The Changing Landscape of Mental Health Crisis Response in the United States

Jim Curry, MD, MPH, Laura Sloan, MD, Walter K. Rush IV, MD, and Chinmoy Gulrajani, MBBS

J Am Acad Psychiatry Law 51:6–12, 2023. DOI:10.29158/JAAPL.220111-22

Key words: crisis response; CIT; MCU; 988 Suicide and Crisis Lifeline

Models of community mental health crisis response have multiplied in the last few decades, yet an estimated one quarter to half of all fatal police encounters continue to be mental health related. Persons with untreated mental illness are 16 times more likely than other civilians to be killed when encountering law enforcement.[1] Being African American and having mental illness are factors strongly associated with police fatality.[2] Moreover, rates of routine mental health care access are particularly low among many minority communities, resulting in adverse interactions with police that too often lead to criminalization, trauma, and deterioration of mental illness.[3,4]

Response systems for mental health crises were broadly classified into three models put forward by Deane and colleagues[5] in 1999 and refined by Hails and Borum[6] in 2003. In this framework, crisis responses are performed by specially trained police, or mental health workers, or both, and are either police-based or mental health-based. Exemplary models include crisis intervention teams (CIT), which are a police-based specialized police response; police co-response teams (CRT), which are a police-based specialized mental health response; and mobile crisis units (MCU), which are a mental-health-based specialized mental health response.[7]

Existing research shows gaps and troubling trends in approaches to crisis response, such as investment in policies lacking evidence of positive patient-level outcomes. In real life, the practical use of these models differs from their theoretical constructs by virtue of their composition, resources, accessibility, and their ability to meet the needs of the community. Because of the differences among models, it is difficult to measure and compare outcomes. Today, there is no single standardized metric for determining the best model.[7,8]

At the heart of the existing crisis response infrastructure in the United States is the 911 call center. How these calls are handled can determine if the incident ends safely, the person in crisis is arrested, or the person is connected to appropriate care. A recent study by the Pew Research Center found that few responding call centers have staff with behavioral health crisis training and specialized resources to address mental health or substance use-related emergencies.[8] Another analysis of 911 calls in eight cities found that 21 to 38 percent of those calls were for mental health, substance use, homelessness, or other quality-of-life concerns that could be better addressed by civilian first responders instead of police.[9] A gradual consensus is building that crisis response systems must shed their reliance on the emergency response system and law enforcement, and must transform from the present limited availability of mental health specialized response to the point where a specialized mental health response is the standard of care.[4,10]

Dr. Curry is Attending Psychiatrist at Abbott Northwestern Hospital, Minneapolis, MN. Dr. Sloan is Attending Psychiatrist at Hennepin Healthcare, Minneapolis, MN. Dr. Rush is ACT Team Psychiatrist at Central Minnesota Mental Health, Monticello, MN. Dr. Gulrajani is Associate Professor, Department of Psychiatry and Behavioral Sciences, University of Minnesota-Twin Cities, Minneapolis, MN. Address correspondence to: Chinmoy Gulrajani, MBBS. E-mail: cgulraja@umn.edu.

Disclosures of financial or other potential conflicts of interest: None.

Recognizing these deficits in the existing infrastructure, and the need to achieve a better system to address mental health crises in the community, Congress enacted the National Suicide Hotline Designation Act in 2020.[11] And although this new law is promising at first glance, it raises the question what the ideal mental health crisis response in the community should look like. In providing this update on community mental health crisis response, we begin first by discussing the existing models of care.

CIT

The CIT model is a specialized police-based prebooking diversion response program. It was developed in 1988 in a joint collaborative effort between the University of Tennessee in Memphis and the Memphis Police Department.[12] In its original conception it included three components: a forty-hour training of self-selected officers by community mental health workers, persons with mental illness and their families, and officers; training and special coding for dispatch officers; and a centralized drop off mental health facility with an automatic acceptance policy to minimize police officer transit time.

Since its inception, CIT has expanded rapidly. At one time it was touted as the most promising partnership between law enforcement and mental health professionals.[12] Today, CIT programs exist in over 2700 communities nationwide.[13] In its original form it called for only self-selected officers to undergo the training, though several departments across the country (including in our home state, Minnesota) decided to have all officers undergo the requisite training. It is, however, unclear how many jurisdictions have effectively implemented all three components of CIT. This is because sizes of police departments vary, and small or remote departments do not always have the resources available for full implementation. In fact, research indicates that only a minority of programs have the third component (i.e., a drop off or receiving facility).[7,14] Several others have not been able to engage local emergency psychiatric services to foster collaboration between police and treatment services.[15]

