From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response

Created by The Front End Project; a collaboration between Fountain House, the Center for Court Innovation (CCI), The W. Haywood Burns Institute, the Technical Assistance Collaborative (TAC), and the Mental Health Strategic Impact Initiative (S2i), with support from the Ford Foundation.

FOREWORD

Ashwin Vasan, MD, PhD, President and CEO, Fountain House

In the midst of the COVID-19 pandemic, we are, perhaps for the first time as a nation, confronting our collective mental health. Trauma, economic insecurity, social isolation, and loss have afflicted all of us; some more than others. It has brought into stark relief not only the scale of the mental health challenge that awaits us – a "second pandemic" of mental illness, whose long tail we will be experiencing for years after the last case of novel coronavirus is sown – but also the inadequacy of our systems and our responses to mental health issues to meet this challenge.

COVID has also, once again, lifted the lid on our original sin in America: the systematic and racist marginalization and disenfranchisement of Black and brown people in this country. Not only are Black Americans more likely to be diagnosed, to be hospitalized, and to die from COVID, they are disproportionately facing the impact of the pandemic on their social and economic stability and their mental health. Amidst a renewed cry for justice and fairness in policing, and the sad truth that our largest mental health treatment facilities are our jails and prisons, we are waking up to the toxic intersection of racism, law enforcement, and mental illness, and to our continued reliance on punishment and criminalization to address what are, in their essence, health issues.

Nowhere are these intersecting systems failures more apparent than in our approach to addressing mental health emergencies, or "crises." People experiencing mental health emergencies are too often met with a response that is ill suited to meet their needs in the moment. Instead of marshaling health, mental health, and social support resources to reach OUT to people in their moment of greatest need, when they are often the most afraid, we deploy our public safety and enforcement resources, which pull people IN to repeated cycles of punishment and institutionalization, and, tragically, too often result in the needless loss of life. Here at the national mental health nonprofit, Fountain House, this issue is personal for us. In 2016, Deborah Danner, a vital and shining member of our community, a 66-year-old woman living with schizophrenia, was killed by the NYPD in her home while in the midst of a mental health crisis. The ripple effects of this tragedy continue to be felt today.

It is for this reason we call this project "The Front End." In many ways, mental health emergency response represents the entryway to a punitive system of mental health treatment that neither meets the health needs of the person, nor makes us safer as a society. The human and economic costs of this system are far-reaching. At the beginning of the second pandemic of mental illness we have been thrust into due to COVID, we must have a serious national conversation about mental health in our country, and how we can build systems grounded in public health, human security, and dignity that can make our society an easier place to live for more people, and especially the vulnerable and marginalized. By focusing on the moment of crisis, a foundationally different approach rooted in health instead of punishment can catalyze change across the mental health system.

In organizing a series of conversations around mental health crisis, we intended to bring together stakeholders and affected people from across the spectrum of services, sectors, policy, and even politics, while creating a central focus on 1) racial equity and justice, and 2) lived experience of mental illness. In doing so, we build upon and also expand the focus of existing mental health crisis reform efforts, including the work being done in communities around upcoming 988 suicide prevention/mental health crisis hotline number implementation to specifically center and uplift the voices of Black, Indigenous, and People of Color (BIPOC) and of people with lived experience. The findings of these conversations, which have been summarized in this report, are intended to serve as a conversation starter, not only narrowly about mental health crisis, but as an entry to a broader conversation around reforming our mental health system and focusing on public health and upstream social determinants of mental health, which are often deterministic in crises and in addressing the needs of people living with mental illness.

This report is intended to be used by a range of stakeholders, from federal policy makers to community leaders. We build on active efforts to center race equity in the work of the new presidential administration, as well as a commitment to addressing police reform and transformation of our criminal legal system. We must seize this moment of opportunity to incorporate the intersection of these systems with mental illness in a way that draws on the traditional mental health stakeholders who have historically led crisis response and treatment efforts, but also broadens the conversation to other sectors. At the community level, we hope that this report will serve as a model for continued dialogue centering racial equity and lived experience, and building off of incredibly active, but siloed, community efforts in criminal justice reform and mental health crisis response, in cities, counties, and states around the country, in a way that brings these related conversations together.

ACKNOWLEDGEMENTS

Recognizing that a critical aspect of narrative and culture change is the voice of those who live what needs changing, we've been honored to lead this work and forefront Fountain House and other Clubhouse members as part of it. My colleagues Mary Crowley, Ruvani Perumal, Nicholas Becerra, and I have also been privileged to work with and learn from our partners in this project: Ken Zimmerman, Keris Jän Myrick, and Margot Cronin-Furman of the Mental Health Strategic Impact Initiative (S2i); Tshaka Barrows of the W. Haywood Burns Institute; Julian Adler and Raquel Delerme at the Center for Court Innovation; and Francine Arienti and Kevin Martone at the Technical Assistance Collaborative. We are exceedingly grateful to david rogers and the Ford Foundation for supporting this project.

This project is based in dialogue – we convened six robust discussion groups tackling thorny challenges in powerful and sometimes poignant conversations. In addition to our full complement of participants listed here, we are particularly grateful to our skilled facilitators who managed these conversations in the challenging world of Zoom: Elliott Madison, Keris Myrick, Andy Keller, Kevin Martone, and Will Snowden. And we especially thank the greatly talented Kenton Kirby, also of the Center for Court Innovation, who did yeoperson's work by co-facilitating all the discussion groups.

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Introduction

When it comes to crisis or mental health emergency response, we are at a crossroads – a moment of opportunity, tragically born out of peril. The murders of George Floyd, Breonna Taylor, and countless others by police officers and the ensuing outpouring of support for the Black Lives Matter movement highlight the structural racism embedded in every area of American society – including the disparate ways in which mental health needs and mental health emergencies are identified, treated, and managed for Black, Indigenous, and people of color (BIPOC), who receive fewer services and have significantly poorer outcomes. Stigma and fear of mental illness, which lead to perceptions that people experiencing mental health crises are a safety risk to themselves and others, compound the well-documented perceived threat that BIPOC face in everyday life. Despite evidence showing that people living with mental illness are far more likely to be victims of violence than perpetrators of it, erroneous assumptions that persons experiencing mental health crises are violent makes law enforcement the default responder. This confluence of mental health emergency and police interaction can be deadly and has led to persons experiencing a mental health emergency accounting for one of every four people killed by police. Given that people of color make up half of all people killed by police, their rate of death at the hands of police during a mental health emergency is likely even higher than that of the overall population.

The past year has also been defined by the ravages of the coronavirus pandemic, which has not only taken hundreds of thousands of lives to date, but has disrupted our nation's economic engine and engendered a secondary mental health pandemic. Already critical, our response to mental health emergencies will be even more vital. The rate of people in the U.S. with mental health concerns such as anxiety, depression, and suicidal thoughts has doubled to more than 40% since March 2020 compared to previous years, according to the CDC – with people of color and low-wealth people among those most affected.

By any standard, we are not making wise decisions on how we identify and address mental health and mental emergencies in our nation. Annual health care spending on mental health disorders was $225 billion in 2019 – more than any other condition – with one in eight emergency department visits in the U.S. involving mental illness or substance use disorders. There is a dismal return on this investment across multiple dimensions: people with serious mental illness have decades-shorter lifespan due to preventable and treatable conditions, represent a quarter of those experiencing homelessness in the U.S., and are significantly overrepresented in our jails and prisons. In addition to the human cost, the failure to provide effective, timely, and appropriate mental health care leads to huge economic inefficiency, such that 60% of total medical expenditures are driven by the 23% of the patient population who have behavioral health needs. Transforming the "front end" of the system – how mental health emergencies develop and are handled – is critical for improving these outcomes. As our project consistently illustrates, it is also what people closest to the problem want.

Significant, critical work is already being done to define what constitutes a crisis system and what policy, funding streams, and practices need to be in place to improve them. The Front End Project, which centers racial equity and the voices of those with lived experience, draws on this notable work (see box on next page for further Front End Project background.). Our landscape analysis, included in Appendix A, synthesizes key aspects of this work as a jumping off point for the set of conversations that led to this vision document.

This vision document articulates both our aspirational North Star Vision and a set of principles and accompanying strategies that contribute to the work being done in the crisis realm by centering racial equity and people with lived expertise in transforming crisis response. We hope that the vision, principles, and strategies identified here further engage those with lived experience; public health and community leaders; elected officials and public sector officials; mental health policy experts and practitioners; experts in addressing structural racism; and neighboring professionals from the health care, housing, and justice sectors alike. Collective and sustained efforts are needed to explore areas identified for action or further inquiry; invest in the development of new practice frameworks and standards of care; and to test, evaluate, and scale effective practice models while continuing to hold and strive toward our North Star Vision of crisis response. We hope this effort serves as a platform to build a movement of the voices of lived expertise as core to this collective effort. As with other social justice reforms, this base is critical for propelling change.

What is the Front End Project?

The Front End Project was initiated to set forth a vision and strategies to transform the front end of mental health emergency (or "crisis") – how mental health emergencies develop and are handled – which in many communities heavily relies on or defaults to law enforcement, and too often gets tangled in the criminal legal system. People with lived experience of mental health conditions participated as central subject matter experts at all phases of the project and – recognizing the disparate impact and outcomes on Black, Indigenous, and people of color (BIPOC) – the work centered racial equity.

The project has consisted of three phases of work: a landscape analysis of existing policies, programs, practices, and systemic challenges or gaps within current crisis system responses; convening of cross-sector discussion groups to tackle thorny issues related to crisis response; and a distillation of lessons learned into this document, featuring a North Star Vision that strives to disrupt the status quo and associated cross-cutting principles that aim to address broad structural issues that impact crisis response and should be considered in the context of the good and ongoing crisis system reform efforts of others in the field.

Landscape Analysis

The Front End Project completed a landscape analysis, included in Appendix A, of the current state of crisis response systems across the U.S. to ground the project in an understanding of how mental health emergencies are defined; the systematic framework and policies that currently guide mental health emergency response; the key features and strengths and/or limitations of response models that are regarded as promising in the field; and the key challenges and gaps that persist. Themes from this landscape analysis informed key questions considered by cross-sector subject matter experts during topical discussion groups, outlined below.

Front End Discussion Groups

The Front End Project benefited immensely from the diverse perspectives, both personal and professional, of those who participated in our series of topical discussion groups. While many group members had expertise in mental health, as either consumers, providers, or policy makers, others came from adjacent sectors that impact and are impacted by crisis systems, including law enforcement, housing, and racial justice advocacy. Each of the discussion groups included participants with experience as people who have been on the receiving end of crisis systems, creating an opportunity for other participants to hear an oft-neglected perspective and learn directly from their lived expertise.

Discussion group topics included

- Defining Mental Health Emergency and Aligning Appropriate Response
- Racial Justice and Equity Issues in Mental Health Emergency Response
- Redefining the Role of Law Enforcement in Mental Health Emergency Response
- Creating Upstream Access: Solutions and Prevention Strategies
- Structuring the Mental Health Emergency Response System (Expanding Beyond Traditional Partners)

The project also hosted an additional discussion group composed solely of people with lived experience who are Fountain House and other Clubhouse members (many of whom also participated in the other discussion groups) to ensure that their perspectives – and often traumatic lived experiences – were honored and heard in a safe community space.

