CRIME AND JUSTICE INSTITUTE

# Behavioral Health Crisis Response Landscape Analysis

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# Acknowledgments

This report was prepared by **Andrea Tyree** and **Lauren Leonard**, with assistance from **Amanda Cosica**. Additional contributions provided by **Barbara Pierce**, **Katie Zafft**, and **Ashley Neufeld**. This report was made possible by the generous support of Arnold Ventures. The content of this report is the responsibility of the authors and does not necessarily represent the views or positions of Arnold Ventures.

## About the Crime and Justice Institute

The Crime and Justice Institute (CJI), a division of Community Resources for Justice, bridges the gap between research and practice with data-driven solutions that drive bold, transformative improvements in adult and youth justice systems. With a reputation built over many decades for innovative thinking, a client-centered approach, and impartial analysis, CJI assists agency leaders and practitioners in developing and implementing effective policies that achieve better outcomes and build stronger, safer communities. CJI works with local, state, tribal, and national justice organizations to provide nonpartisan policy analysis, implementation consulting, capacity-building assistance, and research services to advance evidence-based practices and create systems-level change.

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# Introduction

Over the past decade, a movement to bolster local response to behavioral health crises in a manner like that of crime, fire, and medical emergencies has risen as a top priority for the nation.[1,2] As a result, localities have made strides in strengthening their crisis care continuums consisting of 911 call centers, first responders, crisis stabilization units, and more. One aspect of this continuum, behavioral health crisis response (hereafter referred to as "crisis response"), has gained the most attention as localities have adopted varying approaches to address the growing number of behavioral health crises, including: crisis intervention teams comprised of specially trained law enforcement officers; co-responder programs involving law enforcement and paired behavioral health professionals; and mobile crisis response teams with behavioral health, peer support, and emergency medical services professionals.[3] Crisis response is highly localized, with programs built to meet the specific needs of each community. States that are looking to expand crisis response programs across jurisdictions can use regulatory intervention to invest in factors that facilitate successful implementation of these programs across a variety of localities.

To learn more about these factors, the Crime and Justice Institute (CJI), with support of Arnold Ventures, conducted a landscape analysis of state and federal regulations from 2018 to 2023 that have impacted the adoption and expansion of localized crisis response within states, specifically as it relates to law enforcement. CJI reviewed data from federal statutes and executive orders, enacted state legislation, federal and state agency publications, research literature, and technical reports completed by state agencies, universities, and third-party organizations. CJI also conducted interviews with key stakeholders from law enforcement, alternate response programs, and behavioral health agencies, as well as national organizations involved in this field. Extensive efforts were made to review data from a diverse group of states, including those with crisis response programs in highly populated cities and states building out crisis response across sparsely populated, rural counties.

This report outlines the federal and state initiatives that can support law enforcement agencies and localities in developing robust crisis response models. First, this report provides an overview of the crisis response landscape, detailing the most utilized crisis response models and the factors that have driven the movement to bolster crisis response within the past five years. Five response models are outlined within this report: (1) crisis intervention teams; (2) specialized law enforcement training; (3) co-responder programs involving law enforcement; (4) mobile crisis response teams without law enforcement; and (5) 911 dispatch diversion.

CJI determined that federal and state legislative intervention impacts localities' implementation of crisis response programs by means of (1) funding, (2) cross-agency collaboration, and (3) capacity building. This report outlines statutory opportunities and barriers for each of these three themes as they relate to the models. Following these themes, additional key factors that impact localities' ability to implement crisis response are outlined. These factors fell outside CJI's initial scope of examining crisis response as it relates to law enforcement. However, they serve as investment opportunities for the expansion of crisis response, particularly as it relates to law enforcement, across a diverse set of localities.

# Landscape Overview

The presence and combination of crisis response models varies across states, with localities adopting a combination of services that meet their unique needs. Five of the most relied upon models nationwide are presented within this report. Due to these models at times being conflated and having varying compositions across localities, CJI has defined each model as follows:

- **Crisis Intervention Teams (CIT)**: Specialized units of law enforcement officers who have received a nationally recognized, 40-hour training to identify and de-escalate crisis situations. Core concepts of this model originate from the Memphis (TN) Police Department and therefore this training and operation is often referred to as the "Memphis model."

- **Specialized Training**: Includes crisis intervention, de-escalation, or other related trainings to prepare law enforcement officers for interaction with individuals experiencing a behavioral health crisis, suffering from a substance use disorder, and/or who have cognitive impairment or nonverbal learning disorders.

- **Co-Responder Programs**: Pairs law enforcement with behavioral health professionals, including licensed certified social workers and clinicians, to collaboratively respond to calls for services with a behavioral health element.

- **Mobile Crisis Teams**: Comprised of non-law enforcement behavioral health professionals, peer support specialists, and/or emergency medical service (EMS) professionals who respond to acute mental and behavioral health crises and connect individuals in need with short- and long-term services.

- **911 Dispatch Diversion**: 911 dispatchers who are required to identify calls for service that involve an individual experiencing a behavioral health crisis and divert the first response to active crisis response teams within the area, when possible.

Between 2018 and 2023, crisis response services experienced a wave of social interest and political support. A major signal for this shift in political investment came from Congress with the passage of the American Rescue Plan Act (ARPA) (2021) which increased funding for behavioral health and substance use disorder federal block grants and created new opportunities for states to support behavioral healthcare through programs like Medicaid.[4] Factors contributing to the passage of ARPA and related crisis services legislation include:

- The impact of the COVID-19 pandemic on the rate of behavioral health crisis and substance abuse overdose deaths.[5]
- Rising jail populations and the rate of incarcerated individuals with a known history of mental illness and substance abuse disorder.[6]
- Increased demand on law enforcement to provide behavioral health transports.[7]
- Repetitive dispatching to individuals experiencing behavioral health crisis.[8]
- Emergency room overcrowding by individuals experiencing behavioral health crisis.[9]
- Community based advocacy inspired by tragic outcomes for individuals experiencing behavioral health crisis.[10]

ARPA and subsequent Presidential Budgets allocated billions of dollars to states to aid their expansion of crisis systems or, as it is referred to when the various aspects of these systems work in partnership with each other, their crisis care continuum.[11] In the years following the passage of ARPA, a number of states appropriated a portion of these funds to one or more of the crisis response models outlined above. However, ARPA funds are only available to states through 2025 and cannot support the entirety of the cost of crisis systems statewide. Furthermore, while these funds encourage partnership across crisis services providers within localities and states, ARPA funds do not mandate or provide guidance to localities on how to establish this cross-agency collaboration. In addition, funds do not go far enough to address other capacity-related issues many crisis service providers face today.

