Supporting Women in Crisis

A Review of Community Responses and Research Gaps

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Women's pathways into the justice system often begin with crisis[1]—through experiences of domestic violence, housing instability and homelessness, or behavioral health challenges, such as mental health and substance use disorders. In many cases, law enforcement officers are called as first responders, but their role is not intended to address the underlying drivers of behavior, and they are not trained to do so.

As a result, traditional law enforcement interventions can sometimes unnecessarily deepen criminal justice system involvement and increase costs. To improve outcomes, jurisdictions across the country are exploring alternative approaches designed to divert people from arrest and incarceration and connect them instead to treatment, services, and support in the community.

This review focuses on two categories of community-based responses: "untethered" models, which operate independently of law enforcement, and "tethered" co-response models, which involve formal partnerships between law enforcement and service providers. A third category, "embedded" responses, refers to those housed entirely within law enforcement agencies; because this report is intended to explore alternatives to law enforcement responses, it does not cover embedded approaches. This brief concludes with a research agenda to guide future investment in strategies that produce better outcomes for women in crisis.

In October 2025, the Women's Justice Commission released its first policy report, focused on the front-end of the justice system, from arrest through sentencing. The report outlines

findings and recommendations to address the factors that lead women into the justice system and ensure their safety. Implementation of these priority recommendations will advance the twin goals of safety and justice, ensuring accountability for criminal activity while reducing unnecessary system involvement.

Key Takeaways

- Women often come into contact with the justice system during moments of crisis, including domestic violence episodes, behavioral health challenges, and homelessness. **Most crisis response systems are not designed to meet their individual needs.**
- While some crisis response models operate independently of law enforcement, **most programs involve law enforcement in some capacity.**
- **Few crisis response models have been rigorously evaluated,** especially for their effectiveness with women.
- **Most programs do not collect or report data by sex**, making it difficult to assess whether women are being effectively reached, experiencing different outcomes than men, or being pushed deeper into the justice system.
- To improve **crisis intervention efforts for women**, researchers, funders, and policymakers should prioritize three core areas: 1) strengthen data infrastructure, 2) focus research on women's outcomes and public safety, and 3) conduct longitudinal and cross-system studies.

Introduction

Women's contact with the criminal justice system often stems from overlapping challenges, including experiences of interpersonal violence, behavioral health disorders, and housing instability or homelessness. While women and men interact with law enforcement at similar rates, women are more likely to initiate contact themselves. In 2022, for example, 54% of residents who initiated police encounters were female.[2]

In July 2024, an analysis by the Council on Criminal Justice (CCJ) provided additional context on women's arrest patterns and pathways into the justice system. Although crises like domestic violence, behavioral health challenges, and homelessness frequently lead to law

enforcement contact for women, these situations are rarely the direct cause of arrest. Instead, women are often charged with crimes such as theft, drug possession, or simple assault—sometimes as a result of the crisis itself or the response to it. In this way, crisis-related encounters can become a gateway to justice system involvement.

Law enforcement is typically the first responder in community crises, especially those involving weapons or imminent violence. But police involvement can sometimes escalate rather than calm these encounters, particularly when officers lack specialized training.[3] In May 2021, the CCJ Task Force on Policing released a policy assessment highlighting serious gaps in police training for crisis response. The Task Force recommended improving trauma-informed and de-escalation training, pairing officers with behavioral health professionals, and transferring certain responsibilities to non-law enforcement personnel better equipped to address the root causes of crisis.

Over the past two decades, communities across the nation have adopted crisis response models that shift emphasis from law enforcement to community members and specialized human service professionals, such as social workers, victim advocates, and behavioral health providers. These efforts seek to respond proactively, before a crisis escalates, or reactively, in the moment of crisis. While these initiatives were not designed specifically to meet the needs of women, women experience higher rates of the kinds of behavioral health crises that such response programs address. Women also are most frequently the victims in domestic violence calls. As such, it is essential to understand whether these alternative models adequately respond to the distinct risks and vulnerabilities women face, reduce criminal behavior and justice system involvement, and protect community safety.

Each section below summarizes the range of untethered and tethered models in use, highlights the state of the evidence on their implementation and outcomes, and identifies gaps in evaluation, particularly with respect to women.

