the resulting deadly consequences by citing "excited delirium," a loosely defined term describing a set of symptoms including paranoia, extreme strength, aggressive behavior, and hyperthermia. Excited delirium is not an accepted medical diagnosis: It is not included in the Diagnostic and Statistical Manual of Mental Disorders, and the American Medical Association (AMA) does not acknowledge it.[120] The AMA policy, for example, states that "current evidence does not support 'excited delirium'" or 'excited delirium syndrome' as a medical diagnosis "and opposes the use of the terms until a clear set of diagnostic criteria are validated."[121] The AMA also "opposes the use of sedative/hypnotic and dissociative agents, including ketamine, as a pharmacological intervention for agitated individuals in the out-of-hospital setting, when done solely for a law enforcement purpose and not for a legitimate medical reason."[122]

In addition to restricting officers' direct use, departmental policies should also ban officers from instructing or suggesting that emergency medical services providers use ketamine or other drugs to control a person.

Invest in Equitable Mental Health Care

Mental health emergencies often happen because of a lack of access to preventive or ongoing health care, a problem that disproportionately affects Black people. Many Black people who need mental health care services do not receive them,[123] and Black patients are less likely to receive guideline-consistent care.[124] Latinx, LGBTQ+, and unhoused people also experience well-documented disparities in access to mental health care.[125]

The unmet need for appropriate, high-quality mental health treatment and services may lead to unwarranted encounters with police, interactions that too often end in officers using violence against, inappropriately institutionalizing, or arresting and incarcerating a person with mental illness. Remedying gaps in access to appropriate care for Black people and other groups could address their health needs without criminal legal system involvement. Improved health care access would benefit not only individuals, but also broader public safety: Effective mental health care is associated with decreases in poverty[126] and crime.[127]

MANY BLACK PEOPLE WHO NEED MENTAL HEALTH CARE SERVICES DO NOT RECEIVE THEM, AND BLACK PATIENTS ARE LESS LIKELY TO RECEIVE GUIDELINE-CONSISTENT CARE

Even though police response is inappropriate for mental health crises, transferring responsibility from the police and the criminal legal system to other institutions that have upheld systemic racism in their own right risks replacing one oppressive system with another. Calls to improve public safety by widening the role of social workers and mental health care professionals is complicated by these professional fields' long histories of supporting and furthering racism and racist policies in the United States.

Social workers, psychologists, and both professions as a whole have played active roles in upholding white supremacy and furthering systematic racism by, for example, supporting eugenics,* recruiting Black men into the Tuskegee experiment,** and perpetuating false claims of racial inferiority.[128]

Despite both professions having publicly apologized for their past actions, both continue to engage in practices that disproportionately harm Black and Brown communities.[129] The child welfare system is much more likely to take Black children than White children from their parents, and research indicates that racial bias of social workers may play a role in their decisions on whether to remove children from a home.[130] Black people are regularly overdiagnosed with psychotic disorders like schizophrenia,[131] underdiagnosed with mood disorders like major depression,[132] and are offered medication and therapy at lower rates than White people.[133] In short, Black people have every reason to mistrust these systems.

To right past wrongs and create equity in mental health care, policymakers, social workers, and mental health care providers must direct significant attention and resources toward earning trust among Black and Brown people who continue to be impacted by the deep history of racism in mental health care and social services. The following recommendations can build equity into these systems and make mental health care more accessible for those who urgently need it.

POLICYMAKERS, SOCIAL WORKERS, AND CARE PROVIDERS MUST DIRECT SIGNIFICANT ATTENTION AND RESOURCES TOWARD EARNING TRUST AMONG BLACK AND BROWN PEOPLE

9. **Address systemic racism and promote health equity within the fields of psychology and social work.**

Social workers, mental health practitioners, and both professions should center anti-racism and advance equity in mental health crisis response by taking the following steps:

- Acknowledge, continuously examine, and address the ways in which mental health[134] and social work professionals[135] have supported racist ideas and policies and continue to produce disproportionate racial outcomes.