These limitations of funding, cross-agency collaboration, and capacity building represent key opportunities for states and the federal government to strengthen and expand the availability of crisis response models. In this report, we outline legislative opportunities and barriers related to these topics across the five crisis response models. Although some models lack statutory data or supporting research for each of these three themes, the recurring nature of these themes throughout state statutes, research literature, and conversations with key stakeholders indicate that they are defining factors for the sustainability and success of behavioral health crisis response. Additional factors that impact crisis response models but have not been as present in legislation related to law enforcement are presented at the end of this report.

# Funding

One factor that is key in determining a locality's ability to adopt or sustain any crisis response model is funding. Localities vary in their approach to funding crisis services using a combination of state general funds allocated through legislation, federal grants, Medicaid, private sector contributions, and agency budgets.[12,13] Each of these resources may contribute to multiples pieces of the crisis care continuum, thus enabling localities to meet their unique needs. However, this patchwork system of funding provides its own challenges, such as the ability of localities to secure lasting funding that is not dependent on political will or the competitive grant process.[14,15] These challenges are outlined in further detail below, followed by statutory opportunities for each model to overcome these barriers.

## State Funding

State general funds are a primary funding source for crisis services, providing up to 70 percent of all funding for services across a state.[16] These funds are allocated through state legislation that mandates the establishment or expansion of crisis response services throughout the state. The broad criteria of funding and often limited reporting requirements allow localities to use state general funds for aspects of service that cannot easily be charged to Medicaid or larger grants, such as start-up infrastructure, staff training, and administrative management. Crisis services funded by this resource include crisis call lines, mobile crisis teams, crisis stabilization centers, and crisis intervention training for medical professionals and first responders.[17] State general funds are often directed toward State Mental Health Authorities or other state agencies, which then distribute funds to local services as requested. As one stakeholder stated in conversation with CJI, ***"legislation allows states to unstick certain barriers by enacting a large framework."***[18] In some areas, city or county governments may mimic this approach by allocating funds to certain crisis services through local ordinances.[19] However, as CJI found in our assessment of state legislation, funds are not always allocated indefinitely, and the amount of funding may vary each fiscal year due to political will and priorities. According to an expert in the field, ***"[there must be] enough political will to sustain the work and continue to contribute resources to it. High profile incidents can cause things to happen but are insufficient in sustaining the work."***[20] For these reasons, state general funds have been deemed by some as the funding of last resort.[21]

## Federal Grants

Federal grants are also an avenue by which agencies can fund crisis services, particularly in their pilot phase. Most grant funding for crisis response originates from two agencies: the U.S. Department of Justice (DOJ) and the Substance Abuse and Mental Health Services Administration (SAMHSA). DOJ's Edward Byrne Memorial Justice Assistance Grant (JAG) Program, the Bureau of Justice Assistance's (BJA) Justice and Mental Health Collaboration Program (JMHCP), and numerous grants from the Office of Community Oriented Policing Services (COPS) support law enforcement agencies' adoption and implementation of crisis intervention team training, co-responder programs, and other involvement in local crisis services.[22,23] SAMHSA block grants, like the Community Mental Services Health Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABTBG), support the implementation of community-based crisis services by allocating funds directly to local providers as well as State Mental Health Authorities, which can distribute funds to agencies throughout a state.[24,25] While annual federal grant appropriations provide vital support to local efforts for building out crisis response services, advocates of these services warn localities to use grant funds cautiously, as they are not a solution for long-term, sustainable funding.[26] In some instances, states may establish grant programs to support crisis services for a period of time, but this funding is dependent on continuous legislative approval.

> *"[There must be] enough political will to sustain the work and continue to contribute resources to it. High profile incidents can cause things to happen but are insufficient in sustaining the work."*

## Medicaid

Access to sufficient and lasting funding not only impacts law enforcement's crisis response but also civilian-led mobile crisis response as well as other parts of the crisis care continuum. Medicaid, as an example, has been authorized in every state to fund a portion of one or more localities' crisis care continuum, such as crisis stabilization centers, mobile crisis teams, or peer support services.[27] Organizations and providers that offer these crisis services partner with State Mental Health Authorities and Managed Care Organizations which can bill reimbursable services to Medicaid.[28] Medicaid funding for crisis services has become more accessible to states due to the expansion of individuals eligible for Medicaid coverage through the Affordable Care Act (2010) and the availability of a multi-year, 85 percent federal match through the American Rescue Plan Act (2021) for states that expand Medicaid coverage to include mobile crisis services.[29] However, there are important limitations to this funding. Medicaid regulations lack a clear definition to the "crisis services" that qualify for reimbursement, thus leaving it up to providers and managing authorities to try to meet difficult billing requirements to receive funding for mobile crisis team services.[30] Moreover, neither Medicaid nor private insurance covers the entire cost of these services, meaning that localities still rely on state general funds and other funding sources. Finally, Medicaid does not cover all crisis response models, as law enforcement agencies do not have a direct route to bill Medicaid for potentially reimbursable services rendered by their crisis intervention teams.[31]

## Private Sector

Crisis services may also be supported by private sector contributions or a regional coordinating body's annual budget. In some states, private sector contributions account for up to 30 percent of funding for crisis services.[32] These contributions may come from not-for-profit organizations like United Way or the National Alliance on Mental Illness (NAMI) and can even be in the form of in-kind services, such as training and technical assistance.[33,34] Information on private sector funding of each crisis response model is sparse, which may imply that while this is an opportunity for funding crisis response, it is not a source many localities rely heavily upon.

## Agency Budgets

For certain crisis services, such as crisis intervention teams and co-responder programs, law enforcement agencies adopt and manage the implementation of the service within their jurisdiction. Often, the cost of coordinating these services resides in the agency's budget, which may, in part, be funded by state or federal grant programs.[35] As one key stakeholder pointed out, ***"grants should be used to prove value, but they are not a long-term solution. Funding has to be baked into the [city or agency] budget."***[36] Nation and statewide data is lacking for how many state or local law enforcement agencies supplement the costs of crisis response services with grant funds and how many agencies rely solely on their budget, which hinges on the approval of city or state policymakers.

## Model Analysis: Funding

### Crisis Intervention Teams

Opportunities for funding the CIT model within states include the use of state general funds, federal grants, and to a lesser extent, private sector support, specifically through organizations like NAMI and CIT International.[37] CJI's assessment of state legislation related to crisis response found that a handful of states appropriate general funds or direct state agencies to fund new or existing CIT programs. In Montana, the Board of Crime Control is required to administer and fund a statewide CIT program for law enforcement.[38] In Virginia, the Department of Criminal Justice Services is responsible for this administration but receives a significant allocation of funds from Virginia's ARPA revenues.[39,40] Yet this type of funding is not always stable, as seen in Virginia where funding was only allocated through FY 2022 and in New Hampshire where the allocation ended in FY 2023.[41,42] Further investment will depend on the political will of policymakers to pass similar legislation in upcoming sessions.

