Rethinking Crisis Response in Texas

Criminal Justice Project

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INTRODUCTION[1]

Roughly one out of every five adults in America lives with a mental illness.[2] These conditions vary in severity, and they can manifest in several ways, including emotional and behavioral crises. Mental illness is not a static condition, and therefore symptoms can appear at any time or not at all. Law enforcement officers are increasingly responding to individuals with serious mental illnesses, including **schizophrenia, bipolar disorder, psychosis, post-traumatic stress disorder, and depression**.[3] When responding to these crises, police utilize the system they are familiar with - the criminal justice system. As a result, individuals with mental health conditions are flooding into jails and prisons instead of treatment services.

In recent years, this country has seen a necessary and revolutionary shift in our policing needs and practices. Though much of the conversation has been on important, research-based changes – the actual response to these problems is lacking. We have witnessed time and time again that police response to mental health crises is often ineffective and dangerous, with tragic consequences. One in four of all fatal police encounters involves an adult with an untreated severe mental illness.[4] Law enforcement is often undertrained and underinvested in community-based resources. We should eliminate the use of law enforcement, with rare exceptions, as first responders to 911 calls involving individuals experiencing a behavioral health crisis. Crisis response services should be trauma-informed, community-centered, and supported by evidence-based practices for recovery.

Schizophrenia – A mental illness that affects how a person thinks, feels, and behaves. It may result in some combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning and can be disabling.

Bipolar Disorder – A mental disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.

Psychosis – a state in which a person's thoughts and perceptions are distributed and they may have difficulty distinguishing reality from hallucinations.

Post-Traumatic Stress Disorder (PTSD) – can develop in people who have experienced or witnessed a traumatic event or after a distressing event. Those suffering from PTSD may have flashbacks, bad dreams, and frightening thoughts, leading to cognition and mood symptoms.

Depression – a common but serious mood disorder that causes significant impairment to one's daily life. There are several kinds, including, major depression, persistent depressive disorder, perinatal, seasonal affective disorder, and a severe form of depression which is accompanied by psychosis.

Substance Use Disorder (SUD)– A mental disorder that affects a person's brain and behavior which can lead to an inability to control their use of drugs, alcohol, or medications. Nearly half of individuals who experience a SUD experience a co-occurring mental disorder.

National Institute of Mental Health (2021). Health Topics. from https://www.nimh.nih.gov/health/topics/eating-disorders.

KEY FACTS

- Roughly 1 out of every 5 adults in America lives with a mental illness.[5]
- 1 in 4 fatal police encounters involve an adult with an untreated severe mental illness.[6]
- Mental health disorders are a factor in as many as 1 in 2 fatal law enforcement encounters.[7]
- More than $1.5 billion has been spent to settle claims of police misconduct.[8]
- Law enforcement have reported spending a notable amount of time and resources on responding to and transporting people in calls of crisis.[9]
- Individuals with severe mental illness occupy at least 1 in 5 American prison and jail beds.[10]

BACKGROUND

Mental health crises are not crimes. Yet in our response to these incidents, we treat them in a very similar manner. There are several models that are being implemented around improving response to these crises. Some 911 centers have begun directly employing nurses and mental health professionals who can provide telephone interventions and connect people in crisis to services without ever sending anyone in person. There are also police-based emergency response models, including:

- Sole responder teams where police officers receive additional training to effectively manage behavioral health crises, and
- Co-responder teams where police officers are paired with mental health professionals for certain types of calls.[11]

Additionally, there are community-based responses. This model involves a wide variety of resources that focus on keeping an individual out of the criminal justice system and diverting them to services and programs that can support them instead. Some examples include peer navigator programs where peers will help individuals with behavioral health disorders who are at risk of criminality. Others use Mobile Crisis Teams composed of medics, crisis workers, and peers to respond to people in crisis and provide immediate de-escalation and referral to community-based mental health services. The most prominent example of this type of program is Crisis Assistance Helping Out on the Streets (CAHOOTS), which came out of Eugene, Oregon.

CAHOOTS diverts emergency calls for service involving behavioral health or chronic housing crises away from law enforcement. The program is operated through the White Bird Clinic, a long-standing community organization in Eugene. 911 calls that meet the appropriate criteria are diverted to the White Bird Clinic's mobile intervention services, including calls for welfare checks, transportation to social or medical services, public assistance, non-emergency medical assistance (i.e., mental health and substance use issues), and homeless outreach. However, law enforcement will respond to the call if a weapon is present, or the individual is potentially violent.