CIT outcomes were initially reviewed by Compton and colleagues in 2008.[12] They discovered 12 reports describing empirical research on CIT in three broad categories: those reporting on officer outcomes; those involving disposition of calls eliciting a CIT response; and those describing CIT as an example of prebooking jail diversion. The authors found that evidence was most compelling for officer-level outcomes and concluded that the training component of the CIT model may have a positive effect on officers' attitudes, beliefs, and knowledge relevant to interactions with such individuals. CIT-trained officers have reported feeling better prepared in handling calls involving individuals with mental illnesses. In addition, their review indicated that CIT, in comparison to other pre- and post-diversion programs, may have a lower arrest rate and lower associated criminal justice costs. They underscored a need for demonstrating the connection between officer-level outcomes and patient-level outcomes. The authors noted that for localities focusing almost solely on the officer-training aspect of CIT, patient- and systems-level benefits may be difficult to demonstrate unless training is complemented by other reforms such as dispatcher involvement, the availability of a single point of drop off, and adequacy of treatment services in the community.

In a 2008 critique of CIT programs, Geller[16] noted that research on CIT outcomes assumed that the training accounts for any differences without consideration of numerous other factors that could be involved. Geller questioned whether systemic factors, such as laws, policy, available resources, and insurance factors, may all better account for outcomes and whether CIT may have had minor effects. Geller noted that CIT imposes a cost to police departments and burdens mental health systems. He pointed out that in various localities, differences in the community-based service system, the insurance and entitlement system, the public hospital system, and emergency detention statutes are so vast that any police training related variables are negligible.

In 2019, the Journal published a comprehensive review of research related to CIT by Rogers *et al.*[7] that included 198 studies. They found that most studies involved measures of planning, logistics, and training operations related to CIT, and that outcome-based studies were few and largely based on self-reports of CIT-trained officers. The authors found that CIT has been shown to have some measurable positive outcomes, mainly in the area of officer-level outcomes. These include increased officer satisfaction and self-perception of a reduction in the use of force. In addition, they noted that studies of specific CIT programs have found some positive but mixed outcomes or trends toward statistical significance in terms of increased diversion to psychiatric services overall. This may lead to cost reduction mainly through a

reduction of hospitalization days and inpatient referrals from jail.

Rogers *et al.*[7] also reported that studies lack evidence for a reduction in injuries associated with CIT involvement. They concluded that existing literature on CIT outcomes has not shown consistent reduction in the risk of mortality or death during emergency police interactions with CIT involved officers. In addition, since use of deadly force by the police itself is relatively rare, this low base rate coupled with relatively underpowered studies creates an elevated risk of Type II error (i.e., false negative error). The authors noted that several other variables could affect the outcome of incidents that lead to high-risk encounters with the police, including race of the person, officer characteristics, officer perception of threat and intoxication, militarization of police, and gun ownership patterns. They echoed Geller's concerns about the efficacy of CIT and questioned if the decision to use deadly or injurious force during an encounter may be insensitive to preencounter training such as CIT.[7,16]

CRT

The second crisis response model, CRT, is a police-based, specialized mental health response. It takes an additional step in the direction of mental health specialization by pairing a mental health worker with a police officer during a crisis response. These mental health workers may be social workers, paramedics, nurses, or psychiatrists.[17] This model has similar goals to CIT of diverting individuals from the criminal justice system, increasing access to mental health treatment, and introducing more mental health expertise into these encounters.

CRT implementation varies widely in the integration of police and mental health workers. A 2018 review from the United Kingdom identified 19 variations of CRT across the United States, Canada, Australia, and the United Kingdom.[18] This study found that some teams had a ride-along model where a police officer and mental health worker responded to crises in the same vehicle, which may or may not be a police car. Other teams had only control room support where a mental health worker assisted police remotely by phone or radio. Some teams included both ride-along and control room support.

There is also variation in dispatch models for CRT. Teams may be dispatched by 911 centers or may self-dispatch in response to 911 calls heard over police radio.[17] Some teams only dispatch when called directly by police in the field. Others take calls from a direct line used by emergency services and the public. Teams also differ in the hours of their availability.[18]

Some CRT include both a paired initial team and a subsequent mental health worker evaluation.[17,19–23] For example, the CRT in Indianapolis, Indiana, discussed in Bailey *et al.*[17] contacted individuals 48 hours after the mental health crisis incident by phone or in-person to provide limited case management, connect with treatment and services, provide appointment transportation, and maintain medication regimens.

