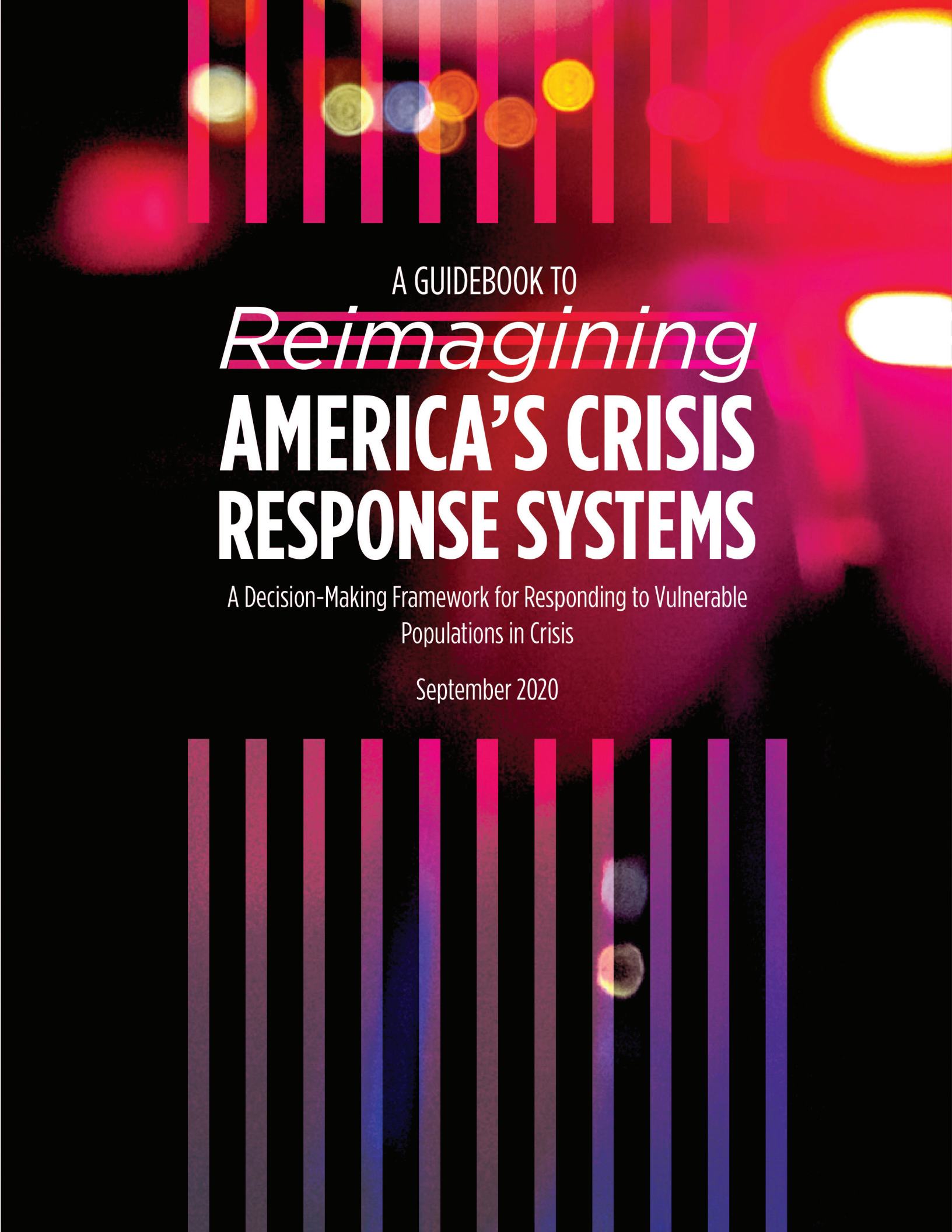

A GUIDEBOOK TO

Reimagining AMERICA'S CRISIS RESPONSE SYSTEMS

A Decision-Making Framework for Responding to Vulnerable Populations in Crisis

September 2020

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A Decision-Making Framework for Responding to Vulnerable Populations in Crisis

The Abt Associates project team (Meg Chapman (Project Director), Holly Swan, Samantha Karon, Elyse Yarmosky, Sarah Steverman, Puneet Kaur, and Daniel Smith) thank Arnold Ventures for their generous support of this work (Grant ID: 19-20674). The views expressed in this guidebook are the authors' and do not necessarily reflect the view of Arnold Ventures.

CHAPTER ONE

WHO IS THIS GUIDEBOOK DESIGNED FOR?

This guidebook is for policymakers and emergency response agencies (particularly law enforcement, fire, and EMS/EMT agencies) considering implementing or expanding crisis response programs in their communities.

WHAT DOES THIS GUIDEBOOK PROVIDE?

We provide a framework for decision-making to improve response to individuals experiencing a crisis as a result of substance use, mental health, or homelessness challenges. The framework is grounded in a systematic review of the range of approaches that have been implemented by first responder agencies in the United States and organizes specific programs (for example, the Oregon-based CAHOOTS program) into program types based on common features (such as responding agency, response activities, and desired outcomes).

In this guidebook, when we refer to **people experiencing SMI or SUD and in crisis**, we are including people who may be presenting symptoms that are common to serious mental health or substance use conditions, but may not have necessarily received an official diagnosis.

We include published examples of programs throughout the guidebook to demonstrate how programs have been operationalized by agencies in specific communities across the country. We also present a series of questions to consider when determining the type of program that would meet the needs of your community.

By organizing programs into types, agencies can use this guidebook as a starting point to select a particular program to adopt, or develop their own program using the components outlined for a particular type of program.

WHAT DOES THIS GUIDEBOOK NOT PROVIDE?

We did not design the guidebook to provide a compendium of individual programs being implemented across the country, nor did we design it as a how-to-guide for implementing or scaling a particular program. Rather, the guidebook provides a summary of the types of programs that jurisdictions have implemented to improve crisis response in their communities and introduces the factors that jurisdictions may consider when determining whether and which types of programs to implement, replicate, or scale. The guidebook is intended as a starting point for decision-making and is not meant to be exhaustive of all options and considerations.

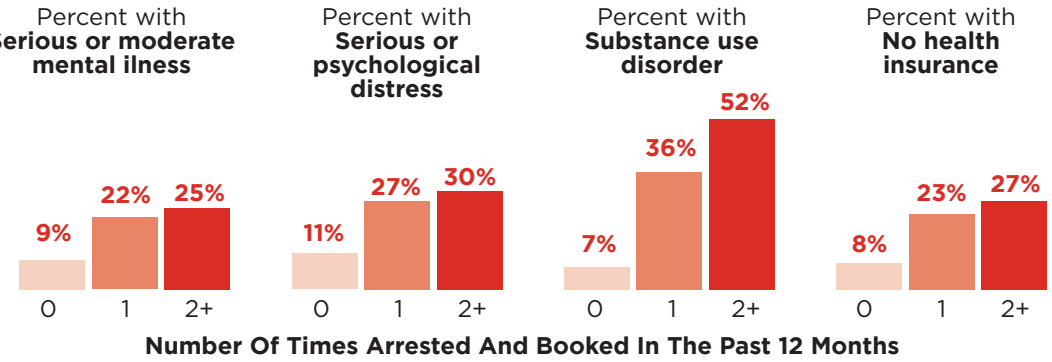
WHY IS THIS GUIDEBOOK NEEDED?

Homelessness and untreated behavioral health conditions are at the root of many crisis-related calls for service.[1, 2] For individuals experiencing homelessness, SMI or SUD, a lack of affordable housing and public behavioral healthcare services makes it difficult to access routine, preventive care. Lack of adequate health and housing services puts these individuals at risk of worsening behavioral health conditions, which often result in a call to 911, a visit to the emergency

Crisis-Related Call for Service is defined as a health or safety emergency caused primarily by a mental health condition, substance use, or lack of housing

department, or arrest and entry into the justice system.[2] This combination of factors has led to the disproportionate representation of vulnerable populations in the justice system, and has over-burdened the emergency response system in the United States with situations that would be more appropriately handled by community service and treatment providers.

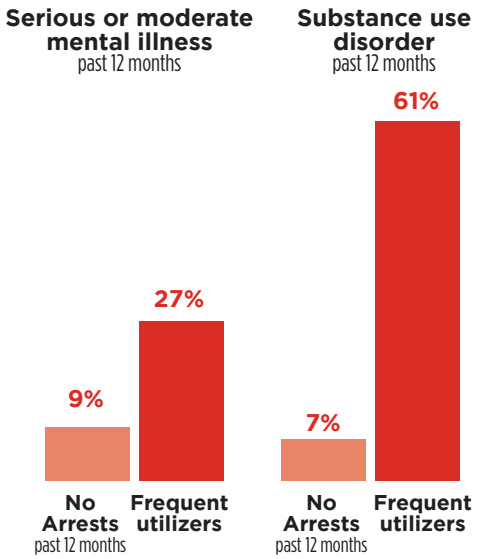
PEOPLE WITH MULTIPLE ARRESTS HAVE SERIOUS HEALTH NEEDS



*Recreated from https://www.prisonpolicy.org/reports/repeatarrests.html

Justice involvement (including police contacts, as well as incarceration) and emergency services are costly and may actually cause harm to rather than help these vulnerable populations. Moreover, these patterns tend to be cyclical, resulting in the frequent use of the justice and emergency response systems among these populations, rather than more appropriate and cost-effective community-based behavioral health and social services.[2]

RATES OF MENTAL ILLNESS AND SUBSTANCE USE DISORDER ARE MUCH HIGHER AMONG "FREQUENT UTILIZERS" OF JAILS



*Recreated from https://www.prisonpolicy.org/reports/repeatarrests.html

As the emergency response system's key institutions, law enforcement agencies and fire departments (which often house emergency medical service (EMS) units) are in a unique position to intervene with these vulnerable populations before they enter the justice system or emergency response system (i.e., emergency departments).[1] To address disparities and to appropriately provide vulnerable populations with the services they need, communities are increasingly seeking to improve and expand models of emergency response to individuals experiencing moments of crisis. However, there is a lack of consolidated information on the various approaches that have been implemented across the country for policymakers to use to ground their decision making.

Key Takeaways

As communities consider approaches to minimize unnecessary engagement of law enforcement in non-criminal or medical matters and, if engaged, improve the nature of the response, this guidebook serves as a resource for considering how existing approaches may be scaled up or expanded to apply to a broader segment of the community.

CHAPTER TWO

HOW WAS THIS GUIDEBOOK DEVELOPED?

The Sequential Intercept Model

The Sequential Intercept Model (SIM) is a useful tool to identify multiples points or intercepts along the justice continuum where communities might intervene through programming designed to divert individuals away from entering or cycling through the criminal justice system and into community-based programming.[3]

EXHIBIT 1: THE SEQUENTIAL INTERCEPT MODEL, ADAPTED FOR THIS GUIDEBOOK

Intercept 0 Community	**Intercept 1** Emergency Response	**Intercept 2** Initial Detention/ Court	**Intercept 3** Jails/Courts	**Intercept 4** Reentry	**Intercept 5** Community Corrections

The original intercepts include interactions with community-based prevention and early intervention efforts (Intercept 0), law enforcement and crisis response systems (Intercept 1), initial detention and court hearings (Intercept 2), jails and courts (Intercept 3), reentry post-incarceration or institutionalization (Intercept 4), and community corrections (Intercept 5). This guidebook focuses primarily on Intercept 1, diversion by first responders prior to entry into the justice system. We also include Intercept 0 programs that aim to prevent crises from occurring or re-occurring if they are led by emergency response agencies.

Community-led prevention programs that operate at Intercept 0 (such as crisis hotlines, crisis centers, restoration centers) are outside the scope of this guidebook, but are important programs for preventing crisis-related encounters with first responders.[4, 5] As state and local jurisdictions explore and consider reforms to reallocate budget spending in their communities, they should keep in mind that scholars have argued that investing in an integrated community-based behavioral health system to appropriately serve the needs of individuals with SMI, SUD, and housing instability could yield both "fiscal and humanitarian" benefits.[6] (For additional resources on this topic, see Appendix B). In Chapter 5, we provide examples of how some states and jurisdictions have taken a comprehensive "next-level" approach to integrating and strengthening the systems encompassed by Intercepts 0 and 1 to improve crisis prevention and provide appropriate intervention for vulnerable populations.

Methods We Used to Find Programs

We identified the programs reflected in this guidebook through a systematic scan of the internet using combinations of search terms specific to first responder agencies (e.g., police, sheriff, fire, EMS, EMT, 911 dispatch), the target populations (e.g., homeless, mental illness, substance use, alcohol, drug), and programs of interest (e.g., crisis response, pre-arrest, diversion). We reviewed websites, news articles, or other online sources containing information about programs that are:

- Located on Intercept 0 or 1 of the SIM
- Currently or recently (within past 10 years) operating in the U.S.
- Designed to meet one or more of the following objectives
  - ✓ Increase the capacity of first responders to identify the signs of SMI, SUD, or homelessness.
  - ✓ Improve first responders' ability to de-escalate emergency situations.
  - ✓ Maximize diversion from the criminal justice system to treatment or other community-based services.

Next, we conducted a targeted search of academic databases (such as PsycInfo) and Google Scholar to identify peer-reviewed articles or other published research on the programs we identified. We then reviewed the research materials to substantiate information gathered from the internet, and to identify any existing evaluations or empirical research that had been conducted on our programs of interest. Through these activities, we developed an understanding of the way each program operated, as well as higher-level commonalities and differences between programs and whether there is any empirical evidence supporting each program.

The Process We Used to Develop Program Models and Program Types

Using documented and published descriptions of each of the identified programs (e.g., type of first responder, activities, objectives), we organized individual programs with shared characteristics into *program types*. After organizing individual programs into program types, it became clear that certain types of programs had more in common than others. Thus, we further categorized program types into overarching *program models*.

Using the SIM and starting with the highest level unit, we identified three *program models*: outreach and prevention (Intercept 0); intervention at 911 call (Intercept 1); and intervention by first responder at the scene of a crisis (Intercept 1). Exhibit 2 shows the relationship between program models and program types, and the specific programs within each type (see Appendix A for a glossary of program names and brief description of programs used to develop the framework). We describe the characteristics of each program model and type in the remaining sections of this chapter. In Chapter 3, we discuss factors for consideration based on the structures and activities for each of these program types.

