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Kentucky Community Crisis Co-Response (CCCR) Model

Stakeholder Engagement and Research Report

June 15, 2023

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Executive Summary

The need for behavioral health services is on the rise in Kentucky and across the nation. According to the Centers for Disease Control and Prevention, more than 50 percent of Americans will be diagnosed with a mental illness or disorder at some point in their lifetime, and an estimated one in five experience a mental illness in a given year.[1] Mental Health America's Annual State of Mental Health in America (MHA) concluded that in 2022, the prevalence of adults in Kentucky with any mental illness was estimated to be 742,000, or 21.9 percent compared to 20.8 percent nationally.[2] Increasing rates of mental illness promote the need for high quality, accessible and appropriate crisis services.

Estimates suggest that at least 20 percent of police calls for service involve a mental health or substance abuse crisis, and the demand on first responders is increasing.[3] Addressing behavioral health needs, referring people to appropriate treatment, and following-up takes time, resources, and expertise that strained first responder agencies often do not have. Incidents may result in inappropriate arrests or transports to emergency departments, neither of which provide optimal care for individuals with behavioral health needs, or other poor outcomes such as unnecessary use of force. As a result, co-response models have emerged across the nation. The co-response model is a police-based intervention that pairs trained officers with mental health professionals to respond to individuals in behavioral health crisis or those with developmental disabilities.

In April 2022, DMS completed the formal Kentucky Mobile Crisis Intervention Services Needs Assessment as part of Centers for Medicare & Medicaid Services (CMS) Mobile Crisis Intervention (MCI) Services Planning Grant. One of the key findings from the Needs Assessment underscored the need to evaluate the use of crisis co-response programs that pair law enforcement or first responders with behavioral health professionals as a complement to the MCI services continuum.

The Kentucky DMS seeks to establish the Kentucky Community Crisis Co-Response (CCCR) Model, which embeds behavioral health resources within law enforcement and emergency medical services agencies in local municipalities to expand access to mobile behavioral health crisis services. The CCCR model is intended to complement statewide community-based mobile crisis intervention (MCI) services provided through behavioral health providers.

The purpose of the *Stakeholder Engagement and Research Report* is to:

- Inform feasibility and potential impact of designing, developing, and implementing co-response programs in Kentucky.

- Gain an understanding of how current law enforcement respond to behavioral health crisis calls and the needs and wants of first responders, communities, and individuals in crisis and their families.

To inform this report, the project team analyzed more than 40 out of state police-mental health collaborative programs (see *Appendix B: Other State Co-Response Programs* for more details).

[1] https://www.cdc.gov/mentalhealth/learn/index.htm#:~:text=How%20common%20are%20mental%20illnesses,some%20point%20in%20their%20lifetime.&text=1%20in%205%20Americans%20will,illness%20in%20a%20given%20year.

[2] https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf.

[3] Abramson, A. Building Mental Health into Emergency Response. More cities are pairing mental health professionals with police to better help people in crisis. American Psychological Association. Vol 52 No. 5. July 1, 2021.

Additionally, the team engaged six stakeholders from outside of Kentucky including representatives from Colorado, Georgia, Utah, Arizona, and Massachusetts; five local Kentucky co-response programs; one statewide co-response model. To understand the current landscape of police-mental health collaboration within Kentucky, the team engaged stakeholders with experience across the co-response continuum including public safety access points (PSAP), behavioral health providers, law enforcement (with and without an existing co-response program), first responders, and community organizations and supports. Twenty-eight total agencies and organizations within Kentucky participated.

Summaries of the co-response programs within Kentucky and from other states engaged are detailed within this report along with related programs that support behavioral health crisis response in Kentucky. Additionally, stakeholder perspectives and research summaries in this report are aligned with the Bureau of Justice Assistance's *Police-Mental Health Collaboration (PMHC) Toolkit, The Essential Elements of PMHC Programs*, which outlines the core areas of consideration for municipalities seeking to adopt or enhance co-response programs.[4]

Key Findings

Collaborative Planning & Implementation. Multi-disciplinary collaboration on the state-level would benefit planning and implementation of co-response on the local municipal level.

Program Design. Co-response programs are designed differently in order to meet the unique needs of the community and must take into consideration local availability of resources.

Specialized Training. Stakeholders emphasized the importance of Crisis Intervention Team (CIT) training but recognize it is not enough on its own and that other specialized training is needed.

Call Taker and Dispatch Protocols. Stakeholders with existing programs emphasized the need for close working partnerships with local PSAPs. Within Kentucky, there are 116 local PSAPs with varying protocol and practice.

Stabilization, Observation, and Disposition. Co-response teams are increasingly adopting new practices to improve encounters: street clothes, unmarked SUVs/Vans for transport, limited use of restraints/lights/sirens.

Transportation & Custodial Transfer. Transporting an individual to appropriate post-crisis services is challenging due to limited transportation options, exisiting regulations and protocols, and availability of behavioral health services. In rural regions of Kentucky trips may take hours.

Information Exchange & Confidentiality. Effective information sharing helps co-response programs tailor responses to individuals in need, increase safety, and enhances their ability to make the disposition while also enabling the program to track outcomes.

Treatment, Supports, & Services. In Kentucky, post-crisis treatment is challenging due to limited availability of wraparound services and behavioral health beds. Barriers are increased in rural regions due to few options for community-based support.

[4] https://bja.ojp.gov/program/pmhc.

Organizational Support. Community partnerships and collaborative training to navigate workforce shortages and increase buy-in of local resources helps to support successful co-response programs.

Program Evaluation & Sustainability. Regular evaluations to report on effectiveness and impact helps justify the program within the local community. Programs report diverse funding sources and often achieve sustainability by identifying cost savings to the community while continuing to leverage grant funding.

Overview and Purpose

Instances of behavioral health crisis are rising in Kentucky and across the nation. According to the Centers for Disease Control and Prevention, more than 50 percent of Americans will be diagnosed with a mental illness or disorder at some point in their lifetime, and an estimated one in five experience a mental illness in a given year.[5] Mental Health America's Annual State of Mental Health in America (MHA) concluded that in 2022, the prevalence of adults in Kentucky with any mental illness was estimated to be 742,000, or 21.9 percent compared to 20.8 percent nationally.[6] Within the same MHA report, Kentucky was ranked 48th in the nation for having high rates of youth with major depression who did not receive mental health services, 74.7 percent in Kentucky compared to 59.8 percent nationwide.[7] Increasing rates of mental illness promote the need for high-quality, accessible, and appropriate crisis services.

In 2021, the Kentucky Department for Medicaid Services (DMS) was awarded nearly $800,000 from the Centers for Medicare & Medicaid Services (CMS) for the Mobile Crisis Intervention (MCI) Services Planning Grant, which supported the development of community-based MCI services for Medicaid members experiencing behavioral health crisis. In April 2022, DMS completed the formal Kentucky Mobile Crisis Intervention Services Needs Assessment in partnership with Myers and Stauffer LC (Myers and Stauffer), which identified the current array of behavioral health crisis services, determined unmet needs within the existing community-based MCI continuum, and explored alternative response methods shifting behavioral health crisis services to qualified multi-disciplinary teams. Stakeholder engagement efforts informed the creation of the needs assessment, the report primarily focused on the provision of MCI services through traditional behavioral health providers to Medicaid members.

After concluding the needs assessment, DMS determined there was a need to evaluate the use of crisis co-response programs that pair law enforcement or first responders with behavioral health professionals as a complement to the MCI services continuum. This report documents and leverages stakeholder engagement and research to inform the feasibility and potential impact of implementing local co-response programs throughout the Commonwealth and a statewide co-response model in Kentucky.

The purpose of the *CCCR Stakeholder Engagement and Research Report* is to:

- Inform feasibility and potential impact of designing, developing, and implementing co-response programs in Kentucky.
- Gain an understanding of how current law enforcement respond to behavioral health crisis calls and the needs and wants of first responders, communities, and individuals in crisis and their families.

Kentucky Crisis Service Delivery Models

In an effort to ensure the timely availability of MCI and related crisis services, DMS has established two crisis service delivery models to provide statewide access to emergency behavioral health care for those in need. Both models are intended to divert individuals in behavioral health crisis away from hospital

[5]https://www.cdc.gov/mentalhealth/learn/index.htm#:~:text=How%20common%20are%20mental%20illnesses,some%20point%20in%20their%20lifetime.&text=1%20in%205%20Americans%20will,illness%20in%20a%20given%20year.
[6] https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf.
[7] IBID.

emergency departments (EDs) and incarceration, provide appropriate interventions, and support placement in the least restrictive environment. The development of these models were informed by the needs assessment.

The first of these models, the ***Kentucky MCI Commonwealth Model***, aligns with the MCI requirements defined within the CMS State Health Officer Letter #21-008. This model includes 24 hours a day, seven days a week, 365 days a year (24/7/365) statewide availability of a two-person mobile crisis team (MCT), comprised of at least one behavioral health practitioner and a paraprofessional from a list of approved provider types, that travels to the individual's location and provides crisis intervention services.

The second service delivery model is the ***Kentucky Community Crisis Co-Response (CCCR) Model.*** Through the CCCR Model, behavioral health professionals or paraprofessionals are embedded within municipalities comprised of traditional first responders (i.e., law enforcement officers [LEOs], emergency medical technicians [EMTs], paramedics, and firefighters) to co-respond to an individual experiencing a behavioral health crisis. This model was designed to align with local priorities and extend behavioral health crisis services into the community where behavioral health provider capacity is limited and service delivery is a challenge.

Under the CCCR Model, behavioral health crisis services will be delivered through a ***community-led Co-Response Unit (CRU), which consists of LEOs, emergency medical services (EMS), or other first responders with specialized training and behavioral health professionals or paraprofessionals accessible either on scene or virtually***. Dispatch of CRU is initiated through calls received by public safety answering points (PSAP). The CCCR Model enables local municipalities to design a co-response program that fits their unique local needs while utilizing available resources. Across the nation and within Kentucky, local municipalities have implemented co-response programs with variability. *Figure 1* shows an overview of the CCCR Model.

Figure 1. CCCR Model Overview

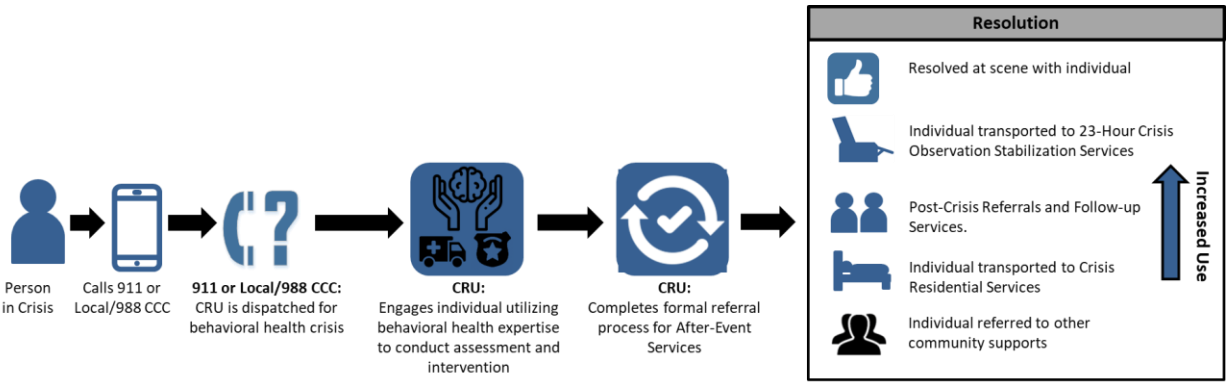
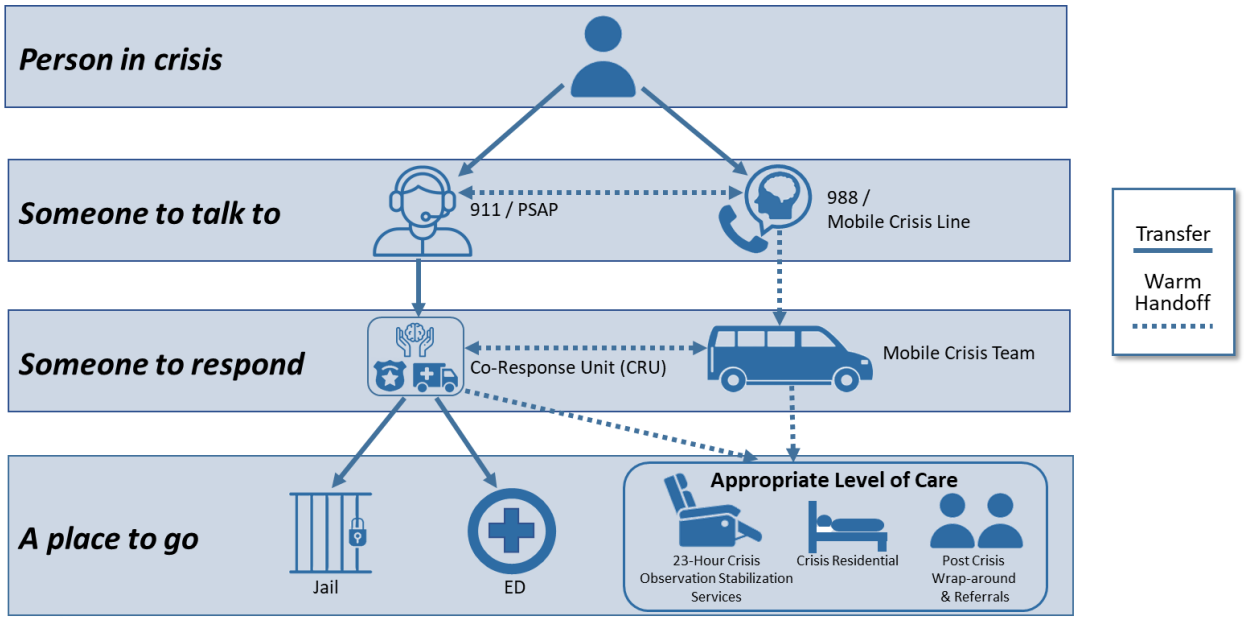


Figure 2 shows the future Kentucky Crisis Care Continuum with both the MCI Commonwealth Model and CCCR Model together, the vision for how the two complementary models work together and utilize resources will aid how individuals receive crisis services.

Figure 2. Kentucky Crisis Care Continuum



Report Structure

The CCCR Model Stakeholder Engagement and Research Report summarizes the approach, participants, and findings from research and stakeholder engagement activities. This document will serve as the foundational element to CCCR Model design and describes the findings from the stakeholder engagement and research conducted from January 2023 to April 2023.

Components of this report include:

- **Methodology.** Outlines what activities and analyses were conducted to evaluate the co-response service environment within Kentucky and to identify practices in other states.
- **Co-Response across the Nation.** Summarizes various co-response programs implemented in other states.
- **Current Co-Response Landscape in Kentucky.** Provides an overview of current Kentucky co-response programs and related service environment.
- **Crisis Co-Response Perspectives.** Identifies challenges and findings related to co-response programs and behavioral health crisis services within Kentucky and lessons learned from co-response programs in other states.

Methodology

The aim of the CCCR Model is to increase the likelihood of crisis resolution at the scene with the individual and increase the utilization of formal post-crisis services rather than EDs, incarceration, or less appropriate negative outcomes. As LEOs and other first responders are currently on the frontlines of behavioral health crisis services, it is critical to understand their perspective. While these groups respond to behavioral health crises in the community, they are limited in training and/or have few protocols in place to appropriately address the situation and achieve optimal outcomes.

Co-response programs are emerging at the state and local levels all across the nation where there is no "one-size-fits-all" approach to community crisis services. Rather, the programs noted in this findings report illustrate the variability of local implementations and lessons learned from other models to inform development of potential core standards and requirements necessary to best address community needs and maximize strengths.

As a step to ensure successful implementation of co-response programs across the Commonwealth, Kentucky DMS, its sister agencies, and key stakeholders will use the results of this stakeholder engagement findings report to acknowledge and address potential barriers and opportunities associated with the development of local co-response programs.

Stakeholder engagement activities were conducted to:

- Gather information about the current barriers and potential opportunities related to crisis services.
- Understand the structure of current Kentucky co-response programs.
- Identify best practices and lessons learned from other co-response programs, both within and outside of Kentucky.
- Recognize the challenges of sustaining co-response programs and delivering crisis services.

Additionally, research was conducted based on information gathered through stakeholder engagement and from other co-response programs across the country.

Stakeholder Engagement

Stakeholder Engagement Methods

The project team used multiple avenues to identify and engage with stakeholders, including stakeholder interviews, focus groups, and document requests to gather qualitative and quantitative data. Data collection instruments were reviewed and approved by DMS. Interview questions were based on previous engagements within Kentucky and research of other co-response models. *Table 1* shows the various stakeholder engagement approaches. In total, 19 interviews and four focus groups were completed which represented 56 unique stakeholders.

Table 1. Stakeholder Engagement Approaches

Stakeholder Engagement Approaches				
	Interviews	**Focus Groups**	**Pre-Interview Questionnaire**	**Document Requests**
Description	Obtain qualitative data from key stakeholders, one-on-one and in small group settings.	Obtain qualitative data from multiple organizations in a large group setting.	Obtain quantitative and qualitative data from stakeholders prior to interviews with existing co-response programs.	Obtain documents and data in lieu of interviews or after completing an interview.
Length	60 – 90 minutes	60 – 120 minutes	5 – 10 minutes	5 – 10 minutes
Completed	19 Interviews/28 Individuals	4 Focus Groups/28 Individuals	7 Responses	9 Stakeholder Requests for Documentation, more than 15 documents received.

Interview and Focus Group Structure

The project team utilized experienced facilitators to conduct semi-structured individual and group interviews or conduct focus groups virtually with selected stakeholders. During these events, an interviewer and a scribe were utilized to ensure efficient use of resources while also capturing key findings from the discussion.

Multiple standardized interview guides were created based on the stakeholder type being interviewed. The scripts outlined the topics and questions for all interviews and focus groups, and had specific questions tailored toward the individuals engaged based on their background. Note that the questions served as a guide, and the experienced facilitators followed any relevant threads of discussion that came up organically. Interviews generally took 30 to 90 minutes, depending on the stakeholder or stakeholder group, as well as their availability.

Focus groups were structured to include participation from multiple organizations and followed a guide with particular topics. The focus group events were scheduled for two hours.

Pre-Interview Questionnaire

For select interviews, a pre-interview questionnaire was sent to gather information before the discussion. The questionnaire was utilized to streamline the interview and enabled the facilitator to ask questions that are more detailed. The pre-interview questionnaire was only sent to stakeholders that were categorized as an existing Kentucky co-response program, local law enforcement, or EMS agency. The final questionnaire was created within Qualtrics, which allowed stakeholders to complete online.

The targeted stakeholders completed their pre-interview questionnaire before the scheduled interview or focus group time. Out of seven individual responses, four respondents elaborated on their current co-response program. Note that the Lexington Community Paramedicine Program (CPP) had three representatives fill out the questionnaire—this was counted as one unique response. Detailed information

from the pre-interview questionnaire was incorporated into relevant sections including: the Current Landscape in Kentucky, Crisis Co-Response Perspectives, and *Appendix A: Pre-Interview Questionnaire Results*.

Document Requests

After completing an interview or a focus group, documents were requested from the stakeholders that aligned to the items discussed. This included policies, procedures, service data, or other documents. Information that contained protected health information and personally identifiable information was not requested or provided.

Stakeholder Management

During the stakeholder engagement process, recruitment of additional representatives from existing interviewees was needed. This informal, yet highly impactful method of recruitment offers additional useful information and provides the research team insight into previously unknown stakeholders.

The project team maintained a stakeholder registry to track stakeholders, communications, and participation. Of the 119 organizations identified and contacted, 34 organizations participated through the various stakeholder engagement methods. All meeting invitations, focus group registrants, reminder emails, and follow-up emails were monitored within the registry.

The stakeholders were separated into groups to gather information based on their regional perspective, engagement within their community, and experience. Once the groups were solidified, DMS sent an announcement for participation to gather information about the current and desired state of crisis response services in Kentucky. Once a stakeholder confirmed a meeting time, the project team sent out the meeting invite to the unique organization and the associated stakeholders. When applicable, the pre-questionnaire was sent alongside the invitation and stakeholders were encouraged to complete it prior to their scheduled event.

As responses to email requests to law enforcement and EMS agencies were limited. The project team began making calls to over 40 identified organizations that were unresponsive or could help facilitate discussions with those types of stakeholders. Engagement efforts were extended to accommodate this effort, and four additional interviews were made with local law enforcement agencies during this time.

Participating Stakeholders

Stakeholders were engaged from February 2023 through April 2023. In total, 34 unique organizations were engaged, representing over 56 individuals as shown in *Table 2*. Engaging existing Kentucky co-response programs, law enforcement agencies, EMS agencies, and other state co-response programs was critical as during the 2022 MCI Needs Assessment, there was limited input from these stakeholder types.

Table 2. Stakeholder Engagement Summary

Stakeholder Engagement Summary			
Stakeholder Category	**Unique Organizations Engaged**	**Unique Organizations Identified**	**Unique Individuals Engaged**
Existing Kentucky Co-Response Programs	5 Local Co-Response Organizations	10 Local Co-Response Organizations	11+
Kentucky Law Enforcement Agencies	1 Statewide Organization 3 Local Agencies	3 State Organizations 28 Local Agencies	6+
Kentucky EMS Agencies	1 Statewide Organization 4 Local Agencies	4 Statewide Organizations 12 Local Agencies	10+
Other State Co-Response Programs	1 Statewide Organization 5 Local Co-Response Organizations	2 Statewide Organizations 23 Organizations	9+
PSAP Organizations	1 Statewide Agency 1 Local Organization	1 Statewide Agency 5 Local Organizations	2+
Peer Support Associations	2 Organizations	9 Organizations	3+
Health Care Associations	2 Organizations	8 Organizations	3+
Health Care Providers	8 Health Care Provider Organizations CMHCs	14 Organizations	12+
Total	**34 Organizations**	**119 Organizations**	**56+**

All of the unique organizations engaged through at least one method is listed in *Table 3*. Some stakeholders participated through multiple methods including interviews, focus groups, and/or pre-interview questionnaires.

Table 3. Stakeholder Participation

Stakeholder Participation		
Stakeholder	**Stakeholder Category**	**Stakeholder Engagement Method**
Adanta Community Mental Health Center (CMHC)	Health Care Provider	Focus Group
Alexandria, Kentucky Sheriff's Department	Existing Kentucky Co-Response	Interview, Pre-Interview Questionnaire
Arlington, Massachusetts	Other State Co-Response	Interview
Bowling Green EMS	Local EMS Agency	Focus Group
Colorado Behavioral Health Administration (BHA)	Other State Co-Response	Interview
CPP – Lexington Fire Department	Existing Kentucky Co-Response	Interview, Pre-Interview Questionnaire
Comprehend CMHC	Health Care Provider	Focus Group
Covington Police Department	Local Law Enforcement Agency	Interview, Pre-Interview Questionnaire

Stakeholder Participation		
Stakeholder	**Stakeholder Category**	**Stakeholder Engagement Method**
Douglas, Colorado	Other State Co-Response	Interview
Forsyth County, Georgia	Other State Co-Response	Interview
Four Rivers CMHC	Health Care Provider	Focus Group
Henderson Ambulance Services	Local EMS Agency	Focus Group
Kentucky Board of Emergency Medical Services (KBEMS)	State EMS Organization	Interview, Focus Group
Kentucky Partnership for Families and Children	Peer Support	Interview
Kentucky Primary Care Association	Health Care Association	Focus Group
Kentucky PSAP/911	PSAP Organization	Interview
Kentucky State Police (Officer in Field)	State Law Enforcement Organization	Interview
Lexington Police Department	Local Law Enforcement Agency	Interview, Focus Group, and Pre-Interview Questionnaire
Lifeskills – Bowling Green	Existing Kentucky Co-Response	Interview, Pre-Interview Questionnaire
Louisville Metro EMS	Existing Kentucky Co-Response	Focus Group, Interview
Madison County Sheriff's Office	Local Law Enforcement Agency	Interview, Pre-Interview Questionnaire
Mental Health of America – Kentucky	Health Care Association	Focus Group
Mountain Comprehensive Care CMHC	Health Care Provider	Focus Group
National Alliance on Mental Illness (NAMI) Lexington	Peer Support	Focus Group
New Vista CMHC	Health Care Provider	Focus Group
Northkey CMHC	Health Care Provider	Focus Group
Owensboro – Daviess County	PSAP Organization	Interview
Pathways – Mt. Sterling	Existing Kentucky Co-Response	Interview, Pre-Interview Questionnaire
PennyRoyal CMHC	Health Care Provider	Focus Group
Seven Counties CMHC	Health Care Provider	Focus Group
Somerset Pulaski EMS	Local EMS Agency	Focus Group, Pre-Interview Questionnaire
Salt Lake City, Utah Police Department	Other State Co-Response	Interview
Yavapai Justice and Mental Health Coalition – Arizona	Other State Co-Response	Interview

Research Overview

The project team conducted research to gather available information across other states related to co-response model design and implementation in order to assess the current national landscape and identify information gaps to be addressed during stakeholder engagement. As stakeholder interviews with existing co-response programs were completed, the information was typically supplemented with additional research. During the interviews with identified state co-response programs, the team was able to tailor questions to gain insight on their initial development process. Furthermore, stakeholders provided recommendations surrounding initiation efforts, relationship building, and sustainability. In total, over 40 co-response or police-mental health collaboratives were researched.

Synthesis of Stakeholder Findings and Research

The project team analyzed data collected through the interviews, focus groups, and document requests to generate meaningful insights and integrate them with research to develop common themes and findings to guide the model design process. The project team analyzed quantitative and qualitative data by:

1. Reviewing the notes and listening to the recording of interviews held in order to ensure all content is transcribed. This step allowed us to become fully familiarized with the responses and helped identify any patterns.
2. Revisiting the core topics that must be addressed from the qualitative responses.
3. Identifying the patterns, common themes, responses, and any outliers that warranted further research or exploration.
4. Summarizing the common themes and major incongruences identified in data analysis, which will serve as model design considerations.
5. Supplementing findings from stakeholder engagement with additional research, documents received, and questionnaire results.
6. Compiling information gathered into the report by co-response or related programs and identifying specific stakeholder perspectives.

Limitations

A significant number of stakeholders were engaged to inform the research report; however, gaps in information gathering still exist due to the limited number of responses received related to certain topic areas and/or information gathered was based upon indirect knowledge or assumptions. Deductions were made based on information provided by DMS, other stakeholders, and discovered by the project team through research and information gathering activities. While every effort was taken to engage stakeholders, some individuals or organizations did not respond. Listed below are specific limitations:

- Less than half of identified stakeholders engaged with the project team. Only 34 out of 119 organizations contacted by the project completed a stakeholder event.
- Low response rate from EMS and law enforcement stakeholders despite emailing efforts, phone calling efforts, and direct referrals from other stakeholders.
- Perspectives may not align with all stakeholder types within Kentucky or across the nation.

- Most participants in Kentucky were unable to provide specific recommendations to a co-response model due to unfamiliarity.
- For existing co-response programs in Kentucky, the information relayed is specific to their local program that is designed to meet the needs within their community. Their responses do not reflect other local co-response programs in the country, as there are many variations.

Co-Response Across the Nation

Community-based, behavioral health-centered co-response programs can lead to better outcomes for individuals with behavioral health issues. Co-response programs are designed to address concerns including: repeat encounters with police, poor connections to care, incarceration of people with mental illness for low-level offenses, unnecessary ED visits, and deaths of people with behavioral health conditions at the hands of police.[8] Co-response, as an additional entry point into the behavioral health crisis system, ensures individuals are diverted away from traditional police response in favor of connection to appropriate behavioral health resources.

Co-response models have been implemented with much variability across the nation. The different approaches can be summarized in the categories shown in *Figure 3*:

Figure 3. Co-Response Approaches

All of the co-response programs analyzed fit into at least one of the four approach categories. Note that some programs utilize multiple approaches depending on the available resources and their local priorities.

