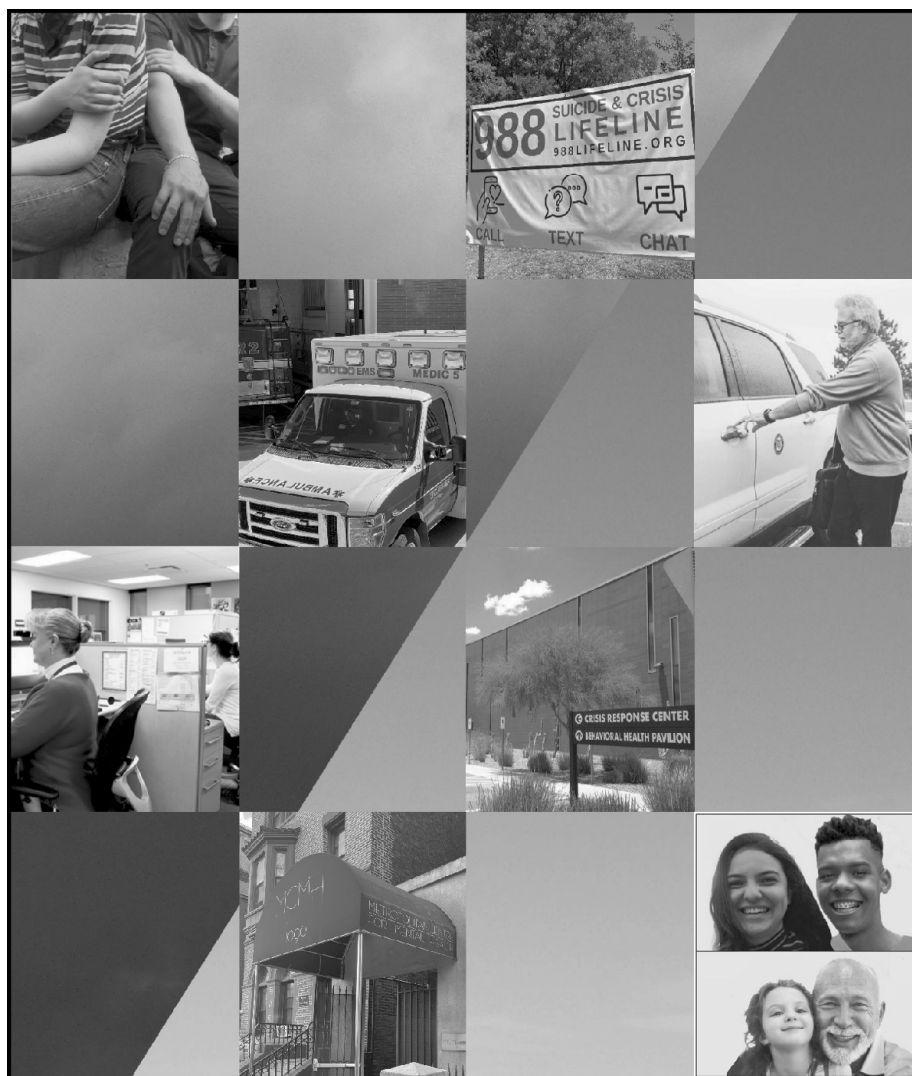




LENDING HANDS

Improving Partnerships and Coordinated Practices
between Behavioral Health, Police, and other First Responders

September 2022

Paper No. 10 in the *From Crisis to Care* Series

Lending Hands: Improving Partnerships and Coordinated Practices between Behavioral Health, Police, and other First Responders

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Tenth in the 2022 From Crisis to Care Series of Ten Technical Assistance Briefs Focused on Building from 988 and Beyond for Better Mental Health Outcomes



National Association of State Mental Health Program Directors

<https://www.nasmhpd.org/content/tac-assessment-papers>

September 2022

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Recommended Citation

Pinals, D. A. (2022). *Lending Hands: Improving Partnerships and Coordinated Practices between Behavioral Health, Police, and other First Responders*. Technical Assistance Collaborative Paper No. 10. Alexandria, VA: National Association of State Mental Health Program Directors.

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

For community and out-of-hospital crisis response to be effective for people with mental illnesses, substance use disorders, intellectual and developmental disabilities and other behavioral health related conditions, there is a need for partnerships, comprehensive protocols, and a range of response options to meet the needs of the particular crisis. Law enforcement, emergency medical staff, and behavioral health crisis responders are key stakeholders that could meet these needs. Yet, officer use of force in these situations remains a significant concern, while safety for responders and others are required, necessitating considerations of what responses for particular situations are needed. Additionally, individuals need to have accessible crisis responses, equitably distributed across all neighborhoods despite varying geographical rural/urban settings and socioeconomic living conditions. Medical issues pertaining to treatments during crisis responses such as urgent stabilization and initial treatment engagement, as well as legal issues pertaining to law enforcement response, use of force considerations, emergency holds and transport of individuals with behavioral health needs, the Emergency Medical Treatment and Labor Act (EMTALA), and the Americans with Disabilities Act (ADA) must be contemplated in partnership response development. This paper outlines many of the underlying factors and provides information and suggestions to improve practices to help move systems in the direction of meeting these needs.

Highlights:

- Law enforcement and its partners still play a role in crisis response and it is necessary for police-partners to receive the necessary tools and training to improve practices while still developing least restrictive responses to crisis.
- Mobile crisis responses have evolved to include numerous models of interdisciplinary response that will require increased coordination.
- The legal regulation of crisis response, evolving case law, Constitutional requirements, and federal statutory guidance such as that pertaining to the ADA will help dictate proper crisis response practices.
- Factors such as medical clearance protocols, less restrictive transportation options, and no wrong door protocols are needed to divert people in crisis from criminal justice system and help overcome barriers to accessing care following a mobile crisis response.
- Out-of-hospital treatment can provide rapid access to care interventions and reduce the need of costly hospitalizations post-crisis response for some individuals.
- To proactively address workforce shortages, it is critical to nurture the current and future workforce who may be exposed to all types of traumatic situations in responding to crises.

Recommendations for Policy Makers, Practitioners and Thought Leaders:

1. Sufficient funding at the federal level for multi-disciplinary crisis responses that can be sustained and grown over time should be prioritized across populations.

2. With the growing need for national standards for behavioral health crisis response, there should be ongoing consideration of the evolution of coordinated 988 and EMS standards in the implementation of 988 and related responses.
3. Out-of-hospital treatment interventions should be explored for specific protocols and resultant quality analyses and their development should involve multi-disciplinary perspectives.
4. Policies for multidisciplinary responses should be built into the crisis delivery system, including those that address staff safety, public safety, and management and treatment of high risk encounters that involve volatile individuals who may have means to harm themselves or others during the encounter, while taking into account Constitutional rights, the ADA, case law and federal statutes that may play a role in shaping practices.
5. Mechanisms for transport of individuals in behavioral health crisis should be considered in a way that reduces reliance upon law enforcement while still upholding principles of safety.
6. Technology should be leveraged for the out-of-hospital community mobile response to maximize access to proper assessment and triage, with the establishment of related protocols regarding needed parameters for technology utilization.
7. Research regarding mobile crisis response, types of responders, and outcomes should be prioritized to help further best practices across communities.
8. Data collection across sites for mobile crisis responses in its various forms should be collected with routine governmental reporting for public awareness and quality improvement across communities and such data should be examined with an equity lens.

The responses needed to manage crisis calls are complex and can be fraught with risk. Yet, these types of events happen daily in communities around the world (see Text Box). Although many people with serious mental illnesses and substance use disorders do not end up in these types of dire situations, some do, and when they do, the alignment and availability of proper responses and resources are critical to alleviate such crises, including the proper legal authority to intervene if needed. Individuals in crisis may have serious conditions and even their own trauma histories, requiring responses to be sensitive and skilled on many levels. Coordinated training for all partners in the response continuum is critical, especially as it relates to actions that can yield safer outcomes for all.