In other states (e.g., Illinois, Kentucky, New Jersey, and Rhode Island), statutes require the integration of CIT into statewide training curricula but do not

allocate funds.[43-46] Mississippi goes so far as to require each county or municipal law enforcement agency to employ at least one CIT officer but allocates no funds to aid agencies in adopting this training for their officers.[47] Law enforcement agencies are expected to finance these CIT programs through a combination of grants, private funding, and their own budgets. Of these statutes, only Illinois, Kentucky, and Rhode Island outline clearly defined requirements for the implementation of CIT programs.[48,49,50] These policies specify a combination of training hour requirements, topics to be covered within training, composition of teams that will present the training, and reporting requirements for CIT-trained officers.

Law enforcement agencies rely on various federal grants to support their implementation of CIT programs including DOJ's JAG Program, BJA's JMHCP Connect and Protect Law Enforcement Behavioral Health Response Program, COPS Office's Implementing Crisis Intervention Teams grant, and BJA's VALOR Initiative Crisis Intervention Training Model program (although the VALOR Initiative recently shifted focus toward officer wellness). Award amounts vary, with the JHMCP grants offering up to $550,000 per award and the COPS Office up to $400,000 per award. Despite the numerous opportunities, many programs only select a handful of agencies each year, creating a competitive process for the more than 18,000 law enforcement agencies nationwide. To address this barrier, some states are creating new funding avenues through state statutes. In Wisconsin, $100,000 is allocated each fiscal biennium to support CIT training among law enforcement agencies across the state.[51]

In addition to providing funding and technical assistance support, organizations like NAMI and CIT International assist law enforcement agencies in spreading out costs of CIT training and implementation through the creation of a regional CIT program or coordinating body.[52] This is further outlined in the Collaboration section of this report. Yet even with private sector and federal agency involvement, state statutes that allocate recurring funds to CIT training are most likely to aid law enforcement agencies across localities in sustaining CIT programs.

## Specialized Training

Like the CIT model, law enforcement agencies rely on state general funds, federal grants, and their individual budgets to support specialized crisis response training. Numerous states—including Connecticut, Massachusetts, Oklahoma, and Utah—have enacted legislative requirements for crisis intervention and de-escalation trainings, often paired together in statutory language, for all of their state and local law enforcement agencies.[53-56] In some states, crisis intervention training can be found paired with training to assist individuals in crisis with autism, dementia, or nonverbal learning disorders.[57-60] These statutes often specify the number of training hours required, such as six hours in Ohio, four hours in Oklahoma, and 16 hours in Utah.[61,62,63] In Minnesota, officers must receive six hours of crisis intervention training alongside four hours of training in assisting individuals with autism.[64] In most cases, this responsibility of training is placed upon the state law enforcement certification board, such as the Connecticut Police Officer Standards and Training Council.[65] While states like Connecticut, Rhode Island, and Washington allocate general funds to assist with the implementation of this training, many states do not specify how this training will be funded, leaving it up to the individual agencies to finance the training.[66,67,68] Minnesota is one of the only states where statutory language outlines clear requirements for specialized crisis intervention training including training hours, training content, data collection and reporting, and the agency responsible for managing the certified training entities and courses offered.[69]

Grants from the DOJ, BJA, and COPS Office can also be used to support crisis intervention training efforts. Some states have established their own grant funds to support these training efforts, such as the Philando Castile Memorial Training Fund in Minnesota which allocates $6 million annually through FY 2026 to support law enforcement training in crisis intervention and de-escalation tactics.[70] The legislature has placed the responsibility of managing this training and its related grant on the Minnesota Peace Officer Standards and Training Board. State legislators may find that establishing state-led grant programs to support law enforcement's crisis intervention training as well as other crisis response services is the most

politically feasible solution to expanding the adoption of this training across agencies.

## Co-Responder Programs

States have used policy as a means of enacting both co-responder pilot programs and grants that support the application of co-responder programs within localities. Pilot programs initiated in Georgia, Illinois, and New Jersey required the continuous regulatory allocation of state general funds to support multiple localities' adoption of co-responder programs.[71,72.73] While Georgia and Illinois clearly outline their pilot programs' duties, training, and member makeup, New Jersey left much of the program criteria to the discretion of Attorney General. Other states use legislation to target general funds to previously established co-responder programs and program expansion, as seen in Colorado, Oklahoma, and Washington.[74,75,76] However, in some instances, allocated funds for co-responders must be split with other crisis response models or crisis services, limiting the statutory impact on local programs.[77,78]

Many states have established grant programs through state statutes to support co-responder programs across localities. In Colorado, the Division of Criminal Justice has been tasked with managing the Multidisciplinary Crime Prevention and Crisis Intervention Grant Program, which awards $2.5 million to law enforcement agencies and local governments, $2.5 million to community-based organizations, and $2.5 million to other qualified groups in FY 2023 and FY 2024 to support co-responder programs and community-led crisis response efforts.[79] A prior Colorado statute allocated similar funds for these efforts in FY 2021 and FY 2022.[80] Minnesota's Innovation in Community Safety Grant, established through statute and managed by the state's Commissioner of Public Safety, offers funding to co-responder teams among other violence prevention efforts.[81] Wisconsin has taken a unique approach, through its Department of Health Services, by awarding its Crisis Program Enhancement Grants to counties, municipalities, and regions and requiring a 25 percent match of awarded funds from those recipients.[82] Overall, fewer states have invested funds into the co-responder model as compared to CIT and specialized training. Statutory appropriations to state agencies like those listed above would be the most politically feasible approach to supporting law enforcement agencies and their behavioral health partners in adopting and sustaining this model, as states already allocate funds to these agencies annually.

