A Framework for Communities Considering a Shift from Crisis Response to Crisis Prevention

Sarah Steverman, PhD, MSW, Elyse Yarmosky, LICSW, Holly Swan, PhD, & Meg Chapman, MA

Individuals and communities typically rely on the conventional emergency response system to respond to calls for service that involve a behavioral health crisis (i.e., a crisis involving mental health, substance use, or homelessness concerns), despite the understanding that such a response is often inappropriate. Ideally, community infrastructure would be designed to prevent and treat behavioral health concerns so as to minimize the occurrence of crises and the need for response. Shifting from an emergency response orientation towards a prevention-oriented, treatment-based approach requires community-level change. Some communities have started this shift by providing specialized training to first responders; others have implemented co-responder models where trained responders partner with behavioral health professionals in response to crisis-related calls for service. Ultimately, a fundamental reimagining of how to handle behavioral health crises—from emergency response to crisis prevention— requires bolstering the community-based behavioral health and service systems such that crises are prevented through universal and accessible mental health and substance use treatment and widespread affordable housing.

> "Shifting from an emergency response orientation towards a prevention-oriented, treatment-based approach requires community-level change."

In this paper, we set out a framework for communities seeking to shift their orientation from crisis response to crisis prevention by identifying incremental changes across multiple system components that can help build healthier communities.

Background

Each day, millions of people in the U.S. are experiencing a crisis. In 2019, over 20 million individuals aged 12 and older reported having a substance use disorder (SUD); over 50 million reported having a mental illness, and of these, 13.1 million of those were considered serious (SAMHSA, 2020); and on any given night over 560,000 people experience homelessness (HUD, 2020). In the United States, when a person is experiencing a crisis related to serious mental illness (SMI), SUD, or housing instability, the conventional emergency response system is engaged and first responders (most frequently law enforcement officers, but also firefighters and EMS/EMT) are dispatched to the scene. However, first responders do not always have the training, skills, and resources to effectively de-escalate and identify the source of the crisis, and connect the individual to needed treatment or resources. As a result, individuals in crisis with behavioral health treatment needs often end up in systems that are ill-equipped to deal with specialized behavioral health issues, such as emergency departments and the criminal justice system (e.g., arrest, incarceration) (Neusteter et al., 2019; Watson, Compton, & Pope, 2019; Sugie & Turney, 2017; Bernstein & Seltzer, 2003; Gur, 2010; Saloner et al., 2014; Abreu et al., 2017). This outcome often exacerbates, rather than mitigates, the underlying problem. In tragic cases, conventional emergency response that involves officers who have not been trained to recognize or deal with a person experiencing a behavioral health crisis can be fatal (Frankham, 2018).

When considering alternative responses that divert individuals away from the criminal justice system, the Sequential Intercept Model (SIM) provides a practical framework by identifying six points, or intercepts, along the justice system continuum where individuals in crisis may be diverted (Policy Research Associates, 2018). The intercepts most relevant for crisis response and prevention include community-based prevention and early intervention efforts (Intercept 0) and law enforcement and crisis response systems (Intercept 1) (Munetz & Griffin, 2006; Abreu et al., 2017; Bonfine, Wilson, and Munetz, 2019).

We expand the justice system application of the SIM to recognize that investing in and intervening at Intercepts 0 and 1 could also facilitate diversion away from the conventional emergency system (e.g., emergency departments). In this framework, we have outlined a theoretical state to which communities may aspire at the extreme end of Intercept 0, where crisis response is exceedingly rare because community-based mental health and substance use services and affordable supportive housing are readily and equitably available, preventing most individuals from escalating to crisis. Such a state represents a shift from relying on the conventional emergency response and criminal justice systems to address mental health, substance use, and homelessness problems in the community to a reliance on a robust, coordinated, and integrated community-based behavioral health systems to address these problems before they become crises (Bonfine, Wilson, & Munetz, 2019).

Rethinking crisis response and moving upstream to a more prevention-oriented community-based response requires programs, policies, and systemic changes to ensure:

- Community-based treatment and prevention services are available, accessible, and utilized
- First responders can minimize their role in crisis response;
- Community behavioral health and homeless services can increase their role in crisis response; and
- Community services and first responders can coordinate seamlessly so when first responders do encounter a crisis—i.e., while on patrol or when responding to a call —they can quickly refer the individual to behavioral health partners.

