

REDESIGNING PUBLIC SAFETY

Mental Health Emergency Response RECOMMENDATIONS

ABOUT THIS SERIES

All communities deserve to have the resources and tools they need to feel safe. Across the United States, communities are working to redesign public safety systems to center racial equity, public health, and community power rather than surveillance and punishment. A growing body of evidence confirms what Black and Brown communities have always known: Safety and equity are dependent on each other, and public safety systems must center equity in order to be effective. The *Redesigning Public Safety Resource Series* highlights evidence-informed practices and community innovations that support this vision of public safety. For each set of recommendations in this series, a companion publication provides detailed information and evidence.

ABOUT THESE RECOMMENDATIONS

Police response to mental health emergencies too often leads to unnecessary violence. People with mental health conditions are [no more likely](#) than anyone else to act violently yet are far more likely than members of the general public to be [injured](#) or [killed](#) by police. Because of systemic inequities in health care access as well as rates of police contact, Black and Brown people—as well as LGBTQ+ people, young people, and those living in poverty—are particularly at risk of these harms when living with mental illness. People who live with mental health conditions or who experience mental health emergencies deserve appropriate, accessible, and high quality treatment and services. People who experience mental health emergencies should be treated equitably, and with dignity and compassion, in the least coercive and intrusive manner possible, without fear of violence or criminalization for seeking help or for exhibiting behavior that falls outside of social norms. The following evidence-informed strategies promote this vision of mental health emergency response and prevention.



Invest in Alternative Response Programs

Police should not be the default responders to mental health calls that do not involve any threat of violence to first responders or others. Community-based first response models, such as CAHOOTS (Eugene, Oregon), STAR (Denver), BHEARD (New York City), and Portland Street Response (Oregon), have taken a different approach to mental health response. Early research indicates that unarmed crisis services [can effectively divert people](#) experiencing mental health emergencies away from arrest and hospitalization, decrease the repeated use of crisis services, and improve the health of people who need emergency mental health care.

- 1. Invest in and study community-based mental health first response models.** Community-based first response systems should be available to dispatch mental health professionals 24 hours a day, seven days a week. These response systems should be able to receive calls redirected from 911, 988, and nonemergency lines. Police and community members should also be able to call these programs directly.
- 2. Use mental health co-response teams if a call cannot be diverted to community-based systems.** These interdisciplinary teams typically include a mental health professional and a specially trained police officer who respond together to mental health emergency calls.
- 3. Use dispatch to divert calls to alternative response programs and mental health service providers.** Dispatchers and embedded clinicians should work from clear dispatch and diversion criteria to prevent bias from influencing decisions about which response is needed. Dispatch should also inform 911 callers that emergency mental health services are available. For example, 911 callers in Austin are asked: “Do you need police, fire, EMS, or mental health services?”



Regulate Police Response

Mental health emergencies are medical emergencies, and should be treated as such. Lawmakers and police departments should implement policies to prevent the disproportionate and serious harms that police contact routinely causes to people experiencing mental health emergencies, and ensure that they receive prompt, safe, and appropriate treatment.

- 4. Require police officers to call for assistance from a specialty mental health team when they encounter a person experiencing a mental health emergency.** Officers should be trained on how to identify and stabilize people who may be experiencing a mental health emergency and the environment around them until a specialized mental health team arrives. Police should defer to available mental health first responders unless police are needed due to a threat of violence.
- 5. Officers should be trained on de-escalation and calming tactics for interacting with a person who is having a mental health emergency.** Officers should be required to use these tactics while awaiting any available, appropriate alternative emergency response.
- 6. Pre-arrest diversion policies should identify criteria for presumptive or mandatory diversion in order to remove bias in discretionary diversion decisions.** This gives more people the opportunity to participate in diversion programs.
- 7. Provide officers with names, contact information, and addresses for community-based mental health and social service resources** to assist them with making appropriate referrals. This information should be readily accessible when officers are responding to calls.
- 8. Prohibit the use of ketamine and other “chemical restraints” by first responders, except for use by emergency medical services when necessary for the patient’s benefit due to a medical emergency.** Police officers should also be prohibited from instructing or suggesting that emergency medical services providers use ketamine or other drugs to control a person.



Invest in Equitable Mental Health Care

Mental health emergencies often happen because of a lack of access to earlier health care, an issue that disproportionately affects Black people. Many Black people who need mental health care services [do not receive them](#), and Black people are [less likely](#) to receive guideline-consistent care.

- 9. Examine and address systemic racism in the practices of mental health professional organizations and providers.** Mental health organizations and providers should center anti-racism and health equity in all of their work. For example, they should:
 - Acknowledge the ways in which [mental health](#) and [social work professionals](#) have supported racist ideas and policies and take reparative action;
 - Improve and expand provider training and screening tools for [racial trauma](#);
 - Develop systems to address overdiagnosis of [psychotic disorders](#) and underdiagnosis of [mood disorders](#) among Black people; and
 - Recruit, support, and promote more non-White mental health care providers.

- 10. Increase access to and quality of services for mental health and co-occurring substance misuse through Medicaid.** Emerging research has shown that Medicaid expansion is associated with lower rates of police calls related to mental health crises.

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

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

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

- 14. Address barriers to virtual care and telehealth**, including inequitable broadband access and inconsistent laws and regulations around telehealth.

- 15. Expand and improve wraparound services for people with mental health conditions.** These social services address needs beyond mental health care and should include housing services, substance use and misuse services, and case management.



Improve Data Collection and Transparency

Efforts to redesign public safety should always include data collection. Data can deepen understanding of the problems that affect a community, help ensure that any new policies are achieving the goal of improved equity and safety, and build evidence for changes not yet made.

- 16. Collect and analyze data on mental health calls for service.** Data on mental health calls for service should be linkable to data collected on police stops and use of force through unique ID numbers. First responders should update the call type information after the call is completed as needed to make sure it is accurately recorded as related to mental health.

- 17. Analyze outcomes of community-based response systems and diversion programs** as compared to outcomes of police response. Studied outcomes should include:
 - Uses of force;
 - Arrests;
 - Involuntary commitment;
 - Calls for police backup;
 - Community-based referrals made by responders. Data should specify the type of service referred and whether or not it was accepted.

- 18. Collect analyzable data on all police stops and uses of force.** For each stop or use of force incident, officers should record whether they perceived the person to be experiencing a mental health or substance use emergency. Data should also include information about the outcome of the call and whether the officer was part of a co-response team.

- 19. Monitor capacity issues in community-based and hospital-based services for people with emergency mental health needs.** Policymakers must monitor and invest in mental health care systems to ensure that call diversion does not overwhelm facilities with limited resources.

- 20. Police departments should sign data-sharing agreements with service providers to ensure proper transition of care, monitor effectiveness, and better serve people with mental health conditions.** These agreements should be one-directional, with police departments granting specific service providers and researchers access to their data without the requirement that providers share their data with police departments.

This brief and the companion report are available at policingequity.org/mental-health



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