[8] https://www.vera.org/behavioral-health-crisis-alternatives.

National Landscape of Behavioral Health Crisis

LEOs are increasingly spending time responding to low-priority 911 calls related to quality-of-life issues or social service needs.

- From 911 data from nine cities, the average percentage of calls in the "mental health" category as identified by the dispatcher is 2.1 percent.[9]
- When 911 data from nine cities was analyzed further by the Vera Institute of Justice, the average percentage of calls that fit for civilian-led or health-first responses was 19 percent.
- The Center for American Progress and the Law Enforcement Action Partnership found that 23 percent to 45 percent of calls for service were less urgent or non-criminal issues such as noise complaints, disorderly conduct, wellness checks, or behavioral health concerns.[10]
- The Center for American Progress evaluated 911 calls from eight cities and concluded 21 to 38 percent of calls involved either homelessness, behavioral health crisis, substance use, and/or quality of life concerns.
- Applied Research Services, Inc. analyzed 3.5 million 911 calls and found that roughly 600,000 calls (18.4 percent) may have been suitable for diversion from 911. Most of these calls were logged as "suspicious person," "criminal trespass," or "street/sidewalk hazard."[11]

PSAP/911 Statistics

- Estimated 240 million calls nationally each year.
- More than 80 percent of 911 calls are made from wireless devices.
- Answer requests for emergency assistance within 10 seconds 90 percent of the time.
- Process of requests for emergency assistance within 60 seconds 90 percent of the time.

Source: National Emergency Number Association 911 Statistics, National Fire Protection Association.

Police and other first responders, who may have limited training and capacity to effectively meet the needs of individuals in crisis, are often required to respond to behavioral health crisis calls. As a result, individuals with behavioral health disorders increasingly encounter law enforcement, potentially exposing them to increased trauma, hospitalization, arrests, and incarceration.

- The Washington Post Fatal Police Shooting Database reports 8,269 fatal police shootings since 2015, 21 percent of which involved mental health crisis.[12]
- In a 2021 report from the Vera Institute of Justice, the rate of fatal shootings by police of people who were experiencing a mental health crisis was 1.29 times higher for Black people and 1.10 times higher for Latinx people, compared to white people.[13]
- Results from a 2020 public survey on American's perception on police: 58 percent of Americans reported "Major Changes Needed" to policing.[14]
- Eighty-eight percent of Black Americans, 63 percent of LatinX, and 51 percent of White Americans selected "Major Changes Needed" as their views on the need for changes in policing. Additionally, ages 18 to 34, followed by 35 to 49 were the age groups in the highest percentage for major changes needed.[15]

[9] https://www.vera.org/downloads/publications/911-analysis-civilian-crisis-responders.pdf.
[10] https://www.americanprogress.org/article/introducing-community-responders-dispatch-right-response-every-911-call/.
[11] https://talk.crisisnow.com/why-partnering-with-911-and-first-responders-is-crucial-to-the-success-of-988/.
[12] https://www.washingtonpost.com/graphics/investigations/police-shootings-database/.
[13] https://www.vera.org/downloads/publications/alternatives-to-policing-civilian-crisis-response-fact-sheet.pdf.
[14] https://counciloncj.org/public-perceptions-of-the-police/#:~:text=Seventy%2Dfive%20percent%20of%20Americans,police%20based%20on%20their%20encounters.%E2%80%9D.
[15] https://counciloncj.org/public-perceptions-of-the-police/#:~:text=Seventy%2Dfive%20percent%20of%20Americans,police%20based%20on%20their%20encounters.%E2%80%9D.

Individuals with behavioral health conditions often experience longer jail time than individuals without behavioral health conditions facing similar charges.

- Fifteen percent of men and 31 percent of women in jails have a serious mental illness (SMI), compared to four percent of the general population.[16]
- State prisoners with mental health challenges are more than two times as likely to have been homeless in the year prior to their arrest.[17]
- Two in 10 prisoners and three in 10 jail inmates reported having a cognitive disability (i.e., down syndrome, autism, dementia, learning disability, intellectual disability, and/or traumatic brain injury).[18]

Mental Health America's State of Mental Health 2023 Report

- In the U.S., there are 350 individuals for every one mental health provider.
- 28 percent of all adults with a mental illness reported that they were not able to receive needed treatment.
- 60 percent of youth with major depression do not receive treatment.
- 23 percent of adults who report experiencing 14 or more mentally unhealthy days each month were not able to see a doctor due to costs.

Source: https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf.

EDs are often the source of care for individuals with behavioral health care needs. Nationally, overall ED volume declined between 2019 and 2020, while the proportion attributable to mental health conditions increased.

- NAMI reported that one in eight of all ED visits nationally are related to mental disorders and substance use disorders (SUDs).[19]
- From 2007 to 2013, the overall rate of ED visits with a principal diagnosis related to mental health, alcohol, or substance abuse increased from 1,527.8 to 1,883.0 per 100,000 population."[20]
- Preventable or avoidable ED visits reduce capacity and cost an estimated $8.3 billion per year, according to a 2019 analysis by Premier.[21]

[16] PsychU Trends in Criminalization of Mental Illness.
[17] https://bja.ojp.gov/program/pmhc/infographic.
[18] IBID.
[19] National Alliance on Mental Illness, "Mental Health by the Numbers," NAMI, last modified February 2022, https://www.nami.org/mhstats.
[20] https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html.
[21] https://www.hfma.org/payment-reimbursement-and-managed-care/payment-trends/63247/.

Overview of Co-Response across the Nation

A comprehensive review of more than 40 state and local programs found that many are in early stages of establishing a statewide crisis response system, many of which include co-response programs. Implementation of co-response programs occurs at the local level with varying degrees as requisite infrastructure (i.e., statues, funding, and administrative regulations) should be in place before providers and staffing, standards and protocols, and training can occur system-wide. From our research, many co-response programs were identified and engaged through stakeholder interviews. Those programs that were engaged are summarized within the section. Additional co-response programs that were researched are documented within *Appendix B: Other State Co-Response Programs*.

Co-response programs are designed and implemented at the local level with wide variability in terms of composition, processes, policies, and funding. However, there are a few examples where there are statewide models or frameworks.

- **Colorado.** Provides funding to co-response programs throughout the state through intergovernmental contracts at an average of $344,000 per program. The co-response programs are required to meet certain operational, data, and collaborative requirements, but have the flexibility to implement a model that works locally.
- **Georgia.** Promotes law enforcement partnerships with behavioral health professionals by providing a framework for co-responder teams to be implemented locally in communities throughout Georgia through Senate Bill (SB) 403.
- **Utah.** In 2023, an initiative was drafted to allocate $2 million to create a grant program where LEOs and a behavioral health professionals respond jointly to incidents where mental health may be a factor. However, the bill did not pass the general session.

Colorado Co-Responder Models

Colorado Statewide Co-Responder Program

Colorado has a Statewide Crisis Response System offering individuals mental health, substance use or emotional crisis help, information and referrals through a crisis call line, mobile crisis services, crisis stabilization services, and respite services.[22] However, Colorado also sees value in a complementary model through their co-responder program that pairs law enforcement and behavioral health specialists to intervene and respond to behavioral health-related calls for police service. The statewide co-responder model utilizes funding from multiple sources to fund local co-responder programs in 24 of the 64 counties in Colorado.[23]

These funds include:

- $5,900,000 per year from Marijuana Tax Cash Fund (Colorado Revised Statute [CRS] 39-28.8-501) as of February 2023.
- $1,900,000 per year from the State General Fund as of February 2023.
- $400,000 per year from Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grants as of February 2023.

[22] https://bha.colorado.gov/behavioral-health/crisis.
[23] https://drive.google.com/file/d/1hEZgpl5Qqm2uwsTyqRhfmrQX8BamOauh/view.

- $1,400,000 per year for SUD and criminal justice system reform through June 30, 2024 – SB08 (2019).
- $2,900,000 per year appropriated for crisis response and criminal justice diversion in SB207 (2017).[24] [25]

Colorado issued a Request for Applications (RFA) in September 2019, called "co-responder RFA SB19-008," which is issuing renewals and just awarded a number of agreements on March 31, 2023. These intergovernmental agreements for fiscal year (FY) 2023 totaled over $10 million and support 29 co-response programs. Although the applicants were to have been counties, cities, or government departments, the awardees are service agencies.[26]

All local programs have the same requirements, same funding, and are five-year agreements, dependent on annual renewals. Half the funding goes to local and county governments or departments and half goes directly to CMHCs.

In Colorado, there are three ways a co-responder team interacts with an individual:

1. Active call responding to police dispatch or police requesting co-responder clinicians on scene.
2. Referral made from law enforcement or community partner to the co-responder team.
3. Follow-up contact where the co-responder team reaches out to the individual after previous contact.

Community programs in Colorado have adopted the following approaches to co-response: 1) an officer and behavioral health specialist ride together in the same vehicle for an entire shift; or 2) a behavioral health specialist is called to the scene, and the call is handled together. If a team is not available, some local police departments have Crisis Intervention Team (CIT) officers available.[27]

Although the statute is in place (CRS 27-60-103), as of the end of 2022, the Behavioral Health Authority (BHA) rules regarding emergency and crisis behavioral health services (Chapter 10) are in draft form. CRS 27-60-103 includes components for public information campaigns specific to behavioral health crisis services. CRS 27-63-106 requires BHA to provide an annual report on the progress made on the behavioral health safety net system from January 1, 2022 to July 1, 2024. The report is to include expenditures, outcomes, and effectiveness measures.[28] The most recent evaluation report is by the Colorado Health Institute, published in August 2021. The report concluded that the Office of Behavioral Health's (OBH) co-responder program continues to connect individuals to care to address their behavioral health needs and found many successes in a reduction in involuntary mental health holds and an increase in the return of law enforcement to patrol duties. However, the programs in different locations connected individuals to behavioral health services at differing rates, stemming from how programs respond to calls for service, after-the-fact referrals, and follow-up.[29]

An evaluation of Colorado co-response programs between July 2020 and June 2021, of more than 25,900 calls (originating from more than 80 communities), 98 percent avoided arrest. In that same

[24] Frequently Asked Questions, https://bha.colorado.gov/behavioral-health/co-responder.
[25] https://legiscan.com/CO/text/SB207/id/1618928.
[26] Public access at https://codpa-vss.cloud.cgifederal.com/webapp/PRDVSS2X1/AltSelfService.
[27] https://bha.colorado.gov/behavioral-health/co-responder.
[28] https://drive.google.com/file/d/1sbh1r4EnV36E6t_SDUju-QT4APFuUYVK/view.
[29] https://drive.google.com/file/d/11X3rl0rBJ4jdtWHlLkwY7IZ1RtMAe467/view.

timeframe, co-responders provided some form of behavioral health service to individuals on 86 percent of active calls, including assessments and referrals to community resources.

- 7,066 de-escalation services provided (defined as utilization of communication techniques to reduce emotional intensity or violent situation).
- The reports include demographic information (ethnicity, race, gender identity, age).
- Additional data points reported include time spent on scene and voluntary status after call.
- 8,895 calls resulted in enrollment (new or previous) behavioral health services.
- 7,977 of the calls were resolved on scene and 2,427 resolved in the ED/hospital.

OBH recognizes that most emergency dispatch systems do not currently have a reliable method for tracking behavioral health-related calls. While some Colorado agencies have begun collecting this information, OBH is allocating resources to help programs work on this effort. [30] [31]

Colorado Urban Co-Response Program

An agreement from 2020 between Arapahoe County, which is part of the Denver metro area, and AllHealth Network, the contractor, includes a scope of services summary that highlights the following:

- On behalf of the Arapahoe County Sheriff's Office, the county municipality established a new behavioral health response program, called the "Co-Responder Program."
- AllHealth Network provided training and education to deputies and other sheriff's office staff to improve overall understanding of behavioral health and mental health issues.
- The agreement requires descriptive data and statistics that can be used to better inform the co-responder program.
- AllHealth Network will supply four licensed clinicians to serve as co-responders, one case manager, and one mental health team lead.[32]

Since the launch of the program, the co-responders answered nearly two percent of the 87,000 911 calls received within Arapahoe County, freeing up 233 hours of law enforcement time, making them available to respond to other calls.[33] For the co-responders within the program, nearly 50 percent of the 1,645 calls were resolved at the scene, 30 percent of calls resulted in a mental health hold or involuntary transport to a hospital, and only two percent resulted in an arrest.

Note that the co-response program of Arapahoe County was not engaged through the stakeholder engagement effort.

Colorado Rural Co-Response Programs

The City of Alamosa (City), located in a rural county of Colorado with a population of 9,806, issued a Request for Proposals (RFP) for qualified providers to collaborate on the provision of a new co-responder program. This program is supported with American Rescue Plan Act funding which expires December 31, 2024. The City is currently reviewing other grant opportunities to sustain the program. According to an

[30] https://bha.colorado.gov/behavioral-health/co-responder.
[31] https://drive.google.com/file/d/1iCG_EUmr6_vz-W2lpNEh4E920tHa6Kw7/view.
[32] https://www.arapahoegov.com/AgendaCenter/ViewFile/Item/11919?fileID=18964.
[33] https://coffeeordie.com/mental-health-calls/.

RFP released by the City, "Since the City of Alamosa has no background in hiring or managing behavioral health staff, it wishes to partner with a provider with such background for the program."[34]

The Alamosa Police Department handles 25,000 to 30,000 calls per year with approximately six to 10 mental health calls per week.[35] In September 2022, they successfully hired a clinician and utilized lessons learned from the Evans Police Department in Colorado to develop the program. The clinician responds alongside LEOs to calls where a mental health situation or SUD may exist. After the de-escalation, the clinician provides follow-up services and checks in. While launching the program, the police chief stated that when responding to behavioral health crises, "[T]he main problem is that we're not trained to do this, we're not counselors. We're cops." As of January 2023, the City of Alamosa applied for a Department of Justice Federal Grant of $530,000 to pay for the program for the next three years and allow for a second co-responder and a case manager.[36]

The City of Grand Junction, Colorado, with a population of 65,560 in a rural county, began their co-response program in 2018 and is sustained with grant funding.[37] Beginning in 2018, Grand Junction received $360,000 per year from the Colorado BHA.[38] In 2022 the co-response program responded to 1,070 calls. The program's success has allowed the clinicians to become full-time employees of the police department rather than contracting with the local CMHC. The City posted a job for a co-responder clinician, which included a job description, as well as salary and benefits.[39] The clinician is expected to respond in partnership with LEOs to situations involving mental health or SUD crises. After providing de-escalation, assessments, and/or clinical intervention, the clinician will provide outreach, referrals, and follow-up to the individuals. Qualifications for the position include two years of clinical social work, co-response, or similar experience and a preference for individuals with a current licensure as a licensed clinical social worker, licensed marriage and family therapist, licensed professional counselor, licensed associate counselor, or psychologist in the state of Colorado. The estimated salary range was noted as $66,072 to $74,364

Note that the co-response programs of Alamosa or Grand Junction were not engaged through the stakeholder engagement effort.

Douglas County, Colorado Youth and Adult Community Response Team

Established as a co-response program in 2017, the Douglas County Community Response Team (CRT) serves 360,000 residents of all ages. The program seeks to streamline emergency service utilization and is made possible through partnerships between law enforcement, county commissioners, fire/EMS services, and mental health providers.

There are four teams for adult services and two additional teams that specialize in youth for schools. Each team has one dedicated LEO that is partnered with the same clinician that works full time. The pair works together for 40 hours a week. The teams are dispatched through the local PSAP directly. Additionally, each team has a dedicated resource specialist that handles the case management aspect

[34] https://cityofalamosa.org/wp-content/uploads/2021/12/Co-Responder-RFP.pdf.
[35] https://alamosanews.com/article/alamosa-police-department-hires-co-responder.
[36] https://alamosanews.com/article/apd-co-responder-program-already-shows-signs-of-success.
[37] https://www.gjcity.org/863/Co-Responder-Unit#:~:text=This%20grant%2Dfunded%20program%20pairs,that%20involve%20behavioral%20health%20crisis.
[38] https://www.kjct8.com/content/news/Therapists-are-joining-the-Grand-Junction-Police-Department-to-help-with-911-calls-468890283.html.
[39] https://www.governmentjobs.com/careers/gjcity/jobs/3580968/co-responder-clinician.

and follow-up services. The teams are available five days a week from 7:00 a.m. to 10:00 p.m. based on the highest volume of mental health calls. The program is currently working on expanding availability to seven days a week.

With the current teams and future operations, the budget, not including in-kind donations, totals $1.4 million, which supports a total nine teams. The budget is supported by $270,000 from Colorado BHA which covers the cost of two clinical teams, uniforms, an iPad, and business cards. The remaining funding includes other grants and $560,000 in general fund money from the local government. Local government commissioners also allocated $2.8 million for the co-responder system to integrate Julota, an application that facilitates communication and referrals to services, with computer-aided dispatch (CAD) system.

In 2019, 688 law enforcement units, 179 fire/EMS workers, and 73 fire/EMS vehicles were made available for non-behavioral health services calls and were replaced by co-response programs. The estimated savings from CRT between 2017 and 2019 exceeded $4.9 million. More than 50 percent of the referrals made to individuals and served by CRT resulted in successful engagement with the needed services and support.[40] Despite being the ranked[41] as the 9th wealthiest counties in the nation, with a median household income of more than $127,000, Douglas County reported barriers to hiring and maintaining a sufficient number of clinicians to meet their workforce needs.

The Douglas County co-response program helped to form the Colorado Co-Responder Alliance (COCRA). All co-response programs in Colorado meet in this alliance to discuss similar encounters and room for opportunities. This collaborative shares best practices between all co-response programs in the state. The program noted that identifying champions, building relationships, and keeping track of data to showcase the benefit of the model is critical for implementing and sustaining a co-response program.

Georgia

Georgia Statewide Model for Behavioral Health Emergency Co-Responder Program

Georgia's statewide co-responder program was established through SB403. This bill became law in March 2022, amending Title 37 of the Official Code of Georgia Annotated, relating to mental health. SB403 was modeled after the successful co-responder program in the Savannah police department. SB403 promotes law enforcement partnerships with behavioral health professionals by providing a framework for co-responder teams to be implemented locally in communities throughout Georgia. For law enforcement agencies that choose to participate in the program, Georgia's Community Service Boards (CSBs) provide behavioral health professionals to assist officers in responding to crises virtually or in person. With guidance from a licensed or certified professional, officers are authorized to refer an individual to a treatment facility, other community support, or an emergency evaluation rather than making an arrest.[42] Currently, Georgia is working to hire licensed mental health clinicians to work in 911 CCCs

[40] https://www.julota.com/news/five-examples-of-successful-co-responder-programs/.
[41] https://www.usnews.com/news/healthiest-communities/slideshows/richest-counties-in-america?onepage
[42] https://ltgov.georgia.gov/press-releases/2022-03-30/statewide-model-mental-health-emergency-co-responder-program-passes.

statewide.[43] The clinicians will help to identify behavioral health calls and record information that will help the co-response team prior to arriving on scene.

Forsyth County, Georgia Co-Response Program

The Forsyth County (County) Sheriff's Office Crisis Intervention Response Team (CIRT) represents a partnership with the local CSB, Avita Community Partners. This partnership began in 2020 with grant funding. The co-response program serves the County's population of 251,283 and is a suburban part of the Atlanta metro area. The team is led by an LEO who is accompanied by a social worker from Avita. Responses to 911 calls are made in unmarked cars, with staff in civilian clothes. A peer specialist follows up with individuals. The social worker and the peer specialist are embedded in and work exclusively with the Forsyth County Sherriff's Office.[44]

Officers throughout the sheriff's office—including deputies and jail staff—receive training in behavioral health, crisis intervention, and other relevant topics. Community group members, school staff, and students receive training—in two years nearly 2,000 individuals were trained. The program engages families and caregivers of individuals in crisis, having engaged over a thousand families and caregivers over two years.[45]

On average, the team receives about seven mental health crisis calls per day. Expenditures are approximately $238,000 per year supporting two teams. Only 1.4 percent of CIRT encounters resulted in arrest, and the number of individuals with mental illness in jail is half its previous level. According to program leadership, CIRT saved the County over $1 million a year by diverting individuals from jail.[46]

Utah

Utah Mental Health Support for Co-Response Programs

In Utah, House Bill (HB) 29 was drafted for the 2023 General Session to allocate $2 million to create a grant program to provide a co-response program where an LEO and a behavioral health professional respond jointly to incidents where mental health may be a factor.[47] The funding would help support best practice co-response teams. In 2021 the Utah Crisis Line received 92,532 calls, 2.9 percent of which required collaboration with law enforcement.[48] In December 2022, Utah Crisis Services reported 73 referrals from first responder agencies, 77 contacts from police departments, and four transfers from fire and EMS departments.[49] Despite HB29 not passing, Utah has successfully passed other bills to support the crisis care continuum.

Statewide Behavioral Health EMS

In March 2021, Utah's SB53 was signed into law creating a license for "behavioral emergency service technicians" and "advanced behavioral emergency services technicians" to train EMS providers to work

[43] http://metroatlantaceo.com/news/2022/03/georgia-senate-unanimously-backs-statewide-model-mental-health-emergency-response/.
[44] https://accesswdun.com/article/2021/8/1028504/forsyth-county-updates-on-sheriffs-office-cirt.
[45] Georgia Statistical Analysis Center, a division of the Criminal Justice Coordinating Council, evaluation of Forsyth County's justice and mental health collaborative program from October 2020 through September 2022.
[46] Interview by Myers and Stauffer with Sgt. Hawkins FCSO, 2/21/23 and Georgia Statistical Analysis Center, a division of the Criminal Justice Coordinating Council, evaluation of Forsyth County's justice and mental health collaborative program from October 2020 through September 2022.
[47] https://le.utah.gov/~2023/bills/static/HB0029.html.
[48] https://healthcare.utah.edu/hmhi/docs/community-crisis-intervention-and-support-services-fy-21-annual-report.pdf
[49] https://healthcare.utah.edu/hmhi/programs/crisis-diversion/.

with patients experiencing substance abuse and/or mental health challenges.[50] Although not a co-response model, behavioral EMTs triage patients, de-escalate mental health crises, and connect patients with appropriate resources. Designated mental health EMS teams can be dispatched through 911 or 988.

Statewide Mental Health Crisis Intervention Council and Autism Training for LEOs

In 2021, Utah signed SB47 into law which required police officers to receive training to learn how to better interact with people on the autism spectrum. More broadly, the law creates a Mental Health Crisis Intervention Council to establish protocols and standards for the training and functioning of local mental health CITs. The council provides oversight of CITs on the state and local level.[51] The State is moving forward with a contract agreement with Kulturecity after a successful Sensory Inclusivity Training pilot in Salt Lake City.[52]

Salt Lake City Police Department

Salt Lake City Police Department serves 186,000 residents, a small city and rural community collaboration and coordination across multiple jurisdictions. In 2018, the city provided $1.3 million in funding to create the co-response program. Currently, the City still funds the social workers, but not within the police department. Services are provided to individuals for free without any billing to Medicaid or any other insurance. The program does not track cost savings to the community as dispatch data is not accurate for that kind of analysis, but information is documented within case notes.

The police department employs a complementary team approach through community connection center, which includes: CIT and Community Connections Team (CCT). The CCT consists of case managers and therapists who are partnered with CIT detectives and a sergeant. It functions as a CRU with a social worker responding to 911 calls alongside a CIT detective. The team addresses “social issue calls” (e.g., unwanted persons, suicidal ideas, mental health concerns, homelessness, and SUD). CIT-trained LEOs at a scene can request a CCT social worker through dispatch when a behavioral health situation is determined. If a social worker is not available, the CIT LEO will make a note for a social worker to follow-up later as a secondary response.

There are currently about 15 to 16 social workers employed by the police department and they are in the process of hiring more, but are having difficulties with workforce shortages. Once fully staffed, CCT social workers will respond Monday through Friday from 8:00 a.m. to 12:00 a.m. and on weekends from 8:00 a.m. to 8:00 p.m. CIT LEOs respond in a blue polo shirt and tan pants rather than a full uniform. The CIT LEOs currently respond in a police vehicle but are working on getting unmarked vehicles as this would help with de-escalation.

CCT works closely with CIT LEOs to conduct CIT trainings for multiple police departments in the region. Officers are required to complete a robust training program including CIT for youth (eight hours at academy), autism training (16 hours per year), post-traumatic stress disorder (PTSD) specialization and officer wellness (eight hours), and recertification and officer resilience CIT training.[53] At the start of the program, social workers worked for two years on outreach efforts before integrating with LEOs. Also, all CCT social workers are required to take law enforcement CIT trainings in order to have a LEO perspective as well.

[50] https://le.utah.gov/~2021/bills/static/SB0053.html.
[51] https://le.utah.gov/~2021/bills/static/SB0047.html.
[52] https://talk.crisisnow.com/mary-sowers-on-getting-rid-of-policy-relics-and-ensuring-988-works-for-people-with-idd/
[53] https://csgjusticecenter.org/projects/law-enforcement-mental-health-learning-sites/salt-lake-city-police-department/.

Additional Programs Evaluated

Yavapai Justice and Mental Health Coalition (Arizona)

Located in a rural county approximately the size of Massachusetts with 235,000 people with a mountain range dividing the area, the Yavapai Justice and Mental Health Coalition (the Coalition) partners with justice and treatment providers throughout the county and has successfully implemented a co-response model that is integrated into their entire crisis care continuum.

The Coalition provides oversight to the county-wide crisis care continuum. The Coalition regularly brings together stakeholders from all facets of the continuum, including but not limited to: representation from MCTs, co-responders, law enforcement, EMS, corrections, and community-based mental and physical health. Polaris, which operates the county's crisis stabilization facilities, plays an active role engaging both MCTs and law enforcement.

The structure of the crisis care continuum in Yavapai County includes:

- Twelve law enforcement agencies have access to 24/7 behavioral health resources.
- Five PSAPs in the county with 988 integration since October 2022 utilize a triage process that supports deployment of behavioral health resources at the point of the call rather than waiting for law enforcement to arrive on scene.
- Strategically placed behavioral health resources through Spectrum Healthcare are utilized throughout the county based on volume and to provide a 30 minute or less response time, 365 days a year.
- Crisis Stabilization Unit, run by Polara Health, allows for immediate warm handoffs by law enforcement to behavioral health professionals 24/7. This allows the LEOs to safely drop an individual off and get back to patrol quickly and is centrally located with 10 chairs and eight beds.
- Yavapai County Sherriff's Office Detention Center screens and coordinates care upon release for people with identified mental illnesses, SUDs, and social determinants of health (SDOH) risks.

There are a total of 20 workers with three to four workers available on both sides of the Arizona mountain range during the peak time from 2:00 p.m. to 12:00 a.m. The lowest staffing level is from 2:00 a.m. to 5:00 a.m. The behavioral health triage protocol took 18 months to develop and is integrated into the CAD system. The three levels of behavioral health crisis triage are:

1. **Significant Safety Concerns.** When there are significant safety concerns, LEOs clear the scene without assistance from behavioral health personnel.
2. **Limited Safety Concerns.** When there are limited safety concerns, co-response with an LEO and behavioral health professional can take place.
3. **No Safety Concerns.** There are no immediate safety concerns where a behavioral professional is utilized.

The Coalition utilizes various funding sources to support the entire crisis care continuum in the county including grants and Medicaid funding through health plans. Half of the funds from Medicaid goes toward claims and the other toward overhead. The Coalition noted that billing for crisis services is not enough to cover the costs, but it is fortunate in Arizona where funding comes from the Medicaid health plans.