Crisis Calls: What May Arise on Any Given Day

Crisis calls are made to call centers 24/7/365. For policymakers working at a distance from the actual calls, it can be helpful to consider and walk through strategies to address plausible scenarios that might lead to the need to deploy a crisis response of some type. In the following examples, there may be real concerns about safety to the responders and to the individual who is the “subject” of the call or others. Each scenario is based on actual narratives that have been described in clinical contexts with the author:

“Hello! Someone please help me. My son Taylor has a hammer and is banging holes in our walls! He pulled everything out of the pantry and cans are everywhere and dishes are broken. He keeps thinking that there are electronic wiretaps in our house and he was hammering our wall to see if he could stop the sounds coming through. He is yelling at my husband who was knocked to the floor. He is telling him to stay away and is convinced we are trying to hurt him! Please help! He has schizophrenia and stopped taking his medications 3 months ago after he left the hospital!”

“I’m calling for help! My father has been depressed lately and has been talking about killing himself after he lost his job. He went to the basement and took a gun- he’s been drinking too. He left the house and headed toward the woods. I’m scared!! Please come help!”

“Help! My sister is crying hysterically and is saying she does not want to live! She and her friends were up all night partying, but she is not well. I think she is on a lot of drugs right now. She sometimes has flashbacks to a bad boyfriend she just left. And now she has a knife and is cutting herself! I can’t get her to put down the knife!!”

“This is local community mental health calling. One of our clients is barricaded in her apartment. We’ve been trying to do well-person visits and have her case manager visit her but over the last week she has refused to let anyone in the apartment. We have reason to believe she is not eating or drinking as she believes her food is poisoned and that we are trying to harm her. She said something about harming her cat. She will not let us into her apartment to check on her. We need her brought to the crisis services unit for an assessment, but we cannot convince her to come with us!”

Today, there is an incredible movement in developing crisis response techniques, especially surrounding the launch of 988, the three-digit number that became available in July 2022 that simplifies access to the National Suicide Prevention Lifeline and will also serve as a national behavioral health crisis number. Part of the evolving dialogue around 988 response centers is about developing strategies that consider which entity or entities should be available to address the caller’s needs to yield the best outcomes. In this national discourse, issues of

equity, justice and least restrictive responses have been highlighted. Indeed, the scenarios above were written to be neutral with regard to the caller's demographic information, to serve as a reminder that proper responses should be available regardless of the individual's background, particularly their race/ethnicity, neighborhood, or socioeconomic status. And yet, if those details were added to the scenarios in the accompanying text box, there may be an immediate shift in the manner in which the crisis response is provided. Therein lies the need for clear policy to achieve just and equitable responses for all.

When developing practices that will yield appropriate and improved outcomes, it is necessary to be aware that in a small percentage of cases, a response that escalates a situation can result in major catastrophic harm, including the death of the person in distress, responders or bystanders. When there is imminent risk of harm, officers on the scene may have to the authority to protect or self-protect, which means using force including lethal force. With that comes scrutiny and criticism, especially given data that individuals with mental illness are disproportionately impacted by officer involved shootings.¹ And as far as disparities within those negative outcomes (see Text Box), one study showed that victims of law enforcement fatal shootings were disproportionately Black, even when unarmed, with about 22% thought to be mental health related and 18% suspected "suicide by cop" incidents.²

Intersection of Race, Mental Illness, and Law Enforcement

Actions of law enforcement have been increasingly scrutinized partially due to recent and relevant tragic deaths at the hands of police, including the murder of George Floyd. As a result the "defund police" movement advocated for sweeping change. As noted studies have shown that with regard to behavioral health crises, Black persons with mental illness are more likely to be victims of police officer shootings.³ Disproportionate police contact with Black and Hispanic communities and neighborhoods of poverty has long been realized. More recently, studies have begun to examine the impact of non-fatal encounters with police, with one review of the existing research showing that individuals with a prior police interaction have poor mental health outcomes compared to those without such interactions.⁴ Thus, the gamut of issues that may involve police need to take into account a range of collateral consequences of such interactions, and their disparate impacts for persons of color and marginalized communities. This all comes at the same time as mass shootings and gun violence are also resurfacing in headlines. A report from Johns Hopkins Bloomberg School of Public Health Center for Gun Violence Solutions reported that firearm related homicide increased by 35% from 2019 to 2020 and that Black males ages 15 to 34 were 20 times more likely to be a victim of gun homicide.⁵ Bailey and colleagues⁶ raise the bar higher by noting that there is critical work to be done in communities where there is intense policing and that violence and injury prevention should factor in patterns of structural racism and the need for community engagement to improve overall health outcomes. In other words, there are many intersecting issues related to race, mental illness and interactions with law enforcement and concerns about injury to people, responders and others on scenes of crises. These will require ongoing attention as police remain a critical component of the public safety system, all while new multidisciplinary models of response to behavioral health crises are emerging.

In addition to concerns about the outcomes for private parties, responses that do not have proper protections can create untoward injury to professional responders. According to the Centers for Disease Control and Prevention (CDC), between 2011 and 2015, law enforcement officers suffered 606 fatal work injuries, with the leading causes being homicides, roadway vehicle incidents, suicides, pedestrian vehicular incidents and accidental shootings (by self and others).⁷ This data shows how responders are also at risk of being harmed during crises, pointing to the need to better understand how they can also be protected while on the scene especially as behavioral health crises may be increasing and involve potentially new types of responders, whose safety is also of tantamount importance.

Thus, with the launch of 988, and the myriad community crisis response programs that are emerging, comes the need for coordination with 911 and public safety responses as a whole. Because the decision to deploy a particular response is typically made at crisis call centers or Public Safety Answering Points (PSAPs), the role of that triage or dispatch is critical. The results of community development in crisis services mean that sometimes the response will include EMS, behavioral health or law enforcement, or all three sectors will join. Communities all over the country are developing collaborative response models, and there may be some areas where additional responses will be folded in, such as peer supports, or even lay responders especially in rural areas. Yet one study examining 911 call centers by Valazquez and Clark-Moorman from Pew Charitable Trusts found that 911 call centers lack resources and training to handle behavioral health crises.⁸ This is all while emergency medical service (EMS) data from Colorado shows that responses to behavioral health cases increased by 146% from 2011 to 2015,⁹ suggesting that even before the pandemic the need for additional resources and the development of best practices was even more imperative. From that initial call, countless decisions will be made with regard to the nature of the emergency, whether it can be resolved by phone or if there will need to be deployment of on-the-ground responders, and what types of responders to include.

Despite the growth of behavioral health and multidisciplinary response teams, there is a lack of clear data on them to help drive practices that could help improve safety and outcomes. In addition to seeking more administrative data, rigorous research in these areas is sorely needed.

Although crisis response models are unfolding, by providing a review of the history of community response and current practices and unique considerations with regard to law and clinical advances in this paper, it is hoped that policymakers will have greater information from which to develop mobile crisis responses with best practices. This paper outlines some of historical development of crisis responders, and then provides considerations for crisis responses with heightened safety concerns where law enforcement or medical services may be needed to lend along with behavioral health responders. It then reviews aspects of crisis services such as transportation issues, medical clearance and other facets important for consideration of an improved response continuum.

Historical Lens of Community Responses and the Path to Today's Landscape

The stigma and fear invoked by images of “men in white coats” and the phrase’s meaning permeated popular culture with negative connotations. Yet over time, calling for help when someone is in mental health crisis shifted from those white coat images to ones of blue uniforms and armed officers.

