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**Department of Justice and Department of Health &
Human Services Guidance for
Emergency Responses to People with Behavioral Health
or Other Disabilities**



DEPARTMENT OF JUSTICE AND DEPARTMENT OF HEALTH & HUMAN SERVICES

Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities¹

In Response to

Presidential Executive Order 14074 – Advancing Effective, Accountable Policing and Criminal Justice Practices to Enhance Public Trust and Public Safety Section 14 – Promoting Comprehensive and Collaborative Responses to Persons in Behavioral or Mental Health Crisis

I. Introduction

On May 25, 2022, the President issued Executive Order 14074, *Advancing Effective, Accountable Policing and Criminal Justice Practices to Enhance Public Trust and Public Safety*. Section 14(a) of the Executive Order directed the Attorney General and the Secretary of Health and Human Services to consult with stakeholders and to issue guidance regarding best practices for State, Tribal, local, and territorial officials on responding to and interacting with persons with behavioral health or other disabilities. This document provides that guidance. It outlines the application of federal disability rights laws in this area, as well as best practices for responding to crises experienced by people with disabilities, including people with behavioral health disabilities, intellectual and developmental disabilities (IDD), or other cognitive disabilities, who are deaf or hard of hearing, or who are blind or low-vision. Pursuant to the Executive Order, the guidance addresses response models, including co-responder teams and alternative responder models; community-based crisis centers and the facilitation of post-crisis support services; and the risks associated with administering sedatives and pharmacological agents such as ketamine outside of a hospital setting to subdue individuals in behavioral or mental health crisis. Federal resources, including Medicaid, that can be used to implement established and emerging best practices are also discussed.

In its *National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit*, the Health and Human Services Department’s Substance Abuse and Mental Health Services Administration (SAMHSA) emphasized the importance of a coherent system to deal with mental health crises. “With non-existent or inadequate crisis care,” SAMHSA stated, “costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care.”² Psychiatric inpatient settings “are over-burdened with referrals that might be best-supported with less intrusive, less expensive services and supports.”³ Further, SAMHSA stated, “In too many communities, the ‘crisis system’ has been unofficially handed over to law enforcement, sometimes with devastating outcomes. The current approach to crisis care is patchwork and

¹ The term behavioral health encompasses both mental health and substance use.

² Substance Abuse and Mental Health Services Admin., U.S. Dep’t of Health and Human Servs., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE 8 (2020), <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care0-2242020.pdf>.

³ *Id.*

delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks; resulting in multiple hospital readmissions, life in the criminal justice system, homelessness, early death and even suicide.”⁴ Law enforcement is too often viewed as the only available entity to respond to emergency calls involving individuals with behavioral health disabilities. Often these situations require public health responses that law enforcement authorities lack the capacity to address, and indeed should not be expected to address. As a result, many individuals experiencing behavioral health crises interact with the criminal justice system when what they need is mental health or substance use disorder services.

Research has shown that as many as 10 percent of all police calls involve a person with a serious mental illness.⁵ Other estimates indicate that 17% of use of force cases involve a person with a serious mental illness, and such individuals face 11.6 times the risk of experiencing a police use of force faced by persons without a serious mental illness.⁶ Further, while representing only 22% of the population, individuals with disabilities may account for 30% to 50% of incidents of police use of force.⁷ In recent years, people with mental illness have accounted for between 20% and 25% of individuals killed by law enforcement.⁸ These interactions are not only harmful and potentially deadly for people with disabilities; they also impose monetary costs on taxpayers. Case studies have demonstrated that when communities respond to individuals in crisis with law enforcement responses like arrest, court, and jail services, taxpayer costs are significantly higher than when crisis response services are utilized pre-booking.

LEGAL FRAMEWORK

Title II of the Americans with Disabilities Act (ADA) prohibits public entities from discriminating against individuals with disabilities, excluding them from participation in the public entity’s “services, programs, or activities,” or denying those benefits on the basis of a disability.⁹ Public entities, including emergency response systems and law enforcement agencies “must make reasonable modifications” to their ordinary practices when “necessary to avoid discrimination on the basis of disability unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.”¹⁰

The ADA, as interpreted by the Supreme Court’s decision in *Olmstead v. L.C.*,¹¹ includes an “integration mandate.” In *Olmstead*, the Supreme Court held that Title II of the ADA prohibits

⁴ *Id.*

⁵ Watson, A. & Fulambarker, A. (2012). The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners. *Best Practices in Mental Health*, 8(2):71.

⁶ Laniyonu, A. & Goff, P. (2021). Measuring Disparities in Police Use of Force and Injury Among Person with Serious Mental Illness. *BMC Psychiatry*, 21.

⁷ Perry, D. (2016). *The Ruderman White Paper on Media Coverage of Law Enforcement Use of Force and Disability*. Ruderman Family Foundation.

⁸ Kimberly Kindy et al., *Fatal police shootings of mentally ill people are 39 percent more likely to take place in small and midsized areas*, Washington Post, Oct. 17, 2020, https://www.washingtonpost.com/national/police-mentally-ill-deaths/2020/10/17/8dd5bcf6-0245-11eb-b7ed-141dd88560ea_story.html.

⁹ 42 U.S.C. § 12132.

¹⁰ 28 C.F.R. § 35.130(b)(7).

¹¹ 527 U.S. 581 (1999).

the unjustified institutionalization of people with disabilities. The Court further held that public entities must provide community-based services to people with disabilities when (a) such services are appropriate; (b) the affected people do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity.¹² A public entity need not provide community services if doing so would “fundamentally alter” its service system.¹³

Public entities may run afoul of the integration mandate if they lack sufficient community-based crisis services to prevent needless institutionalization of people with disabilities.¹⁴ Community-based crisis services play a key role in preventing needless institutionalization, law enforcement encounters, and incarceration of people with disabilities. These services, including mobile crisis services and crisis stabilization services—such as staffed crisis apartments, peer crisis respite centers, and community-based crisis stabilization units—divert many people with disabilities from admission to psychiatric hospitals, emergency departments, and jails.¹⁵ These services are described in more detail beginning on page 10.

Longer-term services are also critical to prevent needless institutionalization. Public entities may violate the integration mandate if they lack sufficient longer-term services to prevent needless institutionalization.¹⁶ Key services needed to avoid unnecessary institutionalization include supported housing, assertive community treatment (ACT), intensive case management, peer support, and supported employment—and Medicaid home and community-based waiver services for people with intellectual and developmental disabilities. Following a crisis, individuals with disabilities should be linked with these services to the extent they need them. These services help to prevent future crises and interrupt cycles of needless institutionalization and incarceration.

The ADA also applies to public entities’ emergency response and law enforcement systems.¹⁷ In many jurisdictions, call centers that dispatch emergency responses can make reasonable modifications to their usual practices to afford equal opportunity to people with disabilities, including by sending a mobile crisis team or other responder rather than law enforcement in appropriate circumstances when a call involves a person with a behavioral health disability and there is no need for a law enforcement response. Equal opportunity requires that people with behavioral health disabilities receive a health response in circumstances where others would receive a health response—for example, if call centers would dispatch an ambulance or a medic rather than law enforcement to respond to a person experiencing a heart attack or a

¹² *Id.* at 607.

¹³ 28 C.F.R. § 35.130(d); *see also* 42 U.S.C. § 12132; 28 C.F.R. § 35.130(b)(7)(i); *Olmstead*, 527 U.S. at 599-600, 603-04, 607.

¹⁴ 28 C.F.R. § 35.130(d).

¹⁵ SAMHSA, NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE, *supra* note 1, at 19. *See also* U.S. Dep’t of Justice, Investigation of Alameda County, John George Psychiatric Hospital, and Santa Rita Jail (Apr. 21, 2021), <https://www.justice.gov/crt/case-document/file/1388891/download> (lack of crisis services and other community services resulted in repeated admissions of people with mental health disabilities to one county’s psychiatric hospital and emergency department as well as contributing to their incarceration).

¹⁶ 28 C.F.R. § 35.130(d).

