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Integrating Mental Health Services into Public Safety Systems: A Review of Policy Frameworks and Crisis Response Models in the United States

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Abstract

The intersection between mental health and public safety within the United States constitutes an urgent yet woefully neglected field of social policy. A legacy of decades of deinstitutionalization, inadequate investment in community mental health capacity, and the structural role of law enforcement as first responders to crises of mental distress has yielded a costly, unjust, and clinically inadequate system. This literature review will address policies guiding the integration of mental health services into public safety systems in the United States, relying on peer-reviewed literature, government policy reports, and program evaluations. The review will chronicle the history of this policy space from the era of deinstitutionalization to subsequent legislative milestones at the federal level, evaluate the effectiveness of traditional law enforcement-based solutions, including Crisis Intervention Training, and analyze newer alternatives, including civilian mobile crisis teams, co-responder models, and telehealth-enhanced dispatch. Results suggest that alternative crisis response strategies, especially civilian-based solutions, show significant gains in terms of diversion, efficiency, and participant outcomes compared to those rooted in law enforcement. Nevertheless, systemic challenges impede efforts to scale and sustain these reforms. Sustained change requires federal, state, and local policy coordination, adequate behavioral health capacity and workforce development, and equity-focused program design.

Keywords: Mental Health Crisis Response; Law Enforcement Diversion; Deinstitutionalization; Behavioral Health Policy; Public Safety Integration

1. Introduction

The U.S. relationship between mental health and public safety is one of the most complicated and consequential relationships in modern social policy (Freudenberg & Heller, 2016). People living with mental illness are now more visible within public safety systems, not as recipients of care, but as subjects of police contact, emergency intervention and incarceration (Taheri, 2016). The convergence suggests a serious structural failure in the way the United States has organized, financed, and delivered mental health services, generating cries for reform (Compton et al., 2023).

According to the National Institute Mental Health (2023), 1 in 5 adults experiences mental illness every year. A sizable fraction of these individuals suffers from serious illnesses like schizophrenia, bipolar disorder, and major depressive disorder that impair functioning. When a person's mental health needs go unmet, they often come into contact with law enforcement, as that is the responder available to them. Officers are trained primarily to control crime rather than manage psychiatric emergencies (Dee & Pyne, 2022). Studies of U.S. police agencies estimate that mental health-related calls account for approximately 5% to 20% of calls for service, depending on jurisdiction and classification methods (Wood & Watson, 2017).

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It has been reported that people with untreated mental illness are 16 times more likely to be killed during a police encounter compared to other civilians (Fuller et al., 2022), which showcases that the stakes of the arising system are life and death. The origins of these failures are historical. The impact of the deinstitutionalization movement in the 1960s and 1970s was to dismantle the state psychiatric hospital system without realizing the community mental health system that was promised to replace it – thereby transferring the management of severe mental illness from the health system to the criminal justice system (Harcourt, 2021; Koyanagi, 2020; Prins, 2021). The consequences linger to this day: a fall in psychiatric bed capacity, growing workforce shortages, and a highly inequitable distribution of outpatient access – conditions made even more unstable by the COVID-19 pandemic (Torrey et al., 2015, Olfson, 2016). In this context, some crisis models emerging from a new generation that is civilian-led and co-responder such as CAHOOTS, Denver STAR programme, and 988 Suicide and Crisis Lifeline have started to divert calls more towards clinical teams (Pinals, 2020; Dee & Pyne, 2022).

This article critically reviews the policy frameworks and crisis response models that guide the integration of mental health services into public safety mechanisms in the United States. Drawing on peer-reviewed literature, government reports, and program evaluations, the review seeks to trace the historical and legislative foundations of current policy, assess the evidence base for existing crisis response models, identify systemic barriers to effective integration, and outline emerging innovations and policy recommendations toward a more coherent, equitable, and clinically grounded system.

2. Historical and Policy Background

2.1. Deinstitutionalization and Its Aftermath

The dismantling of the state psychiatric hospital system from the 1960s, a policy decision is at the heart of America's current mental health crisis. The process of deinstitutionalization was not a one-off event but rather a long and uneven transformation that was driven by a complex interplay of ideas, drugs, laws, and money. With the enactment of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, the federal government committed itself to the replacement of institutions with community mental health centers. Still, the picture of robust community infrastructure that underpinned this legislation was never delivered at the scale to accommodate the individuals released from state hospitals (Koyanagi, 2020).