EXHIBIT 2: EMERGENCY RESPONSE PROGRAM MODEL TYPES

Intercept 0
Community

Program Model: Outreach and Prevention

Program Type:
Specialized Outreach
- HOPE
- QOL

Program Type:
Paired Outreach
- BHRT
- CSOs
- CWP
- HELP
- HSD
- RREACT

Program Type:
Team-Based Outreach
- CARE
- CLEAR
- HOME
- HOST
- HOT

Voluntary Walk-In Programs
- Angel
- Hero Help
- LEAAP
- Safe Station

Intercept 1
Emergency Response

Program Model: Intervention at 911 Call

Program Type:
Specialized Dispatch
- 911-CIT

Program Type:
Embedded Dispatch
- CCD
- DCDP

Program Type:
Transfer to Crisis Center
- MHTP

Intervention by First Responder

Program Type:
Specialized Response
- CI Deputy
- CIT
- DART
- ECIT
- LADDER
- LEAD
- STEER

Program Type:
Embedded Co-Response
- BHRP
- CCR
- CIRT
- CRT
- CT Diversion
- EDGE
- MCAT
- MHST/U-MATTER
- PERT
- SMART/CAMP

Program Type:
Mobile/Virtual Co-Response
Mobile
- CAHOOTS
- CCRI
- CR288
- Diversion First
- EMCOT
- Grady EMS
- HEART
- MCRT

Virtual
- AMC
- CORE
- ETHAN
- Grand Care

Intercept 2
Initial Detention/ Court

Intercept 3
Jails/Courts

Intercept 4
Reentry

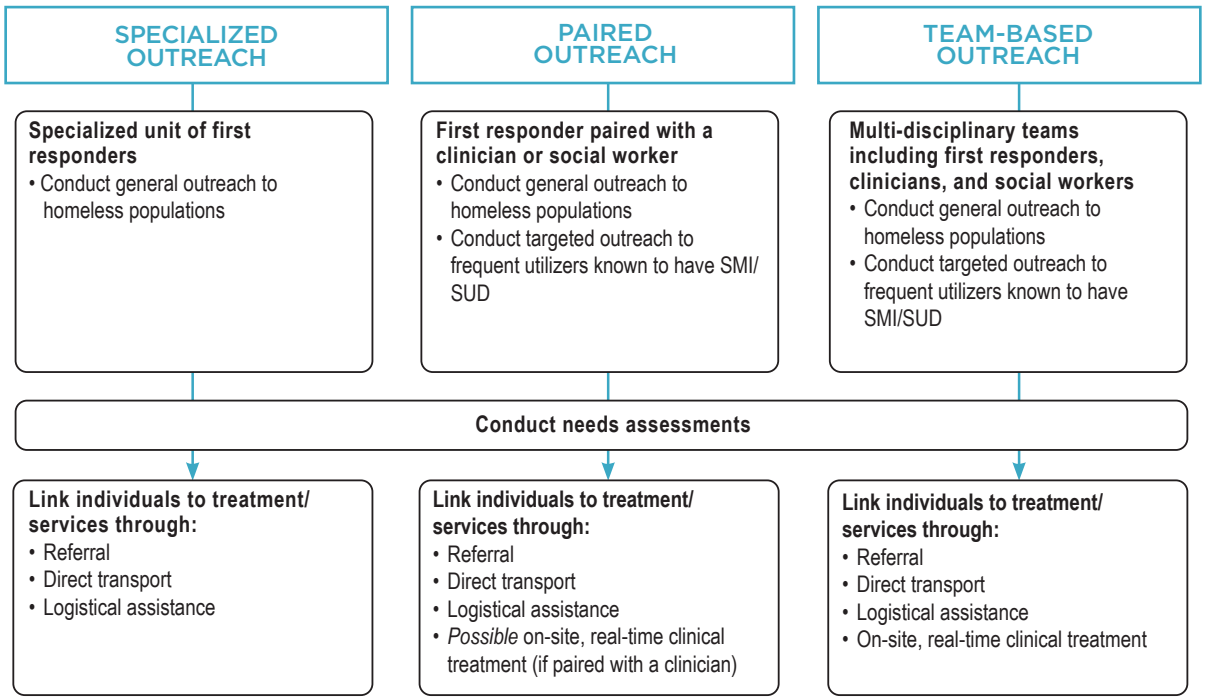
Intercept 5
Community Corrections

What are the First Responder-led Programs at Intercept 0?

PROGRAM MODEL: OUTREACH AND PREVENTION PROGRAMS

This program model contains types of programs that operate at Intercept 0 of the SIM and are focused on first responder led outreach to connect vulnerable individuals to needed services and prevent future crises. By analyzing the commonalities and differences between programs that operate on this point of the SIM, we identified four distinct program types: **specialized outreach**, **paired outreach**, **team-based outreach**, and **voluntary walk-in**. The first three types are the most comparable and are outlined in Exhibit 3.

EXHIBIT 3: INTERCEPT 0 PROGRAM TYPES: OUTREACH PROGRAMS



Specialized outreach represents programs led by specially trained first responders who conduct general outreach in areas with high rates of homelessness in order to identify individuals' needs (such as medical or behavioral health treatment, food or transportation services, state ID services) and provide those individuals with referrals or direct transportation to services to fill those needs.

Program Example

Quality of Life (QOL)

One example of a **specialized outreach program** is the Quality of Life (QOL) program in Indio, CA, which employs a permanent unit of two officers who provide logistical assistance to individuals experiencing homelessness in the form of offering meals, arranging haircuts, providing support to obtain drivers' licenses, as well as making referrals to substance use treatment if needed.

Practices in Modern Policing. (2018). https://www.theiacp.org/sites/default/files/2018-11/IACP_PMP_VulnerablePops.pdf

Program Example

Homeless Outreach and Positive Encounters (HOPE)

Another example of a **specialized outreach program** is the Homeless Outreach and Positive Encounters (HOPE) program, in which teams of plainclothes officers conducts outreach to individuals who are homeless, linking them to resources for basic needs, communicating with other service providers, and training other officers in crisis response principles with the goal of improving the relationship between police and community members experiencing homelessness. The team may also provide support for obtaining IDs and navigating the bureaucracies of further public support.

Practices in Modern Policing. (2018). https://www.theiacp.org/sites/default/files/2018-11/IACP_PMP_VulnerablePops.pdf

Paired outreach programs pair first responders with social workers or clinicians to conduct the type of general outreach described above, or targeted outreach to individuals identified as frequent utilizers of safety-net and public safety services. In programs where the pair includes a clinician (such as the Community Wellness Program (CWP) in Rhode Island or the Behavioral Health Response Team (BHRT) in Oregon), that clinician can provide on-site, real-time treatment (e.g., psychiatric screening, counseling, and suicide risk assessment, brief intervention) for individuals encountered who are in crisis. **Team-based outreach** mirrors paired outreach programs, except that outreach is conducted by multi-disciplinary teams composed of law enforcement, behavioral health clinicians, social workers, and EMT/EMS providers. As with paired outreach, the presence of clinicians in this program model enables on-site, real-time clinical treatment anytime an encountered individual is identified as being in crisis.

Program Examples

Homeless Outreach Team (HOT) and Community, Assessment, Response & Engagement (CARE) Initiative

One example of a **team-based outreach** program is Milwaukee's Homeless Outreach Team (HOT). Created by the city's police department, HOT is a multi-disciplinary team composed of police officers, mental health professionals, and social service providers who conduct outreach in areas with high rates of homelessness, such as temporary encampments. The program partners with Milwaukee County Housing First Initiative, which enables team members to refer individuals to low barrier, supportive housing. Another example of this type of program is the Community, Assessment, Response & Engagement (CARE) Initiative in Modesto, CA. Outreach is conducted by a multi-disciplinary team composed of law enforcement officers, a mental health professional, medical professionals (nurse and paramedic), and a case manager. Information gathered through general outreach is then shared with a separate team within the initiative, composed of representatives from the law enforcement and social service systems. This team then develops individualized intervention plans, facilitates referrals to treatment, and monitors case progress. These cases demonstrate how two jurisdictions use the same type of program, but different team structures, to address the needs of their respective communities.

Milwaukee police department targets homelessness. (2019, November 7). International Association of Chiefs of Police. https://www.theiacp.org/news/blog-post/milwaukee-police-department-targets-homelessness

Community Assessment, Response, & Engagement: CARE Program Report. (n.d.). Stanislaus County. https://www.stancounty.com/pdf/care-program-report.pdf

We also identified a fourth program type under this program model, **voluntary walk-in** programs, which is distinct from the types of programs described above. This type of program represents programs that take place within police or fire departments and commonly target individuals with SUD, particularly opioid use disorder (OUD). In this type of program, individuals voluntarily go to the police or fire department to seek treatment and are granted amnesty if in possession of illegal substances or paraphernalia. First responders then conduct eligibility screenings, which may include medical clearance, and refer the individual to needed treatment or services.

Medical Clearance refers to the process typically conducted by medical professionals (including emergency room physicians and paramedics) to assess an individual for any medical issues that require medical attention prior to receiving psychiatric treatment.

D'Orazio, J.L. 2015. "Medical Clearance of Psychiatric Patients: Pearls & Pitfalls" emDocs. http://emdocs.net/medical-clearance-of-psychiatric-patients-pearls-pitfalls/approaches-early-jail-diversion-collaborations-and-innovations

Program Example

ANGEL

An example of a **voluntary walk-in program** is the ANGEL program in Gloucester, MA. Operated by the Gloucester Police Department, the ANGEL program provides amnesty to individuals seeking help entering into treatment and recovery from OUD. When individuals come to the police department seeking this type of help, police officers screen them on site for eligibility, and if deemed eligible, they are referred to detox or a short-term treatment facility. If the participant has illegal substances or equipment with them, those items are confiscated, but no criminal charges are made. The Gloucester Police Department partners with a peer recovery organization, who is responsible for helping ANGEL participants access longer-term treatment.

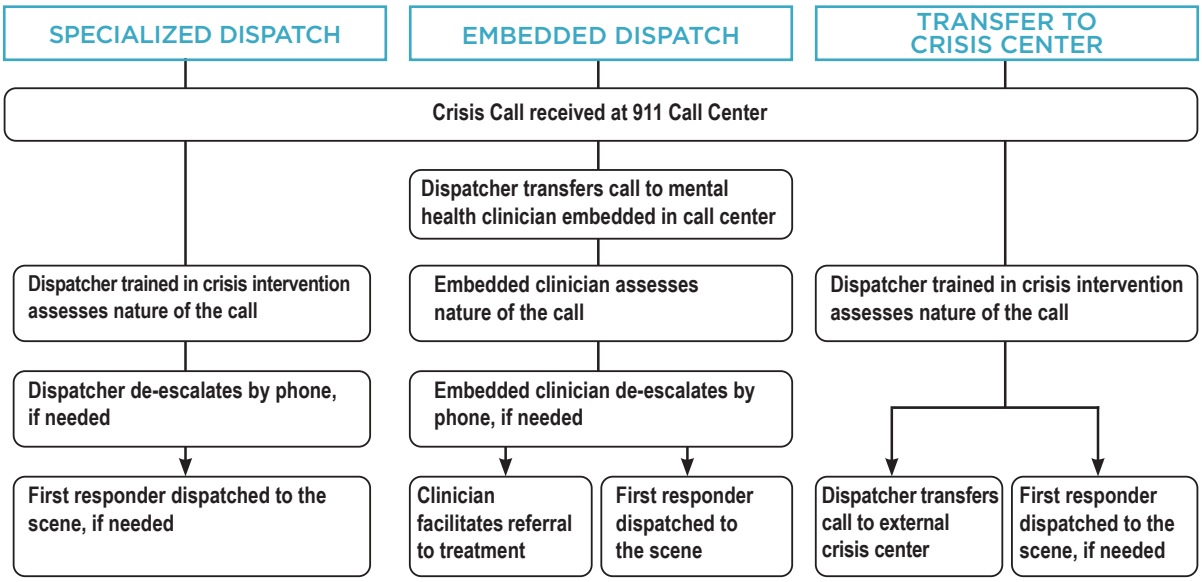
Pfefferle, S., Steverman, S., Gault, E., Karon, S., & Swan, H. (2019, July 24). *Approaches to early jail diversion: Collaborations and innovations.* ASPE. https://aspe.hhs.gov/basic-report/approaches-early-jail-diversion-collaborations-and-innovations

What are the Different Program Models at Intercept 1?

PROGRAM MODEL: INTERVENTION AT 911 CALL

This program model contains programs implemented by 911 call takers, before first responders are engaged. The aim of these programs is to reduce unnecessary dispatch of first responders and work to connect the person experiencing a crisis to the most appropriate resources available. As reflected in Exhibit 4, regardless of program type, the crisis response begins with the receipt of a crisis call, but the response to that call varies by program type.

EXHIBIT 4: INTERCEPT 1 PROGRAM TYPES: INTERVENTION AT 911 CALL CENTER



The first program type, **specialized dispatch**, trains 911 call takers (often using the well-documented Crisis Intervention Training (CIT)) to determine the level of crisis (for example, does the caller have a plan and intent to carry out harm to self or others?), whether the crisis can be safely resolved by phone or if a first responder should be dispatched, and if no response is needed, how to de-escalate the crisis and make appropriate referrals. In **embedded dispatch** programs, behavioral health clinicians are staffed in 911 call centers to de-escalate crisis calls and provide immediate screening and brief intervention services. The clinician is also responsible for either making referrals to treatment, or dispatching first responders to the scene as needed. Lastly, in **transfer to crisis center** programs, rather than training call center staff or adding specialists to the team, calls involving SUD, SMI, or homelessness-related crises are transferred to a community-based crisis hotline where specialists are based. This type of program requires the presence of a community-based crisis hotline in the caller's community.

Program Example

Specialized Dispatch

Chicago's Dispatcher CIT Training program is an example of a **specialized dispatch program**. Under this program, all 911 call takers receive specialized crisis intervention training to help them correctly identify calls that require a CIT response, de-escalate the crisis over the phone, if possible, or initiate the de-escalation process until first responders can arrive at the scene. This program features extensive training of 911 call takers, including a 40 hour CIT training that features methods to communicate with callers experiencing a mental health crisis. This program differs from the embedded dispatch model because it invests in training of 911 call takers, rather than bringing in specialists from other fields to the call center. And it differs from the **transfer to crisis center** model because the intervention takes place in the 911 call center, rather than being routed to specialists that staff a community crisis line. For example, the Distressed Caller Diversion Program (DCDP) in Broome County, NY trains 911 operators to conduct suicide risk assessments over the phone. If the caller meets criteria for imminent risk, a first responder is dispatched; if not, the caller is transferred to a crisis hotline on which a counselor conducts de-escalation over the phone and schedules a follow-up for the caller within the next few days.

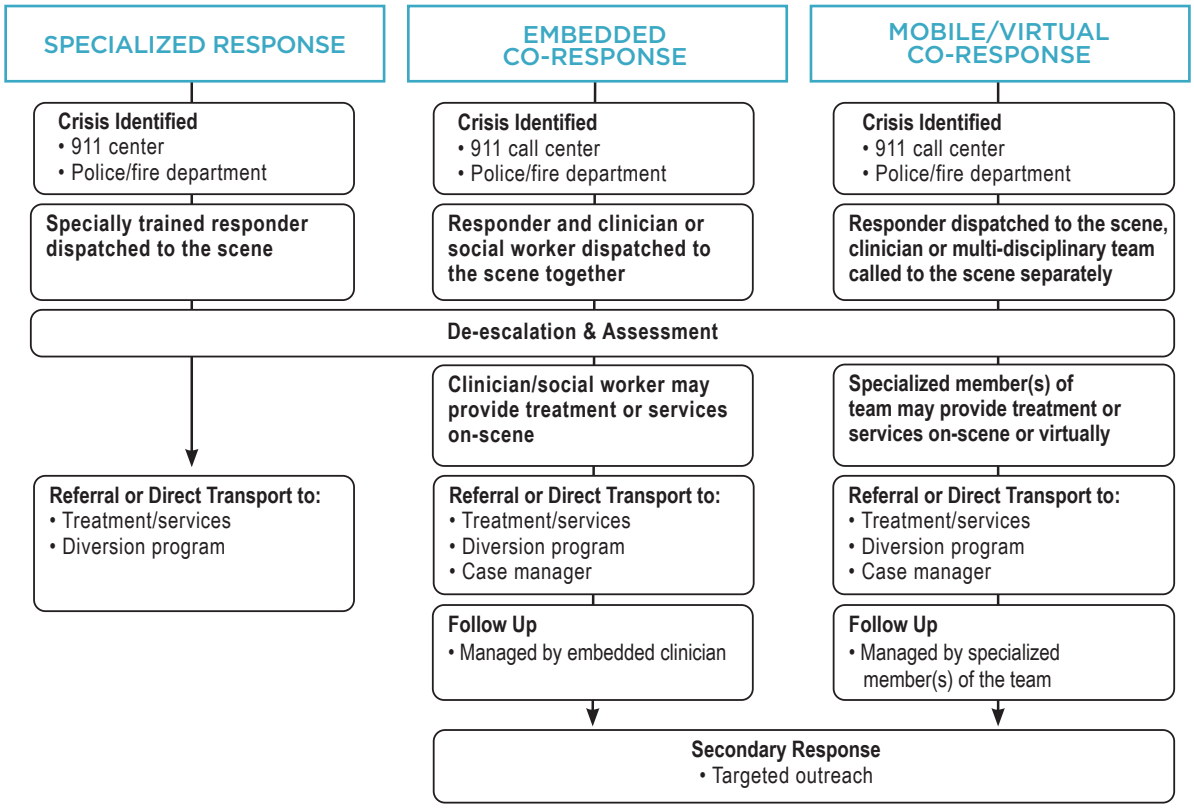
Mayor Emanuel announces milestone in city's mental health emergency response. (2017). Office of the Mayor of Chicago. https://www.chicago.gov/content/dam/city/depts/mayor/Public%20Safety%20Reforms/MentalHealthEmergencyResponse.pdf

Broome County 911 Distressed Caller Diversion Program. *NYS 911 Coordinators Conference.* (2019). https://nys911.com/wp-content/uploads/2019/12/OMH-Diversion-Webinar-short.pdf

PROGRAM MODEL: INTERVENTION BY FIRST RESPONDER

This program model contains programs in which a first responder is dispatched to the scene of a crisis. Programs in this model are initiated with a crisis call from the community to either a 911 call center or directly to a police or fire department's dispatch line. Exhibit 5 illustrates the flow of three first responder intervention program types—**specialized response, embedded co-response**, and **mobile/virtual co-response**—from initiation to response.