- Educate social workers and mental health practitioners in the racist history of the fields.

- Take action to make amends for structural inequity and ongoing harm. This should include tangible resource allocation (for example, expanding operating hours and service capabilities, or providing transportation and accommodations as needed).

- Improve and expand provider training and screening tools for racial trauma.[136]

- Develop systems to address under- and over-diagnosis of certain disorders in particular groups.

- Recruit, support, and promote mental health care providers from the communities they will serve.

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* Eugenics advocates for selective breeding of human populations (i.e., sterilization) to "improve" its genetic composition. Historically advocates of eugenics have attempted to remove certain races and other groups from the gene pool using sterilization, segregation, and even large-scale murder.

** The Tuskegee experiment promised 600 Black men free health care and instead infected about half of them with syphilis and did not provide treatment to them, watching as the men went blind, got serious medical problems, and/or died from the disease.

10. **Increase access to and quality of services for mental health and co-occurring substance misuse through Medicaid.**

Lack of accessible health insurance is a huge barrier to mental health and substance use care: People who are uninsured are significantly less likely to receive treatment.[137] And lack of insurance and cost were the most commonly cited reasons for not seeking care among people in the United States who do not use mental health services.[138] Medicaid aims to fill health insurance gaps by providing coverage for tens of millions of people who do not have jobs that provide health insurance and cannot afford insurance on their own.[139] More than 9 million adults covered under Medicaid in 2015 had a mental illness.[140] After the passage of the Affordable Care Act (ACA), the share of people who had health insurance increased, especially among Latinx, Black, Asian, and Indigenous people.[141] This was due, in part, to the expansion of Medicaid coverage included in the ACA.[142] But as of 2020, about 28 million people remained uninsured nationally, a problem disproportionately impacting Black and Latinx communities.[143] Although all states report data on the racial groups of Medicaid enrollees to federal agencies, a lack of uniform data collection standards prevents complete national monitoring of racial and other inequities in Medicaid access.[144]

28M PEOPLE REMAINED UNINSURED NATIONALLY, A PROBLEM DISPROPORTIONATELY IMPACTING BLACK AND LATINX COMMUNITIES.

State-level expansions in Medicaid coverage have shown to increase participation in important treatment,[145] and providers that accept Medicaid have been found to be the most successful at reducing racial disparities in mental health treatment.[146] Emerging research has shown that Medicaid expansion is associated with lower rates of police calls related to mental health crises, lower rates of police contact, and decreases in crime.[147]

In addition to expanding the number of people eligible for Medicaid, access to mental health care can be improved by increasing provider participation in Medicaid.[148] Policymakers can increase Medicaid participation among providers by increasing payment rates to providers.[149] When Virginia increased provider payments for addiction and recovery treatment services, the number of providers offering those services covered by Medicaid more than doubled.[150] Policymakers can also include funding for student loan forgiveness programs for providers who work in communities that lack sufficient mental health care, expand the types of therapies and care covered by Medicaid and offer technical assistance to providers to assist in complying with Medicaid requirements.

11. **Invest in free and low-cost mental health clinics in Black and Brown neighborhoods.**

Black and Brown people are subjected to racism and discrimination, as well as higher rates of violence and poverty than White people, all of which have documented negative impacts on mental health.[151] To build community trust and address the increased mental health strains that Black and Brown communities face, policymakers and providers should remove as many barriers as possible to receiving care. One significant barrier to care for many people is geographic inaccessibility of mental health services: Black people have to travel further for medical care than their White counterparts.[152] Policymakers should prioritize accessibility to mental health care. The National Network to Eliminate Disparities in Behavioral Health supports organizations and communities working toward equity in mental health care by, for example, highlighting funding opportunities and providing information-sharing opportunities.[153]

12. **Expand and enforce mental health parity requirements for insurance companies to prevent insurers from denying or capping coverage for necessary mental health care.**

When insurance companies limit mental health benefits to a certain amount, it can make it more difficult or impossible to get insurance coverage for vital services. Mental health parity requirements prevent private insurance companies from capping mental health benefits in a given year or in a person's lifetime more than any other medical benefits.[154] Governments should require insurers to pay for necessary mental health care on the same terms the insurers cover physical health care.