## Mobile Crisis Teams

Civilian-led crisis response is funded through a combination of legislative allocations, grant programs, and Medicaid reimbursements. The last five years have seen a wave of enacted legislation to establish and expand community-led mobile crisis response teams. Colorado, Connecticut, Florida, Kentucky, New Hampshire, Oklahoma, Oregon, Virginia, Washington, and Wisconsin have relied on legislative efforts to appropriate funds to their Office of Behavioral Health, Department of Mental Health and Addiction Services, and other state health or behavioral health agencies to support mobile crisis teams.[83-92] A handful of these statutes specify that funds will be prioritized for expanding mobile crisis services to rural areas, such as in Wisconsin.[93] In contrast, other states like Vermont have required the adoption or expansion of mobile crisis teams through state statutes but did not identify how these efforts would be financially sustained.[94] Few statutes provide clear guidance on establishing mobile crisis teams within states. Of states referenced, only Vermont identifies the agency responsible for managing these teams, team responsibilities, and reporting requirements.[95]

As with other models, state legislators have enacted and appropriated funds for grant programs to establish and expand community-led mobile crisis response teams among their localities. California's Community Response Initiative to Strengthen Emergency Systems Grant Pilot Program funds community-based organizations' engagement in crisis response work while Maryland's Behavioral Health Crisis Response Grant Program supports behavioral health authorities in these efforts, including the implementation of mobile crisis teams.[96,97,98] Colorado and Minnesota have created multiple grant programs, often administered by state behavioral health agencies, to fund both mobile crisis response and co-responder programs.[99-102] Notably, Montana's Mobile Crisis Unit Grant Program requires up to $125,000 in

state-funded awards to be matched in local funds.[103] Other states, like Utah initially limit grant eligibility to areas that have been identified as high need and only expand eligibility through subsequent statutes as additional funding becomes available.[104] Statutes that establish grant programs to fund mobile crisis teams, such as in Maryland and Montana, are more likely to provide clearly defined guidance on the implementation of this model.[105,106]

To reduce the cost burden of mobile crisis response on state agencies, some states have amended their Medicaid plans to make certain services reimbursable. In Connecticut, a statute enacted in 2021 made crisis intervention services, case management, and other community violence prevention services available to any Medicaid beneficiary.[107] Illinois and Utah also authorized Medicaid funds to be used for community behavioral health services, including mobile crisis teams.[108,109] This new funding avenue has been driven by the American Rescue Plan Act's authorization of an 85 percent federal match for states that cover community-based mobile crisis intervention services through their Medicaid programs.[110,111] However, this match is only available between 2022 and 2025. It is unclear whether states will continue to expand this coverage once the match closes. As of this year, states have multiple avenues by which statutes and regulations may support the adoption or expansion of mobile crisis teams.

## 911 Dispatch Diversion

Funding for 911 dispatch diversion often stems from a state's general budget, with some using tax revenues to support this core piece of emergency response. A handful of states have begun to invest additional resources into training 911 dispatchers to divert calls to active crisis response programs within their respective localities, including programs without law enforcement involvement. This encourages 911 diversion to crisis response services and is vital to the success of these programs.[112] In Virginia, legislators require CIT training for both law enforcement and 911 dispatchers, ensuring that dispatchers understand the abilities of agencies' crisis intervention teams and could request them specifically when appropriate.[113] In Maine, policymakers directed and funded the state's Emergency Service Communications Bureau to outline the procedures and protocols necessary to ensure 911 dispatchers divert calls to mobile crisis teams when possible.[114] In contrast, state policymakers in Connecticut, Illinois, and Minnesota enacted statutory requirements for state emergency services to incorporate improved 911 diversion to non-law enforcement first responders but did not allocate funds for the updated training and procedures.[115,116,117]

With the recent influx of varying crisis response models, many states are still determining best practices in training dispatchers to refer individuals to the appropriate crisis response services. Despite the presence of mobile crisis teams, 911 dispatchers are often required to dispatch law enforcement to calls for service that involve an individual experiencing a behavioral health crisis. This is a result of dispatchers' legal liability when choosing to place civilians from mobile crisis teams in potential imminent danger.[118] In conversations with key stakeholders, CJI repeatedly heard statements like, ***"911 operators are hesitant to not send police into situations that may become deadly,"*** and ***"[police] officers have an innate nature to be hesitant to turn over dangerous situations to someone else."*** [119,120]

Statutes that provide clear guidance on protocols and training, such as in Connecticut and Illinois, as well as the funding to support these added requirements, are necessary to ensure the success of 911 diversion programs.[121,122] Moreover, requirements for data collection, monitoring, and evaluation of this diversion are likely to aid state emergency services departments as they identify and integrate new practices.

> *"Grants should be used to prove value, but they are not a long-term solution. Funding has to be baked into the [city or agency] budget."*

## Funding Key Takeaways

1. Funding avenues, such as legislation, that lack the consistent and ongoing allocation of funds for behavioral health crisis systems or a means by which these systems can bill costs long-term, will result in significant barriers to crisis response sustainability.
2. Statutes with clear guidance on protocols, training, data collection, monitoring, and evaluation of crisis response programs are most successful in supporting sustained adoption of such programs.[123]
3. One time funding sources such as federal grants should not be considered a sustainable means of supporting the development, implementation, and management of a behavioral health crisis response models, and are most effectively used to support pilot programs and/or proof of concept.
4. Legislative allocations to state health or behavioral health agencies with targeted funding for behavioral health crisis response models will increase the effectiveness of jurisdictional program development across a state.

# Cross-Agency Collaboration

Another key factor in the successful adoption or implementation of crisis response service is agencies' and providers' ability to collaborate. CJI's conversations with key stakeholders highlighted the need for shared learning and coordination among law enforcement agencies, EMS workers, and behavioral health providers throughout a state. Collaboration across agencies addresses the fragmented nature of this field. As one stakeholder put it, ***"interconnecting the systems used by providers and first responders and bridging these [communication] gaps is the biggest challenge of this work."***[124] This collaboration can be facilitated through the creation of regional bodies to manage or assist local crisis response models.[125,126] The need for regional bodies to address the localized nature of crisis response is outlined in further detail below. Statutory implementation of this opportunity can be seen in three out of the five crisis response models.

## Regional Bodies

In most states, crisis response services are managed locally, with available services determined by the capacity of law enforcement agencies and behavioral health providers to implement various models and maintain funding.[127] As a result, the presence of crisis response services can vary widely within a state. A handful of states have attempted to address this disparity with the establishment of regional or statewide bodies to serve as training and technical assistance coordinators for localities' crisis response models. National organizations like the National Alliance on Mental Illness (NAMI), CIT International, and the International Association of Chiefs of Police (IACP) may facilitate the creation of these networks, establishing regional networks to assist localities in implementing crisis response models and identifying funding opportunities. State legislatures may also require a single body, such as a State Mental Health Authority or training center, to facilitate the implementation of training requirements or a crisis response model across localities.[128,129] In these statutory requirements, funds may be allocated to the responsible state agency or state grant programs may be developed to support the creation of this body.[130]

## Model Analysis: Cross-Agency Collaboration

### Crisis Intervention Teams

States that are looking to establish regional bodies to support implementation of CIT should first look to organizations like CIT International and NAMI. These organizations have enabled the creation of statewide CIT networks that serve as technical assistance centers and training coordinators for all interested law enforcement agencies, as seen with CIT Utah, NAMI-Maine, and NAMI-Georgia.[131,132] In other states, a leading law enforcement agency or response program will serve as a training and standards hub for the rest of the state, such as the Memphis (TN) Police Department which established the first CIT program in the nation and served as a guide to many agencies in the early years of CIT adoption.[133]

In many states, enacted statutes require the creation of a regional body to coordinate CIT efforts. This regional body may be active through a State Mental Health Authority, as is the case in at least 19 states according to a 2020 study.[134] In other cases, state statutes require the regional coordination of CIT programs to be led by state training boards or a statewide council.[135] Other states still have established these regional bodies through a collaboration between non-profit organizations, statewide agencies, and training centers without statutory prompting. This can be seen in Ohio with the Criminal Justice Coordinating Center of Excellence (CJ/CCOE) which relies on leadership from a retired Akron Police Department member, the associate director of NAMI-Ohio, and the CJ/CCOE coordinator.[136] This was also the case in Georgia, where a partnership between the Georgia Bureau of Investigation, NAMI-Georgia, and the Georgia Public Safety Training Center enables the coordination of statewide CIT training.[137] As states establish their own regional bodies, they can look at both statutory and non-statutory created bodies to determine the criteria necessary to meet their respective needs. These criteria can be included in regulatory language if states choose to create these bodies through legislation.