EXHIBIT 5: INTERCEPT 1 PROGRAM TYPES: INTERVENTION BY FIRST RESPONDER



In **specialized response** program types, first responders receive specialized training and are the designated staff to be dispatched to the scene of behavioral health crises. Once on scene, the specialized first responder's first task is to de-escalate the crisis and conduct assessments, such as suicide risk, needs assessments, and program eligibility assessments for particular diversion or treatment programs. Based on the results of the assessments, the specialized responder then makes referrals to treatment (e.g., detox, substance use or mental disorder treatment), services (e.g., case management, emergency shelter) or a specific diversion program that partners with the responder's department (such as the LEAD program in Seattle, WA).

All Intercept 1 program models begin with de-escalation, which involves assessing the extent to which the individual is in crisis and assess for suicide or risk of self-harm before trying to assess the specifics of the crisis. For example, the CIT program in the Albuquerque Police Department coaches its officers to focus on communication to encourage a less physical or authoritative approach, referring to it as LEAPS (Listen, Empathize, Ask, Paraphrase, Summarize).

http://www.gocit.org/uploads/3/0/5/5/30557023/student_de-escalation_and_active_listening_12_22_17.pdf

The University of Memphis CIT Center provides de-escalation training that includes the CAF model (calm, assess, facilitate), which they note is a process that helps to define future interventions for the client while enhancing officer safety. They also provide an overview of communication skills necessary for de-escalation, including introducing oneself, active listening, restatement, and communicating acceptance.

http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

If properly equipped and permitted by local laws and policies, specialized responders can also directly transport the individual to a treatment, service, or diversion program.

For example, Diversion First refers individuals directly to Fairfax, VA's community social services center for further support. While the Mental Health Support Team (MHST) refers individuals directly to Tucson's Crisis Response Center.

https://www.fairfaxcounty.gov/topics/diversion-first
https://www.theiacp.org/sites/default/files/2018-11/IACP_PMP_VulnerablePops.pdf

Program Example

Crisis Intervention Team (CIT)

Crisis Intervention Teams (CITs) are a common example of the **specialized response type**. CITs are comprised of teams of law enforcement officers (either a designated group, or an entire unit) that are trained in techniques to respond to calls involving mental health emergencies. CIT programs typically use a standardized 40-hour training curriculum, and may tailor the curriculum to address topics specific to their community, including presentations from local mental health advocacy organizations. Additionally, CIT programs typically designate one law enforcement officer to coordinate the CIT program, which involves managing the relationship between the police and the community, monitoring cases, and organizing trainings.

Dupont, R., Cochran, S., & Pillsbury, S. (2007). *Crisis intervention team: Core elements.* The University of Memphis School of Urban Affairs and Public Policy.

In ***embedded co-response*** programs, social workers or clinicians are staffed at first responder agencies and dispatched alongside first responders. First responders may still receive specialized training, but in this model the behavioral health specialist is responsible for de-escalation, assessment, and referral to needed treatment or services. Involvement of a social worker in this program type introduces the possibility of direct connection of the person in crisis with case management and follow-up services and/or transport to treatment/services. As with the Intercept 0 paired outreach program type, if first responders are dispatched with a clinician, the clinician is able to provide immediate clinical assessments and brief interventions (e.g., Screening, Brief Intervention and Referral to Treatment) at the scene of the crisis, if needed.

Program Example

Systemwide Mental Assessment Response Team (SMART)

The Systemwide Mental Assessment Response Team (SMART) program in Los Angeles, CA is an example of the **embedded co-response type**, and serves as an example of the difference between the embedded co-response program model and the specialized response model. The SMART program is jointly operated by the city's police department and Department of Mental Health, and comprises pairs of law enforcement officers and mental health professionals. The SMART officers receive extensive training, but the program does not use the 40-hour CIT training curriculum commonly used in the specialized response model. Rather, the embedded mental health professional is able to provide the services that are needed to address crisis situations. In this way, the embedded co-response model re-allocates resources that would be required for law enforcement training in the specialized response model to bring the skillset of a mental health professional to the team.

Law enforcement: Mental health learning sites. (2018). CSG Justice Center. https://csgjusticecenter.org/wp-content/uploads/2020/02/Law-Enforcement-Mental-Health-Learning-Sites_Los-Angeles3.27.19_508accessible.pdf

The activities conducted in **mobile/virtual response** programs are the same as the activities conducted in embedded co-response programs; clinicians still respond to crisis calls along with first responders, but rather than being embedded in the first responder's agency, the clinicians are based in community organizations and either transport themselves to the scene, or respond virtually through teleservices. Mobile crisis response programs that incorporate teams of responders provide an added element of medical clearance for transport or referral because the teams often include a paramedic or physician. For example, Colorado Spring's Mobile Crisis Response Team (MCRT) includes a paramedic that can medically clear the individual in crisis so that the person can go directly to specialty treatment.

Program Example

Crisis Assistance Helping Out On The Streets (CAHOOTS)

The Crisis Assistance Helping Out On The Streets (CAHOOTS) program, developed in Eugene, OR, exemplifies **mobile response** programs. The program is composed of teams of medics (nurses or EMTs) and mental health professionals who can be dispatched to the scene of crisis calls by 911. CAHOOTS is operated out of a community-based organization which partners with the 911 system to respond to crisis calls that do not require the presence of a police or ambulance. In this way, the mobile response program coordinates with the law enforcement system, but is dispatched independently to the scene.

CAHOOTS. (2020, May 12). White Bird Clinic. https://whitebirdclinic.org/cahoots/

Program Example

Project ETHAN

In Houston's Project ETHAN program, first responders use telehealth to connect individuals in crisis **virtually** (through a tablet) to an emergency physician so they can receive on-scene assessment and treatment rather than taking an ambulance to an emergency department. Providers can assess symptoms virtually and provide recommendations and information via video call, and schedule in-person follow-up appointments as needed. The provider can also medically clear the patient and determine the appropriate disposition. The field staff on the scene (including fire and EMS personnel) gather important medical information from the individual—including vital signs, medical history, allergies, and medications—and pass this information on to the physician, who ultimately determines if the individual needs immediate transport to an emergency department or, more likely, needs a follow-up appointment within the next several days.

Hagerty, M. (2017, July 3). *Project ETHAN: Reducing unnecessary trips to the emergency room.* Houston Public Media. https://www.houstonpublicmedia.org/articles/news/health-science/2015/08/06/212904/project-ethan-reducing-unnecessary-trips-to-the-emergency-room/

In the context of embedded and mobile/virtual program types, we also identified programs that conduct targeted follow-up with individuals who have experienced a crisis to facilitate referral to services/treatment. These programs include specialized responses conducted by trained police (e.g., MHO), peers dispatched by trained police (PNPCR-MT), or team-based responses conducted by multi-disciplinary teams composed of social service providers, behavioral health clinicians, and first responders (e.g., GROW; CO-OP).

Program Examples

Mental Health Officers (MHO), Peer Network Peer Crisis Response-Montana (PNPCR-MT), Getting Recovery Options Working (GROW), and Community Opioid Outreach Program (Co-OP)

The **Mental Health Officers (MHO)** program in Madison, WI provides specialized training to police officers to become the department's full-time mental health officers to provide follow-up support to individuals who have already come into contact with the police for mental health-related crises. MHOs coordinate with an individuals' other service providers to provide care coordination and also works with patrol officers to create response plans if the individual should be in crisis again. The **Peer Network Peer Crisis Response-Montana (PNPCR-MT)** provides a similar type of follow-up using peer counselors. The PNPCR-MT program provides peer counselors who have been referred by CIT-trained officers to follow-up with and support individuals following a crisis. Peers provide weekly counseling as well as a community-based support group. These two types of response are in contrast to other communities that provide a team-based response. The **Getting Recovery Options Working (GROW)** program, based in Dayton, OH, sends teams of social workers, medics, police officers, and peers in recovery to the homes of individuals who have recently overdosed. The teams offer to help the individual get into treatment and to drive them to a treatment program. The teams also provide naloxone to the individual and family. And the **Community Opioid Outreach Program (CO-OP)**, in Lowell, MA, sends teams of local police officers, firefighters, outreach specialists, and substance use treatment providers to individuals who have had an overdose. The teams are dispatched within 24-48 hours of learning about the overdose.

Law enforcement: Mental health learning sites. (2018). CSG Justice Center. https://csgjusticecenter.org/wp-content/uploads/2020/02/Law-Enforcement%E2%80%93Mental-Health-Learning-Sites_Madison3.27.19_508accessible.pdf

Dayton's GROW Program Helps Fight Local Opioid Epidemic. (n.d.). Get Smart Dayton. https://www.getsmartaboutdrugs.gov/dayton/news/daytons-grow-program-helps-fight-local-opioid-epidemic

Goodnaugh, A. (2018, November 25). This City's Overdose Deaths Have Plunged. Can Others Learn From It? *The New York Times.* https://www.nytimes.com/2018/11/25/health/opioid-overdose-deaths-dayton.html

Key Takeaways

We identified several types of programs that we organized into three overarching models: outreach and prevention; intervention at 911 call; and, intervention by first responders.

Program types vary in who does the responding, the nature of the response, and the intended outcomes of the response.

Organizing programs into types can facilitate decision-making around whether to select a particular program to adopt, or to develop a new program using components of a particular program type.

HOW DO I KNOW WHICH PROGRAM MODEL TO CONSIDER?

Across the program models discussed in this guidebook, an overarching goal is to improve first responders' ability to *divert individuals in crisis away from the justice and emergency systems and into services and programs that will better address their needs.* Such a goal requires a robust behavioral health system with resources available to serve these populations. There are a number of other goals that diversionary crisis response programs can help jurisdictions accomplish, such as cost-savings and improved community health.

Whether you are scaling up an existing program or considering implementing a new one, finding the program type that works for your community starts with identifying which program model is best aligned with your aims. What are you trying to accomplish? What issue are you trying to address?

Selecting a type of program from Intercept 0 or Intercept 1 will depend on whether you want to focus your efforts on intervening before or after a crisis occurs. For example, if you are interested in preventing crisis-related calls for service, you will want to select an *Outreach and Prevention* program from Intercept 0. Conversely, if you are interested in improving your response to crisis-related calls for service, you will want to select an *Intervention at 911 call or Intervention by First Responder* program from Intercept 1. For example, if you are primarily focused on improving your response to calls involving drug overdose, you may want to select a type of program in Intercept 1 that targets the specific goal of fewer fatalities. Comparatively, if you are focused on reducing the number of crisis-related calls from individuals with SMI, you may want to select a program type from either intercept that aims to reduce the prevalence of untreated mental health conditions in the community.

Jurisdictions who currently operate programs at Intercept 1 may choose to expand into prevention by implementing a program model at Intercept 0, or vice versa. Programs at these intercepts can operate simultaneously, or a jurisdiction may want to focus on programs at one Intercept or the other, due to funding or other limitations.

WHAT FACTORS DO I NEED TO CONSIDER WHEN SELECTING A PARTICULAR PROGRAM TYPE?

Once you have determined your aims and which intercept you will focus on, selection of a particular type of program requires a number of considerations, including which agencies will be involved in the response, what partnerships or coordination will be required, what local laws and policies would prohibit or facilitate program implementation, what sources of payment or reimbursement exist to cover services the program would provide, what technology or other resources will be needed to support program implementation, what is the scale of the program, and what training will be required? These considerations are a starting point and not intended to be exhaustive of all factors that may need to be considered in your local context.

WHICH AGENCIES WILL BE INVOLVED IN THE RESPONSE?

Our framework includes programs that are implemented by first responder agencies (law enforcement, fire, EMS/EMT). However, the type(s of responder(s) responsible for intervening before or during a crisis depends on the type of program. Some types, such as **specialized outreach** at Intercept 0 and **specialized response** at Intercept 1 are led by single discipline teams, meaning there is only one type of first responder leading the intervention.

Other types, such as **paired outreach** at Intercept 0 and **embedded co-response** at Intercept 1 involve more than one type of responder, who work together to conduct the intervention. Thus, different types of programs require a different mix of first responders to provide the intervention. The types of responders involved across first responder led program types are represented in Exhibit 6.

EXHIBIT 6: TYPES OF RESPONDERS INVOLVED IN EACH PROGRAM TYPE

Program Type	Responder Type							
	911 dispatcher	Law enforcement	Firefighter	EMS / paramedic	Clinician	Social worker	Physician/ nurse	Peer Specialist
Intercept 0: Outreach and Prevention								
Specialized Outreach		■						
Paired Outreach		■			■	■		
Team-based Outreach		■		■	■	■	■	■
Voluntary walk-in		■	■					■
Intercept 1: Intervention at 911 Call								
Specialized Dispatch	■							
Embedded dispatch	■				■			
Transfer to crisis center	■							
Intercept 1: Intervention by First Responder								
Specialized response		■	■	■				
Embedded co-response		■			■	■		
Mobile/virtual co-response		■	■	■	■	■	■	■

WHAT PARTNERSHIPS OR COORDINATION WILL BE REQUIRED?

Regardless of who is doing the actual responding, partnerships are an important ingredient across all program types. The nature of these partnerships varies between program models, program types, and individual programs. Naturally, programs that involve responders from more than one agency require a partnership between the agencies where each responder is based. For example, **paired outreach** programs pairs law enforcement officers with clinicians or social workers to conduct the outreach. In order to make this partnership possible, the law enforcement agency must partner with the organization that employs the clinician (or social worker), and together determine how these positions will be funded, hours of operation, and other operational considerations. Formal or informal partnerships are also involved in programs that are led by a single type of responder. For example, one of the key elements of CIT programs, a **specialized response** program type, is a formal agreement with designated community-based facilities, such as a respite center, that can receive individuals after CIT-trained officers have de-escalated a situation such that the individual is willing to be connected to care; program success would be difficult to achieve absent the opportunity for a warm-hand off to a receiving facility.[7]

A specialized response program that relies heavily on partnerships is the **Drug Abuse Response Team (DART)** in Lucas County, OH. In this program trained, designated officers respond to opioid overdose calls and offer assistance in enrolling individual in substance use treatment, including transportation to detox. After initial contact, DART officers link individuals to services in the community and conduct follow-up over a two –year period to monitor progress and act as an advocate in the legal system.

