Reviewer-1

Violence and mental illness is a very nuanced issue. The research cited only found that people with mental illness are at higher risk of experiencing force when encountering police. It does NOT say they are dangerous. In order to be credible you need to be much more careful with these types of statements. There is a ton of papers on this, but a good place to start is a 2016 article by Varshney "Violence and mental illness: what is the true story?"

There are no citations in this paragraph that document the danger to officers. The citations show a danger of a person with mental illness being harmed but not of officers being harmed. The literature is there, but it is nuanced and you need to address the nuance and cite it.

You can build a case for training to improve police response, but later you seem to be building the case that they need outside help. Your point is not clear, especially here where you seem to be saying both.

CIT stands for Crisis Intervention Team. Systematic reviews of CIT models focus on models with fidelity to the Memphis Model which trains only some experienced officers, not junior officers who are trained in the academy and not all officers. CIT is not mental health training.

Maybe, but every locality implements CIT differently, which is why you get mixed results.

There may be a need for an alternative, but this paragraph does not build the case for that.

Officer-Only responses do, but CIT is a whole community approach that can include 911 call diversion and co-response.

I don't know what you mean by "external response"?

Co-response has a lot of variations. You need to say if you are talking about embedded co-response or the more traditional mobile crisis approach that has been around since the 1980s or something in between?

CAHOOTS is not an MCT. They were dispatched by 911. MCT's are crisis phone line based. This has been a long standing difference in terminology.

Are you sure? They get a lot less publicity. They tend to cover counties or regions and so more than 1 municipality has access to them.

Why? You don't mention anything in the lit review about legislation. CIT programs are a grassroots movement and rarely involve legislation. You need to build a case for how this is related.

Is it? you don't build a case for these conclusions.

There is no explanation of how you came up with these labels.

I saw not case being built discussing the success of legislation. There is no cited research that connects legislation to successful mental health outcomes.

Again, the literature on this is mixed. Every community implements these differently and a good systematic analysis of current research yields very mixed results with Officer Self Efficacy being the only consistent benefit. And with massive cuts to Medicaid looming in the future, where will the funding come from?

There is no case for these recommendations. There is political science literature that can support this, but it is not cited in this work.

Taheri did not find this result, and it was a very thorough meta analysis.

Arizona is a model CIT program commonly cited by SAMHSA as a best practice model and they have very little state legislation. Arizona is a model CIT program commonly cited by SAMHSA as a best practice model and they have very little state legislation..

The one thing this article did try to build a case for was that response teams were good. Now you say you were just assuming?

This is true, and there is a lot of literature that supports this. You should lean into this statement more an build the case for it in your lit review.