In this paper, we present a framework that identifies several areas where changes may be made as part of a communities' effort to shift from conventional emergency response to behavioral health crises (Intercept 1) to a community-based system that relies on a proactive community-wide approach to preventing behavioral health crises (Intercept 0). Such a shift requires addressing social determinants of health and ensuring comprehensive mental health and substance use treatment and affordable housing are universally available.

Figure 1 presents our framework for shifting from crisis response to crisis prevention. The four phases move from conventional emergency response at the far end of Intercept 1, to specialized or coordinated response, then to behavioral health system response, and then crisis prevention at the far end of Intercept 0. We then outline what each of the seven areas of change would theoretically look like within each phase of the continuum.

Figure 1. A Framework for Shifting from Crisis Response to Crisis Prevention
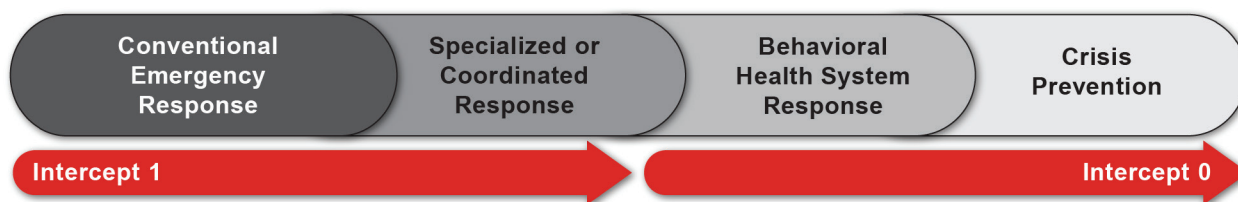
Our framework includes seven areas of change: *crisis-related calls for service, crisis response, social services availability and capacity, coordination and integration of community-based services, proactive outreach, policy, and training*. This framework is not designed to rate or score a particular community's response, but rather to highlight multiple elements that are important to consider when shifting from crisis response to crisis prevention. And while the framework represents a continuum, communities may successfully implement some preventive or proactive programs and policies, while continuing some elements of more conventional emergency crisis response.

Table 1 presents an overall summary of the seven areas of community-level change by stage of the framework.

Table 1: Community Level Characteristics at Each Stage

	Conventional Emergency Response	Specialized or Coordinated Response	Behavioral Health System Response	Proactive BH System
Crisis-Related Calls for Service	911 receive calls; call takers likely not trained in crisis intervention	911 call takers receive specialized crisis intervention training; dispatcher has ability to dispatch specially trained responders or co-response teams; community crisis lines are unavailable or specialized (e.g., suicide prevention only)	Behavioral health clinicians are embedded in 911 call centers; crisis centers are available and provide community members with an alternative to 911 for behavioral health crises; use of 911 is lessened by community outreach and education	Crisis-related calls for service rare; community members are aware of and utilize a 24/7 crisis hotline; if 911 is called, dispatchers are able to immediately hand the call off to the crisis hotline
Crisis Response	First responders respond; limited or no alternatives for emergency crisis support	First responders are trained in crisis intervention and have reliable access to behavioral health professionals	Crisis response is conducted by comprehensive crisis center support (crisis hotline and response teams)	Crisis response system is robust, but rarely used; focus moves to prevention rather than response
Social Services Availability and Capacity	Behavioral health services are fragmented, underfunded, and understaffed; crisis centers do not exist or are beyond capacity; communities lack affordable housing and homelessness services	Behavioral health services are less fragmented and includes crisis centers that are reliably available, 24/7, to first responders and the community	Behavioral health system is robust and includes crisis respite centers, safe sobering units, and comprehensive mental health and substance use treatment; behavioral health services are integrated or coordinated with social service agencies to ensure that clients have access to housing, food, employment, and other necessary supports	Behavioral health system is accessible and comprehensive; community provides universal insurance coverage; focus on alleviating stressors and improving social determinants of health
Coordination and Integration of Community-based Services	Uneven and inconsistent collaboration between first responders and service providers	Relationships between first responders and social services have been formalized; responders are trained in accessing resources	First responders and behavioral health clinicians are trained and coordinated in outreach and response; system may have dedicated clinical staff that serve as first responder liaisons to provide training on crisis response and access to resources	First responders and community members have ready access to community-based services; first responders are part of community-wide efforts to address social determinants of health

