

**Executive Order *Safe Policing for Safe Communities:*
Addressing Mental Health, Homelessness, and Addiction Report**



SAMHSA
Substance Abuse and Mental Health
Services Administration

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Table of Contents

I. Introduction.....1

II. The Justice System as A Safety Net.....2

III. Behavioral Health Crisis Care.....3

IV. Models Addressing Mental Health that Reduce Police Involvement.....6

V. Models Addressing Substance Use that Reduce Police Involvement.....13

VI. Models Addressing Homelessness that Reduce Police Involvement.....16

VII. Models Addressing Children’s Services the Reduce Police Involvement.....21

Conclusion.....28

APPENDIX I: Budget Proposal for Programs to Address Community Policing Efforts.....30

I. Introduction

Section 4(c) of Executive Order 13929, *Safe Policing for Safe Communities*, requires the Secretary of the Department of Health and Human Services (HHS) to survey community-support models addressing mental health, homelessness, and addiction, and within 90-days of the order, to summarize the results of the survey in a report to the President, through the Assistant to the President for Domestic Policy and the Director of the Office of Management and Budget. The findings of this Report highlight the models used by the states addressing mental health, substance use, homelessness, and children's services that reduce police involvement. This document provides best practice examples of programs which decrease contact with law enforcement for persons with mental health problems, substance use issues, and/or who are experiencing homelessness. Although no one system works everywhere, these examples indicate that communities are making tremendous strides in improving behavioral health (BH) crisis services and reducing police involvement.

Our healthcare and criminal justice systems are facing increasing challenges from the growing numbers of individuals experiencing behavioral health (mental health and/or substance use disorder (SUD)) crises. Unfortunately, there are few options available for a person experiencing a true behavioral health crisis. In most of the nation, when 911 receives a call about someone experiencing a behavioral health crisis, it is law enforcement (LE) that responds. LE, emergency departments (EDs) and jails have become the safety nets for behavioral health crises. Behavioral health disorders should logically solicit a public health response, but due to the lack of adequate and organized crisis services, the responsibility has defaulted to a response from LE.

Over 2 million people with serious mental illness (SMI) are booked into jail each year, often for non-violent "nuisance" or "quality of life" crimes such as loitering or vagrancy. Not surprisingly, the prevalence of mental illness and substance use disorders (SUDs) in jails and prisons are three to four times that of the general population.¹² Once in jail, people with mental illness are incarcerated twice as long, and few receive needed treatment.^{3 4 5} Upon release, with Medicaid benefits interrupted and a criminal record, they are likely to be unemployed, homeless and arrested. Thus, the cycle continues.

¹ Steadman HJ, Osher FC, Robbins PC. Prevalence of serious mental illness among jail inmates. *Psychiatr Serv* Wash DC 2009;60 (6):761–5.

² Glaze LE, James DJ. Mental Health Problems Of Prison And Jail Inmates. Bureau of Justice Statistics. NIMH Statistics [Internet]. 2006; Available from: <https://www.nimh.nih.gov/health/statistics/index.shtml>.

³ The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey. Treatment Advocacy Center & National Sheriffs Association. 2014.

⁴ Dumont DM, Brockmann B, Dickman S, Alexander N, Rich JD. Public health and the epidemic of incarceration. *Annu Rev Public Health* 2012;33:325–39.

⁵ The Office of National Drug Control Policy, Washington DC [Internet]. Available from: <https://www.whitehouse.gov/ondcp/>.

II. The Justice System as a Safety Net

The lack of adequate and organized crisis services in the community has put police departments in a difficult position. Typically police are forced to balance public safety and community service. Frequently, the quickest and easiest solution is arrest and incarceration of the individual. But the impact of incarceration on an individual in crisis is great. Jails and prisons lack the policies and staff trained in behavioral health to deal with the needs of a person with behavioral health needs, particularly someone in crisis. Offenders with mental illness are incarcerated twice as long and are three times more likely to be sexually assaulted while incarcerated.⁶ They are also more likely to be in solitary confinement, which exacerbates psychiatric symptoms. And post-release adverse effects include difficulty finding employment, higher risk of homelessness and rearrests, and interruption in Medicaid and other benefits. It is widely believed that they will receive the treatment they need in prison or jail, but the truth is that of prisoners who had a mental health problem, only 34% in state prisons received mental health treatment after admission, followed by Federal prisoners (24%) and local jail inmates (17%).⁷

When LE responds to the call and determines that a transport to an ED is warranted, it takes time away from their usual duties. Transporting an individual and waiting with him/her in a hospital ED is time consuming and often futile. Hospital EDs have inadequate numbers of behavioral health professionals on staff, and most do not have psychiatrists. When the ED cannot treat someone, they often “board” the person (i.e. detain them) anywhere from hours to days, putting the patient and staff at increased risk of harm and incurring uncompensated care expenses for each patient. The patient has a terrible experience with the healthcare system as their crisis continues unabated and untreated, or symptoms worsen as the individual does not receive appropriate care in a stressful environment. Through this time the officer is delayed from returning to duty. Also, studies have shown that an ED visit is very likely to result in an inpatient admission when a bed becomes available, even if not warranted, which is more costly than a crisis response or services received in a crisis stabilization center, which are short term and may better meet the needs of the patient.

It is time for LE to return to policing and for mental health professionals to assume the role of crisis response. The most appropriate role for LE in a behavioral health crisis is limited or none (unless there are imminent safety concerns). It is time to redirect our reliance on LE as mental health crisis responders and create the momentum to develop crisis services systems based in behavioral health principles. HHS has a robust body of research on models designed to support individuals with serious mental illness and co-occurring disorders in the community and divert these individuals from involvement in the criminal justice system. A report from the office of the Assistant Secretary for Planning and Evaluation (ASPE), entitled *Approaches to Early Jail Diversion Collaborations and Innovations*, examines several programs employing a community

⁶ <https://www.bjs.gov/content/pub/pdf/mhppji.pdf>

⁷ <https://www.bjs.gov/content/pub/pdf/mhppji.pdf>

policing approach. The goal of this study was to better understand pre-booking jail diversion interventions for people with SMI, SUDs and co-occurring disorders, and assess how such interventions may inform federal policy.⁸ HHS is committed to supporting law enforcement through relevant federally funded programs, and has already funded competitive grant applications that include partnerships with law enforcement to assist in reducing social burdens on agencies thereby allowing law enforcement to focus on ensuring our public safety and welcomes such applications going forward.

III. Behavioral Health Crisis Care

The Substance Abuse and Mental Health Services Administration (SAMHSA) advances national guidelines in crisis care within a toolkit that supports program design, development, implementation, and continuous quality improvement efforts. It is called the *National Guidelines for Behavioral Health Crisis Care - a Best Practice Toolkit*. Its principal message is that, when needed, crisis services must be available for anyone, anywhere, and anytime.⁹ In order to reduce police contact with individuals experiencing a crisis related to mental health, substance use, and/or homelessness, a no-wrong door comprehensive crisis system should be put in place. Based on the *National Guidelines*, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three core structural or programmatic elements are: Regional Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

- **Regional Crisis Call Center.** In times of mental health or substance use crisis, 911 is typically called, which results in police dispatch. A regional crisis call center provides an alternative. Regional crisis call centers should be made available statewide, provide real-time access to a live mental health professional on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as “Air Traffic Control” to assess and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social services, government agencies, and non-profit organizations.
- **Mobile Crisis Response Team.** Once a mental health crisis has been identified and a crisis line has been called, a mobile response is required if the crisis cannot be de-escalated by phone. In the current system, police are often dispatched to the location of the individual in crisis. But in an effective crisis system, two-person teams, including a clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency

⁸ Pfefferle et al. (2019). Approaches to Early Jail Diversion: Collaborations and Innovations.

<https://aspe.hhs.gov/basic-report/approaches-early-jail-diversion-collaborations-and-innovations#execsum>.

⁹ <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be transported to the appropriate level of care, if needed, as deemed by the clinician and response team.