“Men in White Coats” and Problematic Representations of Access to Care

According to the online resource the “grammarist,” the phrase “men in white coats” is an idiom that is a reference to an image of psychiatric workers or orderlies dressed in white coats “who descend upon a psychiatric patient to subdue him to take him to a mental health facility,” thought to have become popular in the mid-twentieth century.¹⁰ Two historical references speak to this. For example, one in 1936 noted referenced “[running] to the nearest phone to call for the men in the white coats.”¹¹ And another from 1938 related to a sports team article in the “Quincy Patriot Ledger” stating...“It’s too bad that other people have to suffer for the wrong doings of certain people who have been evading the men in white coats.”¹² Even today, the expression relates to psychiatric care and coercion in care, as evidenced by a recent publication out of the U.K. by Dr. George Szmukler, *Men in White Coats: Treatment Under Coercion*.¹³

As police became the default responders, there was a new wave of interest in helping improve their work. The Crisis Intervention Team (CIT) model, which was created after a deadly encounter of police with an individual with mental illness in Tennessee in the late 1990s, is built on the idea that with select officers given proper training, protocols and locations to take people, police responses can be improved and yield more favorable and less deadly or injurious outcomes.¹⁴ Although traditional police uniforms conjure up their own images related to authority and control,¹⁵ the CIT approach incorporated the practice of having a special badge for CIT trained officers that would show that the individual police responder was more “mental health friendly.” This effort aimed to shift prior notions, but overall policing practices continue to be questioned with regard to responses to persons with mental illness. Indeed, a 2018 U.S. Government Accountability Office (GAO) report recorded several Federal law enforcement challenges in responding to individuals with mental illness and the need to enhance those responses,¹⁶ further indicating how far there is still to go in achieving the goals of quality community responses with partnerships across disciplines. To that end, Rahr and Rice from the Harvard Kennedy School comment on the importance of “recommitting American police culture to democratic ideals”, emphasizing the importance of procedural justice (how people are treated during encounters with the law), building community trust such as through positive police contacts all while maintaining officer safety.¹⁷

In the evolution of response to persons with mental illness and the advent of CIT, co-responder, embedded clinicians, and other multi-disciplinary response models emerged. This created more advances in developing pathways to better ascertain how to respond to crises with re-imagined roles rather than the “default” law enforcement response. In addition, progress has been made in how to best leverage the important role well-trained police can play in certain circumstances,

and under what circumstances they could join or provide on scene or available back up to behavioral health responders of other disciplines who might be deployed first.

Although the idea of expanding crisis response beyond police goes back decades, in 2017, Abreu and colleagues introduced to the academic literature and to policymakers the concept of Intercept 0¹⁸ as an expansion of Munetz and Griffin's 1996 Sequential Intercept Model¹⁹ that put forward the idea of stepwise approaches to identifying individuals with mental illness who became involved in criminal processes and redirecting them into treatment. In Abreu and colleague's review of Intercept 0, they delineate the importance of community crisis response as a first step that could decrease the reliance upon law enforcement. Further, they note the two traditional roles of law enforcement, warriors (for whom the role entails public safety protections) and guardians (that support vulnerable people by assisting them with decision-making and helping them take care of their needs) (see Text Box), and emphasize the important role that this "guardian" of society can play in helping individuals with mental illness access care.²⁰ By focusing on the roles of participants in crisis response in engaging individuals and supporting local community mental health crisis responses, the emphasis can shift toward deflection to treatment at the same time the reliance on police partnerships continues and can be refined.²¹

Roles of Police Related to Crisis Services

Guardian: Under the *parens patriae* doctrine, the government's role includes acting almost as parent in caring for vulnerable people such as those with serious mental illness who may be unable to care for themselves. This is one of the doctrines that provides a rationale for civil commitment and related procedures.

Warrior: There is also a rationale of "police powers" that authorizes civil commitment of individuals with mental illness who are at risk of harm to themselves or others. This allows police through their governmental authority to intervene to protect others from harm and keep people safe.

Beyond police and behavioral health professional responses through mobile crisis and co-response, emergency medical services has also grown as a field and been an increasing focus of attention in the behavioral health crisis response continuum. Freedom House was an example of a community-based medical service that came about and ran in the 1960s and 1970s, run as a Black community-based enterprise with physicians in Pittsburgh²² that helped foster the development of professional emergency medical technicians as health care professionals, creating a model of health care system in which Black and white enterprise work for and towards community good. Around the time of its emergence, in 1966, President Lyndon B. Johnson received a white paper entitled *Accidental Death and Disability: The Neglected Disease of Modern Society*,²³ showing high death rates due to vehicle accidents and recommended standardized emergency training for rescue personnel including police and ambulance attendants. This resulted in an early emergency medical technician-ambulance (EMT-A) curriculum published in 1969,²⁴ followed by in 1971 a national standard curriculum for EMTs published by the U.S. Department of Transportation.²⁵ Then in 1973, the Emergency Medical Services Act produced federal guidelines and over \$300 million in funding to develop regional EMS systems across the United States.

Since that time, emergency medical personnel have increasingly responded to mental health problems in out-of-hospital contexts, with one national study of ambulance transports to emergency departments in the United States showing higher rates of ambulance use between 1997 and 2003 for mental health visits, with 31% of patients arriving by ambulance to an emergency department for a mental health visit.²⁶ This increased use of paramedics and other emergency medical service personnel in behavioral health crisis response has called attention to public debates about whether this is a misuse of paramedic services and whether more could be done to prevent these emergency calls for mental health issues in the first place.²⁷

Today, what is clear is that the crisis response space is exciting, complex, and rapidly evolving, with many more stakeholders weighing in to get responses communities want. Additionally, there is an ever expanding need to provide access to mental health services to avoid behavioral health crises in the first place, especially in the context of the human experience with COVID-19. As both these approaches converge, policymakers are aiming to build a better crisis response continuum knowing whatever is built must link to 988, and involve coordination with 911 and partnering organizations including EMS, behavioral health systems and police.

System Considerations for 988, 911 and the multidisciplinary team response landscape: 2022 and Beyond

In *Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988*,²⁸ and in *Crisis Services, Meeting Needs, Saving Lives*,²⁹ basic models for community responses for mental health crises invoking different disciplines are described. Given the growth in this area, an expanded list of examples of available models of community responses to behavioral health crises is summarized in **Table 1**.

There has been a proliferation of different models around the country in which multidisciplinary teams are invoked to respond in a community setting to address crisis calls. The launch of 988 only makes these models even more of an imperative. In a 2018 publication of a systematic review of co-responder models seen in the literature, it appeared that articles from Australia, Canada, the United States and the United Kingdom were more numerous after 2015, and evidenced 19 different “triage models” across 26 articles that met the review’s criteria.³⁰ The models included 12 ride-along approaches, five involved ride-along and control room support with remote assistance via telephone or police radio, and six in which the primary support was via a control room or telephone triage support.³¹

States have established community mobile services for families, youth and adults alike. For example, a non-officer-based general community health response model out of Eugene and Springfield, Oregon, the CAHOOTS model (Crisis Assistance Helping Out on the Streets)³² received enormous public attention especially in the wake of the “defund police” movement and inspired a national movement to build similar services.³³ And, like many similar initiatives around the country, models in Massachusetts³⁴ and Connecticut³⁵ incorporate a youth-focused

mobile crisis intervention and stabilization responses including aftercare follow up services with family partners.

Table 1: Emerging Designs of Community Based Partnership Responses with Law Enforcement, Mental Health Providers, EMS and Others (see also *Crisis Services: Meeting Needs, Saving Lives*)

<i>Dispatch-based behavioral health supports</i>	Behavioral health specialists work within dispatch call centers to be available to assist with calls, provide consultation and support of call center workers and engage in frontline “triage”.
<i>Police-based specialized police response</i>	Law enforcement officers who are specifically trained to manage behavioral health crises and have knowledge of and access to the system to help support their response.
<i>Police-based specialized mental health co-response</i>	Typically involves behavioral health clinicians hired by police departments whose job is to accompany officers on calls where an individual might be in a behavioral health crisis or where a behavioral health specialist might be helpful.
<i>Mental health-based mental health response</i>	Also known as mobile crisis services, where a mental health unit, staff person or team of staff respond directly at the scene of the crisis; Law enforcement may or may not jointly and cooperatively appear on the scene.
<i>Health system-based response</i>	Provided by EMS, Federally Qualified Health Centers, and other health systems where medical personnel are first responders to behavioral health crises.
<i>Street outreach workers</i>	Focus on homeless populations and provide specialized responses to manage crises, refer to treatment and even initiate or provide treatment to people on the streets.
<i>Peer-based crisis responders</i>	Individuals with lived experience respond to families or individuals in distress and connect to other service providers for referrals. These may be tailored to unique populations such as veterans, native Americans, and others.
<i>Multi-disciplinary team responses</i>	Services that bring together medical personnel, behavioral health personnel and law enforcement to be on scene in a community and provide responses leveraging each discipline.
<i>Blended and innovative</i>	Services that involve unarmed officers, peer support collaborations, community response teams that utilize a combination of efforts of any of the above and additional models to enhance options for responding.