¹⁷ State and local government entities are public entities under Title II of the ADA. 42 U.S.C. § 12131(1).

diabetic crisis, equal opportunity would entail dispatching a health response in similar circumstances involving a person with a behavioral health disability.¹⁸

Where a police response is called for, dispatching a co-responder team that includes a police officer and a mental health specialist may be a reasonable modification.¹⁹ In some situations, dispatching an officer with appropriate crisis intervention training may be a reasonable modification. Law enforcement agencies can also make reasonable modifications to their usual practices by arranging for a mobile crisis team or other responder to come to the scene where a law enforcement response is not necessary.²⁰

People with disabilities are more likely to interact with police and more likely to be arrested than their non-disabled counterparts.²¹ Police response tailored to the needs of people with disabilities and in compliance with disability rights laws can improve outcomes for both law enforcement and individuals. Jurisdictions should not assume that the proper response to a crisis is always to send law enforcement, but instead should assess reasonable modifications to their usual practices where appropriate to afford equal opportunity to people with behavioral health and other disabilities.²² What modifications are reasonable in a particular jurisdiction depends on a variety of factors, which may include the existence of mobile crisis services, and other resources that may be available.

In addition, emergency response systems and law enforcement agencies must ensure effective communication with people with disabilities, including those who are deaf or hard of hearing, those who are blind or have low vision, and those who use alternative and augmentative forms of communication, as required by the Americans with Disabilities Act.²³ These entities must give primary consideration to providing the type of communication aid or service requested by a person who is deaf or hard of hearing.²⁴ For example, when a sign language interpreter is needed, law enforcement agencies must provide interpreters who can interpret effectively, accurately, and impartially.²⁵ Emergency response systems must also provide effective communication for people with neurodevelopmental communication disorders, including people who are non-verbal; people with autism spectrum disorder; people with intellectual disability; people with traumatic brain injury and dementia; and people who use alternative communication devices and approaches. Further, these entities must take reasonable steps to provide meaningful

¹⁸ See 28 C.F.R. § 35.130(b)(1)(ii), (iii).

¹⁹ See 28 C.F.R. § 35.130(b)(7).

²⁰ *Id.*

²¹ McCauley, E. “The Cumulative Probability of Arrest by Age 28 Years in the United States by Disability Status, Race/Ethnicity, and Gender.” *American Journal of Public Health* 107, no. 12 (2017): 1977-1981. <https://news.cornell.edu/stories/2017/11/people-disabilities-more-likely-be-arrested>.

²² See 28 C.F.R. § 35.130(b)(1)(iii).

²³ 42 U.S.C. § 12132, 28 C.F.R. §§ 35.130, 35.160(a), 29 U.S.C. § 794(a).

²⁴ 28 C.F.R. § 35.160(b)(2).

²⁵ 28 C.F.R. §§ 35.104 (definition of “qualified interpreter”), 35.160; U.S. Dep’t of Justice, Civil Rights Division, *Communicating with People Who Are Deaf or Hard of Hearing: ADA Guide for Law Enforcement Officers*, available at <https://archive.ada.gov/lawenfcomm.htm> (last accessed January 28, 2023).

access for people with limited English proficiency, as required by Title VI of the Civil Rights Act of 1964 and the Omnibus Crime Control and Safe Streets Act of 1968.²⁶

Currently, in many communities, law enforcement and fire/emergency medical services (EMS) are the only viable 24/7 emergency response option for individuals in crisis who need services or protection from themselves or others. Other jurisdictions have already implemented a full array of crisis response services. Communities across the country are employing response options building on the experiences of these leading jurisdictions. This guidance likewise draws on those experiences and identifies best practices.²⁷

II. Core Principles Informing Best Practices for Responders

Determining the appropriate response to any particular call for crisis response services is a fact-specific inquiry. Nonetheless, there are core principles based in evidence that inform best practices with regard to policies, trainings, response models, interagency agreements, and funding models. These may be subject to geographic, demographic, economic, and workforce factors. They are also subject to the legal requirements discussed above.

a. Person-centered approaches that avoid harm

- i. Jurisdictions should deploy appropriately trained and equipped responders to ensure a safe and effective response.
- ii. Even in crisis situations, responders should attempt to leverage the strengths of each individual they encounter and consider the person's stated preferences to help resolve the incident safely.

b. Diversion to behavioral health services whenever appropriate

- i. Jurisdictions should encourage use of the 988 Suicide and Crisis Lifeline, including through text or chat functions, and other behavioral health resources instead of relying exclusively on 911 for response to behavioral health-related calls, and should develop systems to divert appropriate 911 calls to these resources. A key function of the 988 Suicide and Crisis Lifeline is to assess for imminent risk.
- ii. Where appropriate, law enforcement and dispatch should divert calls to behavioral health responders when they encounter someone demonstrating a need for behavioral health support who is not an immediate threat.
- iii. Law enforcement should develop working relationships with diverse local behavioral health providers and other providers of community services for

²⁶ 42 U.S.C. § 2000d et seq., 42 U.S.C. § 3789d(c), See 28 C.F.R. §§ 42.1 04(b)(2), 42.203(e), *Lau v. Nichols*, 414 U.S. 563 (1974); *United States v. Maricopa*, 915 F.Supp.2d 1073, 1079-81 (D. Ariz. 2012); U.S. Department of Justice, *Final LEP Guidance to Recipients of Federal Financial Assistance*, 67 Fed. Reg. 117 (June 18, 2002).

²⁷ Some of the best practices identified below may be required by the ADA and its implementing regulations.

individuals with disabilities. This may include the formation of a crisis intervention committee with a mission to build an effective regional crisis incident response that considers resources, training, local legal standards, and community expectations.

- iv. A comprehensive array of crisis response services should be developed including call centers, mobile outreach, and community-based crisis services.

c. Peer support

- i. It is generally advantageous to include in the teams responding to a crisis people whose experiences and expertise with addressing mental illness and mental health crises allow them, through person-centered approaches such as shared understanding, trust, respect, and empowerment, to help others experiencing similar situations.
- ii. This principle applies to the full range of crisis services.

d. Trauma-informed approaches and recovery

- i. Understanding and considering the pervasive nature of trauma in human experiences allows service providers and first responders to promote interactions and services that support healing and recovery rather than those that may inadvertently re-traumatize individuals.
- ii. Trainings and policies should emphasize understanding, respecting, and appropriately responding to the effects of trauma at all levels.
- iii. Crisis response should be based on least restrictive standards that minimize the potential for adverse events.
- iv. Crisis response should maximize autonomy and utilize recovery-based approaches.

e. Round-the-clock resources

- i. Crisis services should be available throughout a jurisdiction, at all times of day, and on weekends.
- ii. Crisis providers should connect people to ongoing community-based services that can support them after the crisis passes.
- iii. Crisis stabilization settings should allow visitors 24 hours a day to support individuals in their recovery and communicate, coordinate, and optimize natural supports.

f. Coordination across systems

- i. Law enforcement and mental health agency leadership should work together to examine how people with behavioral health disabilities and other disabilities are coming into contact with law enforcement and/or being incarcerated so that gaps in the service system can be identified and addressed.
- ii. Law enforcement and behavioral health staff should coordinate and share information, with appropriate privacy safeguards in place, so they can identify frequent utilizers of services and connect them with ongoing support with the appropriate privacy safeguards.
- iii. Behavioral health and law enforcement response systems should coordinate with tribal nations on topics such as jurisdiction and available emergency behavioral health responses.
- iv. Behavioral health and law enforcement response systems should coordinate with other relevant entities, such as service systems for people with physical, sensory, intellectual, and developmental disabilities, and other cognitive disabilities (including traumatic brain injuries or dementia). Many people with intellectual and developmental disabilities have recurring interactions with law enforcement that could be avoided or improved through deployment of appropriate responders familiar with their needs. Symptoms of mental disorders may present differently among people with intellectual or developmental disabilities. Further, some people with behavioral health disabilities have co-occurring intellectual and developmental disabilities that necessitate different responses. Coordination and collaboration among state behavioral health, intellectual and developmental disabilities, and Medicaid agencies is also important.
- v. Behavioral health and law enforcement response systems must be knowledgeable and maintain effective partnerships with community systems and services for children and youth with serious emotional disturbance (SED), intellectual and developmental disabilities (IDD), other cognitive disabilities (like traumatic brain injuries), or learning disabilities, and their families. When children have a crisis, family members and/or legal guardians will need to be engaged to provide informed consent and to identify strengths-based approaches that help these children in crisis.
- vi. When responders engage with family members, caregivers, and/or legal guardians, they should make referrals and connections to community resources who can provide ongoing support.

g. Data-Driven implementation and Evaluation of Resources

- i. Law enforcement and emergency management systems should seek to develop data to identify call types associated with behavioral health needs so they can be diverted to a behavioral health response where appropriate.
- ii. Crisis responders should track contacts that result in diversion to behavioral health services to identify trends over time, including trends relating to disability, race, ethnicity, gender, sexual orientation, age, and zip code. They should also track when crisis responses result in involuntary treatment. Data collected should be used to evaluate and improve the effectiveness of services for all individuals.
- iii. Staffing patterns should be developed using data on when calls related to behavioral health crises are most concentrated.