Pfefferle, S., Steverman, S., Gault, E., Karon, S., & Swan, H. (2019, July 24). *Approaches to early jail diversion: Collaborations and innovations.* ASPE. https://aspe.hhs.gov/basic-report/approaches-early-jail-diversion-collaborations-and-innovations

The nature of partnership and coordination, and the extent to which partnerships need to be formalized, also varies by the type of program. For example, **specialized outreach** and **specialized response** programs must coordinate with community-based service providers as part of providing a warm-hand-off; without some form of partnership or coordination with the housing and behavioral health service systems, first responders would not have a source to divert cases to. Other types of programs (i.e., **paired outreach, team-based outreach, embedded co-response**, and **mobile/virtual co-response**) require formal partnerships with social workers, clinicians, or medical staff to assist the first responder. Partnerships between first responders and the social and behavioral health service system may be formalized through a memorandum of understanding (MOUs), or based on contractual relationships between representatives of each sector.

Do partnerships require changes to data systems to support program implementation?

Programs, particularly ones that employ **co-response** or **team-based outreach** approaches, might require data-sharing consistent with the models' partnerships or multidisciplinary collaborations. For example, the Homeless Services Detail (HSD) program incorporates data-sharing among the Philadelphia police, the department of behavioral health, and the office of homeless services. This data-sharing allows HSD to effectively and efficiently identify frequent utilizers of each system that are likely in greater need of the program's services. As another example, the Systemwide Mental Assessment Response Team (SMART) in Los Angeles is an **embedded co-response** program that uses a database to record detailed information about the individuals to which they respond, including information about the individual's condition and medications, which is accessible to all SMART team members.

WHAT LOCAL LAWS AND POLICIES WOULD PROHIBIT OR FACILITATE IMPLEMENTATION OF THE TYPE OF PROGRAM? WOULD IT BE POSSIBLE TO CHANGE ANY OF THOSE LAWS OR POLICIES THAT ARE BARRIERS?

Some types of programs may have components that require an assessment of state and local laws and policies. For example, **voluntary walk-in** programs require the legal ability to grant amnesty to individuals seeking assistance if they are in possession of illicit substances or paraphernalia (e.g., Substance Abuse Good Samaritan Laws).[8] In other programs, state laws related to the conditions under which a citation may be issued in lieu of arrest or the extent to which EMS may transport individuals in crisis to alternative locations can impact pre-arrest diversion policies and practices.[9]

The ANGEL Program in Gloucester, MA implemented a 2015 policy stating that an individual who walks into the police station requesting help for their addiction will not be charged for any drug paraphernalia they might have on them.

Pfefferle, S., Steverman, S., Gault, E., Karon, S., & Swan, H. (2019, July 24). *Approaches to early jail diversion: Collaborations and innovations.* ASPE. https://aspe.hhs.gov/basic-report/approaches-early-jail-diversion-collaborations-and-innovations

Municipal ordinances could also influence what program model you are able to implement. In particular, outreach and prevention programs at Intercept 0 might be guided by existing regulations related to who first responders can—or must—approach and offer services. Other legal barriers could include labor laws, as is the case in Washington where CAHOOTS is implemented; Washington's labor laws prohibit EMTs from working in the police unit.

Philadelphia has a decades-long city ordinance mandating that a person experiencing homelessness who is in need of services must be offered services, even if the person encountering that individual is a law enforcement officer. In response to this ordinance, the city created the **Homeless Service Detail (HSD)** program in 2017, which pairs officers with outreach workers and sends them into the neighborhoods with the highest known rates of homelessness to offer resources and support.

Strengthening partnerships between law enforcement and homelessness services systems. (2019). U.S. Interagency Council on Homelessness.

Other legal considerations center on the protection of personal health information under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA considerations are particularly relevant for **mobile/virtual co-response** program types that may require the exchange of health information among medical providers, law enforcement officers, and other team members. There are a number of resources available that provide guidance for you to follow to ensure you are compliant with these data protections (see Appendix B).

For example, the *virtual co-response* **Emergency Telehealth and Navigation (ETHAN)** program requires the sharing of medical information via video call/tablet, between on-scene responders and an emergency physician.

Langabeer II, J. R., Gonzalez, M., Alqusairi, D., Champagne-Langabeer, T., Jackson, A., Mikhail, J., & Persse, D. (2016). Telehealth-enabled emergency medical services program reduces ambulance transport to urban emergency departments. *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health*, 17(6), 713.

WHAT SOURCES OF PAYMENT OR REIMBURSEMENT EXIST TO COVER SERVICES THE PROGRAM WOULD PROVIDE?

Existing diversion programs are funded by federal grants, city funds, philanthropic organizations, or a mixture of both. Payment considerations for implementation vary by program type. Some outreach and prevention programs in Intercept 0 are funded directly by the city (such as the Quality of Life program); other outreach programs, like CSOs,

involve staff who are employed and paid by the police department. Co-response programs that focus on partnerships between various agencies might receive grant funding from each agency to pool together, as in the case of Early Diversion Get Engaged (EDGE).

In the **Early Diversion Get Engaged (EDGE)** program, teams of officers, behavioral health clinicians, and peer support specialists respond to crisis calls and link individuals to needed services. EDGE brings together multiple agencies that can allocate grant funds to sustain the program.

Project EDGE: "Early diversion, get engaged" (2016). Colorado Commission on Criminal and Juvenile Justice.

In addition to funding the overall program and paying any additional staff you hire, you will need to think about payment and reimbursement for the services offered and provided. For example, if you wanted to implement a type of **embedded co-response** program with an embedded clinician, or a team-based outreach program, you will need to consider the payment and billing structure (e.g., Medicaid) for any on-scene treatments that clinicians provide.

Treatment provided through the **Stop, Triage, Engage, Educate and Rehabilitate (STEER)** program is funded through a variety of state and local contracts, as well as Medicaid. However, the way the program utilized a treatment linkage specialist was outside the scope of Medicaid reimbursement categories. Other sources of funding were needed to cover this aspect of service provision under the program.

Pfefferle, S., Steverman, S., Gault, E., Karon, S., & Swan, H. (2019, July 24). *Approaches to early jail diversion: Collaborations and innovations.* ASPE. https://aspe.hhs.gov/basic-report/approaches-early-jail-diversion-collaborations-and-innovations

WHAT TECHNOLOGY OR OTHER RESOURCES WILL BE NEEDED TO SUPPORT PROGRAM IMPLEMENTATION? DO YOU HAVE THOSE RESOURCES AVAILABLE TO YOU? IF NOT, WHAT EFFORTS AND RESOURCES WOULD BE REQUIRED TO OBTAIN THEM?

All programs will require some resources for implementation, but certain programs will require more resources than others. **Mobile** and **virtual co-response** programs, especially those that incorporate crisis hotlines and tablets with video-based communication capabilities, will require technological capabilities that your jurisdiction may or may not already have. **Embedded co-response** and **embedded dispatch** program types will require you to consider how to situate clinicians within your department or call center, in terms of providing office space, desks, and computers. Programs that provide direct transport of individuals to services will need to consider vehicles and associated costs. For example, ETHAN arranges for taxi service to transport individuals to their scheduled appointments.

The **Community Crisis Response and Intervention (CCRI)** *mobile co-response* program in South Carolina offers a hotline that law enforcement officers can use to request the dispatch of a mobile team to provide mental health assistance and assessment for individuals in crisis.

Community Crisis Response & Intervention. (2019, May 9). South Carolina Department of Mental Health. https://scdmh.net/dmh-components/community-mental-health-services/programs/community-crisis-response-intervention/

The **Clinician and Officer Remote Evaluation (CORE)** *virtual co-response* program provides officers with tablets to connect to mental health clinicians remotely to provide an assessment. Such a resource requires the equipment (tablets) as well as internet or cellular capabilities.

Innovations in telemedicine platforms to assist the treatment and recovery of people with Serious Mental Illness (SMI). (2019). https://www.nasmhpd.org/sites/default/files/CORE%20-%2006-02-19.pdf

WHAT IS THE SCALE OF THE PROGRAM?

Jurisdictions that are considering implementing a program for the first time should consider the size of the population they aim to serve, the number of staff needed to adequately serve this population, and the schedule (e.g., days of the week, shifts) at which the program will operate. Programs may begin with a pilot phase, in which the program operates at a limited capacity relative to its ultimate goal. For example, a jurisdiction implementing a specialized response program for the first time may choose to only train a few staff,

The **Mobile Crisis Assessment Team (MCAT)** in Indianapolis, IN, shifted its schedule after implementation to only work on weekdays when service providers were open, thus improving care coordination. In its initial implementation, the program had paramedics as part of the response team; however, paramedics left the response team after it was determined that they were not acutely needed for the types of calls to which they were responding.

Watson, A. C., Compton, M. T., & Pope, L. G. (2019, October). *Crisis response services for people with mental illnesses or intellectual and developmental disabilities: A review of the literature on police-based and other first response models.* New York, NY: Vera Institute of Justice. Available at https://www.vera.org/publications/crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities

versus an entire unit, and have those staff operate the program part-time during a particular shift until the department has gained a better understanding of the program operations and its initial impact on the population of focus. Later on, this program may be scaled up by training additional staff, operating the program every day of the week, and thereby making this type of response available to greater proportions of the community.

The **Safe Station** program that originated in New Hampshire runs twenty-four hours a day, seven days a week; however, the treatment centers to which the program refers operate on a more limited schedule, limiting the program's ability to make timely referrals.

Safe Station. (2020). The City of Manchester. https://www.manchesternh.gov/Departments/Fire/Safe-Station

WHAT TRAINING WILL BE NEEDED?

Training is a component of all crisis response program models, but the type(s) of training varies based on: 1) the type of responder conducting the intervention, and 2) the type of crisis (housing, mental health, and/or substance use related).

1. *Type of responder*
   a. Programs led by law enforcement or firefighters may require more training resources than programs that incorporate behavioral health professionals.
   b. Program models also differ in whether one dispatcher or responder, an entire unit of responders, or an entire agency/department need to be trained.
2. *Type of crisis*
   a. Housing: Programs that aim to serve individuals experiencing homelessness may include training on the causes of homelessness, local housing system, the protocol for referring individuals to housing, and considerations for interacting with people living in encampments or other public places.
   b. Mental health: Programs that aim to serve individuals experiencing mental health crises may include training on common mental health conditions that may lead to crisis if untreated, methods for identifying if (and which) mental health conditions are present in a crisis (e.g., screening and assessment techniques), and methods for interacting with people who are experiencing a psychiatric emergency (e.g., mental health first aid, de-escalation). These programs may also include training on the local behavioral health treatment system, or this knowledge may be provided by partner organizations represented on the team.
   c. Substance use: Similar to programs serving individuals experiencing a mental health crisis, programs that aim to serve individuals experiencing substance use-related crises may include training on addictive substances that are prevalent in the community, methods for identifying if (and which) substances are present in a crisis (e.g., screening and assessment techniques), and methods for interacting with people who are using drugs or alcohol (e.g., de-escalation, motivational interviewing). Again, these programs may also include training on the local behavioral health treatment system, or this knowledge may be provided by partner organizations represented on the team.
   In addition to training on the delivery of the program, trainings may also include components for increasing awareness of mental health and substance use issues to decrease stigma and address implicit bias.

In addition to training on the delivery of the program, trainings may also include components for increasing awareness of mental health and substance use issues to decrease stigma and address implicit bias.

Key Takeaways

In this chapter, we provide some of the overarching factors that will need to be considered during program planning.

Other considerations may exist depending on the specific needs of your community and existing programming and resources.

It is important to involve relevant stakeholders as early in the process as possible to ensure you have considered all of the contextual factors that may influence programming.

CHAPTER FOUR

HOW DO I KNOW IF I AM ACTUALLY ACHIEVING PROGRAM GOALS?

How a program's goals are achieved will vary based on the program implemented. There is a range of outcomes that may be realized through implementation of a particular program (see Exhibit 7). Determining which outcomes to measure will be related to what outcomes the activities of each program type are designed to produce. It is also important to measure how well the activities of the program were implemented in order to understand the factors that may be contributing to outcomes you observe.

EXHIBIT 7: OUTCOMES BY PROGRAM MODEL

Program Model	Outcomes
Outreach and Prevention	• Reduced number of arrests • Reduced number of ED intakes • Increased connection to treatment • Increased connection to services for unmet needs correlated with justice-involvement (e.g., shelter, food) • Improved responder awareness of SMI/SUD issues and services • Improved client experience/relations
Intervention at 911 Call	• Reduced number of arrests • Reduced number of ED intakes • Improved dispatcher awareness of SMI/SUD issues and services • Increased connection to treatment/services • Reduced repeated crisis-related calls for service
Intervention by First Responder	• Reduced number of arrests • Reduced number of ED intakes • Increased connection to treatment • Improved responder awareness of SMI/SUD issues and services • Reduced use of force • Improved client experience/relations • Reduced use of first responder time and resources

A theory of change is a description of how and why a set of activities are expected to lead to outcomes. Logic modelling is a standard evaluation tool used to articulate a theory of change by documenting the factors that influence program selection and start-up (the inputs), what actually occurs as part of the program (the activities), what the program produces (the outputs), what happens as a result of what the program produces (the outcomes), and the goals that the outcomes aim to achieve (the impact).[10] To assist you in identifying relevant outcomes that might be measured, we include sample logic models for each type of program included in this framework in Appendix C.

As reflected in the logic models, outcomes vary based on the program's target population and the specifics of the intervention. For example, while all types of programs operating at Intercept 1 share many of the same outcomes (reduced number of arrests; reduced number of ED intakes; increased connection to treatment; improved responder awareness of SMI/SUD issues and services; reduced use of force; improved client experience/relations), mobile/virtual program types also include reduced use of first responder time and resources because these programs involve team members who can relieve the first responders from the scene once it is determined their services are not needed. In some cases, mobile crisis teams have replaced first responders and are the designated responders to crisis-related calls for service. In these instances, the programs would be operating at Intercept 0 since they no longer involve first responder agencies and are functioning at the community level.

While diversionary emergency response programs are not new, evaluation of these programs has been remarkably limited, leaving agency leaders and policymakers with very little evidence on which to base their decision-making. Given the lack of empirical evidence for emergency response diversion models, assessing whether what you are investing in implementing is working is of utmost importance. We encourage the development of a logic model as part of program planning to be used to guide and monitor program implementation, and to support future program evaluation activities. Supporting program evaluation is particularly important for individual agencies to understand whether the programs they are investing in are working to achieve their goals, but program evaluation is also important for informing the larger field of evidence.

Evidence is generated through evaluations that measure whether a program achieved the intended goals or outcomes. The more rigorous the evaluation (randomly assigning participants to receive the treatment or not), and the more evaluations that have been done of the program, the more reliable the evidence. For more information on conducting evaluation of diversionary programs, see the Jail Diversion Resource Guide in Appendix B.

What evidence does exist in support of these program types?

As noted in Chapter 2, we conducted searches to identify published evidence for the programs included in this guidebook. Exhibit 8 presents the outcomes that have been measured by program type.

EXHIBIT 8: OUTCOMES MEASURED BY PROGRAM TYPE

		Outcomes Measured								
Intercept	Program Type	Number of ED intakes	Number of arrests	Use of emergency services	First responder awareness of SMI/SUD issue	Client experience	Staff satisfaction	Cost savings	Use of force	Number of overdose fatalities
0	Team-based outreach			■						
0	Voluntary/ Walk-in		■			■				■
1	Specialized response	■	■	■	■	■	■	■	■	
1	Embedded Co-response	■	■	■						
1	Mobile/ Virtual Co-response	■	■	■				■		

The program type that yielded the most published evidence in terms of number of articles and number of outcomes examined, is specialized response. This finding is largely due to the body of literature on the CIT program; we also found some published studies of the LEAD program.