Select quotes from discussion group members are included throughout this report. Fountain House has also produced a video that is on the report webpage featuring highlights of these discussions.

North Star Vision

Our North Star for mental health emergency response is a system that recognizes that a person experiencing a mental health crisis needs a response that is rooted in public health, not public safety. Pursuing this health-first approach requires a shift away from long-held narratives linking mental illness to violence towards a contextualization of mental health needs within the spectrum of health issues any person may face. Simply put, a person experiencing a mental health emergency needs a specialized, health-based response akin to the responses to other emergency health issues such as heart attacks or strokes.

A health-first response unapologetically centers health and well-being above all other outcomes, and creates space for self-determination in the resolution of crises. It emphasizes that public safety has frequently been misused and abused in this space and therefore it is critical for us to be skeptical of its blind assertion to justify blanket policies or programs. People with lived experience in our discussion groups emphatically wanted Peer supporters and mental health experts, not law enforcement, to respond to mental health crises, and noted that very often what is deemed by others to be a crisis is an incident that can be resolved without intervention from the criminal legal system. Indeed, for people of color especially, a law enforcement response can be deadly – the opposite outcome of a public health response.

A public health framing informs not only who will respond to a mental health emergency but also how crisis systems are organized and implemented. It requires that crisis response be embedded within a continuum of prevention and recovery services equipped to provide both primary prevention – the prevention of crises before they happen – and secondary prevention – the prevention of the worst outcomes of mental health crises. This is akin to other health conditions. For example, we attempt to prevent heart attacks before they happen with diet, exercise, and medication, but we treat them when they do occur in order to preserve function to the greatest extent possible. It means ensuring that a range of mental health services are accessible, equitable, and effective for every person who needs them.

A public health framing also recognizes that some drivers of mental health crises live inside the health care system and/or mental health service delivery environment, while others are foundational, living outside of health care systems. Such foundational or “upstream” risk factors can reside in other systems – such as in criminal justice, housing, or employment – that engender trauma, exacerbate existing mental illness, and make crises more likely to occur. Indeed, long-term community investments in sectors that address economic and human security needs are inextricably linked to crisis prevention. It is important to acknowledge these drivers of mental health crises outside of the formal health system and ensure that the reimagining and reconstruction of crisis care fits into the more comprehensive efforts to address structural racism in health care and other key sectors.

Cross-Cutting Principles of Mental Health Emergency Response

Through issue area landscaping and convening discussion groups with cross-sector subject matter experts – particularly those with lived expertise and people of color – we have outlined the following eight aspirational principles for the way crisis response systems should be organized, implemented, and understood. We apply a racial equity lens in our analysis to ensure recognition of the additional burdens of crisis system failures on Black, Indigenous, and People of Color (BIPOC) and the necessity of centering their voices and involvement in reform efforts. We also contextualize crisis systems within broader mental health and community social support systems.

This framework allows us to examine upstream risk factors that create and sustain crises. When possible, we have identified actionable strategies for reform. In many cases, we are aware that there are specific recommendations, programmatic innovations, and policy proposals that are being put forward and offer these as principles to be integrated into, or to inform further development of, such items. Most of these issues are sufficiently complex that further inquiry is required to identify the intersections between these principles with evidence-based and emerging community practices. While some of these concepts may be known and previously expressed by subject matter experts, we believe that our insistence on the input of persons with lived experience, racial equity, and the role of upstream dynamics frames issues in a new light, adding value to crisis system transformation efforts.

Crisis systems should center racial justice and equity.

Structural racism infuses all areas of American society, and the crisis response system is no exception. Indeed, it could be considered a cauldron of the intersection of the criminal legal system with the health care system, both of which have well-documented histories of disproportionately negative outcomes for BIPOC. According to the American Psychiatric Association, "Black people with mental health conditions, particularly schizophrenia, bipolar disorders, and other psychoses are more likely to be incarcerated than people of other races."

> *"People of color are all living with institutionalized racism. No matter what their other diagnosis is, the first diagnosis is [that they are] trouble. And so you have to look at that first before you look at anything else. And then you have to look at what's equity in health care."*
>
> *– Davida Kilgore, MSW, Fountain House member, artist, advocate, therapist*

Furthermore, structural racism in systems such as housing, employment, and education exacerbate risks of trauma and disproportionately impact the mental health of people of color. Racist policies have also led to diminished investments in mental health resources in communities of color, resulting in a well-documented lack of mental health services and equitable access to quality care.

Understanding how white supremacy has shaped mental health and related systems is essential for transforming crisis systems. In addition, the important efforts being made to reimagine and reform the police force, the criminal legal system, and related fields are deeply relevant to the creation of appropriate mental health emergency response. Many of the tools that are increasingly being deployed to address structural racism in other

sectors, such as training, workforce representation, data focus, and public attention, while not an exhaustive solution, are similarly important contributors to creating the needed shifts in crisis response systems.

Areas for Further Inquiry and Action:

- Invest in the development of new frameworks for practice (mental health assessment, diagnostic and treatment models) that center anti-racism and include the voices of impacted populations.
- Convene cross-sectorial executive sessions designed to develop/define practice standards for crisis response that prioritize racial justice and equity.
- Provide infrastructure and leadership support within organizations to make changes through hiring practices that ensure crisis responders reflect the race, culture, and community being served, and that workforce are trained on cultural humility and responsiveness in order to have the tools needed to combat structural racism.

Crisis response should be embedded within a holistic, integrated health care and public health system with high quality, accessible, and equitable services.

The availability of high quality, accessible, and equitable services in an integrated health care and public health system should result in far fewer crises occurring and better resolution of those that do occur. In reality, in many communities, especially Black or brown communities or others where historically marginalized populations reside, such upstream services do not exist at all, resulting in crisis services acting as a replacement for a functioning public health system. The underinvestment in accessible, equitable upstream and crisis services places people at greater risk of experiencing a crisis in a system with low capacity to respond to their emergency. Where resources for crisis prevention and recovery exist, they are often siloed from crisis response services, creating quality disparities and preventing people receiving services from easily moving through the continuum of care and community supports. Crisis response services are most effective when they are a component of a well-resourced, integrated system. Moreover, it is critically important that a crisis service continuum not become a separate and siloed system, but instead serve as a conduit and link to other resources for support, care, and well-being.

> *"I think the problem is in the medical model, we're not taught to think about the person. We're taught to think about the illness and the illness state in the symptomatology, which [means] we're missing the boat. We're totally missing the boat of people's lives and how people stay healthy."*
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> *– Stephanie Le Melle, MD*

Areas for Further Inquiry and Action:

- Ensure all crisis response systems are linked to services and community-level social services including behavioral health providers, integrated health care systems, Peer-run programs and services, and social justice organizations, as well as those that address social determinants of health.
- Provide greater investment in community programs co-designed by community members and people with lived experience as part of the crisis continuum, especially in and by communities of color.

- Incorporate strategies for community participation in the structuring of crisis response systems in order for communities and crisis services recipients to drive the understanding of the resources they need both during and after crises and to co-create solutions.

Individuals in crisis should have all possible opportunities to maximize self-determination and autonomy in defining when they are in crisis and in shaping the response when one is activated.

> *"When planning, designing, and implementing any program, those who are directly impacted should have a seat at the table. In the mental health community, Peers say that there is 'nothing about us without us.' Peers should always be at the decision-making table because we know what's best."*
>
> *– Christina Sparrock, CPA, Peer, advocate*

People in our project with lived experience spoke powerfully about what works when they are experiencing what others may deem a crisis. Indeed, this starts with the definition of crisis – which some of our participants said is too often defined by others, rather than by what a person is experiencing themselves. Many people with a history of mental illness have had the experience of an outside observer such as a neighbor, family member, coworker, or clinician determining that they are in crisis and activating an unwanted or unwarranted response from 911 or law enforcement. Once the response is activated, the quality and capacity of the crisis response system may determine how the responder balances the autonomy and dignity of the person in crisis with the obligations of the responder to follow predetermined protocols for providing care and ensuring public safety. Wherever possible, crisis systems should support self-determination and autonomy such that persons in crisis can define their situation and identify preferred solutions. In the limited instances where the system must override a person's wishes, such as when the safety of self or others is directly jeopardized, it is doubly important that an individual's human dignity be preserved through identifying opportunities for autonomous choice wherever possible.

Areas for Further Inquiry and Action:

- Psychiatric advance directives (PADs) should be encouraged and developed when a person is doing well and used if a person becomes unable to make decisions due to a mental health emergency. States that do not have laws that permit the use of PADs should consider legislation that recognizes their use. First responders and mental health professionals should be trained to ask about PADs in all crisis response.
- States should also explore supported decision-making frameworks and how they may be applied to mental health emergencies.
- Standards for clinical crisis response should ensure that interventions are person-centered, and designed and implemented to maximize autonomy to the extent possible. (For example: while individuals in crisis may not have a choice about being taken to the emergency department or other acute care, they can choose who comes with them and what to bring.)
- As states review and revise civil commitment laws and implement regulations, they should consider principles of self-determination and autonomy.

Crisis responders should focus on creating person-to-person connections and trusting relationships with the person in crisis.

To ascertain what is the most appropriate intervention and resolution when someone is experiencing what others may deem is a crisis requires responders to engage individuals with respect and dignity. Many times, simply developing rapport and hearing people out can lead to a resolution – as in the case of one of our participants, who had an anxiety episode while in an argument with his sister. He said he really just needed some space, but the outcome was that six police cruisers descended and frightened him. Other times, supporting connections to concrete services such as housing or food assistance will help. Peer supporters are particularly suited to this sort of connection, and trained mental health professionals more than law enforcement. Our participants almost universally felt that law enforcement is not trained to provide the necessary response, and sets up a charged and potentially dangerous dynamic for people experiencing a mental health need, particularly for people of color – even as some appreciated individual police officers they have encountered.

This desire for human-to-human connection extends to medical and support staff at hospitals, who sometimes because of institutional pressures or lack of training can subject people experiencing a mental health emergency to dehumanizing practices that would not be tolerated in other medical emergencies. In any hospital setting – as well as law enforcement encounters that do not involve a crime – responders must fulfil their responsibility to recognize individual dignity as they exercise their duty to care. Stigma and discrimination have led to a skewed balance in that regard for people with mental health needs. But the success of non-law enforcement led response models, and particularly models that involve Peer supporters, demonstrate that this balance can be achieved.

> *"It becomes a crisis when people who aren't supposed to get involved, get involved….*
>
> *"Honestly, I think that the advice that I would give would be to be a friend first – show me that I can trust you. Show me, show that person that they can trust you by listening. Listening is the most important thing for a mental health crisis."*
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> *–Arvind Sooknanan, Fountain House member, advocate*

Areas for Further Inquiry and Action:

- The right workforce trained the right way to respond at the right time is critical. Responders should be trained in assessing the situation, engagement and developing rapport, and de-escalation. Professional standards on training and clinical intervention should reflect these human-centered values.
- Educational programs for MSWs, psychiatric residents, Peer supporters, and others who might be responders should include psychosocial rehabilitation and recovery-oriented practices that address whole health and well-being.
- Communities should invest in programs that provide holistic, person-centered supports such as Peer respites and community stabilization programs.