The ramifications of deinstitutionalization without community investments were as severe as lasting. The number of state patients dropped from over more than 550,000 in 1955 to under 100,000 by the 1990s. The community mental health centers, which were meant to absorb this population, were underfunded, poorly located, and unable to cater to people with the most serious mental illnesses (Harcourt, 2021). Formerly institutionalized patients found themselves moving between emergency departments, shelters for the homeless, and jail cells. The scholarly community has long used the term "the criminalization of mental illness" to describe the phenomenon whereby the inability of the health system to offer sufficient care ultimately led to the criminal justice system becoming responsible for treating severe mental illness cases (Prins, 2021).

However, the cost of this shift to society and people affected has been huge. Prisons and jails have become the default institutions providing the most care for psychiatric problems in the United States. Chicago's Cook County Jail, New York's Rikers Island, and the Los Angeles County Jail have all been labeled at some point as the biggest psychiatric treatment centers within their jurisdictions, institutions built for punishment purposes having to do the work of the health care sector (Lara-Millán, 2021).

2.2. Federal Legislative Milestones

Federal legislative efforts to address mental health policy have been episodic, often reactive, and frequently underfunded relative to the scale of need. Nonetheless, a series of landmark statutes have shaped the current landscape in important ways.

The Mental Health Systems Act of 1980 represented an ambitious attempt to restructure federal mental health policy around community-based care and patient rights. However, it was largely repealed by the Omnibus Budget Reconciliation Act of 1981, which converted federal mental health funding into block grants and dramatically reduced federal investment in community mental health, a reversal that accelerated the fragmentation of the system (Koyanagi, 2020).

The Americans with Disabilities Act of 1990 (Jones, 2003) introduced a critical legal framework by prohibiting discrimination against individuals with disabilities, including mental illness, in employment, public services, and accommodations. The Supreme Court's 1999 decision in *Olmstead v. L.C.* interpreted the ADA to require that states provide mental health services in the most integrated community setting appropriate to each individual's needs, a ruling that has since driven significant litigation and policy reform aimed at reducing unnecessary institutionalization (Rosenbaum, 2016).

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) required that insurance coverage for mental health and substance use disorders be no more restrictive than coverage for medical and surgical conditions (Barry et al., 2016). While the law represented a meaningful advance, enforcement has remained inconsistent, and significant disparities in coverage persist across insurance markets (Presskreischer et al., 2022).

The 21st Century Cures Act of 2016 introduced the position of Assistant Secretary for Mental Health and Substance Use, strengthened evidence-based practice requirements, and expanded funding for early intervention programs such as Coordinated Specialty Care for first-episode psychosis (Levin, 2016). It also included provisions to improve crisis services and expand psychiatric bed capacity, though implementation has been uneven across states (Haffajee & Bogen, 2021; Hardy et al., 2019).

Most recently, the Bipartisan Safer Communities Act of 2022 allocated significant new funding for mental health services, school-based crisis intervention, and community behavioral health programs (Brendel et al., 2022; Canady, 2022; Canady, 2025). It also included provisions to strengthen the 988 Suicide and Crisis Lifeline and expand telehealth access; measures that directly bear on the integration of mental health services into public safety systems (Swadley, 2023).

2.3. State-Level Policy Variation

The difference in mental health policy across the United States is one of the most important features of it. The availability of resources for mental health, support services, crisis response mechanism, and legislation might be quite different on account of geography. This creates a patchy system where actual access to care depends heavily on the state one resides in (Cummings et al., 2013; Golberstein et al., 2015).

State laws for involuntary commitment illustrate this variation clearly. Florida's Baker Act, for instance, enables law enforcement professionals, physicians, and mental health practitioners to request an involuntary mental health examination for an individual who appears to meet the criteria for mental illness and harm to self and others. The California legislature enacted Laura's Law to allow court-ordered assisted outpatient treatment of mentally ill persons with a psychiatric history and incarceration or hospitalization experience who will likely not survive safely in the community without supervision. The laws have serious implications for how mental health crises are handled at public safety contacts, and their interpretations and applications differ widely even within states (Swanson et al. 2021).