In 2008, U.S. Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), which instituted mental health parity for employment-based insurance plans.[155] The ACA expanded the MHPAEA parity requirements to apply also to individually purchased insurance plans.[156] Together, the MHPAEA and the ACA greatly expand mental health insurance coverage, making this type of care more affordable and accessible.[157] Compliance has been uneven, however, and significant gaps in coverage remain.[158] Evidence on mental health parity in plans for federal employees has demonstrated effectiveness at increasing the use of mental health and substance use services by people enrolled in the plans, at a lower cost to them, without decreased quality in care.[159] To close the remaining gaps in coverage,[160] policymakers should strengthen enforcement measures and remove exemptions to parity, including for small businesses that self-insure; federal, state, and local governments; and Medicare plans.

MORE THAN HALF OF PEOPLE WHO DEVELOP MENTAL HEALTH CONDITIONS DISPLAY SYMPTOMS BEFORE THE AGE OF 14, AND IT TAKES AN AVERAGE OF 10 YEARS AFTER SYMPTOM ONSET FOR MOST PEOPLE TO GET ACCESS TO TREATMENT

13. **Invest in mental health services and screening for young people.**

Early, culturally competent detection and care can prevent mental health conditions from worsening and prevent mental health crises down the line. More than half of people who develop mental health conditions display symptoms before the age of 14,[161] and it takes an average of 10 years after symptom onset for most people to get access to treatment.[162] Approximately 80% of children and adolescents ages 6 to 17 in the United States with mental health diagnoses did not receive mental health care,[163] and may be at risk of increased victimization,[164] harm to themselves,[165] or exhibit behavioral issues that are routinely met with discipline and arrest instead of supportive care.[166] Students with disabilities are more than twice as likely to be arrested[167] and restrained[168] than students without disabilities.

All young people should have access to mental health screening and care in their communities. But because 70% to 80% of all young people who currently receive mental health services receive it in school,[169] and an estimated 90% of public school students attend schools where the total number of school support staff such as counselors does not meet professional standards,[170] schools are an important location for increasing access to high-quality, culturally competent mental health screening and services.[171]

Both school-based mental health services and initial screenings should strive to guard against documented disparities in mental health diagnosis and treatment,[172] including that Black children are more likely to receive a diagnosis of disruptive behavior disorder[173] and less likely to receive a diagnosis of attention-deficit/hyperactivity disorder. School-based mental health services and screenings should not serve as a tool or excuse to increase school discipline, which is invoked disproportionately often and with greater severity on Black and Latino students.[174] Instead, schools should focus on complying with their ADA obligations to accommodate students with mental health conditions by focusing on changing school environments instead of punishing or pressuring students to change behavior that stems from a mental health condition.

Schools should increase mental health screening availability and provide and refer students to appropriate, affordable, quality care once a mental health condition is indicated. Schools should develop mental health response plans and offer crisis prevention to students, and should partner with local providers to support students' mental health needs. Policymakers should completely fund mental health screening and services so that they are offered free of charge to students.