RESPONDING TO MENTAL HEALTH IN THE HOUSTON AREA

The Harris Center

- Largest behavioral and developmental disability center in Texas.
- 83 cities across Harris County (80,000 individuals served annually).
- State-designated local MH authority.
- **Collaborates with HPD**
  - Mandatory 16 hours of training for all patrol agents.
  - Crisis Intervention Team largest program in nation.
  - MH Unit is a division.
  - Operates a Crisis Call Diversion Center (expanded to Houston Fire Department).
  - Operates a Pre-Charge Jail Diversion Center.
  - Clinician and officer remote evaluation program.

The HART Program

- **Holistic Assistance Response Teams** – program created to directly dispatch 911 and other calls to interdisciplinary first responders' teams, trained in behavioral health and on-scene medical assistance.
- Effective community response to issues related to homelessness, behavioral health, substance abuse, and non-emergency health or social welfare crises.
- 911 dispatchers will identify non-violent emergency calls appropriate for HART response and send teams to the scene.
- Other first responders (EMS, Police, and fire) can also call HART directly.
- HART responders will use their behavioral and medical health training to resolve calls on site and to connect residents to follow-up resources to promote ongoing health and safety.

In Harris County, the Holistic Assistance Response Team (HART) has begun to follow the same model and similarly distinguishes between violent and non-violent calls. The city of Houston also operates a similar program through the Harris Center for Mental Health and IDD – called the Mobile Crisis Outreach Team (MCOT). Many

other cities across the country are developing similar programs, often with promising results. In Denver, initial evaluation shows significant decreases in reports of low-level crime due to the implementation of an alternative responder program.[12]

Alternative response programs such as those mentioned above constitute strong first steps in decreasing exposure to the police for people in crisis and freeing up police time for other public safety work. But **there is still much room for improvement and further evaluation of policies and practices that are becoming the standard**. Implementing these programs involves close coordination with multiple entities, from 911 call centers to police departments to mental health providers.

That said, the potential gains are enormous. For someone suffering from depression, psychosis, schizophrenia, or a behavioral crisis, the presence of armed police only serves to exacerbate their fear and paranoia. Police are trained to be authoritative and commanding, characteristics that are necessary when dealing with a hostile individual not experiencing a mental health crisis; however, they are antithetical when dealing with those in crisis. Someone in crisis requires patience, assurance, and a non-threatening demeanor. Meanwhile, police departments around the country are having difficulty filling funded positions with qualified applicants, and scarce police resources are being used in situations where other professionals would be more effective.

With the recent implementation of the new 988 number by the Substance Abuse and Mental Health Services Administration (SAMHSA), these centers will become more important than ever. The new Lifeline for mental health crises offers 24/7 access to trained counselors who can help people in distress. SAMHSA emphasized that the new three-digit number is just a start – they envision that it will turn into a "robust crisis care response system" with the calls being linked to *community-based providers* that deliver a range of crisis care services.[13] As of now, calls which indicate imminent risk to someone's life that cannot be reduced during the call are redirected to 911. Significantly, however, fewer than 2% of Lifeline calls require any connection to emergency services.[14] In Texas, the Harris Center serves as one of four centers in the state taking the Lifeline calls.

It is vital for the protection and well-being of individuals with behavioral health disorders that we move away from reliance on the police. It is unfair to ask law enforcement to respond to non-criminal activity for which they have little or no training and expect them to do it well. Instead, we must implement practices with mental health professionals who are trained and experienced in helping these individuals. Additionally, programs should use peer specialists with lived experience to help individuals beyond their crisis. There has been an increase in mental health conversations in the wake of mass shootings, increased exposure to police brutality, and the de-stigmatization of mental health disorders. However, fundamental changes remain an urgent and widespread need.

LAW ENFORCEMENT AS PRIMARY FIRST RESPONDER

Law enforcement has become the "first responder" in the place of many nonexistent systems of healthcare and human services.[15] It is unfair to render them responsible for providing services which often undercut their primary purpose of ensuring public safety. Furthermore, local law enforcement often lacks the resources and is stretched too thin to handle it all. Of the 18,000 state and local law enforcement agencies in the United States, nearly half have fewer than ten sworn officers.[16] For some of them to then specialize in other skills is impracticable, especially when other health and human service professionals already possess those skills. Even large police departments are experiencing high rates of vacancies, with fewer officers asked to do more.[17]

Calls to respond to behavioral health crises can take significant police resources for low-level issues that may not even rise to the level of a crime. Between transportation to mental health facilities and waiting for evaluation by a mental health professional, this can be a significant drain on police resources.[18] Additionally, by police serving as first responders to behavioral health calls, the likelihood of a police-citizen interaction

resulting in the use of force goes up.[19] This finding may be unsurprising, given that law enforcement are primarily trained to handle hostile and dangerous behavior, and not mental or behavioral breakdowns. In addition, when police officers use force against an individual, it is shown to be disproportionately used against communities of color.[20] In other words, both police officers and community members of color lose in the current approach.