Table 1 Key Federal Mental Health Legislation and Public Safety Implications (1963–2022)

Legislation	Year	Key Provisions	Public Safety Relevance
Community Mental Health Centers Construction Act	1963	Federal funding for community mental health centers	Initiated deinstitutionalization
Mental Health Systems Act	1980	Community care restructuring	Largely repealed in 1981
Americans with Disabilities Act	1990	Anti-discrimination; Olmstead integration mandate	Reduced unnecessary institutionalization
Mental Health Parity and Addiction Equity Act	2008	Insurance parity for MH/SUD	Expanded coverage access
21st Century Cures Act	2016	Evidence-based practices; crisis services	Expanded early intervention
Bipartisan Safer Communities Act	2022	988 Lifeline; community behavioral health	Strengthened crisis infrastructure

The Affordable Care Act (ACA) expansion of Medicaid also resulted in significant variation in mental health services capacity. States that expanded Medicaid have generally seen improvements in access to mental health treatment, reductions in uncompensated care for psychiatric emergencies, and greater ability to fund community-based crisis services. States that declined expansion have faced persistent gaps in coverage for low-income adults with mental illness, a population disproportionately represented in public safety encounters (Zur et al., 2021).

3. The Traditional Law Enforcement Response to Mental Health Crises

3.1. Police as De Facto Mental Health Responders

The default placement of law enforcement as the first responder in mental health crises in the US is the result of decades of underfunding of community mental health, not a conscious policy choice. Due to their round-the-clock operation and the capability to respond to virtually any disturbance call, police departments are increasingly being called upon to address psychiatric emergencies (involving a mental disturbance) that threaten the safety or order in the community (Wood et al., 2020). Officers occupy a position in the real world for which they are often poorly trained and poorly equipped by organizational culture.

The number of service calls related to mental health is high and increasing (Chiu et al., 2018). A national estimate indicates that anywhere between 10% and 20% of all people whom police contact have a mental illness; in some jurisdictions, this proportion is much higher (Dorn et al., 2013). Across states, law enforcement agencies were surveyed. Urban department officers allocated a disproportionate amount of time responding to calls involving mental illness, compared to calls involving violent crime. Officers only received a fraction of their training hours involved in mental health response (Lacono, 2025). When demand outstrips preparation, the quality and safety of encounters in crisis are at risk.

The legacy law enforcement response problems are more than just under-training. Police hierarchies revolve around authority, submission, and, where needed, use of force principles—at odds with the de-escalation, compassion, and clinical judgment required during a psychiatric crisis, which, in turn, is managed best by humans (Baker & Pillinger, 2019). Usually, the only tools that officers have on them for crime control are guns, handcuffs, and tasers rather than the therapeutic communication skills and clinical evaluation capacities that mental health crises require (Williams & Jones, 2020).

3.2. Use of Force and Mental Health

The merging of police and mental illness can have very harmful consequences. Dozens of research studies show that people with a mental illness are overrepresented among those struck by police, injured by police, and fatally shot by police. In a study conducted by Fuller et al. (2022), they estimated that one in four fatal police shootings of individuals in the United States each year is of a person experiencing untreated mental illness, a figure that has not changed over the years. These outcomes reflect not individual officer failure but systemic misalignment between the nature of mental health crises and the tools available to law enforcement.

High-profile incidents including the deaths of Daniel Prude in Rochester, New York, and Laquan McDonald in Chicago have drawn national attention to the deadly consequences of deploying armed officers as the default response to psychiatric emergencies and have catalyzed public and legislative pressure for reform (Townsend et al., 2023). These cases have also highlighted the compounding role of race: Black individuals with mental illness face significantly elevated risks of fatal outcomes in police encounters relative to their white counterparts, reflecting the intersection of racial bias and mental health stigma within law enforcement systems (Alan et al., 2021).

3.3. Crisis Intervention Training (CIT)

Crisis Intervention Training (CIT), modeled on the Memphis Model developed in 1988, represents the most widely implemented strategy for improving law enforcement responses to mental health crises. CIT programs typically consist of 40 hours of specialized training covering psychiatric disorders, de-escalation techniques, community resources, and legal frameworks. By 2021, CIT programs had been adopted in thousands of law enforcement agencies across the United States, making it the dominant paradigm for mental health training within policing (Watson & Fulambarker, 2021).