In Maryland, the statutory creation of the Crisis Intervention Team Center of Excellence required the regional body to include members of local law enforcement, mental health authorities, and behavioral health advocacy organizations, ensuring that the body will meet the needs of both law enforcement and behavioral health agencies in crisis response.[138] Clearly stated requirements for a regional body's composition and activities can ensure that implementation stays true to policymakers' intentions. It must also be noted that the operation of this state-initiated coordinating body is subject to state budgetary allocations, which brings its own challenges for long-term sustainability, as detailed in the Funding section of this report.

> *"Interconnecting the systems used by providers and first responders and bridging these [communication] gaps is the biggest challenge of this work."*

### Co-Responder Programs

While few examples of regional coordinating bodies for co-responder models were identified in the research, there are opportunities for statutory involvement in this approach to collaboration. In Washington, the state legislature appropriated funds for the University of Washington to research co-responder programs statewide by convening local programs for training and other shared learning opportunities.[139] This statute directed the University to assess co-responder programs throughout the state, including their individual capacities, alignment with local needs, funding strategies, training practices, data systems, and more. University researchers are then expected to make recommendations for how Washington co-responder programs can better align with best practices and assist localities in implementing those recommendations. Washington serves as an example of a state facilitating opportunities for shared learning across localities, with the hope of improving one type of crisis response model statewide.

For states that lack statutory involvement and are looking for more immediate support, the International Co-Responder Alliance (ICRA) is a non-profit organization that serves as a network for co-responder programs nationwide. ICRA offers resources on best practices, guidance on program development, and facilitates connections between co-responder program across states.[140] However, ICRA does not facilitate regional chapters to aid states in strengthening their local networks. State policymakers that are interested in establishing regional coordinating bodies can look to ICRA to identify what resources are necessary to encourage the collaboration of co-responder programs among localities.

### Mobile Crisis Teams

States may also rely on regional bodies to coordinate and assist localities' implementation of alternate response or mobile crisis teams. Similar to the CIT model, these regional bodies may be initiated by state agencies or statutory requirements. State mental health authorities serve as coordinators of mobile crisis teams across localities in at least 16 states.[141] In 2021, Maryland established the Maryland Behavioral Health and Public Safety Center of Excellence to, among other things, create a statewide model for non-law enforcement crisis intervention services.[142] New Jersey enacted a similar law in 2022, requiring the Commissioner of Human Services to establish a comprehensive statewide mobile behavioral health crisis response system, including a mobile crisis team.[143] In Utah, a Mental Health Crisis Intervention Council was created by statute to establish statewide protocols and standards for the training and implementation of behavioral health crisis response teams.[144]

Maryland and Utah's statutes clearly outline the makeup of the regional bodies as well as their expected duties and reporting requirements. While New Jersey's statute outlines the minimum requirement of the statewide mobile crisis system, it left many aspects of the system up to the Commissioner's discretion. No funds were allocated for these regional bodies. Instead, policymakers recommended the coordinating bodies identify grants or scholarships that may provide financial assistance. This lack of funding can severely limit the sustainability of these bodies, as referenced in the Funding section for several of the crisis response models discussed herein.

## Cross-Agency Collaboration Key Takeaways

1. Collaboration between law enforcement, emergency services, behavioral health providers, and policymakers is essential for the development of a holistic, sustainable, and effective behavioral health crisis response system by enabling input from a diverse set of stakeholders.
2. Regional bodies developed through collaboration between non-profit organizations, statewide agencies, and training centers can serve as a key source of technical assistance and guidance for localities' crisis response models.
3. Regional bodies developed through statutory requirement or state agencies are a key factor in managing and assisting crisis response programs across localities and can serve as a unifying force within the state.

# Capacity Building

The third factor in adopting and sustaining crisis response models lies in agencies' capacity to achieve the goals of successful crisis response: de-escalating situations involving individuals experiencing a behavioral health crisis, connecting individuals in crisis with the short- or long-term care they need, and reducing the number of repeat 911 calls driven by these individuals. This capacity building requires effective case management of individuals in crisis, the authority of all crisis response programs to transport individuals to crisis care facilities, and innovative resources to support crisis response services in rural areas. These conditions can be bolstered through statutory intervention, as seen in four of the five crisis response models.

## Case Management

For most crisis response programs, resources are prioritized to ensure there is enough staffing to respond to crisis-related calls for service. However, equally important to this first response is the presence of case management services, to collect information from the individuals involved in these calls and follow-up to ensure those individuals successfully received the short- or long-term services they need. As one key stakeholder explained, ***"case managers can help bridge the gap between resources and systems."***[145] This case management is often omitted from the initial iteration of crisis response programs. According to another stakeholder, ***"the weak point in any model is the [lack of] case management and accountability or follow-up."***[146] A third stakeholder argued that ***"people are aware of this case management gap, but it's largely unfunded."***[147] This lack of attention ignores the fact that high utilizers of 911 need specialized help and more in-depth support than one interaction with a crisis response team can provide.[148] Legislation related to crisis response can specify the need for a case manager in the composition of a crisis response program, thus spurring localities to invest in this capacity building position.

## Transport Authority

Another limitation that numerous stakeholders brought to CJI's attention is the requirement that law enforcement officers must transport individuals in crisis to an appropriate facility, even if alternate response teams are the ones responding to the call for service. This duty, instilled through years of statutes, often requires law enforcement to remain on call when mobile crisis teams are dispatched, partially negating the shift of responsibility from law enforcement to a civilian-led response. In one stakeholder's state, ***"for suicidal calls…while mobile crisis teams are in response, [law enforcement] would be down the road from the call… Because of that, officers feel like since they're already there and know how to handle it, they should be able to handle it."***[149] Despite the presence of alternate mobile response in many states, this statutory requirement absorbs law enforcement agencies' limited resources, particularly when there is significant distance to the closest crisis stabilization facility or extensive wait times for admitting individuals.[150] In addition, it subjects individuals who would otherwise encounter only civilian-led teams to unnecessary contact with law enforcement.