Law enforcement should not be the default or primary responders for mental health crisis.

Police as respondents to mental health emergencies is common in communities, with 911 dispatch often used to initiate the service. While police are able to respond quickly 24/7/365, the presence of law enforcement can elevate an individual's symptoms and escalate behaviors, especially for those who have past trauma experience or come from over-policed areas. This is particularly relevant for Black and Latinx people where the possibility of harm or death by law enforcement is increased. Limited alternative options exist outside of police led or co-led models for crisis response in many communities. Police officers may be more likely to perceive and respond to an individual's potential crisis as a public safety threat as opposed to an opportunity for de-escalation. Many police departments have little to no training on responding to mental health emergencies. To the extent available, Crisis Intervention Team (CIT) trained officers have more knowledge and skills than an average officer to effectively respond. However, alternative response models that are led by or actively involve the mental health system are not as widely available. Further, mental health services are often not available for officers to even refer or divert individuals to in the community when police do respond.

> *"You know, we're trying to operate within the confines of a system that is failing and if you want racial justice and equity in a mental health emergency response [police] should not be included in that response in any part [as] the first and foremost resource to respond to it."*
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> *–Chief RaShall Brackney, PhD*

Slated for implementation in 2022, the 988 hotline will create an alternative to 911 for mental health emergencies. The rollout of 988, which is underway now, will lay the groundwork for a national strategy for emergency mental health response that does not default to or rely on law enforcement as the primary response and is focused on connection with community resources.

Areas for Further Inquiry and Action:

- State and local systems should bring together mental health, law enforcement, 911 dispatchers, and other key constituents to begin planning now for 988 implementation. Planning should minimally address budgeting for the cost of 988 implementation and sustainability, and crisis triage protocols.
- State and local systems should plan for the development and implementation of crisis services that are available geographically throughout the state. This should include identifying the types of services and models that should be implemented; financing of services through braided federal, state, local, and private sources; and the respective roles of mental health crisis services and law enforcement.
- Invest in the scaling of effective mental health system led crisis response and stabilization models as alternatives to the predominant police led and co-led models.
- Develop model frameworks and strategies for behavioral health and law enforcement to engage and coordinate at the local level to determine protocols for law enforcement involvement and referral/handoff in each community's crisis response system.

The role and expertise of Peers should be centered in crisis response, recovery, and prevention.

Over and over in our research and discussion groups, the value and necessity of Peer involvement in response to mental health emergencies was raised. Yet also raised was the lack of Peer involvement in such responses – whether on a first responder call or in an emergency department. Emerging evidence has correlated Peer involvement with reductions in psychiatric symptoms and substance misuse, increased self-care and wellness, reduced hospital admission rates, and longer tenure in the community. Even with the mounting evidence of positive outcomes, advancing Peer support within the continuum of care has been met with ongoing challenges, both structural (policies and financing, role clarity) and implicit and explicit stigma and discrimination.

> *"I find talking to a Peer is really helpful…. When I was arrested by the police during a mental health crisis, if I had a Peer to talk to I think I could relay what I'm trying to say to the police through the Peer and it would have come across a little better…. I get agitated and fearful and I don't think straight and if I had a Peer to advocate for me at that time I think it could have been resolved."*
>
> *– Kimberly Stevens, Fountain House member, advocate*

Crisis response has significant unmet workforce needs. People with lived experience can be vital contributors to the crisis response workforce if those who have interest in the Peer profession or other related roles have access to training, living wage employment, and career ladders.

Areas for Further Inquiry and Action:

- Build on the research base, regulations, and standards already in use to scale programs that advance the integration of Peer workforce, at livable wages, into crisis systems.
- Increase funding for deploying a well-trained workforce of people with lived experience across the continuum of crisis care. This includes investing in career lattices, such as educational and training opportunities, for people who want to leverage their expertise both inside and outside of traditional Peer roles. This investment will maximize the integration of lived expertise across the workforce that impacts crisis services, inclusive of professions such as social work, human resources, occupational therapy, and public policy.
- Address policies that advance the role of trained Peers in integrated teams and settings – inclusive of emergency departments, hospitals, crisis teams, mental health courts, and related programs such as supportive housing/employment.
- Provide training to systems and providers on the role and scope of practice of Peer providers on interdisciplinary teams to facilitate collaboration to reduce stigma and implicit biases about people with mental health conditions having the capability to work on crisis response teams.

Alternatives to emergency departments should be prioritized when possible.

In many communities, the lack of mental health and social support resources means that there are limited or no alternatives to the emergency department for crisis services. This dynamic leads to overuse of health care resources for people who have no acute medical need and would ideally be served in less medicalized, community settings. In addition to the negative financial impacts of defaulting to expensive emergency medical services, there are also significant human costs. While hospitals are supposed to be places of healing, they can be a place of further traumatization for a person who has been brought to the emergency department in the midst of a mental health crisis. Emergency departments are often ill-equipped with the psychosocial resources necessary to provide human-centered crisis intervention and connection to community supports. In addition, risk management protocols in hospitals may require medical teams to implement heightened security practices, such as the use of chemical or physical restraint or one-to-one close supervision (also known as 1:1) for patients experiencing distress or suicidal ideation, which can escalate the crisis.

> *"We have to look at our hospitals, what is their response to a person who is in crisis. We know that different hospitals respond differently… and they're just not equal, they don't provide the care. Sometimes they just want to get that person out and they just medicate them and they don't really try to look at the person as a whole person and treat them."*
>
> *– Claudia Vargas, Peer policy fellow, San Antonio Clubhouse, Inc.*

Areas for Further Inquiry and Action:

- Identify, evaluate, and scale non-hospital based crisis care services such as Peer respites or other community programs.
- Examine payment models, such as Emergency Triage, Treat, and Transport (ET3), that can provide flexibilities to first responders to transport individuals to less restrictive, recovery-oriented services.
- Share resources and best practices or alternatives to emergency departments that are Emergency Medical Treatment & Labor Act (EMTALA) compliant.

Every community should have a standard, universal, and publicly supported response to mental health emergencies on par with the response to other health emergencies.

No equivalent nationwide response system exists for mental health emergencies on par with that which exists within communities for medical emergencies. For most communities, 911 is the default crisis line and emergency mental health programs to transfer calls to are lacking. Even when communities have local mental health crisis programs, the lack of widespread public awareness and integration and coordination of these services with call lines and law enforcement can create access barriers and lead to a default public safety response. Mental health emergencies require a specific type of response that should be specifically and publicly designed for. Individuals should not only know what number to call, they

should also receive a specific and predictable response that is tailored to their local community and based upon the principles outlined in this document.

Areas for Further Inquiry and Action:

- Develop model frameworks and strategies for the integration and coordination of available mental health crisis services with call centers (e.g., 911, 988), law enforcement, and other first responders. This should minimally include clarifying response protocols and clearly articulated roles and responsibilities at the local level, along with strategies for updating as crisis capacity is added within systems.
- Explore the potential to pilot and evaluate strategies for integrating with or referring to mental health providers at 911 dispatch, including modeling potential interfaces between 911 and 988.
- States and localities should, in addition to being actively involved in the 988 rollout to ensure that implementation meets the needs of their communities, continue to build out other core crisis system components to ensure their availability and accessibility within communities.

> *"I think that our mental health systems and our emergency crisis response systems…definitely need to be totally revamped and dismantled and reimagined because the current model is steeped in white supremacy and paternalism and institutionalism – and everything about it is unappealing especially to Black, brown, and indigenous populations. Even the term 'mental health' itself. And so it definitely needs to be revamped and we need to really utilize the insights of communities most impacted and with them co-design solutions."*
>
> *– LaMont Green, DSW*

APPENDIX A:

The Landscape of Mental Health Emergency Response: Setting the Stage for "Front End" Transformation

Created by The Front End Project; a collaboration between Fountain House, the Center for Court Innovation (CCI), The W. Haywood Burns Institute, the Technical Assistance Collaborative (TAC), and the Mental Health Strategic Impact Initiative (S2i), with support from the Ford Foundation.

Mental health emergencies too often result in tragic consequences when the response is based on a public safety versus public health approach. Consider the following strikingly different scenarios:

On October 18, 2016, 66-year-old Deborah Danner was killed in a police shooting after a confrontation in her own apartment in the Bronx, following a mental health call by a neighbor citing erratic behavior. The sergeant who shot Deborah with a gun twice (though he had a taser) — one of five officers in the apartment — was acquitted of murder charges. Deborah, a computer science professional, a member of Fountain House, and a writer, had lived with schizophrenia for more than 30 years, a struggle she wrote about, including these words: ***"We are all aware of the all too frequent news stories about the mentally ill who come up against law enforcement instead of mental health professionals," she wrote, "and end up dead. We should all be aware that these circumstances represent very, very serious problems that need addressing."***

Deborah was known to both law enforcement and neighbors; she was a member of her Bronx community and the Fountain House community, where she had many friends and fans. She did not need to die. According to a Washington Post *database, Deborah was the 771st person shot and killed by American police officers that year. Fully 182 of them (23.6%) were suffering from a mental health crisis at the time of their death. She was the 188th Black person to die as the result of police violence in 2016, despite Black people making up only 13% of the U.S. population (a rate of 32 per million, compared to 13 per million for white people).*

On the podcast Into America, a Crisis Assistance Helping Out on the Streets (CAHOOTS) worker describes her first mental health emergency call: "This girl was crying outside of a grocery store. And her pants had this huge tear – she was mostly naked. And I just got down and I sat down next to her on the ground. And I just sat with her while she cried. And then, when there was a break in the crying, I introduced myself and asked her her name. And she was yelling. She was yelling at me. And she was yelling about the day she'd had and the way that her boyfriend treated her and that she was stranded and she was cold. And all of these really reasonable things to be upset about, right? And instead of criticizing the way she was coping with her feelings, I just said, 'I would like to start by getting you pants. I think I have some pants on the van. Can I grab you some pants?' And my partner went and got the pants. And I was, like, 'These are for you. You can change later. Now, what do we need to do? Your boyfriend left you. Do you have a house?' 'No.' 'Okay. Can we take you somewhere? Is there anywhere that you would feel safe right now?'

"You just start going through the list, assessing what's available to this human. *And she just needed some time. And so we took her to our local crisis center, where they could do some on-scene crisis counseling and let her have a space to just sit and gather her thoughts since she'd clearly had this really traumatic day. And when it was over, I asked my trainers. I said, 'Did that go well? Did I do that okay?' And they're like, 'That's exactly right.* ***You just met her where she was and you helped her get where she needed to go.' And that's the work."***

Introduction

Mental illness and related mental health conditions are common. One in four people will experience a diagnosable mental health condition at some point in their life. Far too many of them will deal with this condition

as part of the criminal justice system as opposed to the health care system. Today, in an era when deadly police violence is top of mind, one in four fatalities at the hands of police involve people experiencing a mental health emergency. The people with mental health needs involved in these incidents are, much like their counterparts incarcerated in jails and prisons, disproportionately Black and brown. This is a public health problem that can and needs to be solved at the front end, before law enforcement is involved at all. But to do this – as with any public health situation – we need to look both further upstream, at how to prevent mental health emergencies in the first place – as well as at emergency responses.