- Crisis Receiving and Stabilization Facilities. In a typical system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7, and should have a no-reject policy. Particularly when police or EMS are dropping off an individual, the hand-off should be “warm” (welcoming) and efficient, and these facilities provide assessment and address mental health and substance use crisis issues. A warm hand-off establishes an initial face-to-face contact between the client and the behavioral clinician. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember and they receive a quick response. Many of the crisis systems in the United States continue to use 911 because either they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of LE in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either the police department’s co-responder team (police officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with police officers who have received Mental Health First Aid and Crisis Intervention Training, including de-escalation methods and behavioral health symptoms; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers then refer to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Call Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Currently, the National Suicide Prevention Lifeline (Lifeline) connects more than 170 local call centers throughout the United States. Call center staff is comprised of professionals and volunteers who are trained to utilize best practices in handling distress calls. Local call centers automatically perform a safety check for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

- 988 – 3-digit behavioral health crisis number. The National Suicide Hotline Designation Act (P.L. 116-172) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. It will replace the National Suicide Prevention Lifeline’s current number, 1-800-273-TALK, and provide nationwide ease of access that connects callers in crisis to the Lifeline and Veterans Crisis Line. The 988 transition will provide support and expansion to the current Lifeline network and will continue utilizing the live-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide. This bill was signed by President Trump on October 17, 2020.
- Building Crisis Services Systems. Most communities across the United States have limited crisis services, but a few have an organized system of services that coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of LE. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding. The FY 2021 President’s Budget requested a 5 percent increase in the Mental Health Block Grant with a set aside based on the increase to promote and develop crisis services across all states.

We have provided examples from states that have developed a variety of systems, many of which support the approach of SAMHSA’s *National Guidelines for Behavioral Health Crisis Care: Best Practices Toolkit*. Although no one system works everywhere, these examples indicate that communities are making tremendous strides in improving behavioral health crisis services and reducing police involvement. In addition, SAMHSA’s *Crisis Now: Transforming Services is Within Our Reach* provides an overview of key elements of crisis care that are in place, and discusses the importance of a comprehensive crisis care system, as often, a system comprising only partial elements may not be adequate.¹⁰ It is a guide to building a system beginning with what a jurisdiction has, and it approaches reform from the perspective of preventing tragedies, i.e., identifying vulnerabilities to address first. The examples below follow the 3 components of crisis services systems’ best practices: (1) crisis call centers, (2) mobile crisis teams, and (3) crisis receiving and stabilization facilities.

¹⁰ <https://theactionalliance.org/sites/default/files/crisisnow.pdf>.

IV. Models Addressing Mental Health that Reduce Police Involvement

There are various existing models which address mental health that can reduce need for LE involvement.

1. **Crisis Response**. This includes crisis call centers, mobile crisis response teams, and crisis facilities/stabilization centers, as well as the presence of peer support. All of these elements are needed for an effective crisis response system.

Crisis call centers offer an alternative to calling 911 when an individual is experiencing a mental health emergency. Peer service response includes telephone services for people who are looking for someone with whom they can discuss their daily struggles. These are staffed with individuals who have lived experience of mental health struggles themselves and who are open to sharing their stories of challenging situations, recovery, and perseverance. Instead of being routed to police or emergency medical services, the call triggers a response appropriate for a behavioral health emergency. In order to appropriately replace a need for 911, the response must be coordinated, effective, efficient, and available at all hours. Examples of this include:

- The National Suicide Prevention Lifeline is a suicide prevention and mental health crisis call center organization (or “hotline”) that operates nationwide linking over 170 local crisis lines and the Veterans Crisis Line. The current number 1-800-273-TALK (established in 2005) is not easy to remember and, as such, the Federal Communications Commission voted in July 2020 for “988” to serve as the nation’s forthcoming new number to connect people to the National Suicide Prevention Lifeline and Veterans Crisis Line.¹¹ Plans include changes that will strengthen the system, provide better back-up for calls, provide uniform training to staff, and provide for quality control. In the meantime, the Lifeline and local crisis lines will link the caller to emergency behavioral health services, and utilize emergency intervention as last resort.
- Air Traffic Control is a term borrowed from the airline industry and is an interconnected dispatch system within a 911 or crisis call center that allows the center to electronically track persons in crisis from the response site, during the transport, and to the provider so that they may be efficiently, empathetically, and effectively routed to the most appropriate response. GPS technology can identify the location of an individual caller through geo-mapping who may need a rescue response, or who simply may need a referral for services nearby. This system is attached to databases that will show where services exist and are available.¹⁰ Through an interconnected system, behavioral health response teams (typically composed of one or two providers including masters-level clinicians and psychiatric technicians) can accomplish the same fast, efficient, coordinated effort as a person would receive from dialing 911, but without involving police or emergency medical services.

¹¹ Crisis Services – Crisis Continuum Umbrella Paper (2020).

- Arizona’s RI International Crisis Response has a 24/7 Behavioral Health Crisis Line that can dispatch GPS-tracked Mobile Crisis Teams and manages an electronic bed placement board. There is also a Tribal Warm Line supported by the American Indian Support Service in the region.¹² Having this available 24/7 allows individuals to reach the crisis line as opposed to 911.
- The Harris Center for Mental Health and Intellectual and Developmental Disabilities (IDD) 911 Crisis Call Diversion in Harris County, Texas, where behavioral health professionals work with 911 dispatch to divert non-imminent risk behavioral health calls away from LE/EMS response, and toward a more appropriate behavioral response which includes: telephonic de-escalation, information and referral to community resources, and/or referral to Mobile Response Teams. By collaborating to divert calls from 911, LE contact can be replaced with effective behavioral health services.
- The Apalachee Center’s (Florida) Mobile Response Team (MRT) is a 24/7 on-call crisis intervention service. The MRT provides emergency behavioral health assessment, and diversion to alternatives to inpatient treatment when appropriate. Apalachee Center’s MRT currently serves all eight counties in its treatment area. Services are provided through phone consultations and on-site response by Mobile Response Team clinicians. Outside Leon County, after hours (and other times when circumstances dictate) face-to-face telehealth is available via tablets provided to County Sheriff’s Departments. The tablet assists with identifying symptomology which enables better choices in selecting a service for the individual. It also allows for the individual to speak to a knowledgeable behavioral health professional if needed (telehealth).

Another element of crisis response includes mobile crisis teams, a non-law enforcement-based response that allows mental health clinicians to respond to crises directly. These MRTs, also called Mobile Crisis Teams (MCTs), may have protocols where LE serves as back-up, but are designed to be a distinct non-law enforcement-based response. Separate from LE, mobile crisis services have expanded in many states based on a variety of policy shifts and intentional program design. These mental health crisis response models serve as a growing non-law enforcement, model of crisis response.¹⁰

- GCAL, Georgia’s Crisis Response utilizes MCTs. During attempts to de-escalate a situation and determine the best way to serve the individual, guidelines help determine what level (if any) of LE is needed, or if MCTs can respond alone. LE support ranges from asking them to accompany, follow behind, or be on standby.¹³ Having LE on standby, rather than as the initial response, reduces police contact with individuals experiencing a behavioral health crisis.

¹² Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm (2020).

¹³ Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the National Guidelines for Behavioral Health Crisis Care (2020).

- Arizona’s RI International Crisis Recovery Response Center (RRC) model utilizes Mobile Response and Stabilization Services (MRSS).¹⁴ MCTs are dispatched by the regional crisis call center in response to crises, instead of dispatching LE. A person in a leadership role must authorize whether a mobile unit can call LE, unless a situation escalates quickly, in which case the unit can immediately call the police. Calls for police to respond have been reduced between 70 and 80 percent (although LE is still often dispatched by 911), resulting in over 22,000 LE hand-offs to crisis providers annually in Maricopa County alone.¹⁵
- Mobile Acute Crisis (MAC) in Pima County, AZ, in 2018, received about 200 calls per month, with half coming from local LE. In FY 2014, there were 4,433 adult and juvenile LE transfers that saved 8,800 hours of LE time, the equivalent of four full-time officers.¹³
- Alaska’s Behavioral Health Aides (BHAs) operate out of regional and tribal health hubs across the state. From these hubs, BHAs are supervised by licensed clinicians through telehealth to assist BHAs in connecting individuals in crisis to higher levels of care, as needed. BHAs are often the first to identify when someone is experiencing a crisis and are the first to respond to traumatic events in the communities they serve. Alaska has found the BHA program is effective at utilizing available human resources in communities that may otherwise not have an adequate supply, or any supply, of licensed behavioral health providers. This resource helps with the implementation of crisis services in rural and tribal areas.¹⁶ Local individuals acting as the first connection between an individual in crisis allows for an empathetic and effective transition to higher levels of care when necessary, without involving LE.
- In rural Colorado, some locations use paramedics who are trained to do an initial screening and then, if appropriate and with the consent of the patient, connect the patient via a tablet with a telehealth provider who interacts with the patient and then informs the paramedic about the next treatment steps. Minnesota uses similar, web-based mobile counselors.²⁵ Trained paramedics acting as triage for a behavioral health crisis reduces the need for LE to intervene.
- In Delaware, MCTs have access to OpenBeds, a treatment referral website that allows the teams to make appointments for follow-up services at all levels of care. Mobile team staff are also the call center staff, and it is often the case that the staff providing the mobile service took the crisis call. They also have a separate and parallel service for Medicaid patients.¹⁷ Effective transitions to the appropriate level for care by individuals knowledgeable about the situation allows for reduced LE involvement in crisis and post-crisis placement.