Many law enforcement stakeholders cited this as a key area by which legislative involvement could streamline and assist crisis response across localities. As one stakeholder stated, ***"the police department does a lot of transports to facilities, but many of those do not require police officers. The hesitancy [in changing this regulation] comes from it being a big lift and figuring out how to bill it and pay for it. The rest of the system perceives this as working, but law enforcement knows that it doesn't."***[151] Legal limitations of transport authority also prevent alternate response programs, like mobile crisis teams, from building their capacity to successfully respond to crisis calls.

## Rural Service

Rural areas pose a unique challenge to behavioral health crisis response, as there are greater distances between individuals and behavioral health services as well as less crisis response services per square mile as compared to metropolitan areas. To overcome these barriers to service, law enforcement agencies and behavioral health providers have had to incorporate innovative resources to adequately respond to and aid individuals in crisis. One such approach is the integration of telehealth services into law enforcement agencies and other first responders. States may adopt programs like Virtual Crisis Care, which utilizes telehealth technology in law enforcement

agencies so that officers can connect individuals in crisis to behavioral health care through tablets or similar devices and subsequently reduce the transport of individuals to crisis facilities, hospitals, or jail.[152] As a representative from one state that uses this technology said, ***"an iPad that can connect with a therapist right then and there has been a huge help to law enforcement [in] connecting an individual with a therapist and getting services and follow-up."***[153] However, statutes related to these innovations which scale up the availability and capacity of crisis response in rural areas are few and far in between.

## Model Analysis: Capacity Building

### Crisis Intervention Teams

CJI's statutory review found that in most states, law enforcement is required to transport individuals in crisis to an appropriate facility for a health assessment or treatment. Statutory language around this requirement exists for both voluntary and involuntary commitment. However, in 2023 Oklahoma enacted a statute allowing the Department of Mental Health and Substance Abuse Services or any entity contracted by this department to provide alternate transport for individuals in crisis, even when law enforcement acts as the first response, if there is not an appropriate facility within a 30-mile radius of the law enforcement agency's headquarters.[154] This enables law enforcement officers in Oklahoma, particularly those on crisis intervention teams who are the primary responders to these calls, to shift a time-consuming task to alternate response teams. This is especially useful in rural service areas, where the nearest emergency receiving facility may be hours away from the site of the incident.[155] Oklahoma serves as a key example of how a change in statutory requirements can shift some crisis response responsibilities away from law enforcement agencies and build alternate response programs' capacity to perform necessary duties.

> *"The weak point in any model is the [lack of] case management and accountability or follow-up."*

### Specialized Training

Rural areas have smaller law enforcement agencies with a greater percentage of officers who are required to respond to calls for service involving a behavioral health crisis. Due to these circumstances, crisis intervention experts recommend that these agencies train a higher percentage of officers in crisis intervention techniques and, if possible, require their officers to participate in the 40-hour crisis intervention team training.[156] This training could also cover the integration of programs like Virtual Crisis Care, which allows law enforcement to virtually connect individuals in crisis with a behavioral health provider. Law enforcement agencies in Oklahoma, South Dakota, and Nevada have adopted this telehealth approach to crisis response, finding particular success in rural areas.

Statutes that allocate funding to promote telehealth in law enforcement and other crisis response models, as seen in Oklahoma and Colorado, ensure agencies have the resources and capacity to successfully integrate these services.[157,158] CJI did not identify many statutes that focused on the need for other specialized law enforcement training in rural areas. However, this is still an opportunity for statutory intervention to scale up law enforcement agencies' capacity to appropriately respond to crisis incidents.

### Co-Responder Programs

In conversations with stakeholders, CJI learned that co-responder programs can serve as an effective form of case management. In Arizona, the Tucson Police Department utilizes its co-responder program not as a first response to individuals in crisis, but rather as a follow-up response to those individuals who have interacted with patrol or their specialized community units. As one individual from this department explained, ***"we didn't expect to become navigators, but that's what we are. [Officers] collaborate with the co-responder teams, who handle case management, to co-determine how to best assist the individuals."***[159] While CJI's research did not uncover any reference to case management within statutory requirements for co-responder programs, or other crisis response models, this nevertheless serves as an opportunity for legislative intervention to build the capacity for local crisis response and scale up these efforts.

Colorado is another state which has attempted to remedy the capacity building barrier of law enforcement mandated transport. While state statutes permitted the transport of individuals between behavioral facilities by any licensed entity, the state still required law enforcement to transport individuals from the site from which the call for service originated. In 2021, the state authorized co-responder team members who are not law enforcement to transport individuals experiencing a behavioral health crisis to the appropriate facilities.[160] Although the impact of this statute in shifting transport responsibility is unclear, it underscores that statutory authorization for crisis transportation by more entities than just law enforcement is possible.

### Mobile Crisis Teams

Specific statutory attention is needed to bolster alternate response teams in rural areas. The long distances between mobile crisis team stations, behavioral health crisis incidents, and emergency receiving facilities can significantly inhibit timely alternate crisis response.[161] Investments must be made in expanding the availability of crisis response teams in rural areas, as was done in Wisconsin through a 2022 statute that allocated $250,000 biannually to establish or enhance crisis response programs in rural areas.[162] Research also suggests that states develop regional behavioral health transport teams to prioritize the transportation of individuals to treatment facilities. These teams do not need to involve law enforcement so long as this form of transport is permitted by state regulations.[163]

> *"An iPad that can connect with a therapist right then and there has been a huge help to law enforcement [in] connecting an individual with a therapist and getting services and follow-up."*

## Capacity Building Key Takeaways

1. Statutory intervention is key to building capacity within crisis response systems through case management, resource investments specifically for rural areas, and clear role delineation between providers.
2. Case management is a frequently overlooked part of the crisis care continuum but can serve as a primary bridge between health and criminal justice systems through information collection and individualized follow-up.
3. Statutes that require law enforcement to transport individuals experiencing a behavioral health crisis, regardless of the presence of a crime, result in unnecessary contact with law enforcement, overtax limited law enforcement resources, and delegitimize the role of behavioral health professionals who are equipped to provide services immediately upon first contact.
4. Adoption of innovative resources like Virtual Crisis Care or other telehealth connections improve rural communities' access to crisis services and behavioral health providers, despite the geographic barriers.