The evidence base for CIT is mixed. Studies have highlighted improvements in officer knowledge, attitudes toward mental illness, and self-reported confidence in managing crisis situations following CIT training (Compton et al., 2014). However, evidence for reductions in arrests, use of force, or improved clinical outcomes for individuals in crisis is more limited and inconsistent (Peterson & Densley,2018). Critics argue that CIT, while valuable, addresses only the symptom,

the lack of officer preparation rather than the underlying structural problem of deploying law enforcement as the primary mental health crisis responder. Furthermore, implementation fidelity varies considerably across agencies, and the benefits of training may erode without ongoing reinforcement and system-level support (Hogan & Goldman,2020).

4. Alternative and Co-Responder Crisis Models

4.1. Typology of Crisis Response Models

The shortcomings of the conventional law enforcement model for mental health crises have inspired the emergence of a multitude of alternative response models in the US (Hogan, M., & Goldman, 2020). The different models differ in their structure, staff, scope, and theoretical orientation. All models agree, however, on a basic premise: mental health crises are clinical events that require a clinical response, and it is neither appropriate nor effective to send armed law enforcement officers to these calls (Marcus & Stergiopoulos, 2022). In general, the alternative models that now exist can be sorted into four typological categories. The initial category describes law enforcement-based models that place mental health practitioners into police departments as consultants, co-responders, or members of a specialized unit, with law enforcement being the primary responder (Lindenfeld et al., 2025). The second category includes co-responders. Here, a mental health clinician and law enforcement officer respond together to crisis calls. This enables clinical assessment capacity and public safety authority. The third and most transformative category consists of civilian mobile crisis teams, in which mental health professionals and peer support specialists respond independently to appropriate calls without law enforcement involvement (Richmond et al., 2021). The fourth category, growing rapidly in the post-pandemic period, involves telehealth-integrated response, in which remote clinical consultation is embedded into dispatch or field response protocols (Zhu et al., 2021).

4.2. Prominent Program Examples

Several initiatives have become prominent models in the national conversation about alternative responses to crises. The CAHOOTS program of Eugene, Oregon, began in 1989 but expanded and was studied in the 2020s (Strickland et al., 2025). Two-person teams of a medic and mental health crisis worker respond to non-violent crisis calls (Richmond, 2021). Crisis Assistance Helping Out on the Streets CAHOOTS receives almost a quarter of the calls received by the Eugene Police Department (EPD) (Burton, 2025). In fewer than 1% of cases, law enforcement backup is requested, which indicates how plausible it is to civilize at least a sizeable portion of mental health calls (Richmond, 2021).

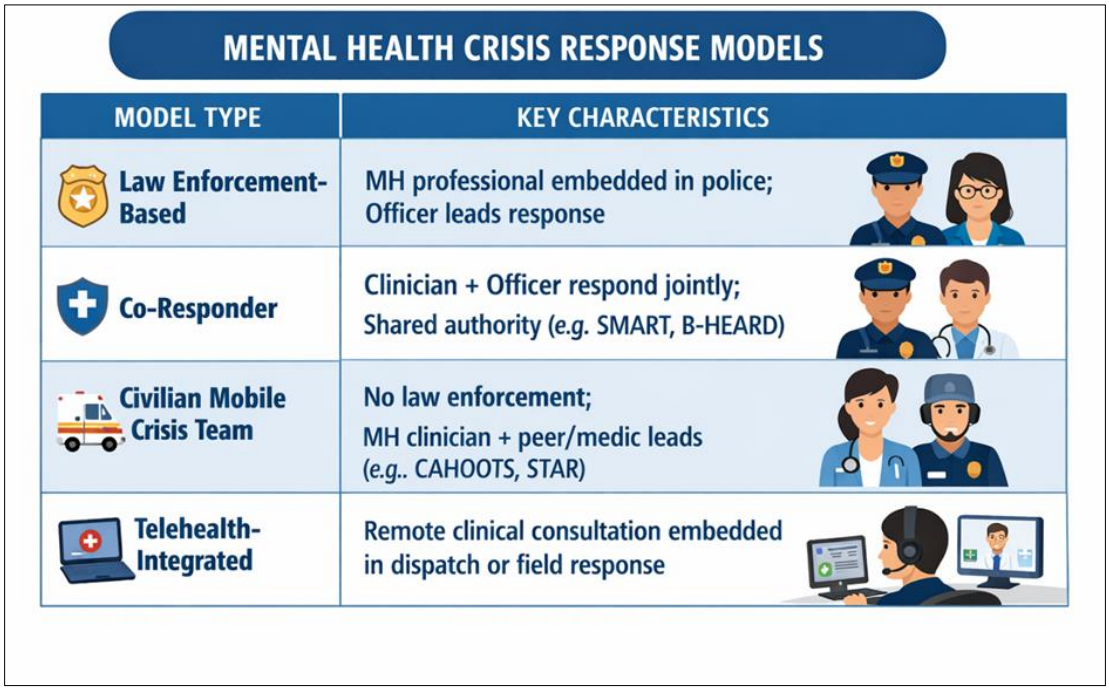

Figure 1 A summarized conceptual framework Typology of Mental Health Crisis Response Models in the United States