14. Address barriers to virtual care and telehealth.

Virtual care and telehealth are two-way communication services in which a health care provider can remotely diagnose and treat patients by telephone, video conference, or using other technology. Historically, telehealth and virtual care have been used sparingly,[175] but can be vital for people who live in rural communities or have difficulty traveling to health care appointments. The COVID-19 pandemic required expanding alternatives to in-person health care and led to temporarily relaxed federal and state restrictions of telehealth and virtual care.[176]

The COVID-19 expansion of these services is temporary and does not address all of the barriers that prevent equal access to these services. Communities with high rates of poverty and patients who have limited proficiency in English have used telehealth and virtual care at lower rates than others.[177] In addition, lack of high speed internet access continues to prevent access in rural communities.[178]

To expand the use of telehealth and virtual care more permanently and comprehensively, legislatures should address the inconsistent and overly restrictive laws and regulations that govern these types of appointments. They should also require Medicaid, Medicare, and private health insurance parity for telehealth and virtual care. To ensure that all communities have equitable opportunity to use these services, policymakers should also expand broadband access, internet subsidies, language accommodations, and other policies that address inequality in usage.

15. Expand and improve wraparound services for people with mental health conditions.

Improving mental health requires more than just access to psychiatry and therapy. To provide holistic mental health care, life stressors such as racism, housing instability, co-occurring substance use issues, unemployment, and physical health issues must all be addressed. Wraparound service programs aim to ensure continuity, coordination of care, and appropriate, culturally responsive service delivery for clients interacting with a variety of systems that address such life stressors. These programs are collaborations among groups of stakeholders that can include nongovernmental health care providers, social service providers, and state and local government agencies—and they have been shown to improve health outcomes.[179] They can also reduce the burden on the client to navigate complicated and uncoordinated systems and help address underlying causes of health issues that might otherwise go unaddressed. There is also evidence that these tangential services could decrease police contacts for people with mental health issues.[180]

To be effective, wraparound services should include more than just coordinated mental and physical health care. They should link service providers and government entities such as case management, housing, substance use services, and the criminal legal system. These links are critical to fill gaps in service and communication, such as when people are not informed of charges filed against them while they are in a hospital. Wraparound services should include providers that are available 24/7 and services for people who are looking for help but are not in crisis. To ensure successful coordination and implementation, wraparound services should use data-driven practices, include family and caregivers in the process, and seek to meaningfully and continually incorporate community feedback.

WRAPAROUND SERVICES SHOULD INCLUDE SERVICES FOR PEOPLE WHO ARE LOOKING FOR HELP BUT ARE NOT IN CRISIS

Improve Data Collection and Transparency

Data analysis is a powerful tool to assess the effectiveness and equity of mental health interventions. It can also ensure that new programming, services, and interventions are grounded in evidence. Data can deepen understanding of the problems that affect a community, shedding light on gaps in service or changes in the needs of a community that may require the redirection of resources.

Effective emergency mental health response looks different in every jurisdiction due to distinct geography, population, and needs for services and response. Local government leaders must therefore use data to continually tailor their systems to best serve their communities. Because data on average interactions between law enforcement and people with mental illness are often lacking, building robust data collection and analysis practices is essential to enable communities to effectively serve people experiencing mental health emergencies.

16. **Collect and analyze data on mental health calls for service.**

Data about calls for service (such as 911 or 311 calls) allow stakeholders to measure community requests related to public safety. Analysis of these data, along with data recorded by first responders, can help communities understand when and where mental health emergencies are occurring. It can also reveal the barriers people face in calling for service when they experience mental health emergencies. With this information, communities can make more informed decisions about where they should invest resources into emergency dispatch systems to maximize public safety, and where there might be opportunities for diversion.[181] For example, the Georgia Department of Behavioral Health and Developmental Disabilities discovered through data analysis that they had long hold times. They then used that data to discover the root causes of their hold times and the most effective solutions.[182]

In order to analyze outcomes of mental health calls for service data, first responder records must be linked to calls for service data. First responders should update the call type information after the call is completed as needed to make sure it is accurately recorded as related to mental health. All data collection systems should make it possible to tell which emergency responses are related to which calls for service. This can be accomplished either by using the same unique identifier (or number) to label a specific incident, or, if systems use different identifiers, including a column in the stop data set that shows the calls for service incident number associated with each mental health emergency response.