CIT is a program designed to provide intensive training to officers focused on crisis de-escalation and interactions with individuals with SMI/SUD. Originally created in Memphis, TN, CIT has since been widely adopted in police departments across the country. Although several published studies of CIT exist, very few have rigorously studied its effectiveness in reducing arrests for individuals experiencing a crisis. The limited evidence that exists suggests that CIT is associated with reduced arrests.[11, 12] More frequently, researchers have examined CIT's impact on officer-level outcomes (awareness of SMI/SUD issues; use of force; staff satisfaction). A 2010 comprehensive review of the CIT literature documented the evidence that CIT improves officer preparedness; improves officer attitudes when responding to SMI/SUD crisis-related calls; alters responder beliefs and decreases stigma; increases identification of calls involving crisis related to SMI; increases transports to treatment by CIT officers; reduces involuntary transports; increases access to services by linking individuals to community-based providers.[13] More recent studies have also shown that CIT is associated with reduced use of emergency services[14]; reduced use of force[15, 16]; and officer satisfaction.[16]

LEAD (Law Enforcement Assisted Diversion) comprises teams of officers trained in the program who respond to 911 calls. Established in 2011, LEAD was designed to improve public safety, reduce crime, and save costs associated with conventional law enforcement strategies.[17] Since starting in Seattle, LEAD has been implemented in various cities including Baltimore and San Francisco. Scholars out of the University of Washington have evaluated Seattle's LEAD program using a combination of non-randomized comparisons of outcomes among LEAD participants to non-LEAD participants, and comparisons of outcomes among LEAD participants before and after receiving the intervention. The studies indicate that LEAD is effective at improving a number of outcomes for participants, including obtaining housing and employment (and associated income and benefits)[18], and reducing recidivism, measured as instance and number of arrests, instance and number of misdemeanor and felony charges, jail bookings and prison incarcerations.[18, 19] An implementation study of San Francisco's LEAD program demonstrated that the model could be replicated in another location with some adaptation to the local setting.[20] We also found a pre-pilot assessment of law enforcement buy-in to the LEAD program in Baltimore.[21]

Also at Intercept 1, we found some published studies of embedded co-response programs, specifically the MCAT, CRT, and PERT programs (see Exhibit 9). Each study we identified was descriptive in nature and did not include comparison groups, so we are unable to draw strong conclusions about their effectiveness. However, descriptive information from these studies suggest that this type of program (embedded co-response) is associated with reduced numbers of arrest, reduced repeat contacts, increased service utilization, and cost savings.

EXHIBIT 9: OUTCOMES MEASURED IN EMBEDDED CO-RESPONSE PROGRAM STUDIES

	Outcomes Measured					
Program Name	**Nature of the incident**	**Incident location**	**Case disposition (arrest, transport to emergency department, etc.)**	**Repeat contact**	**Services used**	**Cost (case clearance time/responder released)**
MCAT[22]	■	■	■	■		
CRT – Seattle[23]	■	■	■	■	■	■
CRT – Boston[24]	■		■			
CRT - Colorado Springs[25]				■	■	■
PERT[26]					■	

Project ETHAN, a mobile/virtual co-response program, was evaluated using a more rigorous design that incorporated a non-random (quasi-experimental) comparison of two matched groups of people who receive different treatment.[27, 28] In this evaluation, the "treatment" group received intervention in the Project ETHAN program and the "comparison" group received transport to an ED – the usual response in Houston, where the program is implemented. Findings from this evaluation showed that individuals who received a response from Project ETHAN experienced a reduction in ambulance-enabled ED utilization and a 44 minute reduction in median response time (defined as the time EMS unit is notified to the time unit is back in service for the next call) which the authors equated to a lower cost of care (although they do not quantify cost). No differences were found between the two groups with respect to patient diagnosis or in in overall satisfaction by patients served (over 85% satisfied in each group). Another finding from this evaluation is that only 55% of patients presented at appointments for which they were referred by Project ETHAN. The primary reason cited for not presenting was that symptoms had subsided.

Evidence for the program types within Intercept 0 is even more scant. However, we did find quasi-experimental studies of one team-based outreach program (HOME) and one voluntary walk-in program (Hero Help). For the HOME study[29], evaluators conducted a retrospective analysis of patterns among clients that used emergency services (EMS) more than 4 times per month before and after HOME intervention. They found that the average use of EMS prior to HOME intervention was 18.72 responses per month; after the first contact with HOME, use significantly dropped to 8.61. Hero Help was also shown to improve treatment engagement, retention, and success, as well as other outcomes for individuals with SUD or who experienced a non-fatal overdose, compared to a random selection of participants who entered treatment through means other than Hero Help.[30] A descriptive study of the ANGEL program (a voluntary walk-in program) found that the program was feasible to implement and acceptable to participants.[31] The program also demonstrated some success in helping participants find initial access to treatment, primarily through short-term detoxification services, but since there was no comparison group, we are unable to draw strong conclusions. However, the authors noted that implanting ANGEL in the context of a fragmented behavioral health treatment system focused on acute episodic care was a barrier.

Key Takeaways

Logically, it seems reasonable that implementing the types of programs included in this guidebook should improve outcomes for individuals in crisis. However, there has been very little testing of this logic.

On the one hand, decision-makers should acknowledge and apply the evidence that does exist for these various programs. On the other hand, decision-makers should acknowledge the gaps in our understanding of whether and how these programs work to improve outcomes.

By identifying your goals and articulating a theory of change for your programming, you will be able to monitor and assess whether your investments are leading to improved outcomes. Such monitoring is still important when adopting existing programs, even if they have been shown to be effective in other locations, since your local context may impact program implementation and outcomes differently.

WHAT IF I WANT TO DO MORE THAN IMPLEMENT A PARTICULAR PROGRAM OR PROGRAM TYPE IN MY LOCAL JURISDICTION?

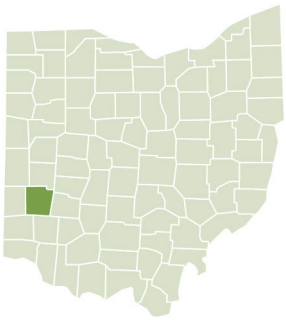
Identifying or developing a new program in your local community is a good place to start. However, broader efforts are likely necessary in order to fully realize the impact of a reimagined crisis response system. Depending on what you want to accomplish, as well as the resources, support, and stakeholder buy-in available to you, you may be ready to embark on such an effort to reimagine crisis response in your community, beyond local implementation of a particular program or program type. Perhaps you want to implement more than one program model in your county and invest in one program type at each intercept. Perhaps you want to scale a particular program within an entire region of your state. Or, perhaps you want to take a statewide approach to addressing SMI, SUD, or homelessness and work toward strengthening and integrating the systems encompassed by Intercepts 0 and 1 to improve crisis prevention and provide appropriate intervention for when crisis response is needed. In this chapter, we provide published examples we found of county-, regional-, and state-level efforts to reimagine and improve crisis prevention and response. These examples are not intended as an exhaustive list of efforts across the country; rather, they are illustrative examples to promote further dialogue in your communities.

County-Level Efforts

LINCOLN COUNTY, NC – CIT STEERING COMMITTEE[32]

Lincoln County, NC, has scaled implementation of CIT training to multiple first responders. The Lincoln County CIT Steering Committee coordinates CIT training for law enforcement, 911 call takers, and EMS staff. In addition to scaling CIT, Lincoln County also created a drop-off location for behavioral health crises which involved renovation of an existing behavioral health urgent care center. The county staffs a CIT trained police officer at the drop-off, and with extended hours, to secure any intakes. These investments ensure that all first responders have a place to divert individuals in crisis to that is not a correctional facility or emergency department. In 2017, the Lincoln County CIT Steering Committee was awarded the "Outstanding Partnership Award" from NAMI-NC.

DAYTON, OH – COMMUNITY OVERDOSE ACTION TEAM (COAT)[33]



Dayton, OH's Community Overdose Action Team (COAT) serves as the coordinating body for a variety of initiatives in the county, including community-based programs (Conversations for Change, Families of Addicts, Peers for Change, and Life Enrichment Center), first responder led overdose follow-up programming (GROW), a mobile crisis team (MCRT) housed in the police department, Narcan disbursement that is funded by the Department of Public Health and distributed by police officers and fire fighters, and partnership (through GROW) with a private sector outpatient treatment program.

Conversations for Change:
Community gatherings led by the police department and community-based service providers to bring individuals experiencing SUD and COAT members together.

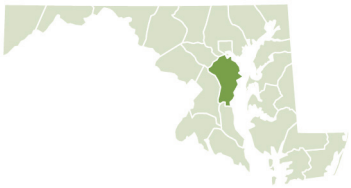
Families of Addicts:
A volunteer-led support group for individuals with SUD and their families.

Peers for Change:
Peer support specialist is partnered with a licensed social worker to conduct follow up with people who have experienced an overdose.

Life Enrichment Center:
A faith-based, non-profit that serves as a meeting place for needle exchange and other community initiatives.

GROW:
Getting Recovery Options Working program sends teams of social workers, medics, police officers, and peers in recovery to the homes of individuals who have recently overdosed to facilitate linkage to treatment.

ANNE ARUNDEL COUNTY, MARYLAND[34, 35, 36]

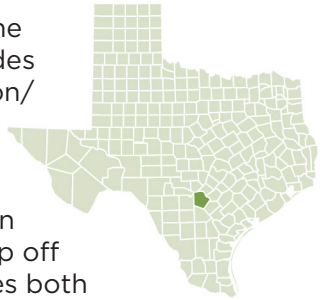


Anne Arundel County, MD, is an example of a county that has invested in more than one program model – two types of intervention by first responder, and one type of outreach and prevention. Under first responder led intervention, Anne Arundel County has implemented mobile crisis teams (MCRTs) and an embedded co-response program that pair police officers with a licensed behavioral health clinician. One reason Anne Arundel County implemented both program types is because the embedded co-response program they implemented is able to respond to cases where there is a security threat, whereas the mobile crisis team is not able respond to such cases. This consideration highlights the importance of identifying the factors that facilitate or impede the implementation of a particular program, depending on what you are trying to achieve. Under the outreach and prevention model, Anne Arundel County has also implemented Safe Station, a voluntary walk-in program. They have scaled this program such that all police and fire departments in the county are Safe Stations.

BALTIMORE COUNTY, MD - CRISIS RESPONSE SYSTEM[37, 38]

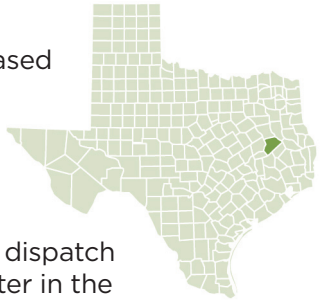
In 2001, the Baltimore County police department, the County Health Department, and a non-profit behavioral health service provider formed a partnership to address crisis response in the county. Through this partnership, Baltimore County has implemented an in-home intervention team that consists of mental health clinicians who provide appointment-based, intensive services in-home for non-acute crisis intervention and follow up, an embedded co-response team staffed by one police officer and one mental health clinician, and a crisis care center that provides diagnostic assessments and medical evaluations within 48 hours of call time. To coordinate each of these programs, the county developed a 24 hour crisis hotline where calls are answered and screened by mental health professionals who triage the call to the in-home team, co-response team, or the crisis drop off center.

BEXAR COUNTY, TX - JAIL DIVERSION PROGRAM[39, 40]



The Bexar County, TX jail diversion program consist of 1) a crisis line that staffs two psychiatric registered nurses at all times and provides 24/7 service for crisis calls, mental health outreach, and information/ referrals; call takers can conduct mental health screening and contact the jail diversion staff; 2) a crisis intervention team (CIT); 3) a co-response team composed of teams of mental health professionals and trained sheriff's deputies that is dispatched when clinical assessments are needed at the scene of the crisis; 4) a drop off center (Crisis Care Center) for responders to divert to that provides both medical and behavioral health services for patients; even hours are reserved for law enforcement drop-offs only and require a 23-hour hold; and 5) outpatient services provided by three outpatient clinics that are formally partnered with the jail diversion program and are all run by one community-based partner. The Oversight Committee serves as the coordinating body that conducts evaluations of the program, disseminates information about the program at the state-level, and serves as a liaison with the Texas state legislature to secure funding.

HOUSTON, TX - POLICE MENTAL HEALTH COLLABORATION[41, 42]



The Houston Police Department has partnered with a community-based crisis center (the Harris Center) to implement programs within each program model at both intercepts. In Intercept 1, under intervention by first responder, they have implemented CIT training for all cadets, an embedded co-response program that pairs a CIT-trained officer with a licensed mental health clinician (CIRT). Under intervention at 911 call, they have implemented an embedded dispatch program that embeds mental health counselors from the Harris Center in the central dispatch facility. These mental health professionals work with the 911 call takers to identify and triage non-emergency mental health calls away from first responders.

In Intercept 0, Houston has implemented a team-based outreach program (HOT) that comprises police officers and case managers from the Harris Center who conduct street outreach to chronically homeless individuals in the community. Houston has also invested in a drop-off center so first responders have somewhere to divert individuals to other than a correctional facility or emergency department. Also under Intercept 0, Houston has invested in a Chronic Consumer Stabilization Initiative with the goal of taking a pro-active, community policing approach to help keep prior consumers from going into crisis again. Under this initiative, the Houston Police Department flags cases they respond to most frequently, and case managers from the crisis center work with those cases to help them engage in services to reduce subsequent crisis.

Regional-Level Efforts

CAPE FEAR, NORTH CAROLINA[43, 44, 45]

Cape Fear, a region in North Carolina, is an example of a region of counties that coordinated their efforts to strengthen diversionary crisis response in the area. Cape Fear comprises New Hanover, Brunswick, Columbia and Pender counties. Through this effort, Cape Fear established the Community Partners Coalition, a coordinating body that coordinates activities and programming by organizations that serve people with SUD in the region. These activities include the implementation of LEAD, CIT, a Naloxone program, and the Quick Response Team – a team that includes a peer support specialist for substance use, a licensed behavioral health specialist, and a part time psychiatrist or other medical professional who conduct follow-up with individuals known to have experienced an overdose.

State-Level Efforts

MARYLAND[46, 47]

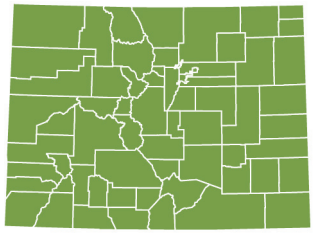
Maryland has a robust statewide crisis response system that includes program types at both intercepts, including co-response teams (14 across the state), specialized response (crisis intervention teams), crisis hotlines (each region of the state has a hotline, which refers cases to designated service providers), Safe Stations across the state, four walk-in crisis centers across the state, at least one drop off center, short-term residential facilities in three counties for individuals in SUD crisis (detox and short term intervention), and peer recovery support and care coordination.

MASSACHUSETTS[48, 49, 50]

The Massachusetts Department of Mental Health (MA DMH) began funding police-led jail diversion programs in 2007. Since then, their grant funding portfolio has grown substantially and by the end of 2019, there were 65 grant funded projects across the state including the establishment of: crisis intervention teams in police department; embedded co-response teams; and regional CIT Training & technical assistance Centers (**CIT-TTACs**). Beginning in 2018, the MA DMH also started funding grants to: backfill costs of CIT training fees, support consultants who work on any of the funded projects; conduct Sequential Intercept Mapping in local police departments and establish stakeholder groups; and enhance pre-existing drop-off sites to readily receive individuals brought in by police for diversion.

> The CIT-TTAC model was introduced in 2014 to "create hubs for CIT development across a region. Each CIT-TTAC partners with surrounding towns and police departments to provide consolidated CIT training, specialized trainings for other public safety personnel, development of community partnerships, development of organizational affiliations, mentoring of new programs/grantees, and technical assistance with the development of relevant policies, procedures, and protocols."
>
> Source: https://www.mass.gov/doc/fy2019-annual-report-on-jailarrest-diversion-grant-program/download p.8

COLORADO[51]



In Colorado, they have scaled co-response teams in 26 local police departments through state Marijuana Tax revenue and authorized by state legislation. LEAD, a specialized response program, is also currently being implemented in four counties and under evaluation by the University of Colorado.