Denver's Support Team Assisted Response program, which started in 2020, also sends out civilian teams of mental health clinicians and paramedics to low-acuity crisis calls. Based on an evaluation of the first six months of STAR, the

program has responded to over 700 calls requiring zero police backup, and they have been linked to reductions in crime in the areas (Dee & Pyne, 2022). The B-HEARD program in New York City began in 2021. It uses a co-responder model with mental health clinicians accompanied by emergency medical staff. Results show promising rates of diversion from emergency departments and jails.

5. Systemic and Structural Challenges

5.1. Funding and Resource Constraints

Despite the abundance of promising models for crisis response, the incorporation of mental health services into public safety systems in the United States is severely hampered by funding silos and a lack of resources. Payment for mental health services is made through a complex and often incoherent mix of federal, state, local, and private sources including Medicaid and Medicare, federal block grants, state appropriations, county behavioral health budgets, and private insurance – with little coordination across the streams (Alabi et al., 2026). The short-lived funding mechanisms create chronic instability for community-based initiatives, which are always funded from short-term grants. Expenditures for mental health and substance use are low compared to the burden of disease they represent. Public safety agencies incur unreimbursed expenditures, most notably for mental health crisis response (Mantel, 2016).

The funding crisis is worsened by the lack of workers. The U.S. is suffering from a significant gap, and it is worsening, in the availability of psychiatrists, psychologists, licensed clinical social workers, and peer support specialists who can staff alternative crisis response programs. Many counties, especially rural and low-income urban counties, have no practicing psychiatrist (Beck et al., 2018). The COVID-19 pandemic accelerated provider burnout and attrition, further thinning an already stretched workforce at precisely the moment when demand for crisis services was surging.

5.2. Data and Information Sharing

The integration of mental health and public safety systems is highly dependent on the capacity to exchange pertinent data, but there are legal, technical, and cultural factors that significantly constrain such data exchange between the two systems. HIPAA law limits the release of health information from the medical records of the patients without their permission, thereby making it hard for the law enforcement agencies, emergency services, and crisis response teams to get the relevant clinical histories that may help them make informed decisions about the intervention strategies (Beckerman et al., 2008). There is no interoperable data exchange network between the public safety systems and the health information systems, and it is difficult to follow up on the patient's progress throughout the various contacts with the two systems (Walker et al., 2023).

5.3. Racial and Ethnic Disparities

Disparities along lines of race and ethnicity permeate the intersection between mental health and public safety. African Americans, Native Americans, and other communities of color experience disproportionate interactions with police officers during mental health emergencies, increased use of force against such individuals, and lower likelihoods of being linked to voluntary mental health treatment after an interaction with law enforcement (Laniyonu & Goff, 2020). Such disparities occur due to the cumulative impact of structural racism operating in tandem within both the criminal justice and mental health sectors, including racial discrimination in policing, lack of mental health resources in communities of color, and language and cultural barriers to accessing such resources (Vinson & Dennis, 2021). Failing to incorporate racial equity into any reform agenda is thus likely to perpetuate current disparities.

5.4. Rural and Underserved Communities

Another structural obstacle is geographic inequality. The shortage of mental health professionals, lack of crisis stabilization facilities, and delays in responses create problems for the application of mobile crisis services in rural areas (Reinert et al., 2022). Telehealth seems to be a good way to reach rural areas, yet it requires the presence of broadband internet connections in those regions which does not occur uniformly in rural and tribal areas (Zur et al., 2020). The tribal nations have their own difficulties, related to the complicated jurisdictional structure and the provision of culturally sensitive crisis and mental health services to people suffering from trauma, substance abuse, and suicide (Dawson et al., 2020).