	Conventional Emergency Response	Specialized or Coordinated Response	Behavioral Health System Response	Proactive BH System
Proactive Outreach	Limited or non-existent proactive outreach to address behavioral health concerns	Outreach is occurring and being conducted by multi-disciplinary teams that include behavioral health clinicians	Outreach is entirely done by behavioral health professionals, including licensed clinicians (e.g., social workers) and peers	Proactive outreach and referral to needed services by behavioral health clinicians are prominent and the primary investment
Policy	Policies do not support an alternate response to conventional emergency response; funding for alternatives is unstable and time-limited	Strong and effective relationships are written in policy via MOUs; legal impediments have been removed; alternative crisis response programs receive increased and stable funding	Formal coordination among social services through MOUs or payment policy; funding previously allocated to crisis response may be earmarked for the behavioral health system in the service of crisis prevention	Local, state, and federal policies ensure robust, effective behavioral health, healthcare, and social service systems to meet the needs of all individuals; housing services are available; universal health insurance coverage exists; addressing social determinants of health are prioritized through progressive policies
Training	Specialized training in behavioral health crisis identification and intervention is inconsistent	All 911 call takers and first responders are trained in crisis intervention; clinicians are trained to support first responders	All first responders receive evidence-based training in de-escalation and crisis response; all first responders are trained on how to access the behavioral health crisis system, make referrals, and maintain relationships with staff	All first responders receive evidence-based training in de-escalation and crisis response; all first responders are trained on how to access the behavioral health crisis system, make referrals, and maintain relationships with staff

Conventional Emergency Response

At this stage, the community's crisis response system is comprised of a patchwork of responses that lack coordination in regard to program outcomes, implementation, and funding. The community relies on first responders to respond to crisis-related calls for service, and approaches crises with minimal levels of training and limited coordination with behavioral health service providers.

Crisis-Related Calls for Service

Call takers at 911 call centers likely do not have training in behavioral crisis identification and intervention and follow standard protocols for triage and dispatch. Technology and systems for emergency dispatchers to directly connect with behavioral health crisis providers are not in place. Similarly, alternative community crisis lines have not been implemented.

Crisis Response

Crisis response is entirely the purview of first responders, and community members do not have alternatives to access emergency crisis support from behavioral health clinicians.

Social Services Availability and Capacity

At this stage, the behavioral health treatment systems may be fragmented, underfunded, and understaffed. Wait-lists for non-crisis services tend to be long, leading to some people who need services not being able to access the appropriate level of care to maintain stability and avoid crises. Crisis centers are likely not available in the community, which means conventional emergency services (i.e., emergency departments) or criminal justice institutions (e.g., jails) become the default option for those in crisis. In addition, communities may have a lack of affordable housing and homelessness services, making it difficult for individuals to obtain and maintain housing.

> **Conventional Emergency Response**
>
> Due to a lack of resources and other policy and systemic limitations, first responders do not have the time, resources, or knowledge of the complex systems that may be available in the community to address behavioral health and housing problems.

Coordination and Integration of Community-based Services

Coordination between behavioral health programs and first responders has likely not been established at this stage.

Proactive Outreach

At this stage, communities have limited or non-existent proactive outreach to address behavioral health or homelessness problems and prevent crises from happening in the first place. If some outreach does exist, the programs are limited, emergency response-led, do not include behavioral health providers, and do not address systemic problems to prevent crises on a large-scale.

Policy

In the conventional emergency response stage, policies do not support an alternate response. Communities have not addressed legal impediments to information sharing and medical clearance or transport policy and practice requirements. Additionally, funding sources for training or alternative responses are likely unstable or time-limited, like grants and short-term appropriations.

> **Medical Clearance**
>
> 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, 2015). Medical clearance can be a barrier to immediate behavioral health crisis response.

Training

Although first responders are likely trained in de-escalation techniques, the degree to which this training is specialized to include behavioral health-related crises is inconsistent. At this stage, there has not been widespread adoption and implementation of specialized training (e.g., Crisis Intervention Training (CIT) or Mental Health First Aid (MHFA)).

Specialized or Coordinated Response

At the Specialized or Coordinated Response stage, behavioral health is more explicitly integrated throughout the community's crisis response system. The community has transitioned away from using the conventional emergency system as the primary response to SMI-, SUD-, and homelessness-related crises. First responders are receiving specialized training and co-response and team response models are more prevalent, with policies and training to support these models. Behavioral health clinicians play a larger role as partners in co-response as well as proactive outreach before crises occur.