The effects of these encounters are substantial and long-lasting. One study showed how excessive force against a Black person has ripple effects on every Black person in that community.[21] A sample of approximately 40,000 Black respondents in the U.S. found that for every police killing of an unarmed Black person that respondents were exposed to over three months, there was an average increase of .14 additional poor mental health days per individual.[22] For the health and safety of entire communities, fully trained, community-based teams would be more appropriate first responders in these situations.

Aside from the physical and mental consequences of a law enforcement response to behavioral or mental health crises, the practical consequences are also injurious. Exposure to the criminal justice system affects an individual's ability to get a job, find housing, and is financially burdensome.[23] People with disabilities already face barriers of entry to spaces; adding a criminal record makes living with a disability an even greater challenge. Furthermore, if a person ends up incarcerated, that means they will not receive necessary treatment, exacerbating their condition.[24]

CIT MODELS ARE INEFFECTIVE

Much of the conversation on improving the outcomes for behavioral and mental health crises focuses on using the sole responder model discussed above, often referred to as a Crisis Intervention Team (CIT) model. CIT is a police-based response model which has been popularly implemented. However, research has contradicted the claims that this model effectively decreases excessive force against people experiencing behavioral health emergencies.[25] Despite these studies, the model has already been implemented nationwide by more than 2,700 law enforcement agencies.[26] The CIT model has three core components:

1. 40-hour comprehensive training for officers wishing to participate.
2. Establishment of a fully staffed CIT leadership team.
3. A facility capable of receiving referrals.

The training generally includes basic education about mental illness, causes, signs, symptoms, information on involuntary commitment criteria, communication skills, and de-escalation strategies. Though this sounds good on paper, there is little evidence to show that the CIT approach is effective.

In a comprehensive review of CIT programs across the U.S., researchers found insufficient evidence to conclude any benefits or harms of the model.[27] Researchers defined the success of the program through the stated goals of CIT. Though they vary from state to state, the goals are to reduce arrest rates of those with mental health problems, reduce officer use of force, and minimize injury to the officer and the individual. There was insufficient evidence that the model reduced officer injury; however, the study did find enough evidence to conclude that CIT had no effect on arrest outcomes or officer use of force.

Furthermore, many who have undertaken this line of research have concluded that there is a severe lack of meaningful assessment of events in the field as law enforcement responds to CIT-related calls.[28] The majority to date are, instead, focused on officer outcomes. That is, there is evidence to show that CIT effectively increases the officer's knowledge and confidence; however, it is not reflected in the officer's behavior. The CIT model has increased the number of transportations to mental health facilities. Still, researchers believe that much of the call's outcome is determined by the dispatcher's first impression rather than the CIT officer's enhanced assessment skills.[29]

Finally, two studies have shown the CIT model produces perverse outcomes. A study by the National Institute of Health (NIH) found there was no statistical difference between the use of force between officers who received CIT training and those who did not.[30] The other study conducted by the same team at the NIH showed that individuals who officers perceived to have mental health or behavioral issues were more likely to be subject to the use of force and more likely to be perceived by the responding officers as violently resisting.[31]

SOME ALTERNATIVE MODELS ARE STILL NOT IDEAL

Another model often promoted by advocates is the co-responder model, where police are accompanied by mental health professionals while responding to mental health or behavioral crises. Though this model is better in some ways because it prioritizes an interdisciplinary response, it also lacks research on its effectiveness. Systematic analysis has failed to produce evidence that these approaches can successfully mitigate the risks of arrest, abuse, or other trauma at the hands of police.[32] Because the police remain the decision-makers in this model, they often default to standard police practices in the end, despite the presence of other professionals.

Existing research indicates that co-responder programs are more successful than traditional police responses at providing consumers with behavioral health services. However, those receiving care report previous traumatic interactions with law enforcement, suggesting that this model retraumatizes those experiencing a behavioral health crisis even if the risk is reduced.

WHY ARE THESE PROGRAMS INEFFECTIVE?