Domestic Violence Victimization

More than 75% of incarcerated women report experiencing domestic violence at some point in their lifetimes.[4] For many, such experiences are directly linked to their involvement in the criminal justice system. Women may be arrested for defending themselves against abusive partners, for using substances—either alongside their abuser or as a coping mechanism—or for committing crimes under pressure or coercion from a partner.[5]

Over the last 50 years, advocacy by women survivors has helped shift perceptions of domestic violence, which was once seen as a private, family matter and is now considered a public safety issue that warrants law enforcement intervention.[6] The federal Violence Against Women Act (VAWA), which was part of the 1994 Crime Bill, helped build a national framework for responding to domestic violence, leading to a robust network of services that often operate independently from law enforcement.[7] While some states had domestic violence prevention and intervention initiatives prior to VAWA, the law formalized these efforts and ensured that every U.S. state and territory now maintains a domestic violence and/or sexual assault coalition as part of a national network.[8]

Despite such progress, the increased criminalization of domestic violence has also produced unintended consequences, particularly for women experiencing abuse.[9] Mandatory arrest policies, initiated to ensure that law enforcement takes domestic violence seriously, have in some cases resulted in the arrests of survivors instead of—or in addition to—their abusers.[10]

In addition, research on domestic violence responses has not kept pace with the rapid acceleration of program development. Major gaps include a lack of standardized outcome measures, limited longitudinal research, inconsistent program implementation across jurisdictions, and poor data sharing among service partners.[11] Another challenge to assessing the effectiveness of responses is that many programs are tailored to local conditions and vary widely in structure, making comparisons difficult. Some programs, such as those involving shelters and hotlines, intentionally limit data collection to protect the safety and confidentiality of survivors, further complicating efforts to evaluate outcomes.

Untethered Responses: Advocates, Hotlines, and Shelters

Victim and Legal Advocates

Advocacy programs aim to support victims by improving access to services, promoting safety, and ensuring survivors' perspectives are heard. Advocates offer emotional support, safety planning, and education about legal rights and available services.[12] Some specialize in medical, legal, or housing advocacy, helping survivors navigate emergency department visits or court processes, or secure housing when abusers control finances or essential documents.

A 2019 analysis[13] established that advocacy is most effective when:

- It accounts for the abuser's influence on the survivor's decisions and behavior;
- Interventions are holistic and tailored to the survivor's risks and needs;
- Pregnancy and caregiving responsibilities are considered;
- A strong, trusting relationship is fostered between the advocate and survivor;
- Advocates have sufficient time, resources, and boundaries; and,
- The impact of an intervention's setting—whether a healthcare facility, courtroom, emergency shelter, or a rural or urban location—is considered.

An evaluation of one advocacy program, which provided intensive individual support and resource connections to women in a shelter who had abusive partners, found that after two years, participants had experienced less abuse and reported higher social support and quality of life than those in the control group, who were not offered the same individualized services. The reduction in abuse, however, was no longer significant at three years.[14] These findings suggest that follow-up services may help sustain protective benefits like social support and well-being.

Another longitudinal study compared outcomes for a community-based (untethered) victim advocacy program to those from a criminal justice referral (embedded) program.[15] The community-based model, characterized by more intensive services and confidentiality, was associated with significant reductions in PTSD symptoms.[16] At six months, 34% of women in the untethered intervention group demonstrated a clinically meaningful reduction in PTSD symptoms, compared to 17% in the embedded group, although this difference was not statistically significant. In addition, 28% of those in the untethered intervention group had reductions in depression symptoms, compared to 14% in the embedded group, although again, these differences did not reach statistical significance.

Crisis Hotlines

National domestic and sexual violence crisis hotlines, launched in the 1990s under VAWA, offer phone, text-based, mobile app, online, and AI-supported education and services.[17] More than 11 million calls have been made to such hotlines, with call volume increasing over time. Due to privacy protections, these programs limit data collection, making formal evaluations difficult.[18] But user surveys, focus groups, and anonymous monitoring consistently show that hotlines meet urgent needs, from emotional support to safety planning, referrals to additional

community services, and education on abuse patterns, laws, and resources.[19]

Emergency Shelters

Domestic violence shelters provide short-term housing for survivors and their children, along with access to legal aid, support groups, and advocacy. Some shelters, however, exclude survivors with criminal charges, serious behavioral health issues, or older male children.[20] Research shows that shelters can improve mental health, safety, and social support, and reduce exposure to abuse.[21] As with hotlines, however, safety concerns limit data collection, and most evaluations focus on short-term impacts, leaving gaps in our understanding of the long-term effects of these programs for women and their children.