This paper is designed to provide a landscape of where we are – how we define a mental health emergency (or "crisis"), how we currently respond, and what are alternatives and paths to get to a truly public health first approach. Its goal is to inform a series of related discussions, rooted in this landscape, that move to recommendations for a reimagined front end – one that aims to lift the voices of those with lived experience, account for trauma and racial inequity, restore wellness, and reduce these unacceptable outcomes. Specifically, the paper sets up five discussions premised on how we define a mental health emergency, how current responses trigger and exacerbate racial inequities, and what reimagined emergency mental health response should look like in the United States, including what the role of law enforcement should be, as well as that of nontraditional partners and upstream, preventative solutions.

A Note About Terminology

Throughout this paper, the term "emergency" is primarily used to connote the diverse crises that can lead to an emergency response. The term "crisis" is also used at times as it remains the common terminology for labeling emergency mental health response policies, programs, and/or services.

Also, while primarily referring to mental health emergencies, the paper and ensuing discussions envision a holistic approach that recognizes the impact of a range of factors, including substance use/misuse, on crisis experience and response.

Key questions to be considered as part of these discussions in order to determine what is needed to make the envisioned system a reality are highlighted throughout this paper. To set the context, current emergency mental health response policies, programs, and practices are briefly explored, along with models regarded as promising, in order to identify gaps as well as positive factors within the current landscape. Learnings that can inform emergency mental health policy, practice, and funding, including from alternative, community led responses in other areas (e.g., violence interruption), are also considered.

This paper and the ensuing discussions are a means to an end. Working at the intersections of the public health and criminal legal systems, this project aims to disrupt both current practices that exist on the ground and the systemic framework and policies that currently guide emergency mental health response services, in order to lead us toward a health-first response to mental health emergencies across the country.

Background

Ideally, a comprehensive system of prevention, early intervention, treatment, and support services exists so that individuals who experience mental illness and related mental health conditions have access to the tools they need to manage and recover. At times, individuals may experience a mental health emergency that requires a more focused response. The experience of a mental health crisis is often defined by whether an individual is assessed to be a danger to themselves or others. This assessment, however, is highly subjective, and prone to being influenced by who is making the assessment and how, as well as factors such as race, stigma, trauma history,

language skills, and housing status. Crisis experience itself is also subjective, such that crises related to social determinants of health such as housing may bring about or exacerbate a crisis for one individual and not another. It may also be the case that a crisis requires a response from or coordination with other systems and community resources when the need is for services and/or supports related to other social determinants of health or to substance use/misuse, which may also help prevent future crises from occurring.

When a mental health emergency response is triggered for whatever reason, crisis services have a role in assessment and triage, as well as de-escalation, stabilization, and referral for ongoing intervention as appropriate. However, access to emergency mental health services varies widely across the United States, as does agreement on best practices. The absence of both all too often has tragic consequences.

The failure of public and private systems to support responsive, best practice, community-based emergency mental health services leaves too many people without an emergency mental health system, and reliant on a response that defaults to and is built around law enforcement. Rather than a medical or public health system response focused on caring for the individual, the system is organized with a public safety bias focused on serving the community by controlling the "threat." Too often, when a law enforcement response is the default rather than last resort, individuals with mental illness become victims of excessive force or homicide by law enforcement, or end up entangled in the criminal legal system.

Defining Mental Health Emergency & Aligning Appropriate Response

The first discussion this paper sets up considers different definitions regarding what is or is not considered a mental health emergency, what should be central to a definition that activates a mental health or other system response, and what is important in doing so. The impact that stigma, discrimination, trauma, and other factors (e.g., community culture, public safety/control) have in shaping emergency response will be explored to help reframe the issue toward better alignment with meeting individual needs. The type of intervention that may be needed to address issues that are not a psychiatric emergency, but when an intervention is needed to support an individual, will also be explored, as will questions such as: What type of response is needed for someone who is not experiencing a psychiatric emergency, and is in need of services and/or supports related to their mental health, substance use/misuse, or other social determinants of health? Whose responsibility is that and what other systems or community resources need to be at the table?

This emergency response system, or lack thereof, is drastically different than the response that ensues when an individual experiences a medical emergency like a broken bone or heart attack. An organized network of emergency medical services (EMS) exists in communities to respond to medical emergencies that people experience. EMS is responsible for managing medical emergencies, sometimes after the initial situation is contained by first responders such as law enforcement or the fire department for safety reasons (e.g., an auto accident). EMS provides initial stabilization or treatment and then triages the person to the next appropriate system, which may include transportation to the emergency department. At times, the emergency may warrant the need for inpatient treatment, but often the emergency can be addressed in the community.

Unfortunately, a parallel response system for mental health emergencies does not exist. In February 2020, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) released its National Guidelines for Behavioral Health Crisis Care outlining a potential framework to establish nationwide capacity to respond to mental health emergencies. The guidelines describe three core components deemed essential to meeting the mental health emergency needs of anyone, anywhere, anytime: 24/7 regional crisis hotlines; 24/7 mobile crisis response; and crisis stabilization programs. What currently exists, however, varies widely across states and communities

such that many communities' approaches lack one or more of these core components, and others have no formal response system at all.

This variation may be the result of funding priorities, policy decisions, or both. Budget cuts to behavioral health systems at the federal, state, and local levels have had a significant impact on the availability of crisis intervention services. State and local governments that fund only mandated services[1] are those most likely to be lacking true crisis intervention and response services, with the role of crisis worker being merely to facilitate the mental health involuntary commitment process.

States that have a strong focus on crisis intervention and response, and that perform a cost-benefit analysis and view the up-front investment in services as saving costs upstream, are more likely to fund a comprehensive array of crisis services that includes the core components outlined in the SAMHSA guidelines. Further, states and communities that embrace treating symptoms and de-escalating behaviors associated with mental illness using the least restrictive environment are more likely to provide active crisis intervention and response services, whereas those who profess a "tough on crime" approach are more likely to treat behaviors that may stem from mental illness and related mental health conditions as criminal behavior, dispatching law enforcement as the first responder and often leading to arrest, citation, and/or incarceration for nonviolent, misdemeanor offenses.

SAMHSA's National Guidelines for Behavioral Health Crisis Care

SAMHSA outlines three core components deemed essential to meeting the mental health emergency needs of anyone, anywhere, anytime:

- ✓ 24/7 regional crisis hotlines;
- ✓ 24/7 mobile crisis response; and
- ✓ crisis stabilization programs.

As discussed in other sections of this paper, using police as respondents to mental health emergencies is common in communities, with 911 dispatch often used to initiate the service. Systematic decreases in funding for community mental health care dating back to the 1960s have paralleled increases in funding for law enforcement, expanding the role of police in communities. This dynamic has been particularly visible since the passage of the 1994 Crime Bill. Today, the balance is such that more funding is available for police to perform crisis response than for mental health programming designed to effectively prevent and respond to mental health emergencies. The result is a higher prevalence of models in many communities that are police led or co-led in partnership with the mental health system.

Regardless of whether crisis response is led by the police, the mental health system, or a combination of the two, historical and structural racism, as well as racial, cultural, and ethnic inequities and disparities, impact the response and related outcomes. Rates of mental illness for Black and Latino populations are nearly the same as rates of mental illness for white populations; however, they experience a disproportionately higher burden of disability from these illnesses as compared to whites. When they do access services, communities of color often

[1] State mental health systems must meet certain standards set by the federal government, e.g., the Community Mental Health Services Block Grant requires funding of "Emergency Mental Health Services." However, states have significant authority to make decisions about their mental health systems' regulations and available services, including the services a state is required to provide using state general funds, and standards for involuntary mental health commitment.

receive a much poorer quality of care. Among people with any mental illness, 48% of whites received mental health services, compared to 31% of Blacks and Latinos and 22% of Asians.[2]

To better understand the ways in which our mental health and emergency response systems are inadequate at meeting the needs of the mental health community, one must examine the role that systemic and structural racism – which include historical, cultural, and institutional/policy implications – play in creating barriers to accessing critical services. These structural biases impact the mental health system overall by creating barriers in accessing adequate insurance coverage and care, and create a lack of diversity in the mental health workforce which, in turn, worsens the issue of culturally competent care and often leaves language barriers largely unaddressed. In addition, the lack of a diverse workforce contributes to a higher level of stigma in communities of color where the stigma around mental illness is already high, again creating significant barriers to accessing services. This, coupled with other oppressive systems like the criminal legal system – which disproportionately targets Black and Latino people – creates a form of trauma that forces many people into poverty or traps them in a fractured system where they cycle through the various institutions – shelters, jails, hospitals – that create more harm than help.

This is reflected in the emergency mental health response system as well, where emergency mental health care is often led by, or connected to, public safety and law enforcement. As cited in this paper's opening scenario, nearly a quarter of deaths by police in 2016 were people experiencing a mental health emergency. Of those, a disproportionate number were Black and other people of color.[3] This statistic comes as no surprise considering the already frayed relationship between law enforcement and communities of color where the dispatching of a police officer escalates the situation dramatically. With many people of color not able to access consistent and regular mental health services, they are more likely to experience a mental health emergency, thus triggering a law enforcement response that not only endangers their lives, but criminalizes mental illness and creates a domino effect that precludes them from accessing housing, appropriate care, and employment, and impacts other social determinants of health.

Current Response Models

Here we briefly explore existing models regarded as promising practices in the field for emergency mental health response, highlighting key features and strengths and/or weaknesses of these models, and related outcomes. A distinction is made between those that include a formal role for law enforcement and those that are solely led and managed by the mental health system. While neither SAMHSA's national crisis care guidelines nor these models necessarily represent the "gold standard" of emergency mental health services, each of the models described incorporate all three core SAMHSA guideline components, though they may differ in how they are designed and implemented. Thus, we consider how each model is aligned in terms of how the response is activated, how it is performed, and what community supports for stabilization are tied to the response.

[2] American Psychiatric Association (2017). "Mental health facts for diverse populations." Retrieved on 10/29/2020 from: https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts

[3] Washington Post (n.d.). "Fatal force: Police shootings database." Retrieved on 10/29/2020 from: https://www.washingtonpost.com/graphics/investigations/police-shootings-database/

Models That Include Law Enforcement

The majority of existing crisis response program models are either completely law enforcement led and managed, or co-led and managed in partnership with the mental health system. Law enforcement-inclusive response models use the 911 system for crisis response activation. Promising models using 911 have integrated mental health providers at this point of contact to provide assessment and support to callers in crisis. In Houston, the Crisis Call Diversion (CCD) program has embedded tele-counselors in the 911 call center and dispatchers are able to directly connect callers to a clinician.

Promising practice models for mental health emergency response that are police-involved fall into two categories: models that train police to be effective responders on their own, and models that team law enforcement with a mental health specialist to perform a co-response. Crisis Intervention Team (CIT), sometimes referred to as the "Memphis Model," was developed in 1988 and is the most well-known and broadly used police training model. CIT provides self-selecting officers with a 40-hour training that includes education on mental health and substance misuse, exposure to individuals with lived experience of mental illness, and training on verbal de-escalation skills.