Other initiatives are unfolding that invoke various disciplines in the responses. Take Texas, for example, which has grown Multi-Disciplinary Response Teams (MDRT) with the support of Meadows Mental Health Policy Institute with funding from Pew Charitable Trusts.³⁶ These teams approach crisis response with a focus on health outcomes, relying upon best-practice responses to medical emergencies for people with chronic illnesses that invokes a paramedic, a licensed master’s prepared mental health professional and a law enforcement officer with advance crisis and mental health training.³⁷ Results of that program have shown some promising findings, with 40% of 6,679 response contacts also helping link individuals to community services.³⁸

There is also much literature on the CIT model. For example, one study showed that use of force, arrests and injuries were infrequent in Colorado after the implementation of crisis

intervention teams.³⁹ Another study examining police reports from 2003 to 2005 showed that 45% of CIT events involved suicide crisis and 26% involved a threat to others, and that use of force, while related to the violence potential of the event, was used only in 15% of events posing serious to extreme risk of violence.⁴⁰

Even with these advances, with the transition to 988 that officially began in July 2022, there is an increased demand for better responses. Thus, it is more critical than ever to examine what might be best and better practices. In one Canadian rapid review of the literature from 2010 and 2020 comparing outcomes across police, co-responder and non-police models, researchers found sobering results across 62 articles: studies were observational and lacked control groups, making findings of low-to moderate quality with potential for bias.⁴¹ According to the review, there was no rigorous evidence to show that CIT models improved crisis outcomes. Co-responder models showed some improved outcomes compared to police-only responses yet evidence was mixed. The authors found that non-police models varied significantly across studies making the data too limited to generalize conclusions, though youth models and crisis resolution home treatments showed some positive results. Overall, the study highlighted the critical need for better data and ongoing research to help shape policies and practices for mobile response models.

Policies will need to be established to achieve best outcomes during multidisciplinary responses. In the CIT International guidebook,⁴² policies are recommended related to call-taking and dispatch role in gathering mental health information, procedures to follow in the event a CIT officer is unavailable, the on-scene role of the CIT officer when safety is an issue and when it is not, additional resources available to CIT officers, procedures for voluntary and involuntary psychiatric evaluations including for children, transport for voluntary and involuntary psychiatric evaluations, and coordination with receiving centers. They also tackle issues such as removal of offensive and stigmatizing language from policies, arrest procedures for persons with mental illness when that is necessary, expected wait times and locations, reduction in the use of physical and chemical restraints, communication with the individual, their family and the role of peers, to name a few. Given the trends in crisis response mechanisms, cross-discipline type protocols and policies are increasingly needed. This is crucial as the response scene itself can become a place that could get crowded, and response approaches could vary for different responders. Even in the CIT guidebook, for example, there are specific provisions how a scene should be controlled, indicating that CIT officers as opposed to other officers would be lead officers during a mental health call.⁴³ With more responders potentially present, outcomes could be very different depending on how their policies compliment or contradict each other.

In applying these concepts, consider the fictionalized crisis scenarios depicted above and how best to approach responses to them. In each of them, there may be a need for a continuum of responses that takes into account the least restrictive type analysis balanced with safety consideration. The least restrictive alternative is a term that supports maximizing the autonomy of the individual until or unless a more coercive, legally authorized approach is warranted for safety reasons. To that end, the Vera Institute provides a typology of responses along a

continuum ranging from less to more police involvement that may signal both how much a community has invested in alternative response types and how a response might best suit the community's needs.⁴⁴ Pushing further, but safely, toward behavioral health responders will help move the needle on least restrictive approaches.

Laws and Regulations Abutting Clinical Practices in Crisis Response

When individuals are in crisis, they may be engaging in what might otherwise be arrestable offenses. Yet, one of the goals of crisis response is to divert individuals from criminal and juvenile justice processes and reroute them to treatment whenever feasible. As noted, the original sequential intercept model addressed the role of police in being able to expand alternatives to arrest. Yet how these situations play out may also relate to laws, statutes and practices. For example, it has long been recognized that there is a great deal of discretion for how officers respond to situations involving individuals with mental illness.⁴⁵ Exceptions to this discretion generally involve when behavior rises to felony levels, where there is a victim, or when laws such as domestic violence laws specifically limit officer discretion and require arrest under some circumstances. With jail diversion and decriminalization, as well as build-out of crisis stabilization settings and crisis receiving units that are police-friendly, there will likely be increasing use of mental health services in lieu of police response, arrest and incarceration. This is one of the goals of programs such as CCBHCs and other services.⁴⁶

Case law related to arrestable offenses is also interesting to consider. In the 1960s and 1970s, some of these issues arose in two major landmark cases that are still relevant today. In the 1962 case, *Robinson v. California*,⁴⁷ a police officer arrested a man who had heroin tracks in his arms, because at the time there was a statute in California that made it a misdemeanor to be addicted to narcotics. He was found guilty and sentenced to 90 days in jail. However, his case was appealed and ultimately heard by the U.S. Supreme Court, which found that it was an Eighth Amendment violation and considered cruel and unusual punishment to sentence Mr. Robinson for the status of being addicted to narcotics. Only a few years later, in 1968, the U.S. Supreme Court was asked to clarify whether it was also cruel and unusual punishment to arrest and convict someone who was publicly intoxicated by acting in a disorderly manner. In *Powell v. Texas*,⁴⁸ the high Court found that the conviction in Texas was able to be upheld as the conviction was based on Mr. Powell's behavior that was against the law, not based on the status of being intoxicated.

Today, recognizing the high utilization of criminal processes for individuals with substance use disorders and co-occurring conditions, states are examining laws that decriminalize possession of illegal substances. Oregon's Measure 110, for example, sets up a mechanism to help route people to treatment in lieu of arrest and incarceration when they are found in possession of substances that would previously have authorized an arrest.⁴⁹ In addition, by 2017 approximately 40 states and the District of Columbia had passed expanded Good Samaritan laws that provided immunity from arrest for individuals who called 911 who were witness to or experiencing an opioid-related overdose even when they were in possession of illegal substances and paraphernalia.⁵⁰ With these laws aiming to decriminalize behavioral health issues, and a goal of

diverting individuals from criminal and juvenile justice responses, responders on the street will require greater guidance on what to do with various behaviors that may run afoul of the law but may be directly related to mental illness or substance use disorders.

There are also several important legal cases that examine police conduct in use of force situations. This is a very complicated area of jurisprudence, but in one 1989 U.S. Supreme Court decision, *Graham v. Connor*,⁵¹ the Court looked at the reasonableness of force used by an officer and determined that the test of reasonableness would include an examination of the particular circumstances and whether that there would have been probable cause to believe that there was an immediate threat to the safety of the officer or others. In another case related to community policing of individuals with mental illness similar to one of the crisis call scenarios above, *City and County of San Francisco v. Sheehan*,⁵² the U.S. Supreme Court heard arguments regarding a situation in which Teresa Sheehan had an encounter with police. She had a mental illness and lived in a group home in San Francisco and had threatened her social worker after he tried to conduct a welfare check. He summoned police for help transporting her to a facility for a 72-hour involuntary commitment. The police officers entered her room without a warrant, and she grabbed a knife and threatened to kill them. They withdrew and called for backup. Not waiting for the backup officers to arrive, they returned to her room with weapons drawn, she again threatened them with a knife and they in turn shot her several times. Though she survived, she sued the officers and the city, alleging Fourth Amendment violations of her right to be free from warrantless search and seizure and violation of the Americans with Disabilities Act (ADA). With regard to the ADA, the question was whether law enforcement was required to provide accommodations to a person with mental illness, despite her being armed and violent, when taking her into custody. As there had been a split in lower courts on this issue, this case was viewed as a potential game changer for police conduct. However, the ADA question was unanswered by the Court, given legal technicalities of how the questions were posed to the Supreme Court justices. With regard to the Fourth Amendment issue, the Justices sided with police indicating the nature of the emergency and potential injury to the occupant negated the need for the warrant and thus held their use of force was reasonable under the circumstances described.