Tethered Co-Response Models: Coordinated Community Response

While most domestic violence hotlines and shelters are typically untethered from law enforcement, tethered co-responses to domestic violence involve collaboration between police and community service providers. These range from informal localized partnerships to formalized initiatives such as Coordinated Community Responses, where providers may respond alongside law enforcement or follow up with victims after police reports are filed.[22]

Coordinated Community Responses are broad, community-based collaborations that align service provision across agencies during domestic violence cases.[23] For example, the commonly referenced “Duluth Model”—which originated in Duluth, MN, in the 1980s—coordinated responses across 11 agencies, including law enforcement, courts, corrections, and victim service organizations.[24] Programs using the Duluth Model aim to increase system efficiency and effectiveness, improve service coordination, enhance the safety and well-being of victims and children, and hold abusers accountable.

Although Coordinated Community Responses have been evaluated more than many other domestic violence interventions,[25] their local customization makes it difficult to assess their overall effectiveness. A systematic review found promising evidence for specific components—such as advocacy, hotlines, counseling, and transitional housing—which were linked to improved outcomes for survivors, including increased access to healthcare and safety planning, and greater likelihood of arrests and convictions of abusers.[26] But one evaluation of a program designed to increase criminal justice sanctions for male domestic

violence abusers found that arrests and prosecutions of females also increased significantly.[27] While evaluations of Coordinated Community Responses offer insight into how criminal and social systems can work together, outcome data are rarely disaggregated by sex, making it difficult to assess how well these models serve women specifically.

Behavioral Health Crises

Behavioral health issues are pervasive among justice-involved women, who are more likely than men to experience the kinds of crises that lead to emergency response, hospitalization, or law enforcement contact. Research shows that 66% to 68% of women in prison or jail are diagnosed with a mental health condition, compared to 35% to 41% of men, and up to 72% of women meet criteria for a substance use disorder, compared to 57% of men.[28] While 8% of the U.S. general population has co-occurring mental health and substance use disorders, the rate rises to 22% among incarcerated women and 10% among incarcerated men.[29]

Roughly a quarter of people with mental health disorders are arrested at some point in their lives.[30] Among women, those with co-occurring conditions are 19 times more likely to be arrested than women with neither condition; women with co-occurring conditions accounted for more than 1 in 5 female arrests from 2017 to 2019.[31]

Despite their lack of clinical training to address the complex needs that surface during a behavioral health crisis, law enforcement officers are frequently the default responders. Once on site, officers must triage limited resources and focus on those perceived to pose the greatest public safety risk. Given such limitations, people in crisis may face arrest or the use of force instead of being connected to care, especially when community-based services are not available.

Recent federal guidance underscores the need to reassess this approach. In 2023, the U.S. Departments of Justice and Health & Human Services affirmed that Title II of the Americans with Disabilities Act (ADA) requires public agencies to prioritize health-based responses over law enforcement for people with behavioral health disabilities.[32] The guidance emphasizes that routinely dispatching police to behavioral health crises, especially in the absence of reasonable alternatives such as mobile crisis teams or co-responder models, may violate the ADA's integration mandate. At the same time, the guidance acknowledges that public safety must remain paramount; in situations involving a credible threat of serious harm, such as the presence of a weapon, law enforcement may be necessary and appropriate. But in many behavioral health crises, community-based responses may better meet individual needs

while preserving public safety.

Crisis response models for behavioral health vary in structure, and despite the growing use of such programs, the evidence base remains limited.[33] Many programs are small-scale, grassroots initiatives with limited funding for evaluation. Few studies have compared the effectiveness of different response models, and most have focused on short-term administrative outcomes such as emergency room transports, rather than on participant outcomes or experiences. Critically, few studies disaggregate outcomes by sex, making it difficult to assess how well these responses meet the specific needs of women in crisis.

Untethered Responses: Hotlines and Assertive Community Treatment

Crisis Hotlines and 988

In 2020, Congress established 988 as the national phone hotline for suicide prevention and behavioral health crises, transitioning from an existing 1-800 hotline telephone number.[34] The 988 call and text services are provided by behavioral health centers, including Certified Community Behavioral Health Clinics,[35] which meet federal standards for 24/7 crisis care and coordination with other service providers.