Co-response models, where police officers (often CIT trained) or other first responders are partnered with a mental health clinician or Peer to respond to mental health emergencies, are extremely prevalent and come in a variety of response team compositions. The majority of these models partner a police officer with a licensed clinician, such as the Mental Health Support Team (MHST) in Tucson, AZ, or with a virtual clinician such as the Clinician and Officer Remote Evaluation (CORE) program. Other co-response teams include a medical provider such as an EMT, nurse, or paramedic such as the Rapid Integrated Group Healthcare Team (RIGHT CARE) in Dallas, TX or Community Response Team (CRT) in Colorado Springs, CO. Still others forgo police involvement in the crisis response beyond 911 activation unless there is a public safety concern, such as CAHOOTS in Eugene and Springfield, OR. CAHOOTS has recently been in the national spotlight, with their model of intervention teams consisting of a medic (nurse or EMT) and a crisis worker (trained Peer specialist or clinician) responding to mental health crises being replicated across the country. The CAHOOTS response is connected with the White Bird Clinic, which helps facilitate connecting individuals in crisis with stabilization and prevention services along the continuum of care. The model also explicitly centers race equity.[4]

Law enforcement led emergency mental health response models that are considered promising have resources to help stabilize persons in crisis tied to their response, either developed as part of their program or through pre-existing options such as hospital emergency departments and other mental health system resources. Perhaps the two most well-known law enforcement led stabilization models are Diversion First in Fairfax, VA, and Law Enforcement Assisted Diversion (LEAD), first established in Seattle, WA, but with multiple sites nationally. Both programs partner with local mental health programs to keep individuals with behavioral health needs out of the criminal justice system by providing officers responding to a behavioral health crisis with an alternative to arresting them. These programs provide a crisis center or similar resource where individuals in crisis can be taken for assessment, support, and connection with concrete and treatment resources.

[4] Morgan. E. (June 14, 2020). "Racism is a public health crisis: A statement from CAHOOTS." Retrieved on 11/6/20 from: https://whitebirdclinic.org/racism-is-a-public-health-crisis/

Summary Analysis of Models Involving Law Enforcement			
Law Enforcement Led Models			
Key Features	**Strengths**	**Weaknesses**	**Outcomes**
▪ Activated through 911 ▪ Police are trained to effectively respond and intervene ▪ Includes stabilization services as part of the response or through partnerships with emergency department (ED) and mental health (MH) providers	▪ Integrates MH-trained staff and/or MH providers at 911 call center to provide assessment and support to callers in crisis ▪ A trained officer has more knowledge and skills than an average officer to effectively intervene with a person experiencing a mental health emergency ▪ Connects individuals to MH treatment ▪ Police are able to respond quickly, 24/7/365	▪ The presence of law enforcement can elevate symptoms/ escalate behaviors, especially for those who have past trauma experience or come from an over-policed area ▪ Increases the possibility of harm/death for the person in crisis ▪ Capacity of CIT-trained officers is far more limited than the need ▪ Lacks involvement of Peers ▪ Is not designed to connect individuals to social services/ supports ▪ Marginalized communities may be less willing to seek services that involve law enforcement	▪ CCD has resulted in successful diversions and cost savings ▪ Pilots in NYC and LA have resulted in 911 call centers linking callers to MH providers ▪ There are mixed reviews on the effectiveness of CIT across "objective measures of arrests, officer injury, citizen injury, or use of force"
Law Enforcement Co-Responder Models			
Key Features	**Strengths**	**Weaknesses**	**Outcomes**
▪ Typically activated through 911 ▪ Involves partnering a police officer or other first responder with an MH clinician and/or Peer	▪ Provides MH response while ensuring public safety ▪ Allows MH clinician/ Peer to de-escalate and stabilize the situation ▪ Goal is to divert from unnecessary ED admissions/ incarceration ▪ Reduces risk of harm/death for person in crisis	▪ Public safety officer likely to perceive and respond to assessment of threat as opposed to opportunity for de-escalation ▪ Presence of a police officer can elevate symptoms/escalate behaviors, especially for those who have experienced past trauma or come from an over-policed area ▪ Marginalized communities may be less willing to seek services that involve law enforcement	▪ LEAD associated with reductions in criminal justice utilization, recidivism, and associated costs; program participants are more likely to have housing, employment, and income after referral to LEAD. ▪ Diversion First reported diverting 1,700 people from arrest in 2019

Mental Health System Led Models

Emergency mental health services in many communities are oriented around a mental health system led response. However, these models are in the minority compared with the number that involve law enforcement. These programs may still access law enforcement at times to ensure the safety of people with lived experience, family members, and emergency mental health responders, but the emergency mental health system leads the response, is organized, and has the capacity to provide the continuum of emergency mental health services.

Mental health system led response models are activated by a mental health crisis hotline or other non-911 local emergency line. While some crisis hotlines, such as the National Suicide Prevention Hotline, work separately from local programming, many are integrated into local mental health nonprofits, hospitals, or community programs that encompass a spectrum of services. Activating a crisis response through a mental health provider, as opposed to 911, means that an individual is directly connected with a mental health clinician who can provide assessment and de-escalation via phone, potentially heading off the need for an in-person response. Callers who are fearful of a police response may prefer to request help in this manner because the likelihood of police involvement is far lower than if they call 911.

Crisis response models that do not include police are generally termed “mobile response teams” (MRTs) or “psychiatric mobile response teams” (PMRTs). MRTs have been around since the 1970s and still remain the leading model for mental health led crisis response. MRTs are activated through non-911 crisis lines and are often part of an integrated response from the same agency running the crisis line. MRTs are staffed by licensed mental health providers and/or Peer support specialists who respond directly to community members in crisis. MRT clinicians are trained to provide assessment, de-escalation, and referral to stabilization services as needed.

Crisis stabilization services that are mental health system led can either be integrated into the same program that provides the hotline and response or run through external programs. Centerstone, which provides a hotline, MRT, and psychiatric urgent care center, is a good example of an integrated model with multiple locations around the country that allows one agency to manage a response from activation through stabilization, ensuring continuity of care for participants. Promising external stabilization models include programs within the medical system, such as comprehensive psychiatric emergency programs as well as community-based models, also with several locations across the country, such as The Living Room and Rose House, which provide short-term respite, often on a walk-in basis, for community members in crisis. The Living Room model is designed to provide a calm, nonthreatening setting where an individual can be removed from a “crisis” situation, de-escalate and stabilize, and eventually return to their living arrangement or be referred to an alternate setting without admission to an inpatient bed or incarceration.

Summary Analysis of Mental Health Led Models			
Key Features	Strengths	Weaknesses	Outcomes
▪ Uses an alternate telephone number to 911 to initiate response, available 24/7/365 ▪ Responders are mental health clinicians/ practitioners trained to approach a person in crisis with a psychosocial health approach, trauma-informed care, and racial equity ▪ Agencies provide a whole spectrum of crisis care services ▪ May include a person with lived experience	▪ Individual is directly connected with a mental health clinician who can provide assessment and de-escalation via phone, potentially heading off the need for an in-person response ▪ Integrated into local mental health system, nonprofits, hospitals, or community programs supporting connection to a spectrum of services ▪ Building a sense of empowerment and belief in recovery can carry over into mitigating future crisis events.[5] ▪ Inclusion of Peers ▪ Reduces the likelihood of admission to jail or emergency department ▪ Reduces costs to taxpayers ▪ Reduces incidents of harm/death to individuals in crisis	▪ Variable community awareness of available crisis services (e.g., non-911 crisis line) can limit utilization ▪ In urban areas, multiple mental health organization-based crisis lines may exist, causing further confusion about how to access help ▪ Limited state and local mental health funding to support core services for crisis response ▪ Services may not be available 24/7 or able to respond in a timely way to emergency situations ▪ Rely on the availability of community stabilization programs (e.g., housing) ▪ Health insurance plans may restrict post-crisis services/options	▪ Data on overall effectiveness of these models has not been systematically examined; outcome data is tracked at the local program level, if at all

Gaps Within the Current Emergency Mental Health Response Landscape

Despite the existence of emergency mental health response models that employ promising practices and produce some favorable outcomes, several key challenges and gaps persist at the individual, program design, and systems levels that affect the availability and quality of emergency mental health response services. Here we briefly examine these. We also suggest the need to explore areas beyond the traditional mental health or law enforcement response that warrant further consideration in any paradigm shift toward a more accessible, equitable emergency mental health response system.

Individual-Level Challenges and Gaps

Mental health emergencies and related responses are shaped by a multitude of individual-level factors, including an individual's mental health and/or substance use/misuse, other co-occurring conditions (e.g., physical, cognitive

[5] International Initiative for Mental Health Leadership Crisis Now 2 Summit (2019). "International declaration: Taking the lead – Investing in community crisis response/continuum." https://crisisnow.com/wp-content/uploads/2020/07/IIMHL-DC-Crisis-Declaration-FINAL-1-4.pdf

and/or medical), and access to treatment, as well as housing status and other factors including racial, ethnic and cultural considerations, and trauma histories.

Co-occurring conditions. People experiencing a mental health emergency are likely to have one or more co-occurring conditions or factors that impact crisis assessment and response. A high percentage of emergency mental health response calls involve substance use/misuse, but law enforcement or emergency mental health response services are often called about individuals with other co-occurring conditions as well, such as a primary or secondary intellectual or developmental disability or a medical condition. The co-existence of these conditions can exacerbate or mimic psychiatric symptoms and affect the person's emergency and response to intervention. Responders to mental health emergencies must be aware of the likely existence of one or more co-occurring conditions, as well as appropriate best practice responses in these situations. Further, emergency mental health responders must be equipped to assess, triage, and connect individuals with primary substance use/misuse disorders to the appropriate level of care within the substance use treatment system using evidence-based interventions like motivational interviewing and Screening, Brief Intervention and Referral to Treatment (SBIRT).[6]

Racial justice and equity in access to care and crisis response. Adopting an intersectional lens when examining the current mental health emergency response system, in conjunction with critical race theory, provides an opportunity to bring to the forefront the ways in which power, privilege, and systems of oppression elicit inequities during mental health emergency responses. With law enforcement either formally involved or as the default emergency mental health response in many communities despite a lack of clinical training and preparation to address such emergencies, racism, implicit bias, and the effects of power and control in these encounters (as with non-mental health emergency encounters) contribute to negative and disparate outcomes for Black, Indigenous, and people of color (BIPOC).[7] These negative outcomes are compounded for individuals with other historically oppressed social identities (i.e., citizenship or immigration status, class, ability, gender, or sexuality).