17. **Analyze outcomes of community-based response systems and diversion programs.**

Jurisdictions should compare the outcomes of community-based response systems to outcomes of police response and assess any racial or other demographic disparities. Demonstrating outcomes of innovative pilot programs is necessary to maintain and increase funding, and can spur other jurisdictions to adopt similar programs.[183] Outcomes analyzed in the data should include:

- Uses of force;

- Arrests;

- Involuntary commitments;

- Calls for police backup;

- Acceptance and refusal rates of community-based referrals from first responders; and

- Referrals to community-based mental health resources.

Jurisdictions should also collect and analyze data to determine the effectiveness of any diversion programs used. They should specifically examine outcomes related to health and well-being (such as hospitalization rates and stability of housing), in addition to rearrest rates.

18. **Collect analyzable data on all police stops and uses of force.**

Police should record data for every stop or use of force incident. Stop records should be stored electronically in a spreadsheet or database format.

For data to be analyzed for patterns of police contact with people experiencing mental health emergencies, officers should record whether they perceived the person to be experiencing a mental health or substance use emergency, or whether dispatch indicated a potential mental health or substance use issue. Forms for recording data should distinguish mental health crises from substance use crises. Data should also include information about the outcome of the call and whether the officer was part of a co-response or other specialized mental health response team.

A complete list of the information needed to collect meaningful data on all stops is available on CPE's Justice Navigator platform at: www.justicenavigator.org/for-law-enforcement/collect-data. For more detailed guidance on traffic stop data, including how to address common technical limitations to data collection, see CPE's report, *Collecting, Analyzing, and Responding to Stop Data: A Guidebook for Law Enforcement Agencies, Government, and Communities*.[184]

POLICE SHOULD RECORD DATA FOR EVERY STOP OR USE OF FORCE INCIDENT

19. **Monitor capacity issues in community-based and hospital-based services for people with emergency mental health needs.**

Policymakers must monitor and make targeted investments in mental health care systems to ensure that local resources are able to support increased access and referrals. Referrals to providers must result in timely, appropriate care.

20. **Police departments should sign data sharing agreements with service providers to ensure proper transition of care, monitor effectiveness, and better serve people with mental health conditions.**

Data sharing agreements are how departments and service providers detail the data they will provide the other entity or entities, what can be done with that data, and how it should be safeguarded. Although data sharing agreements can be complicated because of patient privacy laws and regulations, they are important to facilitate co-ordination among stakeholders and providers involved in mental health emergency response. They also can ensure that each element of the system is providing effective handoffs to other agencies and providers. Data sharing agreements can allow policy-makers and stakeholders to get a full picture of how people interact with legal, health, and other service systems. This picture can allow policymakers and stakeholders to analyze outcomes for individuals across systems. These agreements should be one-directional, with police departments granting specific service providers and research-ers access to their data and should not require or allow providers to share their data with police departments.

Conclusion

People with mental illness routinely face criminalization and violence instead of being met with responses that will keep them safe. The recommendations in this report describe many possible starting points for shifting the default response for mental health emergencies from one based in law enforcement to one grounded in public health.

Communities that are ready to redesign their mental health emergency response systems need to gather information to prioritize their next steps. This might include answering questions such as: Which com-munity-based alternative response models should be developed or expanded? Is dispatch effectively diverting calls to specialized mental health responses? Do police departments have clear and enforced policies as to when officers should call for assistance with a mental health emergency—and what they can and cannot do in such situations? What strengths and weaknesses currently exist in public health and community-based system capacities to meet the priorities of Black and Brown communities? And what barriers to accessible and high-quality diagnoses, prevention, and treatment exist for people with unmet mental health needs—particularly Black and Brown people?

To effectively redesign mental health emergency response, stakeholders must meaningfully engage with, and prioritize the needs of, the people who are most impacted by disparities and harm in the current systems. Systemic racism in medical care and stigma surrounding mental illness play significant roles in driving disparities in mental health care. The expertise of people who are impacted by such factors is fundamental to understanding and redesigning systems that can deliver safety for all people in mental health emergencies.

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