Nearly all Certified Community Behavioral Health Clinics work with criminal justice agencies to offer diversion services, targeted outreach, and training.[36] Clients who receive services experience, on average, about 60% less time in jail, a 70% reduction in hospitalization, and a 40% reduction in homelessness.[37] Such outcome data, however, are not disaggregated by sex or type of behavioral health crisis, and symptom reduction or other behavioral health outcomes are not included. These omissions limit understanding about whether these programs effectively divert women from justice system involvement.[38]

Assertive Community Treatment

Assertive Community Treatment is a model designed to support people with serious mental illness through intensive mental health and case management services delivered by multidisciplinary behavioral health teams in community settings.[39] A meta-analysis of programs serving people experiencing homelessness found a significant 37% average reduction in homelessness among participants in randomized controlled trials, with even

larger effects reported in less rigorous studies.[40] The trials also found encouraging and statistically significant improvement in symptoms, with participants exhibiting a 26% average reduction in mental health symptoms. The studies did not assess impacts of the intervention on public safety or arrest diversion, and although they included mixed-gender samples, none disaggregated findings by sex. As a result, it is unclear whether Assertive Community Treatment effectively meets the needs of women with serious mental illness.

Alternative First Response

Alternative first response models, such as mobile crisis units or community responder teams, dispatch trained healthcare professionals to address non-emergency incidents involving substance use and mental health disorders or other social service needs. These multidisciplinary teams typically provide immediate assistance for people in crisis, as well as connections to voluntary treatment services or other community-based supports. While alternative responders are dispatched independently of law enforcement, teams operate in coordination with the local public safety infrastructure and may call for police back-up if necessary.

A recent evaluation of the longest-running mobile crisis program in the United States, Crisis Assistance Helping Out on the Streets (CAHOOTS) in Eugene, OR, found that team deployment was associated with a 13% reduction in arrests, 7% fewer inpatient psychiatric stays, and a 12% increase in outpatient behavioral health visits compared to standard law enforcement response.[41] On average, people served by a mobile crisis unit spent about four fewer days in jail per year compared to those who experienced a standard police response. The cost savings associated with mobile crisis response models can be substantial. In 2017 the CAHOOTS program operated on an annual budget of approximately $2.1 million. Mobile crisis teams responded to 17% of all calls to the Eugene Police Department in 2017 and police back-up was needed in fewer than 1% of calls, resulting in an estimated cost savings to the city of about $8.5 million annually. (The combined annual budgets of the police departments in Eugene and neighboring Springfield are $90 million).[42]

Tethered Co-Response Models: Crisis Response Models

In many communities across the country, law enforcement and behavioral health professionals are collaborating to better respond to people in crisis. Two common models are

highlighted below.

Crisis Intervention Teams

Crisis Intervention Teams train officers to recognize and de-escalate behavioral health crises, with the goals of avoiding arrest and diverting people to psychiatric care.[43] Some teams consist solely of trained officers, while others use a co-responder model.[44] Implementation and staffing vary widely across jurisdictions.

Most evaluations of this approach focus on administrative metrics such as arrest rates, officer safety, and transport decisions, rather than longer-term participant outcomes.[45] A 2022 systematic review and meta-analysis found no statistically significant reduction in arrest rates among program participants and no consistent improvements in officer safety associated with these programs.[46] The review's authors concluded that while many jurisdictions adopt these programs with the goal of reducing arrests, their actual impact remains unclear. Although some individual studies have reported promising results, these effects did not hold up when tested with larger samples and more rigorous evaluation methods, highlighting the need for stronger evidence on program effectiveness. In addition, none of the studies disaggregated outcomes by sex, and persistent data quality issues further limit understanding, especially regarding how these programs affect women.

Despite these limitations, one frequently observed outcome is that Crisis Intervention Team officers are more likely to transport individuals to hospital emergency departments for services.[47]

Co-Responder Teams

Co-responder teams pair trained law enforcement officers with behavioral health professionals to handle 911 calls related to mental health, substance use, or homelessness.[48] Some teams also include paramedics, social workers, or advocates.[49] These models aim to de-escalate crises, connect people to services, and reduce the risk of crime, arrest, and injury for participants and officers.[50] While typically reactive, some teams conduct proactive outreach to people with complex needs or those with whom they have made contact in the past.

One review comparing co-responder models to standard law enforcement responses found

that these programs were associated with very low arrest rates during crisis encounters—ranging from 2% to 5% of all cases handled by the co-responder teams.[51] These models also increased behavioral health referrals in up to 75% of cases and lowered hospital admissions (from 82% to 52% in one study). Officers involved in these programs reported improved attitudes toward people in crisis and gave high marks to the model, with 86% describing their program as “very good” or “superior” compared to standard responses. However, follow-up data from one program showed that 22% of individuals served by the team were arrested within seven months, suggesting the need for more robust long-term supports to sustain initial diversion gains.