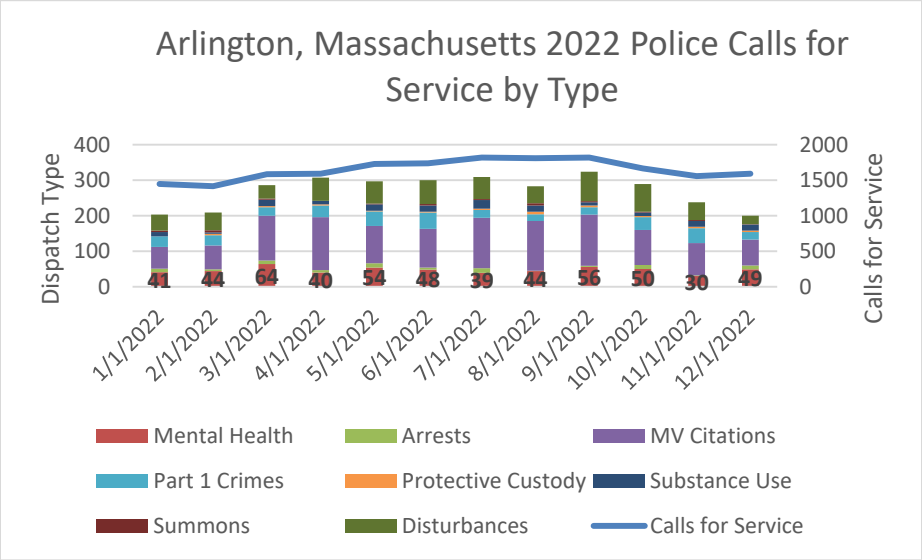
Data is gathered from all coalition partners, including SDOH-related information. This data is shared among all coalition partners and used to conduct cost savings analysis focused on Medicaid and tax dollars saved through community ER diversion programs.

Arlington, Massachusetts Police Department Co-Response and Jail Diversion Program

Located in Middlesex County Massachusetts, the Arlington Police Department serves 46,000 people in a suburban jurisdiction of more than five square miles close to two urban centers. The program began in 2012 and includes a co-response program and targeted initiatives spearheaded by a mental health clinician embedded in the police department. Targeted initiatives within the program include: jail diversion, hoarding response team, elder abuse prevention taskforce, and the Arlington opiate outreach project. Cross-sector case management is facilitated through strong community partnerships.[54]

The Arlington co-response program is designed to allow a behavioral health professional to dispatch to an active behavioral health situation with the responding LEO and can also provide follow-up services. The behavioral health professional is available from 11:00 a.m. to 7:00 p.m. and is dispatched if the call is initially deemed as a mental health call or if an LEO calls the clinician to meet at the scene. The stakeholder interviewed estimated that they completed an average of 60 dispatches per month. This aligns to their 2022 data, as seen below in *Figure 4*, which stated an average of 47 mental health dispatches per month (1.2 percent of local population).[55]

Figure 4. Arlington, Massachusetts 2022 Police Calls for Service by Type



LEOs participating in co-response receive comprehensive multi-modality training including instruction in mental health first aid (MHFA) (required for all officers, not limited to co-response), trauma-informed care, youth/brain development, context-specific crisis management and intervention techniques, signs and symptoms of mental illness, signs and symptoms of overdose, narcan deployment and distribution training, common psychiatric medications and usage, suicide risk and prevention, and relevant laws and

[54] https://csgjusticecenter.org/projects/law-enforcement-mental-health-learning-sites/arlington-police-department/.
[55] https://lookerstudio.google.com/reporting/4073fa90-0220-4428-b198-77efe322538d/page/NNBYB.

statutes. The police department collects and analyzes data comprehensively in a system that allows for specialized clinician access. Arlington receives a mental health grant from the State for the co-response program but also utilizes local dollars to sustain the program.

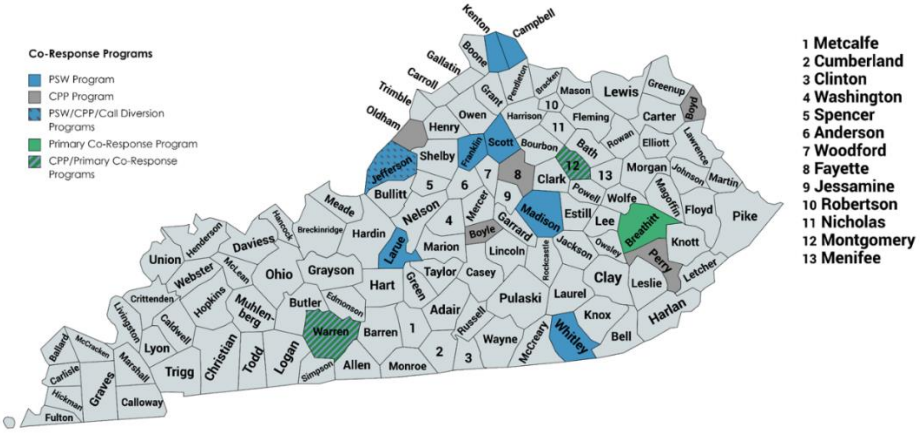
Current Co-Response Program Landscape in Kentucky

Within Kentucky, a number of co-response programs exist to meet the needs of individuals experiencing a behavioral health crisis in the community. These co-response programs fit into the following approaches:

- **Primary Co-Response Programs.** There are currently three programs within Kentucky that utilize LEOs who have access to a behavioral health professional during an active behavioral health crisis. This includes: Mt. Sterling Pathways Co-Response Program, Bowling Green Lifeskills Co-Response Program, and the Kentucky River Community Care (KRCC) Co-Response Program.
- **Secondary Co-Response Programs through Community Paramedicine Programs (CPPs).** There are eight active CPPs within Kentucky that provide at-home care for non-emergent medical situations rather than relying upon ambulance. Note that each CPP has different resources and protocols.
- **Secondary Co-Response Programs through Police Social Workers (PSWs).** There are 13 PSW programs in Kentucky that are community-based policing initiatives designed to decrease the number of repeat callers to 911 by utilizing social workers to respond to calls relating to unmet social service needs, build and maintain community partnerships and public outreach, and identify training opportunities for law enforcement.

Kentucky's current co-response programs are noted in the map in *Figure 5*. Some counties are served by multiple co-response programs, and existing co-response programs may provide services outside of the county they are based in. The map provides a summary of where primary co-response programs, CPPs, and PSW programs may operate.

Figure 5. Map of Kentucky Co-Response Programs



Note: There may be additional co-response programs within the Commonwealth that were not identified through research and stakeholder engagement efforts.

Law Enforcement-Led Co-Response

Mt. Sterling Pathways Co-Response Program

The Mt. Sterling Pathways Co-Response Program began operations in March 2022 through a SAMHSA supplemental grant of $174,466 for the first year. The co-response team is a partnership between the Pathways CMHC and the Mt. Sterling Police Department. The team is comprised of a mental health associate and a peer support specialist (PSS) who are housed at the police department, plus an LEO. The team is available Monday to Friday from 11:00 a.m. to 7:00 p.m. Goals of the program include diversion from jails, EDs, and hospitals, and a redistribution of LEO time, decreasing behavioral health cases.

The behavioral health resource is not paired with a designated law enforcement office but is able to respond to any behavioral health crisis situation at the request of officer. The Pathways team also monitors the police radio for behavioral health situations. The co-response team can conduct de-escalation, intervention, and transportation to appropriate services such as crisis units, detox programs, homeless programs, 28-day treatment programs, and other residential treatment. In practice, the co-response team does not respond to active criminal situations which pose a risk to the team's safety; however, exceptions may be made. Examples include individuals charged with public intoxication and other misdemeanors. Numerous trainings are available for emergency services staff, on topics including crisis, suicide and violence, and substance use. The co-response team utilizes an agency vehicle with Global Positioning System (GPS) tracking for in-person response and has access to telehealth services through a tablet and a hotspot for connecting with a qualified mental health professional (QMHP).

The program has been successful and expanded from the City of Mt. Sterling to include all of Montgomery County within the first year of operation. Over the first year, the program diverted 14 individuals from imminent incarceration, eight from psychiatric hospitalization, and 11 from hospital EDs, saving the County a conservative estimate of $46,000.

Pathways is in the process of reapplying for the SAMHSA grant to expand the service area to Rowan County. If the grant is not awarded, the program would end, as the County does not have plans to fund it.

Bowling Green Lifeskills Co-Response Program

Lifeskills CMHC and the Warren County Sheriff announced the launch of a co-response team on October 1, 2022 that pairs an LEO with a therapist that can respond in person to active crises.[56] A CIT therapist provides outreach and crisis responses with the Warren County Sheriff Department to both adults and children. The therapist is directly sourced by the sheriff's office, and they work in the Warren County Service Center. Currently, there is only one therapist that works with the CIT Team, but Lifeskills is currently recruiting for three additional therapists.

During a police response, the officer may request a therapist to join them on-scene. The therapist will arrive at the scene, conduct an assessment, and connect the patient to any resources necessary. The therapist primarily works Monday through Friday from 10:00 a.m. to 6:00 p.m., but is available for calls

[56] https://www.bgdailynews.com/community/lifeskills-launches-co-response-crisis-program/article_6fff1141-6dac-5a47-aae4-64ea294884c0.html.

during the weekend. Since its launch in October 2022, the program is focused on adapting the therapist to the police force and strengthening Lifeskill's policies for the program. Case management is a critical component of the program to address frequent users, and the therapist tracks follow-up data monthly. The quality improvement director is involved in logging data to track the number of call outs, follow-ups, cross-systems planning, distinguishing intellectual/developmental disability (I/DD) or SUD occurrence, and the amount of time spent on the call. However, representatives express that it is difficult to track the time saved for the sheriff upon intervention.

As stated during the stakeholder engagement interview, the co-response program goals are to increase cost savings by reducing arrests, hospitalization rates, and overall costs associated with behavioral health calls. To increase access to resources and improve community relations, the co-response program has created local partnerships with organizations that provide resources to housing, homelessness, addiction, and food insecurity. A $200,000 grant from the Office of National Drug Control Policy funds the co-response program and a separate outreach for opioid response. Additionally, the Warren County Sheriff's Office is able to offset their costs of co-response through their partnerships with Lifeskills and the City of Bowling Green. For example, the costs of transport personnel are paid by Lifeskills. Lifeskills reimburses the sheriff's office the expenses for salaries, fuel, and insurance.[57]

Kentucky River Community Care Breathitt County Co-Response Program

KRCC CMHC works closely with local law enforcement and EMS on mobile crisis response to individuals with SUD and overdose. During the stakeholder engagement process, KRCC was not responsive to requests. It is unknown how the co-response program is utilized in Breathitt County.[58]

Co-Response via Community Paramedicine Programs

Generally, a CPP is a community-based health care model, in which paramedics work outside their typical scope of care (i.e., emergency response and transport) to deliver community-based health care. In practice, community paramedicine maximizes the use of emergency care resources and enhances access to primary care for medically underserved populations. Programs are increasingly integrating behavioral health into community paramedicine, as the model continues to evolve.[59]

There are currently eight CPPs operating in Kentucky, including programs in Lexington, Louisville, Boyle County, Murray, Boyd County, Oldham County, and Bowling Green.[60] According to KBEMS, all CPPs in Kentucky remain in pilot phase despite launch six years ago. Pilot programs are required to submit quarterly reports to KBEMS.[61] The primary goals of the CPPs are to navigate low-acuity patients away from urgent resource use and to continue care for an acute event to

> The CPP detective described the program as: *"Perfect marriage of response. It is a collective engagement to get a better idea what the individuals needs are medically, and from the law enforcement perspective. Our social workers get an even better idea how to respond to that individual."*

[57] https://warrencountykysheriff.com/wp-content/uploads/2020/02/Warren-County-Sheriff-Annual-Report-2019-UPDATE.pdf.
[58] https://www.chfs.ky.gov/agencies/dms/Documents/MobileCrisisInterventionAssessment.pdf.
[59] https://www.usfa.fema.gov; See also Rural Health Information Hub "Community Paramedicine Toolkit."
[60] https://kbems.ky.gov/KSTARS/Documents/Publications/MIHCP_Year6Report.pdf.
[61] https://kbems.ky.gov/KSTARS/Documents/Publications/MIHCP_Year6Report.pdf

prevent unnecessary readmission back to inpatient facilities.

As noted in the most recent CPP annual report, the programs have been successful with 302 EMS transports prevented, 315 ED visits prevented, and 40 hospital readmissions prevented from June 1, 2021 to May 31, 2022. Also, the number of patient encounters the eight CPPs have responded to has increased 70 percent from the previous year to 1,404. While looking at patient encounters, there is an estimated $159.74 per EMS dispatch savings when comparing a CPP response to a traditional EMS response.

CPP Lexington, Kentucky

The Lexington CPP follows a multi-disciplinary model, which allows the program to find needed resources for the vulnerable populations being served by the team after thorough assessments. Their goals include: reducing arrests, jail diversion, reducing costs associated with behavioral health calls, increasing access to crisis services, reducing hospitalization rates, ED diversion, reducing injuries to officers/consumers, and improving community relations.

The CPP uses a secondary approach where they respond after the de-escalation has been settled. The CPP may use the online portal to receive internal referrals from LEOs for the secondary response. Composition of the team varies based on available resources at the time and the needs of the individuals. The programs responds from Monday through Friday during business hours (8:00 a.m. – 5:00 p.m.) but is also available after-hours to assist, as needed. The program is able to leverage a Bureau of Justice Assistance (BJA) grant to support the two clinical social workers, the firefighters are paid by the city, and the detective is the only permanent position for CPP.

The CPP in Lexington partners with local community organizations such as CMHCs, certified community behavioral health centers, housing organizations, resources for homelessness, food pantries, social services, local charities, local advocacy groups, faith-based organizations, and addiction facilities. The CPP team is dispatched through 911 and referrals from within/outside agencies.

Lexington's CPP is not primarily focused on behavioral health or behavioral health crisis; however, 988 calls received by New Vista from callers within the CPP response zone are transferred for community paramedicine dispatch instead of traditional MCT. The Lexington CPP also operates as a Quick Response Team (QRT) program to address narcotic-related medical emergencies, referral to SUD treatment/recovery services, and harm reduction education. The QRT is funded by federal and state grants, including the Comprehensive Opioid Stimulant Substance Abuse Program (COSSAP) and Kentucky KORE through DBHDID.

Since the implementation of the CPP in Lexington, there has been a significant decrease in EMS responses—6.5 percent from 2017 to 2019. Through providing at-home care for non-emergent medical situations, the CPP has been able to reduce the number of patients in hospital EDs and number of readmissions after a patient is discharged.[62]

[62] https://www.allisongibsonphd.com/cpp.

Police Social Workers

PSWs are community-based policing initiatives designed to decrease the number of repeat callers to 911. Through this policing model, police departments hire social workers to respond to calls relating to unmet social service needs, build and maintain community partnerships and public outreach, and identify training opportunities for law enforcement. There are a total of 13 PSW programs within Kentucky.[63] Some of the PSWs in Kentucky have formed a collaborative, including members from Alexandria, Campbell County, and Highland Heights.

PSWs in Alexandria, Kentucky

In 2016, the Alexandria Police Department hired a PSW after a report concluded that 67 percent of their calls are related to unmet social service needs. The program was initially funded through a Victims of Crime Act grant, but is now fully funded by the city. Today, an estimated 80 percent of PSW calls are follow-up post-police encounter. The PSW reviews all police calls received and monitors the police radio for callers that may benefit from social and community supports. When calls are identified, the PSW follows up post-police encounter with recommended referral/connections and diversion support. The PSWs can develop a treatment plan for individuals that can help the individual address physical health, behavioral health, and other unmet needs. While the treatment plan can be developed by a PSW, they cannot be added to it and are not able to track it. However, the PSW can conduct welfare checks and regular follow-ups while utilizing a running list to help support individuals proactively who have higher needs in the community. The PSW also refers individuals to 988 and will even call 988 together with the individual. Nearly all officers within Alexandria are CIT trained through the statewide Kentucky program. The officers can directly request the PSW if they feel they can help the situation. The Alexandria program would like to expand to the entire county.

Notably, the current police chief of the Alexandria Police Department was the “most vocal opponent” to the program during the initial planning.[64] Since the program began operations, the chief sees the value in having PSWs address repeat callers for non-criminal issues as it helps the residents get the needed services, while also freeing up the officer to respond to emergency situations. For example, a war veteran had called 911 60 times in one year which reduced the availability of police resources to respond to other situations. The PSW was able to work directly with the individual and connect him to treatments through the U.S. Department of Veterans Affairs. The costs of the social worker is also lower than hiring a new LEO when factoring in training and equipment. In 2020 it was noted that hiring an LEO would cost $100,000 up front, whereas a social worker would be half that amount.

Programs Supporting Co-Response in Kentucky

Other programs and entities also support behavioral health crisis responses in Kentucky. Law enforcement agencies, EMS agencies, 911 centers or PSAPs, and behavioral health providers including the CMHCs are all resources to support co-response programs within the state. Summaries of some of these resources are provided within this section.

[63] https://linknky.com/news/health/2023/03/16/erlangers-innovative-police-social-work-program-i-am-100-here-just-to-help-you/.
[64] https://www.theguardian.com/us-news/2020/sep/19/alexandria-kentucky-police-social-workers.

Kentucky's CIT

Kentucky Revised Statute (KRS) 210.365 defines CIT training for firefighters and law enforcement including the curriculum, reporting, and jail triage system.[65] CIT officers are trained to create connections between law enforcement, first responders, mental health providers, and work with the individual's natural supports as needed. Through collaborative community partnerships and intensive training, CIT improves officer-to-individual communication, identifies mental health resources and social service supports for those in crisis, while ensuring officer and community safety. While CIT is not co-response, officers with this specialized mental health training are often selected to respond to scenarios where mental health may be a contributing factor.

In a study, evaluating the costs and savings of CIT in Louisville there was a net savings of more than $1 million per year, after accounting for all associated program costs.[66] The Louisville Police Department noted that the cost of training nearly all of the officer training costs was $146,079. Savings included reduced costs from deferred admissions to hospitals, jails, and psychiatric institutions. Medicare and Medicaid were the two largest beneficiaries of the savings due to deferred hospital admissions.

911 Call Centers

In Kentucky, individuals who experience a behavioral health crisis, or their family or friends reach out for assistance on their behalf, typically call 911 or 988 emergency lines. PSAPs answer those calls and triage to the most appropriate responder for the crisis, such as LEOs, EMTs, or where available, co-response teams or MCTs. There are over 116 PSAPs in Kentucky, which answered over 3.5 million calls in FY 2022.[67]

The 911 Services Board has oversight of the PSAPs and ensures the reporting requirements are followed. Notably, the 911 Services Board does not have authority to enforce policies which results in each PSAP having their own unique policies and procedures. However, the 911 Services Board is working with a statewide coalition to develop a framework for statewide policies, but there are significant barriers.

Local PSAPs are funded from a variety of sources including state general funds, city/county general funds, Commercial Mobile Radio Service (CMRS) distribution formula, and grants.[68] In a report filed with the Federal Communication Commission in 2019, the estimated total cost to provide 911 services in Kentucky was $116,658,319.[69] The 911 Services Board voted unanimously to award more than $2.1 million in grants for the 2022 grant cycle. Awards ranged from $2,430 to $298,787 primarily funding technology and/or equipment upgrades. At the time of this report, the 911 Services Board was accepting applications for 2023 competitive grants.

Louisville Metro Crisis Call Diversion Program

Within the Louisville Metro Crisis Call Diversion Program (CCDP), non-violent behavioral health-related calls to 911 are diverted or deflected away from police responses that traditionally result in arrest/incarceration or hospitalization. The program is commonly referred to as the Diversion Program or

[65] https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=51247.
[66] https://www.jrsa.org/pubs/sac-digest/vol-28/il-polinvprogrms.pdf.
[67] https://homelandsecurity.ky.gov/About/PublishingImages/Pages/Annual-Reports/2022%20KOHS%20Annual%20Report.pdf.
[68] https://911board.ky.gov/Documents/2019%20KESC%20Financial%20Reviews.pdf
[69] https://www.fcc.gov/file/17542/download

the Deflection Program. Services offered through this program include diversion, mobile crisis, and respite.

- **Diversion services** are provided by crisis triage workers (CTWs) who work in the Metro's Emergency Management Services call center (referred to as MetroSafe) alongside the 911 crisis team. The MetroSafe call takers divert 911 behavioral health calls to CTWs. The process starts by: identifying the callers' needs, diverting the calls, de-escalating the callers when needed, and resolving the callers' needs over the phone. When the situation dictates, the CTW sends the caller to the local CMHC, Seven Counties Services (SCS), Crisis Information Center for additional assistance to dispatch the MCT or to provide respite services.[70]
- **Mobile crisis assistance** is provided by a two-person team through the SCS CMHC. The MCT responds when callers' situations are deemed by CTWs to require in-person crisis assistance. The MCT can refer callers to needed services (e.g., outpatient BH treatment); coordinate transport to the hospital (e.g., University of Louisville Emergency Psychiatric Services or to respite services; and/or connect the individual to natural supports (e.g., family members or friends).[71]
- **Respite services** are provided for callers who are deemed to be in need of stabilization. The Center is located at the SCS CMHC Addiction Recovery Center where the individual is provided with a space for stabilization, behavioral health services, and referrals for up to 24 hours.[72]

Prior to the launch of CCDP, the Commonwealth Institute of Kentucky at the University of Louisville received planning-related funding in January 2021 from Louisville Metro Government. This funding was used to identify recommendations regarding how alternative responder interventions could be applied and adopted to meet the needs of the community. The final budget for 2023 included approximately $4.5 million for the 911 call diversion effort. The current mayor, Craig Greenberg, plans to ask the Metro Council for more funding in the 2024 budget for the Diversion Program.[73] The program is currently in Phase 2 of 3 phases.[74]

- **Phase 1: December 2021 – June 2022.** Pilot operations limited to fourth division for CIT 911 calls. Planned to expand the program to 24/7 coverage.
- **Phase 2: July 2022 – June 2023.** The program was expanded to include divisions 1, 2, 3, and 5. A team was deployed for non-CIT calls, protocols were implemented, deployment of fire, and EMS through CCDP; and continued evaluation.
- **Phase 3: July 2023 – June 2024.** Plans include expanding Louisville Metro Police Department (LMPD) patrol divisions, developing a "no wrong door" approach, and continued evaluation.

The Louisville Metro local government operates the CCDP and MetroSafe, while subcontracting with the SCS CMHC to provide behavioral health services through the MCT or respite services, and train the CTWs. Louisville Metro also subcontracts with the University of Louisville School of Public Health and Information Sciences to provide evaluations, reviews, and recommendations for the CCDP.

Since the launch, the CCDP has diverted approximately 1,200 911 calls, assisted more than 600 individuals with crisis services, supports, and referrals to needed services. This effort enabled the LMPD

[70] University of Louisville. (June 2022). Louisville Metro Crisis Call Diversion Program Pilot Final Evaluation Report.
[71] Ibid.
[72] Ibid.
[73] https://www.courier-journal.com/story/news/politics/metro-government/2023/03/21/louisville-crisis-call-diversion-program-expands-lmpd-divisions-behavioral-health/70030912007/.
[74] University of Louisville. (June 2022). Louisville Metro Crisis Call Diversion Program Pilot Final Evaluation Report.

to save more than 345 labor hours, which allowed officers to respond to incidents requiring more intensive police involvement in the city. The CCDP operates from 2:00 p.m. – 10:00 p.m. daily currently, with plans to expand to 24 hours when additional funding is available.

Current data collection and tracking include:

- Number of deflection calls, tracked by 911 triage worker.
- Number of callers who were stabilized, tracked by 911 triage worker.
- Type of deflection.
- Number and types of transports.
- Transportation locations.
- Number of arrests or citations resulting from the calls.

As part of the University of Louisville evaluation, clinical psychologists are reviewing the 911 calls coming in that meet behavioral health markers. They offer training and support to ensure the 911 triage call takers are able to recognize the crises and are able to provide the appropriate response, and how EMS is being included in the process. The program evaluators have released two reports on the CCDP:

- **Louisville Metro Alternative Responder Research and Planning Final Report**, September 2021. This report provided as evaluation of the initial phase of the project. The objectives included designing a pilot program to determine how to deflect 911 calls that did not require a police response, as well as determining how those calls could be addressed more effectively, thus freeing LMPD resources and reducing costs.[75]
- **Louisville Metro CCDP Pilot Final Evaluation Report**, June 2022. This report included a description of implementation, community and stakeholder perceptions, economic outcomes of the CCDP, and recommendations to expand and strengthen the model.[76]
- **2023 Report**, the evaluators plan to release a report in June 2023 that will address program interventions.

Criteria for the 911 triage team to deflect calls to CCDP[77] is defined below. The CCDP does not currently include 988 crisis calls in the program. However, they recognize the importance of capturing all crisis calls to better serve individuals with behavioral health crisis in the Louisville Metro region and are contemplating plans for including those calls in the program.

- Calls must come from 911 crisis line.
- Triage team determines the need for CCDP.
- Available in all eight LMPD divisions, but not in smaller cities.
- Must be a first- or second-party caller.
- Frequent callers are referred to CCDP.
- Exclusion criteria for CCDP: possession of weapon, suicidal or homicidal intensions, medical response needed, or history of violence.

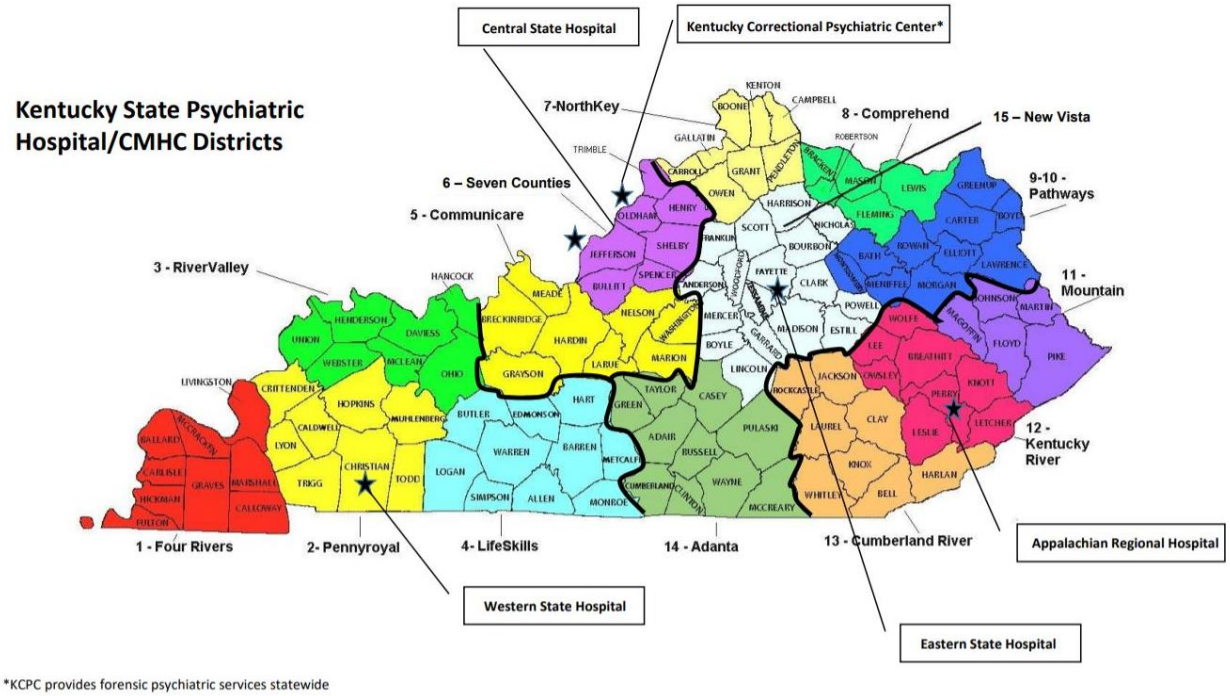
[75] University of Louisville. (Sept.2021). Alternative Responder Model Research and Planning Final Report.
[76] University of Louisville. (June 2022). Louisville Metro Crisis Call Diversion Program Pilot Final Evaluation Report.
[77] Ibid.

