

CO-RESPONSE:

A Better Model Than Crisis Intervention Teams for the Mentally Ill

January 2026

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Introduction

Police officers across the U.S. must perform an impossible balancing act: respond promptly and effectively to dangerous situations involving people in states of psychosis, and de-escalating when possible to avoid using the level of force that is often associated with violent incidents. Police have become the de facto frontline social workers of the street—making them psychologists and medical responders in addition to their duties as law enforcement. Their interactions with the mentally ill population have grown in number and complexity as medical institutions have retreated from caring for this challenging population. In response to these situations, many police departments created agency-specific, specialized Crisis Intervention Teams (CIT) to de-escalate situations involving mentally ill people and guide them towards treatment.¹

But this model continues to rely on responses to public safety hazards caused by people with untreated serious mental illness (SMI), rather than proactively engaging with unwell individuals who are most likely to end up in dangerous altercations with the public and law enforcement. As a result of the current model, police are too often in situations where they use force on individuals who are better described as sick than criminal. The consequences can be tragic.

Law enforcement has struggled to respond to these crises in the ways preferred by mental health advocates.² These advocates tend to see uses of force against people with mental illness as inappropriate, despite the fact that many of these situations are genuinely matters of life and death for the public and officers alike. In fact, the mentally ill are 16 times more likely to be killed in a law enforcement encounter and account for 25 percent of all law enforcement contacts.³⁻⁵ But overall, police use of lethal force is remarkably low at a rate of 1 in 54,000 overall contacts in 2018, a rate that stayed relatively constant through 2024.⁶⁻⁷ However, the fact that mentally ill individuals are often ensnared in the criminal justice system, too often lethally, is undeniable.

These tragedies have created unworkable friction between law enforcement and mental health advocates, limiting the much-needed opportunities for collaboration to develop better ways to prevent people from spiraling into psychosis in the first place.



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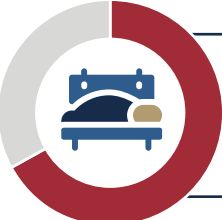
The recent White House Executive Order 14321, “Ending Crime and Disorder on America’s Streets,” offers a new path forward to address the public safety and health hazards of mental illness before crises arise.⁸ The Certified Community Behavioral Centers (CCBHCs) with more than 500 sites across the U.S. and territories offer an invaluable asset to law enforcement that exceeds the capabilities of CIT.⁹

CCBHCs are legislatively mandated to provide 24/7 mental health and substance abuse treatment to all, regardless of the severity of their illness and the ability to pay.¹⁰ Further, their function is to be mobile beyond the four walls of the clinic, which positions them as a highly trained and resourced partner in the field to law enforcement.¹¹

Through the use of assisted outpatient treatment (AOT), CCBHCs can do what the CITs have been working towards for years, matching individuals with treatment to reduce criminality and violence.¹²

Mental Illness and Violence

The prevailing belief that the mentally ill are not dangerous or violent is only partially true.¹³ Among the seriously mentally ill, the numbers are much higher as these individuals have little or no access to care and are often relegated to prisons, emergency rooms, or streets, where they continue to deteriorate toward violence.¹⁴ And since the imposition of deinstitutionalization policies, the number of homeless individuals reported as mentally ill has increased to 67 percent, with one-third of the highly visible unsheltered homeless population being seriously mentally ill.¹⁵⁻¹⁶ Moreover, they are more likely to be victims rather than perpetrators of crime.¹⁷



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The high visibility of this population is important as 13–17 percent of law enforcement calls for service involve the unsheltered homeless, and between six and 10 percent of all law enforcement calls for service involve the seriously mentally ill.¹⁸⁻²⁰ Lack of access to alternatives, and willing service partners to provide them, incarceration for the seriously mentally ill is increasing. Twenty percent of the jail population, estimated at 550,000, and 15 percent of the 1,071,000 inmates in state prisons are estimated to have SMI.²¹ Further, 63 percent of those are serving a sentence for a violent offense.²² While the exact number of individuals with SMI who are incarcerated for a violent offense is largely unknown, studies have shown that these individuals are 3.5 times more likely to commit an act of violence than the general population.²³

Responses by Law Enforcement

To stem the tide of the seriously mentally ill entering the criminal justice system, law enforcement agencies across the nation have exercised their role as gatekeepers by instituting a Crisis Intervention Team model (CIT), now seen as the gold standard of police response models.²⁴

The Memphis Police Department initiated the first known CIT in 1988 in collaboration with mental health professionals and advocates in response to a police-involved shooting of an individual with mental illness.²⁵ Today, there are over 2,700 CIT programs across over 17,000 law enforcement agencies, with the majority (67%) existing in local agencies.²⁶⁻²⁷ Law enforcement volunteers were given 40 hours over five days of intensive classroom and hands-on, experiential training on de-escalation techniques.²⁸

This CIT model expanded to several states and jurisdictions as law enforcement saw a proactive way to advance the tenets of Problem-Oriented Policing in collaboration with mental health agencies. CIT is embraced mainly by law enforcement, but not as much by the mental health community.²⁹ The problem is further exacerbated by the number of mentally ill individuals who also become homeless as a result of the severity of their mental illness and frequently co-occurring substance abuse, which can lead law enforcement to focus on the crime rather than the illness.