Other lower court decisions have found that when there is the direct threat such as seen with a person with mental illness who has a knife, use of force—even deadly—may not violate the ADA during a police encounter.⁵³ In another case, the Sixth Circuit Court of Appeals reviewed the circumstances of an alleged unlawful mental health seizure of a woman they brought to a hospital in handcuffs and in its ruling the Court noted the insufficient data to justify such a seizure after her husband had left her home with her firearm and after she had denied being suicidal when police inquired.⁵⁴

Taken together, the case law is replete with examples of the complexities of police encounters as they relate to individuals with mental illness. Under the law, there is no carte blanche to use of force, but it is allowable by police in certain circumstances. In legal cases there is a balancing test of the given circumstances to understand where and when violations of individual rights occurred. Issues related to judgments of probable cause for the officer to justify their actions

and considerations of the degree of threat the individual may be posing will come into play where there is litigation against officers with regard to their conduct.

With more and more multidisciplinary teams involved in responses, some of this liability may spill over to other types of responders, yet it remains to be seen how their liabilities will be examined by courts, and whether behavioral health responders will be reviewed similar to EMS in terms of relying upon emergency medical clinical standards of care. There may also be examination under the lens of laws like the ADA or even the Emergency Medical Treatment and Labor Act (EMTALA) that requires stabilization before transfer, though EMTALA generally applies to emergency departments or facilities. It is not unreasonable, however, to imagine that when CMS funding for crisis response services is sought, some of the provisions of EMTALA could be developed over time for these out-of-hospital crisis scenarios. This remains to be seen but does support the imperative to establish best practices in the field and to take into consideration legal issues when developing policies and protocols for assessing an individual's presentation, conduct during a response, and stabilization of an individual's clinical condition.

Even with additional partners in the crisis response framework, policymakers should understand that the delicate issues that could be at play if too much emphasis is placed on decreasing police roles, especially while other services are not yet in place. Such efforts, even well-intentioned, could lead to unintended consequences, if interpreted to mean law enforcement is no longer needed for work that society has come to rely upon for ensuring public safety. Take, for example, the aftermath of House Bill 1310 in Washington, which placed additional parameters upon police to limit the use of force and to foster the use of de-escalation strategies when possible.⁵⁵ It was reported in *The Seattle Times* that even before the bill went into effect there were multiple instances of law enforcement taking “hands-off” stances and not responding as they would have previously when in receipt of calls regarding people in behavioral health crises.⁵⁶ With these stories in mind, it is important to ensure that efforts to expand alternative responses do not also alienate law enforcement, who still have a critical—even if narrower—role to play in behavioral health crises where significant safety and security issues arise.⁵⁷

Transport of Persons with Mental Illness and Related Laws

As part of a response to a crisis, police may be called upon to transport an individual to a site where a clinical evaluation can take place or they may execute an involuntary detention or hold. Mental health laws in each state have provisions related to transport of people with mental illness and execution of such holds, that generally include liability protections for peace officers with certain uses of restraint, as well as delineate when and how such restraints can be used.^{58,59} State rules and law enforcement departmental policies may further the guidance around these circumstances. For example, in Michigan, the Mental Health Code indicates that a peace officer may transport an individual to an approved service program or emergency medical service, and take them into protective custody “with that kind and degree of force that is lawful for the officer to arrest that individual for a misdemeanor without a warrant. In taking the individual, a peace

officer may take reasonable steps to protect himself or herself.”⁶⁰ Whether an ambulance or law enforcement transports individuals can depend on many facets of a crisis response.

The use of law enforcement for some of these functions has recently been called into question. For example, a recent national survey by the Treatment Advocacy Center found that in 2017 the costs associated with transporting people with mental illness by law enforcement were significant with 21% of officer time spent transporting individuals with mental illness, and risked further criminalizing the people being served.⁶¹ Moreover, transporting people with mental illness by law enforcement often involves the use of handcuffs and police vehicles, and this can create stigma, shame and humiliation for an individual who is not under arrest but is instead experiencing a behavioral health crisis. Mental Health America has noted concerns about children with mental health needs and advocated that they should not be handcuffed while being transported in the community—especially out of school— and that prior to use of any restraint, respondents should use de-escalation techniques and work with support systems to promote voluntary agreement with transport to avoid restraints all together.⁶² Although Non-Emergency Medical Transport (NEMT) is a benefit provided by CMS when an individual beneficiary requires transportation to and from medical appointments, some advocates are considering NEMT alternatives with regard to transportation to crisis stabilization units. This may be effective, especially as they may not be considered “emergency” sites like emergency departments and thus may not invoke billing like an ambulance transport in an emergency setting. Without appropriate alternatives settled, the default response can become law enforcement transports. With workforce shortages among EMS, and the problematic nature of law enforcement as a default mode of accessing needed transport for persons in crisis, use of NEMT may become an important option to consider for those situations that would allow for this.

Discussion about transports has catalyzed some innovation. In Virginia, an Alternative Transportation Sub-Group of the Mental Health Crisis Response and Emergency Services Advisory Panel Interim Report from October 2016⁶³ reviewed processes in the state including transportation of individuals to an emergency evaluation, temporary detention transports following a medical clearance and assessment of need for such detention, post-commitment transports and discharge transports. From that work, Virginia recently rolled out a whole framework of new approaches for transporting individuals on Temporary Detention Orders.⁶⁴

Oklahoma is another state that has focused on transport of persons with mental illness. In 2021, the Governor of Oklahoma signed into law a bill that requires direct transport by law enforcement to a mental health facility within 30 miles for those in mental health crisis, and require that the Department of Mental Health and Substance Abuse Services to provide transport themselves if there is no facility within 30 miles.⁶⁵ This has shifted many transport responsibilities to behavioral health providers from what had recently been the work of law enforcement.

Transportation activities for individuals in mental health crisis require an additional layer of scrutiny and could lead to refinement of functions, eliminating the need for particular first

responders spending time needlessly on transportation type functions that could be accomplished in different ways. Alternative strategies such as those that are destigmatizing and utilize the least amount of coercion and restraint should be maximized.

Clinical Considerations for Out-of Hospital Care

Traditionally emergency medical first responders administer protocols, such as CPR, or initiate medications under the control of a medical authority at an emergency scene to save a life. With decreasing criminalization and efforts at jail diversion, there will be increasing need to be able to manage complex behaviors in community settings that could correlate to any number of conditions, including those that might be best suited for immediate psychiatric or behavioral health treatment intervention beyond de-escalation or linkage supports. There will also be a growing need to be trauma-informed and responsive to people who have trauma histories, given that the behavioral health populations have high rates of exposure to adverse childhood experiences and trauma.