¹⁴ [Making the Case for a Comprehensive Children’s Crisis Continuum of Care \(2018\)](#).

¹⁵ RI International Data

¹⁶ Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S (2020).

¹⁷ Financing Mental Health Services (2020).

- RI International’s Crisis Response Center (CRC) in Peoria, Arizona includes a crisis receiving and stabilization facility that provides an alternative option to ED drop-offs and pre-booking jail diversion by LE and others. The program receives more than 80 percent of its clients, including persons experiencing homelessness, through LE drop-offs. This model incorporates technology, crisis centers, and suicide prevention interventions to effectively manage persons in distress by creating a methodology that de-emphasizes routing individuals to emergency or police departments. This model involves quick police drop offs (approximately 10 minutes) of persons in crisis at the crisis receiving and stabilization facility.
 - The “Rediscover Assessment and Triage Center” (ATC) in Kansas City, Missouri is a regional crisis center that addresses both mental health and SUD related crises. It was originally established through collaboration with the criminal justice and hospital healthcare systems. This program has expanded to include walk-ins and referrals from community-based providers. Case management and connection to peers are areas of significant focus at the triage center.¹⁸ By addressing both mental health and SUDs and providing easy access for the community, this center reduces the need to involve LE in behavioral health and substance use crises. Electronic psychiatric behavioral health bed registries are a means to build better linkages to psychiatric services in a crisis context. These bed registries have been developed in an effort to curb ED boarding times (boarding is detaining without treatment). Individuals coming for acute assessments who need a psychiatric hospital bed could be sent to one without delay.¹⁰ A bed registry can be used to identify an appropriate nearby available bed, so that the patient is not turned away after traveling a long distance when a bed is not available at a crisis stabilization unit.¹⁵ A 2017 report by NASMHPD Research Institute (NRI) of existing bed registries showed 16 states had some type of bed registry and eight states were in some phase of planning for one. Psychiatric bed registries can enable communities to avoid an overreliance on LE by finding appropriate placements for individuals in crisis.
2. **Peer Support. Such services, including the Living Room Model, are extremely effective in crisis response services and reduce reliance on law enforcement to appropriately engage individuals experiencing behavioral crises.**¹⁹
- Peer-operated Living Rooms at RI International’s Crisis Response Center (RRC) focus on good contact with the person in distress by creating a welcoming environment. This “fusion model” combines the direct and safe access of a hospital ED with the recovery- oriented approach of the Living Room. Individuals in crisis are immediately greeted by a peer staff who orients them to the care they will receive. There is active engagement and collaboration throughout their stay, and they become active participants.¹⁰ On the rare

¹⁸ National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (2020).

¹⁹ Ostrow L. Evaluating Peer-Operated Crisis Care Alternatives. Johns Hopkins School of Public Health Presentation to Columbia University/Nathan Kline Institute, September 2012.

occasion when there is a medical complication as well, additional treatment is organized by the Crisis Recovery Center, including transportation where appropriate. None of the functions are delegated to LE, as the police officer is immediately released to return to duty following a LE referral. The program has not refused a single police referral in the past five years, despite over half being involuntary. LE engages in zero “wall time,” by-passing the ED completely. The burden on police is eased, and the experience for the person in crisis is improved.¹⁰ Participants are paired with a team of Peer Support Specialists in recovery, encouraged to work with the team, and empowered to develop their own recovery team. This model demonstrates the importance of peer support in crisis and recovery systems and their ability to serve individuals more effectively than in emergency or police departments.

- The Living Room model in Skokie Illinois addresses some of the barriers that individuals might face in going to a traditional ED when in psychiatric crisis by providing immediate, client-centered, and recovery-oriented services, as well as being embedded into a home-like setting in the community, promoting autonomy, respect, hope, and social inclusion.¹⁰

3. **Police-Friendly Drop-Offs. Designed to minimize the time individuals spend with LE and reduce entry into the criminal justice system. By creating streamlined entry points for LE, their time and resources are saved, and the individual in crisis receives appropriate care from behavioral health professionals, as well as peer support.**

- The Restoration Center in San Antonio, Texas is designed as a community crisis resource and as a “police friendly” drop off site to help improve jail diversion initiatives for persons with mental illness and substance use. People from around the country have traveled to visit the site to learn about its vision and mission and to see how it could be adapted to their local communities.¹⁷
- The Arizona Crisis Recovery Center has a never-reject approach to LE drop-offs¹⁷, to ensure that police will bring individuals with behavioral crises to the center, instead of the police or ED. There is a secure drop-off location for the officer with a computer available to draft reports, snacks, and a dedicated restroom. In addition, the officer is not asked to wait for an evaluation of the person to be completed. A peer leader greets the individual, introductions are made, and the LE officer shares any available paperwork and returns to his/her public safety work within 10 minutes.¹⁷
- Judge Ed Emmett Mental Health Diversion Center in Harris County, Texas is a pre-charge alternative for LE to drop off people with mental illness who are picked up for low-level misdemeanors. This program is a collaboration between the Harris Center for Mental Health and Intellectual and Developmental Disabilities, LE, and the Harris County District Attorney office. This alternative offers a way for police officers to avoid charging individuals with mental illness, minimizes such individuals’ time in the criminal justice system, and provides them with appropriate services.

4. **Co-Responder Models.** These are designed specifically to have a behavioral health mobile crisis provider co-respond with police to a scene without the provider necessarily being stationed in the police department or riding in the police car.¹⁰ A coordinated response by LE and mental health professionals to divert individuals from the criminal justice system is important in minimizing criminalization of mental illness and ensuring people are treated in the least restrictive settings.¹² These models are a step towards transitioning to models that further reduce police involvement.
- Clinician and Officer Remote Evaluation (CORE) at The Harris Center for Mental Health and IDD in Harris County, Texas provides LE officers and deputies who work patrol with technology and resources to efficiently respond to mental health crisis calls in the community, linking them to real time licensed master level clinicians. CORE clinicians using Tele-Health video technology link LE with stationary mental health clinicians who complete mental health crisis assessments. When mental health professionals determine the appropriate LE response to individuals experiencing a behavioral health crisis, the individual can be linked to appropriate services and reduce contact with the criminal justice system.
 - Best practices in crisis intervention, such as CPI (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and Therapeutic Options (Therapeutic Options, Inc.), are highly effective and the utilization of such positive practices minimizes the need for physical interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and clients in the crisis setting.¹⁷
 - Crisis Response Teams in Seattle, Washington operate through a contract between the police department and the local mental health agency to have mental health clinicians work directly with CIT officers. A qualitative study of the program found that the model improved encounters between LE officers and people experiencing mental health crises, as well as better utilizing police department resources.¹⁰
 - The Co-responder model in Massachusetts establishes partnerships between the provider organizations, advocates, the state Department of Mental Health, and other stakeholders and has continued to grow across the state. This model embeds a clinician in local police departments to ride with police and respond to crises.⁴² In addition to having specialized behavioral health staff assigned to work within local police departments to jointly respond to crises, they were able to leverage the entire mobile crisis service to help the communities they serve. This model has shown successful outcomes for jail diversion, cost savings, and shifts in police culture and attitudes about managing mental health crises. On average, 75% of individuals presenting with criminal behavior are diverted from arrest and into appropriate treatment. Included in this model is the use of mobile crisis teams to divert people from the criminal justice system.

- The Veterans Mental Evaluation Team (VMET) at Long Beach VA Medical Center Team consists of a mental health trained VA Police Officer and a licensed mental health clinician who respond with local law enforcement to veterans in crisis, conduct welfare checks, and provide follow-up calls and visits. The pairing of a licensed mental health clinician and a VAPD officer decreases veteran anxiety throughout the engagement process and provides an opportunity to link veterans to appropriate services or treatment. The team is specially trained to use the least restrictive methods and possess extensive training and certifications that afford them the skills, techniques, and abilities to effectively and appropriately deescalate a mental health crisis. It is a coordinated response that involves communications and support from local LE. Some data includes first year impact statistics: 70 veteran lives saved (VMET constitutes a life saved as responding to a veteran at imminent risk with means and ability for completion of suicide); 823 calls received- crisis, welfare, and follow-up calls; 27 psychiatric holds placed (they have been able to minimize the amount of involuntary hospitalizations). The team can also communicate with the veteran to come in voluntarily for most calls, citing 52 calls responded to with assistance from the local police agency and 4 housing placements. As for its second year impact, 1074 total calls for service to include initial and follow-up calls; 58 outside agency assists: 58 involuntary holds: 16 imminent risk saves: 20 permanently housed directly by VMET. Fresno CA, Manchester NH, Oklahoma City OK, and Houston TX have also implemented VMET.