# Additional Key Factors

CJI identified several other factors that impact localities' ability to scale up crisis response programs but fall outside the original scope of this project. These factors were repeatedly mentioned during key stakeholder interviews as barriers to the successful expansion and sustainment of crisis response across localities. In our assessment of statutory opportunities and barriers, CJI found a lack of existing legislative intervention for the crisis response models around these factors. However, there are opportunities for legislative statutes to address the challenges related to these topics. Topics such as 911 alternatives, crisis stabilization centers, behavioral health workforce, information sharing, and political buy-in should be considered opportunities for further research and investment to expand and sustain crisis response.

## 911 Alternatives

With a growing number of crisis response program models, 911 call center dispatchers must correctly identify and transfer behavioral health related calls to the appropriate local response. This serves as a challenge for both law enforcement and dispatchers, with one stakeholder stating, ***"it's tricky because we don't always know calls are mental health calls before [law enforcement is] there."***[164] As mentioned in this report, one solution to this is to improve 911 dispatcher training regarding the ability and availability of law enforcement and alternate response teams. In addition, there is a growing trend for 911 call centers to embed clinicians who can more effectively assess the need for alternate response and, in some cases, de-escalate crises over the line.[165] Yet to divert a significant portion of behavioral health calls away from law enforcement patrol response and onto trained crisis response teams, states and localities must establish alternative numbers to call.

In 2020, Congress passed the National Suicide Hotline Designation Act which transitioned the existing National Suicide Prevention Lifeline number to 988.[166] In the following years, a wave of state legislation appeared regarding the 988 crisis hotline. As of the writing of this report, nearly every state has enacted legislation to support local implementation of this hotline.

Ensuring the integration of 988 into localities' crisis care continuum can help shift away some of law enforcement's responsibility to be the leading response to behavioral health calls. However, the success of this integration depends on effective coordination between 988 and 911 call centers, law enforcement, alternate response teams, and crisis stabilization centers.[167] One stakeholder illustrated the importance of collaboration early in the process, citing their own state's experience: ***"The state 911 director was part of the planning process in selecting the state 988 call center, [which] helped ensure there was trust in the 988 infrastructure by 911 partners."***[168]

## Crisis Stabilization Centers

Just as localities must build out capacity in the front end of crisis response systems, they must also ensure the back end of the system has the capacity to provide short- and long-term care to those in crisis. This need for available crisis stabilization centers or emergency receiving facilities for individuals experiencing a behavioral health crisis was an overarching theme in CJI's conversations with key stakeholders. ***"Alternative destinations, like crisis stabilization centers, are the next step [in expanding behavioral health crisis initiatives]. There's a need for a place that's not the emergency department or jail. It should cover [services like] sobering, arrest diversion, and it has to allow walk-ins. This will ultimately reduce calls for service,"*** according to one stakeholder.[169] Another stakeholder added, ***"mental health and behavioral health treatment facilities need more funding. This has been chipped away at and the responsibility has shifted to law enforcement... Diversion programs involving law enforcement only work if there is something to divert to."***[170]

More than hospitals and emergency rooms, law enforcement officers and other crisis responders need facilities that provide peer support and other low-level therapeutic services. CJI heard from key stakeholders that in many places, ***"there's a need for constant supervision/ support for individuals experiencing crisis, but there aren't locations to provide this."***[171] Specifically, localities must establish centers that have no-refusal policies and options for both short-term (24- to 72-hour) care, and long-term (60 to 90 day) care.[172] CJI learned from stakeholders that many states struggle to provide the latter type of care. ***"There are not enough 90-day options for people. Especially when it comes to substance use,***

***there's no way someone can stabilize in 72 hours,"*** one stakeholder explained, with others sharing similar sentiments.[173,174] Without spaces that can provide an array of services to individuals experiencing varying levels of crisis, first responders are more likely to continually be called upon to assist those individuals.

This facet of the crisis care continuum is key to ensuring response teams have a lasting impact on both deescalating crises and reducing repeat 911 calls. States can encourage the establishment of these centers through legislation that allocates grant funds or general revenues to crisis centers, such as in Colorado, Connecticut, Oklahoma, and Oregon.[175-178] Furthermore, states would benefit from assessing where there are gaps in service and applying that assessment to statutory language, specifying if these centers must provide short- or long-term care to qualify to receive funding. While statutory funding cannot sustain these centers long-term, it can expand the availability of services across a state.

## Behavioral Health Workforce

A successful shift away from law enforcement as the primary responders to behavioral health crises and onto alternate response and co-response requires an increase in the behavioral health workforce.[179] Co-responder programs and mobile crisis teams employ clinicians, counselors, and peer support specialists to de-escalate crisis situations and connect individuals in crisis to the resources they need. Even with program funding, many municipalities face obstacles in recruiting a sufficient workforce to support these programs. This is in part due to these positions requiring a specialized background and the perception of inadequate pay for the job responsibilities and hours. As one stakeholder put it, ***"it's a job you can burn out of very easily, without adequate pay and support, retention rates will drop."***[180] ***"Salaries for [members of] co-responders and mobile crisis teams need to be competitive to encourage more people to join the workforce,"*** another added.[181] A limited workforce stifles localities' ability to build out their crisis response programs to reach a larger area of service. In the words of another key stakeholder, ***"[there is a] growing desire of law enforcement to not be part of the response, but there's not enough [behavioral health] workforce to support this."***[182]

CJI's stakeholder conversations uncovered the need for an education pipeline for individuals who want to be a part of crisis response programs, but do not necessarily want to work in law enforcement or EMS. While statutory involvement in this solution is minimal, other recommendations for increasing behavioral health workforce capacity include: requiring all health plans to reimburse the full range of behavioral health and substance use providers; enacting federal telehealth legislation; addressing inadequate pay for the behavioral health workforce; expanding loan repayment assistance and forgiveness programs for this workforce; and increasing state and federal funding for mental health training programs.[183] As one stakeholder pointed out, when it comes to improving behavioral health capacity in crisis response, ***"there are less legislative barriers for adopting civilian [mobile] response and co-response compared to the reality of implementing these models."***[184]

## Information Sharing

In localities with multiple crisis response models, the coordination of services between programs and with health providers is often limited by agencies' inability to share and access data. In the words of one stakeholder, ***"everybody uses their own system, and they don't connect."***[185] This sharing of activity data is key to preventing individuals who interact with multiple crisis response programs from continuously cycling through justice systems or systems of care. Instead, programs can ensure these individuals are directed toward the resources they need.[186]

Unfortunately, the challenges that come with this cross-agency data sharing, such as incompatible data management systems and ensuring HIPPA protections, have prevented many localities from reaching this level of collaboration within their crisis care continuum. Statutory requirements for improved data management and sharing can aid localities in scaling up their crisis response systems. States like Colorado, Montana, and Utah are attempting to overcome these challenges through the statutory inception of a statewide data management task force or council. These bodies will review criminal justice data collection requirements and make recommendations to state leadership and criminal justice agencies on how to connect the various record systems and standardize data collection throughout the state.[187,188,189] States can follow this model to assess how to connect the data used by law enforcement agencies, 911 call centers, and behavioral health first responders to advance the collaboration between all parties involved in crisis response.[190]