There is conflicting evidence about whether the CRT model reduces psychiatric hospitalizations or costs.[18,22,24,25] Puntis *et al.*[18] found four related studies that demonstrated a decrease in mental health holds (see below) when comparing co-response to police-only responses. Jenkins and colleagues[26] found that mental health hold rates were reduced but hospital admission rates were increased when CRT responded in-person but not when they provided consultation to police over the phone. Notably, the mental health holds cited in Puntis[18] and Jenkins[26] are a type of police detention in the United Kingdom that, while not considered an arrest, can include relocation of a person having a mental health crisis to a police station.

Bailey and colleagues[17] found that people served by CRT had a lower likelihood of arrest at the crisis incident compared with people served by a police-only response, and this was particularly true for Black individuals. Lopez[27] showed that for mental health crisis calls, 1.4 percent of individuals served by a CRT were arrested, compared with 13.3 percent of individuals served by a police-only response.

Puntis *et al.*[18] cited studies that have shown that after a CRT was introduced, citizens' perceptions of procedural justice improved, encounters were felt to be less traumatic or criminalizing, and responders were perceived as more skilled at de-escalation. Providers have reported in studies that co-response interventions are valuable and improve collaboration among police and medical professionals. Surveys of police officers, however, reported no perceived difference in effectiveness, ability to respond to those in crisis, stigmatization, or level of mental health training between models.

MCU

A third model of crisis response is the mental-health-only response, in which mobile mental health

teams (Mobile Crisis Units) respond separately from police. This response still requires coordination with emergency services and police for both dispatch and backup because most people in the United States currently call 911 when experiencing a mental health crisis and these teams depend on police backup for situations that are beyond their capacity.[28]

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends this mental-health-only response as the preferred crisis response modality in its 2020 National Guidelines for Behavioral Health Crisis Care.[28] These guidelines recommend that a crisis response team, also known as a mobile crisis team, should, at minimum, pair a clinician with a peer in two-person teams, should not restrict services to particular locations or times, and should provide warm hand-offs in care, including transportation when needed. SAMHSA also recommends using law enforcement only in special circumstances, using real-time GPS technology to support connection to resources, and the ability to schedule outpatient follow-up appointments. Notably, the mental health only response is one piece of the recommended crisis response system which also includes a regional crisis call center and crisis receiving and stabilizing facilities.

The CAHOOTS (Crisis Assistance Helping Out On The Streets) program in Eugene, Oregon, began over 30 years ago and includes many of the SAMHSA recommended practices.[28,29] This team pairs a medic and a crisis worker trained in mental health who respond to crises in program vans. Training includes class time, field time, and mentorship. It is administered by a local nonprofit organization which has a human services partnership with the city and is funded by the city government, a coordinated care organization, and donors. The teams are integrated into the police department with an official communication protocol whereby 911 calls are diverted to CAHOOTS via radio. The radios also allow for police backup, though out of 24,000 calls in 2019, police backup was only required for 150.[29]

Several communities have developed crisis systems based on the CAHOOTS model with variations based on local needs and municipal organization. One common refrain is the need to partner with law enforcement and other stakeholders to foster understanding and trust. An evaluation of the similarly situated Denver STAR (Support Team Assisted Response) program found collaboration helpful for assignment of calls.[30] A report from Olympia, Washington, cites the value of ongoing stakeholder meetings to discuss difficult cases.[31]

The mental-health only response is consistent with a person-centered approach. It relies on trust over force. On an individual level, crisis workers can "meet people where they are"[32] rather than with a law enforcement or public safety agenda. On a broader level, a mental-health-only response system may be safer for people of color because they tend to experience violence at the hands of police at a higher rate.[4,32]

Regarding outcomes, SAMSHA's 2014 Crisis Services report[33] found research to support that mobile crisis teams "are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from the emergency department to services, and better than hospitalization at linking people in crisis to outpatient services" (Ref. 33, pp 10–11).

988 Suicide and Crisis Lifeline

The 988 Suicide and Crisis Lifeline was launched in July 2022 and is a new development in how mental health crisis response teams can be mobilized. It evolved from the National Suicide Prevention Lifeline (NSPL), which has existed since 2005. The number of calls to the NSPL grew from about 50,000 calls in 2005 to about 2.6 million calls in 2021.[34] With this increased usage, there was a growing recognition of the need for an easier to remember number to replace the NSPL and improve access.

The 988 Lifeline was also created out of concern about the patchwork system for accessing mental health crisis services across the county. In some states, each county may have a different mental health crisis response number, and 911 call centers often lack the resources to handle mental health crisis calls.[8,35] By unifying crisis response numbers with 988, the hope is that there can be more training, standardization, and dissemination of best practices to call center counselors.