5. **On-Demand Mental Health Services. These services reduce the need for individuals or concerned community members to contact law enforcement by providing an accessible alternative to have their behavioral health needs met.**

- In Massachusetts, on-demand mental health clinics resulted from advocates calling for same-day access while considering the challenges to funding services of this nature. Further, in opioid use disorder care, there has been much done around the country to get immediate access to medication assisted treatment (MAT) for opioid use disorders.¹⁰
- The Certified Community Behavioral Health Clinics model also sets forth a path to reduce LE involvement, given that the model requires easy access to care and 24/7/365 crisis services. It is being examined as a model in various states. Federal standards of practice for CCBHCs include the ability to respond effectively to the needs of individuals with co-occurring mental health and substance use disorders (COD).²⁰
- Michigan’s “Stay Well” initiative launched after the statewide stay home order in response to COVID-19 went into effect, has been sustained even after the lifting of the restrictions.¹⁰ The state’s efforts put forth several options to persons in need of emotional supports, including a peer warm line that has received thousands of calls, crisis counseling with “Stay Well” counselors, video resources, and written guides for the public on managing stress

²⁰ Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What’s Known, What’s New, and What’s Now? August 2019 Alexandria, Virginia.

and anxiety pertaining to COVID-19. These ongoing resources provide communities with support to address mental health needs before crisis. On-demand services reduce the need to call emergency medical services or police for behavioral health crises.

V. Models Addressing Substance Use that Reduce Police Involvement

1. ***Behavioral Health Crisis Centers.*** These centers allow individuals experiencing a behavioral health crisis, including involvement with substance use, to be greeted by peers and trained professionals who can effectively respond to the crisis and provide the person with the appropriate level of care without involving law enforcement or the emergency department.
 - The “Rediscover Assessment and Triage Center” (ATC) in Kansas, Missouri is a regional crisis center that addresses both mental health and SUD related crises. It was originally established through collaboration with the criminal justice and hospital healthcare systems. The center has expanded to include walk-ins and referrals from community-based providers. Case management and connection to peers are areas of significant focus at the triage center. There is an accessible center for individuals to receive robust and appropriate mental health and substance use disorder services without getting involved in the criminal justice system.
 - Tucson, Arizona’s Crisis Response Center (CRC) provides services in coordination with community stakeholders through implementation of a no wrong door policy, and has access to a comprehensive treatment system for SUD available 24/7.¹² The no-wrong door policy makes substance use treatment more accessible. It reduces the need to call on LE. The CRC increases personalized, comprehensive, care.
2. ***Peer Support.*** The presence of peer support as integral part of SUD treatment services are extremely effective in crisis response services and other programming to appropriately engage individuals experiencing substance use crises and reduce reliance on law enforcement.²¹
 - AnchorMore, a pre-crisis program in Rhode Island, deploys Peer Recovery Specialists to overdose hotspots to engage high-risk individuals. Weekly team calls identify areas where overdoses have been most prevalent, and calls may be convened more often if there is a marked increase in an area not previously identified. Teams of peers are sent to these areas and dispense Narcan (opioid overdose reversal medication) kits. During these interactions, peers establish connections with active users, and will provide referral to treatment and recovery services when individuals are interested. This program has demonstrated a high

²¹ The Role of Recovery Support Services in Recovery-Oriented Systems of Care” U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment DHHS Publication No. (SMA) 08-4315 Printed 2008

rate of engagement for services with an at-risk population.¹² By using peers to engage high-risk individuals, services are administered without LE, and peers make connections with the population before, during, and after crises.

- Kentucky's Bridge Program, a peer support program, provides post-overdose peer support to individuals with SUD presenting in EDs. It also involves hospitals providing induction onto MAT. This crisis point is seen as a successful point of intervention and engagement for care.¹² By engaging individuals using peers at this point of crisis, involvement with LE is avoided and the individual is engaged with the appropriate care.
 - Pennsylvania's peer support community-based care management teams involves outreach to clients in EDs post overdose and extends such outreach to correctional facilities, primary care settings, and other community-based settings. The aim of the outreach is to engage individuals in their successful Center of Excellence program, expanding access to MAT, providing case management to address other social determinants of health, and encouraging continued involvement with health and mental health treatment.¹³ Peers are effective in engaging individuals experiencing substance use crises with other services, reducing current and future involvement with LE by connecting them to substance use and mental health services.
3. **Co-Responder Models: Designed specifically to have a behavioral health mobile crisis provider co-respond with police or emergency medical services to a scene without the provider necessarily being stationed in the police department or riding in the police car.¹⁰ A coordinated response by law enforcement and mental health professionals to divert individuals from the criminal justice system are important in minimizing criminalization of mental illness and ensuring people are treated in the least restrictive settings.¹² These models are a step towards transitioning to models that further reduce police involvement.**
- In Rhode Island, the Hope Initiative is a state-wide collaboration between LE and substance use professionals to help guide those in need toward recovery. Teams respond to individuals who have recently survived an overdose, as well as responding to community referrals for outreach from friends and family members.¹² The presence of substance use professionals reduces the criminalization of individuals experiencing a substance use crisis.
 - West Virginia's Quick Response Teams are composed of emergency response personnel, LE officers, and a substance use treatment or recovery provider who contact individuals within 24-72 hours of their overdose to offer and assist those individuals with recovery support, including referrals to treatment options.¹² This response system engages a person experiencing a substance use crisis to offer recovery support services without criminalizing overdoses.

- Massachusetts Post Overdose Support Teams program has teams of first responders, public health advocates, and harm reduction specialists who return to the site of a non-fatal overdose to provide follow-up services to overdose victims and their families.¹² Specialists on this team are able to more effectively serve those experiencing substance use crises without involving LE.
 - Manchester, New Hampshire’s Safe Station program provides fire stations as open doors for individuals seeking help for substance use disorders, 24/7. Fire Department personnel conduct a brief medical assessment before connecting these individuals to treatment and recovery resources. This program involves only emergency medical services, and links individuals to the correct resource avenues without ever involving LE. Police Assisted Addiction & Recovery Institute is a national network of police departments spanning 32 states that offer simple, stigma-free, non-arrest pathways to treatment and recovery based on the Angel Program established by the Gloucester Police Department in Massachusetts in 2015.
4. **Supportive Services. These services support individuals with co-occurring mental health and substance use disorders (COD) without involving LE or the criminal justice system. Individuals experiencing homelessness or income insecurity are also supported by these programs, which help to reduce crises and help stabilize individuals post-crisis, reducing law enforcement involvement.**
- Supportive Housing for Individuals with COD have proven success.¹⁹ Extensive “Housing First” literature emphasizes the value of engaging homeless individuals with COD in scattered-site housing environments (sometimes termed “wet housing”) with supports to help them succeed in the housing, while making better decisions over time about managing their various challenges. Sober housing or “recovery residences” are a valuable element of the continuum of support for individuals (including those with COD) who may wish to live in a supportive sober environment to help them maintain abstinence. Prioritizing supportive housing and resources sets individuals up with services that can reduce interaction with LE due to substance use and homelessness. Individual Placement and Support Model (IPS) of supported employment had cumulative employment rates of 60%, compared to 24% of those in a conventional program.²² Coordinated Specialty Care (CSC) for people experiencing first episode psychosis is driving an increased focus on supported education and employment.²³ In the OnTrackNY CSC program, 44% of participants had co-occurring substance use, and education and employment rates increased from 40% to 80% with six months of program participation. These programs do not criminalize substance use.

²² Mueser K, Campbell K, Drake RE. The Effectiveness of Supported Employment in People With Dual Disorders. *J Dual Diagn* 2011 Jan 1;7(1-2):90-102. doi: 10.1080/15504263.2011.568360. Epub 2011 May 11.

²³ Heinszen RK, Goldstein AB, Azrin ST. Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care, National Institute of Mental Health. Available from <https://www.nimh.nih.gov/health/index.shtml>.

Instead, they provide individuals with financial and employment support necessary for their recovery, rather than involving them with LE.

- Certified Peer Support Specialists (CPS), individuals with lived experience of mental illness and/or SUD who have undergone formal training and certification, can gain employment to serve others. CPS have shown positive impact on those who receive this support. Access to CPS provides individuals in recovery the supports they may need to assist them avoid or to work through a crisis without involving LE.
- Motivational Enhancements (ME) and Cognitive-Behavioral Interventions have shown potential for success for individuals with co-occurring schizophrenia or other SMIs and SUDs receiving appropriate integrated interventions. Evidence suggests that those who participated in these interventions participated more in treatment, reduced substance use, spent more days in stable housing, and experienced fewer hospitalizations and arrests.

