I3 Mental Health Crisis Response Teams and the Challenges of Evidence-Based Police Reform

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Learning Overview: After attending this presentation, attendees will: (1) have an increased understanding of the role of law enforcement in mental health emergencies, (2) learn the history of mental health crisis response teams, (3) learn how they are typically implemented, and (4) the data behind them.

Impact on the Forensic Science Community: This presentation will impact the forensic science community by providing a review of mental health crisis response teams, the evidence supporting them, and areas where further research would be helpful to inform public policy decisions.

It is not unusual for People with Mental Illness (PMI) to interact with law enforcement. In the United States, 25% of PMI have been arrested at some point in their lives, and between 6% and 10% of police contacts with the public involve a person with serious mental illness.[1,2] Beginning with de-institutionalization in the 1960s, the burden of assisting PMI in crisis has fallen increasingly on law enforcement.[3] Police officers are typically the first responders if a PMI has allegedly violated the law, appears to be acting bizarrely, or is otherwise unable to care for themselves. They act as triage workers, determining whether a PMI should be taken for emergent mental health evaluation, arrested, or linked with local support services such as community mental health clinics and homeless shelters. To address this evolving role, police departments in the 1980s widely began to implement training programs for their officers regarding interactions with PMI; however, this alone has not proven to be sufficient.[4]

Mental health crisis response teams have been broadly implemented in cities across the country to help meet this need. They arose out of the 1987 police shooting death of a Memphis man with mental illness and were created for the purpose of decreasing officer and civilian harm during psychiatric crises. These situations have been found to end in violence more frequently—a study on Medicaid® data found that individuals with schizophrenia are three times more likely to die from encounters with law enforcement officials than the general population.[5] There have been a variety of crisis response team models implemented in the United States, typically in two broad forms: police-based (e.g., officers with special training or with embedded mental health workers) and mental-health based (e.g., field-based mental health evaluation teams).

Although crisis response teams have existed in various implementations since 1987, data regarding their efficacy are both limited and unclear. Available data regarding the efficacy of these models in terms of decreasing arrests, officer/civilian injury, or increasing mental health linkage are mixed.[6] Other studies note that PMI often report difficulty with mental health follow-up and case management after their initial encounter with first responders.[7] This lack of data is important from a public policy perspective, especially in the wake of increased scrutiny of police and the budgets of law enforcement agencies in 2020. Media reports and public discourse have called attention to the lack of community mental health resources and increasingly point at initiatives like crisis response teams as a "safer" approach to police involvement with PMI.[8] Municipal officials are beginning to heed similar calls—in July 2020, the Los Angeles County Board of Supervisors announced plans to close one of its largest jails in favor of diverting funds for mental health treatment and other programs.[9]

In order to make public policy decisions like this, officials should have access to accurate data about the efficacy of interventions, including crisis response teams. This presentation will summarize existing data on crisis response teams and highlight areas where further research is needed to help inform these choices. Existing systemic barriers faced by crisis response teams in accomplishing their goals, such as increasingly long wait times for inpatient psychiatric admission, will also be discussed.

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