Community Mental Health Centers

In 1964, Kentucky passed the Community Mental Health Services Act, which funded the construction of its CMHCs, making it the first Commonwealth/state to have a regional network of mental health organizations.[78] Kentucky has 14 CMHCs that provide community-based behavioral health services to those with mental health, I/DD, and/or substance abuse needs through 14 regional boards or regions.[79]
Figure 6. Kentucky CMHC Regions Map

shows the 15 CMHC regions, which are aligned to counties and Kentucky state psychiatric hospitals. Note that Pathways serves Region 9 and Region 10. CMHCs provide services to Kentuckians with mental health, developmental and intellectual disabilities, or substance abuse and have also supported several co-response programs.

Figure 6. Kentucky CMHC Regions Map



The Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) contracts with Kentucky's 14 CMHCs to provide behavioral health services, including a crisis line/National Suicide Prevention Line (NSPL) answering, MCI services, and additional follow-up services, as needed by the client. Required crisis services array identified in the contract between DBHDID and each CMHC includes the following:[80]

- Screening (e.g., telephonic screening and triage).
- Behavioral health crisis assessments, including involuntary hospitalization evaluations as defined in KRS 202A and KRS 645.

[78] https://www.opencounseling.com/public-mental-health-ky#:~:text=Public%20mental%20health%20services%20in%20Kentucky%20are%20managed%20and%20overseen,a%20network%20of%2014%20CMHCs.
[79] https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/cmhc.aspx.
[80] Kentucky 988 Implementation Plan, January 2022.

- Counseling and intervention to stabilize the situation (e.g., MCI services, residential crisis stabilization, crisis intervention, and crisis respite).
- Psychiatric consultation (e.g., psychiatrist, medical doctor, or advanced practice registered nurse on call for consultation and medication management).
- Information and referral services to connect individuals and families with community resources (e.g., support for delivery of suicide prevention services by the Kentucky River Regional Prevention Center [RPC] staff).
- Observation and/or follow-up to ensure stabilization (e.g., 23-hour observation, telephonic/text/email follow-up to ensure continued stabilization).
- Therapeutic and supportive services to prevent, reduce, or eliminate the crisis situation (e.g., support delivery of community response services after suicide attempt by RPC staff, peer support, case management, emergency residential care, etc.).
- Coordination of transportation services for individuals needing an involuntary hospitalization (to and from the hospital).
- Safety planning for self-harm or suicide risk.
- Assessment and coordination of appropriate level of care for SUDs.

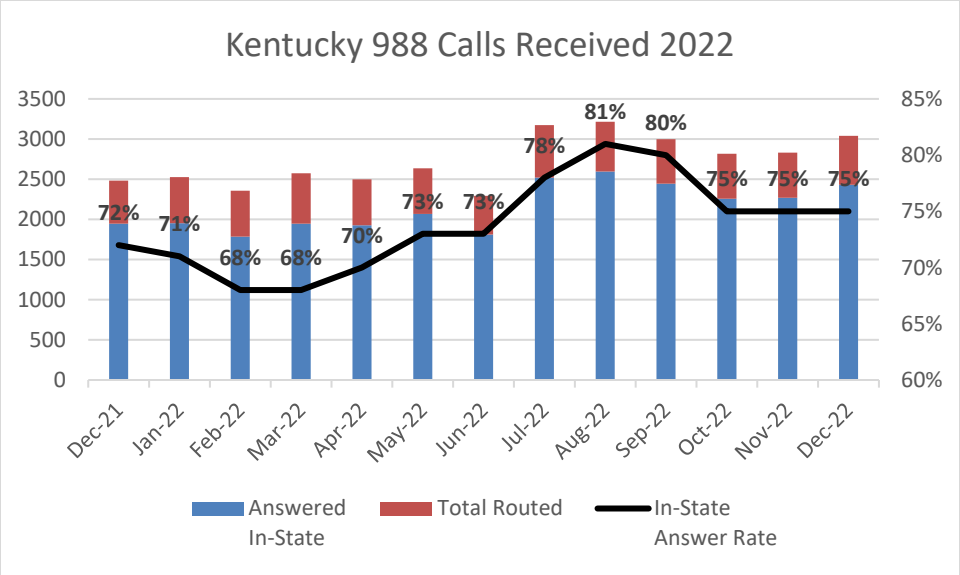
Crisis Call Centers

While each of the CMHCs staff a CCC, 13 of these organizations are accredited by the NSPL. This accreditation ensures NSPL requirements are met, increasing consistency in how local crisis lines operate. For the regions served by Comprehend, Pennyroyal is providing call center services. All 13 of the NSPL accredited CMHCs utilize Vibrant for 988 call center technology, which was launched on June 30, 2022. Note that as of April 30, 2022, all call centers are in the process of onboarding to NSPL or were fully accredited. All NSPL accredited call centers in the Commonwealth are collectively referred to as the Kentucky Lifeline.[81]

Kentucky's CCCs serve thousands of residents each month. Kentucky residents calling the NSPL, Spanish Language Line, and the Veteran's Crisis Line are routed to the local/regional networks. Since the launch of 988 call line in July 2022, call volume has increased as seen in *Figure 7*.

Figure 7. Kentucky 988 Calls Received 2022

[81] Ibid.



Federal funding for 988 Lifeline in FY22 was $282 million which was allocated to strengthen network operations and local crisis call center capacity. According to SAMHSA's 988 Appropriations Report, Kentucky stated plans to use $3,286,740 from for the implementation of 988 Lifeline response.[82] Kentucky House Bill 516 was introduced in February 2023 to establish a 988 suicide and crisis lifeline fund and sought to amend KRS 186.162 adding a specialized 988 license plate to generate moneys for the fund. One day following the bills introduction, it was sent to Appropriations and Revenue. [83]

Mobile Crisis Teams

The main objective of MCTs is to reduce psychiatric hospitalizations, including hospitalizations that follow an ED admission, and unnecessary visits to the ED.[84] Kentucky MCI services are provided by members of the MCT, which includes licensed behavioral health care professionals, supervised associates, peer supports, and case managers.[85]

In state fiscal year (SFY) 2019, CMHCs were asked to report on their MCT availability. Twelve CMHCs recorded that their MCT is staffed during regular business hours of operation. The remaining two CMHCs only had an on-call MCT available during normal business hours. Five CMHC MCTs were staffed during evenings and weekends outside of business hours, and the remaining 10 CMHCs MCTs were available on call during evening and weekend hours.

Composition of the MCT varied across CMHCs. According to the SFY 2022 CMHC Annual Compilation Documents:

- Adult peer support is available in 10 CMHCs; the remaining four CMHCs have limited access to peer support.
- Family peer supports are available in seven CMHCs; three CMHCs have limited access to family peer supports, and four CMHCs do not have any family peer supports.

[82] https://www.samhsa.gov/sites/default/files/988-appropriations-report.pdf
[83] https://apps.legislature.ky.gov/record/23rs/hb516.html
[84] Substance Abuse and Mental Health Services Administration, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*, HHS Publication No. (SMA)-14-4848, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014, https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4848.pdf.
[85] Kentucky CMHC MCI Stakeholder Interviews, February–March 2022.

- Youth peer supports are available in six CMHCs with limited access in one CMHC organization. Seven CMHCs do not have any youth peer support.
- Composition of the MCT can vary depending on the location of the individual in need, resources available, and minimum qualifications.
- Eight Kentucky CMHCs offer QRTs targeting overdose response and prevention. Adult QRT is available in seven of 14 CMHC regions. Child QRT is available in six regions.[86]
- CIT training is another approach to crisis response involving LEOs who receive specialized training in behavioral health crisis, including addiction diversion. Thirteen out of 14 CMHCs have CIT training for adults, two of which provide coverage limited to certain locations/counties. Thirteen out of 14 regions have CIT training for children, two of which provide coverage limited to certain location/counties within the region.

Kentucky Opioid Response Effort

The Kentucky Opioid Response Effort (KORE) program's mission is to expand and sustain an equitable, recovery-oriented system of care and reduce opioid-related overdose deaths in the Commonwealth of Kentucky by increasing access to evidence-based prevention, harm reduction, treatment, and recovery support services.[87] KORE is led by DBHDID and is federally funded through SAMHSA grants[88]—28,625 Kentuckians have received treatment services through a KORE-funded initiative (2018 through 2022). Some of the programs that KORE supports includes:

- QRTs comprised of peer support, first responders, and behavioral health providers to help individuals who have experienced an opioid-related overdose or complication connect with harm reduction, treatment, and recovery services.
- Recovery community centers (RCCs) serve as local hub for community-based supports to provide peer support, advocacy, and linkages to housing, education, employment, and transportation.

Quick Response Teams

As part of the KORE project, QRTs provide assertive outreach in communities across the state to engage people who experienced an overdose within 24 to 72 hours of the crisis event. They provide harm reduction (e.g., naloxone, fentanyl test strips), linkage to treatment/recovery services, and supportive wraparound services to the individual who experienced an overdose, family and friends, and community members. Outside of the KORE grant project, the QRT model is used to deploy MCI services in rural and urban settings and also provides engagement to communities with high rates of overdose and disparities.[89]

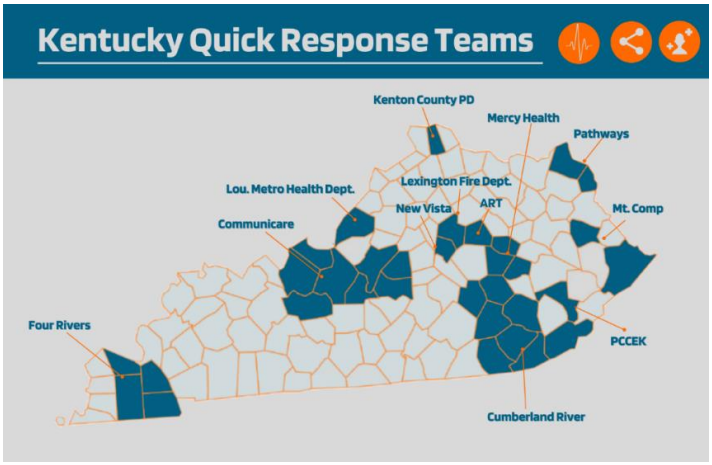
In June 2022, Kentucky received an additional $36 million in state opioid response funding from SAMHSA.[90] The budget for each QRT ranges from $110,000 to $200,000. The budget for each QRT is used to support a variety of operations and implementation costs such as the cost for PSSs, first responders (e.g., EMS, etc.), travel expenses, outreach and engagement supplies, marketing, naloxone, fentanyl test strips, and more. In order to support the recovery of individuals with opioid misuse

[86] Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2022.
[87] https://www.chfs.ky.gov/agencies/dbhdid/Pages/kore.aspx.
[88] https://www.chfs.ky.gov/agencies/dbhdid/Documents/AboutKORE.pdf.
[89] https://www.centerforhealthandjustice.org/chjweb/tertiary_page.aspx?id=109&title=Quick-Response-Teams:-Interdisciplinary-Overdose-Response-and-Prevention.
[90] Kentucky MCI Needs Assessment 2022.

addictions, KORE supports a variety of services that help these individuals seek job training, employment, and recovery housing.

KORE programs and initiatives are in operation in every county statewide (see *Figure 8*). KORE funds 12 QRTs operating 33 counties. KORE-funded QRTs have served 1,423 individuals.

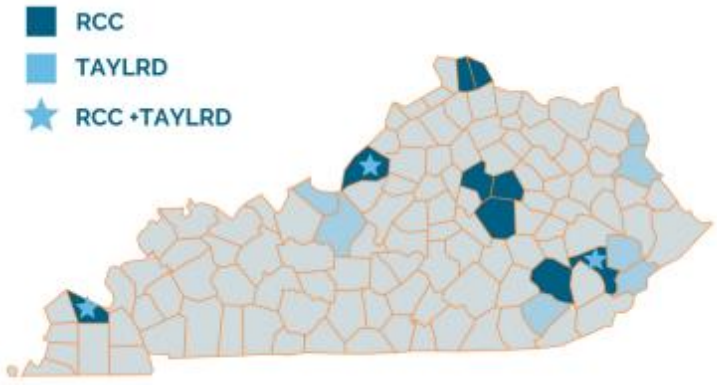
Figure 8: Kentucky QRTs Map



Recovery Community Centers

The peer-operated centers serve as local hub for community-based supports.[91] Individuals are able to obtain services at the RCCs to access recovery information and resources. DBHDID recently announced a new funding opportunity in 2023 to support four additional RCCs. The notice of funding opportunity (NOFO)[92] describes the requirements for the one-year grant. Requirements include: the entity either must be a non-profit 501(c)3 or quasi-governmental agency, have an existing steering committee or willingness to develop one, at least two years of experience working with individuals experiencing SUD, must submit quarterly reports and other data. The NOFO closed on January 4, 2023 with an anticipated start date of July 1, 2023 with a maximum of $300,000 per awardee with no matching requirement. As of August 2021, there were 11 KORE-funded RCCs within Kentucky, and four youth drop-in centers as seen in *Figure 9*.

Figure 9. Kentucky RCCs Map



[91] https://www.recoveryanswers.org/resource/recovery-community-centers/.
[92] https://www.chfs.ky.gov/agencies/dbhdid/Documents/RCCNOFO.pdf.

Crisis Co-Response Perspectives

Summary of Stakeholder Perspectives

Barriers

- Law enforcement and public safety buy-in. Hiring the "right" resources for law enforcement and behavioral health professionals.
- Budgetary and funding constraints in cities and counties, especially in rural and frontier communities.
- National workforce shortages challenge staffing of crisis response positions.
- Law enforcement's perceived and/or potential liability ensuring safety of behavioral health professionals.
- PSAPs and 988 CCCs perceived and/or potential liability in data sharing and warm hand-offs.
- Triage and dispatch protocols vary significantly at the local level and should align with local needs.
- Lack of integration means data collection is often a manual burden.
- Program evaluation and reporting on volume, impact, and cost savings is a barrier without standardization.
- Limited availability of local resources for referral and/or wraparound. Rural communities have limited access to behavioral health crisis services and community-based supports (e.g., housing/shelter, transportation) in general.

Stakeholder-Reported Barriers Specific to Kentucky

- Limited options for post-crisis services or transportation results in a reliance upon EDs and jails.
- There is no single authority to develop a standardized statewide triage and dispatch policy.
- KRS 202A specifies criteria for involuntary hospitalization and can limit how law enforcement and behavioral health community respond.
- Ensuring service delivery considers health disparities, particularly regions such as Eastern Kentucky.
- During a behavioral health crisis, transportation to and from locations is particularly challenging in rural regions where round trip travel may take hours.

Lessons Learned from Existing Co-Response Programs

We identified the following lessons learned from the existing co-response programs:

- Co-response program design varies in order to meet the unique needs of the community and availability of local resources.
- Require CIT for co-responding officers, as well as supplemental trainings (e.g., MHFA, autism/sensory inclusivity training, etc.)
- Ensure behavioral health crisis triage framework and dispatch protocols align to local priorities and available resources.
- Meeting the needs of the local communities might require crisis response that address SDOH-related crises.

Lessons Learned from Existing Co-Response Programs

- Participating law enforcement agencies should evaluate their co-response program's effectiveness, while maintaining a level of flexibility that allows for adoption of new practices (e.g., reduced use of restraint, updated uniform, unmarked vehicles for transport, etc.)
- Nearly all well-established co-response programs outside of Kentucky recommended thinking through data infrastructure prior to launch.
- Behavioral health professionals participating in co-response recommended leveraging provider types like PSS, community health workers, case managers, mental health associates, and bachelor-level social workers for secondary response and follow-up services.

Statewide Co-Response Model Best Practice

Establish a taskforce with state-level representation that reflects the goals and objectives of co-response and reflects the landscape of the state.

Observed Operational Practices

We observed the following operational practices from the existing co-response programs:

- **Collaboration.** Municipalities participating in the design of their co-response must take steps to understand the community's needs by engaging local leaders.
- **Availability.** The majority of the teams are available Monday through Friday afternoon and evenings (e.g., 11:00 a.m. to 7:00 p.m.) to align with the highest volume and to address resource constraints.
- **Trainings.** Conduct crossover trainings between law enforcement, EMS, and behavioral health providers within the local community to ensure the "right fit" between the different cultures.
- **Uniforms.** Have LEOs "dress down" (e.g., civilian clothes, polo uniform) in order to appear more casual and approachable.
- **Requirements.** Allow for flexibility on co-response requirements and composition as each local community has different needs and resources available.
- **Follow-Up Services.** Connecting stakeholders to follow-up services (e.g., behavioral health, community supports, etc.) is critical to help the individual and for the success of any co-response program.
- **Data and Outcomes.** Effective information sharing helps responders tailor response to individuals in need, evaluate the program, and enable the ability to track cost savings to the community.

Stakeholder Perspectives: Ideal Kentucky Co-Response Care Continuum

- **Healthcare Association.** "Having the whole team [co-response team] there, with a social worker and the EMS to help the [behavioral health] physician and then de-escalate as necessary and then having the follow up… The follow-up is really key."
- **Kentucky PSAP.** Within the community, it is important to recognize that police do not need to respond to every behavioral health situation, increase funding for 911/PSAPs to improve processes and reduce stigma related to behavioral health crisis calls, and have CMHCs partner with their PSAPs to deliver strong in-person MCTs rather than relying upon law enforcement.

Stakeholder Perspectives: Ideal Kentucky Co-Response Care Continuum

- **Kentucky Police Officer.** The police would arrive on scene first to de-escalate and secure the scene. A mobile unit of behavioral health professionals would be requested to the scene once deemed safe, which would require collaboration and integration. A behavioral health professional becomes another person needing protection and that can be a huge burden on the officers.
- **PSS.** "Sometimes I think they [peer supports] can maybe de-escalate much quicker than even the mental health professional just because they're talking peer to peer… So I would love to see a kind of a combination of [peer supports] with support from a clinical person and law enforcement or EMT."
- **EMS Agency.** Would like a regional approach where an on-duty behavioral health professional can receive individuals from EMS and de-escalate or transport the individual to additional services. EMS would also be reimbursed for transporting to the behavioral health professional as that is not currently reimbursable.
- **Organization with a Co-Response Program. "**I would love to pay for law enforcement to be actually with the [co-response] team … Manpower—those are kind of challenges there, but it is just a community that wants it." The co-response resources engage the situation after law enforcement arrives.
- **Health Care Association.** Bring everyone to the table. Regional health care associations, CMHCs, and federally qualified health centers (FQHCs) should be meeting with their local LEO/EMS. Appropriate referrals are necessary for the benefit of the patient.
- **Local Kentucky Police Department.** Ability for law enforcement or first responders to bring an individual who has a behavioral health crisis to a temporary place that is safe and has access to a behavioral health professional such as a 23-hour crisis stabilization unit. This would avoid jail or hospitalization and reduce the need for the individual to wait for appointments.
- **Local Kentucky Sheriff's Department.** "My department is great about willingness to work with mental health programs. The biggest thing is we operate on a budget and that might be a challenge. To do anything co-response, we'd want to make sure it's feasible and something that works well with the officers, is this something our officers could use practically."

Essential Elements of a Co-Response Program

Individuals with mental illnesses represent a relatively small but significant number of calls encountered by LEOs each day.[93] Historically, LEOs have often had limited or no training for addressing the complex needs of this population. As a result, these encounters frequently are time-intensive, resulting in LEOs taking these individuals into custody (e.g., jail, EDs, or mental health facilities), often due to a lack of more appropriate alternatives and resources to address the needs of the individual. LEOs frequently encounter the same individuals on a regular basis, creating a sense of frustration for LEOs, placing a strain on limited resources, and little to no resolution to address the root cause of crisis for the individual, often behavioral health treatment, and/or addressing SDOH (e.g., food, housing, transportation, natural supports).

In an effort to address this complex issue, the BJA, U.S. Department of Justice, developed the The Essential Elements of PMHC Programs, "Ten Essential Elements", document as the centerpiece of a series of resources developed to assist law enforcement and their community partners. The document is based on extensive research to address specialized response programs for law enforcement that include CIT and law enforcement-mental health co-responder models.

The following section applies the BJA "Ten Essential Elements" as a guide for consideration as stakeholders from across the Commonwealth work collaboratively to develop the Kentucky CCCR Model. These essential elements provide general guidance for developing criminal justice-mental health collaboratives which can apply to crisis co-response programs with the goal of increasing the likelihood of crisis resolution at the scene with the individual and increase the utilization of formal post-crisis services. Co-response programs are typically designed in partnership with law enforcement, which is why the BJA's essential elements were utilized in this report to frame specific findings and stakeholder perspectives related to co-response. Despite being designed for law enforcement, the 10 elements align with factors for any co-response program, whether the program utilizes law enforcement, first responders, behavioral

[93] https://bja.ojp.gov/program/pmhc/learning/essential-elements-pmhc-programs/1-collaborative-planning-and-implementation

health professionals, peer supports, or other resources. The stakeholder findings have been aligned to the following elements:

1. Collaborative Planning and Implementation.
2. Program Design.
3. Specialized Training.
4. Call-Taker and Dispatcher Protocols.
5. Stabilization, Observation, and Disposition.
6. Transportation and Custodial Transfer.
7. Information Exchange and Confidentiality.
8. Treatment, Supports, and Services.
9. Organizational Support.
10. Program Evaluation and Sustainability.

Element 1: Collaborative Planning and Implementation

"Making sure that the agencies' leadership is truly bought in and all of that, making sure that the agencies who are involved law enforcement and behavioral health that they have adequate kind of champions at the right levels, so not just leadership involvement."

– Out-of-State Co-Response Program

Collaborative planning and implementation is centered on bringing together high-level representation of the systems serving the community in a co-response continuum. The nature of co-response requires strong partnership between behavioral health systems, public safety (i.e., law enforcement), and emergency services (i.e., first responders and PSAPs). Being that co-response programs are often designed to meet the unique needs of local residents, collaborative planning and implementation may also include additional perspectives from communities such as hospitals, advocacy groups, housing officials, and non-profit organizations.

Essential Element: Collaborative Planning and Implementation

"Organizations and individuals representing a wide range of disciplines and perspectives and with a strong interest in improving law enforcement encounters with people with mental illnesses work together in one or more groups to determine the response program's characteristics and guide implementation efforts."

Kentucky Background and Findings

Within the Kentucky behavioral health crisis continuum, efforts exist on the regional level to facilitate ongoing high-level collaboration.

- Through Kentucky's CIT Advisory Committee, local law enforcement, mental health professionals, and advocates connect and establish partnerships in the local communities. The Advisory Committee works to accomplish its mission (to sustain effective interactions among law enforcement, mental health providers, individuals with mental illness, their families and communities) by raising public/stakeholder awareness through education and outreach, and providing assistance to communities interested in developing CIT programs.[94]
- The 911/988 Committee currently meets monthly to facilitate collaboration and coordination between Kentucky's PSAPs and CMHC-operated 988 CCCs. The objective of the ongoing meeting is to establish and implement a mental health protocol seeking to integrate into emergency medical dispatch protocol. Stakeholders recommended leveraging this effort to promote co-response services with hospitals, law enforcement, community mental service programs, and EMS.
- Within CMHC Region 6, Seven Counties (CMHC) and Bluegrass (FQHC) host regular, multi-stakeholder meetings bringing together law enforcement agencies, CIT training coordinators, EMS/paramedicine, all hospitals, and identified health care providers within the region. During these meetings, stakeholders discuss what went wrong and what went right with the purpose of exchanging lessons learned for improvements on the individual-level, practice-level, and system-level.
- Twelve PSWs actively working in local police departments across Kentucky have formed a collaborative to discuss experiences.
- Kentucky Safety and Prevention Alignment Network is a collaboration between public and private organizations and individuals dedicated to promoting safety and preventing injuries throughout the Commonwealth of Kentucky.[95]

[94] http://kentuckycit.com/.
[95] https://www.safekentucky.org/.

Stakeholder Perspectives

Throughout engagement, stakeholders within Kentucky and across the nation agreed multi-disciplinary collaboration on the state-level would benefit implementation of co-response on the local municipal-level. A collaborative at the state-level should assume an active oversight and advisory role in the work required under all 10 essential elements.

"Getting those groups (CMHCs, FQHCs) to the table with EMS, law enforcement as well, can help address the patient's family practice needs and behavioral health needs and get them referred to programs. You know, there are patients in these situations that are going to do much better being referred to a Community Mental Health Center."

– Focus Group: Kentucky's Healthcare Associations

Kentucky Highlight:
Mt. Sterling/Pathways Co-Response

"Buy-in is a slow process. Only a handful of police embraced the program to start and reach out to the co-response team for de-escalation or intervention. However, a sheriff in another county saw the team doing their protocol at a nearby town and it allowed the program to expand into the county, having seen the value offered by the co-response program services."

Barriers

Stakeholders cited the following as barriers related to planning and implementation:

- All stakeholders engaged cited "buy-in" from law enforcement to be the biggest challenge to overcome in state-level involvement and local municipal-level program planning.

Local law enforcement and first responder agencies report budget constraints as a barrier to co-response adoption, particularly so in rural communities.

- Demonstrating the value to high-level leadership was a commonly cited challenge among established co-response programs engaged. Many stakeholders noted that one of the benefits of co-response is cost savings to the law enforcement agency due to appropriate resource allocation; however, such cost savings may be difficult to demonstrate initially.
- Workforce shortages across the nation, especially critical on the behavioral health side, are likely to pose barriers and not limited to embedding resources within the agency, but also critical coordination between partners in the co-response continuum.

"The biggest barrier is buy-in from the police side."
– Out-of-State Program (Utah)

"I see getting buy-in from your law enforcement partners as paramount and identifying the Champions at each organization."
– Out-of-State Program (Colorado)

"Commit to frequently reaching out to champions to increase the possibility of buy-in, as the plan has to be intentional. Regular conversations are needed to keep building trust. Law enforcement is outcome-driven."
– Out-of-State Co-Response Program (Arizona)

Lessons Learned from Other Community Co-Response Programs

Co-response programs have been established or are emerging across the nation with varying approaches to collaborative planning and implementation. In review of programs across the nation, some states are providing oversight in an effort to address barriers that exist on the local level. While the degree of state-level oversight varies, only a few states have moved toward a statewide co-response model.

Statewide Co-Response Model: The Colorado Co-Responder Program, administered by the Colorado Department of Human Services, OBH, supports communities seeking to implement alternative approaches to 911 calls relating to behavioral health crisis. The statewide model authorizes the development and implementation of local co-responder programs, sets forth minimum standards for local programs, and provides oversight. A key administrative requirement includes the establishment of local steering committees for governance and oversight.

To prevent "scope creep," the Colorado Office of Behavioral Health distinguished co-response as a model to address diversion from Justice and Corrections, providing an alternative response for "frequent and high utilizers" of 911 services.

Statewide Collaboratives: In Colorado, co-response programs participate in the COCRA to discuss similar encounters and share best practices.

Policy Efforts: In 2022, Utah signed into law a bill (HB47) to establish Mental Health Crisis Intervention Council to establish protocols and standards for the training and functioning of local mental health CITs on the state and local level.[96]

Facilitation of Partnerships: Georgia's SB403, signed into law March 2022, set forth a framework for local communities seeking to adopt co-response. For law enforcement agencies who choose to participate in the program, Georgia's CSBs will provide behavioral health specialists to assist officers in responding to a crisis virtually or in person. Currently, Georgia is working to hire licensed mental health clinicians to work in 911 CCCs statewide. The clinicians will help to identify behavioral health calls and record information that will help the co-response team prior to arriving on scene.[97]

Health Equity Spotlight

The mission of the North Carolina Taskforce for Racial Equity in Criminal Justice is the examination of racial disparities and implementation of evidence-based systemic changes in the criminal justice system. In its third year, the taskforce focused on implementing programs that promote public safety, while minimizing racially-inequitable practices and reducing the burden on law enforcement. Since its creation, the taskforce has collaborated and supported Pitt County, Greensboro, and Charlotte to design and implement co-responder programs to support people in crisis.