VI. Models Addressing Homelessness that Reduce Police Involvement

1. **Behavioral Health Crisis Response Teams**. These teams collaborate with LE in terms of communication and backup, but respond independently (without any police officers) to most emergencies and connect the individual in crisis to the appropriate resources.
 - White Bird Clinic in Eugene, Oregon is a Federally Qualified Health Center (FQHC) that provides a range of health and behavioral health services including a 24/7 crisis hotline, a crisis walk-in clinic, and a 24/7 CAHOOTS (Crisis Assistance Helping Out On The Streets) mobile crisis team.²⁴ The CAHOOTS mobile crisis team was designed as an alternative to police intervention in response to mental health crises in the community. This clinic has a close partnership with local LE through a Memorandum of Understanding (MOU) to divert individuals in crisis, including those experiencing homelessness and addiction, from police contact as much as possible. It involves the deployment of two-person teams, consisting of a medic and a mental health crisis worker, who can provide a trauma-informed response to help diffuse crises. CAHOOTS mobile crisis team staff are well-known to homeless individuals in the community because White Bird Clinic is also a Health Care for the Homeless provider. The CAHOOTS team responds to calls involving individuals with mental and/or substance use disorders that come in through 911, as well as through the police non-emergency line. The team shares a dispatch radio with police and emergency services, allowing it to intervene if the police are called in response to a homeless individual, thereby diverting police contact. The team also works to actively find and engage those individuals identified by patrol officers for quality of life offenses, to divert them from further justice system involvement. A recent report showed that, in 2019, out of approximately 24,000 CAHOOTS calls, police backup was requested only 150 times.¹⁰

²⁴ Effective Behavioral Crisis Care for Individuals Experiencing Homelessness (2020).

- Netcare Access in Columbus, Ohio operates a range of behavioral health crisis services for Franklin County. Individuals, businesses, and other providers can call Netcare’s 24/7 crisis hotline to request assistance from a specialized mobile outreach service called ROW ONE that transports approximately 1,500 publicly intoxicated persons per month off the streets to safe locations that include homeless shelters, substance use and mental health treatment centers, crisis centers, and hospitals. The organization also recently began staffing the county’s homeless services hotline, so staff have good working knowledge of the community and its resources.²³ This program includes specialized mobile outreach services for immediate crisis situations. A mobile team will be dispatched to the individual’s location to provide urgent mental health and substance use intervention services. This program effectively connects individuals experiencing homelessness and substance use challenges with treatment and shelter without the presence of LE.
 - The Baltimore Crisis Response, Inc. (BCRI) in Baltimore City, Maryland operates a range of behavioral health crisis services. Approximately 70 percent of the individuals served are homeless or unstably housed. BCRI’s mobile crisis team, composed of a clinician and a nurse, is accessed through its mobile crisis hotline. The team is often called by shelter or transitional housing providers when a homeless individual experiences a crisis that is beyond the staff’s ability to effectively manage. While BCRI does not utilize a co-responder model, the team is sometimes called to accompany police to homeless encampments to help defuse a crisis or to encourage individuals in crisis to come into care. The BCRI is accessed through mobile crisis hotline. The team is well-trained to be aware of the environment. This program uses trauma-informed and gentle engagement techniques to encourage individuals to come into care.²³ This MCT demonstrates the ability of behavioral health and medical professionals to respond to an individual experiencing homelessness, reducing the need for LE.
 - Crisis Service Solutions in Phoenix, Arizona relies on a MCT to respond to behavioral health crisis situations. There is a quick warm hand-off between LE and the crisis receiving center. LE buy-in and collaboration with crisis services is critical to the success of these models.²³ When LE has a way to contact behavioral health crisis teams, they can provide a warm handoff of the individual experiencing homelessness and mental health crisis, providing the person with more appropriate services and limited contact with the criminal justice system.
2. **Crisis Stabilization Units. These locations serve individuals experiencing homelessness (and potentially SUDs and/or mental health challenges) following contact with crisis services.**
- The CAHOOTS MCT in Eugene, Oregon is utilized when a homeless individual is considered to need acute care in an inpatient setting. The CAHOOTS team facilitates transport and transition of care at the hospital ED and ensures that the person is triaged. If

an individual chooses police transport, CAHOOTS staff stays with the person and similarly facilitates transition of care at the ED. The team is able to resolve most crises by focusing on immediate needs, thereby diverting homeless individuals from further crisis or acute care.²³ The ability of CAHOOTS to stay with the person throughout this process helps to ensure that any connection with LE and EDs will be mitigated by behavioral health teams.

- Netcare Access in Columbus, Ohio provides step-down care for homeless individuals with mental illness following a stay in its Crisis Stabilization Unit (CSU) through a nine-bed crisis residential program called Miles House funded by the Franklin County Alcohol, Drug and Mental Health system. The program also serves individuals discharged from psychiatric inpatient units. It provides for a stay of up to two weeks, during which individuals can apply for and access transitional housing, also funded by the county, or other available housing resources in the community. Peer Specialists work to support homeless individuals as they transition from the CSU back to the community, and provide recovery supports for those who choose a brief stay at Miles House while gaining access to housing and other community resources.²³ Providing substance use treatment, housing services, and peer support are effective ways of serving individuals experiencing homelessness without involving LE.
- BCRI in Baltimore City, Maryland facilitates an individual accessing a bed in BCRI's Crisis Residential Unit if the assessment warrants it. The individual is returned to the homeless provider's setting once stabilized. BCRI operates 21 psychiatric crisis beds and 18 SUD treatment beds that offer medical withdrawal from substances. Case managers work to transition homeless individuals to ongoing treatment, housing, and other supports post-care. Case managers actively work to make referrals to these providers and to connect individuals with benefits and entitlements. BCRI is able to effectively connect homeless individuals with housing once they are stabilized through direct partnerships with transitional and permanent housing providers. The program provides individuals with 30 days of medications either as a bridge while they wait for prescribing appointments or in the event their Medicaid coverage has lapsed. This service makes housing providers more receptive to warm handoffs following crisis care.²³ This program provides a bridge, including housing services, rather than sending an individual into the criminal justice system or an ED and back to the streets, minimizing current and future LE connection.

3. **Collaborating between and among Behavioral Health Services, Homeless Housing Systems, and Law Enforcement.** In terms of crisis response, short stays in crisis receiving and stabilization settings allow homeless individuals to continue to be engaged as they begin the process to access housing and other needed treatment, services, and support, while reducing contact with law enforcement and emergency medical services.

- Contact referrals into the local homeless response system, as well as in-house staffing for warm handoffs once an individual is ready to transition from crisis care, is an effective combination of strategies for ensuring continued engagement and linkages with longer-

term resources. Coordination with appropriate housing and behavioral health services for individuals experiencing homelessness can reduce future contact with LE.

- Proactive collaboration with homeless housing systems and law enforcement is essential, including information sharing and warm handoffs. If the crisis program is called to respond to a homeless individual, the program should engage homeless providers to share information on the best ways to contact the individual's homeless outreach teams, shelter staff, or case managers, in order to garner as much information as possible to support crisis triage and response, and to facilitate a transition back into services as applicable once the individual is stabilized. When homeless housing systems and LE coordinate efforts, experts in housing and behavioral health can provide the individual with appropriate services instead of furthering contact with LE.
- Continuum of Care (CoC) providers are local entities that coordinate HUD's homelessness assistance grants. They each input data into the Homeless Management Information System (HMIS). This data-sharing collaboration assists crisis services to quickly locate participants, as well as tap into collateral contacts that can be leveraged to create sustainable warm handoffs from crisis services. Crisis programs like BCRI and CAHOOTS use flexible funds to support their own staff who link people willing but not otherwise engaged with housing, treatment, and supports. Staff such as these in either system can be important connectors between the two.²³ MOUs establish clear roles and responsibilities for each entity. These partnerships can lead to broader knowledge and collaboration at the systems level where MOUs can be created as well. When behavioral health, homeless housing systems, and LE coordinate efforts, persons experiencing homelessness and behavioral health crises can be connected to the correct services without further engagement with LE.

4. Healthcare Recommendations for Persons Experiencing Homelessness. By improving access to healthcare for persons experiencing homelessness, many challenges can be addressed by appropriate providers without involving law enforcement.