With the deterioration of funding for public mental health services in the U.S., we have witnessed the increased use of law enforcement in the management of and emergency response to individuals experiencing or perceived to be experiencing mental health issues. Mental health treatment can be cost prohibitive, limited, and coercive – and lack cultural competency. The mental health care system, where people in general have little to no control over treatment and care, is particularly oppressive and harmful to BIPOC and LGBTQIA+ communities.[8] Racial and gender disparities in access to diagnosis, treatment, and care lead to increased negative outcomes for people with mental illness during encounters with law enforcement. Far too many of these encounters result in arrest and incarceration, injury, and death. Individuals with untreated mental illness are involved in at least one in four

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[6] Boss, R., Sadwith, T., & Daly, B. (2020). "Addressing substance use in behavioral health crisis care: A companion resource to the SAMHSA crisis toolkit" (Beyond Beds: Crisis Services, Assessment #4). Alexandria, VA: National Association of State Mental Health Program Directors. Retrieved on 11/6/20 from: https://www.nasmhpd.org/sites/default/files/2020paper4.pdf

[7] American Public Health Association (2018). "Addressing law enforcement violence as a public health issue" (Policy Statement 201811). Washington, DC: American Public Health Association. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence

[8] Altiraifi, A. & Rapfogel, N. (2020). "Mental health care was severely inequitable, then came the coronavirus crisis." Washington, DC: Center for American Progress. Retrieved on 10/29/2020 from: https://www.americanprogress.org/issues/disability/reports/2020/09/10/490221/mental-health-care-severely-inequitable-came-coronavirus-crisis/

fatal police shootings, making them sixteen times more likely to be killed during a police encounter than individuals without mental illness in law enforcement encounters.[9]

The criminalization of mental illness is particularly prominent for low-income and homeless individuals, and at the same time, lack of stable housing and income has been shown to trigger mental health symptoms.[10,11] We know that due to historical and structural racism (e.g. Jim Crow laws, redlining, and other racist housing policies), BIPOC disproportionately experience homelessness and poverty. The structural inequities that affect BIPOC at greater rates than their white counterparts exacerbate mental health issues and create a cyclical effect that is difficult to escape. Intensifying this cyclical relationship is the racial bias leading to unfounded stops by law enforcement. These instances, even when they do not result in physical violence, are associated with exacerbated adverse mental health outcomes such as symptoms of posttraumatic stress disorder, anxiety, and depression.[12]

Racial Justice & Equity Issues in Mental Health Emergency Response

This discussion will address emergency and treatment and support services through a racial justice and equity lens. Often, mental health emergency response is led or co-led by law enforcement. In other locations, crisis programs may be the lead. In either response, historical and structural racism, racial, cultural and ethnic disparities, or other racial inequities impact the response and related outcomes. This discussion will identify and highlight existing racial, cultural, and ethnic issues in crisis and treatment and support services, including the intersectionality and disparities for people of color who are LGBTQIA+. Strategies or lessons learned from other areas that can inform how to address the issue in crisis services will be considered. Recommended strategies, systemic, programmatic, and/or financial reforms that foster prevention and crisis response services that are responsive to the racial, cultural, and ethnic backgrounds of individuals with lived experience and their families will be raised, with consideration given to data availability, systemic reviews, workforce composition, metrics, and participation/voice/accountability.

Given the role of law enforcement in responding to mental health emergencies in many communities, new strategies must be considered. While not necessarily focused on mental health, concepts or practices from nontraditional, community led interventions may serve to inform mental health emergency response and complement core crisis system components. These approaches toward reducing community violence, tackling racism and discrimination, ending homelessness, and addressing poverty and other social determinants of health are largely absent from the design of traditional crisis response services.

Two examples include the Newark Community Street Team in New Jersey and Youth Alive's Caught in the Crossfire (CiC) program in Oakland, CA. The Newark Community Street Team employs nontraditional community leaders, including those who have been formerly incarcerated and those who have been engaged in the drug trade. They are trained as mentors and interventionists, and support at-risk youth and young adults 14-30 years old through a case management model.[13] Violence interrupters in the CiC program are problem-solvers who take to the most dangerous streets at the most dangerous times of night to engage young

[9] Fuller, A., Lamb, H. R., Biasotti, M., & Snook, J. (2015). "Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters." Arlington, VA: Treatment Advocacy Center. Retrieved on 10/29/20 from: https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted

[10] American Public Health Association (2018). "Addressing law enforcement violence as a public health issue" (Policy Statement 201811). Washington, DC: American Public Health Association. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence

[11] Vitale, A. (2017). *The end of policing*. Brooklyn, NY: Verso Books.

[12] Ibid.

[13] The Newark Community Street Team. Retrieved on 10/29/2020 from: https://www.newarkcommunitystreetteam.org/about-us/

people, diffuse tensions, mediate conflicts, and encourage alternatives to violence. These interrupters are people who have been there, who have either worked in street outreach for years or who have been on the other side, who understand the language, the codes, and the barriers to a new life for young gang and group members in Oakland.[14]

Preliminary reports on the Cure Violence model, a model that uses a public health approach and violence interrupters to prevent, treat, and control violence, show the promising impact of utilizing nontraditional and community led interventions. A 2017 report on the initiative in New York City neighborhoods showed a 63% reduction in shootings and 37% reduction in gun injuries in the South Bronx, as well as a 50% reduction in gun injuries in East New York.[15] Other studies indicate a shift in attitudes and beliefs towards violence and law enforcement. These findings can act as an impetus to create and fund alternative emergency mental health responses that do not involve law enforcement or other customary system players.

Trauma-Informed Care Principles

SAMHSA's Trauma-Informed Care in Behavioral Health Services outlines the following guiding principles for trauma-informed care that should inform mental health emergency service delivery:

- ✓ Safety
- ✓ Trustworthiness and transparency
- ✓ Peer support and mutual self-help
- ✓ Collaboration and mutuality
- ✓ Empowerment, voice, and choice
- ✓ Ensuring cultural, historical, and gender considerations inform the care provided

Trauma-informed emergency mental health response. Rates of trauma experience are high among individuals who experience mental health conditions. This can be as a result of many different types of experiences, including sexual, physical, or verbal abuse; racism and discrimination; negative encounters with law enforcement or medical institutions; or injuries sustained in accidents. A trauma-informed approach should be foremost when engaging an individual who is experiencing a mental health emergency. Aggressive confrontations with a person experiencing a mental health emergency can exacerbate the emergency and result in added trauma. The mere presence of law enforcement in some instances may escalate a crisis, particularly for an individual who has experienced trauma as a result of past police involvement.

Law enforcement does not receive significant training in trauma-informed care and response. CIT training begins to address this for responding officers, but law enforcement on the whole is not adequately trained in trauma-informed care or response. Similarly, training in trauma-informed care and response is often lacking for crisis counselors due to lack of time or resources for training. There is also a need for training and support to address vicarious trauma among emergency mental health responders. While some advanced CIT training may address the issue among law enforcement personnel, few resources exist overall to assist responders in handling trauma-related stress.

Program-Level Challenges and Gaps

As noted throughout this paper, many communities lack one or more of the core service components recommended in SAMHSA's national crisis care guidelines, and without these minimum services, a robust

[14] Youth Alive! Intervention. Retrieved on 10/29/2020 from: http://www.youthalive.org/caught-in-the-crossfire/

[15] Delgado, S. A., Alsabahi, L., Wolff, K., Alexander, N., Cobar, P., & Butts, J. (2017). "Denormalizing violence: The effects of Cure Violence in the South Bronx and East New York, Brooklyn." New York, NY: John Jay College of Criminal Justice. Retrieved on 10/29/2020 from: https://johnjayrec.nyc/2017/10/02/cvinsobronxeastny/

emergency mental health system does not exist. Our review of existing emergency mental health response models revealed that those that are led and managed by the mental health system are in the minority, and the default program model that exists in many communities is designed, led, and operated by law enforcement.

Even in systems that have one or more of the core crisis system service components, key program-level gaps still exist that affect the quality, effectiveness, and responsiveness of services. Examples include:

- a simple, accessible crisis hotline does not exist in every community. In many places, crisis hotlines either do not exist, multiple hotlines or warm lines exist, or hotlines are part of other call lines (e.g., 911 or 211);
- many call lines are not operated on a 24/7 basis;
- counselors answering call lines often do not have sufficient training in clinical or racial, ethnic, and cultural issues;
- mobile response teams do not exist, or do not have enough capacity to respond;
- crisis stabilization programs do not exist in most communities; and
- linkages with nonemergency mental health services or other critical support services (e.g., housing, food) do not exist or are not coordinated.

In systems where response to mental health emergencies is led or co-led by law enforcement, other gaps and challenges exist. A few examples include:

- 911 is the primary call center for mental health emergencies, and most systems do not have emergency mental health programs to transfer calls to;
- several police led crisis programs do not have clinicians involved in the response;
- while they may be the primary responder in most communities, most police departments have little to no training on mental health emergencies; and
- CIT-trained officers are not always available, and often do not have mental health services to refer or divert a person to.

Several law enforcement led models do build in important components of crisis services, such as access to trained behavioral health professionals, as well as quick linkages to treatment services such as crisis stabilization centers where they exist. But lacking in many communities are non-911 crisis hotlines staffed by trained mental health professionals as opposed to a police dispatcher. Using the public safety-housed 911 number traditionally results in a police officer responding, containing the situation, arresting or detaining individuals, and bringing them to jail or an emergency department.

There are an estimated 240 million calls to 911 each year.[16] While data is difficult to aggregate nationally, local data suggests a large volume of these calls are related to mental health emergencies, most of which do not

[16] Neusteter, S.R., Mapolski, M., Khogali, M., & O'Toole, M. (2019) "The 911 call processing system: A review of the literature as it relates to policing." New York, NY: The Vera Institute of Justice. Retrieved 11/3/20 from: https://www.vera.org/downloads/publications/911-call-processing-system-review-of-policing-literature.pdf

require a law enforcement response. For example, the Houston police department created the 911 CCD program as an alternative to handling the 37,032 mental health calls it received in 2014, resulting in substantial cost savings and diversion from police contact to care for individuals experiencing mental health-related crises.[17] Crisis care provider CIT International estimates that about 80% of mental health calls to 911 are resolved without the need for police involvement when diverted to a crisis line.[18] While it may not be possible to prevent law enforcement involvement in every mental health emergency, defining appropriate roles, responsibilities, boundaries, and authorities can go a long way in minimizing unnecessary police involvement.

Redefining the Role of Law Enforcement in Mental Health Emergency Response

This discussion will specifically examine the current role of law enforcement in mental health emergency response services and recommend or redefine strategies, systemic, programmatic, and/or financial reforms that eliminate the use of law enforcement in response to mental health emergencies as a default, as well as in non-crisis situations. Some current models that rely on law enforcement and others that do not will be discussed, along with the evidence base and strengths and weaknesses related to each approach. The conversation will push deeper into emergency response strategies that rely more on a public health first approach. The role that community-policing strategies should or should not play, in addition to the role that nontraditional partners could potentially have in an envisioned emergency response system, and where funding should be leveraged or diverted from, will also be explored.

Another consideration for program design is that while some mental health system led and co-responder models include Peers with lived experience in the response, the involvement of Peers and Peer led programming within all core components of effective crisis systems remains a major gap. Approaches that use trained Peers to engage individuals who are experiencing a crisis can be highly effective in helping to de-escalate and stabilize an individual's situation. Peer supports have also been effectively utilized to follow up with individuals post-crisis and to facilitate access to community-based care and supports.