- **Enhance Accountability.** The taskforce established a robust governance and oversight network including, but not limited to: citizen oversight boards and local governing bodies and diversity/inclusion workforce criminal justice workforce requirements.[98]
- **Increase Availability of Training.** The taskforce ensures funding is available to provide officers with CIT training, MHFA certification, and programs that promote/educate officers on cultural inclusion and diversity.[99]

Opportunities

Upon evaluating stakeholder feedback and reviewing trends across the country, collaborative planning should be centered on the multi-disciplinary, high-level oversight committee. Conclusions from stakeholder engagement points to topics that should be addressed by a workgroup during the collaborative planning and implementation phase.

- Goals and objectives of state-level involvement in co-response programs across the state.
- Strategies for differentiating between co-response and MCI.
- Workforce and capacity building.
- Communication tactics for community outreach.

[96] https://le.utah.gov/~2021/bills/static/SB0047.html
[97] https://ltgov.georgia.gov/press-releases/2022-03-30/statewide-model-mental-health-emergency-co-responder-program-passes.
[98] https://ncdoj.gov/north-carolina-task-force-for-racial-equity-in-criminal-justice-releases-2022-report/.
[99] https://ncdoj.gov/north-carolina-task-force-for-racial-equity-in-criminal-justice-releases-2022-report/.

- Identify potential need for policy, legislative, and regulatory updates.
- State requirements of local models:
  - Data collection and reporting.
  - Local convening body.
  - Training and education.

> *"There are opportunities to build capacity of peer support specialists by increasing reimbursement rates, improve hourly rates, and provide career advancement paths."*
> *– PSS Focus Group*

Kentucky's existing co-response programs, as well as out-of-state programs recommended conducting research and outreach to successful programs in other jurisdictions to inform collaborative planning and implementation. A program in North Georgia outlined their experience setting up a co-response team: *Implementation of a co-response may take between one to two years in order to get the necessary buy-in, secure funding, and to setup the necessary infrastructure.*

> *"If in Kentucky, it's very difficult, I would say it's worth it. If it's a hard system to set up, it's worth it. If it requires some out-of-the-box thinking or some long hours. If it's more frustrating than it should be, it's worth it."*
> *– Out-of-State Program (Georgia)*

Element 2: Program Design

"A big piece of the program is really making those connections and building those relationships with law enforcement so that there's trust and understanding of what the response is going to be and really tailoring the response to law enforcement needs."

– Out of State Program (Colorado)

Co-response models are designed to operate on the local-level and offer solutions to address barriers, which impede optimal response to residents in behavioral health crisis. Local models and programs are designed and implemented in variations to meet the unique needs of residents of the community, while also taking into consideration the availability of resources. In general, stakeholders engaged echoed this sentiment by prioritizing barriers and opportunities specific to the region/community to better meet the needs of their local communities and residents served.[100]

Essential Element: Program Design

"The Planning Committee designs a specialized law enforcement-based program to address the root causes of the problems that are impeding responses to people with mental illnesses and make the most of available resources."

Kentucky Background and Findings

"Recognize police aren't needed for every call. Actively look for alternative responses to ensure callers are getting the most appropriate response."

– PSAP in Kentucky

Within Kentucky, police/first responder programs are offering alternative response to behavioral health crisis calls. This includes police-led co-response, diversion and deflection initiatives, PSW community-based policing, community paramedicine pilots, CIT, and QRTs. Existing co-response programs (Mt. Sterling/Pathways, Lifeskills/Bowling Green, and Breathitt/KRCC) have varying practices and operations.

Stakeholder Perspectives

The localized nature of co-response and the observed variability across the nation has given way to four types of approaches. The majority of stakeholders engaged have adopted a hybrid of response approaches, many including one primary type and one secondary type.

- **Primary Team.** A dedicated team consisting of an LEO or first responder, and a behavioral health resource that responds to an active behavioral health crises. Typically a permanent partnership.
- **Primary Resources.** Dedicated behavioral health or peer support resource(s) that can respond with any LEO or first responder in the community during an active behavioral health crises.
- **Secondary Follow-Up Team.** A dedicated team consisting of at least two resources (LEO, first responder, behavioral health, social worker, case manager, or peer support resources) that responds after the crisis is de-escalated.
- **Secondary Follow-Up Resources.** Dedicated behavioral health, social worker, case manager, or peer support resource(s) that conducts follow-up after the situation has been resolved. Can be done remotely or in person.

[100] https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/LE_Essential_Elements.pdf

Barriers

Co-response programs face increasing concern around behavioral health workforce shortages trending nationwide. **Existing co-response programs reported that finding "the right" behavioral health resource is often the most challenging barrier to address when designing a local program.** Hiring clinical resources can be difficult based on local resource constraints and the need to ensure the resource is an appropriate fit for the community. Other barriers include:

- Kentucky's behavioral health crisis providers and representatives from CMHCs reported that behavioral health professional shortages negatively impact delivery of timely services.
- A program in Colorado cited workforce-related barriers as a top concern, particularly in locating clinicians that are interested or willing to serve alongside law enforcement.
- Stakeholder cited that PSS would be ideal for co-response; however, few Kentucky communities have a well-staffed peer support program, and those that do are largely SUD-focused.
- All existing co-response programs engaged recognized the professional differences between law enforcement/first responder and behavioral health culture.
- Many clinicians may be hesitant to join a co-response team as it would require responding to potentially unsafe situations.

Stakeholder-Driven Recommendation

Increase use of bachelor-level health staff, particularly students of graduate programs, to fill gaps in local workforce; however, it is questionable if they are trained and qualified.

- The majority of out-of-state co-response programs embed a behavioral health professional that is a full-time employee of the police department or municipality. However, many of the models engaged referenced contracting resources from their local, community-based facility during initial pilot.

All of the stakeholder types engaged recognized that some populations are less apt to seek behavioral health care, particularly black, indigenous, and people of color (BIPOC), LGBTQ+, and unhoused. According to both advocacy and peer support stakeholders, seeking behavioral health services in the United States is difficult for many cultures and is no different in Kentucky. Historically, the cultures of African American and Latinx communities have discouraged focus on behavioral matters, often creating barriers to seeking treatment. Stakeholders representing Kentucky's Health Care Association discussed issues specific to individuals in the LGBTQ+ community accessing services, such as the systemic barriers in general, as well as challenges related to many providers being ill-equipped to address their concerns. Individuals who are unhoused tend to have unique issues, such as stigma and discrimination from the community. There is a prevalence of co-occurring mental health and SUDs. Behavioral health inequity is a major contributing factor to barriers of access and impacts to crisis services.

- Rural versus urban communities: Transportation is an issue and tends to look different in urban versus rural. It impacts people getting timely access to care, often leading to crisis. Individuals living in severe poverty is an issue particularly in Appalachia.

"Barriers exist from the system itself to the cultures that the individual may live in."
– Kentucky PSS

- The COVID-19 pandemic and natural disasters (e.g., tornadoes and flooding) have created unique needs for individuals who were affected, such as PTSD and lack of access to services.
- Kentucky's CMHCs have observed that most LEOs have minimal knowledge or capacity to assist individuals in behavioral health crisis.
- Justifying co-response may be a challenge in rural geographies, particularly if services are only needed a few times a week. Rural areas experience difficulty implementing crisis services due to lack of volume and resources.

"It depends on where you live in Kentucky. There are certain regions of Kentucky that the education system is very quick to call the police, which escalates and so many of those young people might end up going through juvenile justice. And in some other areas, it might be more about child welfare. You know, a lot depends on who your child welfare worker is, some of them are told what services they have to get and where they have to go, so they really don't get to choose even though they're supposed to."

– Peer Support Association in Kentucky

Lessons Learned from Other Community Co-Response Programs

BJA's Police-Mental Health Collaboration (PMHC) Toolkit states that effective co-response programs are defined by collaborative partnerships with law enforcement agencies, mental health providers, and other complementary community-based entities to produce better outcomes for consumers, officers, and agencies. The goal of each local program should be to create positive change for law enforcement, communities served, and their residents. The toolkit outlines the variation of program design on the local level.[101]

"There is no one 'right' type [of PMHC program]. Agencies need to first assess their community's needs and resources to determine which type [of co-response program] is most appropriate. That is, some agencies incorporate elements of different approaches into their programs, such as relying upon CIT officers or generalists and augmenting them with co-responder or mobile crisis teams."

– BJA PMHC Toolkit

Verified by research in a national scan of existing programs, and echoed in stakeholder engagement, design of a local co-response program varies and will depend on the community's needs and available resources. Flexibilities exist in co-response practice and component design; however, in general, programs meet the following as defined by BJA:

> *Working as a co-responder team, a specially trained officer and a mental health crisis worker respond together to mental health calls for service. By drawing upon the combined expertise of the officer and mental health professional, the team is able to link people with mental illnesses to appropriate services or provide other effective and efficient responses. The most common approach is for the officer and crisis worker to ride together in the same vehicle for an entire shift, while in other agencies, the crisis worker meets officers at the scene and they handle the call together. Co-responder teams can respond throughout the entire jurisdiction, or they work in areas with the greatest number of mental health calls.*[102]

In Practice: In Colorado, each community implements co-response differently. Some have a dedicated team of officers and behavioral health specialists who respond to emergency calls during their shifts. Others deploy a behavioral health specialist to a scene if an officer requests their assistance. Any time a co-responder is deployed—either as first response or in response to a request for help—it is considered an on-scene response call in the co-responder vocabulary, and services provided are considered on-call services.

Opportunities

Throughout the engagement, stakeholders emphasized the importance of positioning co-response as a solution to barriers within local behavioral health crisis systems. Stakeholders both within Kentucky and across the nation confirmed that response types within co-response models often vary depending on the needs of the community and availability of resources. **Many agencies reported that their effort to adopt co-response started with an evaluation of data, leading to the design of a program based on local need.**

"Rather than mandating a single policy then providing different options. Give them liberty to tailor the program that best fits their community/county."

– PSAP in Kentucky

- A PSW program in Kentucky based their program on results from research concluded in 2016 that investigated mental health-related 911 calls in the state. Sixty-seven percent of the calls were non-emergency social service related.

[101] https://bja.ojp.gov/program/pmhc/learning.
[102] https://bja.ojp.gov/program/pmhc/learning#gowafd.

- During an interview, a North Georgia LEO outlined how a 2017 research study looking for ways to improve outcomes for citizens identified the opportunity to incorporate a mental health resource on the team.
- Existing programs navigate limited behavioral health resources by determining co-response availability based on high call volume times. The majority of the teams are available Monday through Friday starting in the late morning to the evening (e.g., 11:00 a.m. to 7:00 p.m.).
- Representatives of a paramedicine program in Kentucky outlined how their program evaluated data from behavioral health responses to enhance their program and advocate for updated regulations.

Stakeholders expressed that "meeting the unique needs of the community" may evolve over time, but many successful programs allocate resources to address health equity of local residents. **Many existing programs, both within Kentucky and across the nation, ensure equitable behavioral health crisis response through partnerships, training/education, and community outreach.**

- Local behavioral health programs recommend municipalities interested in implementing a co-response program should evaluate local, community-based supports and their ability to service historically underserved populations.
- Colorado requires all co-response programs that receive funding from their behavioral health administration to establish a steering committee for local governance and oversight which helps with community buy-in.
- Kentucky's PSS community agreed that parents of children with serious emotional disturbance often have negative experiences with law enforcement during their child's behavioral health crisis. They recommended incorporating scenario-based training for co-responders on how to interact with parents during a child's crisis.

> *"I really see a lot of value in community mental health centers and community-based clinics for holistically caring for patients in an integrated health care type of way."*
>
> *– Healthcare Association in Kentucky*

Element 3: Specialized Training

"Ideal crisis response program should have training on behavioral health issues for every law enforcement agency. Understand that there is a level of intimidation from police officers."

– Kentucky Behavioral Health Crisis Provider

Law enforcement personnel responding to incidents involving individuals with suspected behavioral health conditions and/or behavioral health crisis receive dynamic and comprehensive training, often provided through specialized programs. Additionally, dispatchers, call takers, behavioral health co-responders, and support staff receive training tailored to their needs within the scope of co-response. Through effective training, officers learn to identify signs and symptoms of mental illness, how to utilize a range of stabilization and de-escalation techniques, and they learn about disposition options, community resources, and legal issues. Within the PMHC Toolkit, the BJA outlines core components of a robust and comprehensive training program for co-response:[103] [104] [105]

Essential Element: Specialized Training

"All law enforcement personnel who respond to incidents in which an individual's mental illness appears to be a factor receive training to prepare for these encounters; those in specialized assignments receive more comprehensive training. Dispatchers, call takers, and other individuals in a support role receive training tailored to their needs."

- **Peers and Families Training.** LEOs hear stories from people and their family members who have personally experienced a mental health crisis. A perspectives panel is an opportunity for officers to gain a deeper understanding of mental illness and the experience of responding to and interacting with a person living with an SMI in crisis.
- **CIT Training.** Extensive 40-hour curriculum taught over five consecutive days. Materials emphasize understanding mental illness and incorporates communication skills, practical experience, and role playing.
- **MHFA for Public Safety.** Eight-hour course designed for LEOs, first responders, corrections officers, 911 dispatchers, and other public safety professions. It teaches a five-step action plan which includes skills, resources, and knowledge to help individuals in crisis connect with appropriate professional, peer, and self-help care.
- **Recruit Academy Training.** Agencies should recognize that because all their officers respond to mental health calls, they need specialized training, knowledge, and skills to respond appropriately.
- **In-Service and Roll Call Training.** Provide law enforcement agencies with opportunities to convey new policies and tactics to officers, refresh knowledge, and reinforce skills learned in previous trainings. Roll call trainings must exist alongside a more comprehensive and robust program to be effective.
- **Special Topics and Information to Customize Training Programs Pathways to Justice, a National Curriculum for Criminal Justice Professionals on Intellectual and Developmental Disabilities.** A comprehensive, community-based training program provides critical information about people with I/DD to three primary audiences (law enforcement, legal professionals, and victim service providers). Pathways is available at no cost to law enforcement agencies and district attorneys' officers and contains six modules, three of which are profession specific.

[103] https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/LE_Essential_Elements.pdf.
[104] https://bja.ojp.gov/program/pmhc/training.
[105] https://thearc.org/our-initiatives/criminal-justice/pathway-justice/.

Kentucky Background and Findings

"In an ideal system, citizens would be aware that there are highly-trained specialty officers equipped to respond to complex behavioral health emergencies, citizens wouldn't be afraid to call the police during a behavioral health crisis."
– Kentucky LEO

CIT Training Findings

- Most states have regulations outlining statewide CIT training requirements, including curriculum and cadence of continuing education.
- While CIT training does not define co-response, the majority of law enforcement and first responders acting as a co-responder are CIT training certified.

LEOs in Kentucky receive training through Kentucky's Police Academy Training managed and provided by the Justice and Public Safety Cabinet, and the Department of Criminal Justice Training. In 2023, updates to the training program included "improvements to standard classroom training and online course options." More than 2,000 seats were made available for online in-service training for the year 2023.[106]

LEOs looking to receive additional training on responding to individuals in crisis relating to behavioral health may take courses to become crisis intervention certified. CIT training is a specialized training program designed for LEOs and first responders. Crisis intervention officers are trained to create connections between law enforcement, first responders, mental health providers, and work with the individual's natural supports, as needed. Kentucky Statute 210.365 outlines the CIT training curriculum.

- The objective of this training is to train LEOs and first responders to effectively respond to individuals who may have mental illness, SUD, I/DD, or dual diagnosis.
- The training is intended to reduce injuries, inappropriate incarceration, and liability, while improving risk management practices.
- Through collaborative community partnerships and intensive training, CIT training improves officer-to-individual communication and identifies mental health resources and social service supports for those in crisis, while ensuring officer and community safety.

Kentucky's PSAP telecommunicators receive 160 hours of training upon onboarding through the Public Safety Dispatch Academy. Additional trainings are made available through Kentucky's Police Academy, designed for telecommunicators to better understand issues around behavioral health.[107] Some of these trainings include cultural awareness, suicide caller, and barricaded subjects.

Kentucky's stakeholders provided additional insight into trainings available to law enforcement and first responders:

- Thirteen out of 14 of Kentucky's CMHC regions have active CIT training programs.[108]
- An existing co-response program in Kentucky is seeking to establish a partnership with the Coalition of Underserved to create a local law enforcement Behavioral Health Crisis Training Series.
- Kentucky State Police troopers are crisis intervention trained, but some troopers also receive FBI Crisis Negotiation training for high-risk crisis scenarios (e.g., hostage negotiation).
- A PSW program in Kentucky currently accepts one college student intern interested in the field to ride along for a hands-on learning experience.
- To alleviate some training issues, some local programs conduct smaller crisis, behavioral health, or social service trainings to local programs. Pathways and the Alexandria, Kentucky PSW help conduct smaller trainings, when possible.

[106]https://static1.squarespace.com/static/5c6ff8fe704680322ef00e02/t/6386013fcfbdfc639f2faf1d/1669726528980/2023-Course-Schedule-Book.pdf.
[107]https://static1.squarespace.com/static/5c6ff8fe704680322ef00e02/t/6386013fcfbdfc639f2faf1d/1669726528980/2023-Course-Schedule-Book.pdf.
[108] Kentucky CMHC Annual Crisis Services Compilation Documents, SFY2022.

Stakeholder Perspectives

Stakeholders emphasized the importance of CIT training for police departments and co-response programs, but recognize barriers and challenges that continue to exist in both obtaining certification and topics within the course curriculum.

> *"I'd like to see, for officers who may or may not be crisis intervention trained and even myself, more information and literature on new techniques, or maybe findings, that we could use to refresh training."*
>
> *– Crisis Intervention-Trained LEO in Kentucky*

Barriers

Kentucky stakeholders noted barriers related to trainings and recognized that there are opportunities to improve behavioral health crisis response.

- Law enforcement in Kentucky recognize the benefits of CIT training to officers, but also report barriers to officers obtaining certification due to the one-week training requirement.
- Crisis intervention certification is often cost-prohibited to smaller agencies in Kentucky, particularly in rural areas.
- Kentucky CMHCs observe that even with widely available CIT training, there is an opportunity for LEOs to increase their knowledge and capacity required to respond to behavioral health crisis scenarios.
- Health care associations expressed potential benefit in providing LEOs and EMS with educational resources around 988 that address common misperceptions in the community and to better prepare responders to promote benefits of the behavioral health crisis line.
- Health care associations recommended increased education to build awareness on veteran's behavioral health struggles, reduce stigma on LEO and first responder mental health, and should include MHFA.
- Representatives from Kentucky's PSS workforce expressed concern that law enforcement continues to inadvertently "blame" parents/caregivers for their child's behavior during a crisis. They recommended this could be addressed through increased training on stigma and appropriate communication with parents.

The Case for Sensory-Inclusive Training

- One in six individuals in the U.S. have a sensory need.
- People with invisible disabilities tend to react differently and get overwhelmed more easily than neuro-typical individuals due to various sensory sensitivities.
- Communication challenges can present increased opportunity for confusion, actions that can be misinterpreted, and escalate emergency situations.
- Behaviors include avoiding eye contact, being unsteady on their feet, appearing agitated or pacing, not complying with directions, and being sensitive to touch.

Lessons Learned from Other Community Co-Response Programs

> *"The officers were really crying for help. Like help me deal with these calls because I just don't have the training. You've been training me for 20 years to be a cop and now you're putting me here in front of this. Give me the tools like you give me all these tools, all this training. I need help."*
>
> *– Arlington, MA*

Many co-response programs require supplemental training for co-responders to address gaps in standard crisis intervention programmatic training. Specialized supplemental trainings reported include:

- MHFA is a commonly cited supplemental training for crisis intervention trained officers and co-responders.

- In North Carolina, the Buncombe County Sheriff's Office requires co-response officers to spend a full shift shadowing community mental health workers, in addition to 40 hours of CIT training, in order to better understand the impact of mental illness and the surrounding stigma.[109]
- In Austin, Texas, co-location of 911 and 988 lead to the creation of a hands-on collaborative training of 911 staff and LEOs on use of inclusive and person-first language. The training resulted in a staff-wide shift from scripts like "Are you bipolar?" to "Have you ever received a diagnosis of bipolar disorder?"[110]
- In 2021, Utah signed SB47, *Statewide Mental Health Crisis Intervention Council and Autism Training for LEO,* into law. The law requires police officers to go through training to learn how to better interact with people on the autism spectrum.[111] This is in addition to other crisis intervention required trainings.
- In Salt Lake City, both LEOs and social workers are required to complete CIT training which provides the social worker with perspective of how an LEO would respond.
- Yavapai County, Arizona recommends utilizing crossover trainings with law enforcement and behavioral health professionals to improve practice among crisis responders. Upon implementation of a crossover training program, law enforcement reported increased confidence in responding to individuals with behavioral health, and behavioral health providers reported improved ability to address safety concerns in the field. Both reported greater understanding for the counterpart's perspectives.

Opportunities

> *"Integration of training on SUD concerns, homelessness, and SDOH-related issues in the model for a patient-centered approach."*
>
> *– Kentucky EMS Stakeholder on Training Needed for Successful Co-Response*

Co-response programs are intended to meet the unique needs of the community. **Stakeholders from out-of-state programs commonly recognize that "what works for one town, might not work for your town." Given the variability of co-response models, training programs must also adapt to meet the unique needs of residents served.** This includes supplemental training for law enforcement, but also considers training for 911 staff, dispatchers, behavioral health resources, and in some cases, residents of the community.

- Representatives from Kentucky's law enforcement, first responder, and peer support workforce noted from their experience, social workers may benefit from additional training centered on resources and support options available for children and families specific to local communities.
- Kentucky's advocates and peer supports recognized the need for training and education that communicates both structural and cultural barriers LGBTQ+ and racial minorities face when seeking mental health care.
- Kentucky's homeless population accounts for a considerable portion of mental health crisis calls. Stakeholders recommended relationship building and appropriate placement training for crisis teams specific to local supports available for homeless individuals.
- Many police-mental health programs, both within and outside of Kentucky, incorporate behavioral health resources (i.e., PSWs, case managers, peer supports, and licensed clinicians) on the police radio frequency in an effort to ensure individuals receive the best available response. Behavioral health resources within these programs receive training around "civilian use of police radio frequency."
- Stakeholders representing Kentucky's peer workforce are looking for a state-approved standardized PSS curriculum to ensure consistency across the Commonwealth.

[109] https://www.buncombecounty.org/governing/depts/justice-services/councils-advisory-groups/coordinated-community-response.aspx.
[110] https://www.austintexas.gov/edims/document.cfm?id=302634.
[111] https://www.sltrib.com/news/2021/04/09/slc-first-responders/.

Element 4: Call-Taker and Dispatcher Protocols

"You never know what situation you're going into as law enforcement."
– Kentucky Crisis Intervention-Trained Officer

PSAPs play an essential role in the co-response continuum, thus, partnership and coordination are imparative to ensure individuals are receiving the appropriate response. Guidelines from BJA outline the steps that should be taken when a 911 call taker receives a request from a call involving a suspected behavioral health issue:[112]

Essential Element: Call-Taker and Dispatcher Protocols

"Call takers and dispatchers identify information to direct calls to the appropriate responders, inform the law enforcement response, and record this information for analysis and as a reference for future calls for service."

- Gather descriptive information on the person's behavior.
- Determine whether the individual appears to pose a danger to themselves or others.
- Ascertain whether the person posesses or has access to weapons.
- Ask about history of mental health or substance abuse treatment, violence, or victimization.

Kentucky Background and Findings

In Kentucky, individuals who experience a behavioral health crisis, or their family or friends reach out for assistance on their behalf, typically call 911 or 988 emergency lines. PSAPs answer those calls and triage to the most appropriate responder for the crisis, such as LEOs, EMTs, or where available, co-response teams or MCTs. There are 116 PSAPs in Kentucky which answered over 3.5 million calls in FY 2022.[113] The 911 Services Board has oversight of the PSAPs and ensures that the reporting requirements are followed. Notably, the 911 Services Board does not have authority, through statute or regulation to enforce policies which result in each PSAP having their own unique policies and procedures. However, the 911 Services Board is working with a statewide coalition to develop a framework for statewide policies.

Within Kentucky, the Owensboro PSAP has established a formal partnership via a Memorandum of Understanding (MOU) with the River Valley Behavioral Health CMHC to refer 911 behavioral health calls to 988 and support dispatch of MCTs rather than dispatching LEOs. This could possibly be accomplished successfully in other regions. Working with the local PSAP/911 and local crisis call lines is a necessary step to create triage process to enable co-response teams to respond and to coordinate with MCTs when available within the community.

Seven Counties reported currently having triage workers located in the 911 call center. The triage workers transfer calls to their crisis care workers and have the option to have a police officer accompany them.

While co-response programs are typically dispatched through 911, there is overlap and lessons learned from 988 CCCs that may be applicable to behavioral health related 911 calls. For 988 callers, stakeholders reported that:

- Most callers prefer to remain anonymous.
- The launch of 988 has increased CMHCs' uptake of people calling to find resources for behavioral health.
- Children and youth are more likely to call 988 than a traditional 911 emergency line.
- There has been an increase in crisis calls from youth.

[112] https://bja.ojp.gov/program/pmhc/learning/essential-elements-pmhc-programs/4-call-taker-and-dispatcher-protocols
[113] https://homelandsecurity.ky.gov/About/PublishingImages/Pages/Annual-Reports/2022%20KOHS%20Annual%20Report.pdf.

- Youth callers frequently do not want their parents involved. Triage workers respect their wishes unless there is a risk identified.
- Callers should ensure individuals calling a crisis line do not feel stigmatized for calling in. This would prevent them from calling in again, if needed.

Stakeholder Perspectives

Barriers

Kentucky stakeholders identified several barriers for the triage and dispatch process related to co-response programs:

- The consensus was that "spotty" coverage of behavioral health services (i.e., available only during certain hours or days per week) is not adequate to serve the needs of Kentuckians in crisis.
- Co-response teams will not typically respond to situations where there is active violence or major safety issues.
- Information received from dispatch can be unreliable which may result in inappropriate resources responding for the situation or even further escalation of the situation.
- Often, parents of children with behavioral health challenges refrain from calling in the future if they have a negative experience with a crisis call.
- As noted by peer supports, there may be hesitation from some individuals and families to utilize 911 during a crisis as they may have had negative experiences in the past.

PSAP Barriers

- The 911 services have no authority to develop statewide policies.
- Within Kentucky PSAPs, data about what happens after the call is not tracked, and limited personal information on the caller is captured, which may make it difficult to link calls to responses and services provided to individuals.
- PSAPs within Kentucky may have hesitation in leveraging co-response teams as they be resistant to changing their protocols, and some have even voiced favoring dispatching MCTs rather than utilizing a co-response team.

Lessons Learned from Other Community Co-Response Programs

Existing co-response programs have made strides in ensuring dispatch of appropriate response services through implementation of call-taker and dispatcher protocols that complement police-mental health response. Examples of practices vary, but include statewide behavioral health crisis triage frameworks, embedded behavioral health professionals within 911 centers, co-location of PSAP/911, and citizen use of police radios.

- Virginia was the first state to implement a statewide behavioral health crisis triage framework, standardizing triage in both PSAP and 988 call centers.[114]
- Since co-locating their 911 and 988 call centers, Austin, Texas has seen an increase in diversion, de-escalation, and collaborative efforts between staff (behavioral health, 911 call takers, and police). It was additionally reported that co-location has resulted in a natural shift in inclusivity, adoption of person-first language, and reduced stigma.[115]
- Increasingly, 911 call centers are moving toward adopting call options like "press 1 for police, 2 for fire, 3 for ambulance, and 4 for mental health."[116]
- Georgia is currently working toward embedding behavioral health resources in 911 call centers across the state.