One program, the Co-Responder Hot Spot Outreach Team in Baltimore, MD**,** pairs officers with behavioral health professionals to target areas with high levels of crisis-related calls, or “hot spots.”[52] A pilot evaluation showed that 18% of initial contacts involved people with behavioral health needs, and that the team conducted an average of four follow-up visits with 25 individuals.[53] About 75% of follow-ups were with people who were not previously connected to services, and the team provided on-scene counseling in one third of visits. Despite these findings, none of the studies reviewed disaggregated outcomes by sex. Without this information, it is impossible to know whether these models effectively serve women or address their distinct needs and vulnerabilities in crisis situations.

Homelessness

The number of women in the U.S. experiencing homelessness has grown sharply in recent years, with a 35% overall increase since 2015 and a 68% rise in unsheltered homelessness among women.[54] Although women made up about 40% of the total population experiencing homelessness in 2024, they accounted for 72% of those in emergency shelters or transitional housing.[55]

Women face distinct risks and barriers in homelessness. Interviews suggest that some women trade sex, drugs, or other resources for temporary shelter, which increases their vulnerability and often excludes them from official homelessness counts like the annual Point-In-Time survey.[56] While both women and men experiencing homelessness report high rates of behavioral health disorders, women are more likely to have experienced childhood trauma and to report suicidal thoughts and suicide attempts.[57]

Many models address homelessness, but the research base remains thin.[58] Major gaps include a lack of studies that disaggregate findings by sex, limited quantitative evaluations

overall, and inconsistent implementation of programs across communities.[59]

Untethered Responses: Transit Teams, Housing First, and Libraries

Transit-Based Teams

In several transit systems, behavioral health providers or trained "transit ambassadors" provide outreach and conflict resolution, either as transit employees or in collaboration with social service agencies.[60] Some systems have created centralized service hubs near major transit stations, or conduct targeted outreach to people with frequent law enforcement contact. In one qualitative study, transit staff said they perceived civilian-led outreach as more effective than law enforcement-involved responses. They also emphasized that limiting police involvement to incidents posing a clear public safety risk improved rider outcomes and fostered trust with homeless people experiencing behavioral health crises.[61]

While transit-related programs show promise, existing research is limited to qualitative findings and lacks gender-specific analysis.[62] In addition, program goals vary widely—from connecting people to housing or services to reducing visible homelessness or improving transit operations—making cross-site comparisons difficult. More rigorous evaluation is needed to assess which approaches improve outcomes, particularly for women experiencing homelessness or behavioral health crises.

Housing First Approaches

Permanent supportive housing with a "Housing First" approach, which offers long-term housing with voluntary support services, is one of the most effective strategies for reducing criminal justice system involvement among people experiencing homelessness. In New York City, for example, participants in Housing First programs experienced a 40% reduction in jail days, and a 38% drop in arrests over two years, averaging 19 fewer days in jail compared to a control group.[63] A Housing First program in North Carolina saw even larger impacts, with arrests falling by 78% and jail days by 84% in the year after participants enrolled.[64]

While some research has explored health, housing, and other outcomes for women, such programs are not specifically tailored to women's needs and few studies have examined impacts on women's arrests or jail time.[65] Given that women often experience homelessness

differently than men, program adaptations and disaggregating findings by sex are critical to understanding how well Housing First models serve women.

Libraries

Libraries are a critical resource for many people experiencing homelessness, offering computers, internet access, and help with housing, employment, and financial assistance applications.[66] Enhancing such support, some libraries have hired social workers or partnered with social work programs to provide case management, outreach, community engagement, and services that people can access simply by showing up—no paperwork, appointments, or pre-screening required.[67]

In a series of qualitative interviews in 2023, various library stakeholders in three U.S. cities—including visitors experiencing homelessness, library police or security, front-facing staff, social workers embedded in libraries, branch managers, and chief executive officers—said the presence of library-based social workers reduced law enforcement involvement with people experiencing homelessness.[68] They credited the social workers with providing de-escalation services, advocacy, and connection to resources, actions that often eliminated the need for law enforcement intervention. These findings, while encouraging, were qualitative and did not include an analysis disaggregated by sex. Nationwide, at least 49 cities now employ dedicated library-based social workers, 96 partner with social workers, and 29 hold office hours with social service professionals.[69]

Tethered Co-Response Models: Street Outreach and Transit-Based Teams

Street outreach and transit-based teams are two related approaches that deploy unarmed professionals, such as paramedics, EMTs, behavioral health clinicians, and trained ambassadors, to respond to people in crisis in public spaces.[70] While outreach teams operate across neighborhoods, transit-based teams are embedded in transportation systems such as subways and bus lines. Both models aim to de-escalate crises, provide immediate support, and connect people experiencing homelessness or behavioral health crises to shelter, medical care, and ongoing services—offering help that respects individual needs, dignity, and personal readiness.