> *"Diversion programs involving law enforcement only work if there is something to divert to."*

### Political Buy-In

One factor that is not present in statutory language, but certainly impacts the legislative process behind enacted statutes, is the political buy-in of local and state leaders for crisis response programs. In conversations with stakeholders, CJI learned that relationship building between city leadership, behavioral health agencies, law enforcement agencies, and policymakers can directly impact the models that are adopted or supported by legislation. In one state, ***"[the] Department of Mental Health helped to facilitate connections between law enforcement agencies and providers by getting them in the same room to discuss these topics."*** As one stakeholder shared and numerous others repeated in similar words, ***"relationship building across all involved agencies is key. Changes [to the crisis care continuum] cannot be made in a silo."***[191] Federal mandates to change local law enforcement policies and practices also play a major role in influencing political buy-in toward crisis response models.[192] For example, the DOJ's Settlement Agreement with the state of Virginia regarding how they treat individuals experiencing developmental disabilities has impacted how the state develops crisis response.[193] CJI heard similar commentary from stakeholders involved in Baltimore (MD) and Alburquerque (NM), two cities with police departments who are under a federal consent decree.

A key factor that can influence political buy-in is the evaluation of programs. Models that are believed to be effective, based on outcome data and published evaluations, are more likely to receive more bipartisan support. Yet effectiveness takes time to assess. Crisis intervention teams and some mobile crisis teams have been in effect for more years than 911 dispatch diversion or co-responder programs. As a result, there is more outcome data related to CIT and alternate response that city leadership and policymakers can use to advocate for the continued implementation of these programs across states. This data must be both collected and evaluated. As one stakeholder clarified, ***"[You can have] great data collection, but there needs to be the people available to interpret the data."***[194] Further evaluation of co-responder programs, 911 dispatch diversion, and newer variations of mobile crisis teams could lead to increased legislative activity for these programs.

## Conclusion

The purpose of this report was to identify state and federal regulatory barriers and opportunities related to law enforcement's behavioral health crisis response. Specifically, this landscape analysis focused on statutory impacts to crisis intervention teams, specialized law enforcement training, co-responder programs, civilian-led mobile crisis response teams, and 911 dispatch diversion programs. CJI conducted a comprehensive review of federal and state statues within the last five years (2018-2023) related to these crisis response models and conducted interviews of subject matter experts from national organizations, state behavioral health agencies, and law enforcement agencies.

Statutory intervention has a direct and profound impact on the successful implementation of crisis response programs, particularly as it relates to law enforcement. Initiatives that bolster the availability of funding, increase potential for cross-agency collaboration, and enable agencies to build capacity directly impact a locality's ability to adopt and sustain crisis response programs. These three themes are identified throughout this report as means by which policymakers can address barriers to the adoption and sustainability of crisis response across a state.

Despite a wave of social interest and significant federal investment in the last five years, funding remains a primary barrier to behavioral health crisis response implementation for both law enforcement and civilian-led programs. A lack of ongoing statutory allocations, underdefined expectations of fund utilization, and failure to directly target behavioral health crisis response models are the primary barriers to program sustainability. Although law enforcement must often seek funding from various sources to adopt new initiatives, such as through state general funds and federal grants, these sources are not bottomless and cannot support every agency across a state long-term. Crisis response stakeholders have begun to integrate new sources into their funding streams, such as Medicaid which, as of recent, allows some crisis services to be reimbursable to the state health coverage program. However, the lack of a clear definition of which

services qualify for reimbursement has created confusion and limited statewide application of this resource.

States like Colorado, Connecticut, Oklahoma, and Washington have made significant progress in developing crisis response models due to a consistent and deliberate allocation of funds. These states have also relied on state health or behavioral health agencies, which are subject to ongoing funding, to manage or support crisis response programs across localities. This ensures support to the greater crisis care continuum, which in turn allows law enforcement the opportunity to fulfill its public safety role without putting undue strain on its already limited resources.

Cross-agency collaboration was championed by many stakeholders as a key opportunity for the successful implementation of crisis response models. Despite this recognition, many stakeholders also expressed that it is an up-hill battle to collaborate across law enforcement, behavioral health, and other first responders' systems. The need to share information and unify learning across the crisis care continuum can be achieved through the creation of regional bodies to help localities meet their crisis response goals. These bodies can be established by state statute, national organizational assistance, or collaboration between state agencies.

If crisis response goals are collaboratively set and funded, localities must then consider building agencies' capacity to operate and sustain their crisis response models. Case management is a highly sought after element of the crisis care continuum and has become the focus of law enforcement and alternate response programs alike in recent years. Yet it is perhaps one of the most underutilized elements due to a limited behavioral health workforce, competing programmatic priorities, and limited agency funding. Because law enforcement is often designated as the first responder to a behavioral health crisis event, individuals in crisis are more likely to be funneled into a system that is not designed to provide the continuous health and social service support they need. This likelihood increases when state law permits only law enforcement to transport individuals in crisis to crisis stabilization facilities, hospitals, or, when necessary, jail. This statutory requirement acts as a barrier to providing immediate, consistent access to behavioral health resources and puts an undue strain on law enforcement's workload. Statutory authorization for behavioral health professionals to transport individuals experiencing a behavioral health crisis and funding of case management positions within agencies are necessary for localities to build effective crisis response programs.

The effort to understand the landscape of behavioral health crisis response in the United States does not stop here. Although CJI has provided a comprehensive landscape analysis of the opportunities and barriers to adopting and sustaining behavioral health crisis models, there are numerous opportunities for additional research related to the implementation of crisis models that would serve to augment the statutory-centric research synthesized here. In addition, further research should be devoted to the factors that indirectly support law enforcement and facilitate the growth of crisis response models: 911 alternatives, crisis stabilization centers, behavioral health workforce, cross-agency information sharing, and program evaluation. These factors have gained more attention in recent years and serve as opportunities for further statutory and localized investment.

> *"Relationship building across all involved agencies is key. Changes [to the crisis care continuum] cannot be made in a silo."*

# Endnotes


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123. For examples of statutory language that includes clear guidance on model adoption or implementation, see: Illinois H.B. 3653 (2019), Kentucky H.B. 513 (2019), and Rhode Island H.B. 5881 (2023) for crisis intervention teams; Minnesota H.F. 1 (2020) for specialized crisis intervention training; Maryland H.B. 108 (2021) and Montana H.B. 660 (2019) for mobile crisis teams; and Connecticut H.B. 5001 (2022) and Illinois H.B. 1364 (2023) for 911 dispatch diversion.
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