[114] https://talk.crisisnow.com/virginia-develops-statewide-911-call-matrix-to-divert-mental-health-and-substance-use-crises/.
[115] CrisisTalk Article: Austin's 911 Call Center Integrates Mental Health Call Crisis Diversion (June, 1, 2021).
[116] https://talk.crisisnow.com/911-must-be-part-of-the-988-conversation/

Model Spotlight: Statewide Behavioral Health Triage Framework

In response to a fatal police shooting of a Richmond resident experiencing a behavioral health crisis, Virginia developed the Marcus Alert system to provide clear 911 protocols that divert people in mental health, substance use, or developmental disability crisis from a law enforcement response. While local and regional 911 call matrices have been successfully implemented to triage behavioral health calls (for example, Austin, Texas and Tucson, Arizona), Virginia's Marcus Alert program boasts the first statewide matrix to standardize protocols in their 911 call diversion system. **These protocols include the following provisions: the majority of 911 behavioral health call divert to the 988 system; regional behavioral health mobile crisis hubs and law enforcement have formal agreements; and law enforcement agencies have a specialized response to behavioral health calls.** The Marcus Alert system is made up of four risk levels for standardized triaging:[117]

- **Level-1 Routine.** 911 call centers triage to regional 988 call centers for phone intervention with a trained behavioral health professional with referral for in-person or in-clinic services within 72 hours.
- **Level-2 Moderate.** 911 call centers triage to regional 988 call centers. 911 operator recommends in-person intervention for calls triaged at a Level 2. Regional call centers or mobile crisis hubs dispatch an MCT.
- **Level-3 Urgent.** Nuanced approach. Consider specialized populations (e.g., I/DD, youth, etc.) to ensure people get the response they need, not necessarily a default law enforcement dispatch. Specialized behavioral health teams often respond to Level 3 with a police team staged nearby (but out of sight) in case they are needed.
- **Level-4 Emergent.** Requires dispatch of EMS or police. Calls triaged level 4 typically indicate there is an active suicide attempt, an assault, or a present and accessible weapon. Behavioral health team is staged nearby, so when EMS or law enforcement deem a scene safe and stable, the behavioral health team may get involved.

Opportunities

Co-response programs require standardized triage protocols at the local level to ensure the appropriate resources are deployed.

- Through the 911 Services Board there may be an opportunity to provide different options or best practices to fit the needs of the community the 911/PSAP serve.
- Identify PSAP champions for co-response and MCT dispatch which would help to support the improved crisis care continuum and reduce reliance upon law enforcement and EMS for behavioral health situations.
- Successful co-response programs rely upon a well-defined triage and dispatch protocol that aligns to local priorities and available resources.
- An analysis of 911 data should be conducted at the local level to determine community needs and available resources which would help inform dispatch and triage protocols.

[117] https://talk.crisisnow.com/virginia-develops-statewide-911-call-matrix-to-divert-mental-health-and-substance-use-crises/.

Element 5: Stabilization, Observation, and Disposition

"Patient outcomes are just going to be much better if we get them taken care of right away versus just shuffling down the line and they just don't get that care."

– Kentucky Behavioral Health Association

In practice, co-response teams resolve responses to people with mental illnesses safely, and when appropriate, link to behavioral health supports and services to reduce the likelihood for future encounters with the criminal justice system.[118]

Essential Element: Stabilization, Observation, and Disposition

"Specialized law enforcement responders de-escalate and observe the nature of incidents in which mental illness may be a factor using tactics focused on safety. Drawing on their understanding and knowledge of relevant laws and available resources, officers then determine the appropriate disposition."

While it is not an officer's job to diagnose, it is critical they are aware of the different types of disabilities people may have and consider how it is impacting the situation. Awareness can lead to better outcomes for everyone when trying to talk to or work with people with disabilities. Providing individuals with connections to the right types of services and supports can decrease criminal justice involvement.[119]

Kentucky Background and Findings

Today, Kentuckians benefit from the existing co-response that offers an alternative response to behavioral health crisis. Through PSWs and CPPs, individuals receive follow up post-police encounter with recommended referral/connections and diversion support for the individual and potentially reduce future encounters with law enforcement, EMS, and medical professionals. The CPPs have been successful with at-home and/or community-based care for non-emergent medical situations to reduce the number of patients in hospital EDs and the number of readmissions after a patient is discharged. Diversion and deflection through the primary co-response programs (Mt. Sterling and Bowling Green) addresses high utilizers of services and connecting them with community-based behavioral health services. MCTs operated through regional CMHCs often have MOUs with local law enforcement. A commonly cited purpose behind these MOUs is for the benefit of safety.

Other programs within Kentucky can also support the crisis care continuum or be integrated into co-response programs.

Stakeholder Perspectives

Barriers

"Sometimes the people that need help the most don't get it right off because somebody else is ahead of them and it gets a little frustrating because, you know, families want these people to get help and they get a little discouraged and upset."

– Kentucky Crisis Intervention-Trained Officer

There are differing opinions on what the ideal crisis response would look like: law enforcement de-escalates and secures the scene before other resources are engaged, a joint response with law enforcement and a behavioral health professional, or a behavioral health professional only response. A recurring theme among law enforcement was the concern for escalation prior to arrival and the need to ensure safety of all individuals at scene. Stakeholders reported several barriers regarding providing stabilization.

[118] https://bja.ojp.gov/program/pmhc/learning/essential-elements-pmhc-programs/5-stabilization-observation-and-disposition
[119] https://bja.ojp.gov/program/pmhc/infographic-2.

- Many LEOs reported their experiences where they go into a response with information from the dispatcher and arrive to an escalated scene. Depending on the type of response dispatched, the situation may escalate even further (e.g., MCT, co-response, LEO, EMS).
- LEOs are responsible for the safety of their unit, the individual, and EMS/fire during a response. It was noted that for high-risk responses having a behavioral health professional would greatly increase the burden on the LEO.
- Primary co-response is not ideal for high-risk behavioral health calls due to safety. Example scenarios given include, but not limited to: hostage situations, active self-harm or harm of others, and public display of lethal weapons. During these scenarios, it was recommended that the best solution would likely be a secondary response or an MCT staged outside the range of danger.

> *"The safe space of a mental health facility versus on the road where it's unpredictable. You know, we're stopping to talk to somebody on the sidewalk like you said, we get a suspicious person on the sidewalk. We go talk to them turns out they're in mental health crisis. There's so much more that could go on. The environment is not secured. Whereas once we've got them into a mental health facility we can control that environment, it's safer for the mental health professionals and for the consumer, everyone involved. Even if that controlled environment is a mobile unit, we can make that mobile unit a controlled environment. But it has to be once we've stabilized the situation to the extent of there are no weapons and this person is being reasonable."*
>
> *– Former Crisis Intervention-Trained FBI Crisis Negotiator Officer in Kentucky*

Additional barriers reported by stakeholders included lack of community-based supports for officers to leverage, limited availability of diversity in the public safety workforce, and competing professional priorities.

- Rural communities have limited access to behavioral health resources and related crisis services in general. Stakeholders cited this as a contributing factor to repeat calls for service.
- Within Kentucky, the law enforcement, first responder, and behavioral health workforces have limited diversity and can make it difficult to engage individuals of BIPOC.
- A female officer reported being called to crisis scenes when a female individual refuses to talk to the men on scene. Lack of gender diversity for high-risk crisis work may lead to added stress on the officers and individuals served.
- EMS response to behavioral health crisis situations can vary based on the local area. Typically, the main objective is to de-escalate the situation and then transport the individual to the next level of care, when necessary, which is typically the ED.

Lessons Learned from Other Community Co-Response Programs

Most co-response teams (with primary response approach) have the goal to de-escalate the situation, identify follow-up services, and transport the individual to those services, when possible.

- Some programs take a more holistic approach to ensure crisis response and de-escalation includes addressing the "root cause" of the crisis, which in some cases may include SDOH.
- Many established programs across the country boast an integrated crisis response system with coordination and collaboration between co-response teams and MCTs.
- Some local police departments integrate street outreach and/or homeless outreach teams within their CRU.
- An EMS-run mobile behavioral health unit in Colorado keeps a two-day supply of inventory on board. Example of supplies includes water, food, clothes, blankets, baby supplies (e.g., diapers and formula), and hygiene products.
- Programs are evaluating increasing staffing of PSS resources for improved de-escalation.

Peer-Centric Co-Response in Olympia, Washington

Peer outreach is the backbone of the crisis response unit of Olympia. Individuals in crisis are referred by law enforcement and community members, but in specific areas of the city with a crisis response unit, team members are able to provide a real-time response to crisis. CRU implemented a layered approach to crisis response. Since the program often focuses on immediate response and care, it will often refer individuals who have frequent contact with the program to Familiar Faces, a peer-run post-crisis program within the police department.[120]

Community engagement and collaboration is a stated priority of the Olympia Police Department. Members of the CRU spend much of their time building relationships with community members and organizations to establish meaningful connections and better understand their needs. The CRU distributes regular surveys with law enforcement officials to gain perspectives on the strengths and weaknesses of the program. The team is present every day at the City of Olympia-sanctioned encampment for people experiencing homelessness, working to build relationships, and better understand the challenges and how to best support them.[121]

Opportunities

The stakeholders provided recommendations and opportunities to improve crisis services.

- Co-response teams may receive a better response to the community if they utilize unmarked cars and civilian clothes.
- For youth, school systems are often the first place where behavioral health issues are encountered. There is an opportunity to increase awareness and training related to available behavioral health crisis services.
- Law enforcement and other first responders may need more training that addresses stigma and the challenges families face when a family member have an SMI or SED.
- Kentucky has done a good job in mobilizing behavioral health and other resources to address natural disasters and other emergency events in local communities. The responses could be leveraged to enhanche behavioral health crisis continuum.

[120] https://csgjusticecenter.org/publications/expanding-first-response/program-highlights/olympia-wa/.
[121] Ibid.

Element 6: Transportation and Custodial Transfer

"Transportation is an issue and tends to look different in urban and rural settings. It impacts people getting timely access to care and leads to crisis. Individuals living in severe poverty is an issue, particularly in Appalachia."

– Healthcare Association Kentucky

During a co-response encounter and after de-escalation and disposition, transportation to a facility equipped to provide necessary care is often required.[122] Depending on the scenario, this may be the traditional law enforcement and first responder transport to jail/arrest and hospital/ED, or a lesser restrictive facility like crisis living room, residential treatment facility, crisis stabilization, or respite.

Essential Element: Transportation and Custodial Transfer

"Law enforcement responders transport and transfer custody of the person with a mental illness in a safe and sensitive manner that supports the individual's efficient access to mental health services and the officer's timely return to duty."

Kentucky Background and Findings

Regardless of the responding entity (law enforcement, first responders, or behavioral health professionals), there may be a need to transport or refer an individual who is in crisis to additional services. As behavioral health resources are limited across Kentucky and there is limited awareness of alternative or community-based programs the default in many communities is to refer individuals to EDs, hospitals, or jails. Additionally, current policies and processes in local communities typically default to these higher level of services which may not always be appropriate for the individual.

CPP Lexington

Working on a pilot program with the University of Kentucky to open up diversion of suicide calls transportation via EMS to Eastern State Hospital and Good Samaritan instead of being limited to local hospital EDs.

Some co-response programs such as Mt. Sterling have protocols in-place to transport individuals to the next level of care for appropriate services such as crisis stabilization. Teams transport to crisis stabilization units, 28-day programs, or residential SUD treatment facilities, when necessary. However, regulations in Kentucky present unique challenges.

KRS 202A.0813 includes transportation and examination of petition respondent for court-ordered evaluations.[123] The court may order that the LEO transport the respondent to a hospital or site designated by the cabinet so the respondent shall be examined without unnecessary delay by a QMHP. The LEO may authorize an ambulance service designated to transport the person to a hospital.

Kentucky Administrative Regulations (KAR) outlining Non-Emergency Medical Transport (NEMT) do not specifically mention behavioral health or behavioral health crisis. 907 KAR 3:066[124] outlines the following requirements for NEMT: a) the recipient is traveling to or from a Medicaid-covered service; b) the service is determined to be of medical necessity; and c) free transportation is not available. 907 KAR 1:060 outlines requirements for whether an individual meets the criteria for "medical necessity:"

- Medicaid members' medical condition requires transport by a stretcher.
- Medicaid member is traveling to or from a Medicaid-covered service.
- The service is the least expensive available transportation for the recipient's needs.

[122] https://bja.ojp.gov/program/pmhc/learning/essential-elements-pmhc-programs/6-transportation-and-custodial-transfer
[123] https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=46748.
[124] https://apps.legislature.ky.gov/law/kar/titles/907/003/066/.

NEMT services, within the current administrative regulations, are often unrealistic for use within the behavioral health crisis system due to the process requiring advance scheduling. Services are scheduled during office hours and requests must be submitted 24 to 72 hours in advance, depending on the transportation provider.

Stakeholder Perspectives

"We'll take them to Eastern State Hospital, our go-to for transporting people who are a danger to themselves or others. And the problem is we take them there and then <they> release them right away. Then they go back to doing the same thing."

– Kentucky Crisis Intervention-Trained Officer

Barriers

According to stakeholders in Kentucky, transportation is among the top barrier to the provision of community-based behavioral health crisis services across the board. Police and first responders typically complete services by transporting individuals to the nearest available location such as a hospital, ED, or jail even if other services may be more appropriate. This is, in part, due to regulations, the need for officers to get back to patrol for other service calls, and limited availability of nearby alternative resources.

Given the frequent history of traumatic experiences among people with mental illnesses, custodial restraints may create acute stress, which, in turn, may escalate their degree of agitation. Local programs may identify the need to collaborate with state-level oversight to review policies regarding restraints in custodial situations and balance considerations of officer and citizen safety with the impact of these controls on people with mental illnesses.

– The Essential Elements of a Specialized Law Enforcement-Based Program

Specific barriers identified related to transportation and transfer include the following:

- On the state-level, Kentucky does not currently permit EMS (advanced life support and basic life support) to transport to "alternative destinations." Many EMS agencies do not receive reimbursement unless transport to hospital ED is initiated and completed.
- Police may lack the ability to transport to a variety of behavioral health facilities, or they have limited awareness of the community-based supports available to individuals served.
- Behavioral health providers in Kentucky report EMS being unwilling to respond to and/or transport behavioral health clients when the call did not originate in an EMS dispatch. It is suspected that this is due to stretcher criteria or medical necessity.
- When transporting individuals to a mental health facility, the ambulance must wait until a doctor has released the ambulance after examination, which could result in an eight-hour turnaround time.
- In rural areas of Kentucky, transporting individuals to mental health beds could take two to four hours for a round trip, which is a significant amount of time and reduces the ability to respond to other emergencies.
- Police-led co-response programs in Kentucky report continued use of restraints for transportation of individuals who received a behavioral health response to the next level of care. These transports often occur in a traditional police vehicle.
- Response and transportation to appropriate services may be limited based on regulations which stipulate where EMS can send individuals. This may result in unnecessary ED utilization as sometimes this is the only legal option to transport an individual.

Lessons Learned from Other Community Co-Response Programs

Transportation related to behavioral health services is a challenge for other states as well, but they have taken steps to mitigate some of the barriers. Many police-led or managed co-response programs outfit their behavioral health units with response vehicles that also function for transport. Commonly referenced vehicle descriptions include

unmarked fleet vans or plain white SUVs with a plexiglass partition between the front seat and back seat sections.[125] Increasingly, programs are beginning to discuss whether co-response teams should adopt protocol limiting use of restraints.

- In Denver, Colorado, the EMS-run co-response team, referred to as the Emergency Response Team (ERT), rides in the Support Team Assisted Response (STAR) Fleet. The vehicles are fleet vans able to transport to short-term stabilization, drop-off centers, or mental health day cares, and are supplied with inventory to address clients' SDOH needs.[126]
- The Madison County, Tennessee co-response program ran a pilot for mental health transport units. The pilot resulted in statewide adoption of mental health transport units consisting of an emergency medical responder riding in a specialized van with a non-uniformed sheriff's deputy in order to safely transport all people being brought in for an involuntary mental health assessment or hold.[127]
- Harris County, Texas implemented a virtual co-response model after a successful pilot. Due to the large geographic size of the county, prior to going virtual, the co-response team was only able to provide two in-person responses per day. Equipping 100 crisis intervention-trained patrol deputies with an iPad resulted in increased access to masters-level behavioral health clinicians, as providers could be accessed in a virtual setting around the clock.[128]
- Through Emergency Triage, Treat, and Transport (ET3) paramedicine programs in California, Washington, and North Carolina received payment for transporting clients with behavioral health needs to alternative destinations such as short-term crisis stabilization, residential treatment facilities, and/or behavioral health urgent cares.[129]

ET3 CMS Payment Model: California's Community Paramedicine Pilot Program (CCPPP), Mental Health and Substance Abuse

The ET3 Model allows payments for EMS innovations including the transportation to alternative destinations, facilitating appropriate treatments in place at the scene, and use of emergency telemedicine. CCPPP focused on non-ED transport for individuals with mental health conditions and/or individuals presenting with SUD with the stated goal of cost savings from hospital diversion. Pilot outcomes:

- 301 of 311 individuals presenting with mental health conditions were successfully transported to a crisis center instead of the ED. Averted ED visits saved an estimated $330,000 over the two and a half year pilot period.
- Served 730 patients presenting with SUD in 13 months with estimated cost savings of $240,000 in the diversion from ED to sobering facilities.

Opportunities

The stakeholders provided the following recommendations for changes to improve current transportation and custodial transfers:

- Encourage law enforcement-led co-response programs to update policy and procedures regarding restraints of behavioral health clients determined not to be a risk to self or others.
- Promote law enforcement-led co-response programs to offer transportation via behavioral health unit.

[125] https://www.gpb.org/news/2022/06/08/law-enforcement-enlists-mental-health-experts-help-save-lives-paradigm-shift-in.
[126] https://www.denvergov.org/files/assets/public/public-health-and-environment/documents/cbh/2022_midyear_starreport_accessible.pdf.
[127] https://www.mcso-tn.org/.
[128] http://www.harriscountycit.org/wp-content/uploads/Implementation-Guide-June-9-2020.pdf.
[129] Medicaid Opportunities in the Emergency Triage, Treat, and Transport (ET3) Model: CMS Joint Informational Bulletin (August 2019).

- Update necessary regulation to allow for EMS treatment in place via A0998.
- Update necessary regulation to allow for EMS transport to alternative destination (i.e., short-term stabilization).
- Develop a partnership with behavioral health and EMS for transportation purposes. This can be helpful and may provide a viable opportunity.
- Create a new class of transportation that is cost-efficient and can more easily transport individuals to behavioral health resources.
- The Kentucky CPP is a pilot program written into regulations and there is an opportunity to enhance the program through updated regulations.[130]

[130] CPP Lexington Interview 3/3/2020

Element 7: Information Exchange and Confidentiality

"If you are starting a program, one of your success factors has to be data reporting because you're not going to be able to have sustainability for any of these programs financially if there's not effective data… If we can't prove there's patient improvement and there's cost savings, we aren't going to continue to get funding for it."

– Kentucky Focus Group Participant

Law enforcement and mental health professionals should exchange information about people with mental illnesses who frequently come in contact with the justice system for many reasons:[131]

- Information sharing is essential to achieve desired outcomes by helping responders be more sensitive to individual needs.
- Reduce injury.
- Enhance ability to determine next steps.

Essential Element: Information Exchange and Confidentiality

"Law enforcement and mental health personnel have a well-designed procedure governing the release and exchange of information to facilitate necessary and appropriate communication while protecting the confidentiality of community members."

Kentucky Background and Findings

There are more than 380 law enforcement agencies with over 200 ambulance services, and 100-plus PSAPs in Kentucky which represents a significant number of data sources.[132] [133] Each local agency may have its own data policies and separate data systems, which increases the complexities of sharing information. When factoring in other behavioral health providers and community supports, this further showcases the difficulties in exchanging information and ensuring the confidentiality of individuals in the community.

However, to combat these issues, some co-response programs have been able to separate information. The Alexandria PSW program utilizes a separate system to store clinical information outside of the police CAD system to ensure confidentiality. The PSW is also able to add notes on individuals that assist LEOs in their responses, especially for high utilizers. Additional background information on high utilizers can help de-escalate situations quicker.

"Collecting a hundred data points. Takes two weeks to completely fill it out because lacking resources."

– Kentucky Board of EMS

For EMS data, local agencies collect data in their own systems, but also send that information to the statewide KBEMS system. KBEMS utilizes a data quality score to ensure information sent by local agencies meet a certain threshold. The statewide KBEMS system could be a good statewide source, but there are limitations on what information is captured, which should be factored in.

[131] https://bja.ojp.gov/program/pmhc/learning/essential-elements-pmhc-programs/7-information-exchange-and-confidentiality
[132] 2008 Census of State and Local Law Enforcement Agencies, by Brian A Reaves, US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, July 2011.
[133]https://kbems.ky.gov/About/Pages/default.aspx#:~:text=As%20of%202022%2C%20there%20were,%26%20Educational%20Institutions%20(TEIs).

Stakeholder Perspectives

Barriers

"HIPAA [Health Insurance Portability and Accountability Act] plays a barrier when coordinating with partners, particularly EMS. Lack of follow-ups and referrals are the result."

– Kentucky Co-Response Program

All stakeholders engaged within Kentucky and across the nation reported challenges with data collection, sharing, and reporting. Even well-established programs cite difficulties in updating reporting fields and data collection requirements. Some specific barriers noted by Kentucky stakeholders related to data collection, sharing, and reporting include:

- 911/PSAPs may be resistant to new technology or data collection as they are already overwhelmed and there is no way to mandate any changes statewide.
- 911/PSAPs do not necessarily capture mental health data, and policies vary between the 118 entities within Kentucky. There is no single code statewide to capture if the call is mental health related.
- Local law enforcement agencies utilize different CAD software that varies between cities, counties, and at the statewide level. Information captured between each agency may differ significantly and is based on what the individual provides, which may not be accurate.
- There are concerns about what information should be captured within law enforcement CAD systems as police records can be utilized by the public. This concern has resulted in some data not being collected or it being collected in separate systems that are operated by social workers or behavioral health professionals.
- Most co-response programs must track information manually which is time consuming and could result in inaccuracies.
- An existing co-response program in Kentucky cited HIPAA as a barrier for data sharing which results in decreased outcomes.
- All engaged stakeholders in Kentucky, law enforcement, EMS, and behavioral health providers are concerned with liability around data collection and sharing.
- Data from 911 calls are difficult to analyze as the fields may vary depending on location of PSAP and how calls are coded.

Within Kentucky, law enforcement, EMS, 911/PSAP, and behavioral health provider stakeholder groups reported concern around liability when it comes to data collection and sharing.

- Behavioral health providers expressed concern around the collection of personal information.
- 988/CCCs are reluctant to collect any identifying information.
- Many 911 centers are worried about potential liability if/when calls are to be transferred to 988.
- Crisis responders including MCTs, EMS, and LEOs have to contend with potential liability for responses that are passed off to another party.

Lessons Learned from Other Community Co-Response Programs

Nearly all established co-response programs interviewed recommended having the data infrastructure implemented prior to providing services. This will help track services and costs, while also allowing for easier justification of the co-response team in the future.

Stakeholders reported that integrated technology streamlines the data collection and reporting process. The Douglas County, Colorado Co-Responder Program implemented Julota software used to track all information on responses, including insurance information as the program wants to understand why individuals were engaging through the co-response program rather than seeking behavioral health care through their own insurance options.

"In hindsight, it's good to have that [data] on the upfront because it's hard to five years down the road decide to implement a new addition."

– Out-of-State Model

Opportunities

- Law enforcement programs that support individuals' social and behavioral health needs may utilize a separate system outside of the law enforcement CAD system in order to capture information that may be more sensitive and provide notes about how best to approach an individual when they are distressed.
- CAD or other systems can be leveraged by co-response programs to review available historical information on the individual being served to drive better responses.
- Having a statewide uniform data reporting tool for co-response programs, similar to Colorado, helps streamline data and can be designed to align with requirements of the program.
- Working with law enforcement and PSAPs is necessary to gather the necessary data for reporting requirements.
- Tracking the volume of behavioral health calls at the PSAP or law enforcement agency can help determine optimal times to operate a co-response program.

"The Fire Department and the Police Department. It's a perfect marriage of response because oftentimes, we are responding to the same individuals, but there's a time and a place for each response. When you put the picture together of the many times the Fire Department responds to an individual and how many times the Police Department responds to that same individual but separately… You begin to get a much better idea of what this individual's needs are medically. So we have a greater idea of what to offer this person and then we add in our social workers and we can get an even better idea of how to respond and what services to offer. An even better idea of how to meet their needs medically and in their everyday setting."

– Kentucky CPP Lexington

Element 8: Treatment, Supports, and Services

"The follow-up is really key. How can we get clinics to open up appointments for follow-up within 72 hours at most?"

– Kentucky Behavioral Health Advocate

Co-response programs provide an additional entry point to the behavioral health crisis system, thus, increasing access. Specially trained law enforcement and first responders are equipped to make connections linking individuals in need to supports and services that promote long-term wellness. A robust co-response continuum may reduce the likelihood an individual makes repeat calls for service and decreases the chances of future negative encounters with law enforcement.[134]

Essential Element: Treatment, Supports, and Services

"Specialized law enforcement-based response programs connect individuals with mental illnesses to comprehensive and effective community-based treatment, supports, and services."

Kentucky Background and Findings

Within Kentucky, there are examples of services specifically designed for post-crisis that are already being utilized such as peer supports, CPPs, and PSW programs. While there are limitations regarding current protocols for referring individuals to community-based supports, the current infrastructure can be leveraged. The current Kentucky co-response programs and CMHCs could be utilized to identify best practices regarding referrals to other supports.

- Peer supports can help with post-crisis services. For example, individuals discharged from Eastern State Hospital can be referred to the Participation Station, "a peer operated center that creates a safe environment where individuals with SMI can learn and develop vital skills to enhance their recovery experience and provide an empowering spring-board for opportunities to return to a productive, healthy, and meaningful life."[135]
- Through CPPs, a team of two or three members, such as a behavioral health provider and a member of the CPP follow up with individuals who have non-emergent requests and connect them to resources. They do not include LEOs to accompany them due to the potential for a negative response from the individual. They also provide outreach to individuals who are unsheltered with street outreach workers and other personnel.
- PSW that follows up post-police encounter with recommended referral/connections and diversion support. The PSW can develop a treatment for individuals that can help address physical health, behavioral health, and other unmet needs. The PSW also refers individuals to 988 and will even call 988 together with the individual.

Stakeholder Perspectives

Barriers

Availability of behavioral health beds is a barrier within Kentucky and across the nation. Stakeholders in Kentucky report having limited community-based supports to refer individuals in need—they are particularly dire in rural and remote geographies. While "limited availability of behavioral health facilities/services for referral" continues to be a barrier for crisis response programs, stakeholders also report limited availability of community resources altogether. This includes, but is not limited to: short-term stabilization, sobering facilities, emergency/crisis shelters, respite, and even charities like food pantries.

[134] https://bja.ojp.gov/program/pmhc/learning/essential-elements-pmhc-programs/8-treatment-supports-and-services
[135] https://www.namilexington.org/participation-station/.

The stakeholders reported several barriers that interfere with treatment, supports, and services:

- Workforce capacity and staffing issues for LEOs and EMS make it difficult to refer individuals to other services or conduct check-ins.
- Follow-ups can be a challenge due to disparities contributing to lack of internet or phone services such as for unhoused individuals.
- Many law enforcement and first responders do not have the knowledge or capacity to provide behavioral health services to people in crisis, resulting in lack of follow-up and care navigation.
- PSWs often create a treatment plan for an individual, but are not able to be added to it in order to track progress and address any future gaps of care.
- Lack of resources is a major barrier in Eastern Kentucky communities that were devastated by flood, as many residents continue to live in tents and do not have basic needs being met.

Many stakeholders in Kentucky referred or transported individuals in a behavioral health crisis to hospital EDs and state psychiatric hospitals. Both types of facilities may carry a negative connotation and conjure trauma, especially in historically marginalized groups that are already less likely to seek treatment.