Key Takeaways

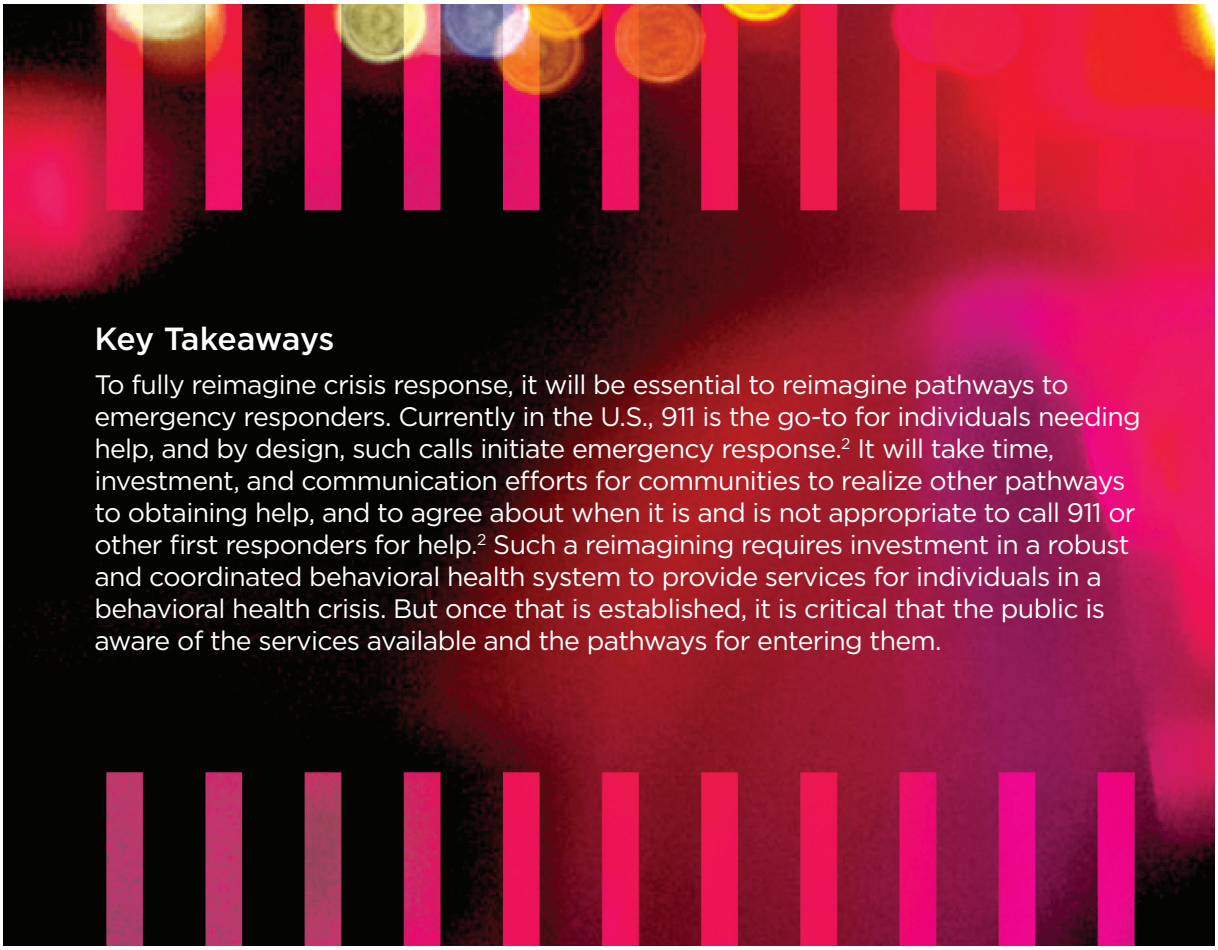
Improving how first responders respond to crisis-related calls for service among people experiencing SMI, SUD, or homelessness is only part of the solution to a complex problem. Reimagining crisis response has to address the prevalence of crises in the community and the reliance on emergency and public safety services during times of crisis.

Before implementing new, or scaling existing crisis response programs, communities should assess the full array of programs, policies, services, partnerships, and resources available for both crisis prevention and treatment.

CONCLUSION

This guidebook provides a framework for considering the different types of programs for preventing and improving emergency response to individuals experiencing SMI, SUD, and/or homelessness. By focusing on program components and not branded programs, we hope to demonstrate how different programs are operationalizing the same program components in their communities, in some cases, borrowing from more developed programs to tailor to the needs of their communities.

We focus on first responder-led diversion efforts because first responder agencies are often the channel through which crises are identified and responses are initiated. As communities consider budget adjustments and investment in other services to prevent crises among individuals experiencing SMI, SUD, and/or homelessness (e.g., affordable housing, access to education, employment opportunities, food security, accessible and reliable public transportation, and robust and coordinated behavioral health systems), the number of people in crisis and their reliance on emergency response systems should reduce. In the meantime, the types of programs covered in this guidebook support efforts to minimize dispatch of first responders and, when they do respond, ensuring they have the training and support to safely, effectively, and justly de-escalate, screen, and connect individuals to needed services and care.



Key Takeaways

To fully reimagine crisis response, it will be essential to reimagine pathways to emergency responders. Currently in the U.S., 911 is the go-to for individuals needing help, and by design, such calls initiate emergency response.[2] It will take time, investment, and communication efforts for communities to realize other pathways to obtaining help, and to agree about when it is and is not appropriate to call 911 or other first responders for help.[2] Such a reimagining requires investment in a robust and coordinated behavioral health system to provide services for individuals in a behavioral health crisis. But once that is established, it is critical that the public is aware of the services available and the pathways for entering them.

PROGRAM DESCRIPTIONS

OUTREACH AND PREVENTION (INTERCEPT 0)

Specialized Outreach

- **HOPE (Homeless Outreach and Positive Encounters):** plainclothes officers conduct outreach to homeless individuals, connecting them to needed services, linking them to resources for basic needs, communicating with other service providers, and training other officers in CIT principles with the goal of shifting the relationship between the police and the homeless population. Created and implemented in San Antonio, Texas.
- **QOL (Quality of Life Unit):** permanent unit of two law enforcement officers who engage with homeless individuals to provide basic services including meals and haircuts, as well as linkage to treatment for SMI/SUD. Implemented in Indio, CA.

Paired Outreach

- **BHRT (Behavioral Health Response Team):** team consisting of patrol officers and licensed mental health providers who conduct pre-crisis outreach to people with serious mental illness (SMI) who have had previous encounters with the police. The team travels in pairs in special, non-police cruiser cars. Other officers can refer cases to the team. Implemented in Portland, OR.
- **CSOs (Community Service Officers):** social workers employed by the police department support high-need individuals (including people with SMI/SUD, and survivors of interpersonal and domestic violence) by providing and linking to community services. Implemented in Birmingham, AL.
- **CWP (Community Wellness Program):** plainclothes officers and mental health professionals conduct outreach to individuals known to be living with SMI or SUD, offer them services, and link them to ongoing treatment. Originally, outreach took place one day a week; now, funding has allowed for up to 10 consecutive daily check-ins on individuals needing services. Implemented in Warwick, RI.
- **HELP (Health, Efficacy, and Long-term Partnerships):** social workers who routinely engage with homeless individuals share necessary information with police and conduct patrol with police officers to offer transport of individuals to shelters. From shelters, homeless individuals can apply for more long-term housing. Implemented in Honolulu, HI.
- **HSD (Homeless Service Detail):** officers are paired with outreach workers to go into neighborhoods with the highest rates of homelessness and connect individuals to needed services. Administrative data from the police, behavioral health department, and offices of homeless services match their data to develop a list of frequent utilizers. Created and implemented in Philadelphia, PA.
- **RREACT (Rapid Response Emergency Addiction and Crisis Team):** a team consisting of a paramedic and social worker respond to a local hospital emergency room to engage individuals who have just experienced an overdose; links individual to substance use treatment. Partnership between Columbus PD, Columbus Fire, Central Ohio Hospital Association, and various community-based organizations. Created to fulfill high demand for opioid-abuse treatment. Implemented in Columbus, OH.

Team-Based Outreach

- **CARE (Community Assessment, Response and Engagement):** provides targeted services for homeless individuals living with SMI and/or substance use disorder (SUD). An Engagement Team (composed of a case manager, fire department paramedic, mental health clinician, police officer, police sergeant, probation officer, nurse, and social worker) provides direct services in the field. Implemented in Modesto, CA.
- **CLEAR (Community Law Enforcement Assistance Recovery):** team members (including a police officer, nurse, social worker, recovery coach, and data analyst) use police data to identify individuals with SUD; they then reach out directly to the individuals to offer help overcoming their addiction. Implemented in Winthrop, MA.
- **HOME (Homeless Outreach and Medical Emergency):** partnership between the San Francisco EMS, fire department, department of public health, and human services agency. Teams consisting of a paramedic captain, intensive case managers, outreach workers, and nurse practitioners conduct outreach and support for homeless individuals. Goal is to identify and conduct outreach to frequent users of systems and connect them to community-based care and treatment.
- **HOST (Homeless Outreach Street Team):** a team of police officers, social workers, paramedics, and behavioral health specialists offer support and resources for individuals pre-crisis. Goal is to reduce jail bookings and ER usage and increase enrollment in a homeless management coordinated care system. Created and implemented in Austin, Texas.
- **HOT (Homeless Outreach Team):** trained police officers, mental health professionals, and social service officers conduct outreach to homeless individuals, providing basic services and linking to ongoing support. In Milwaukee, WI, HOT officers are CIT-trained and also partner with the local Housing First initiative. In Wichita, KS, HOT officers conduct outreach pre-crisis and respond to crisis-related 911 calls.

Voluntary Walk-in Programs

- **Angel:** any individual who enters the police department and requests help with opioid use is connected to a detox or treatment facility by the watch commander on duty. Individuals who possess drugs or drug equipment when requesting help are given amnesty and not charged with possession. Implemented in Gloucester, MA.
- **Hero Help:** individuals who contact the police and ask for treatment assistance are allowed entry into drug and/or alcohol addiction treatment in lieu of criminal arrest. Individuals who enter the program are then enrolled in a 23-hour observation facility where they receive a clinical assessment and are triaged to appropriate levels of care. Implemented in Delaware.
- **LEAAP (Law Enforcement Addiction Assistance Program):** based in police departments. County residents can come to the police station to ask for help and treatment. Drugs or paraphernalia on their persons are handed over and they are given amnesty for possession; police then screen them for eligibility, and if eligible, they are assigned to a volunteer to usher them through the linkage to treatment process.
- **Safe Station:** an individual in need can present at any time to local fire station that has been dubbed a “Safe Station” and seek assistance. The firefighters conduct a brief assessment to determine is emergency medical care is needed, then contacts a local mental health/behavioral health center. A representative from the treatment center arrives and can transport the patient to appropriate treatment. Initially implemented in Nashua, NH; currently implemented in Manchester, NH and Providence, RI.

INTERVENTION AT 911 CALL (INTERCEPT 1)

Specialized Dispatch

- **911-CIT:** 911 call takers are trained in mental health awareness and de-escalation techniques, which allows the call takers to correctly identify which calls warrant CIT-team dispatch. Implemented in Chicago, IL.

Embedded Dispatch

- **CCD (Crisis Call Diversion):** places mental health professionals in 911 dispatch centers to respond to crisis calls. Mental health professionals help to de-escalate situation over the phone; in the instance that police are needed, the professionals can provide life-saving information to the police before they are dispatched to the scene. Implemented in Houston, TX.
- **DCDP (Distressed Caller Diversion Program):** 911 dispatch determines if incoming call pertains to a person with SMI or who is in emotional distress; call-taker conducts a risk assessment to determine if person is eligible to be connected to a counselor at a crisis center (i.e. do not have a specific plan or timeframe for harm to self or others). Counselor then provides de-escalation over the phone and schedules a mobile crisis team to reach individual, as well as follow-up over the next two days. Implemented in Broome County, NY.

Transfer to Crisis Center

- **MHTP (Mental Health Transfer Program):** partnership between 911 dispatch center and local county crisis line to reduce unnecessary police dispatch for mental health-related calls. Protocols are used to triage 911 calls and determine which can be safely transferred to a hotline staffed by mental health professionals. Implemented in Multnomah County, OR.

INTERVENTION BY FIRST RESPONDER (INTERCEPT 1)

Specialized Response

- **CI Deputy (Crisis Intervention Deputy):** a single deputy designated to respond to crisis calls with the goal of de-escalating the situation and connecting the case to the necessary services. This is a singular position within the Whatcom County Sheriff's Department responsible for diverting people with SMI from the justice system. The deputy also serves as a liaison between law enforcement and various other agencies. Implemented in Whatcom County, WA.
- **CIT (Crisis Intervention Team):** provides intensive training to officers focused on crisis de-escalation and interacting with individuals with SMI/SUD; encourages partnership between law enforcement, mental health professionals, and addiction specialists. Created in Memphis, TN; since then, has been widely adopted in many cities and counties.
- **DART (Drug Abuse Response Team):** trained, designated unit of officers respond to opioid overdose calls and offer assistance in enrolling individuals in substance use treatment, including transportation to detox. After initial contact, DART officers link individuals to services in the community and conduct follow-up over a two–year period to monitor progress and act as an advocate in the legal system. Implemented in Lucas County, OH.
- **ECIT (Enhanced Crisis Intervention Team):** a team composed of officers who have volunteered for more advanced training in crisis management (all officers receive basic CIT training). The ECIT team is the first team to be dispatched to crisis calls. Implemented in Portland, OR.

- **LADDER (Linkage to Addiction Recovery through Emergency Response):** focuses on training fire department paramedics to link people who use substances to treatment and care. Fire department paramedics engage individuals they encounter and refer them to appropriate resources and treatment. Currently implemented in Baltimore City Fire Department in Baltimore, MD.
- **LEAD (Law Enforcement Assisted Diversion):** a pre-booking diversion program led by law enforcement with formal partnerships with behavioral health, prosecutorial, and community-based stakeholders. Teams of LEAD-trained officers respond to 911 calls. Contacted individuals can form a "social contract" with the program and will receive follow-up from a behavioral health clinician with no further police involvement in cases with no criminal charges. If a case could involve an arrest, individuals can have an assessment scheduled and must attend the assessment or else charges will be filed. Since starting in Seattle, LEAD has been implemented in various cities including Baltimore and San Francisco.
- **STEER (Stop, Triage, Engage, Educate and Rehabilitate):** individuals with SUD-related crises are diverted from the justice system to substance use treatment. If no criminal charges are present, STEER offers case management and access to treatment within two days. If criminal charges are present, law enforcement determines whether to offer STEER at the call for service; criminal charges are abated if individual accepts and enters treatment. Implemented in Montgomery County, MD.