- Evidence-based practices like Assertive Community Treatment (ACT) and Critical Time Intervention (CTI) models of care have proven effective. ACT has multi-disciplinary care teams and intensive services that have been shown to reduce homelessness and improve mental health. CTI is a care coordination model for people with SMI transitioning from institutional care to community settings, specifically designed to prevent homelessness and other negative outcomes. Both of these models emphasize limited caseloads, which is a vital element in achieving desired outcomes.
- To improve institutional discharge protocols, state mental health programs can establish model policies, standardize them across many venues of care, and require adherence to these standards as a condition of contractual agreements. Regularly evaluating discharge outcomes can shed light on where targeted improvements and resources are needed.

- Medical respite care is another option for discharge, with these programs serving as a stabilizing venue to further develop a longer-term care plan, apply for benefits, and identify permanent housing options. To increase community capacity along a CoC, there should be short-term crisis response and long-term residential stability, as well as workforce training to increase skills and prevent burnout.
- Safety net providers such as Federally Qualified Health Centers, Community Mental Health Centers, and Certified Community Behavioral Health Clinics (among others) are critical partners who can help identify needed resources and strategize where additional capacity could have the largest impact. Overall, integrated care models, and harm reduction and trauma-informed approaches to care, are essential for this population.²⁵

5. ***Supportive Program and Policy Recommendations for Persons Experiencing Homelessness.*** **Individuals experiencing homelessness or income insecurity are supported by these programs which help to reduce crisis and help stabilize individuals post-crisis, reducing LE involvement.**

- Supportive housing is an evidence-based strategy to improve health, reduce total costs of care, and decrease use of inpatient psychiatric hospitals by combining healthcare and support services with housing. That said, firmer self-sufficiency focused requirements and a trauma-informed care approach are necessary to ensure supportive housing efforts are effective in achieving these goals.
 - To address some income challenges, the SSI/SSDI Outreach, Access and Recovery (SOAR) program increases access to benefits for people with disabling mental and substance use disorders, increasing access to benefits for people with behavioral health issues who are experiencing (or at risk of) homelessness.
 - Supported employment programs also work with people experiencing homelessness by helping link individuals to employment and income, with the aim of establishing a path to housing and greater self-sufficiency.
- Other support services include street outreach and intensive case management, which include outreach to areas where people experiencing homelessness congregate (encampments, public libraries, soup kitchens, shelters, etc.) and engagement in intensive case management and care coordination. Advocating for programs promoting peer specialists, community health workers, and other supportive roles can produce better outcomes, particularly when employing those with lived experience and building career ladders for these individuals to bolster further employment opportunities.²⁴

²⁵ [Going Home: The Role of State Mental Health Authorities to Prevent and End Homelessness Among Individuals with Serious Mental Illness \(2018\).](#)

VII. Models Addressing Children's Services that Reduce Police Involvement

1. **Mobile Crisis Intervention.** Children need access to mobile crisis interventions that can serve them at any time or place. These services include crisis call centers, mobile crisis teams, peer support, and community-based services. The availability of these resources reduces the need for law enforcement to be involved in children's crises.
 - More robust mobile crisis interventions (MCI), defined as “on-site, face-to-face crisis response” 24/7/365 for youth in a behavioral health crisis, are needed, including the ability for a comprehensive behavioral health assessment, intervention, stabilization and coordination.¹⁰ MCI has allowed crises to be addressed where they occur - be it at home, in schools, or elsewhere in the community. The services include in-home follow up after the crisis.
 - Emergency Mobile Psychiatric Services (EMPS) is part of Connecticut's youth mobile crisis service, and has demonstrated significant reduction in ED visits and positive outcomes. The 2014 average cost of an inpatient stay for Medicaid-enrolled children and youth was \$13,320, while the cost of Mobile Response and Stabilization Services (MRSS) was \$1,000, a net savings of \$12,320 per youth.
 - Mobile Crisis Intervention Services in Connecticut are available at no cost to all youth in the state under age 18. A single statewide call center, currently accessed by dialing 2-1-1, deploys providers to the crisis location. The providers are comprised of 160 trained behavioral health professionals from 14 different sites, allowing for on-site response within 45 minutes of when notified that a child is experiencing a behavioral health need or crisis. Mobile crisis clinicians have specific safety protocols that help determine when back up LE response is needed and how it should be coordinated. Mobile Crisis provides ongoing care to youth and families for up to 45 days to offer stabilization and linkages to ongoing behavioral health support.¹¹ Since data collection began in 2011, the number of Mobile Crisis response episodes of care increased by 54%, with 14,585 episodes in 2018 alone. For two consecutive years, schools have provided the greatest proportion of referrals to Mobile Crisis (44.3% in 2018). Schools often use Mobile Crisis as an alternative to transporting a child to the ED or contacting LE. A recent study demonstrated that, over a period of 18 months, youth using Mobile Crisis had 25% lower ED use than a comparable group. In Fiscal Year (FY) 2013, EDs referred to EMPS 1,121 times and 553 referrals were coded as “inpatient diversions.”¹³ Most (88%) of parents or guardians report satisfaction with Mobile Crisis and 2018 data demonstrate significant decrease in problem severity and increase in functioning among youth who received Mobile Crisis. Models such as these offer guidance to other jurisdictions considering expanding strategies of non-LE based youth crisis response.¹⁰

- Children’s Crisis Outreach Response System (CCORS) in Colorado has served 4,445 unique youth with a total of 5,438 service records. Out of the 5,438 total service records, only 15 (fewer than 1 percent) indicated that the CCORS encounter ended with a foster care placement. Between 2013 and 2015, CCORS was successfully able to divert 91 to 94 percent of hospital admissions. This saved \$3.8 to \$7.5 million in hospital costs and \$2.8M in out-of-home placement costs.¹³ The ability of this crisis response team to divert children from foster care demonstrates the effectiveness of providing the appropriate services instead of child welfare/protective services or LE.
- Children’s Rural Mobile Crisis Response Team (RMCRT) in Nevada had 86 percent of youth successfully diverted from the hospital in 2017 and served 243 youth and families across rural Nevada.¹³ The call volume has increased in recent years. The rural team intends to expand coverage using telehealth and has already equipped many of its rural schools, hospitals, and Juvenile Detention Centers with the telehealth program the RMCRT uses for interventions, allowing for more efficient crisis response.¹¹ The RMCRT also developed an agreement with the Nevada Rural Hospital partners to treat youth in EDs. Under the agreement, RMCRT connects via video or in-person to reduce unnecessary inpatient care, which otherwise can involve hours-long transit to Reno or Las Vegas.¹³ This comprehensive system allows children to be served in an appropriate crisis response setting instead of reverting to juvenile detention centers or hospitals.
- Children’s System of Care in New Jersey uses a single contracted systems administrator (currently PerformCare) to authorize Mobile Response and Stabilization Services (MRSS) as part of a comprehensive, high-quality children’s behavioral health delivery system. Care management and family support organizations, schools, and other community partners can access a 24/7 toll-free number and follow the menu prompts provided for an urgent situation. The help-line staff ask a series of questions to determine if the child should be evaluated for hospitalization; if so, the family or caregiver is referred to a local screening center. The child welfare agency’s use of MRSS for children ages 4 and older who are removed from home to foster care has shown outcomes that include zero placement disruptions due to behavior.¹³ The services provided by this crisis care system allows children to stay with their family and receive the necessary support without involvement of the juvenile justice system.
- Children’s Behavioral Health Initiative in Massachusetts maintains a statewide 24/7 toll-free number. To access services, a caller enters their zip code to receive the number of the closest Mobile Crisis Intervention (MCI) provider. 24/7 crisis hotline is the primary way people are referred to MRSS. Hotline operators field referrals from a variety of sources (parents/caregivers, schools, LE, etc.), triage the call, and dispatch mobile intervention teams when necessary. Crisis assessments are conducted in a hospital ED if the youth presents an imminent risk of harm to self or others, if youth and/or parent/caregiver refuses the required consent for service in the home or an alternative community setting, or if a request for MCI services originates from a hospital ED. In instances in which a youth is

sent to an ED, the MCI team mobilizes to the ED. The number of hospital-based interventions are closely monitored to ensure that MCI services are delivered primarily in community settings.¹³ MCI services are available to children covered by MassHealth (Massachusetts Medicaid), Medicare, and some commercial insurance plans, as well as the uninsured; the toll-free number assists families with insurance/coverage questions. MCI service providers coordinate with the child's primary care provider, other care management programs, and/or other behavioral health providers in the delivery of MCI services. By providing comprehensive, community-based services, children receive the support they need without coming into contact with the juvenile justice system.