The primary goal of CITs is to de-escalate situations and help individuals experiencing a severe mental health event to gain control of their emotions, thoughts, and behavior. While these teams have become popular and are supported by nationally recognized organizations, they are difficult to implement and to employ effectively from a logistical perspective.³⁰ Follow-up training to ensure that officer skills are kept current is often sporadically offered and competes with other “necessary training” that officers must go through.³¹

CIT training focuses on three elements: ongoing, operational, and sustainment for the officers.³² The ongoing (initial identification and training of officers) and operational (training dispatchers and other support staff) are relatively easy. However, it is the sustaining element (ongoing training, partnership building, and community outreach) where many agencies fall short.³³ CIT programs depend on collaborative connections with external agencies to connect individuals in crisis with appropriate resources such as mental health treatment and substance abuse treatment programs, support groups, living arrangements, and other needed psychosocial

services.³⁴ Unfortunately, the multitude of techniques for effective de-escalation through CIT tend to drive potential officers away, as it takes them out of the field and places them in a tedious classroom setting to learn skills that are only occasionally useful.

While theoretically these teams work collaboratively with local hospitals or other medical facilities to ensure that the mentally ill receive necessary attention, the reality is that law enforcement agencies often work in isolation or at the will of community-based mental health providers, who have a negative view of law enforcement.³⁵ This places additional strain on the agency in terms of personnel and funding, as they must respond to all calls for service with limited resources. These efforts were further strained by the 1994 Violent Crime and Law Enforcement Act.³⁶ Furthermore, due to the decentralized nature of law enforcement agencies and the lack of standardized training models, CIT programs have had inconsistent implementation.³⁷

This inconsistency has affected CIT's effectiveness. Research studying CIT as an evidence-based program finds that effectiveness depends on how one defines evidence-based. If the metric is a reduction of officer stigma and increased officer knowledge of street-level mental illness, then CIT can be considered effective.³⁸ However, other law enforcement outcomes (specifically the intended outcomes of reducing the use of force with the mentally ill), show little to no effect.³⁹ Yet, CIT is lauded for its ability to divert mentally ill individuals from the criminal justice system into appropriate treatment.⁴⁰ With the reality that law enforcement increasingly continues to be the first responder to those in a mental health crisis, and the subsequent drain on agency resources, a co-responder model is needed.⁴¹

The Co-Responder Model

Gaining frequency in the United Kingdom, Canada, and Australia, the co-responder model pairs law enforcement with mental health practitioners to respond to mentally ill individuals in crisis.⁴² This represents a significant change from CIT, which is law enforcement-centric, to an interprofessional collaborative approach. Further, it represents a similar change from the mobile crisis unit model, which is behavioral health practitioner-centric and focuses on an alternative to law enforcement, utilizing nurses, social workers, and occasionally psychiatrists.⁴³⁻⁴⁴



Unfortunately, the mobile crisis unit model tends not to consider the impact of crisis response services (as their function is to operate outside these law enforcement-based services) and suffers from unreasonable delays in service.⁴⁵ The fully integrated co-responder model is the best approach to responding to mental health crises by embedding a mental health expert with a law enforcement partner.⁴⁶ This model allows the law enforcement officer to focus on

the risk of the situation while the mental health expert focuses on the needs of the offender to provide a better connection to needed community-based services.⁴⁷ This model provides transparency to law enforcement of those who have been referred to services or are in need of services, further reducing the probability of escalating a crisis.⁴⁸

Improving the Co-Responder Model with Certified Community Behavioral Health Centers

The question then becomes how the fully integrated model is implemented. The Certified Community Behavioral Health Centers (CCBHC) are in the best position to do this. With supported expansion under Executive Order 14321 through the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), CCBHCs are legislatively required to provide 24/7 access to mental health and substance abuse care and community-based services.⁴⁹⁻⁵⁰ Further, CCBHCs also incorporate proven treatment supervision models such as AOT, assertive community treatment (ACT), and forensic assertive community treatment (FACT), with the last being the most appropriate for those who are criminally involved.

The co-response model is most closely aligned with FACT in form, as it combines both law enforcement and treatment practitioners in the field, but differs in function. While FACT is applied to those already criminally involved, the co-responder model primarily seeks to divert individuals toward treatment before they are involved with the criminal justice system. As such, this model provides the best opportunity to appropriately address the negative impact of the mentally ill offender on the criminal justice system by creating a legislatively required partnership between law enforcement and CCBHC agencies.

Conclusion

Given the exponential growth of the seriously mentally ill in the unsheltered homeless population and the impact that this population has on the criminal justice system, the need for change is urgent. The high visibility of this population with law enforcement and the public has left many police departments scrambling for appropriate and more compassionate responses. However, they have largely been expected to do this on their own through agency-specific CIT. This has done little to reduce the incarceration of the seriously mentally ill. Instead, through Executive Order 14321, "Ending Crime and Disorder on America's Streets," states now have the opportunity to partner with existing CCBHCs and CITs in a co-responder model that emphasizes access to treatment, even for those who have committed a crime.

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