Embedded Co-response

- **BHRP (Behavioral Health Response Program):** A full-time behavioral health coordinator is housed within a police unit and oversees the co-response team, manages officer training, and supervises the mental health liaison position. The coordinator also oversees a working group for crisis providers, which includes key people from emergency departments, inpatient facilities, substance use and mental health clinics, shelters, and other community-based organizations. The mental health liaison is dispatched to calls with officers and provides assessment, de-escalation, and links to services. Implemented in Portland, ME.
- **CCR (Community Crisis Response):** embeds two mental health clinicians in the police department; they ride along with police to calls involving people with SMI to de-escalate situation, provide assessment, and provide linkage to treatment. Implemented in Bozeman, MT.
- **CIRT (Crisis Intervention Response Team):** pairs officers (some programs use CIT-trained officers) with mental health professionals to respond to individuals with SMI in crisis. Established in Houston with a partnership between Houston PD and a local mental health clinic.
- **CRT (Crisis Response Team):** law enforcement officers (who may be trained in CIT) and mental health clinicians are paired to respond to calls involving a mental health crisis, triage intervention, and conduct outreach/follow-up. The team also maintains partnerships with local behavioral health organizations (such as the Boston Emergency Services Team (BEST) in Boston) and the National Alliance on Mental Illness (NAMI). Implemented in Seattle, WA and Boston, MA
- **CT Diversion (North Central Connecticut Diversion Team):** pairs CIT-trained law enforcement officers with behavioral health clinicians to assess and respond to calls involving individuals in SUD/SMI-related crises. Initially created in response to Connecticut's opioid crisis.
- **EDGE (Early Diversion, Get Engaged):** teams of officers, behavioral health clinicians, and peer support specialists respond to crisis calls and link individuals to needed services. Clinicians can ride along with officers or transport themselves to the scene; they can also offer to ride along with the individual who elects to be dropped off at treatment. The peer facilitator conducts a warm handoff to outside service providers. Implemented in Boulder, CO.

- **MCAT (Mobile Crisis Assistance Team):** teams consisting of a law enforcement officer, a behavioral health clinician, and a paramedic respond to crisis calls to divert individuals from justice system. Teams provide linkage to further treatment and conduct follow-up. Implemented in Indianapolis, IN.
- **MHST (Mental Health Support Team)/U-MATTER (United Medication Assisted Treatment Targeted Engagement Response):** a specialized unit of the Tucson PD consisting of specially trained officers and an embedded clinician who respond to calls involving SMI. Under U-MATTER, "drug counselors" are dispatched along with the MHST when they respond to calls; MHST & drug counselors are then able to facilitate referral to treatment programs rather than charging individuals with minor possessions. Implemented in Tucson, AZ.
- **PERT (Psychiatric Emergency Response Team):** a team consisting of a PERT-trained officer and a licensed mental health clinician respond to 911 calls for mental health emergencies; goal is to link individuals with mental health treatment. Officers receive 8 hours of PERT training with the opportunity for more advanced training. PERT is based on the Memphis CIT model. Implemented in San Diego, CA.
- **SMART (System-wide Mental Assessment Response Teams)/CAMP (Case Assessment and Management Program):** partnership between the Los Angeles Police Department and the Los Angeles County Mental Health department. Teams of officers and mental health professionals are dispatched to assist individuals with SMI in crisis. Individuals are diverted to psychiatric care. Individuals' data are entered into a database that only SMART officers have access to, thus potentially improving care coordination and flagging for future encounters. CAMP provides more intensive case management for high-need individuals referred to LAPD's SMART (System-wide Mental Assessment Response Teams) program. Implemented in Los Angeles, CA.

Mobile Co-response

- **CAHOOTS (Crisis Assistance Helping out on the Streets):** mobile crisis intervention via a team that includes a medical responder (nurse or EMT) and a mental health professional. Started in Eugene, OR, CAHOOTS is currently implemented in several cities including Indianapolis, Denver, Portland, and New York.
- **CCRI (Community Crisis Response and Intervention):** a hotline staffed by mental health clinicians is available for law enforcement to request onsite, virtual, or community-based services; CCRI then guarantees those services within 60 minutes. Implemented in South Carolina.
- **CR288 (Chandler Fire Department Crisis Response Team):** deploys behavioral health clinicians alongside law enforcement/firefighters to provide evidence-based practices to individuals in psychiatric distress. Implemented in Chandler, AZ.
- **Diversion First:** law enforcement-led diversion program targeting people with SMI, SUD or IDD in one county. Formal partners include the county's Community Services Board, which operates a center for drop off and assessment, sheriff's office, police and fire departments, and the juvenile justice system. All officers can drop off cases experiencing SMI/SUD-related crises at the community's social service center, where CIT-trained officers are co-located 24/7 to conduct assessment. The program also includes two mobile teams of mental health providers who can come on the scene in more acute cases.
- **EMCOT (Expanded Mobile Crisis Outreach Team):** first responders on the scene request the dispatch of mental health providers if crisis is determined to be related to SMI. Mental health providers conduct assessments on scene and connect individuals to psychiatric treatment. Implemented in Austin-Travis County, TX.

- **Grady EMS (GRADY EMS Upstream Crisis Intervention Group):** multi-disciplinary crisis response team consisting of a licensed counselor, a clinical social worker, and sometimes a third-year psychiatry resident. The team self-dispatches, co-responds with ambulances, or responds at the request of EMS caregivers on scene. The program also enables 911 dispatchers to transfer some calls directly to a mental health crisis hotline. Implemented in Atlanta, GA.
- **HEART (Homeless Emergency Assessment & Response Team):** partnership between fire department and public health department to provide services to homeless individuals who frequently call 911 for non-emergency health/psychological issues. Two-person teams of a fire department paramedic and an outreach specialist are dispatched to respond to calls and link callers to services. Implemented in San Francisco, CA and several other cities in the country.
- **MCRT (Mobile Crisis Response Team):** teams of law enforcement officers, paramedics (including fire department paramedics) and mental health specialists are dispatched to respond to 911 calls involving individuals with SMI, as well as general crisis calls. MCRTs exist in various cities across the U.S. and conduct varied outreach/follow-up with individuals, with the primary goal to divert individuals with SMI from emergency departments and the justice system.

Virtual Co-response

- **AMC (Assessment/Mobile Crisis Team):** 24/7 mobile psychiatric assessment team; provides triaging and links people in psychiatric distress/crisis to ongoing treatment. Implemented in Charleston, SC.
- **CORE (Clinician and Officer Remote Evaluation):** provides responding law enforcement officer with a tablet virtually connected to a remote mental health clinician, who can provide triage and assessment to individuals in crisis. Implemented in Harris County, TX.
- **ETHAN (Emergency TeleHealth and Navigation):** a telehealth program that can be initiated by paramedic/EMS on scene. An individual in crisis is offered to be connected with an emergency physician virtually, via video call. Emergency physicians are specifically on-call to respond. If the physician determines that the individual does not need immediate medical attention, they can refer the individual to care at a later date or for a follow-up assessment. Implemented in Houston, TX.
- **Grand Care:** law enforcement officers and hospitals are provided with mobile tablets so that responding officers can link individuals in crisis with licensed mental health professionals upon encounter, providing 24-hour face-to-face virtual communication.

Targeted Follow-up Programs

- **CO-OP (Community Opioid Outreach Program):** a multi-agency partnership program that conducts outreach to individuals who suffer non-fatal opioid overdoses. A team consisting of a police officer, firefighter, outreach specialist, public health official, and local substance abuse provider responds to the individual within 24-48 hours of a known overdose. The team then connects the individual to treatment. Implemented in Lowell, MA.
- **GROW (Getting Recovery Options Working):** a mobile crisis response team consisting of law enforcement officers, fire department paramedics, certified peer supports, and overdose specialists. The team connects people who have experienced an overdose and their family members/friends to treatment, recovery support services, overdose prevention education, and community outreach. Implemented in Dayton, OH.

- **MHO (Mental Health Officers):** full-time mental health officers are embedded into a police department to provide follow-up support to individuals who have already come into contact with police for mental health-related crises. MHOs coordinate with service providers and share information with patrol officers to inform response plans. Implemented in Madison, WI.
- **PNPCR-MT (Peer Network Peer Crisis Response-Montana):** peer support specialists are activated by CIT-trained officers to follow up with and coordinate community care for individuals who have been in recent crisis. Peer specialists provide weekly follow-up with consenting individuals and build long-term supportive relationships. They also hold a community support group and develop outreach materials for law enforcement to distribute. Implemented in Montana.

RESOURCES RELATED TO IMPROVING RESPONSE TO VULNERABLE POPULATIONS

Addressing Mental Health in the Justice System

- Brief report about various state laws/policies regarding pre-arrest intervention, diversion, and re-entry.
  https://www.ncsl.org/documents/legisbriefs/2015/lb_2331.pdf

Approaches to Early Jail Diversion: Collaborations and Innovations

- Review of current landscape and implications for policy of pre-booking diversion programs for people with serious mental illness (SMI), substance use disorder (SUD), and co-occurring disorders.
  https://www.abtassociates.com/files/insights/reports/2020/jail-diversion-final-report-_1.10.20_update.pdf

Behavioral Health Crisis Services - Models and Issues

- Publication developed by Health Management Associates that reviews different behavioral health crisis response models, including challenges and potential strategies for addressing challenges.
  https://mihealthfund.org/wp-content/uploads/2018/10/HealthFund_BehavioralHealthCrisisServices.pdf

Data-Drive Justice Playbook

- Playbook developed by the National Association of Counties highlighting strategies related to pre-arrest diversion, crisis stabilization, and housing and social supports, particularly among high-utilizers.
  https://www.naco.org/sites/default/files/documents/DDJ%20Playbook%20Discussion%20Draft%2012.8.16_1.pdf

Divert to What? Community Services that Enhance Diversion

- Publication developed by the National Alliance on Mental Illness to help communities identify gaps and opportunities in existing mental health services, including crisis care.
  https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Divert-to-What-Community-Services-that-Enhance-Diversion/DiverttoWhat.pdf

Effective Homeless Crisis Response System for Homeless Veterans

- Toolkit developed by the Department of Housing and Urban Development to support homeless crisis response systems for veterans.
  https://files.hudexchange.info/resources/documents/Vets-at-Home-Crisis-Response-System-Toolkit.pdf

GAINS Center for Behavioral Health and Justice Transformation

- Center focused on expanding access to services for people with mental and/or substance use disorders who come into contact with the justice system.
  http://www.samhsa.gov/gains-center

Jail Diversion Program Evaluation Resource Guide

- Resource guide informed by the Assistant Secretary for Planning and Evaluation's Research Project, State Interventions for Diverting Individuals with Serious Mental Illness and Co-occurring Disorders from the Justice System. The guide is designed to support the design and implementation of program evaluation of jail diversion programs.
  https://fliphtml5.com/jdba/mbyo/basic

Permanent Supportive Housing Evidence-Based Practices (EBP) Kit

- Outlines the essential components of supportive housing services and programs for people with mental illness; discusses how to develop new programs within mental health systems that are grounded in evidence-based practices.
  http://store.samhsa.gov/product/PermanentSupportive-Housing-Evidence-Based-Practices-EBPKIT/SMA10-4510

Re-Imagining Crisis Response: The Crisis Diversion Facility Model

- Outlines the development and rationale of the crisis diversion facility model, which offers stabilization and services to individuals in crisis through a central building
  https://www.healthmanagement.com/wp-content/uploads/AVPolicyBrief_v10.pdf

Stepping Up Initiative

- Initiative focused on reducing number of people with mental health disorder in jails.
  https://stepuptogether.org/

The Legislative Primer Series for Front End Justice: Mental Health

- Primer on all of the intercepts on the SIM to assist policymakers with reducing the prevalence of individuals with mental health disorder in jails
  https://www.ncsl.org/portals/1/HTML_LargeReports/Mental_Health_Report_32598.pdf

The Sequential Intercept Model

- Description of the Sequential Intercept Model presented by Policy Research Associates
  https://www.prainc.com/wp-content/uploads/2018/06/PRA-SIM-Letter-Paper-2018.pdf

Resources Specific to Improving Emergency Crisis Response among First Responders

BJA Police Mental Health Collaboration Toolkit

- Toolkit developed to support collaborations among law enforcement and the community on issues of mental health, including essential elements and examples of collaborations.
  https://pmhctoolkit.bja.gov/

Building Successful Partnerships between Law Enforcement and Public Health Agencies to Address Opioid Use

- Report developed by the Police Executive Research Forum that presents discussions regarding approaches, including specific programs, law enforcement agencies are implementing that focus on prevention and treatment of opioid and heroin use and abuse.
  https://cops.usdoj.gov/RIC/Publications/cops-p356-pub.pdf

Citation in Lieu of Arrest Final Report and Literature Review

- Report and literature review on benefits, concerns and challenges associated with issuing citations in lieu of arrests, published by the International Association of Chiefs of Police
  https://www.theiacp.org/resources/citation-in-lieu-of-arrest-final-report
  https://www.theiacp.org/resources/document/citation-in-lieu-of-arrest-literature-review

Crisis Response Services for People with Mental Illnesses or Intellectual or Developmental Disabilities: A review of the literature on police-based and other first response models

- Report developed by the Vera Institute as part of the Serving Safely Initiative that presents a literature review of published research on programs targeting persons with SMI or I/DD.
  https://www.vera.org/downloads/publications/crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities.pdf

Improving Responses to People with Mental Illnesses: The essential elements of a specialized law enforcement-based program

- Publication developed by the Council of State Governments Justice Center discussing 10 essential elements for specialized law enforcement based-responses to people with mental illness.
  https://csgjusticecenter.org/publications/improving-responses-to-people-with-mental-illnesses-the-essential-elements-of-a-specialized-law-enforcement-based-program/

Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Individual Jurisdictions

- Report developed by the Council of State Governments Justice Center and Police Executive Research Forum to provide guidance on designing a program that meets a community's specific needs, including problems and community characteristics that can affect the design and planning.
  https://csgjusticecenter.org/wp-content/uploads/2020/02/Tailoring_LE_Initiatives.pdf

Improving Responses to People with Mental Illnesses: Strategies for Effective Law enforcement Training

- Report developed by the Council of State Governments Justice Center and Police Executive Research Forum to identify challenges associated with providing specialized training to law enforcement and potential strategies to address the challenges.
  https://csgjusticecenter.org/wp-content/uploads/2020/02/le-trgstrategies-1.pdf

Police and Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People with MH Needs

- Publication developed by the Council of State Governments Justice Center to present strategies to support the development and sustainment of police-mental health collaborations.
  https://csgjusticecenter.org/wp-content/uploads/2020/02/Police-Mental-Health-Collaborations-Framework.pdf

Police, Treatment, and Community Collaborative (PTCC)

- Information about the Police, Treatment, and Community Collaborative (PTCC), an organization of practitioners in law enforcement, behavioral health, advocacy, and public policy, that seeks to increase behavioral health and social service options available through law enforcement diversion programs
  https://ptaccollaborative.org/about/

Policing in Vulnerable Populations

- International Association of Chiefs of Police report that describes promising programs among agencies participating in the Advancing 21st Century Policing Initiative that focus on police interactions with vulnerable populations (persons experiencing SMI, SUD, and/or homelessness)
  https://www.theiacp.org/sites/default/files/2018-11/IACP_PMP_VulnerablePops.pdf

Responding to Individuals in Behavioral Health Crisis via Co-responder Models

- Brief developed by Policy Research Inc. and the National League of Cities to introduce different types of co-response models.
  https://www.theiacp.org/sites/default/files/SJCResponding%20to%20Individuals.pdf

Responding to Persons Experiencing a Mental Health Crisis

- Model policy published by the International Association of Chiefs of Police
  https://www.theiacp.org/sites/default/files/2018-08/MentalIllnessBinder2018.pdf

Smart Policing Initiative

- Collaborative consortium composed of the BJA, CNA, and over 30 local law enforcement agencies that are testing solutions to serious crime problems in their jurisdictions
  https://bja.ojp.gov/program/strategies-policing-innovation-spi/overview

Statewide Policies Relating to Pre-Arrest Diversion and Crisis Response

- Article reviewing state laws and regulations relevant to pre-arrest diversion strategies
  https://www.rstreet.org/wp-content/uploads/2019/10/Final-187.pdf

Tailoring Crisis response and Pre-Arrest Diversion Models for Rural Communities

- Action brief developed from the SAMHSA pre-arrest diversion expert panel that identifies strategies and technologies rural communities may apply to support pre-arrest diversion.
  https://store.samhsa.gov/product/Tailoring-Crisis-Response-and-Pre-Arrest-Diversion-Models-for-Rural-Communities/PEP19-CRISIS-RURAL