- Children's Crisis Outreach Response System (CCORS) in Seattle/King County, Washington provides immediate services for children and youth ages 3 to 18. CCORS staff will come to a private home or other community setting to assess and stabilize children and youth who pose a risk of harm to self or to others. Staff works to provide immediate stabilization, same-day and next-day appointment coordination, emergency psychiatric assessment and medication review, in-home support services, school coordination, parent education, and linkage with long-term services.¹³ These immediate and comprehensive services provided in the locations that children spend time allows resources to be provided without utilizing LE.
- Behavioral health aides (BHA) as part of the MRSS team in Oklahoma focus on community stabilization. The BHA provides stabilization services to the youth and family by assisting the child and family team following the incident or stressor that precipitated a crisis. In Oklahoma, the MRSS teams are housed with community mental health partners and could be housed with other community organizations such as the YMCA/YWCA, or the police department. The BHA builds a relationship with the youth, and provides behavioral skills development services, securing natural supports, and assisting with respite services to families as needed. These stabilization strategies are effective for recovery and reintegration during a transition from acute intervention or crisis stabilization to the community. MRSS teams may include paraprofessionals, as in Oklahoma, with deep community ties to facilitate access to local supports and/or peer support services.¹³ These services allow children to stay in the community while they get services for their crisis, and do not require interaction with LE.
- In Oakland Community Health Network in Oakland County, Michigan, the local behavioral health authority, works with Common Ground, a community mental health agency to provide 24/7 crisis services, which include peer support.¹³ Community mental health clinicians and peers provide effective services for children without utilizing LE. Assessment in mobile response and stabilization services can use a standardized screening and assessment tool, such as the Child and Adolescent Strength and Needs (CANS) or the Child and Adolescent Service Intensity Instrument (CASII). These tools can help to ensure that services are delivered appropriately and effectively. A common assessment tool can assist in identifying children, youth, and young adults who present with high-risk

behaviors, uncovering the child’s and family’s strengths and needs, and determining which services and supports are most appropriate to meet identified needs. Within a comprehensive children’s behavioral health delivery system, a common assessment tool allows various child-serving agencies to “speak” the same language and ensures a common understanding of the child’s and family’s strengths and needs.¹³ By keeping open communication and monitoring of a child’s behavioral health needs, reliance on LE can be reduced.

- Strategies for encouraging coordination and collaboration have MRSS teams co-located with system partners like community mental health centers and/or LE agencies, and include the use of crisis text lines, warm lines, and suicide prevention hotlines. Staff is often located in a separate location from the organization’s headquarters, preferably in the community, and includes paraprofessionals on MRSS teams who understand the culture of the community and/or can provide peer support.¹³ The availability of these interventions throughout the community allow children to access these resources for behavioral health crises and reduce the involvement of LE.

2. **School Mental Health Models.** These models are examples of school-based interventions that provide students with the opportunity to receive services at any time without needing to involve law enforcement in behavioral health issues or crises.

- School-based clinics for children and youth are important to help to assure easily accessible services. The promotion of these clinics to identify and treat mental health issues early and increasing capacity in the treatment system to serve low-income children and youth will link individuals to resources earlier and enable receipt of comprehensive care. Support services must be linked to the entire family, such as connection to housing assistance and other benefits, family therapy, and coordinated care plans.²⁴ Ensuring that mental health services are available to all students, regardless of socioeconomic status, and monitoring students to provide early intervention, can reduce the need to utilize LE in schools.
- Comprehensive School Mental Health Systems (CSMHS) are increasingly installed in schools.¹¹ These systems provide a full array of tiered services, often referred to as multi-tiered systems of support (MTSS); and include universal behavioral health promotion activities for all students. There are selective prevention activities for those most at risk of developing behavioral health conditions. Early intervention services, such as clinical assessment and treatment, for those students who screen positive for behavioral health conditions. These systems rely on meaningful partnerships between school systems and community programs so that children are supported by collaborative school- employed behavioral health professionals and community behavioral health providers. The components of CSMHS are divided into tiers: *Tier 1*: Promotion of positive social, emotional, and behavioral skills and overall wellness for all students; *Tier 2*: Supports and early intervention for students identified as at-risk for mental health concerns; and *Tier 3*:

Targeted interventions for students with serious concerns that impact daily function.²⁶ The presence of comprehensive supports throughout the school system for all children allow schools to better serve all students, particularly those who indicate needing services, and reduce the need for LE involvement.

- Social Emotional Learning (SEL) programs are increasingly utilized at schools across the nation, with students demonstrating significantly greater social-emotional skills and significantly fewer conduct problems, emotional distress, and substance use problems than their peers who do not participate in such programs.¹¹ Behavioral health treatments delivered in schools have demonstrated success at reducing mental illness, including anxiety and depression, post-traumatic stress, behavior disorders, and substance use problems. These services can reduce the need for LE to be involved in behavioral issues, mental health challenges, or substance use.
- School Emotional and Behavioral Health (EBH) Crisis System is divided into several tiers in order to implement each aspect of the system for comprehensive services: Tier 1: Universal Prevention: Safe School Ambassador Program, Enhanced Positive Behavioral Supports (PBS); Tier 2: Early Identification: Kognito At-Risk online mental health training for educators and staff; Tier 3: Assessment and Service Linkage: Mapping existing school/community EBH supports, streamlining referral and assessment processes, creating EBH Coordination Teams comprised of school and community EBH partners; Tier 4: Crisis Response: Develop a standardized EBH Crisis Response Protocol, Life Space Crisis Intervention training for educators and staff; and Tier 5: Post-Crisis Relapse Prevention: Process for Crisis Assessment and Relapse Prevention (P-CARP). The impact of school EBH crisis systems include the following: an increase in school staff knowledge and preparedness to address EBH issues across the continuum; an increase in student actions and behaviors to prevent mistreatment and improve school climate; more on-site crisis response and threat assessments; 56% fewer suspensions and 75% fewer office referrals.²⁵ These benefits can reduce the need for LE to be involved in schools.
- Community partners of multiple types of organizations may enhance the collaborative care system for a community, such as mentorship programs (e.g., Big Brother/Big Sister), after school programs, recreation and parks programs, youth sports leagues, youth and family advocacy organizations, faith organizations, and youth groups.¹¹ These links between schools and other community programs in which students spend time increase comprehensive support and resources while not involving LE in behavioral health needs.

²⁶ [Presentation on Improving the Child and Adolescent Crisis System: Moving from a 911 to a 988 Culture \(Sharon Hoover, 2020\).](#)

3. **Examples of School Districts Implementing School Mental Health Models.** These schools have implemented different aspects of school mental health models in order for their schools to provide more comprehensive services and interventions for their students, which can reduce reliance on law enforcement.

- District of Columbia Public Schools (DCPS) have made high-quality school mental health a priority in a large, urban school district that employs 266 school social workers and psychologists to serve more than 48,000 students across 113 public schools. They developed a Workload Analysis that includes recommendations for school administrators and teams to optimize social work and psychology service delivery time in the school building. DCPS worked on advancing social and emotional learning curricula in classrooms by collecting data on current task-sharing practices among educators and mental health providers. They use School Mental Health Quality Assessment, a quality indicator within the SHAPE System, which shows substantial growth nearing “Mastery” in Resource Mapping.²⁷
- Seneca Family of Agencies and Education for Change Public Schools (Seneca/EFC) in Oakland, California, through its school mental health system, has significantly increased its screening data collection effort. The program includes assigning care coordinators to this task and providing feedback to school staff and administrators about student strengths and needs, resulting in more than 2,000 students screened during the 2018-19 school year. Seneca/EFC also surveyed clinician-reported barriers and successes to using screening data and is currently training and supporting clinicians’ ability to integrate this data into decision-making and collaborative service planning with the school team.²⁶ This increased assessment capability allows schools to more effectively serve its students comprehensively which can reduce a need to utilize LE.
- Wisconsin’s model reflects the adoption of a School Mental Health Framework in the state. This framework defines and outlines key elements to implement comprehensive school mental health systems in districts and schools across Wisconsin. The framework offers the foundational elements to build and sustain school mental health systems. It is designed to integrate mental health and wellness supports into a multi-tiered system of support.²⁶ By integrating mental health supports throughout the system, schools can support children’s behavioral health needs without the presence of LE.
- Massachusetts School Mental Health Consortium (MASMHC) advances school mental health quality and sustainability to: (1) increase awareness of mental health problems; (2) promote mental well-being through education and prevention activities; and (3) increase access to, and utilization of, evidence-based mental health services and supports. MASMHC is comprised of school districts committed to improving school mental health

²⁷ Hoover, S., Lever, N., Sachdev, N., Bravo, N., Schlitt, J., Acosta Price, O., Sheriff, L. & Cashman, J. (2019). *Advancing Comprehensive School Mental Health: Guidance From the Field*. Baltimore, MD: National Center for School Mental Health. University of Maryland School of Medicine.

services and supports available to students in Massachusetts. Member districts voluntarily participate based on their recognition of the significant mental health and substance use needs of students, and work with the MASMHC through shared learning, collaboration, and consultation. Member districts attend monthly MASMHC meetings, complete needs assessments, participate in professional development, develop action plans to advance school mental health in their own community, and share best practices and policies.¹³ These schools' collaboration to provide comprehensive mental health services to their students allows them to implement effective supports and assessments without utilizing LE.