Some out-of-hospital treatments have resulted in considerable controversy especially when it is thought that law enforcement is making clinical decisions, such as the use of Ketamine, which was associated with use of force situation and untimely death of Elijah McClain.⁶⁶ This resulted in professional organizations⁶⁷ and leading academicians calling attention to the risks of police involvement in medical decisions and the need to re-examine the risk-benefit ratio of Ketamine with regard to quelling agitation versus the risk of it causing respiratory suppression.⁶⁸

Nonetheless, just as CPR was established as a community-based life-saving response, with careful attention to proper protocols, there will likely be evidence-based expanded activities to help get treatment to people in behavioral health crisis who need it when they need it—even in home with a mobile crisis response. Especially in children’s behavioral health, there is a great deal of discussion about initiating and continuing “stabilization services” post immediate response.⁶⁹ In general emergency response circles, there has been increasing exploration of what specific treatment interventions could be administered on scene to help improve outcomes overall for people’s underlying conditions. For example, some EMS systems are exploring whether to induce treatments for opioid use disorder beyond overdose prevention, such as through initiation of treatment medications like buprenorphine.⁷⁰ As another example, an emerging protocol called PsySTART® (Psychological Simple Treatment and Rapid Triage) is a real-time triage and case management behavioral health tool for emergency medical responders to address pediatric behavioral health crises or during traumatic events.⁷¹ Other avenues for very early in-the-field interventions might some day involve addressing individuals with first episode psychosis, bipolar disorder, and other conditions. This could include the benefit of a virtual psychiatric review and recommended initiation of some treatment on the streets with those first responder multidisciplinary teams. With the exciting developments of mobile crisis response, the possibilities for early, proper engagement and initiation of treatment and linkage to ongoing care are plenty.

Medical Clearance and No Refusal Policies

With multiple potential responders resolving crises on the scene and determining whether to transport individuals to alternative sites for further evaluation and stabilization, two additional areas of concern will need attention.

First is the question of whether the individual is medically appropriate for a site other than a hospital. There is a growing body of research regarding the concept of “medical clearance” or “medically stable for transfer” determinations. With emergency department overcrowding, many states have identified that protocols for medical clearance are creating part of the delay, as sending and receiving facilities debate back and forth about whether an individual has received adequate medical screening to be sent to a facility that has fewer medical services than the emergency department. Potentially unnecessary and costly testing of patients was identified in four out of five emergency department visits in one study.⁷² A national effort to examine medical clearance practices found that the evidence supported history, physical examination, vital signs and mental status examinations as the minimum necessary elements in the evaluation of psychiatric patients.⁷³

Some states have adopted protocols related to medical clearance being promoted for statewide uptake. Take Michigan, for example, where state leaders are currently pursuing acceptance across all hospitals of the MI-SMART protocol,⁷⁴ which was developed through a comprehensive process involving a review of the literature, an environmental scan of several states and their processes, and multiple convenings of an advisory group consisting of psychiatrists, emergency medicine physicians, nurses, administrators and others. In this protocol, a standard assessment form, the SMART form⁷⁵ provides a rubric of items to review as the basic medical clearance protocol, which can then flag items such as neuroimaging, other medical assessments, or lab tests needed for further review before the medical provider can determine an individual as medically stable for transfer. Similar approaches have been recommended and described in the literature.⁷⁶

Second, to serve anyone at anytime, it will be important to have the ability to allow anyone to enter for immediate screening at the crisis stabilization site. Even if upon evaluation it is determined that the individual warrants a different level of care, the idea of a “no refusal policy” is critical to the successful “warm handoff” from a community mobile responder or law enforcement to a crisis evaluation point of contact. Arizona’s Crisis Response Center is a great example of a system that adopted a “no wrong door” approach. If an individual is brought to the facility by law enforcement officers, the clinical staff will help evaluate the patient to ensure their stability before they determine where the person may need to go next.⁷⁷ Without security on site but with well-trained staff, they accept all comers and believe this helps decriminalize individuals whose behavioral health conditions may exhibit themselves with extreme behaviors. Consistent with SAMHSA’s National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit promulgated in February 2020, the idea of the program is that they can serve anyone at anytime.⁷⁸ These types of policies are important to promulgate as programs roll out across the country (see Text Box).

Community Partnership Considerations: Partnership Development Including Policy and Protocol

As noted in prior publications on behalf of NASMHPD, *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies*⁷⁹ and *Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988*,⁸⁰ the authors emphasize the key ingredients of successful responses rest in community partnerships. Though the partnerships are critical, without an amalgamation of training, policies and protocols that take into account the various responders involved in a community, there could still be the potential for a response that runs afoul and becomes unsafe for all. Such protocols and trainings are starting to emerge, such as through SAMHSA's numerous playbooks that lay a foundation of instruction from dispatch to responder.⁸¹ But just like in the development of EMS standards, there will likely need to be ongoing development in these areas to help drive practices across disciplines as more is learned about the actualities of the various mobile responses.

Workforce Needs and Concerns

The largest potential impediment within the plans for improved crisis services is the ubiquitous and multidiscipline-impacted workforce shortage. In a field where there can be high burnout and trauma given the intensity of mobile responses working in high-risk scenarios, it is critical to attend to the needs of the workers, build a quality workforce, and give them the tools they need to be successful. Addressing issues of trauma are necessary, as exemplified in communities like Miami, Florida that established a peer network and trauma responsive supports for its officers.⁸² Furthermore, disparities in care delivery and in workforce members can create additional layers of chronic stress as structural racism compounds everyday stress and responses. Nurturing a workforce and helping them build increasingly with the concepts of posttraumatic growth baked into organizational planning may be helpful in this regard as was highlighted in one review examining pandemic-driven considerations to enhance such growth.⁸³

Conclusions and Future Directions

In the scenarios above, one could imagine their unfolding in any number of ways, from escalation and tragedy to de-escalation and return to safety with linkage to ongoing treatment. With police and others each playing critical roles in the mix of responders, policymakers would do well to consider these scenarios as they build out protocols and avenues for response across different regions and for different partners who might be called to respond. Even though they are likely only a small percentage of what 988 will receive in its call lines, they are nonetheless some of the most vexing scenarios that will require due diligence for proper responses that are equitably applied across populations. Future activities will necessitate increasing standards development for protocols. More robust data collection and research related to what happens with calls received and triaged through dispatch, what happens on the scene out-of-hospital, and what happens with transport on the way to other places, will be needed to develop better responses. The 988 call centers and linked service delivery system will undoubtedly require

increasing collaboration and systems networking with 911, other partners, and community members who have a vested interest in favorable outcomes for all.

This is a pivotal time in the field of behavioral health crisis response with much at stake. It is important that the build-out of various crisis response models, and the incorporation of law enforcement when needed, is successful. Taking stock of successes as well as near misses and examining “failures” are necessary components and must occur to continue to improve quality along the way. This paper aimed to lay out some foundational principles and background while highlighting areas for consideration to help in the development of the enhanced services of tomorrow. The current momentum for crisis service innovations and improvements can be leveraged to help policymakers and administrators move their staff and their systems to make available the right responses at the right time. For the sake of people who are at their most vulnerable during a behavioral health crisis, leveraging this momentum is critical and the time to do so is now.