The 911 Call Processing System: A Review of the Literature as it Relates to Policing

- Literature review that captures the history, technology, metrics, and datasets related to 911 calls, published by the Vera Institute
  https://www.vera.org/publications/911-call-processing-system-review-of-policing-literature

Resources Specific to Crisis Intervention Team (CIT)

Crisis Intervention Team (CIT) Core Elements

- Presentation of CIT core elements
  http://www.cit.memphis.edu/information_files/CoreElements.pdf

Crisis Intervention Team (CIT) Programs: A Best Practices Guide for Transforming Community Responses to mental Health Crisis

- Guide developed by CIT International for starting and sustaining a CIT program.
  https://www.citinternational.org/bestpracticeguide

CIT Advocacy Toolkit

- Toolkit designed by National Alliance on Mental Illness to help providers advocate for CIT programs
  http://www.gocit.org/uploads/3/0/5/5/30557023/cit_advocacy_toolkit.pdf

Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step by Step Guide

- Guide developed by SAMHSA to promote use of data to inform implementation and monitoring of CIT programs.
  https://store.samhsa.gov/product/Crisis-Intervention-Team-CIT-Methods-for-Using-Data-to-Inform-Practice/SMA18-5065

The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners

- Primer for mental health providers on the CIT Model that reviews the model's key elements, implementation and related challenges, and variations in the model.
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769782/

Advancing Crisis Intervention Teams Programs in Tennessee: Tools, Guidelines, and Recommendations

- State report that provides review of core components CIT programs, and guide for program sustainment.
  https://www.tn.gov/content/dam/tn/mentalhealth/documents/Advancing_CIT_Programs_in_Tennessee_ALL.pdf

Pay for Success and the Crisis Intervention Team Model: Insights from the PFS-CIT Learning Community

- Issue brief to help stakeholders decide whether and how to implement or expand their CIT program and how pay-for-success can be helpful.
  https://www.urban.org/sites/default/files/publication/94741/pay-for-success-and-the-crisis-intervention-team-model_1.pdf

Resource Specific to Law Enforcement Assisted Diversion (LEAD)

Law Enforcement Assisted Diversion (LEAD): Core Principles, Fact Sheet and Evaluations

- Basic principles and evaluations of the evidence-based diversion program LEAD published by the LEAD National Support Bureau
  https://www.leadbureau.org/resources

Resources Specific to the Health Insurance Portability and Accountability Act (HIPAA) and Data Sharing

Data-Driven Justice and the Health Insurance Portability and Accountability Act FAQ

- Frequently-asked questions related to HIPAA in the context of data usage to understand and analyze emergency response
  https://www.naco.org/sites/default/files/documents/DDJ%20HIPPA%20FAQs.pdf

Health Insurance Portability and Accountability Act (HIPAA) FAQ

- Basic information about HIPAA which can be particularly important when law enforcement works with people with substance use disorder and/or mental health concerns
  https://www.hhs.gov/hipaa/for-professionals/faq/2073/may-covered-entity-collect-use-disclose-criminal-data-under-hipaa.html

HIPAA FAQs for Professionals

- General information about HIPPA from the Department of Health and Human Services
  https://www.hhs.gov/hipaa/for-professionals/faq/index.html

HIPAA Disclosures for Law Enforcement Purposes

- Specific information about HIPAA in the context of law enforcement use and disclosure form the Department of Health and Human Services
  https://www.hhs.gov/hipaa/for-professionals/faq/disclosures-for-law-enforcement-purposes/index.html

HIPAA Privacy Rule and Sharing Information Related to Mental Health

- Specific information about HIPPAA in the context of mental health, from the U.S. Department of Health and Human Services Office for Civil Rights
  https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf

Information Sharing in Criminal Justice–Mental Health Collaborations: Working with HIPAA and Other Privacy Laws

- Guidebook outlining policies for HIPAA in the context of inter-agency collaboration in the criminal justice system
  https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG_CJMH_Info_Sharing.pdf

Legal Agreements and Supporting Documents from Actionable Intelligence for Social Policy

- Information regarding best practices for sharing data securely in social policy work
  https://www.aisp.upenn.edu/resources/legal-agreements-and-other-supporting-documents/

LOGIC MODELS: INTERCEPT 0 PROGRAM MODEL TYPES

Intercept 0: Specialized Outreach

Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Impacts
Crisis Identification • Patrol/General Outreach Response Prep • Training (entire unit) • Partnerships/ Coordination Responder • Law Enforcement	• Assessment/ Screening • Referral to needed treatment/ services • Direct transport to needed treatment/ services • Logistical assistance (e.g., obtaining state ID)	• % of individuals encountered who receive assessment/ screening • % of individuals assessed who are referred to treatment/ services • % of individuals assessed who are directly transported to treatment/ services • % of individuals assessed who receive logistical assistance • % of encounters that result in arrest • % encounters that result in ED intakes • % of encounters receiving a complaint • % of responders trained • Number of partnerships established	• Reduced number of arrests • Reduced number of ED intakes • Increased connection to treatment • Increased connection to services for unmet needs correlated with justice-involvement (e.g., shelter, food) • Improved responder awareness of SMI/SUD issues and services • Improved client experience/ relations	• Reduced reliance on systems not designed to deal with specialized behavioral health issues • Cost-savings • Reduced instances of substance misuse • Reduced overdose fatalities • Reduced instances of untreated mental health conditions • Reduced number of crisis related calls for service • Improved community health • Reduced number of individuals experiencing homelessness (or related factors)

Intercept 0: Paired Outreach

Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Impacts
Crisis Identification • Patrol/General Outreach • Targeted Outreach Response Prep • Training (responder(s)) • Partnerships/ Coordination • Laws/Local Policies Responder • Law Enforcement • Clinician • Social Worker	• Assessment/ Screening • Brief intervention (if needed and paired with a clinician) • Referral to needed treatment/ services • Direct transport to needed treatment/ services • Logistical assistance (e.g., obtaining state ID)	• % of individuals encountered who receive assessment/ screening • % of individuals assessed who are referred to treatment/ services • % of individuals assessed who are directly transported to treatment/ services • % of individuals assessed who receive logistical assistance • % of encounters that result in arrest • % encounters that result in ED intakes • % of encounters receiving a complaint • % of responders trained • Number of partnerships established	• Reduced number of arrests • Reduced number of ED intakes • Increased connection to treatment • Increased connection to services for unmet needs correlated with justice-involvement (e.g., shelter, food) • Improved responder awareness of SMI/SUD issues and services • Improved client experience/ relations	• Reduced reliance on systems not designed to deal with specialized behavioral health issues • Cost-savings • Reduced instances of substance misuse • Reduced overdose fatalities • Reduced instances of untreated mental health conditions • Reduced number of crisis related calls for service • Improved community health • Reduced number of individuals experiencing homelessness (or related factors)

Intercept 0: Team-Based Outreach

Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Impacts
Crisis Identification • Patrol/General Outreach • Targeted Outreach Response Prep • Training (first responder(s)) • Partnerships/ Coordination • Laws/Local Policies • Payment systems • Data system structured for identifying and flagging frequent utilizers Responder • Law Enforcement • EMS/EMT • Clinician • Social Worker • Physician/Nurse	• Assessment/ Screening • Brief intervention (if needed) • Use of EBPs (e.g., motivational interviewing) • Referral to needed treatment/ services • Direct transport to needed treatment/ services • Logistical assistance (e.g., obtaining state ID)	• % of individuals encountered who receive assessment/ screening • % of individuals assessed who are referred to treatment/services • % of individuals assessed who are directly transported to treatment/services • % of individuals assessed who receive logistical assistance • % of encounters that result in arrest • % encounters that result in ED intakes • % of encounters receiving a complaint • % of responders trained • Number of partnerships established	• Reduced number of arrests • Reduced number of ED intakes • Increased connection to treatment • Increased connection to services for unmet needs correlated with justice-involvement (e.g., shelter, food) • Improved responder awareness of SMI/SUD issues and services • Improved client experience/ relations	• Reduced reliance on systems not designed to deal with specialized behavioral health issues • Cost-savings • Reduced instances of substance misuse • Reduced overdose fatalities • Reduced instances of untreated mental health conditions • Reduced number of crisis related calls for service • Improved community health • Reduced number of individuals experiencing homelessness (or related factors)

Intercept 0: Voluntary Walk-ins

Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Impacts
Crisis Identification • Walk-in/ Voluntary Response Prep • Training (first responder(s)) • Laws/Local Policies • Partnerships/ coordination • Technology/ Resources Responder • Law Enforcement • Firefighter • EMS/paramedic	• Assessment/ Screening • Referral to needed treatment/ Services • Medical clearance • Direct transport to needed treatment/ services	• % of individuals encountered who receive assessment/ screening • % of individuals assessed who are referred to treatment/ services • % of individuals assessed who are directly transported to treatment/ services • % of encounters that result in arrest • % encounters that result in ED intakes • % of encounters receiving a complaint • % of responders trained • Number of partnerships established	• Reduced number of arrests • Reduced number of ED intakes • Increased connection to treatment • Improved responder awareness of SMI/SUD issues and services • Improved client experience/ relations	• Reduced reliance on systems not designed to deal with specialized behavioral health issues • Cost-savings • Reduced instances of substance misuse • Reduced overdose fatalities • Reduced number of crisis related calls for service • Improved community health

LOGIC MODELS: INTERCEPT 1 PROGRAM MODEL TYPES

Intercept 1 (911): Specialized Dispatch

Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Impacts
Crisis Identification • 911 call Response Prep • Training (Dispatcher(s)) Responder • 911 dispatcher	• De-escalation • Assessment/ screening	• % of crisis-related calls for service that involve crisis stabilization • % of crisis-related calls for service that result in responder dispatch • % of dispatchers trained	• Reduced number of arrests • Reduced number of ED intakes • Improved dispatcher awareness of SMI/SUD issues and services	• Reduced reliance on systems not designed to deal with specialized behavioral health issues • Cost-savings

Intercept 1 (911): Embedded Dispatch

Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Impacts
Crisis Identification • 911 call Response Prep • Partnership/ coordination • Technology/ Resources Responder • 911 dispatcher • Clinician	• De-escalation • Assessment/ screening • Referral to needed treatment/ services • Follow-up	• % of crisis-related calls for service that involve crisis stabilization • % of crisis-related calls for service that result in responder dispatch • % of crisis-related calls for service that result in referral to treatment/services • % of crisis-related calls for service that result in follow-up • Number of partnerships established	• Reduced arrests • Reduced ED intakes • Increased connection to treatment/ services • Reduced repeated crisis-related calls for service	• Reduced reliance on systems not designed to deal with specialized behavioral health issues • Cost-savings • Reduced instances of substance misuse • Reduced instances of untreated mental health conditions • Reduced number of crisis related calls for service

Intercept 1 (911): Transfer to Crisis Center

Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Impacts
Crisis Identification • 911 call Response Prep • Partnerships/ Coordination • Laws/Local Policies • Technology/ Resources Responder • 911 dispatcher	• De-escalation • Assessment/ screening • Referral to needed treatment/ services	• % of crisis-related calls for service that involve crisis stabilization • % of crisis-related calls for service that result in responder dispatch • % of crisis-related calls for service that result in referral to treatment/services • Number of partnerships established	• Reduced arrests • Reduced ED intakes • Increased connection to treatment/ services • Reduced repeated crisis-related calls for service	• Reduced reliance on systems not designed to deal with specialized behavioral health issues • Cost-savings • Reduced instances of substance misuse • Reduced instances of untreated mental health conditions • Reduced number of crisis related calls for service

Intercept 1 (First Responder): Specialized Response

Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Impacts
Crisis Identification • 911 call • First responder dispatch line Response Prep • Training (first responder(s)/ entire unit) • Partnerships/ Coordination • Laws/Local Policies Responder • Law enforcement • Firefighter	• De-escalation • Assessment/ screening • Referral to needed treatment/ services • Referral to specific diversion program • Direct transport to needed treatment/ services	• % of responses that involve crisis stabilization on the scene • % of responses that involve an assessment/ screening • % of assessed individuals referred to treatment/ services • % of assessed individuals referred to a specific diversion program • % of assessed individuals directly transported to treatment/ services • % of encounters that result in arrest • % encounters that result in ED intakes • % of encounters that involved the use of force • % of encounters receiving a complaint • % of responders trained • Number of partnerships established	• Reduced number of arrests • Reduced number of ED intakes • Increased connection to treatment • Improved responder awareness of SMI/SUD issues and services • Reduced use of force • Improved client experience/ relations	• Reduced reliance on systems not designed to deal with specialized behavioral health issues • Cost-savings • Reduced instances of substance misuse • Reduced overdose fatalities • Reduced instances of untreated mental health conditions • Reduced number of crisis related calls for service

Intercept 1 (First Responder): Embedded Co-Response

Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Impacts
Crisis Identification • 911 call • First responder dispatch line Response Prep • Training (first responder(s)/ entire unit) • Partnerships/ Coordination • Laws/Local Policies • Payment systems • Technology/ Resources Responder • Law Enforce-ment • Clinician • Social worker • Paramedic	• De-escalation • Assessment/ Screening • Brief intervention (if paired with a clinician) • Use of EBPs (e.g., motivational interviewing) • Referral to needed treatment/ Services • Referral to specific diversion program •Direct transport to needed treatment/ services • Case management • Follow-up	• % of responses that involve crisis stabilization on the scene • % of responses that involve an assessment/ screening • % of assessed individuals referred to treatment/ services • % of assessed individuals referred to a specific diversion program • % of assessed individuals directly transported to treatment/ services • % of encounters that result in arrest • % encounters that result in ED intakes • % of encounters that involved the use of force • % of encounters receiving a complaint • % of individuals who receive case management services • % clients who receive follow-up • % of responders trained • Number of partnerships established	• Reduced number of arrests • Reduced number of ED intakes • Increased connection to treatment • Improved responder awareness of SMI/SUD issues and services • Reduced use of force • Improved client experience/ relations	• Reduced reliance on systems not designed to deal with specialized behavioral health issues • Cost-savings • Reduced instances of substance misuse • Reduced overdose fatalities • Reduced instances of untreated mental health conditions • Reduced number of crisis related calls for service

Intercept 1 (First Responder): Mobile/Virtual Co-Response

Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Impacts
Crisis Identification • 911 call • First Responder dispatch line • Community-based crisis line Response Prep • Training (first responder(s)/ entire unit) • Partnerships/ Coordination • Laws/Local Policies • Payment systems • Technology/ Resources Responder • Law Enforcement • Firefighter • EMS/paramedic • Clinician • Social worker • Physician/Nurse	• De-escalation • Assessment/ Screening • Brief intervention • Use of EBPs (e.g., motivational interviewing) • Medical clearance • Referral to needed treatment/ services • Direct transport to needed treatment/ services • Case management • Follow-up	• % of responses that involve crisis stabilization on the scene • % of responses that involve an assessment/ screening • % of assessed individuals referred to treatment/ services • % of assessed individuals referred to a specific diversion program • % of assessed individuals directly transported to treatment/ services • % of encounters that result in arrest • % encounters that result in ED intakes • % of encounters that involved the use of force • % of encounters receiving a complaint • % of individuals who receive case management services • % clients who receive follow-up • % of responders trained • Number of partnerships established • % of individuals transported to EDs by first responders	• Reduced number of arrests • Reduced number of ED intakes • Increased connection to treatment • Improved responder awareness of SMI/SUD issues and services • Reduced use of force • Improved client experience/ relations • Reduced use of first responder time and resources	• Reduced reliance on systems not designed to deal with specialized behavioral health issues • Cost-savings • Reduced instances of substance misuse • Reduced overdose fatalities • Reduced instances of untreated mental health conditions • Reduced number of crisis related calls for service • Expanded workforce capacity

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