4. **Pediatric and Psychiatric Services. These services include primary care services and psychiatric services that can provide children with resources to address behavioral health needs without involving law enforcement.**

- Pediatric Primary Care can provide families with de-escalation approaches and behavioral health checkups during routine physical checkups. For more complex issues, collaboration and behavioral health support for pediatricians by behavioral health providers has emerged as an effective approach, with improved behavioral health outcomes for youth compared to standard care.¹¹ The involvement of primary care physicians can increase knowledge of and access to resources to promote mental health that do not involve LE.
- Population-based care (systematic efforts to screen or track all patients for a condition and track outcomes), measurement-based care (using validated tools to identify and monitor responses to treatment of particular behavioral health conditions), and evidence-based behavioral health services (specific psychological interventions, such as motivational interviewing, problem-solving, psychotropic prescribing, psychoeducation) can be useful in integrating mental health services into pediatric care. A guide for initiating collaborative behavioral health care within pediatric primary care has been devised by the American Academy of Child and Adolescent Psychiatry.¹¹ These strategies integrate mental health into pediatric care and provide children with increased access to services and monitoring of behavioral health needs, which can reduce the need for LE involvement in behavioral health crisis in children and adolescents.
- Child psychiatry access programs (CPAPs) are facilitated referral models (coordinated care model) where pediatricians have rapid (within an hour) access to behavioral health providers located off-site, who consult with pediatricians about mental health conditions, including crises, but do not assume direct care of the patient.
- Massachusetts Child Psychiatry Access Program (MCPAP) has remained the model most states now emulate. CPAPs have been implemented in over 30 states in the past decade. Initial calls from the pediatrician are immediately triaged by a MCPAP care coordinator who either: (a) provides the pediatrician viable behavioral health resources (e.g., a counselor appropriate for the child's condition, who is geographically feasible, and who takes the family's insurance), or (b) connects the pediatrician, within 60 minutes, to a

MCPAP child psychiatrist, psychologist, or social worker to discuss the case and plan treatment. While the MCPAP behavioral health provider does not assume care of the child/family, they remain a consultation support for the pediatrician to manage the case, or until care is transitioned, if necessary, to a local behavioral health provider for ongoing treatment. Over 95% of Massachusetts pediatricians participate in the program, and satisfaction with services has remained high since creation of the program.¹¹

- National Network of Child Psychiatry Access Programs (NNCPAP) is a national infrastructure of 30+ state programs to support pediatric primary care physicians as they manage the psychiatric issues of their patients. These programs initially relied on remote call centers, but now many include face-to-face evaluations of patients with unclear diagnoses, and also telepsychiatry meetings with patients. These CPAP programs provide an alternative rapid route for children and families experiencing urgent behavioral health needs, and also an opportunity for mass distribution of relevant mental health information (e.g., crisis call center information, de-escalation approaches for families) through the NNCPAP network that allows relevant information to be applied to specific regions or States.¹¹ These comprehensive systems provide pediatricians with the resources to connect patients to the behavioral health services they need in a fast and effective way without involving LE.

Conclusion

It is critical that crisis services systems be designed to serve anyone, anywhere, and anytime. The *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit*, developed by SAMHSA (<https://www.samhsa.gov/find-help/implementing-behavioral-health-crisis-care>), advances national guidelines in crisis care within a toolkit that supports program design, development, implementation and continuous quality improvement efforts.²⁸ This toolkit provides guidelines to build a comprehensive and integrated crisis services system, the first line of defense in preventing tragedies and waste of resources, including reducing police contact with individuals experiencing a crisis related to mental health, substance abuse, and/or homelessness. This document provides best practice examples of programs which decrease contact with LE for persons with mental health problems, substance use issues, and/or who are experiencing homelessness. Although no one system works in all settings, these examples indicate that communities are making tremendous strides in improving behavioral health crisis services and reducing police involvement. This Report has provided an overview of successful approaches to crisis care and access to ongoing mental health, substance use, and services focused on housing and related social needs. Communities across the nation can use the information about service needs of the population experiencing behavioral health crisis and interventions that have been utilized successfully to determine what might be most useful in addressing these issues in their areas. When communities commit to the approach of SAMHSA’s National Guidelines and dedicate resources,

²⁸ <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

they are likely to reap the benefits of better care, better health outcomes, lower costs, and improvement in the community environment.

APPENDIX I: Budget Proposal for Programs to Address Community Policing Efforts

SAMHSA recommends the following appropriated activities consistent with the 2021 Budget to support the ultimate goals of the Executive Order.

Mental Health Awareness Training:

- The identification of signs and symptoms of mental illness are critical to addressing these conditions as early as possible. Early intervention can help to prevent further progression of mental illness and potential tragedy.
- This program provides general mental health/signs and symptoms of mental health crisis or mental illness training to those not necessarily trained in mental health. This training is made available to general members of society who are on the front lines of interacting with individuals including: first responders, members of the faith community, family members, and school personnel.
- In addition, Crisis Intervention Training (CIT) teaches law enforcement and first responders methods of assessing and safely interacting with individuals who may be exhibiting signs of serious mental illness e.g.: psychosis and agitation.
- **FY 2021 Budget: \$22 million**

Crisis Intervention Services:

- 24/7 crisis intervention services would provide behavioral health services for individuals with acute mental health crisis.
- These crisis services would relieve burden on law enforcement by providing a means by which they can safely deliver a person to needed care and are not required to stay with the person as trained mental health professionals would be available.
- These services would evaluate and provide direct services or assist a person with obtaining hospitalization if needed as well as linkage and follow up to assure that entry of the person to a treatment program was successful.
- The FY 2021 President's Budget requested a 5 percent increase in the Mental Health Block Grant with a set aside based on the increase to promote and develop crisis services across all states.
- **2021 Budget: \$35 million (NEW PROGRAM)**

Expansion of First Episode Psychosis (FEP), Assisted Outpatient Treatment (AOT) and Assertive Community Treatment (ACT) Programs:

- These programs are recognized evidence-based practices which serve individuals 1. in early phases of severe mental illness (SMI), the majority of which have onset in adolescence and young adulthood, such as first episode psychosis (FEP) or 2. Individuals who have longer histories of SMI and are served by ACT or AOT. These programs are fundamentally based on the strong evidence that comprehensive services delivered within communities via multidisciplinary teams of behavioral health professionals can lead to improved outcomes in SMI.

- SAMHSA funds the FEP program through a 10% set aside in the mental health block grant. SAMHSA has small programs in AOT (\$15M) and ACT (\$5M) currently.
- Intervening at the stage of a first episode of psychosis can prove to be life changing/saving. Providing the needed care as early as possible is imperative in preventing the further progression of mental illness and consequences of such.
- ACT/AOT programs are critical in ensuring individuals with serious mental illness are not going untreated. The treatment of these individuals via the type of comprehensive care offered in this program can prove exceptionally beneficial. SAMHSA's AOT program has shown significant decreases in hospitalization, ED visits, criminal justice involvement and substance use (see draft report to Congress on AOT programs).
- Current programs are insufficient in scope to reach all who are at risk.
- These programs can assist with the homeless population with serious mental illness.
- These programs reduce the burden of SMI on law enforcement by providing intensive team- based care to the most seriously mentally ill.
- **2021 Budget: \$126M (EXPANSION OF EXISTING PROGRAM)**

Criminal Justice Programs (Early Diversion and other Innovations):

- Serious mental illness is disproportionately represented in incarcerated populations; the majority of whom do not receive treatment of their SMI while incarcerated. This proposal supports the development and implementation of early diversion programs so these individuals do not become incarcerated. Instead, treatment services are made available to address an individual's mental illness. Further, this program would support the implementation of innovative behavioral health and community police partnerships, for example, co-responder programs that include law enforcement and mental health professionals.
- SAMHSA has further bolstered efforts to serve individuals in the criminal justice system through making explicit the allowability of the use of the Mental Health Block Grant to provide services while an individual is incarcerated. This step along with the proposed funding increase for early diversion programs here serves as an important step to address the mental and substance use disorder treatment needs of this population.
- **2021 Budget: \$9M (EXPANSION OF EXISTING PROGRAM)**