References

- ¹ Fuller DA, Lamb HR, Biasotti M, et al: Overlooked in the undercounted: the role of mental illness in fatal law enforcement encounters. Treatment Advocacy Center, 2015.
<https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf>
- ² DeGue S, Fowler KA, Calkins C. Deaths due to use of lethal force by law enforcement findings from the National Death Reporting System, 17 U.S. States, 2009-2012
Am J Prev Med 2016; 51, S3:S173-S187. [https://www.ajpmonline.org/article/S0749-3797\(16\)30384-1/fulltext](https://www.ajpmonline.org/article/S0749-3797(16)30384-1/fulltext)
- ³ Ibid.
- ⁴ McLeod MN, Heller D, Manze MG, Echeverria SE. Police Interactions and the Mental Health of Black Americans: a Systematic Review. J Racial Ethn Health Disparities 2020; 7(1):10-27
- ⁵ Johns Hopkins Center for Gun Violence Solutions. A Year in Review: 2020 Gun Deaths in the U.S. Baltimore, MD, Johns Hopkins Bloomberg School of Public Health, 2022.
<https://publichealth.jhu.edu/gun-violence-solutions>
- ⁶ Bailey JA, Jacoby SF, Hall EC, et al: Compounding Trauma: the Intersections of Racism, Law Enforcement, and Injury. Curr Trauma Rep 2022; 12:1-8
- ⁷ U.S. Bureau of Labor: Fatal Occupational Injuries to Emergency Responders. U.S. Bureau of Labor Statistics, 2019. https://www.bls.gov/iif/oshwc/cfoi/er_fact_sheet.htm
- ⁸ New Research Suggests 911 Call Centers Lack Resources to Handle Behavioral Health Crises. The Pew Charitable Trusts, 2021. <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/10/new-research-suggests-911-call-centers-lack-resources-to-handle-behavioral-health-crises>
- ⁹ Concialdi M: Interacting with the mental health crisis victim. EMS World Print online expo. Emergency & Mobile Medicine Learning Network, 2017.
<https://www.hmpgloballearningnetwork.com/site/emsworld/article/218581/interacting-mental-health-crisis-victim>
- ¹⁰ Men in White Coats. Grammarist, 2022. <https://grammarist.com/idiom/men-in-white-coats/>
- ¹¹ Tréguer, P: The men in (the) white coats: meaning and origin. World Histories, 2021.
<https://wordhistories.net/2021/05/20/men-white-coats/>
- ¹² Ibid.
- ¹³ Szmukler G: Men in White Coats: Treatment Under Coercion. Oxford, United Kingdom, Oxford University Press, 2018
- ¹⁴ Usher L, Watson AC, Bruno R, et al: Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises. Memphis, TN, CIT International, 2019.
<https://www.citinternational.org/resources/Best%20Practice%20Guide/CIT%20Guide%20Interactive%20Web%20Version%20Final.pdf>
- ¹⁵ Johnson RR: The psychological influence of the police uniform. Police1 by Lexipol, 2017.
<https://www.police1.com/police-products/apparel/uniforms/articles/the-psychological-influence-of-the-police-uniform-bhN9cdehTsvjzbMh/>
- ¹⁶ U.S. Government Accountability Office (GAO): Federal Law Enforcement: DHS and DOJ are working to enhance responses to incidents involving individuals with mental illness, U.S. GAO, 2018.
<https://www.gao.gov/products/gao-18-229>
- ¹⁷ Rahr S, Rice SK. From Warriors to Guardians: Recommitting American Police Culture to Democratic Ideals. Harvard Kennedy School New Perspectives in Policing, 2015.
<https://www.ojp.gov/pdffiles1/nij/248654.pdf>
- ¹⁸ Abreu D, Parker TW, Noether CD, et al: Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. Behav Sci Law 2017; 35(5-6):380-395

-
- ¹⁹ Munetz MR, Griffin PA. Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatr Serv* 2006; 57(4):544-549
- ²⁰ Abreu D, Parker TW, Noether CD, et al: Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behav Sci Law* 2017; 35(5-6):380-395
- ²¹ Isselbacher, J: As mobile mental health teams work to de-escalate crises, some warn their models still rely on police partnerships. *STAT News*, 2020. <https://www.statnews.com/2020/07/29/mobile-crisis-mental-health-police/>
- ²² Edwards ML: Pittsburgh's Freedom House Ambulance Service: The Origins of Emergency Medical Services and the Politics of Race and Health. *J Hist Med Allied Sci* 2019; 74:440-466
- ²³ U.S. Department of Transportation: 50 Years of Modern EMS. EMS.gov, 2020. <https://www.ems.gov/OEMShistory.html>
- ²⁴ Edgerly D: Birth of EMS: The History of the Paramedic. *Journal of Emergency Medical Services*, 2013. Available at: <https://www.jems.com/administration-and-leadership/birth-ems-history-paramedic/>
- ²⁵ U.S. Department of Transportation: 50 Years of Modern EMS. EMS.gov, 2020. <https://www.ems.gov/OEMShistory.html>
- ²⁶ Larkin GL, Claassen CA, Pelletier AJ, Camargo CA: National Study of Ambulance Transports to United States Emergency Departments: Importance of Mental Health Problems. *Am J Prev Med* 2006; 21(2): 82-90
- ²⁷ Ford-Jones PC, Chauhan C: A Critical Analysis of Debates Around Mental Health Calls in the Prehospital Setting. *Inquiry* 2017; 54:46958017704608
- ²⁸ Pinals DA, Edwards ML: Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988. Technical Assistance Collaborative Paper No. 4. Alexandria, VA, National Association of State Mental Health Program Directors, 2022. <https://www.nasmhpd.org/content/tac-assessment-papers>
- ²⁹ Pinals DA: Crisis Services: Meeting Needs, Saving Lives. Alexandria, VA, National Association of State Mental Health Program Directors, 2020
- ³⁰ Puntis S, Perfect D, Kirubarajan A, et al: A systematic review of co-responder models of police mental health 'street' triage. *BMC psychiatry* 2018; 18(1):256
- ³¹ Ibid.
- ³² Climer BA, Gicker B: CAHOOTS: A Model for Prehospital Mental Health Crisis Intervention. *Psychiatr Times* 2021; 38:1. <https://www.psychiatrictimes.com/view/cahoots-model-prehospital-mental-health-crisis-intervention>
- ³³ Waters R: Enlisting mental health workers, not cops, in mobile crisis response. *Health Aff (Millwood)* 2021; 40(6)
- ³⁴ Center for Public Representation: About Rosie D. Northhampton, MA, Center for Public Representation, 2008. <http://www.rosied.org/page-67061>
- ³⁵ Connecticut State Department of Children and Families: Mobile Crisis Intervention Services. Connecticut, Department of Children and Families, 2022. <https://portal.ct.gov/DCF/Behavioral-Health-Partnership/Mobile-Crisis-Intervention-Services>
- ³⁶ Meadows Mental Health Policy Institute: Multi-Disciplinary Response Teams: Transforming Emergency Mental Health Response in Texas. Dallas, TX, Meadows Mental Health Policy Institute, 2021. <https://mmhpi.org/wp-content/uploads/2021/06/MDRT-Transforming-Crisis-Response-in-Texas.pdf>
- ³⁷ Ibid.
- ³⁸ Isselbacher J: As mobile mental health teams work to de-escalate crises, some warn their models still rely on police partnerships. *Stat News*, 2020. <https://www.statnews.com/2020/07/29/mobile-crisis-mental-health-police/>