WHAT IS ADDED AT THIS STAGE: training for 911 call takers to identify a behavioral health crisis and systems and support for them to dispatch a co-response team or specially trained responder in response; reliable access to behavioral health clinicians for first responders when responding to crisis; formal partnerships between first responders and the local behavioral health system.

Crisis-Related Calls for Service

At this stage, emergency call takers receive crisis intervention training and are able to de-escalate over the phone, when possible. If dispatchers determine an individual is in crisis, they have the ability to send a co-response team (police and behavioral health clinician) directly at the point of call. If a co-response team is not available, a first responder who has received crisis intervention training can be dispatched. An alternative community crisis line is either not available or if it is available, it is not equipped to handle all forms of crises (e.g., crisis line is for suicide prevention only).

Crisis Response

Unlike the conventional emergency response stage, when communities have a specialized or coordinated response, first responders are trained in crisis intervention and ideally have access to co-response teams made up of behavioral health clinicians and professionals. At this stage, the ideal is for co-response teams to be implemented and funded at a level that allows first responders to have access to behavioral health partners 24 hours a day, 7 days a week to respond to crises.

Social Services Availability and Capacity

At this stage, behavioral health systems are less fragmented and include 24 hour crisis centers that are available to both community members and co-response teams or trained first responders to bring individuals in crisis. Crisis centers provide an alternative destination to emergency departments and local jails for people experiencing a behavioral health crisis. When a person is interacting with the co-response team or receiving care at the crisis center, they are able to receive a warm handoff to their treatment team (if they are already engaged in services) or access an intake and assessment with a behavioral health provider who will then be able establish a treatment plan and begin services.

Coordination and Integration of Community-based Services

There is increased coordination with the more robust behavioral health system. Relationships between first responders and behavioral health programs, departments, and hospitals exist and have been formalized; first responders know they can make referrals and hand-offs to crisis centers and clinicians, and know how to do so (i.e., calling a hotline, paging a clinician directly, engaging in an intake process for a crisis center).

Proactive Outreach

At this stage, proactive outreach is being conducted by designated teams of specialized first responders, or ideally, multi-disciplinary teams that include behavioral health clinicians. Under this model, first responders and behavioral health professionals conduct outreach together, often in communities with high rates of homelessness, to identify individuals who are in need of services and get them engaged in treatment.

Policy

At this stage, strong and effective relationships between first responders and the behavioral health system are formalized via memorandums of understanding (MOUs) or other formal agreements. Legal impediments to implementing alternative responses have been removed and policies have been revised to support coordination. Alternative crisis response programs and collaborating behavioral health providers receive increased and stable funding so as not to have to rely on time-limited grants.

Training

911 call takers are trained in crisis intervention techniques to either de-escalate over the phone and divert the need for physical response altogether, or help to prepare for responder intervention. All first responders are trained in crisis intervention, as well as in how to manage crises specific to individuals with SMI, SUD, or housing concerns. And clinicians are trained to help support first responders.

Behavioral Health System Response

In communities with a crisis response system led by the behavioral health system, first responders are mostly removed from such responses. At this stage, the behavioral health system leads a comprehensive approach to addressing crisis response, including implementing alternative ways for community members to access help during a crisis, increased community outreach, and changes in policy and training to support community- and agency-level changes. Although the focus is still on response, crisis prevention becomes more prominent through increased availability of behavioral health treatment services and proactive outreach.

WHAT IS ADDED: 911 dispatch includes behavioral health professionals and automatically connects to the behavioral health crisis system; some communities may have an alternative number and/or mobile technology to access crisis services; behavioral health led crisis systems (e.g., 24-hour crisis teams); outreach and education to the public to be aware of available behavioral health crisis services; behavioral health providers conduct proactive outreach

Crisis-Related Calls for Service

At this stage, 911 call centers are staffed with embedded behavioral health clinicians who can receive calls diverted to them by call-takers and/or communities have an established crisis number. When a community member calls 911 for a behavioral health crisis, call takers automatically connect the person to the embedded clinicians or community crisis line. Outreach education is done by staff at the crisis center to community members, families, teachers, etc., to offer an alternative to calling 911 when individuals are in crisis.

Crisis Response

The behavioral health system has comprehensive crisis response that includes 24/7 crisis hotline staff and crisis response teams. These teams are well trained and funded so they are able to appropriately respond to crises and ensure the safety of the client, community, and themselves. The crisis team has a robust behavioral health system available to them to provide services to the individual in crisis, including crisis respite centers, safe sobering units, and comprehensive mental health and substance use treatment. The crisis center is open 24/7 and walk-ins are encouraged, thus aligning more closely with the needs the community and of first responders who may still encounter an individual in crisis.