Congress passed the National Suicide Hotline Designation Act of 2020[11] in October 2020 to establish 988 as the new national mental health crisis number. This law permitted states to levy taxes to respond to 988 calls and mandated specialized services for populations at high-risk for suicide, including LGBTQ youth, minorities, and people living in rural areas.[11] Under this law, states are considered largely responsible for implementing and building the necessary

infrastructure for the 988 Lifeline with the help of some federal grants.[36]

Prior to the launch of the 988 Lifeline, the National Alliance on Mental Illness (NAMI) and the National Association of State Mental Health Program Directors (NASMHPD) drafted a Model 988 bill,[37] which included the creation of 24/7 988 crisis hotline centers and 24/7 mobile crisis teams. It also recommended follow-up for people who access 988 services, creation of annual reports on 988 usage, and payment of crisis services by Medicaid.

As of September 30, 2022, 19 states had passed or had pending 988 implementation legislation. For example, Washington state passed some of the most comprehensive legislation, which includes a 988 fee added to phone bills, funding appropriations, a crisis response funding account, a strategy committee, reporting requirements, and a health insurance coverage mandate for behavioral health emergency services. In contrast, Minnesota, our home state, has existing funding for NSPL call centers but did not pass additional 988 implementation legislation that was introduced in Spring 2022.[38,39]

At its launch, the 988 Lifeline was described as a national network of more than 200 crisis centers that provide 24/7 support to people experiencing a mental health crisis. Beginning July 16, 2022, all phone companies and text messaging providers were required to route all calls and text messages to "988" to the 988 Suicide and Crisis Lifeline. A call is routed to a local crisis center based on the caller's area code.[34]

In the week that the 988 lifeline was launched, it received over 96,000 calls, texts, and chats, a 45 percent increase from the week before and a 66 percent increase compared with the NSPL during the same week in 2021.[40] Analysts project that 988 will receive 24 million contacts annually by 2027, though this could reach 41 million depending on calls routed from local emergency numbers.[41]

Conclusions

The current mental health crisis response system in the United States consists of a patchwork of varying models and services with no standardization. Experience from the last 50 years informs us that the ideal response system would require several components functioning together in synchronicity. Such a system would have a dedicated hotline for reporting a mental health crisis, trained dispatchers for activating the crisis response, mobile mental health professionals responding to the crisis, and law enforcement support where needed. An ideal response system would also have seamless drop off locations where persons in crisis are triaged by competent professionals and connected with services in the community according to their outstanding treatment needs.[42] This requires resources to fund such treatment services and strong partnerships among community stakeholders. At present, we are far from the ideal.

At the heart of an effective crisis response system is relationships, not only between caregivers and persons in crisis, but also among responders. Although the CIT model was well intended and conceived with many of these components, in a majority of localities it has been reduced to the one component of training of police officers, with no clear reduction in adverse population outcomes. Rural, remote, and impoverished communities have continued to struggle with resources, especially drop-off locations and continuation of care. A collaborative mental-health-only response recently adopted by several communities stands out as a rare instance of reducing the role of police that both police and reformers agree on. This model calls for mental health professionals to accompany law enforcement or serve as first responders. In these communities too, the outcomes of these models are difficult to measure. In the end, the most telling outcome variables remain the rates of mortality and morbidity of persons in mental health crisis during police encounters. These numbers remain alarmingly high, especially for minority and underserved communities who risk not only injury and death but also criminalization and traumatization during such encounters.

With the enactment of the National Suicide Hotline Designation Act of 2020 and creation of the 988 Suicide and Crisis Lifeline, Congress hopes to address some of the deficits in the existing crisis response system. Preliminary information indicates that states vary widely in adopting 988 implementation legislation as permitted by this Act. Although many states have not adopted any legislation to support 988, others have used this opportunity to expand community mental health services in their state and to enact fees to fund those services. It is clear that nationwide implementation of 988 as a centralized suicide hotline will take years, if not decades.

Yet, we believe that the establishment of the 988 Suicide and Crisis Lifeline is an important first step in

the right direction. It marks the disentanglement of mental health crisis response from other types of emergency responses, especially those based in law enforcement. Its predecessor, the 911 emergency hotline, was enacted in the late 1960s, but it was not until toward the end of the 20th century that coverage was achieved for over 90 percent of Americans.[43] It is expected that like the gradual development of 911, building the capacity of 988 will take time. Critical tasks going forward include meeting call centers' workforce demands, creating the infrastructure to respond to calls, quality control for dispatching emergency responses, and ensuring continued funding. Development of clear protocols for coordinating calls between 911 and 988 is also an imperative that will ensure that a person receives the appropriate crisis services.[36]

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