III. Best Practices, Policies, and Training Components

Programs, policies, and trainings focused on interactions with individuals in crisis or with disabilities should give the jurisdictions and law enforcement members the necessary information and tools to:

- Identify individuals in crisis or with a physical or mental disability;
- Be aware of and experienced in principles and practices for responding to an individual in crisis or with a disability, including by diverting the individual to behavioral health services and ensuring effective communication for persons with disabilities, meaningful access to persons with limited English proficiency, and cultural competence; and
- Ensure there are appropriate and available resources with which to connect individuals immediately after the urgent/emergency event.

a. Call Handling, Dispatching, and Off-Ramping

Contacts with law enforcement can begin with a 911 call or text or a community contact between law enforcement and a person with a disability. In either case, assessment of the situation and a decision about the services that will best address the situation is key to an effective contact and successful outcome. These assessments and processes should identify opportunities to appropriately divert people from law enforcement contact and to facilitate access to the type of support that they need.

- i. The new national 988 Suicide and Crisis Lifeline number offers a single number for people to call when they are having a behavioral health crisis. The 988 and 911 systems need to be closely coordinated to provide the right response for each situation. Because many calls to 911 are calls for

behavioral health services or support, public safety answering points in many jurisdictions can divert a substantial portion of these calls to 988 to receive an appropriate clinical response. This type of rerouting reduces the burden on law enforcement of responding to calls that can most effectively be handled by behavioral health clinicians and increases the likelihood that people get the support they need in a crisis. Emergency medical responders or law enforcement, sometimes in collaboration with behavioral health professionals, will still respond to situations where the person in crisis or others are at imminent risk of physical harm. Local 911 and 988 centers should establish protocols for transferring calls, as well as coordinating between text-to-911 and 988 text and chat functions, based on established criteria.²⁸

- ii. Jurisdictions should develop effective call triage programs to enable communities to connect people in need of emergency and non-emergency assistance to the most appropriate response as quickly as possible.
- iii. Jurisdictions should highlight the availability of 988 text and chat functions in order to maximize the reach of 988.
- iv. Jurisdictions should also raise awareness of Warm Line services (phone lines providing mental health support, typically staffed by peer support workers and focused primarily on non-emergency calls) nationally and in their localities.
- v. There are multiple efforts examining how to update the call taking, screening, and dispatch system and processes to better assess need and promote appropriate diversion to 988 and other behavioral health services. Some recommendations include a formalized set of screening questions at the outset of a call that help identify appropriate candidates for diversion. Examples include:
 - 1. [Transform911](#) -- a project led by the University of Chicago Health Lab to bring together experts to examine how to transform the nation's 911 system. The Transform911 [Blueprint for Change](#) offers multiple recommendations in a seven-point plan for transforming 911.
 - 2. [Taking the Call](#) – a national conference organized in part by the Council of State Governments Justice Center, with support from

²⁸ The National Emergency Number Association (NENA), a non-profit organization focused on improving 911 services, has a 911/988 Interactions Work Group that seeks to provide call and information-sharing solutions to emergency communications centers (ECCs) and 988 call centers. The work group aims to identify best practices and to address each entity's role and responsibility, as well as the processes and training needed to properly handle mental health crises. The work group also seeks to define how the 988 system can interconnect and utilize the 911 system for accurate 988 call routing and support for text messaging to 988. See National Emergency Number Association, Join NENA's 911/988 Interactions WG, <https://www.nena.org/page/911-988OpsWG>.

the U.S. Department of Justice Bureau of Justice Assistance. The conference consisted of two days of plenary sessions and breakout discussions and provided resources for jurisdictions looking to implement innovations to ensure emergency calls receive the most appropriate response.

- vi. **Specialized Dispatch Tracking:** Some jurisdictions use data systems that allow call takers and dispatchers to flag addresses of individuals with particular needs so responders can better meet those needs. Some systems also track and include information around the best ways to de-escalate a particular individual caller, words to avoid using with the individual, treatment plans, and contact information for their behavioral health clinician.
- vii. **Behavioral Health Staff at Dispatch Center:** One model of alternative response is to co-locate a behavioral health clinician in the call center so that call takers can do a “warm hand-off” after their screening, allowing the behavioral health expert to take over a call and become the dispatcher. This person has greater expertise to assess the needs of a caller with behavioral health or other disability and determine what supports to dispatch, if any.

IV. Crisis Response Models

A variety of response models with a designated mental health component operate across the country. The two primary models are mobile crisis teams, in which a team of mental health staff and peers respond to the individual in crisis, and co-responder teams, in which a team including law enforcement and a mental health professional respond jointly. The appropriate approach in a given situation in a particular jurisdiction will depend in part on the assessment of risk and imminent threat, as well as the characteristics of the jurisdiction. A small jurisdiction that has no mobile crisis capacity and that shares mental health staff with other jurisdictions may face different constraints than a large urban jurisdiction with greater resources.

a. Mobile Crisis Teams

- i. Mobile crisis services are generally provided by a team of people including a mental health clinician and, frequently, a peer support provider.
- ii. The team responds in real time to the location of the person in crisis, engages the person, assesses the person’s needs, intervenes to de-escalate the situation, and connects the person to ongoing behavioral health services that can prevent future crises.
- iii. If law enforcement is the first responder to an incident in a jurisdiction with mobile crisis services, law enforcement should also be able to request mobile crisis services for the individual if they determine that behavioral

health treatment would be more appropriate than law enforcement engagement.

- iv. The success of these teams is dependent on developing multi-disciplinary partnerships, providing cross-system training, sharing data across systems, and identifying follow up care for referrals from the teams.
- v. Services should be provided where the person is experiencing a crisis (home, work, religious institution, park, school, group home, assisted living facility, nursing home etc.) and not be restricted to select locations within the region or particular days/times. If situations warrant transition to other locations, mobile crisis teams should connect individuals through in-person transfers of care, coordinate transportation where needed, and provide 24/7 access for optimal coverage.
- vi. Best practices include incorporating trained peers with lived experience and expertise in recovery from mental illness and/or substance use disorders (SUD) and formal training within the mobile crisis team; and responding without law enforcement accompaniment, unless special circumstances warrant inclusion. Peers may support individuals' justice system diversion and following a crisis.
- vii. Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff, ideally in teams of two. For example, a master's or bachelor's level clinician, including psychiatric nurses, may be paired with a trained peer support specialist with the backup of psychiatrists, psychologists, advanced practice registered nurses or other master's level clinicians who are on-call, as needed.
- viii. Mobile crisis services should strive to be available 24/7 and can be provided to adults, children, youth and families. Service requests should be simple and coordinated, with preferred response times by the mobile crisis team under one hour (2 hours in rural settings). Effective models also provide follow-up access to mental health and /or developmental disability support providers within 48 hours either via telehealth or in-person services.
- ix. Mobile crisis teams should have the capability to make referrals to outpatient care and to follow up to ensure that the individual's crisis is resolved, or they have successfully been connected to ongoing services. Some crisis interventions may also include the development of strategies for identification of triggers, safety planning, advance directives, including psychiatric advance directives (PADs), and related illness management to reduce future risk of crises.