Social Services Availability and Capacity

Crisis centers, led by behavioral health clinicians, are available to the community 24/7 and the community is aware of the crisis center and knows how to access it (e.g., walk-in, hotline). The crisis center is accessible, including geographically; it sits within the behavioral health system and coordinates with other aspects of the behavioral health system, like psychiatric clinics, residential treatment centers, and detox units. The behavioral health system has comprehensive treatment options, and is integrated or coordinated with social service agencies to ensure that clients have access to housing, food, employment, and other necessary supports.

Coordination and Integration of Community-based Services

Behavioral health clinicians conduct regular outreach with first responders and are embedded in 911 call centers; these relationships are formalized via MOUs. If first responders encounter someone with a behavioral health crisis while on patrol or during a response, they are able to immediately access behavioral health responders to address the situation. The behavioral health system may have dedicated staff that serve as first responder liaisons who provide training to first responder agencies on the crisis response process, ensuring 911 dispatchers and first responders are able to access the behavioral health crisis system.

Proactive Outreach

Outreach is entirely done by behavioral health professionals, including licensed clinicians (e.g., social workers) and peers.

Policy

Behavioral health systems closely coordinate with housing and other social services to address housing availability, food insecurity, employment, and other drivers of homelessness and stress among populations with SMI and/or SUD. Coordination may occur by MOU or payment policy, where payment for behavioral health and social services are blended or braided to provide comprehensive services rather than piecemeal fee for service arrangements. Funding previously allocated to crisis response may be earmarked for the behavioral health system in the service of crisis prevention.

Training

At this stage, all first responders receive evidence-based training in de-escalation and crisis intervention in case they encounter a behavioral health crisis in their line of duty, as well as to ensure interactions with individuals while on patrol are safe for all involved. Critically, all first responders are trained on how to access the behavioral health crisis system, make referrals, and maintain relationships with behavioral health system staff.

Crisis Prevention

At this stage, the community focus is preventive, and is led by a proactive behavioral health system that addresses social determinants of health and safety. In these ideal circumstances, community members have universal and robust insurance coverage, and use of crisis services is exceedingly rare as mental health and substance use treatment is readily available, affordable housing is a community-wide priority, and social determinants of health like racism and violence are addressed systemically.

WHAT IS ADDED: Universal insurance coverage, to include a robust behavioral health benefit, and payment flexibility to allow coverage of prevention and social services that promote mental health, prevent substance use and homelessness, and avoid crises; progressive housing policy to reduce housing instability and prevent homelessness; community commitment to improving social determinants of health like reducing racism, sexism, violence, environmental health, etc.

Crisis-Related Calls for Service

While crisis-related calls for service should be rare at this stage, community members are aware of and utilize a 24/7 crisis hotline when someone does experience a crisis related to SMI, SUD, or homelessness. In the rare case when someone calls the 911 call center for help, 911 call takers are able to immediately hand the call off to the crisis hotline.

Crisis Response

At this stage, the crisis response system is robust, but its use is rare. The robust behavioral health system is connected with accessible and adequate healthcare and social service agencies. The focus of the behavioral health system moves toward prevention rather than response, and so the occurrence of crises is limited.

Social Services Availability and Capacity

Like the previous stage, the behavioral health system is accessible and comprehensive. Since the community has universal insurance coverage, behavioral health providers have incentive to move upstream and provide comprehensive services to keep people healthy and prevent mental health and substance use needs, especially those that may be caused or exacerbated by stress due to finances, housing instability, trauma and violence, and other social determinants of health. As a whole, the behavioral health system is integrated within the larger community's health and social service system to prioritize the health of the entire community.

Coordination and Integration of Community-based Services

Because first responders are trained in recognizing and de-escalating individuals in crisis, if they encounter such an individual while on patrol or during a response, they are able to immediately access behavioral health responders to address the situation. In communities at this stage, first responders will be encountering far fewer individuals in crisis due to robust investment in housing and behavioral healthcare. Additionally, first responders are part of community-wide efforts to address social determinants of health, including efforts to eliminate systemic racism and reduce violence.

