

The Crisis Assistance Helping Out on The Streets (CAHOOTS) Act

As the country grapples with advancing racial justice, reducing police brutality, addressing mental health and substance use disorder (SUD) needs and reimagining public safety, Oregon offers a model for moving forward. For over 30 years, Eugene, Oregon's White Bird Clinic has led the way in using health care, rather than law enforcement, to respond to individuals who are experiencing a mental health or SUD related crisis. The innovative Crisis Assistance Helping Out on The Streets (CAHOOTS) model dispatches mobile teams of health care and crisis workers to provide Oregonians with necessary care and connect them with service providers instead of immediately involving law enforcement.

Using the successful model outlined by White Bird Clinic and similar programs across the nation, Senators Ron Wyden and Catherine Cortez Masto, along with Representative Peter DeFazio, have introduced the *Crisis Assistance Helping Out on The Streets (CAHOOTS) Act* to help states adopt their own mobile crisis response models through support from Medicaid.

The CAHOOTS Act:

- Provides additional federal Medicaid funding support for state implementation and administration of multidisciplinary mobile crisis teams that are available 24/7, every day of the year, and trained in trauma-informed care, de-escalation, and harm reduction to provide voluntary assessment and stabilization services for individuals in crisis, as well as coordination and referrals to follow-up care and wraparound services, including housing assistance. Teams must be able to provide or coordinate transportation to help individuals reach their next step in care.
- Provides states with an enhanced federal Medicaid funding (a 95% federal match) for three years to provide qualifying community-based mobile crisis services to individuals experiencing a mental health or SUD crisis. The Act also provides \$25 million to states for planning grants and evaluations to help establish and evaluate these mobile crisis programs.
- Requires mobile crisis teams to partner with key community resources to facilitate referrals and coordinated delivery of care. For example, teams must have relationships with behavioral health providers, crisis respite centers, housing assistance providers such as public housing authorities, and other organizations and agencies that provide social services.
- Directs mobile crisis teams to be connected to regional hotlines and emergency medical service systems. Mobile crisis teams under this option must not be operated by or affiliated with state or local law enforcement agencies, though teams may coordinate with law enforcement if appropriate.
- Requires states that provide mobile crisis services under the new state option conduct a robust evaluation of the impact of mobile crisis services on emergency room visits, the involvement of law enforcement in mental health or SUD events, diversion from jails, and other outcomes. States must also report on the models and programs they design, including how people are connected to care following the delivery of mobile crisis services. States must also report on the demographic information of the individuals their teams help in order to identify and help address health disparities.
- Requires the U.S. Department of Health and Human Services to summarize states' results and identify best practices for delivering effective mobile crisis intervention services.