b. Co-Responder Teams

- i. Co-responder teams include an officer trained to respond to mental health crises and a co-responder. The co-responders vary in training. For example, some may be peer support specialists while others are mental health clinicians.
- ii. Research has shown that in jurisdictions with co-responder models as compared to law enforcement responses, law enforcement officers are more likely to divert individuals from the formal justice process.
- iii. Examples of jurisdictions implementing this service include: the Boston Police Department's Crisis Response Team (CRT), which responded to over 1,000 calls between 2011 and 2016, with only 9 resulting in arrest²⁹; the Seattle Police Department's Crisis Response Unit (CRU) and CRT, where only 1% of calls resulted in an arrest³⁰; the Boulder, CO Early Diversion Get Engaged (EDGE) program which is estimated to save the county about \$3 million annually by reducing incarcerations and hospitalizations³¹; and the Arlington, MA CRT which de-escalates 65-percent of its calls³².

c. Crisis Intervention Training (CIT)

- i. Crisis Intervention Training (CIT) programs provide training to law enforcement officers with the goal of improving outcomes of law enforcement interactions with people experiencing behavioral health crises. CIT trained officers can provide a specialized police response to individuals experiencing a behavioral health crisis in situations where police presence is needed.
- ii. Success is dependent on the training the officers receive, and is most effective when law enforcement, mental health providers, individuals living with mental illness, and family and community leaders work together.³³

²⁹ Melissa S. Morabito et al., "Police Responses to People with Mental Illnesses in a Major U.S. City: The Boston Experience with the Co-Responder Model," *Victims and Offenders* 13, no.8 (2018): 1093-1105.

³⁰ Helfgott, Jacqueline B., Matthew J. Hickman, and Andre P. Labossiere. "A Descriptive Evaluation of the Seattle Police Department's Crisis Response Team Officer/Mental Health Professional Partnership Pilot Program." *International Journal of Law and Psychiatry* 44 (2016), 109-122. doi:10.1016/j.ijlp.2015.08.038.

³¹ The EDGE program, Boulder County's CRT, is a collaboration between the Boulder Sheriff's Department, the City of Boulder, and Mental Health Partners in Colorado. Email correspondence between the CSG Justice Center and Mental Health Partners, September 14, 2020. See also Frank Cornelia and Moses Gur, "Early Diversion for Individuals with Mental Illness" (PowerPoint presentation, Colorado Behavioral Healthcare Council, September 8, 2016).

³² Bureau of Justice Assistance, *Justice & Mental Health Collaboration Program* (Washington, DC: Bureau of Justice Assistance and CSG Justice Center, 2019).

- iii. CIT International, a private entity that provides training and other resources to support the “Memphis Model” of crisis intervention training, generally suggests that 20-25% of a department’s frontline employees receive the 40-hour training, along with other recommendations in their [Best Practice Guide for Transforming Community Responses to Mental Health Crises](#).
- iv. CIT trainings exist for call-takers/dispatchers. For example, CIT International offers an 8-hour online course for 911 call-takers to prepare them to identify crisis calls, understand their role in triaging these calls, and begin the de-escalation process.
- v. Promising practices for the CIT Model include:
 - 1. Developing strong community partnerships;
 - 2. Developing cultural competence of CIT personnel;
 - 3. Treating CIT as a program, not just a training;
 - 4. Training enough employees in CIT to cover every shift;
 - 5. Seeking volunteers to participate in the CIT program;
 - 6. Training all front-line employees in at least a basic level of mental health awareness;
 - 7. Ensuring that dispatchers are CIT-trained and prepared to respond;
 - 8. Recognizing CIT-trained personnel for their work; and
 - 9. Regularly evaluating and measuring the CIT program’s impact and outcomes.

d. Special considerations for all models

- i. All staff should be trained to identify and interact with people who have intellectual and developmental disabilities (IDD). Agencies should establish connections with local providers or the State Developmental Disabilities networks, including State Protection and Advocacy systems (P&As), State Councils on Developmental Disabilities (DD Councils), and those that participate in State Medicaid programs and University Centers on Excellence in Developmental Disabilities (UCEDDs). Policies should provide guidance for interactions with people with IDD.
- ii. Staff should also be trained to respond to children in crisis and to work with both children and their families. Youth are at high risk of experiencing mental health crises, yet their unique circumstances—including that youth act and react differently than adults as a result of differing cognitive abilities and developmental progress—are often not included in “standard” crisis response training.³⁴

³⁴ League of Minnesota Cities, “Best Practices in Law Enforcement Responses to Mental Health Crises.” 2022.

- iii. Staff should also be trained in how to work with older adults, including people with dementia, and their families and caregivers.
- iv. Staff should be trained in evidence-based practices to appropriately respond to individuals who are experiencing crises as a result of substance use.
- v. Evidence based staff should be trained to appropriately respond to individuals with traumatic brain injury, dementia, and other neurological disorders.
- vi. Training for call takers, law enforcement, health responders, and alternative responders should incorporate implicit bias training on behavioral health CLAS (Culturally and Linguistically Appropriate Services) standards and other cultural competency models.
- vii. Individuals with direct experience receiving crisis services should be involved in developing and conducting training as well as with implementation. Staff should be trained to engage in effective communication with people with disabilities. Organizations representing individuals with disabilities should be consulted, including centers for independent living, P&As, DD Councils, UCEDDs, organizations representing individuals who are deaf or hard of hearing, organizations representing individuals who use alternative and augmentative communication, and organizations representing individuals who are blind or have low vision.
- viii. Localities should have systems and processes in place to reduce repeat encounters with individuals in crisis, including using data to identify individuals who frequently access the crisis system, developing alternative response options, establishing clear policies and procedures for encounters, actively promoting models such as peer respite and other peer-run supports, and regularly reviewing performance of all system components.

V. Crisis Stabilization Services

Crisis Stabilization Services facilitate resolution of crises over a short period, usually ranging from a few hours to several days. Crisis stabilization services can be delivered in a variety of settings including staffed crisis apartments, peer crisis respite centers, and community-based crisis stabilization units.

- a. Crisis apartments were developed to ensure that crisis services can be provided in an integrated setting and, in particular, “home-like, non-hospital environments[s].”³⁵

³⁵ SAMHSA, NATIONAL GUIDELINES, *supra* n. 1., at 12.

- b. SAMHSA has recognized the importance of peer support workers in crisis settings, and its National Guidelines highlight the use of peer crisis respite programs. These programs are typically staffed by individuals with lived experience with psychiatric disability, although clinical staff may be involved to support assessments.³⁶
- c. Community-based crisis stabilization units can be freestanding or part of a larger facility. In accordance with the ADA's integration mandate and the *Olmstead* decision, crisis services must be offered in the most integrated setting appropriate unless doing so would fundamentally alter the service system.³⁷ These facilities provide initial screening and assessment, and short-term and longer-term stabilization in a non-hospital environment. They should accept drop-offs and walk-ins on a 24/7 basis.³⁸ These settings provide law enforcement and mobile crisis teams with a safe location to bring individuals in crisis, often instead of bringing them to jail or the emergency room. These settings can effectively engage family and informal caregivers by supporting a 24 hour a day visitor policy.

VI. De-Escalation

De-escalation best practices are an important component of how a jurisdiction approaches these interactions.

- a. Law enforcement agencies should have policies, trainings, and mission/value statements that prioritize the need to de-escalate interactions whenever possible.
- b. Recently, research involving the University of Cincinnati, the Louisville Metro Police Department, and the International Association of Chiefs of Police, produced evidence that implementation of the Integrating Communications, Assessment, and Tactics (ICAT) training program from the Police Executive Research Forum (PERF) produced a significant reduction in officer use of force following de-escalation training.³⁹
- c. Agencies should:
 - i. Link policies to evidence-informed training;
 - ii. Expect all supervisors to support a culture of de-escalation;

³⁶ *Id.* at 25.

³⁷ *See supra* notes 10, 13.

³⁸ *Id.* at 22-23.

³⁹ Engel, R., Corsaro, N., Isaza, G., & McManus, H. (2020). [*Examining the Impact of Integrating Communications, Assessment, and Tactics \(ICAT\) De-escalation Training for the Louisville Metro Police Department: Initial Findings.*](#)

- iii. Reward successful de-escalation efforts;
- iv. Hold officers accountable to their de-escalation policies and training; and
- v. Enhance public reporting and transparency.