Proactive Outreach

Proactive outreach by behavioral health clinicians is prominent at this stage, connecting individuals with healthcare, social services, and resources for housing. Outreach staff recognize early risk factors or signs of mental health concerns or substance use (e.g., identifying children who have experienced trauma, identifying adolescents who are experimenting with substances, etc.), and can make referrals to early intervention programming meant to offer support and prevent development or progression of mental illness and/or substance misuse.

Policy

Communities at this stage benefit from local, state, and federal policies that ensure robust, effective behavioral health, healthcare, and social service systems to meet the needs of all individuals. Community-wide affordable housing is available and accessible; supportive housing for individuals with higher needs is also available. Policies and programs are in place to prevent and address substance use (e.g., prescription drug monitoring programs to prevent overprescribing; easy and early access to substance use treatment; evidence-based preventive education for children and teens). There is universal health insurance coverage, which guarantees all individuals access to preventive healthcare. Additionally, communities prioritize addressing social determinants of health through progressive policies to address systemic racism, reduce community and interpersonal violence, increase access to high quality child care and education (especially for families with low-income), and address environmental health.

Training

First responders receive training in evidence-based mental health and substance use-related crisis de-escalation techniques and receive comprehensive training on how to collaborate with the behavioral health system.

Conclusion

As communities increasingly consider shifting from a conventional emergency response led by first responders to a prevention-oriented response to behavioral health crises, there are multiple interrelated components of their systems that must be assessed and addressed. While some stakeholders may be motivated to entirely transform their crisis response and treatment systems, lack of political will from community leaders and members and scarce funding likely mean that opportunities for systems change will be incremental rather than wholesale across all of the components. But to achieve the aspirational prevention-oriented approach, both the first responder systems and the behavioral health systems must change the policies and procedures that support the conventional ways of operating.

The framework we present is intended to assist communities in understanding their current approach to handling behavioral health crises and identify potential next steps to shifts to a more behavioral health centered and prevention-oriented response. However, research is needed to better understand how to implement these new systems and policies and their overall impact on emergency, criminal justice, behavioral health, and housing outcomes.

References

Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. Behavioral Sciences & the Law, 35(5-6), 380-395.

Bernstein, R. and Seltzer, T. (2003). "Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform." The University of the District of Columbia Law Review, 7 U.D.C. L. Rev. 143: 143-162.

Bonfine, N., Wilson, A. B., & Munetz, M. (2019, December 4). Meeting the needs of justice-involved people with serious mental illness within community behavioral health systems. Psychiatric Services. https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201900453

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

Frankham, Emma. 2018. "Mental Illness Affects Police Fatal Shootings." Contexts 17 (2):70–72. doi:10.1177/1536504218776970.

Gur, O. (2010). "Persons with Mental Illness in the Criminal Justice System: Police Interventions to Prevent Violence and Criminalization." Journal of Police Crisis Negotiations, 10:220–240. DOI: 10.1080/15332581003799752

Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. Psychiatric Services, 57(4), 544-549.

Neusteter, S. R., Mapolski, M., Khogali, M., & O'Toole, M. (2019, July). The 911 call processing system: A review of the literature as it relates to policing. New York, NY: Vera Institute of Justice. https://www.vera.org/publications/911-call-processing-system-review-of-policing-literature

Policy Research Associates. (2018). The sequential intercept model: Advancing community-based solutions for justice-involved people with mental and substance use disorders. https://www.prainc.com/wp-content/uploads/2018/06/PRA-SIM-Letter-Paper-2018.pdf

Saloner, B., Bandara, S.N., McGinty, E.E., and Barry, C.L. (2014). "Justice-Involved Adults With

Substance Use Disorders: Coverage Increased But Rates Of Treatment Did Not In 2014." Health Affairs, 35(6): 1058–1066. DOI: 10.1377/hlthaff.2016.0005

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Sugie, N.F., and Turney, K. (2017). "Beyond Incarceration: Criminal Justice Contact and Mental Health." American Sociological Review, 82(4): 719–743. DOI: 10.1177/0003122417713188

U.S. Department of Housing and Urban Development (HUD), 2020. The 2019 Annual Homeless Assessment Report (AHAR) to Congress. https://www.huduser.gov/portal/sites/default/files/pdf/2019-AHAR-Part-1.pdf

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. https://www.vera.org/publications/crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities

**BOLD
THINKERS
DRIVING
REAL-WORLD
IMPACT**

Contact Us

Meg Chapman, MA, Project Director
meg_chapman@abtassoc.com
301.634.1740

abtassociates.com