> *"As soon as you say 'State Hospital' they shut down, say they don't want to go. But if we could get somebody to the <unit> instead we might not get stuck."*
>
> *– Kentucky Crisis Intervention-Trained Officer*

Lessons Learned from Other Community Co-Response Programs

Many well-established co-response programs have a robust behavioral health crisis continuum, often including integrated mobile units (i.e., MCT, co-response, and additional specialized teams), as well as designated options for referrals meeting the needs of individuals requiring a spectrum of care levels.

- Olympia, Washington's Familiar Faces is housed within the police department and is operated by PSSs. The Familiar Faces staff receive referrals from the co-response teams directly from LEOs and 911 call takers for high utilizers. PSSs offer services to reduce the likelihood of repeat calls for service, some of which are offered to clients on a permanent roster, all of which are free/voluntary/community-based.
- Yavapai, Arizona's Justice and Mental Health Coalition centers around a network of partnerships and an integrated statewide crisis system. Yavapai is a large rural county, but has been successful in their efforts to offer a robust behavioral health crisis continuum by bringing key stakeholders together regularly. This ensures all components of the local continuum are aware of available supports and services. The County's crisis stabilization unit plays a major role in facilitating these meetings, and through increased collaboration and coordination, which has increased the capacity for immediate hand-offs by law enforcement to behavioral health professionals 24/7/365.[136]
- Roselle Park, New Jersey's Arrive Together Co-Response Program has reduced emergency callers being referred to jails and hospitals. The majority of callers are able to stay at home, there are fewer responses where force is used, a reduction in the time people in crisis wait for a mental health screening, a continuation of contact in the community between the officer or social worker and residents, and less stigma in the emergency response process.[137]

[136] https://www.ycsoaz.gov/Divisions-and-Bureaus/Detention-Services-Division/Reach-Out-Program#:~:text=The%20Reach%20Out%20is%20a,represented%20in%20the%20justice%20system.
[137] https://www.njoag.gov/ag-platkin-and-colonel-patrick-j-callahan-announce-new-jersey-state-police-awarded-over-500000-federal-grant-to-expand-arrive-together-mental-health-crisis-response-initiative/.

Emerging Best Practice: Louisiana's Bridge Center for Hope encompasses six programs, including a short-term psychiatric unit, a detoxification unit, a 23-hour observation unit, a respite unit, mobile support teams, and a care management team with the goal to provide a full continuum of behavioral health services under one roof. The founding principle was to find solutions "once people go into longer-term care, it severs their ties, they lose community connections, and it's a lot more difficult for them to re-engage in their community, including finding meaningful employment and housing." Funding for the center was supported by the passing of Medicaid Expansion (July 2016) and 6.2 million dollars each year gained from an additional millage on property tax (passed with 67 percent support).[138]

Opportunities

Connecting stakeholders to follow-up services (behavioral health, community supports, etc.) is critical to help the individual and for the success of any co-response program.

- There is willingness from LEOs and EMS to connect individuals to follow-up services if there is increased staffing or additional to help with the follow-up.
- While responding to the initial crisis is important, having secondary responses can help alleviate future crises and there are many existing examples in Kentucky that could be leveraged (PSW and CPP).
- Municipalities with PSWs, CPP, or other supportive programs may be more open to a formal crisis co-response program as the LEOs may already be CIT trained, the community may have a more formal network of community supports, and the local law enforcement agency may be more open to alternative responses.

[138] https://talk.crisisnow.com/kathy-kliebert-on-how-disasters-can-be-a-catalyst-for-change/.

Element 9: Organizational Support

"The biggest piece of success is being flexible, and having continuous conversations with the community."
– Out-of-State Program

Essential Element: Organizational Support

"The law enforcement agency's policies, practices, and culture to support the specialized response program and the personnel who further its goals."

The law enforcement agency's policies, practices, and culture support the specialized response program and the personnel who further its goals of increased access, improved safety, decreased justice involvement, reduced costs, and improved community relations. Throughout research and engagement, stakeholder-driven recommendations and identified opportunities point to ongoing organizational support being equally critical for programmatic success and community buy-in. Today, critical workforce shortages and the public perception of law enforcement continue to challenge co-response programs nationwide. **In effort to further its mission while navigating critical barriers, programs are increasingly prioritizing collaborative partnerships, law enforcement transparency, community outreach, and practice change within law enforcement and first responder workplace culture.**

Kentucky Background and Findings

"In Northern Kentucky, they all meet at the same table. Multi-stakeholder meetings where the talk about what went wrong and what went right. Asking how can we better do this?"
– Healthcare Association in Kentucky

All existing co-response programs within Kentucky have been successful in getting buy-in from law enforcement and the community-based resources. While some of these programs noted challenges in receiving buy-in once the program was implemented, the value was clear for all those involved—better outcomes for individuals and more availability for law enforcement or first responders for other services. Other highlights regarding enhancing organizational support include:

- A CMHC in Kentucky remarked that they have a good working relationship with first responders in their community. Their CIT committee purchased iPads for the local LEO agency to connect with behavioral health professionals.
- Stakeholders representing Kentucky's PSAPs stated that in order to improve processes and reduce stigma around behavioral health calls, 911 call centers must establish a relationship with their local CMHC and/or behavioral health provider network.

Stakeholder Perspectives

Barriers

According to research from Eastern Kentucky University, EMTs regularly face hazards that range from injury to infectious disease to a host of mental health issues. The suicide rate of EMS personnel is five times greater than the general population.[139]

[139] Eastern KY University Report, https://www.itrauma.org/wp-content/uploads/2017/10/EMS-Suicide-Dariusz-Wolman.pdf.

PSAPs/911 have long faced issues with workforce from recruitment, retention, and staff performance.[140]

- 911 call-takers earn on average $47,000/year and call centers are typically underfunded.
- One quarter of 911 professionals have symptoms of depression and PTSD, on par with rates among police officers and firefighters. Research has demonstrated when you have PTSD and/or depression it affects decision-making, concentration, attention, sleep—all critical in being able to perform successfully, particularly under pressure.
- There is currently no uniform national training standards for 911 staff.

> *"Law enforcement and first responders often experience burnout from working with individuals in crisis with SUDs or SMI who are frequently in need of crisis services. It's evident in instances of ambulances refusing to transport patients and police handcuffing individuals experiencing behavioral health crisis."*
>
> *– Healthcare Association in Kentucky*

In a 2020 survey of 434 police officers in an urban setting, 12 percent had a lifetime mental health diagnosis, and 26 percent reported current symptoms of mental illness. Of those officers identified, 17 percent sought mental health services within the past 12 months.[141]

The reality is that crisis work can be stressful, dangerous, and traumatic. **Stakeholders reported increasingly moving to adopt and change existing practices to address burnout, resiliency, and responder mental health.**

> *"Crisis providers, as strong as they are, are the providers and responders who go through a great deal of stress and burnout from seeing all these traumatic situations and traumatic lifestyles."*
>
> *– Mental Health Advocate in Kentucky*

- All stakeholder groups engaged cited workforce shortages and responder burnout being a top concern.
- All stakeholder groups referenced low crisis responder wages/salary contribute negatively to retention efforts. This included law enforcement, first responders, behavioral health crisis mobile crisis providers, peer support, dispatchers, and 911 call takers.
- Many law enforcement and first responder stakeholders willingly and openly shared their experiences with PTSD, whether it was personal or observed.
- EMS providers willingly and openly shared how the opioid epidemic has impacted first responders. Many EMTs/SUD crisis response workers provide emergency overdose services to the same individuals on a regular basis, and the resulting trauma when those individuals do not survive the next overdose.
- Existing co-response models tend to require some variation on officer resiliency training in addition to participation in police department wellness programs.
- With lived experience being the essential function of a PSS, many also have to prioritize their own wellness, ongoing support, and commitments to family members which can make it difficult to complete a 40-hour work week.
- Law enforcement, first responders, and behavioral health crisis providers continue to worry about liability as it relates to their position within the crisis continuum.

Lessons Learned from Other Community Co-Response Programs

Establishing that co-response programs are a high priority for agencies can be demonstrated through visible and practical changes in how the agency partners with the community and realigns internal processes.[142] **Stakeholders**

[140] 988 Crisis Jam August 2022; https://talk.crisisnow.com/911-must-be-part-of-the-988-conversation/
[141] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7542299/#:~:text=In%20this%20survey%20study%20of,current%20symptoms%20of%20mental%20illness.
[142] https://bja.ojp.gov/program/pmhc/learning/essential-elements-pmhc-programs/9-organizational-support

reported a varying degree of new practice and protocol adoption within their local programs, many of which included how officers interact with individuals served and coordination with partners outside of traditional justice and corrections.

- Stakeholders reported a wide spectrum of uniform requirements for co-responders from least casual (street clothes) to most formal (sworn officer uniform). Perhaps the most common policy cited was the "dressed down" uniform which includes some variation on khakis and a branded polo.
- Many established co-response programs include transportation to the next level of care (i.e., drop-off centers, short-term stabilization, community-based crisis campuses, walk-in clinics, behavioral health urgent cares, and/or crisis living rooms).
- Commonly referenced co-response transport vehicles include plain, unmarked SUVs with a discreet division between driver and passage for safety.
- Few co-response teams mentioned altering response protocols to meet the needs of residents with suspected I/DD (e.g., reduced use of lights and sirens).
- Many co-response programs utilize technology to support delivery at the scene including GPS, tablets, radios, and access to information on the individual being served through CAD or other systems.
- Stakeholders recognized the need to support the mental health of all those who provide services in the crisis care continuum due to the stress and potentially unsafe situations.

Stakeholders agree on the importance of collaboration and coordination within the behavioral health crisis continuum. Partnerships with community providers, services, and advocates play an important role in addressing crisis response and follow up, but also contribute to long-term success. Throughout the engagement, stakeholders discussed the importance of partnerships and perspectives from community service providers that address the SDOH (e.g., housing, transportation, etc.) that contribute to crisis situations for individuals.

- Many mature co-response teams host regular meetings with local behavioral health providers and community resources to discuss high utilizers, plans of action for individuals, and to further refine their processes and collaboration.
- All stakeholders (law enforcement, EMS, behavioral health) noted that 911/PSAPs have issues hiring and staffing centers. Stakeholder perspectives provided emphasize the need to bring these partners together in effort to brainstorm workforce solutions.
- In Colorado, many of the co-response programs are part of the COCRA to discuss similar encounters and share best practices.
- Statewide models tend to require programs to implement an advisory committee or convening body to provide local oversight.

Feedback from stakeholders indicated that co-response programs have to contend with public perception. **Existing co-response programs emphasized throughout engagement that ongoing community outreach is required to build and maintain public trust.** All engaged existing co-response programs leverage media channels that facilitate social connections within the community to build trust and increase awareness.

- A community-based co-response program in Colorado promotes the team through county commissioner video messages, faith-based organizations, and hospitals. *The team is not promoted as a product, but as a way to show the great work that is being accomplished.*
- In Mt. Sterling, Kentucky, the co-response team is utilizing social media, the local newspaper, and business cards provided to LEOs to promote co-response teams, which is helpful within the community.
- Stakeholders recommended identifying "champions" within the community and community partners.

Opportunities

In evaluation of co-response models, programs should ensure ongoing organizational support includes the workforce: stress and burnout within crisis work, workplace culture supportive of practice change that benefits consumers, and efforts to build upon collaboration and coordination. Stakeholders within and outside of Kentucky from established programs emphasized the significance of building public trust in law enforcement and transparency regarding programmatic outcomes to bolster public perception of behavioral health crisis services.

- Ensure programs adopt practices that address mental health among crisis responders.
- Increase training around co-responder mental health (i.e., resiliency, PTSD).
- Adapt SAMHSA's Strategies to Mitigate Compassion Fatigue among Crisis Workers.
- Increase pay for EMTs, 911 call takers, and PSSs, as recommended by stakeholders.
- Make available literature and educational resources that contain professional development opportunities, new emerging trends in co-response practices, and evidence-based practices.
- Require oversight committees on the local level with membership determined by the co-response program, but recommended guidelines set forth by the State.
- Implement a community outreach strategy that includes engagement with partners, consumers, and the general public. This should be done by local programs.

A critical part of organizational support includes tailored communications to historically marginalized groups within the community. Stakeholders referenced the importance of partnering with disenfranchised groups to encourage them to have a voice, providing the unique consumers' perspectives, and validating potential concerns. Stakeholders representing existing co-response programs recommend partnering with local activist groups, consumer advocacy groups, grassroots campaigns, and faith-based organizations to reach audiences in creative ways.

Element 10: Program Evaluation and Sustainability

"My department is great about willingness to work with mental health programs. The biggest thing is we operate on a budget and that might be a challenge. To do anything co-response, we'd want to make sure it's feasible and something that works well with the officers, is this something our officers could use practically?"

– Kentucky Crisis Intervention-Trained Officer

Program evaluation should seek to gather valuable insights on promising trends, a sense of the program's potential impact and effectiveness, and recommendations to guide future program efforts. The evaluation design equally embraces review of quantitative and quantitative data.[143]

Essential Element: Program Evaluation and Sustainability

"Data collected and analyzed to help demonstrate the impact of and inform modifications to the program. Support for the program is continuously cultivated in the community and the law enforcement agency."

Kentucky Background and Findings

For any successful program, it is essential to understand the impact to the local community. As co-response programs are initiated, it is important to have robust data collection to understand volume, costs, diversions, and savings to the community. Additionally, the ultimate goal is better serve individuals in the community and identify the impact to individuals to help paint the story of the benefits of the program.

The Mt. Sterling Pathways co-response program has been successful in tracking the number of diversions away from jails and has calculated the cost savings to the community. Additionally, the program has received great feedback from individuals served showing the impact on their lives and the community. These stories showcase the value of the program. As part of the SAMHSA grant, Pathways captures the savings and these impactful stories.

For all primary co-response programs, PSW programs, and CPP programs in Kentucky, there is a notable impact on their local communities. However, sustainability is always a concern as these programs cost money and are difficult to maintain. Most of the co-response programs started because of grant funding, and some noted that the program would not be sustainable without supplemental funding. Even for programs like Mt. Sterling, which have demonstrated real cost savings to the community, the local budgets are too thin to sustain the program on its own. Sustainability by showcasing the value to the local community is critical to hopefully obtain local funding, but there is still a reliance upon supplemental funding. The recently launched Lifeskills Bowling Green co-response program noted sustainability as one of their critical focuses and would explore billing individuals in the future, but is willing to operate the program at a loss for the foreseeable future.

Stakeholder Perspectives

Barriers

Sustainability of new and existing co-response programs is a continued concern identified by stakeholders. Key factors included funding, workforce, buy-in from law enforcement and community resources, and access to the need community-based supports.

- Co-response programs are typically unsustainable without grants or supplemental funding.
- Local municipality budgets are typically too small to fund a co-response program even if they demonstrate real cost savings to the local community.
- There is no standard formula or reporting for co-response programs which makes it difficult to compare programs.

[143]https://bellevuewa.gov/sites/default/files/media/pdf_document/2022/CCAT%20Program%20Evaluation%20FInal%20December%202021.pdf.

- Other local constraints such as availability of behavioral health professionals, access to community-based resources, and workforce constraints for law enforcement and first responders make it difficult to sustain programs.
- Pay for law enforcement, first responders, and behavioral health professionals is low and require regular interactions with potentially unsafe situations.

Lessons Learned from Other Community Co-Response Programs

Sustainability is a concern for even well-established co-response programs due, in part, because of constraints on local resources and the difficulty in tracking outcomes. Most co-response programs rely on either state or federal grants to initiate the program, but some have been successful in showcasing the value to their local communities.

- Colorado BHA provides over $10 million each year in funding to 29 local co-response programs within 24 of the 64 counties in Colorado. The agency utilizes intergovernmental contracts with basic service, collaboration, and data requirements.
- In Douglas County, Colorado, the co-response program is able to calculate cost savings for the community by factoring in jail and hospital diversions, while also calculating savings for releasing other LEOs to respond to other types of service calls. They are able to leverage funds from Colorado BHA, local dollars, and other grants to support multiple teams with the goal of providing 24/7 availability.
- Some co-response programs are able to track the number of deferrals and diversions away from EDs, jails, and hospitalization and can calculate the cost savings to the community.
- The majority of the other co-response programs are available Monday through Friday afternoon and evenings to align with the highest volume and to address resource constraints.
- Nearly all co-response programs rely on federal or state grant funds to initiate or sustain their programs. No programs described billing individuals to receive payments from any insurer currently.

Opportunities

According to Kentucky stakeholder feedback, when implementing a co-response program in any community, it is imperative to ensure it can be sustained. If a program cannot be successful and has to end services, this would result in a reduction of needed services in the local community and could reduce the availability of related behavioral health crisis services. When developing a statewide model for co-response, the following factors should be reviewed:

- Evaluate the distribution of state funds to support co-response programs across all areas with simple requirements to allow flexibility so the programs can align to local needs and available resources.
- Require data collection to demonstrate how effective the program is and to calculate the cost savings is impactful.
- Utilize storytelling through community outreach to help show the value to the community and ensure the program can be sustained. Develop a local communication plan to highlight value and impact to individuals within the community.
- Align the availability of the team with the highest volume, to address resource constraints, and help with sustainability when programs are started.

Appendices

Appendix A: Pre-Interview Questionnaire Results

Out of the seven responses received through the pre-interview questionnaire, four respondents elaborated on their current co-response program and are detailed in *Table 4*. Information from co-response programs that completed the pre-interview questionnaire was utilized to update information within the report. The four co-response programs were asked what types of goals their program aimed to achieve which included:

- Reduce arrests.
- Increase access to behavioral health crisis services.
- Reduce the use of force.
- Reduce injuries to officers/consumers.
- Improve community relations.
- Increase law enforcement/first responder availability.

Table 4. Kentucky Co-Response Program Respondents from the Pre-Interview Questionnaire

Program Name	Year Established	CMHC Association (if applicable)	Type of Behavioral Health Staff	Sourcing of Behavioral Health Staff
Police Social Workers in Alexandria, Kentucky	2016	N/A	Case Manager	Employed by the Sheriff's Office
CPP Lexington, Kentucky	2018	N/A	Licensed Behavioral Health Professional	Employed by First Responder Agency
Mt. Sterling Pathways Co-Response Program	2022	Pathways	Peer Support Specialists	TTI Grant via DBHDID
Bowling Green Lifeskills Co-Response Program	2022	Lifeskills	Licensed Behavioral Health Professional	Contracted through Lifeskills

Three different stakeholders that completed the pre-interview questionnaire stated they did not have a co-response program which included the Madison County Sheriff's Department, Covington Police Department, and Somerset-Pulaski County emergency medical services (EMS). These respondents provided insight into how their agency addresses behavioral health crises, participates in CIT, and coordinate efforts with outside organizations. The Covington Police Department representative was the only response that expressed no prior knowledge of MCI services or mobile crisis teams MCTs and indicated they were unsure about the benefits on increased behavioral health support. Lastly, Somerset-Pulaski County EMS was the only respondent who indicated an interest in establishing a co-response program incorporating behavioral health staff within their agency. *Table 5* highlights three stakeholders' familiarity and perception of behavioral health services.

Table 5. Law Enforcement or First Responder Agency Respondents from the Pre-Interview Questionnaire

Agency	Familiarity with MCI/ MCT Services	CIT Trained Staff	Partnerships	Interest in Implementing a Co-Response Program
Madison County Sheriff's Department	Yes	Yes	Yes; New Vista	Unsure
Covington Police Department	No	Yes	N/A	Unsure
Somerset-Pulaski County EMS	Yes	No	N/A	Yes

Appendix B: Other State Co-Response Programs

A wide review of states found that many are in early stages of establishing a statewide crisis response system, many of which include co-responder programs. Often, implementation is happening by degrees as requisite infrastructure—statues, funding, and administrative regulations—needs to be in place before providers and staffing, standards and protocols, and training can occur system wide. Nevertheless, there have been advances made in statewide systems and, in some cases, long-running successful co-response models at the municipal and county level. Listed below are additional co-response programs or related programs that were researched to supplement stakeholder engagement findings.

Colorado

Boulder, Colorado Early Diversion, Get Engaged (EDGE) Project

Project EDGE is a local collaboration between justice and mental health agencies. The program leverages Substance Abuse and Mental Health Services Administration Early Diversion grant funding and aims to address behavioral health needs of people involved in, or at risk of, justice system involvement by providing an array of community-based services. The program was designed to keep individuals with behavioral health issues out of the criminal justice system while maintaining public safety priorities. Diversion teams are composed of law enforcement and peer support who are trained in crisis intervention. A mental health partner is included when needed. Multi-agency collaboration and cultural responsiveness are core components of the project. Behavioral health professionals collaborate with law enforcement to support case management, housing placement, primary and mental health care, and family supportive services.[144]

Colorado Springs Community Response Teams (CRTs)

The Colorado Springs CRT model includes local behavioral health professionals and first responders from the fire department. CRTs have reduced emergency department (ED) admissions by directing individuals in crisis to appropriate services. Additionally, diverting 911 calls to the CRT reduces the burden on other emergency responders.

Denver Support Team Assisted Response (STAR) Program

Operating within the City and County of Denver, STAR is managed by the Denver Department of Public Health and Environment in partnership with Denver Department of Safety. STAR employs emergency response teams (ERTs) that include emergency medical technicians (EMTs) and behavioral health clinicians to engage individuals experiencing distress related to mental health issues, poverty,

[144] https://www.samhsa.gov/criminal-juvenile-justice/grants-grantees/early-diversion.

homelessness, and substance abuse. ERTs are dispatched through Denver 911 communications and respond to low-risk calls where individuals are not in imminent risk. Services provided through STAR include medical assessment and crisis triage, crisis intervention, de-escalation, transportation, and resource connection for community members in need. The program is currently limited to seven days a week 6:00 a.m. to 10:00 p.m., identified high call volume times.[145] As of July 2022, there were four units running throughout the city. Staffing includes eight clinicians, six medics/EMTs, and plans to expand to five units, 10 clinicians, and 10 medics/EMTs.[146] Between January 2022 and July 2022:[147]

- STAR responded to 2,837 calls for service.
- Zero calls for back-up due to safety concerns.
- Top three calls for service: welfare check, trespass/unwanted party, and assist (code indicates 911 request for service/courtesy ride).
- Denver Department of Safety identified an additional 5,891 calls that could have been fully addressed by the STAR program.
- 1,132 clinical encounters with reported primary concerns: mental health (80 percent), environmental (23 percent), suspected substance use (17 percent), age related (five percent), and developmental (two percent).
- 1,543 encounters were considered non-clinical and included services like “general support,” “resource education,” and “behavioral health education.”

Denver, Colorado: Transit Officers in Co-Response

One of Denver’s co-responder programs focused on public transportation. Trained transit officers and behavioral health clinicians are sent to evaluate disruptive passengers for medical causes and/or potential criminal conduct. Based on findings, the co-response team determines next steps, which may include calling for medical back-up, assisting the individual in need of community resources, or transporting the individual to a drop-in center or walk-in clinic.[148]

Colorado EMS Access to DocLine

EMS programs responding to behavioral health crisis calls in four regions in Colorado are able to use DocLine for outpatient referrals, virtual provider consults, 24/7 nurse triage, scheduling, and bed census. DocLine is operated by UCHealth in partnership with health systems.[149]

Georgia

Atlanta-Based Policing Alternatives and Diversion (PAD) Initiative

Atlanta determined that nearly one-fifth of 911 calls could be diverted from 911 to non-law enforcement community care providers. Many of these calls are more appropriate for Atlanta’s 311 community response services. Atlanta 311 provides residents the option of reporting non-emergency concerns related to mental health, substance abuse, and/or poverty.

[145] https://www.denvergov.org/Government/Agencies-Departments-Offices/Agencies-Departments-Offices-Directory/Public-Health-Environment/Community-Behavioral-Health/Behavioral-Health-Strategies/Support-Team-Assisted-Response-STAR-Program.
[146] https://www.denvergov.org/files/assets/public/public-health-and-environment/documents/cbh/2022_midyear_starreport_accessible.pdf.
[147] https://www.denvergov.org/files/assets/public/public-health-and-environment/documents/cbh/2022_midyear_starreport_accessible.pdf.
[148] https://www.rtd-denver.com/rider-info/safety-and-security/rtd-transit-police.
[149] https://www.uchealth.org/referrals/.

Atlanta-based PAD accepts referrals from this 311 line, and from pre-arrest diversions from law enforcement. PAD responds to a variety of call types including basic needs, mental health, public disturbance, welfare, public health, public indecency, and substance use. PAD triages 311 calls, and calls deemed as urgent or important are responded to by a harm reduction team within 30 minutes. Calls determined to be less urgent are responded to within 72 hours.[150] Supportive service lines like Atlanta 311 can help distinguish non-emergency calls and reduce the demand on 911 lines.

Key challenges identified by PAD, include the demand for services exceeds capacity, little community awareness of Atlanta 311, and a very high number of requests for housing assistance.[151]

City of Savannah Police Department Behavioral Health Unit

The City of Savannah police department employs a behavioral health clinician to ride 40 hours per week with a law enforcement officer trained in crisis intervention and to co-respond to 911 calls indicating a behavioral health crisis. Officers are trained to provide de-escalation on scene, schedule doctor's appointments, and make referrals to community supports. Co-response teams arrive on scene in an unmarked car—no flashing lights, only a thin partition dividing the front and back. Police on the co-response team wear blue polo shirts and khakis, rather than typical police uniforms.[152]

In 2021, 270 individuals were served by the behavioral health unit and only three were arrested (these three did not have outstanding warrants). Two-hundred sixty-seven of the 270 were directly connected to services. Additionally, the unit conducted more than 100 follow-up visits post-encounter.

Cobb County Partnership for Assistance, Treatment, and Health (PATH)

Established in 2019, Cobb County PATH pairs licensed mental health clinicians with uniformed police officers. The teams are dispatched through 911 to mitigate crises onsite with the objective that individuals remain at home; however, each team has the ability to order involuntary committal or arrest. Since its launch, PATH has reported reduced use of force and has responded to more than 1,000 crisis calls. According to information published in 2022, 45 percent of calls are resolved on site in the community, and only three percent resulted in arrest.[153]

Louisiana

Statewide Crisis System with Law Enforcement Components

Louisiana's new community-based crisis services continuum includes EMS, law enforcement officers, and coroners. The statewide framework centers on decriminalization of mental illness in communities through partnerships, diversifying the behavioral health system entry points, and limiting use of restraints for individuals in crisis.

Co-responder teams are triaged and dispatched through 911; however, 988 calls may be transferred to EMS or law enforcement officers (LEOs), and first responders often encounter behavioral health crises in the field. Louisiana is currently working towards establishing standardized behavioral health crisis training for 911 operators statewide, following successful pilots in Baton Rouge and New Orleans. Calls to the

[150] Justice Center, Council of State Governments, https://csgjusticecenter.org/publications/expanding-first-response/program-highlights/atlanta-ga/.
[151] Slides from Taking the Call conference, Identifying and Triaging Calls: 911, 311, 988, and Beyond, https://takingthecall.csgjusticecenter.org/identifying-and-triaging-calls-911-311-988-and-beyond/.
[152] https://www.gpb.org/news/2022/06/08/law-enforcement-enlists-mental-health-experts-help-save-lives-paradigm-shift-in.
[153] https://cobbcountycourier.com/2022/03/co-response-vital-to-strengthening-georgias-mental-health-system/.

988 crisis line are assessed for appropriate response, and warm handoffs are made for potential co-response or mobile crisis. The triage considers the following:[154]

EMS	LEO or Coroner
• Potentially involuntary. • Immediate emergency care access (overdose, suicide attempts). • Person unwilling to seek services voluntarily, imminent risk of harm to self or others. • Medical comorbidity, intoxication, significant agitation. • Unresolved mental health needs.	• Potentially involuntary. • Immediate but limited mental health response. • Potential for incarceration or avoidable legal charges. • Higher recidivism.