Programs created through law enforcement are ineffective for several reasons. For one, local and state governments prioritize law enforcement budgetary concerns.[33] This means law enforcement automatically become first responders to all community needs, even needs they are not trained to respond to. Because the police are historically expected to meet these needs, officers consistently associate mental health crises and substance abuse with criminal activity.[34] However, as demonstrated, mental and behavioral health crises cannot be treated with the same tactics used to subvert crime. **Mental and behavioral health crises need to be treated by mental health professionals.**

Additionally, not all those who need mental health crisis intervention receive it through these programs. A tour of the Harris Center in Houston revealed that the individuals diverted there were receiving compassionate care and tailored guidance for life after the program. The directors and staff are clearly fierce advocates for those walking through the door and provide everything from beds, food, care coordinators, and more. But for the most part, individuals can only be brought to the center with police discretion. Due in part to statutory restrictions, certain offenses, which still involve a mental health crisis, are not eligible for diversion (e.g., suicide attempts and family disputes).

Another major factor in their ineffectiveness is that individuals experiencing mental health crises do not respond well to police intervention.[35] A qualitative study exploring mental health consumers' attitudes towards police identified greater fear and less trust of law enforcement amongst those with mental illnesses. It is intuitive that **persons already in distress, experiencing trauma, will not respond well to authoritative commands and the threat of weapons or arrest**. Instead, what is needed is compassion, empowerment, and de-escalation.

RECOMMENDATIONS FOR REFORM

There are several steps that local and state governments can take to improve the crisis response implemented for people in behavioral health crises:

1. Funding that would support the use of mental health professionals as the primary responders in calls for crises should be prioritized.
2. Emergency calls to respond to a mental health crisis should be diverted away from law enforcement to individuals or groups equipped to respond in a humane and evidence-based way.
3. Police responsibilities involving non-criminal activity should be reassigned to more appropriate services.
4. There must be an ongoing and extensive assessment of the programs already in place to implement necessary changes as the programs grow and continue.

The benefits of these improvements are two-fold. For one, persons with mental health problems are prevented from entering the criminal justice system where they do not belong. Secondly, it will lessen the burden on law enforcement, allowing them to focus their resources and time on their true purpose of ensuring public safety.

CONCLUSION

The current policy movement regarding mental health is extremely encouraging. Even a decade ago, we were still fighting stigmas regarding mental and behavioral health issues that today are met with sympathy, compassion, and treatment. Diversion programs recognize the need to keep people out of jail and instead offer treatment, housing, food, and other resources. However, progress for the sake of progress is not enough. Crisis response is an ever-evolving practice and therefore we must meet this challenge with meaningful assessments and adjustments. The modern trend of co-responder models is a step in the right direction, but people in crisis are still suffering from contact with the police. **Reducing police interaction with individuals in crisis represents the most immediate and practical strategy for diminishing the many costs of exposure to the criminal justice system.** With the recommendations provided in this brief, policy makers can lessen the heavy burden placed on their law enforcement agencies and better utilize trained mental health professionals and specialists.