Information-related needs and sharing is another challenge to consider at both the program and systems levels as it impacts mental health emergency response and related outcomes. Federal and state privacy laws, such as HIPPAA[19] and 42 CFR Part 2 regulations[20] pertaining to confidentiality of information related to substance use, continue to present challenges in emergency mental health response whether led by a mental health program or law enforcement. Emergency responders (and dispatchers) must often evaluate an individual's risk to self or others while not being able to put a crisis in context of a person's psychosocial and medical history. Without understanding past behavior it can be difficult to predict future behavior. If responders have access to a person's history, they have a better ability to respond in a way that is individualized and more likely to result in a better outcome. Maintaining a history of past crisis system contacts, what worked/what didn't work and final dispositions in a mental health crisis call center database, for example, could provide important information about

[17] Houston Police Department, Mental Health Division (October 18, 2017). "Crisis call diversion program." Retrieved on 11/3/20 from: https://perma.cc/XW5L-TCXB.

[18] Substance Abuse and Mental Health Services Administration (2020). *National guidelines for behavioral health crisis care – a best practice toolkit*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[19] https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

[20] https://www.hhs.gov/about/news/2020/07/13/fact-sheet-samhsa-42-cfr-part-2-revised-rule.html#:~:text=The%2042%20CFR%20Part%202,substance%20use%20disorders%20(SUD).&text=Part%202%20continues%20to%20prohibit,patients%2C%20absent%20a%20court%20order

what triggers an individual may experience (e.g., has past police presence escalated the situation?) and what is effective at de-escalating the situation.

System-Level Challenges and Gaps

At a systemic level, several key gaps exist that impact the availability of comprehensive emergency mental health response services across the country. These include the fact that these services are not considered essential on par with other emergency response services (e.g., fire, police, EMS); that there is inadequate planning and coordination and diffuse accountability for these services across levels of government and systems; that adequate, coordinated funding is lacking to ensure the availability of emergency mental health services in all communities; and that resources for workforce training/development and public education is inadequate.

Emergency mental health services are not considered essential. Unlike law enforcement and firefighters, emergency mental health services are not considered essential. As a result, law enforcement is the only resource for responding to mental health emergencies in many communities because they lack any of the recommended crisis system components in their local mental health system. In these communities, law enforcement has become responsible for – or is perceived to be responsible for – all response and management of mental health emergencies. This can have tragic consequences and contributes to the disproportionate number of people with mental health conditions in the criminal legal system.

Police powers are delegated by the Tenth Amendment to the U.S. Constitution to states to establish and enforce laws protecting the welfare, safety, and health of the public.[21] Whereas federal and state laws and regulations exist that authorize, govern, regulate, and fund these first responder services, few laws exist regarding the availability of emergency mental health services. EMS, while not necessarily considered essential at the same level as law enforcement, has evolved over time such that beginning in the 1960s, a series of reforms, legislation, standards, and funding at the federal and state levels has resulted in EMS being an expected service that exists within most communities.[22] While a range of issues – such as population density, geography, and funding – influence what police, fire, and EMS capacity looks like in communities, there is an expectation in most communities that these first responders will show up if called. Law enforcement in the U.S. is made up of about 18,000 federal, state, county, and local agencies. Each agency has varying legal and geographic jurisdictions, ranging from single-officer police departments to those with more than 30,000 officers.[23] This type of data is not quantifiable for emergency mental health responders.

Recent legislative efforts in Congress have sought to fill the gap in national access to emergency mental health response services. The bill that designates 988 as the national suicide prevention and mental health crisis hotline

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[21] "Police Powers" definition from the Nolo Press Plain-English Law Dictionary, as cited by the Cornell Law School Legal Information Institute. Retrieved on 10/29/2020 from: https://www.law.cornell.edu/wex/police_powers#:~:text=In%20the%20United%20States%2C%20state,and%20health%20of%20the%20public.

[22] Shah, M. N. (2006). "The formation of the emergency medical services system." *American Journal of Public Health*, 96(3), 414–423. https://doi.org/10.2105/AJPH.2004.048793

[23] U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. "National sources of law enforcement employment data." NCJ 249681. Revised October 4, 2016.

(S2661) passed both houses in Congress and was signed into law on October 17, 2020.[24] The 988 call hotline creates an avenue to divert mental health emergencies away from 911 right from the start and begins to lay the groundwork for a national strategy for emergency mental health response.[25] In August 2020, Senators Catherine Cortez Masto (D-NV) and Ron Wyden (D-OR) introduced legislation, the Crisis Assistance Helping Out On The Streets (CAHOOTS) Act, that seeks to establish mobile crisis response teams throughout the country, and establishes requirements for states to evaluate the impact on outcomes such as emergency department visits, law enforcement involvement in emergency response, and jail diversion, and for the U.S. Department of Health and Human Services (HHS) to report on these outcomes and promote best practices.[26] However, the bill faces an uphill battle due to the anticipated costs associated with implementation. Representatives Katie Porter (D-CA), Tony Cárdenas (D-CA), Ayanna Pressley (D-MA), and Mary Gay Scanlon (D-PA) introduced the Mental Health Justice Act in October 2020,[27] which is also modeled on the CAHOOTS program and seeks to establish a federal grant program that encourages state and local governments to develop the capacity to dispatch mental health responders rather than law enforcement in response to 911 calls involving individuals with mental health issues. A third bill also introduced in October by Senator Chris Van Hollen (D-MD) and Representative Karen Bass (D-CA), the Community-Based Response Act, would establish a new grant program within HHS to provide a community-based emergency response option beyond law enforcement for populations including those "who have historically faced discrimination or would benefit from a social services-based response to emergencies."[28]

The COVID-19 pandemic has highlighted the important role of emergency mental health services along with the challenges that emergency mental health responders have experienced as a consequence of these services not being considered as essential. Two recent surveys evaluated ongoing service trends, program impacts, and staff experiences as the pandemic continues to impact communities across the U.S., and found:[29]

- crisis call centers have experienced increased call volume since the beginning of the pandemic;
- mobile crisis teams have struggled to maintain capacity and to respond due to lack of operational resources such as personal protective equipment (PPE), technology, and funding;
- there is increased risk of staff exposure to illness resulting in staff shortages and turnover;
- there is increased fatigue, stress, and burnout due to increased demand, risk of exposure, and shortage of staff; and
- coordination of and access to services are strained due to lack of available services while experiencing increased demand.

These survey results point to the need for emergency mental health responders to be afforded the same protections as their essential health care worker counterparts in order to assure high quality and uninterrupted service delivery. This includes fair compensation that reflects the importance of their work, access to adequate

[24] https://www.congress.gov/bill/116th-congress/senate-bill/2661

[25] Federal Communications Commission (2020). "Fact sheet: 988 and suicide prevention hotline." https://www.fcc.gov/sites/default/files/988-fact-sheet.pdf

[26] U.S. Senate Committee on Finance (2020). The Crisis Assistance and Helping Out on the Streets (CAHOOTS) Act. https://www.finance.senate.gov/imo/media/doc/Cahoots_One%20Pager_8.04.20.pdf

[27] https://porter.house.gov/uploadedfiles/mental_health_justice_act_one_pager.pdf

[28] https://www.vanhollen.senate.gov/imo/media/doc/ONE-PAGER_Community-Based%20Response%20Act%20-%20Press.pdf

[29] TBD Solutions (2020). "2020 COVID-19 impact survey: Behavioral health crisis providers (April & June 2020)." https://www.tbdsolutions.com/papers-presentations-2/

supplies of PPE and health and safety products, and technology that provides flexibility and safety through minimal exposure to health risk.[30]

There is inadequate planning and coordination and diffuse accountability for emergency mental health services. When an individual experiences a mental health emergency in any place and at any time, implementing an appropriate response that does not default to law enforcement involvement requires proactive planning and coordination among multiple systems at multiple levels. Instead, what exists is a lack of shared responsibility for emergency mental health response and a fragmented system in which far too many individuals fall between the cracks, cycling in and out of crisis and, far too often, emergency departments and jail. Diffusion of accountability occurs horizontally and vertically across governmental agencies. Various federal agencies that may have a regulatory, funding, or other interest in emergency mental health services do not plan together. This scenario plays out at the state and local government levels, as well as in the private sector. Within many communities, system-wide planning efforts are largely lacking and often only occur because of high-profile incidents, promising initiatives specifically designed to divert individuals with mental illness from the criminal justice system like the Stepping Up initiative[31] and the use of Sequential Intercept mapping,[32] or as a result of settlement agreements involving mental health systems and *Olmstead* or police departments.[33,34]

Creating Upstream Access: Solutions & Prevention Strategies?

This discussion will focus on how to create timely and equitable access to prevention, early intervention, treatment, and recovery supports. This group will establish where public systems should be with an eye toward minimizing the need for crisis services or law enforcement to begin with. How do we reframe the conversation away from public safety toward public health? What are core components of a fully accessible system? What can be done structurally through laws, regulations, or policies that can support this shift? What are existing gaps and why do they exist? How do we shift resources upstream? Where do we shift resources from? How can we identify early warning signals? How do social determinants of health promote overall mental health and wellness?

Successful resolution of mental health emergencies also relies on access to upstream treatment, services, and supports that can prevent or help a person resolve and move past their emergency. When upstream treatment, services, and supports do not exist, there is little for emergency mental health programs or law enforcement to coordinate with when responding to an individual in need.

Years of underfunding of the behavioral health system has resulted in its deterioration and overall effectiveness. Responsiveness and accountability in ensuring follow-through with treatment referrals is often lacking, as are efforts to foster linkages that can address other services and/or supports that an individual may need to address social determinants of health (e.g., housing). Prevention services are largely nonexistent, timely intervention is

[30] National Association of State Mental Health Program Directors (2020). "National survey of crisis responders reveals COVID-19 is stretching resources, stressing staff." *NASMHPD Weekly Update,* 6(25), 1. https://nasmhpd.org/sites/default/files/July_10_2020_NASMHPD_Weekly_Update.pdf

[31] Stepping Up Initiative (n.d.). "Stepping Up: A national initiative to reduce the number of people with mental illnesses in jails." Retrieved on 10/29/20 from: https://stepuptogether.org/

[32] Policy Research Associates (n.d.). "The sequential intercept model." Retrieved on 10/29/20 from: https://www.prainc.com/sim/

[33] Martone, K., Arienti, F., & Lerch, S. (2019). "Olmstead at 20: Using the vision of Olmstead to decriminalize mental illness." Boston, MA: Technical Assistance Collaborative. Retrieved on 10/29/2020 from: http://www.tacinc.org/knowledge-resources/publications/reports/olmstead-at-20/

[34] U.S. Department of Justice Civil Rights Division (n.d.). "Ensuring equality in the criminal justice system for people with disabilities." Retrieved on 10/29/2020 from: https://www.ada.gov/criminaljustice/cj_related_resources.html

compromised, and emergency response is too often all that is available, especially during evenings, nights, and weekends. Few upstream interventions are built into crisis response programs that can help prevent a mental health emergency, and these programs are not likely, nor should they be responsible, to solve all upstream service access issues. However, pre-crisis interventions or early warning systems could be established to help reduce the likelihood of a mental health emergency, or to de-escalate a situation before it rises to the level of an emergency.

There is a lack of adequate, coordinated funding to ensure the availability of emergency mental health services in all communities across the country. While emergency mental health programs need to be designed and structured based on local community needs, there is no national funding strategy for supporting them. Heavy financial investment to support law enforcement is a disincentive to fund emergency mental health services due to the belief that law enforcement will respond to anyone, anywhere, and at any time. In order for emergency mental health services to be available, there must be an organized funding strategy to support operation of programs on a 24/7 basis like there is for police, fire, and EMS. Federal, state, and local agencies do not provide enough funding, nor is it coordinated, to ensure the capacity and availability of emergency mental health services in all communities across the country.