VII. Access to Ongoing Community-Based Services

- a. **Permanent Supported Housing:** Permanent supported housing includes a housing subsidy and an individually tailored package of support services to enable a person to live successfully in their own apartment or home. The services are typically delivered in mainstream housing units scattered throughout the community, to promote integration.⁴⁰ Individuals have a lease and full tenancy rights. Participation in services is voluntary, and housing is not conditioned on individuals accepting services. Individuals receive support services to help them choose, secure, and maintain housing.⁴¹ In addition, they have access to a comprehensive set of services to address their individual needs; these may include case management, SUD treatment, Assertive Community Treatment, supported employment, home health services, independent living skills training, and home/environmental modifications or other services.
- b. **Assertive Community Treatment:** Assertive Community Treatment (ACT) is an individualized, highly coordinated, team-based approach that helps people with serious mental illness who are most at risk of psychiatric crisis, hospitalization, and criminal justice system involvement succeed in the community.⁴² It is one of the oldest and most widely researched evidence-based services for people with serious mental illness.⁴³ ACT teams are comprised of a multi-disciplinary group of professionals, typically including a psychiatrist, a nurse, an employment specialist, a housing specialist, a SUD specialist, a peer support specialist, and other mental health professionals such as social workers, counselors, or occupational therapists.⁴⁴ Services are delivered in community settings where the support is needed, rather than in offices or clinics. The team is available 24 hours/day, 7 days/week, for as long as needed.⁴⁵ ACT reduces the use of inpatient services, increases housing stability, leads to better substance-abuse

⁴⁰ Substance Abuse and Mental Health Services Admin., U.S. Dep’t of Health and Human Servs., *Permanent Supportive Housing: Building Your Program* (“*Supportive Housing Toolkit*”) 2-4 (2010), <https://store.samhsa.gov/sites/default/files/d7/priv/buildingyourprogram-psh.pdf>.

⁴¹ *Id.* at 2, 3, 5.

⁴² Case Western Reserve Univ., Jack, Joseph and Morton Mandel School of Applied Sciences, Center for Evidence-Based Practices, *Assertive Community Treatment* (2022), [https://case.edu/socialwork/centerforebp/practices/assertive-community-treatment#:~:text=Assertive%20Community%20Treatment%20\(ACT\)%20is,in%20the%20criminal%20justice%20system](https://case.edu/socialwork/centerforebp/practices/assertive-community-treatment#:~:text=Assertive%20Community%20Treatment%20(ACT)%20is,in%20the%20criminal%20justice%20system).

⁴³ *Id.*

⁴⁴ Substance Abuse and Mental Health Services Admin., U.S. Dep’t of Health and Human Servs., *Assertive Community Treatment: Building Your Program* (“*ACT Toolkit*”) 14 (2008), https://store.samhsa.gov/sites/default/files/d7/priv/buildingyourprogram-act_1.pdf.

⁴⁵ *Id.* at 18.

outcomes, and yields higher rates of competitive employment.⁴⁶

- c. **Peer Support Services:** Peer support services are provided by peer support specialists who have navigated their own recovery process and who, through shared understanding, trust, respect, and empowerment, help others experiencing similar situations.⁴⁷ Specific peer support services include peer respite, peer bridgers, and hearing voices groups. Peer support workers can play a variety of roles, including counseling; advocating for people in recovery; sharing resources and building skills; building relationships and community; mentoring; and helping individuals envision a different life, set goals, and make decisions.⁴⁸

VIII. Key Factors for Local Jurisdictions to Consider

a. Assess needs

- i. The first step every jurisdiction should take in designing a crisis response system—or to evaluate their current system—is to use any available data to assess the need for crisis services and the intersection with the justice system.

b. Understand resources

- i. Jurisdictions should identify and document all existing crisis response resources along with any potential additions to the system. This process should consider resources available across the relevant stakeholder groups. Through this process, jurisdictions can identify existing gaps and prioritize the use of resources to fill them.

c. Create a local plan

- i. As noted throughout the available best practice guides and research, any crisis/special needs plan must be directly informed by local factors and stakeholder input. Models that have worked in other jurisdictions must be adapted to the needs, personnel, geographic characteristics, demographics, resources, and other specific factors of the individual community developing its approach to responding to people experiencing a behavioral health crisis.

d. Address people in frequent crisis

⁴⁶ *Id.* at 8.

⁴⁷ Substance Abuse and Mental Health Services Admin., U.S. Dep’t of Health and Human Servs., *BRSS TACS: Bringing Recovery Supports to Scale, Who Are Peers?* (last updated Apr. 26, 2022), <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>.

⁴⁸ *Id.*

- i. Research in many areas of human behavior notes that the source of greatest need/challenge consistently is concentrated among a small number of individuals and/or locations.
 - ii. Different sources of data indicate that high utilizers of behavioral health services may represent 6% of patients but generate 26% of service visits.⁴⁹
 - iii. When feasible, jurisdictions should work with county and state Medicaid offices to share data and conduct outreach to populations that may be at higher risk for repeat hospitalizations.
 - iv. Person-centered planning, psychiatric advance directives, Wellness Recovery Action Plans, and other self-directed approaches may be useful in preventing crises and avoiding coercive actions such as involuntary hospitalizations and outpatient commitments.
- e. **Promote alternatives to arrest where appropriate and consistent with public safety**
 - i. Research consistently finds that the criminal justice system does not address the underlying needs of individuals with behavioral health problems, and it can often intensify the crisis and traumatize or retraumatize people, with little to no reduction in potential criminal conduct.
 - ii. Jurisdictions should develop response models and trainings that incorporate evidence-based de-escalation principles and person-centered practices that help minimize arrest and incarceration in these instances except where necessary to ensure the immediate safety of the community.
- f. **Prevent and limit use of force in encounters with people with disabilities**
 - i. Ultimately, the goal of implementing these tools, training, and policies is to increase trauma informed services and supports to eliminate harm to individuals encountering law enforcement/first responders, including the use of seclusion and restraint, which also minimizes the risk to law enforcement officers/first responders, and community members.

IX. The Use of Sedatives Outside of a Hospital Setting to Subdue Individuals in Crisis

- a. Agencies should work with their Fire/EMS medical directors on establishing policies and procedures.

⁴⁹ Jiang, H.J. et al. (23 February 2017). "Characteristics of emergency department visits for super-utilizers by payer, 2014." Agency for Health Care Research and Quality.

- b. The incident-level decision on whether to administer a sedative should not be made at the direction of or by law enforcement.

X. The Use of Federal Resources, including Medicaid, to Implement Best Practices

- a. States should consider amending Medicaid plans to expand coverage for allowable crisis-related services, such as mobile crisis response, crisis stabilization services, and peer services, as well as longer-term services including Assertive Community Treatment and peer support services.⁵⁰
- b. States can currently choose to cover community-based mobile crisis intervention services under Medicaid and, pursuant to section 9813 of the American Rescue Plan Act of 2021, can receive an enhanced federal medical assistance percentage of 85% if the services meet certain requirements. For example, mobile crisis teams must include at least one behavioral health care professional qualified to conduct an assessment and “other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response, including nurses, social workers, peer support specialists, and others,” and the team must be trained in trauma-informed care, de-escalation strategies, and harm reduction, and must be able to respond in a timely manner.⁵¹ States must ensure that the mobile crisis team can, where appropriate, provide screening and assessment, stabilization and de-escalation, and coordination with and referrals to health, social and other services and supports, as needed. Mobile crisis services must also be available 24 hours a day, every day of the year.⁵² A state must demonstrate that the additional federal funds will supplement and not supplant the level of state funds spent on these services in past years.⁵³ The enhanced match is available for the first 12 fiscal quarters in which a state meets the requirements during the five-year period spanning April 1, 2022 through March 31, 2027.
- c. Jurisdictions may pursue available federal Medicaid match for allowable administrative costs for crisis call centers, including allowable technology tools and services. Federal Medicaid match can be used to cover certain administrative activities such as operating call centers and access lines and dispatching mobile

⁵⁰ See, e.g., Substance Abuse and Mental Health Servs. Admin., U.S. Dep’t of Health and Human Servs., MEDICAID HANDBOOK: INTERFACE WITH BEHAVIORAL HEALTH SERVICES, MODULE 3, THE BEHAVIORAL HEALTH SERVICES BENEFIT PACKAGE (2013), ; U.S. Dep’t of Health and Human Servs., Health Care Financing Admin., State Medicaid Director Letter, June 7, 1999 (describing Medicaid coverage of ACT), <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD060799b.pdf>; U.S. Dep’t of Health and Human Servs., Centers for Medicare and Medicaid Servs., SMDL #07-011, Aug. 15, 2007 (describing Medicaid coverage of peer support), <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf>.