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REFERENCES & ENDNOTES

[1] Special thanks go out to Natasha Malik, Criminal Justice Policy Intern. Natasha served as the primary author on this issue brief. Brennan Griffin, Senior Deputy Director of Texas Appleseed, served as co-author.
[2] U.S. Department of Health and Human Services (2022). National Institute of Mental Health. "Mental Illness." Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.
[3] Center for American Progress (2016). *Disabled Behind Bars: The Mass Incarceration of People with Disabilities in America's Jails and Prisons*. Retrieved from http://www.americanprogress.org/issues/criminal-Justice/dlsabled-behind-bars/ps
[4] Fuller, Doris A, et al. (2015). *Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters*. Treatment Advocacy Center. Retrieved from https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf?ftag=MSF0951a18.
[5] U.S. Department of Health and Human Services (2022). National Institute of Mental Health. "Mental Illness." Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.
[6] Fuller, Doris A, et al. (2015). *Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters*. Treatment Advocacy Center. Retrieved from https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf?ftag=MSF0951a18.
[7] Ibid.
[8] Alexander, K.L., Rich, S., & Thacker, H. (March 9, 2022). *The hidden billion-dollar cost of repeated police misconduct*. The Washington Post. Retrieved from, https://www.washingtonpost.com/investigations/interactive/2022/police-misconduct-repeated-settlements/
[9] Treatment Advocacy Center: Road Runners (May 2019). *The role and impact of law enforcement in transporting individuals with severe mental illness, a national survey*. Retrieved from https://www.treatmentadvocacycenter.org/storage/documents/Road-Runners.pdf
[10] Fuller, Doris A, et al. (2015). *Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters*. Treatment Advocacy Center. Retrieved from https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf?ftag=MSF0951a18.
[11] Beck, J., Reuland, M. & Pope, L. (November 2020). Behavioral health crisis alternatives. Retrieved from https://www.vera.org/behavioral-health-crisis-alternatives
[12] Dee, T.S. & Pyne, J. (2022). *A community response approach to mental health and substance abuse crisis reduce crime*. Science Advances (8), 2106. Retrieved from https://tom-dee.github.io/files/sciadv.abm2106.pdf
[13] SAMHSA. (n.d.). *988 Suicide & Crisis Lifeline*. SAMHSA. https://www.samhsa.gov/find-help/988
[14] Ibid.
[15] Headley, A.M. & Wright, J.E. (2020). *Is representation enough? Racial disparities in levels of force and arrests by police*. Public Administrative Review, (80), 1051-52.
[16] Ibid.
[17] The New York Times (December 25, 2022). *As Applications Fall, Police Departments Lure Recruits With Bonuses and Attention. Retrieved from https://www.nytimes.com/2022/12/25/us/police-officer-recruits.html?smid=url-share*
[18] Treatment Advocacy Center: Road Runners (May 2019). *The role and impact of law enforcement in transporting individuals with severe mental illness, a national survey*. Retrieved from https://www.treatmentadvocacycenter.org/storage/documents/Road-Runners.pdf
[19] Laniyonu, A. & Goff, P.A. (2021). Measuring disparities in police use of force and injury among persons with serious mental illness. BMC Psychiatry (21), 500. https://doi.org/10.1186/s12888-021-03510-w
[20] Bor, J., Venkataramani, A.S., Williams, D.R., & Tsai, A.C., (2018). *Police Killings and Their Spillover Effects on the Mental Health of Black Americans: A Population-Based, Quasi-Experimental Study*. Lancet (392), 10144, 302-310.
[21] Ibid.
[22] Ibid.
[23] Center for American Progress (2016). *Disabled Behind Bars: The Mass Incarceration of People with Disabilities in America's Jails and Prisons*. Retrieved from http://www.americanprogress.org/issues/criminal-Justice/dlsabled-behind-bars/ps
[24] Ibid.
[25] Nemschoff, D. (2022). *An evaluation of crisis-intervention team (CIT) training*. Munich Personal RePEc Archive, 114948.
[26] National Alliance on Mental Illness. Crisis intervention team (CIT) programs. Retrieved from https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs#:~:text=In%20over%202%2C700%20communities%20nationwide,mental%20illness%20and%20their%20families.
[27] Taheri, S.A. (2016). *Do crisis intervention teams reduce arrests and improve officer safety? A systematic review and meta-analysis*, Criminal Justice Policy Review, SAGE Publications.

[28] Compton, M.T., Neubert, B.N.D, Broussard, B., McGriff, J.A., Morgan, R. & Oliva, J.R. (2011). *Use of force preferences and perceived effectiveness of actions among crisis intervention team (CIT) police officers and non-CIT officers in an escalating psychiatric crisis involving a subject with schizophrenia*. Schizophrenia Bulletin (37).
[29] Ritter, C., Teller, J.L.S., Marcussen, K., Munetz, M.R., & Teasdale, B. (2011). *Crisis intervention team officer dispatch, assessment, and disposition: Interactions with individuals with severe mental illness*. International Journal of Psychiatry (34) 30, 31-32.
[30] Morabito, M.S., Socia, K., Wik, A. & Fisher, W.H. (2017). *The nature and extent of police use of force in encounters with people with behavioral health disorders*. International Journal of Psychiatry (50), 31.
[31] Morabito, M.S., Kerr, A.N., Watson, A., Draine, J., Ottati, V. & Angell, B. (2012). *Crisis intervention teams and people with mental illness: exploring the factors that influence the use of force*. Crime & Delinquency (58), 71-72.
[32] Puntis, S., Perfect, D., Kirubarajan, A., Bolton, S., Davies, F., Hayes, A., Harriss, E. & Molodynski, A. (2018). *A systematic review of co-responder models of police mental health 'street' triage*. BMC Psychiatry (18) 256-57.
[33] Stettin, B., Frese, F.J., & Lamb, H.R. (2013). *Mental health diversion practices: A survey of the states*. The Treatment Advocacy Center.
[34] Boyd, J., Boyd, S. & Kerr, T. (2015). *Visual and narrative representations of mental health and addiction by law enforcement*. International Journal on Drug Policy (26) 636, 642-43.
[35] Goldberg, V., White, C., & Weisburd, D. (2019). *Perspectives of people with mental health problems at hot spots: Attitudes and perceptions of safety, crime, and the police*. Behavior, Science, and Law. DOI: 10.1002/bsl.2440.