At the federal level, there is discussion about a set aside for crisis services in the SAMHSA's Mental Health Services Block Grants to states, but those funds are limited and already spread across other important services. Certified Community Behavioral Health Centers authorized by Congress are required to make available 24/7 crisis services,[35] but they do not exist in all states or in all communities within states that do have them. Recent activity in Congress regarding 988 and the CAHOOTS Act attempt to address two of the core components in the SAMHSA guidelines. Like 911, the 988 emergency line will need funding to support its infrastructure. However, no direct appropriations are tied to it at this time, and implementation of the line will be spotty depending on how states approach funding it through fees or other mechanisms. Meanwhile, the National Suicide Prevention Lifeline,[36] a national network of local crisis centers that provide 24/7 hotline services, does not link up with the patchwork of local crisis or warm lines that exist throughout the country. Further, while the CAHOOTS Act calls for enhanced federal Medicaid matching funds (95%) for three years and $25 million in planning grants to implement the programs, the federal Centers for Medicare and Medicaid Services has not issued any guidance on how Medicaid funds can be used to fund emergency mental health services, and no widely accepted approaches exist to using Medicaid or Medicare as a source of financing for these services.

Other systems that benefit from and rely on the availability of emergency mental health services are not obligated to provide funding to support these services. For example, the U.S. Department of Veterans Affairs (VA), which primarily provides for veterans' health and mental health services directly, supports a national Veterans Crisis Line that is affiliated with the National Suicide Prevention Lifeline to address the emergency mental health needs of veterans.[37] However, the VA does not support emergency mental health program capacity despite the

[35] U.S. Substance Abuse and Mental Health Services Administration (n.d.). "Criteria for the demonstration to improve community mental health centers and to establish certified community behavioral health clinics." Retrieved on 10/29/2020 from: https://www.samhsa.gov/section-223

[36] National Suicide Prevention Lifeline: https://suicidepreventionlifeline.org/

[37] Veterans Crisis Line: https://www.veteranscrisisline.net/

fact that veterans often first encounter the publicly funded emergency mental health system, or law enforcement, due to a mental health emergency before receiving services through the VA.

Structuring the Mental Health Emergency Response System (Expanding Beyond Traditional Partners)

Many mental health emergency response services exist throughout the country, but few are comprehensive or truly responsive. Many rely on the use of law enforcement as the first responder or as a lead co-responder when this may not be necessary. Others do not rely on law enforcement, but have limited capacity. Building from the three core crisis system components recommended in SAMHSA's national crisis care guidelines, this discussion will identify strategies to improve the design and response of crisis systems, considering questions such as: What is the ideal emergency response system and what gaps exist in terms of realizing it? What is needed to design a truly responsive crisis system that is not reliant on the use of law enforcement? What is needed to respond to a mental health emergency with an eye toward diversion from acute care services to accessible treatment and supports? What is needed for crisis programs to facilitate referrals or access to other needed supports, such as housing, food, and health care? What is the role of technology and data infrastructure to work across systems to facilitate connections to accessible treatment and supports? Are there new roles for potential non-traditional partners envisioned for the emergency response system? What fiscal opportunities exist? Are there financing models that should be considered? Who should contribute?

State general funds, if made available through the state mental health authority, are usually the primary source of funding within states for the establishment and availability of crisis services, especially call centers and mobile response teams.[38] Every state mental health and Medicaid system is structured differently resulting in no single strategy for funding emergency mental health services. In Delaware and Nebraska, Medicaid manages its own crisis service systems that cover its own patients.[39] Most states utilize some form of managed care to cover individuals on Medicaid, but there is significant variability as to whether and how managed care pays for emergency mental health services, even though crisis codes do exist. Arizona braids Medicaid, SAMHSA Block Grants, and state general and county funds into a crisis system that can accept all referrals. Arizona also has reimbursement rates for services that represent their true costs.[40] In some regionally organized states, city or county governments in the regions provide funding for services to augment state, Medicaid, and other funding.[41]

Other systems that rely on, but are not obligated to fund, emergency mental health services include private health insurers. The mental health parity laws passed in 1996[42] and 2008[43] suggest that emergency mental health services should be covered like emergency medical services. Despite covering most of the population, however, private insurers rarely pay for emergency mental health services. State mental health and Medicaid agencies could coordinate with state insurance commissioners and private insurers to support emergency mental health services, but progress is difficult to achieve without leverage.

[38] Shaw, R. (2020). "Financing mental health crisis services" (Beyond Beds: Crisis Services, Assessment #7). Alexandria, VA: National Association of State Mental Health Program Directors. Retrieved on 11/6/20 from: https://www.nasmhpd.org/sites/default/files/2020paper7.pdf

[39] Ibid.

[40] Ibid.

[41] Ibid.

[42] Mental Health Parity Act of 1996, P.L. 104–204

[43] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343

Resources for workforce development and public education is inadequate. Many mental health systems have few to no resources for training emergency mental health workers. Several states do have laws requiring training for police officers, but law enforcement, overall, dedicates few resources to training on mental health and other conditions and related responses, such as CIT or other strategies and interventions to de-escalate a crisis.[44] Recent studies have raised questions about the effectiveness of some training and related outcomes, including for CIT.[45]

Further, adequate training on racial, ethnic, and cultural issues is tangentially provided in curriculums. The lack of comprehensive training programs can be tied to the issue of emergency mental health services not being considered essential, failure to identify the need for training, and a lack of funding. For the emergency mental health workforce, this can lead to fatigue, burnout, and turnover. For law enforcement, this can lead to more physical confrontations versus nonviolent engagement.

Training and educational needs extend beyond the mental health workforce and law enforcement to others, such as 911 dispatchers, who need to learn and know the protocol and options that exist when connecting an individual to an appropriate emergency response, and one that dispatches law enforcement only as a last resort. Systems also lack resources for public education that can impact crisis response and related outcomes. In many communities, systems are set up to encourage individuals, family members, and others to call 911 if there is a mental health emergency as opposed to promoting non-911 crisis lines if they exist. Public education regarding alternatives to calling 911, and appropriate language to use when 911 is the only option so calls are appropriately triaged, are critical. Education to combat stigma and self-stigma related to mental health conditions is also essential as these present real barriers to individuals accessing care, in addition to impacting emergency response.

The Case for Reinvestment in Front End Transformation

Decision makers responsible for policy, program development, and funding will want to consider the evidence based on the effectiveness, and limitations of, the current configuration of mental health crisis services in states and communities across the country and the potential impact of investment in a re-envisioned emergency response system. To be effective and to have buy-in, policies must take into account the perspectives of those with lived experience. And, recognizing the disproportionate impact of mental health emergency responses on people of color, they must be developed using a race equity lens.

Recent analyses and reports from others in the field have reviewed and summarized the existing evidence base on current crisis response models. So as not to recreate their cataloging and analyses of program models, links to these and other key resources are included in the Appendix for further reference.

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[44] Compton, M. T., Broussard, B., Hankerson-Dyson, D., Krishan, S., Stewart, T., Oliva, J. R., & Watson, A. C. (2010). "System- and policy-level challenges to full implementation of the crisis intervention team (CIT) model." *Journal of Police Crisis Negotiations: An International Journal*, 10(1–2), 72–85. https://doi.org/10.1080/15332581003757347

[45] Rogers, M., McNiel, D., & Binder, R. (2019). "Effectiveness of police crisis intervention training programs." *Journal of the American Academy of Psychiatry and the Law,* 48(3). https://doi.org/10.29158/JAAPL.003863-19

Current emergency responses, particularly where law enforcement is the default front end response, can have a costly toll. The more an individual cycles through hospitals, the criminal legal and homeless systems during crises versus receiving more appropriate care from the mental health and other services and/or support systems, the greater the price tag. This is not to mention the human toll that the current public safety bias in responding to individuals who experience mental health emergencies can take. A comprehensive emergency response system that does not rely on law enforcement, diverts individuals from acute care to accessible treatment and supports, and facilitates access to other needed services and supports across systems and community resources stands to improve, and possibly save, the lives of those who need and come in contact with mental health emergency services. In order to fully catalyze front end transformation and move toward this re-envisioned system, new federal funding streams, strategies that enable states and communities to better coordinate these with existing resources, and some reinvestment of dollars spent by law enforcement agencies, may all be needed to develop and sustain comprehensive mental health emergency response services toward this end.

Appendix B: Resources for More Information

"Beyond Beds: Crisis Services TA Coalition Assessment Working Papers." (November 2020) National Association of State Mental Health Program Directors. https://www.nasmhpd.org/content/tac-assessment-papers

"The Case for Violence Interruption Programs as an Alternative to Policing." (June 2020) The Justice Collaborative Institute. https://filesforprogress.org/memos/violence-interruption.pdf

"City and County Leadership to Reduce the Use of Jails: Engaging Peers in Jail Use Reduction Strategies." (October 2020) Policy Research, Inc. and the National League of Cities. https://www.nlc.org/wp-content/uploads/2020/10/Peers_Support_Brief_v3.pdf

Crisis Now Library. National Association of State Mental Health Program Directors. https://crisisnow.com/library/

"Crisis Response Services for People with Mental Illnesses or Intellectual and Developmental Disabilities: A Review of the Literature on Police-Based and Other First Response Models." (2019) The Vera Institute of Justice. https://www.vera.org/publications/crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities

"'Defunding the Police' and People with Mental Illness." (August 2020) The Bazelon Center for Mental Health Law. http://www.bazelon.org/wp-content/uploads/2020/08/Defunding-the-Police-and-People-with-MI-81020.pdf

"Emergency Response and Crisis Stabilization: Cities Leading the Way." (October 2019) National League of Cities and Arnold Ventures. https://www.nlc.org/wp-content/uploads/2019/10/YEFHW_MentalHealth_SubstanceUseHomelessness_FINAL_102919v1.pdf

"A Guidebook to Reimagining America's Crisis Response Systems: A Decision-Making Framework for Responding to Vulnerable Populations in Crisis." (September 2020) Abt Associates and Arnold Ventures. https://www.abtassociates.com/files/Projects/PDFs/2020/reimagining-crisis-response_20200911-final.pdf

"Modern Justice: Using Data to Reinvent America's Crisis Response System." (May 2018) Laura and John Arnold Foundation. https://craftmediabucket.s3.amazonaws.com/uploads/PDFs/DDJ-MODERN-JUSTICE.pdf

"National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit." (February 2020) Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

"Responding to Individuals in Behavioral Health Crisis via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers." (January 2020) Policy Research, Inc. and the National League of Cities. https://www.prainc.com/wp-content/uploads/2020/03/RespondingtoBHCrisisviaCRModels.pdf

"A Roadmap for Exploring New Models of Funding Public Safety." Center for Policing Equity. https://policingequity.org/images/pdfs-doc/CPE_RoadMap.pdf

"Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response." (March 2021) Group for the Advancement of Psychiatry and the National Council for Behavioral Health. https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56