Law enforcement plays a variety of roles in these models. Some teams are dispatched

through 911 and coordinate closely with officers, who remain available for backup; others operate more independently, with police involved only when safety threats arise. In some jurisdictions, outreach staff and law enforcement work in formal partnership, while in others, responders aim to provide support without a uniformed presence.

While qualitative reports suggest that clients find these models helpful, rigorous evaluation is limited. Existing studies do not disaggregate outcomes by sex, and few assess whether these responses effectively meet women's needs. One exception is the LA Metro program, which provides temporary motel stays for vulnerable riders, including women and children, sheltering 25 to 40 people per month. Interviewees described the program as successful in connecting individuals to resources and services.[71] Still, more research is needed to understand how these approaches serve women and whether additional supports are required.

Spotlight: The Street Crisis Response Team (SCRT) in San Francisco.

SCRT is a non-law enforcement street outreach team that includes medical personnel and homeless service professionals or peer providers.[72] Dispatched through 911, the team provides on-scene crisis support and post-crisis follow-up. Qualitative analysis indicated that clients preferred interaction with SCRT over traditional first responders and felt their immediate needs were met.[73] But the program has been less effective in addressing the long-term housing and social challenges related to homelessness. In 2024 monthly reports, 37% to 49% of clients the team referred to follow-up care through the city's Office of Coordinated Care were women.[74] Currently, no evaluations disaggregate findings by sex.

Conclusion and Implications

Communities across the country have increasingly invested in crisis response strategies aimed at reducing harm, connecting people to care, and minimizing justice system involvement.[75] But little is known about how well these approaches work for women, who often enter the system as a result of trauma, behavioral health needs, or housing instability. Most programs have not been evaluated with women in mind, and those that collect data rarely report outcomes by sex. Further, evaluations don't typically assess whether these crisis responses influence the likelihood of future criminal behavior and justice system involvement.

Without stronger data and more sex-specific research, jurisdictions risk investing in interventions that overlook—or worsen—the challenges women face without effectively protecting public safety or reducing justice system involvement. Ensuring that these approaches are truly beneficial requires asking: Are women being reached? Are they being helped? And what would it take to build crisis response systems that are designed for, and effective with, women from the start?

To build a crisis response network that demonstrably helps women, research must go further—asking not just what works, but what works for whom. The following agenda outlines next steps for getting there.

A Research Agenda to Center Women in Crisis Response

To build a stronger foundation for effective crisis intervention, researchers, funders, and policymakers should prioritize three core areas:

1. **Strengthen the Infrastructure Needed to Collect and Report Disaggregated Crisis Response Data**
   Collecting and reporting disaggregated data—such as sex, race, and crisis type—across all crisis response models is essential for understanding impact and improving outcomes. While some programs, such as hotlines and shelters, limit data collection for safety reasons, privacy-preserving strategies exist, including using de-identified administrative data, voluntary participant surveys, and aggregate reporting. Without reliable demographic and outcome data, it is impossible to evaluate who is being served, how effectively, and at what cost.
2. **Advance Research Focused on Women's Outcomes and Public Safety Impacts**
   Research should examine both the public safety outcomes of crisis response programs and their specific effects on women, particularly those with trauma histories, caregiving responsibilities, and complex behavioral health needs. Evaluations should assess justice system diversion, service connection, long-term health and stability, and whether programs reduce harm or risk in the community. Where feasible, studies should compare models and include cost-benefit analyses to identify which approaches offer the greatest return on investment across justice, health, and housing systems.
3. **Prioritize Longitudinal and Cross-System Studies that Track Long-Term Outcomes and Costs**
   To understand whether crisis response programs work over time, studies must track

long-term outcomes across health, housing, and criminal justice systems—not just short-term or siloed effects. Effective diversion should reduce offending and long-term justice involvement without overburdening other systems, and researchers should track outcomes over time. Funders should support cross-agency data sharing and multi-year studies that assess whether interventions reduce recidivism, improve well-being, and offer long-term savings—or simply shift burdens from one system to another.

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Endnotes

[1] In this report, a crisis is defined as a difficult or dangerous situation that disrupts normal functioning and requires immediate attention and action.

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