Though there exists a statewide framework, co-responder transportation largely depends on the behavioral health infrastructure in the communities. 988 relies on EMS for transportation to the ED and LEOs for transport of individuals who are involuntarily committed. Cities like New Orleans and Baton Rouge have drop-off facilities for LEOs to take individuals in crisis for further assessment and stabilization.

North Carolina

Statewide Taskforce for Racial Equity in Criminal Justice

The taskforce's mission is the examination of racial disparities and implementation of evidence-based systemic changes in the criminal justice system. In its third year, the taskforce focused on implementing programs that promote public safety while minimizing racially inequitable practices and reducing the burden on law enforcement. Since its creation, the taskforce has collaborated and supported Pitt County, Greensboro, and Charlotte to design and implement co-responder programs to support people in crisis.

In evaluation of the current public safety landscape, the taskforce prioritized solutions to improve policing practices, some of which were relevant to co-response: appropriate response to situations concerning mental illness, autism, substance use disorder (SUD), and homelessness; expand access to diversion programs; wellness taskforces to address unique community needs; and funding for grassroots organizations. The taskforce ensures funding is available to provide officers with crisis intervention team (CIT) training, mental health first aid (MHFA) certification, and programs that promote/education officers on cultural inclusion and diversity.[155] With the mission to "enhance accountability," the taskforce established a robust governance and oversight network including but not limited to:

- Citizen oversight boards.
- Local governing bodies to access and review law enforcement recordings and bodycam footage.
- Diversity and inclusion in the criminal justice workforce requirements (for departments of a certain size).

[154] https://ldh.la.gov/assets/docs/BehavioralHealth/Crisis_Services/REGIONAL_MEETINGS_CRISIS_PRESENTATION_CAHSD_10_11_21.pdf.
[155] https://ncdoj.gov/north-carolina-task-force-for-racial-equity-in-criminal-justice-releases-2022-report/.

Stakeholder engagement efforts were critical for the creation of recommendations and solutions. The taskforce works with local governments, leaders, consumers, and community organizations to learn about impacted communities. Part of the outreach component includes gathering and incorporating public input to enhance public trust in the justice system. The taskforce was initially slated to conclude at the end of 2022, but instead, expanded to include representation from advocates for criminal justice reform, victims' and disability rights, people with lived experience, prosecutors, public defenders, judges, and elected officials.[156]

Chapel Hill

Established in 1973, Chapel Hill's co-responder program is one of the country's longest running programs. The crisis units within the program provide assistance to individuals experiencing psychiatric emergencies, assessments for suicidal or homicidal crises, runaway juveniles, hostage situations, traumatic events like first responder trauma, death notifications, and community mental health outreach. Peer support specialists are a hallmark of the program, assisting and assessing individuals who are overdose survivors or who are otherwise struggling with substance abuse. Many of the peers in the program have had previous crisis experience as a consumer, receiving response from the co-responder unit. The Chapel Hill co-responder program responds to an average of 93 in-person calls and 200 phone call situations per month.[157]

Officers receive specialized mental health training and advanced de-escalation tactics, but it is also recognized that training does not substitute the expertise of mental health professionals and community mental health partnerships.

Buncombe County Sheriff's Office

Since 2008, many officers of the Buncombe County Sheriff's Office have received 40 hours of CIT training. As of October 2019, more than 60 percent of sworn officers at the sheriff's office completed CIT training. The county requires CIT officers to spend an additional full day shadowing community mental health workers, furthering their knowledge on mental health diagnoses, medications, impact of stigma, and de-escalation. Clinical experts and community partners regularly join the sheriff's office for knowledge exchange and technical assistance. Key partners include law enforcement, courts, social workers, community agencies, mental health care, and physical health care providers.[158]

Charlotte-Mechlenburg Police Department (CMPD)

CMPD is the largest police department between Washington D.C. and Atlanta Georgia, with almost 2,000 officers on the force. In 2016, CMPD made MHFA training mandatory for all officers. As of 2018, the program has trained more than 90 percent of their police force. The updates to CMPD training requirements was initiated to address the increasing frequency of police interactions with individuals experiencing behavioral health crisis.

Assistant Chief Veronica Foster: *We realized our force didn't have the expertise and information <we> needed to interact with people experiencing mental health challenges. While CIT training was being offered to a subset of officers, department leadership wanted something that could be delivered to everyone. Being such a large police force, it would be impossible to train everyone in CIT since it's so intensive. MHFA is exactly what our force needed, something relatively short and scalable, but still effective in providing our officers with the know-how to handle sensitive situations. Besides helping*

[156] https://ncdoj.gov/north-carolina-task-force-for-racial-equity-in-criminal-justice-releases-2022-report/.
[157] https://www.julota.com/news/five-examples-of-successful-co-responder-programs/.
[158] https://www.buncombecounty.org/governing/depts/justice-services/councils-advisory-groups/coordinated-community-response.aspx.

officers in situations involving mental health crisis, MHFA had the additional value in lending more credibility to CMPD officers' actions in the eyes of the larger community. The community wants to know that all our officers have a basic level of training about mental health. We want to be able to assure the community that we do have a basic understand of mental health.[159]

Observed results from MHFA training:

- CMPD's police academy inclusion of MHFA as part of the required police academy curriculum.
- Advocates from Mental Health America of Central Carolina provide MHFA training in person.
- CMPD began tracking officer interactions with individuals living with mental health disorders and record outcomes of such interactions.
- Officers report MHFA training has helped them better identify and deescalate situations where an individual might be experiencing a mental health crisis.
- Lt. Wagner made national news after his squad encountered an autistic individual who resisted attempts of restraint. The Lt. cited MHFA for his ability to recognize what was happening, step in to calm the individual, and de-escalate.
- CMPD initiated a program in 2018 to develop systems that enable officers to connect individuals living with mental health issues to the longer-term care they need.
- CMPD announced they have joined the International Association of Chiefs of Police's One Mind Campaign, which seeks to ensure successful interactions between police and persons living with mental illness.

Tennessee

Madison County Co-Response

The Madison County inter-agency collaboration serves 97,663 residents in western Tennessee. The collaboration includes representation from city, county, and state criminal justice and behavioral health agencies.[160] Key features include:

- Comprehensive training for officers includes 40 hours of CIT and MHFA certification.
- 24/7 stabilization unit referral resource.
- Pre-trial diversion program and a pre-trial risk assessment for judges.

Ran a pilot program for mental health transport units in the state of Tennessee, which has been expanded statewide. This unit consists of an emergency medical responder riding in a specialized van with a non-uniformed sheriff's deputy in order to safely transport all people who are being brought in for an involuntary mental health assessment or hold.[161]

Chattanooga Police Community Policing

The Chattanooga Police Department received a $1million grant from Volunteer Behavioral Health to fund a community policing initiative including eight positions and serving seven counties in Middle and East Tennessee, which includes both rural and urban areas. The initiative aims to address 911 calls where the

[159] Mental Health First Aid for Public Safety Charlotte-Mechlenburg Police Dept. Case Study https://www.mentalhealthfirstaid.org/case-studies/charlotte-mecklenburg-police-department/.
[160] https://csgjusticecenter.org/projects/law-enforcement-mental-health-learning-sites/madison-county-sheriffs/.
[161] https://www.mcso-tn.org/.

primary concern is related to behavioral health or social determinants of health (SDOH). Since its start, the program averaged 30 to 45 mental health crisis calls per week.

The community policing program is centered on pairing embedded behavioral health clinicians with CIT-trained LEOs. Multi-disciplinary teams are dispatched through 911 or summoned in the field by patrolling officers. Teams provide services like de-escalation, transport, referrals, and follow-ups to ensure access to substance abuse assistance, mental health treatment, and support for their SDOH needs. Central to the program's success, participating officers spend time doing outreach to residents, visiting sites like food pantries and shelters and building rapport with residents and staff.

Texas

Austin, Texas: Expanded Mobile Crisis Outreach Teams (EMCOT)

Austin's EMCOTs are activated through local Public Safety Answering Points for immediate co-response to psychiatric crises. Dispatched teams aim to de-escalate crises and connect individuals to appropriate treatment services, diverting them from EDs and jails. EMCOT is a collaborative effort between integral care (the local mental health agency and community behavioral health center), Austin 911 call center, Austin Police Department, Austin-Travis EMS, and the Travis County Sheriff's Office. Since the program's inception in 2013, EMCOT co-response with law enforcement avoided arrests and involuntary commitment in the majority of cases.[162]

Since Integral Care crisis center clinicians have been co-located within the Austin 911 call center, diversion, de-escalation, and collaboration between behavioral health staff, 911 operators, and police has increased. The close working conditions contributed to knowledge exchange and trust building, and has led to successful training and education programs. Other outcomes of co-location include:

- The 911 call center staff shift to inclusive and person-centered language (e.g., instead of asking "Are you bipolar?" call takers ask, "Have you ever received a diagnosis of bipolar disorder?").
- Austin police officers are more apt to call on EMCOT when they encounter an individual showing signs or symptoms of a mental health crisis.
- There is a new 911 option for mental health-related calls and an updated 911 script: "Are you calling for police, fire, EMS, or mental health services?"[163]

If 911 callers respond that they are calling for mental health services, a crisis center clinician joins the call. The 911 call operator remains on the line for the duration of the call in case police or EMS are also needed. EMCOT is on incoming calls and helps identify the need for mental health support. Callers are not transferred or put on hold; instead, call participants conference each of the team members in, as needed (e.g., if EMS begins to recognize there is a mental health component).

Harris County Sheriff's Office (HCSO) Telehealth Program

Harris County, Texas has a population 4.7 million, covers 1,788 square miles, and encompasses 41 municipalities. HCSO is the largest sheriff's office in Texas and third largest in the nation, with 4,600 employees. HCSO collaborated with JSA Telehealth, Cloud 9, Verizon Wireless, and the University of Texas on a three-week pilot program connecting three patrol deputies with psychiatrists via iPads. The pilot was later extended to a year-long evaluation (2018 to 2019) through funding received from Arnold Ventures. As the shortage of behavioral health workforce in Harris County, mental health calls to the

[162] https://www.austintexas.gov/edims/document.cfm?id=302634.
[163] CrisisTalk Article: Austin's 911 Call Center Integrates Mental Health Call Crisis Diversion (June, 1, 2021).

Houston Police Department increased more than 110 percent. HCSO sought a telepsychiatric program to increase "quick and affordable" access to behavioral health professionals, divert individuals with mental illness from jail to treatment, increase law enforcement and citizen safety, and eliminate unnecessary transport to hospital EDs.[164]

The cost for nine full-time, masters-level clinicians from Harris Center for the Crisis Intervention Response Team (CIRT) co-responder program is $900,000 annually. The cost to equip 100 patrol deputies with an iPad with which they can connect to a masters-level clinical is $905,000 annually. In-person co-response is currently in practice; however, is not a viable solution given the large geography. The clinicians and deputies riding together in Harris County are typically only able to provide two in-person responses per day due to the distances units are required to travel. Clinicians in a virtual chat can conduct significantly more assessments without contending with travel and wait times.[165]

Texas mandated 16 hours of CIT training for Texas Peace Officers in 2005 through the Bob Meadours Act, Senate Bill (SB) 1473. The CIT mandate was later expanded to 40 hours with the passage of Sandra Bland Act SB1849 in 2017.

Houston Police Department Mental Health Division

Urban co-response program serving a population of 2.3 million. The Mental Health Division is a collaboration between the Houston Police Department (HPD), mental health professionals in Houston/Harris County, and advocacy groups such as National Alliance on Mental Illness (NAMI). Through the collaboration, the HPD works with the community to develop multi-faceted strategies for responding to those experiencing mental health crises. HPD employs a multi-faceted strategy staffed by various personnel including CIT patrol officers, co-responder units, homeless outreach teams (HOT), boarding homes enforcement detail, chronic consumer stabilization initiative, crisis call diversion program, senior justice assessment center, trained dispatchers, and call takers.[166]

Houston's co-responder teams are known as CIRT and they partner with a Houston CIT officer with a masters-level licensed clinician from Harris Center for Mental Health and IDD. The officer and the clinician attend roll call together and ride along in a patrol car. CIRT objectives are to assist officers with CIT-related calls, conduct proactive and follow-up CIT investigations, respond to SWAT calls as a resource when available, and handle the most serious CIT calls.[167]

Of note, HOT works closely with the co-response unit, and is comprised of one sergeant, six HPD police officers, one metro police officer, one senior police officer, and four case managers from the Harris Center for Mental Health and IDD. The teams provide homeless individuals with the following assistance: housing, social security cards, passports, birth certificates, shelter referrals, medical equipment, employment, bus fare, medical care, and mental health treatment. HOT works with numerous community-based organizations to provide assistance.[168]

All officers receive mental health training including: 40-hour CIT training; eight-hour annual advanced CIT classes; state-mandated eight-hour CIT refresher training with their Basic Peace Officer Certification; 40-hour Mental Health Peace Officer course for veteran officers; state-mandated 40-hour CIT for basic, intermediate, and advanced certification; state-mandated eight-hour de-escalation class for all cadets with

[164] http://www.harriscountycit.org/wp-content/uploads/Implementation-Guide-June-9-2020.pdf.
[165] Ibid.
[166] https://csgjusticecenter.org/projects/law-enforcement-mental-health-learning-sites/houston-police-department/.
[167] https://www.houstoncit.org/cirt/.
[168] https://www.houstoncit.org/hot/.

basic, intermediate, and advanced certifications; and 24-hour telecommunications crisis class for dispatchers.[169]

Washington

Spokane County Regional Behavioral Health

Spokane County Regional Behavioral Health Administrative Services Organization released a request for proposals (RFP) in October 2022 for a first responder/co-responder program.[170] The RFP is intended to operate in conjunction with existing behavioral health co-responder teams, expand community engagement, and increase the number of opportunities for diversion to prevent involvement in the criminal justice system. The RFP is funded through a federal block grant of $100,000. The funds will be for one full-time Washington State Department of Health licensed mental health professional to be maintained within a first responder agency within the Spokane Regional Service Area. The goals of the co-responder program include de-escalation of crisis situations; diversion of individuals from the criminal justice system and reduction in recidivism; connection to necessary community resources and medical and behavioral health services; and additional entry points into the physical and behavioral health system to prevent higher acuity involvement and promote early intervention.

Olympia Police Department (OPD) Crisis Response Unit (CRU) and Familiar Faces

Peer outreach is the backbone of the crisis response unit of Olympia. Individuals in crisis are referred by law enforcement and community members, but in specific areas of the city with a CRU, team members are able to provide a real-time response to crisis. Olympia's CRU within the OPD provides free, confidential, and voluntary community-based crisis response. CRU implemented a layered approach to crisis response. Since the program often focuses on immediate response and care, it will often refer individuals who have frequent contact with the program to Familiar Faces. Operated by OPD, and staffed with outreach specialists, Familiar Faces works towards lasting stability to those in constant crisis.[171]

- Since April 2019, CRU averages between 500 to 600 contacts per quarter.
- 3,108 calls since program start, zero staff injuries have been reported and only two calls for police back-up were required due to safety concerns.
- Staffing includes four crisis response specialists, two crisis response lead workers, and two outreach specialists (Familiar Faces). At the start of the program, staffing was established via contract with a local behavioral health provider, but has since transitioned to city employment.

CRUs are dispatched through Thurston County 911 Communications Center (TCOMM 911), OPD's non-emergency line, and/or over the shared police radio frequency. Modeled after CAHOOTS, CRUs use police radios to identify and respond to calls that usually go straight to police, a practice which required a culture shift in the OPD. Rather than dispatching CRU based on specific criteria, TCOMM 911 shares all potentially eligible calls coming through 911 or Olympia's non-emergency line over shared police frequency. CRUs receive extensive training on using the police radio frequency as civilians.[172] Community engagement and collaboration is a stated priority of the OPD. Members of the CRU spend much of their time building relationships with community members and organizations to establish meaningful connections and better understand their needs. The CRU distributes regular surveys with law enforcement officials to gain perspectives on the strengths and weaknesses of the program. The team is present every day at the City of Olympia's sanctioned encampment for people experiencing

[169] https://www.houstoncit.org/.
[170] SCRBH ASO RFP for a First-Responder Co-Responder Program.
[171] https://csgjusticecenter.org/publications/expanding-first-response/program-highlights/olympia-wa/.
[172] https://www.vera.org/behavioral-health-crisis-alternatives/cru-and-familiar-faces.

homelessness—working to build relationships to better understand the challenges and how to best support them.[173]

CRUs are funded by revenue generated from the Public Safety Levy, an increase in property taxes approved by voters in November 2017. The levy allocated $110,100 in startup costs and $497,000 in annual costs. From 2018 to 2020, Familiar Faces received funding from Washington Association of Sheriffs and Police Chiefs grant and additional contributions from city funds. The 2022 budget for CRU and Familiar Faces was $2 million.[174]

City of Tacoma Homeless Outreach Team (HOT)

The City of Tacoma authorized a study for the Tacoma Police Department to analyze and make recommendations on the feasibility of alternative responses to mental health crises, homelessness-related issues, and certain types of calls for service traditionally handled by police officers that could be handled by civilian responders. The study specifically reviewed the diversion of homelessness-related and mental health crisis calls. After analysis of a reassignment of major functions of the HOT to other agencies, the study recommended the creation of a new non-police team of civilian responders to respond to calls centered on mental health crisis and homelessness-related issues.

The study found that the co-response model of pairing officers with clinicians in the field to respond to mental health crisis events is highly effective, but HOT is neither typically the primary unit for these types of calls, nor are they deployed during the hours in which they are most likely to occur.

The study also found that the shared roles between HOT and Neighborhood and Community Services (NCS) for outreach to homeless encampments poses organizational difficulties and hinders effective coordination. To address this, the study recommended that outreach responsibility be fully shifted to NCS, with two additional NCS outreach worker positions hired to handle the increased workload.

The study identified a number of challenges, including response to mental health crisis events, where the feasibility of diversion has certain limitations and involves more complicated questions to be asked of the individual in crisis. For instance, a key aspect of the designated clinical responder position is the ability to place individuals on involuntary holds. This inherently requires a need for an officer. In an alternative model where the team is organized outside of the police department, there may be greater challenges in filling the positions. Diverting these types of calls to civilian response does not entirely remove the need for police presence at these events, particularly for incidents involving an individual engaged in or appearing to display a propensity to commit violent acts. Responders must be able to provide basic medical care and administer naloxone in emergency situations.[175]

Additional Models

Cochise County, Arizona: Rural Co-Response

The Cochise County Board of Supervisors approved an agreement between Legacy Foundation of Southeast Arizona and the Cochise County Sheriff's Office to create a county-wide mental health support team to serve the rural area. At the start, the team consisted of three hired behavioral health professionals and one detention officer in partnership with CIT officers.

[173] Ibid.
[174] https://www.vera.org/behavioral-health-crisis-alternatives/cru-and-familiar-faces.
[175] Matrix Consulting Group. Final Report on the Alternative Response Study for Tacoma Washington, May 21, 2021.

Roselle Park New Jersey Arrive Together Program

The purpose of a New Jersey co-response program—Arrive Together—is to address the mental health needs of people in crisis and to reduce the risk of responses ending in violence. Teams are called by either a 911 or a 988 dispatcher or by a uniformed officer at the scene to respond to emergencies involving people in emotional distress. Two-person teams arrive in unmarked cars without flashing lights or sirens, with a police officer in casual clothes accompanying a mental health counselor.

New Jersey's Attorney General's Office created the pilot program after the 2020 police killing of George Floyd. As of February 2023, the program is expanding to 10 of New Jersey's 21 counties, and state leaders plan to expand it statewide. Governor Murphy promised to include $10 million in the next fiscal year's budget for the expansion.[176] The current expansion is partially funded by a grant of over half a million dollars offered through the U.S. Department of Justice's Bureau of Justice Assistance called "Connect and Protect: Law Enforcement Behavioral Health Response Program."[177]

The results include fewer emergency callers being referred to jails and hospitals, with the majority of callers able to stay at home, as well as fewer arrests and fewer responses where force is used. Other reported benefits include an increase in trust between the police and the community, a reduction in the time people in crisis wait for a mental health screening, a continuation of contact in the community between the officer or social worker and residents, and less stigma in the emergency response process.

Every officer and mental health screener in the co-response program must complete intensive training where they learn techniques to de-escalate conflicts without resorting to force. The training includes topics such as the special needs of combat veterans and people struggling with addiction.[178]

Wichita Police Department

The Wichita Police Department utilizes a co-responder unit called the Integrated Care Team, an MCT in conjunction with COMCARE (the largest CMHC in Kansas), and a well-established HOT. Two community support specialists are embedded within the police department and assist officers in connecting families with public health programs for parenting-skills building, mental illness or SUD services, and similar safety network supports. HOT runs the "finding a way home" program, working to reunite people experiencing homelessness with family around the county who are willing to provide housing or assistance. All officers in the Wichita Police Department receive MHFA training and more than 100 (out of 690) officers have completed CIT training certification.[179]

Grand Lake, Oklahoma Integrated Crisis Response: Virtual Co-Responder Units*

Virtual co-response is a trend that municipalities and states are using to address provider shortages through telehealth. One example is the Grand Lake Mental Health Center (GLMHC) which provides integrated health services to more than 250,000 people within a 4,500 square mile service region. In response to rising behavioral health crisis and increasing provider shortages, GLMHC partnered with local hospitals and police departments. Through the collaboration, mobile tablets are provided for virtual co-response: hospital staff, LEO, and first responders connect in real-time to expedite delivery of behavioral health crisis services from GLMHC. Virtual co-response has reduced inpatient stays from 1,115 in 2015 to 402 in 2017. The reduction in ED and inpatient admissions over two years resulted in an estimated savings of $6,560,700. Law enforcement and first responders have expanded their use of the

[176] https://www.nytimes.com/2023/02/09/nyregion/new-jersey-police-mental-health.html.
[177] https://www.njoag.gov/ag-platkin-and-colonel-patrick-j-callahan-announce-new-jersey-state-police-awarded-over-500000-federal-grant-to-expand-arrive-together-mental-health-crisis-response-initiative/.
[178] https://www.nytimes.com/2023/02/09/nyregion/new-jersey-police-mental-health.html
[179] https://csgjusticecenter.org/projects/law-enforcement-mental-health-learning-sites/wichita-police-department/

mobile tablets beyond crises to address health disparities within the community, facilitating connection to community services.[180]

Kansas City Public School District 500: Law Enforcement in Schools

This public school district launched an MHFA training program designed for school resource officers, counselors, district employees and staff, and members of the parent-teacher association. Local law enforcement are invited to join the sessions for specialized training on how to address students experiencing a behavioral health crisis in the classroom. The program has adapted a co-responder model to utilize a team approach to students in crisis. Teams consist of trained resource officers, school counselors, and a teacher or administrator. Depending on the situation, outside assistance may be requested from parents and guardians or police officers trained in MHFA.

Modesto California Community Mental Health Paramedicine

Launched in 2015 and operated by Mountain Valley EMS, Modesto CPP was established to address psychiatric needs within the community. An integral component of the program's success is the ability to transport to psychiatric ED and/or outpatient clinics. According to paramedics in the program, providing community mental health can mean anything from late night tacos with a friendly supportive chat, to check-ins to ensure psychiatric treatment compliance, to de-escalation of mental health crises. For one patient, they check on him regularly, bring him tacos, and remind him to take his medications. Increasingly, community paramedics are assuming the follow-up component within the mental health crisis continuum.[181]

New York City's (NYC) Behavioral Health Emergency Assistance Response Division (B-HEARD)

Launched as a pilot program in June 2021, B-HEARD operates jointly by the Fire Department of the City of New York's EMS and NYC Health + Hospitals, with the Mayor's Office of Community Mental Health providing program oversight. B-HEARD teams typically provide response to calls including suicidal ideation, substance misuse, mental illness, and physical health problems exacerbated by mental health concern. In addition to on-scene crisis intervention, the teams can also provide emergency medical care and request transportation.[182]

- Dispatched through the 911 dispatch center, call takers analyze calls to determine if there is a mental health component and when B-HEARD is an appropriate response.
- Operates seven days a week, 16 hours per day, in 15 NYC police precincts.
- Staffing includes two EMT/paramedics and a social worker from NYC Health + Hospitals.

Data is made publicly available through the NYC Mayor's Office and includes metrics related to operations and outcomes, which are monitored frequently:[183]

- 22% of mental health-related calls routed to B-HEARD teams.
- 82% of calls routed to B-HEARD get an in-person response.
- 92% of people served "accepted" assistance (compared to national average of 87% for 911).
- 46% of people assisted were transported to a hospital for additional care.

[180] SAMHSA, Tailoring Crisis Response and Pre-Arrest Diversion Models for Rural Communities. Available at: https://store.samhsa.gov/sites/default/files/d7/priv/pep19-crisis-rural.pdf.
[181] https://khn.org/news/community-paramedics-work-to-link-patients-with-mental-health-care/.
[182] https://csgjusticecenter.org/publications/expanding-first-response/program-highlights/newyork/.
[183] https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/12/FINAL-DATA-BRIEF-B-HEARD-FIRST-SIX-MONTHS-OF-OPERATIONS-12.15.21-1.pdf.

- 47% of people assisted were transported to a community-based care location.

Rural Pennsylvania SDOH Co-Responder Unit: Co-Response and Social Needs

Launched in 2020, the Bucks County Co-Responder pilot program serves several rural communities. The program aims to provide more effective emergency response through the addition of clinical support; divert individuals with primarily social service needs from the criminal justice system; and to generally increase the use of community services. Two-person teams are fully funded from mental health block grant dollars and include a mobile social worker team embedded into one township police department. The team partners with law enforcement and serves as a liaison in addressing social service needs of individuals contacting 911. Co-responders are dispatched through 911 to address mental health and drug-related concerns and serve children, teens, adults, and older adults. Police arrive at the scene first to assess safety and to call co-responders to scene. A pilot program in Bensalem Township showed a significant decrease in the time police officers spent responding to social service calls as they diverted to co-responders. The pilot also showed that 55 percent of co-response calls were diverted away from arrest or incarceration and connected to behavioral health or human service providers.[184]

Montpelier and Washington County, Vermont: Training for Co-Responder Model

Montpelier Police Department and Washington County Mental Health officials developed a program to bring together police, behavioral health crisis clinicians, fire department personnel, EMS, 911 dispatchers, and state attorneys. The partnership developed an innovative training approach—all partners participated in a one-day, scenario-based training called “Two Team.” The training was designed for rural crisis providers to adapt for co-response. Thirty-five LEOs were trained and are participating in co-response. Since the launch of Two Team, the program has added the following partners: hospital EDs, local mental health agencies, and NAMI Vermont. The co-response curriculum has been updated with more content relevant to peer advocates and a new objective to “allow participants to learn each other’s language and limitations when responding to mental health crisis.”

Western New York Peer-Led Mobile Crisis Outreach (People USA)

The Westchester Forensic Mobile Team works directly with law enforcement in the field and courts seeking Alternatives to Incarceration (ATI), to provide immediate crisis response and/or transition care services to people at risk of entering the criminal justice system due to under-addressed mental health, addiction, or SDOH issues.[185] Local courts utilize the Westchester County Department of Community Mental Health’s ATI system to activate forensic mobile team services, which are available 24/7/365. Calls from courts get an immediate dispatch by the peer-led crisis team. The nature of calls originating from the court system are in response to a magistrate in need of assistance with an individual during the arraignment process.[186]

Nebraska Respond, Empower, Advocate, and Listen (REAL) Program: Peer Co-Response

Established by the Mental Health Association of Nebraska, REAL leverages evidence-based peer support services to support the diversion of behavioral health crises. REAL works in partnership with law enforcement and community-service organizations. An established referral process links individuals in crisis to trained peers. The peers provides free, voluntary, and non-clinical support. The REAL program met its goal of reducing emergency protective orders and involuntary placement. From 2011 to 2018, there was a 44 percent decrease in participants taken into emergency protective custody by law personnel.

[184] https://www.buckscounty.gov/1650/Co-Responder-Program.
[185] https://people-usa.org/program/forensic-mobile-team/.
[186] Ibid.