-
- ³⁹ Khalsa HK, Denes AC, M Pasini-Hill D, et al: Specialized Police-Based Mental Health Crisis Response: The First 10 Years of Colorado's Crisis Intervention Team Implementation. *Psychiatr Serv* 2018; 69(2):239-241
- ⁴⁰ Skeem J, Bibeau L: How does violence potential relate to crisis intervention team responses to emergencies?. *Psychiatr Serv* 2008; 59(2):201-204
- ⁴¹ Marcus N, Stergiopoulos V: Re-examining mental health crisis intervention: a rapid review comparing outcomes across police, co-responder, and non-police models. *Health Soc Care Community* 2022; 0:1-15. <https://onlinelibrary.wiley.com/doi/10.1111/hsc.13731>
- ⁴² Usher L, Watson AC, Bruno R, et al: Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises. Memphis, TN, CIT International, 2019. <https://www.citinternational.org/resources/Best%20Practice%20Guide/CIT%20Guide%20Interactive%20Web%20Version%20Final.pdf>
- ⁴³ Ibid.
- ⁴⁴ Beck J, Reuland M, Pope L: Behavioral Health Crisis Alternatives: Shifting from Police to Community Responses. Vera Institute of Justice, 2020. <https://www.vera.org/behavioral-health-crisis-alternatives>
- ⁴⁵ Teplin L : Keeping the Peace : Police Discretion and Mentally Ill Persons. *National Institute of Justice Journal*, 2000. <https://www.ojp.gov/pdffiles1/jr000244c.pdf>
- ⁴⁶ Schuffman D, Parks J, Rose S, Pinals DA: Responding to and Preventing Crises: CCBHCs, Urgent Care and an Example of One Health System in Maryland and its Approach to Crisis Services within an Accessible Psychiatric Care Continuum. Alexandria, VA, National Association of State Mental Health Directors. <https://www.nasmhpd.org/content/tac-assessment-papers>
- ⁴⁷ Robinson v California, 370 U.S. 660 (1962)
- ⁴⁸ Powell v Texas, 392 U.S. 514 (1968)
- ⁴⁹ Lantz M, Niebuurt B: Measure 110 Background Brief. Salem, Oregon, Oregon Legislative Policy and Research Office, 2020. [https://www.oregonlegislature.gov/lpro/Publications/Background-Brief-Measure-110-\(2020\).pdf](https://www.oregonlegislature.gov/lpro/Publications/Background-Brief-Measure-110-(2020).pdf)
- ⁵⁰ National Conference of State Legislatures: Drug Overdose and Good Samaritan Laws. National Conference of State Legislatures, 2017. <https://www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx>
- ⁵¹ Graham v Connor, 490 U.S. 386 (1989)
- ⁵² City and County of San Francisco, California, et al. v. Teresa Sheehan, 575 U.S. ____ (2015)
- ⁵³ Ferdows A, Botello T. Police Response to Threat by Person with Mental Illness. *J Am Acad Psychiatry Law* 2021; 49 (1):118-121
- ⁵⁴ Scott JA, Pinals DA: Police requirements to perform a mental health seizure. *J Am Acad Psych Law* 2020; 48 (4):558-561
- ⁵⁵ HB 1310 – 2021 – 22, Concerning permissible uses of force by law enforcement and correctional officers. Olympia, Washington, 2022. <https://app.leg.wa.gov/billsummary?BillNumber=1310&Initiative=false&Year=2021>
- ⁵⁶ Seibel K: Why is law enforcement refusing behavioral-health calls. Seattle, Washington, Seattle Times, 2021. <https://www.seattletimes.com/opinion/why-is-law-enforcement-refusing-behavioral-health-calls/>
- ⁵⁷ Kaminski RJ: Police foot pursuits and officer safety. Columbia, South Carolina, University of South Carolina, 2007. https://www.researchgate.net/publication/249009937_Police_Foot_Pursuits_and_Officer_Safety
- ⁵⁸ Commonwealth of Massachusetts: M.G.L. c. 123, Section 21: Transportation of mentally ill persons; restraint. Boston, Massachusetts, Commonwealth of Massachusetts, 2020. <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter123/Section21>

-
- ⁵⁹ Michigan Legislature: Mental Health Code (Excerpt) Act 258 of 1974, 330.1276. Lansing, Michigan, Michigan Legislature, 2022. [http://www.legislature.mi.gov/\(S\(dpcbkisoozjbd2kf1oti52q\)\)/mileg.aspx?page=getObject&objectName=mcl-330-1276](http://www.legislature.mi.gov/(S(dpcbkisoozjbd2kf1oti52q))/mileg.aspx?page=getObject&objectName=mcl-330-1276)
- ⁶⁰ Ibid.
- ⁶¹ Treatment Advocacy Center. Road Runners: Role of Law Enforcement in Psychiatric Crisis Response. Arlington, VA, 2019. www.treatmentadvocacycenter.org/road-runners
- ⁶² Mental Health America Board of Directors : Position Statement 59 : Responding to Behavioral Health Crises. Alexandria, VA, Mental Health America, 2022. <https://www.mhanational.org/issues/position-statement-59-responding-behavioral-health-crises>
- ⁶³ Virginia Division of Legislative Services: Alternative Transportation Sub-Group of the Mental Health Crisis Response and Emergency Services Advisory Panel Interim Report. Richmond, Virginia, Division of Legislative Services, 2016. <http://dls.virginia.gov/groups/mhs/final%20interim%20report.pdf>
- ⁶⁴ Littlehales A: Virginia completes rollout of 'alternative transports,' paving way for more mental health resources. Norfolk, VA, 13 News Now. <https://www.13newsnow.com/article/news/crime/virginia-completes-rollout-of-alternative-transports-mental-health-resources/291-206a4523-49c3-42aa-b069-76471be34a7e>
- ⁶⁵ Governor Signs law enforcement mental health transport measure. Oklahoma City, Oklahoma, Oklahoma Senate, 2021. <https://oksenate.gov/press-releases/governor-signs-law-enforcement-mental-health-transport-measure>
- ⁶⁶ Ortiz E: Elijah McClain was injected with ketamine while handcuffed. Some medical experts worry about it during police calls. NBC News, 2020. <https://www.nbcnews.com/news/us-news/elijah-mcclain-was-injected-ketamine-while-handcuffed-some-medical-experts-n1232697>
- ⁶⁷ Moran M: Board Adopts Position Against Diagnosis of 'Excited Delirium,' Police Use of Ketamine. Psychiatr News 2021. <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.2.21>
- ⁶⁸ Appelbaum P: Excited Delirium, Ketamine, and Deaths in Police Custody. Psychiatr Serv 2022; 73:7. <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.20220204>
- ⁶⁹ Schober MA, Harburger DS, Sulzbach S, Zabel M: A Safe Place to Be: Crisis Stabilization Services and other supports for Children and Youth. Alexandria, VA. National Association of State Mental Health Program Directors, 2022. Available at: <https://www.nasmhpd.org/content/tac-assessment-papers>
- ⁷⁰ Carroll GG, Wasserman DD, Shah AA, et al: Buprenorphine Field Initiation of ReScue Treatment by Emergency Medical Services (Bupe FIRST EMS): A Case Series. Prehosp Emerg Care 2021; 25(2):289-293
- ⁷¹ Western Regional Alliance for Pediatric Emergency Management. PsyStart. <https://wrap-em.org/index.php/mentalhealth>
- ⁷² Yun BJ, Chou SC, Nagurney JM, et al: ED utilization of medical clearance testing for psychiatric admission: National Hospital Ambulatory Medical Care Survey analysis. Am J Emerg Med 2018; 36(5):745-748
- ⁷³ Wilson MP, Nordstrom K, Anderson EL, et al: American Association for Emergency Psychiatry Task Force on Medical Clearance of Adult Psychiatric Patients. Part II: Controversies over Medical Assessment, and Consensus Recommendations. West J Emerg Med 2017; 18(4):640-646
- ⁷⁴ Michigan Psychiatric Care Improvement Project: MI-SMART Psychiatric Medical Clearance. Lansing, Michigan, Michigan Department of Health and Human Services and Michigan Health and Hospital Association, 2022. <https://mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/>
- ⁷⁵ <http://smartmedicalclearance.org/forms/>
- ⁷⁶ Thrasher TW, Rolli M, Redwood RS, et al: 'Medical Clearance' of Patients With Acute Mental Health Needs in the Emergency Department: A Literature Review and Practice Recommendations. WMJ 2019; 118(4):156-163

-
- ⁷⁷ Richmond LM: Tucson Shares Blueprint for Crisis System Success. *Psychiatric News*, 2022. <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.1.7>
- ⁷⁸ National guidelines for behavioral health crisis care best practice toolkit. Rockville, MD, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, 2020. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care02242020.pdf>
- ⁷⁹ Balfour ME, Hahn Stephenson A, Winsky J, et al: Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA, National Association of State Mental Health Program Directors. 2020. Available at: <https://www.nasmhpd.org/sites/default/files/2020paper11.pdf>
- ⁸⁰ Pinals DA, Edwards ML: Law Enforcement and Crisis Services: Past Lessons for Partnerships and the Future of 988. Alexandria, VA, National Association of State Mental Health Program Directors, 2021. https://www.nasmhpd.org/sites/default/files/4_LawEnforcement-CrisisServices_508.pdf
- ⁸¹ Substance Abuse and Mental Health Services Administration. 988 Partner Toolkits. Available at: <https://www.samhsa.gov/find-help/988/partner-toolkit>
- ⁸² New Program Aims to Help Police Officers Struggling with Job-Related Stress. Miami, FL, CBS Miami, 2021. <https://miami.cbslocal.com/2021/11/04/new-program-aims-to-help-police-officers-struggling-with-job-related-stress/>
- ⁸³ Olson K, Shanafelt T, Southwick S. Pandemic-Driven Posttraumatic Growth for Organizations and Individuals. *JAMA* 2020 ; 324(18):1829–1830