⁵¹ U.S. Dep’t of Health and Human Servs., Centers for Medicare and Medicaid Servs., SHO #21-0008, Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services, Dec. 28, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf>.

⁵² U.S. Dep’t of Health and Human Servs., Centers for Medicare and Medicaid Servs., SHO #21-0008, Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services, Dec. 28, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf>.

⁵³ *Id.*

crisis teams as needed to assist Medicaid beneficiaries.⁵⁴

- d. Jurisdictions should consider demonstration opportunities such as the Certified Community Behavioral Health Clinic (CCBHC) demonstration under Medicaid that requires 24/7 crisis care, among other services. SAMHSA and states have also supported the development of CCBHCs outside of the demonstration program. There are more than 500 CCBHCs operating across the country, designed to ensure access to coordinated comprehensive behavioral health care by providing a set of nine core services and serving anyone who requests care for mental health or substance use, regardless of ability to pay, place of residence, or age. In March 2023, SAMHSA issued updated criteria for CCBHCs, applicable beginning in July 2024, that respond to new developments such as 988.⁵⁵ Among other guidelines, these new criteria require CCBHCs to have a care coordination partnership with the 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located.
- e. Jurisdictions should maximize affordable housing opportunities for people with disabilities, including through use of United States Department of Housing and Urban Development (HUD) resources such as Housing Choice Vouchers, Mainstream Vouchers, and Section 811 Project Rental Assistance. These resources, as well as the Low-Income Housing Tax Credit program, can be used to support the development of housing units for people with disabilities scattered throughout the community. In addition, Medicaid reimbursement is available for a broad array of housing-related services, including services that support transition to housing and tenancy-related services.⁵⁶ Generally, Medicaid coverage of housing-related services and supports does not include room and board for a Medicaid beneficiary. While there are limits, states can use Medicaid, specifically through state plan amendments and waivers to address an individual's social determinants of health (SDOH) and/or associated health-related social needs.

XI. Summary of Recommendations and Next Steps

- a. Government entities should provide behavioral health crisis response services in parity with the services provided to those experiencing medical emergencies.⁵⁷
- b. Law enforcement should be trained in legal standards for imposing transport holds and other actions in the mental health context, and on how to work

⁵⁴ *Id.*

⁵⁵ Substance Abuse and Mental Health Servs. Admin., U.S. Dep't of Health and Human Servs., Certified Community Behavioral Health Clinics (CCBHCs) (last updated March 16, 2023), <https://perma.cc/TAC8-LR2K>.

⁵⁶ U.S. Dep't of Health and Human Servs., Centers for Medicare and Medicaid Servs., CMCS State Health Official Letter #21-001, Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH) (January 7, 2021), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>.

⁵⁷ League of Minnesota Cities, Best Practices in Law Enforcement Responses to Mental Health Crises." 2022.

cooperatively with other crisis response professionals.⁵⁸

- c. Jurisdictions should ensure that alternative response models and diversion facilities are open to all and serve individuals encountered by all types of crisis responders.
- d. Jurisdictions should ensure that all individuals involved in a potential crisis response receive at least basic CIT training, along with annual refresher training. These trainings should be scenario-based and interactive in nature.
- e. Jurisdictions should ensure that all individuals involved in a potential crisis response receive cultural competence training with regular evaluation.
- f. Jurisdictions should assess and adapt their current data collections processes and tools to ensure they are routinely collecting and analyzing data on the availability of, use of, and outcomes of the different response/service options.
- g. Jurisdictions should include de-escalation policies and trainings as central to all positions across the emergency response continuum—from call taker to patrol officer/first responder, alternative responders, and follow-up service providers.
- h. Clinical decisions—including the use of sedatives on the frontline—should be based on person-centered practices, trauma informed approaches, and the responsibility of clinically-trained individuals.

XII. Resource Appendix

PUBLICATIONS / BRIEFS

1. **Best Practices in Law Enforcement Responses to Mental Health Crises**: Compiled by the League of Minnesota Cities in partnership with the Minnesota Chiefs of Police Association and the Minnesota Sheriffs Association, this guide chronicles current response challenges faced by agencies and identifies realistic solutions and approaches for addressing those challenges based on a set of mutually agreed-upon guiding principles.
2. **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**: The Vera Institute of Justice launched Serving Safely in May 2018 as a national initiative to improve police responses to people with serious mental illnesses and intellectual/developmental disabilities (I/DD). The initiative’s Research and Evaluation Committee developed this literature review as a first step toward creating a research agenda for the field that identifies knowledge gaps and prioritizes options for

⁵⁸ *Id.*

scalable research and evaluation. This summary of the published research to date provides an overview of nine types of police-based and related emergency response models that have received some research attention, as well as the methodological approaches used to evaluate them and their results.

3. **[Improving Officer Response to Persons with Mental Illness and Other Disabilities: A Guide for Law Enforcement Leaders](#)**: This guide provides recommendations for policies and collaborations to ensure the safety of communities and law enforcement officers alike. It highlights the key components of strategic approaches officers can take to improve their interactions with individuals dealing with mental health problems or intellectual/developmental disabilities.
4. **[Improving Outcomes for People in Contact with the Criminal Justice System Who Have Intellectual or Developmental Disabilities](#)**: This guide suggests steps criminal justice administrators can take to improve the identification and response to the needs of people with I/DD who are involved with the criminal justice system.
5. **[Best Practice Guide – Responses to People with Behavioral Health Conditions and Developmental Disabilities: A Review of Research on First Responder Models](#)**:

The Academic Training to Inform Police Responses Best Practice Guide reviews available research on the delivery and impact of police, behavioral health (BH), disability, and community responses to BH and intellectual and developmental disabilities (IDD)-related crisis incidents. The chapters of this guide present information on existing response models, identify evidence-informed best practices, and outline key lessons for the development and delivery of crisis response programs designed after these models.

Available Chapters:

[Crisis Intervention Teams \(CIT\)](#)

[Co-Responder Teams](#)

[Law Enforcement-Based Case Management Services](#)

[Law Enforcement Assisted Diversion \(LEAD\)](#)

[Mobile Crisis Teams](#)

[Crisis Resolution and Home Treatment Teams](#)

[EMS and Ambulance-Based Responses](#)

6. **[Bureau of Justice Assistance Style Guide for Using the Sequential Intercept Model: Behavioral Health and Intellectual and Developmental Disability Considerations](#)**: Developed by The Academic Training to Inform Police Responses Initiative, this style guide contains guidelines for content related to criminal justice and behavioral health and intellectual and developmental disabilities, including concepts, terminology, and definitions.
7. **[Olmstead at 20: Using the Vision of Olmstead to Decriminalize Mental Illness \(2019\)](#)**: Developed by the Technical Assistance Collaborative following a convening of national

stakeholders, including state and local government representatives, service providers, and advocates, this guide explores why the promise of the ADA and *Olmstead* remains unfulfilled for too many people with mental illness who are needlessly incarcerated and proposes recommendations for addressing these issues through policymaking and advocacy.

8. **Mental Health Conditions & Developmental Disabilities: Why Know the Difference:**

Developed by The Academic Training to Inform Police Responses Initiative, this two-page resource describes mental health conditions and developmental disabilities, common behaviors and characteristics, and the differences between mental health conditions and developmental disabilities.

9. **Developmental Disabilities: What Law Enforcement Officers Need to Know:**

Developed by The Academic Training to Inform Police Responses Initiative, this two-page resource provides examples of law enforcement encounters with people with developmental disabilities, discusses how understanding more about disabilities leads to safe and effective interactions, and provides examples of possible behaviors of people with developmental disabilities and recommended responses.

10. **A Matter of Public Health and Safety: How States Can Support Local Crisis Systems:**

The COVID-19 pandemic aggravated deep-rooted systemic problems related to inequitable access to necessary care and services to address—and prevent—mental health crises in communities. This brief details five actions state policymakers can take to fund and sustain local crisis systems.