6. Emerging Innovations and Future Directions

6.1. Predictive Analytics and Risk Stratification

The use of data-driven technologies to support mental health crises is one of the most rapidly developing areas within the field (Sundaram et al., 2024). The use of predictive analytics which involves using administrative data, call records, and clinical records to identify those who are at an increased risk of a crisis has been tested in several jurisdictions as a way of providing proactive care for high-risk individuals. Several police departments have developed "high utilizers" interventions that target people who are high users of crisis services to manage their cases and break the revolving door cycle before it results in emergency intervention (Coley et al., 2021). While such interventions are potentially valuable in terms of focusing scarce resources on those who need them most, they also present serious ethical challenges related to privacy, civil liberties, algorithmic discrimination, and the possibility that predictive technologies could perpetuate race-related disparities in system involvement.

6.2. Trauma-Informed and Recovery-Oriented Systems

There is increasing empirical evidence to back the need for incorporating the elements of trauma-informed care in crisis intervention programs. As explained by Saunders et al. (2023), trauma-informed care recognizes the reality that many people engaging with public safety systems have a history of adverse childhood experiences, interpersonal violence, and systemic trauma, and any form of crisis intervention that replicates the dynamics of coercion and punishment only serves to retraumatize the individual and hinder their recovery process. Recovery-focused care systems, which focus on self-determination, peer support, and community integration, as opposed to symptom management and control by institutions, provide an alternative framework for the development of crisis interventions based on the experiences of people living with mental illnesses (Gonzalez Miranda et al., 2022).

6.3. Peer Support Integration

The use of people who have personally experienced mental illness and crisis as peer support specialists, crisis navigators, and community health workers in crisis intervention systems is one of the most innovative and underused approaches in this field. Peer specialists provide a unique blend of experience-based credibility, cultural competency, and relational trust that can make a significant impact in crisis situations, especially for those with past negative experiences of clinical and law enforcement interventions (Karyczak et al., 2021). Some places have started to utilize peer specialists as part of mobile crisis teams, crisis stabilization units, and post-crisis services with early results indicating enhanced engagement, adherence, and recovery outcomes. (Dee & Pyne, 2022).

6.4. Legislative and Policy Recommendations

Turning the evidence base into sustainable policy changes involves actions at different levels of governance. At the national level, sufficient appropriation of funds to support the 988 Suicide and Crisis Lifeline, community behavioral health centers, and mental health workforce development initiatives is crucial (Purtle, 2023). States should be encouraged through Medicaid financing to build crisis stabilization capacity, use the Sequential Intercept Model at the statewide level, and create standards for alternative crisis programs (Reinert et al., 2022). Locally, cities should develop civilian crisis response capacity, develop mechanisms for community oversight, and involve affected communities, especially those of color and people with lived experience of the criminal justice system and mental illness, in the design and evaluation of the programs.

6.5. Research Gaps and Future Agenda

In spite of the quick proliferation of new models for crisis response, the literature is still deficient in some important areas. First, there is a lack of longitudinal research investigating the long-term effects of crisis diversion programs on mental health recovery, housing stabilization, and involvement in the criminal justice system. Second, there is a need for comparative effectiveness studies assessing the relative merits of various types of models in different locations and among different populations to help make resource-allocation decisions. Third, there is a need for studies focused specifically on the issue of equity, namely whether or not new models will either reproduce existing disparities or mitigate them. Finally, the application of implementation science approaches would prove useful in understanding why some models succeed and others fail.

7. Conclusion

In the context of the United States, the incorporation of mental health services into public safety systems goes beyond mere policy considerations and becomes an essential component of justice and functionality of the society in question. As this review paper demonstrates, the current state of affairs can be explained by tracing the origins of a crisis response framework that has repeatedly failed to adequately address the needs of people suffering from various forms of psychopathology. Initially, the problem was rooted in the collapse of community mental health infrastructure, which was caused by the process of deinstitutionalization and resulted in the defaulting of law enforcement agencies on their responsibility to provide adequate crisis response. Drawing from the findings of previous sections, one may conclude that only a complete rethinking of the existing paradigm and the introduction of a new one is likely to bring about any improvements in this area. In particular, the use of a diversified approach to crisis management, which involves the deployment of mental health professionals, peer support specialists, and community resources, is required. At the same time, the systemic barriers documented in this review thus funding fragmentation, workforce shortages, data siloing, racial inequity, and geographic exclusion make clear that program-level innovations, however promising, cannot substitute for the structural policy reforms needed to build a sustainable and equitable system.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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