11. **Advancing the Work of Peer Support Specialists in Behavioral Health-Criminal Justice Programming:**

Peer support specialists draw on their lived experience with behavioral health conditions and criminal justice involvement to support participants of behavioral health-criminal justice programs. This brief highlights four key strategies gleaned from interviews that can be used to advance the work of peer support specialists including in models such as co-response teams.

12. **Building a Comprehensive and Coordinated Crisis System:**

Across the nation, communities are grappling with how to respond to crisis calls, particularly ones involving people with behavioral health needs. As they work to build and expand their crisis systems, communities are also looking to expand beyond typical police responses. This brief highlights the continuum of responses that make up a comprehensive, coordinated crisis system and offers guidance for building a system that addresses local needs.

13. **Community Responder Programs: Keys to Building a Strong Call Triage Process:**

Effective call triaging enables communities to connect people in need of emergency and non-emergency assistance to the most appropriate response as quickly as possible. For community responder programs call triaging can ensure that they receive the information needed to safely address a situation. This brief provides recommendations for ensuring a successful, strong call triage process for community responder programs.

14. **[Community Responder Programs: Understanding the Call Triage Process:](#)** Community responder programs are an increasingly common component of local emergency response systems across the country. One challenging aspect of implementing such programs is ensuring that community responders are included in the local call triage process so that emergency call centers can identify and relay appropriate calls to them. This brief highlights the different ways call triage can be used to inform and dispatch community responders.
15. **[Creating Buy-In: Best Practices for Collaborating with Referral Sources for Crisis Stabilization Units:](#)** Crisis stabilization units offer law enforcement officers and mobile crisis teams a safe place to bring people in behavioral health crisis, often in lieu of arrest or emergency hospitalization. However, they can be challenging to establish without the appropriate funding and support from key partners. This brief offers three best practices for collaborating with referral sources to ensure success.
16. **[Developing and Implementing Your Co-Responder Program:](#)** Many law enforcement agencies are seeking alternatives to arrest or hospitalization to help ensure best outcomes for people in need. One approach that is growing in popularity, known as co-responder programs, pairs health care professionals with officers to respond to behavioral health crisis calls. This brief describes ways to ensure these programs are successful.
17. **[Financing Community Responder Programs:](#)** While every jurisdiction's budgetary landscape is different, this brief offers four common sources of funding. To budget for community responder programs, many jurisdictions have started leveraging multiple funding streams, which can help protect the program against lapses in service if one funding source ends.
18. **[How to Reduce Repeat Encounters: A Brief for Law Enforcement Executives:](#)** Law enforcement agencies across the country face the challenge of how to efficiently respond to people that their officers frequently encounter. This brief provides practical steps law enforcement executives can take to address and improve outcomes for this population.
19. **[How to Successfully Implement a Mobile Crisis Team:](#)** As officers are increasingly tasked with responding to people in crisis, jurisdictions are seeking ways to support their law enforcement agencies. For many communities, mobile crisis teams—trained health professionals who can provide on-the-scene crisis assistance—are a great option. This brief provides an overview and offers four tips to ensure success.
20. **[How to Use 988 to Respond to Behavioral Health Crisis Calls:](#)** In 2020, the Federal Communications Commission FCC and Congress established a universal phone number for behavioral health crises and suicide preventions to directly connect people to crisis responders—988. This brief highlights important facts about the new crisis line and offers tips to help communities prepare for its national launch in 2022.

21. **Implementing Specialized Caseloads to Reduce Recidivism for People with Co-Occurring Disorders:** Many criminal justice leaders are beginning to look to specialized caseloads as a tool for reducing recidivism among people who have mental illnesses and co-occurring SUDs. This brief presents five key practices for successful implementation of specialized caseloads.
22. **Mental Health Training: Strategies for Small and Rural Law Enforcement Agencies:** Small and rural jurisdictions, which make up the majority of police departments across the country, often face distinct challenges that make it difficult to implement the types of mental health training programs that larger and urban agencies can access. This brief details strategies to develop and implement comprehensive, high-quality training that creatively addresses their unique challenges.
23. **Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs:** Increasingly, law enforcement officers are called on to be the first, and often the only, responders to calls involving people who have mental health needs. This framework can help law enforcement agencies across the country better respond to the growing number of calls for service they receive involving this population.
24. **Preparing 911 Dispatch Personnel for Incorporating New First Responder Teams:** Traditional first response options have usually included police officers, the fire department, and emergency medical services but jurisdictions are increasingly expanding to build out a network of crisis responses that better address the needs of their communities. This brief provides PSAP administrators with key elements and options, as well as examples of how some jurisdictions have used these elements.
25. **Program Overview: Law Enforcement-Mental Health Learning Sites:** New strategies are being adopted around the country to improve the outcomes of encounters between law enforcement and people who have mental health conditions. The Law Enforcement-Mental Health Learning Site program is a national resource for law enforcement and behavioral health agencies looking to tailor response models and implementation strategies to their community's needs. This brief provides a detailed overview.
26. **Strengthening Partnerships Between Law Enforcement and Homelessness Service Systems:** This policy brief highlights five emerging cross-systems strategies local law enforcement and homelessness response leaders can use to respond to people who experience unsheltered homelessness and have frequent contact with law enforcement.
27. **The Role of Probation and Parole in Making Housing a Priority for People with Behavioral Health Needs:** Finding permanent housing is often a challenge for people leaving prison or jail, particularly for people with behavioral health needs who often cycle between homeless shelters, jails, and psychiatric institutions. This brief explains how probation and parole officers can help people obtain safe and affordable housing as they reenter the community.

28. [**Tips for Successfully Implementing a 911 Dispatch Diversion Program:**](#) A diversion model showing great promise across the U.S. is 911 dispatch diversion, sometimes called crisis call diversion. The approach aims to reduce unnecessary police contact by connecting people to mental health professionals when someone contacts 911 due to a behavioral health crisis or other health or social service need. This brief outlines four tips for successfully implementing 911 dispatch diversion in a community.
29. [**Tips for Successfully Implementing Crisis Stabilization Units:**](#) A growing number of jurisdictions are creating crisis stabilization units (CSUs) to provide officers with an option to link people to the most appropriate supportive services, help reduce arrests, and improve outcomes for people with behavioral health needs. This brief provides an overview of CSUs for criminal justice professionals and offers universal, practical tips to design and operate a successful CSU.
30. [**Advancing an Alternative to Police: Community-Based Services for Black People with Mental Illness \(July 2022\):**](#) Developed by the Bazelon Center for Mental Health Law and the NAACP Legal Defense Fund, this issue brief examines the incarceration, institutionalization, and police encounters that people with mental illness—particularly those who are Black—face in law enforcement encounters when community-based mental health services are not available to meet their needs. The publication recommends a series of actions that should be taken to address these issues.
31. [**Law Enforcement Engagement with People with Behavioral Health Issues and Developmental Disabilities:**](#) In August 2020, a multi-disciplinary group of individuals with subject matter expertise in police responses to people with behavioral health conditions and/or developmental disabilities convened virtually to participate in the Law Enforcement Engagement with People with Behavioral Health Issues and Developmental Disabilities Stakeholder Roundtable. This roundtable was designed to inform the work of the Academic Training to Inform Police Responses by facilitating discussions related to: (1) opportunities to advance the safety and effectiveness of police engagement with people with behavioral health (BH) conditions and/or developmental disabilities (DD); (2) best practices in current crisis response models and collaboration between police and service provider partners; and (3) existing and needed products and resources to support police agencies and their service provider partners in the delivery of effective responses. The Stakeholder Roundtable hosted presentations on existing efforts in police responses to people with BH conditions and/or DD. These presentations were designed to facilitate discussions of best practices in police and community responses, methods of police-mental health and police-disability collaboration, and potential barriers to effective responses to people with BH conditions and/or DD.
32. [**U.S. Dep’t of Justice, Civil Rights Division, Communicating with People Who Are Deaf or Hard of Hearing: ADA Guide for Law Enforcement Officers:**](#) This technical assistance document highlights the ADA’s requirements for law enforcement officers in interacting with people who are deaf or hard of hearing.

33. [**Training for Law Enforcement \(Tool Kit\) - Tourette Association of America:**](#) This toolkit provides resources to law enforcement, EMTs, first responders, and other support personnel to help understand and support children with Tourette Syndrome and Tic Disorders.

TOOLS / OTHER RESOURCES

1. [**Justice and Mental Health Collaboration Program \(JMHCP\):**](#) The Justice and Mental Health Collaboration Program (JMHCP) supports innovative cross-system collaboration for individuals with mental illnesses or co-occurring mental health and SUDs who come into contact with the justice system.
2. [**Law Enforcement-Mental Health Collaboration Support Center:**](#) The Law Enforcement-Mental Health Collaboration Support Center offers free training, resources, and support to communities wanting to improve their law enforcement and community responses to people with behavioral health conditions or intellectual and developmental disabilities.
3. [**U.S. Department of Justice Civil Rights Division and United States Attorney's Office, Western District of Kentucky, Civil Division, Investigation of the Louisville Metro Police Department and Louisville Metro Government:**](#) This findings report following an investigation in Louisville includes findings that there is reasonable cause to believe these entities discriminated against people with behavioral health disabilities when responding to them in crisis and to calls for emergency services. Among other things, the report finds that LMPD officers are the primary and generally the sole responders to situations involving behavioral health issues in Louisville, even in instances where safety does not require a law enforcement presence, that many incidents could be safely and more effectively resolved through a response by behavioral health professionals, such as a mobile crisis team, or with co-responding behavioral health professionals along with appropriately selected and trained officers, and that reasonable modifications could be made to avoid unequal treatment of people with behavioral health disabilities.
4. [**American Rescue Plan Act of 2021: Guide to Advancing Justice-Related Goals:**](#) This guide outlines need-to-know information about how state and local leaders can leverage American Rescue Plan funding to advance eight key criminal justice priorities, including reducing criminal justice involvement for people with behavioral health needs and funding crisis services.
5. [**Law Enforcement-Mental Health Learning Sites Program:**](#) 14 Law Enforcement-Mental Health Learning Sites are available to help agencies looking to tailor successful implementation strategies and response models to address their own distinct problems and circumstances.

6. **[Police-Mental Health Collaboration Self-Assessment Tool](#)**: The tool helps law enforcement agencies and their behavioral health partners assess their progress toward implementing high quality partnership-based interventions. It is designed to provide unique resources that help agencies improve their responses to calls for service for people with behavioral health needs.
7. **[Police-Mental Health Collaboration Toolkit](#)**: The toolkit serves as a clearinghouse for PMHC information and resources.
8. **[Taking the Call Conference Resources](#)**: This repository of session recording, briefs, tools, evaluations, and resources is intended to help communities build effective and comprehensive crisis systems. These resources touch on topics including co-responder models, alternative responder models, mobile crisis, community crisis centers, post crisis services, and the financing of these services.
9. **[Sharing Behavioral Health Information within Police-Mental Health Collaborations](#)**: This web-based tool provides information on best practices for sharing information between law enforcement and behavioral health agencies to facilitate the effective operation of PMHCs. This includes the need to effectively respond to someone in mental health crisis as well as gauge demand for behavioral health.
10. **[National Survey of Police-Mental Health Collaboration Programs in Large U.S. City Police Departments](#)**: With support of the Bureau of Justice Assistance, the University of Cincinnati Center for Police Research and Policy conducted a survey of 70 law enforcement agencies within large U.S. cities. This map, which was constructed in partnership with the Council of State Government Justice Center, shows the frequency of collaborative law enforcement-behavioral health interventions within those agencies. These initiatives aim to improve individual and community health outcomes, reduce unnecessary law enforcement contact for people with behavioral health needs or people experiencing homelessness, and protect public safety.
11. **[National Center on Advancing Person-Centered Practices and Systems](#)**: The National Center on Advancing Person-Centered Practices and Systems (NCAPPS) is an initiative from the Administration for Community Living and the Centers for Medicare & Medicaid Services that helps States, Tribes, and Territories implement person-centered thinking, planning, and practice in line with U.S. Department of Health and Human Services policy. The goal of NCAPPS is to promote systems change that makes person-centered principles not just an aspiration but a reality in the lives of people who require services and supports across the lifespan. NCAPPS will assist States, Tribes, and Territories to transform their service and support systems to implement U.S. Department of Health and Human Services policy on person-centered thinking, planning, and practices. It will support a range of person-centered thinking, planning, and practices, regardless of funding source.
12. **[Traumatic Brain Injury and the Criminal Justice System \(ncdhhs.gov\)](#)**

13. [PowerPoint Presentation \(maryland.gov\)](#) Traumatic Brain Injury: Overview for Law Enforcement and Public Safety Professionals
14. [safereturn_lawenforcement.pdf \(alz.org\)](#) Alzheimer's Disease Guide for Law Enforcement

WEBINARS

1. [**Improving Law Enforcement Responses to Persons with Mental Illness and Intellectual/Developmental Disabilities**](#): This webinar provides participants with strategies to improve the behavioral health crisis response for individuals with mental illnesses and I/DD. It presents models of mental health crisis response, including Crisis Intervention Teams, mobile crisis, co-responder, and stand-alone mental health response training. It also discusses how research addresses the effectiveness of models for responding to individuals with I/DD and directions for future research.
2. [**Federal Support for Behavioral Health and Justice Responses: Best Practice, Resources and Education**](#): This webinar discusses behavioral health interventions and BJA resources that can assist with strategic planning and program implementation to address mental health disorders, co-occurring mental health and SUDs, substance use and addiction, criminal justice system responses, school responses, and responses to populations such as youth, tribes, and veterans.
3. [**Justice Briefing Live: Responding to Homelessness: Effective Strategies for Law Enforcement and Community Partners**](#): People who experience homelessness often have frequent—and sometimes repeated—interactions with law enforcement and PMHCs are well-situated to intervene in these situations. This webinar featured a live demonstration of the newly revamped BJA PMHC Toolkit, which includes several new modules specifically focused on responding to homelessness.
4. [**Right Person, Right Time, Right Response**](#): In this fieldwide virtual discussion, experts shared resources and facilitated a discussion to identify strategies and best practices—with and without law enforcement—for early responses at Sequential Intercept Model intercepts 0 and 1. Topics include collaboration, funding, adjusting response needs, and identifying more appropriate goals of support.
5. [**Using the Web-Based Self-Assessment Tool and Technical Assistance Centers to Improve Police and Community Responses to People with Behavioral Health Needs**](#): While some jurisdictions have established partnerships between their police departments and behavioral health system counterparts, many still struggle. This webinar focused on how to effectively develop cross-system responses that can benefit the people impacted most by these systems.
6. [**Law Enforcement Responses for People with Have Mental Health Needs**](#): In this webinar, presenters discuss six questions that law enforcement executives should

consider when developing or enhancing PMHCs in their jurisdiction and share practical approaches that have been implemented in the field.

7. **Policing and People with Developmental Disabilities: Emerging Issues in the Field:** Presented by the U.S. Department of Justice, Bureau of Justice Assistance's Academic Training to Inform Police Responses Initiative, this webinar provided an overview of this topic from the perspectives of law enforcement and a person with a developmental disability, including emerging issues and practical tips officers can use to respond effectively to this population.
8. **Crisis Response for Rural Communities:** Presented by the U.S. Department of Justice, Bureau of Justice Assistance's Academic Training to Inform Police Responses Initiative, this webinar featured two programs that have adapted crisis response for use in rural communities. Panelists presented the innovative approaches in crisis response implemented by their programs and discuss the challenges of ensuring the needs of individuals in crisis who live in rural communities are met. Additionally, the Academic Training project team highlighted key resources to support rural communities developing and implementing crisis response in their jurisdiction.
9. **Transforming Dispatch and Crisis Response Services:** Presented by the U.S. Department of Justice, Bureau of Justice Assistance's Academic Training to Inform Police Responses Initiative, this webinar featured four programs that have leveraged the training, policies, and procedures of 911 call-takers and dispatch when restructuring their community's response to crisis incidents. Panelists presented the innovative approaches in crisis response implemented by their programs and discussed the challenges of ensuring appropriate services are dispatched to crisis incidents to best meet the needs of individuals.

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