SALT LAKE COUNTY CRISIS RESPONSE POLICY PROPOSAL

May 2025

PRESENTED BY:

Office of Homelessness & Criminal Justice Reform & Salt Lake County Criminal Justice Advisory Council (CJAC)

SALT LAKE COUNTY
OFFICE OF HOMELESSNESS AND CRIMINAL JUSTICE REFORM

EXECUTIVE SUMMARY

Salt Lake County's crisis response continuum needs better coordination and integration to improve outcomes for individuals and families in crisis while reducing reliance on emergency departments and jails. The current system spans many siloed jurisdictions and disciplines, resulting in costly inefficiencies and compromised outcomes. Law enforcement is the primary responder to mental health and substance use crisis events despite limitations in their ability to resolve mental health or substance use challenges in the field and a tendency to default to transport to emergency departments and arrests, both of which are expensive and associated with poor outcomes. Collectively, these system challenges highlight the need for a robust, coordinated crisis response continuum by adopting the following recommendations:

Recommendations

Salt Lake County Crisis Response Coordinating Task Force

Establish a governing task force, co-led by law enforcement and behavioral health, to support and advise the coordination of the crisis response continuum.

Centralized Post-Crisis Care Program

Establish a centralized post-crisis care program that supports individuals after the crisis with ongoing services and system navigation.

Cross System Data Integration & Information Sharing

Enhance macro-level data integration across systems through comprehensive analysis to inform programs and policies while improving micro-level real-time information for first responders when working with a person in crisis.

MCOT Transportation Services

Facilitate MCOT's ability to transport low acuity, voluntary patients to a higher level of care.

Enhanced Co-Response Coordination

Address coordination gaps between law enforcement, MCOT teams, and police-based social workers. Enhance on-scene collaboration, coordination, and communication.

Enhanced First Responder Training

Develop training that:

- *Support knowledge retention and reinforce key techniques for crisis response.*
- *Are tailored to the trends and situations officers experience.*
- *Include information about community resources.*

By implementing these recommendations, Salt Lake County can craft an efficient, data-driven, and person-centered coordinated crisis response continuum. This coordinated approach aims to reduce the strain on emergency services and law enforcement, improve public safety, and ensure that individuals in crisis receive timely and appropriate care.

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INTRODUCTION

This report integrates **stakeholder perspectives** with a **quantitative analysis** of response data to present an initial picture of crisis response in Salt Lake County. The report also presents a set of recommendations based on **nationwide best practices** and **identified gaps**. Together, these elements are intended to guide strategic planning and coordination and develop a clear path toward the goal of a **robust, coordinated crisis response continuum**.

First, to support this goal, the Salt Lake County Office of Homelessness and Criminal Justice Reform conducted a yearlong research project to examine the systems that respond to crises. The research team conducted fifty interviews with crisis response professionals to understand challenges across various response modalities.

Then, in collaboration with the Criminal Justice Advisory Council (CJAC) Crisis Response workgroup, the team developed recommendations to build towards a cohesive and coordinated continuum. These recommendations were refined through law enforcement and behavioral health focus groups, and the result reflects a balance of perspective and priorities among a diverse set of stakeholders.

Next, conversations and data revealed that the crisis response system is not distinct; rather, it is a continuum of systems, each working under its own parameters and to its own ends. Mapping this continuum was important for understanding the following key questions: Who is responding to crises in our community? How do clients move between systems and across different response modalities? How do these agencies and providers collaborate and share information? Where are the gaps?

Recommendations for the crisis response continuum were the second deliverable. Stakeholder consensus and best-practice research informed each recommendation, and key players have expressed a commitment to coordinate across response modalities.

While the Crisis Response Coordinating Task Force (1) can lead the implementation of recommendations 2–5, these measures can be pursued independently or in tandem.

This guidance, as with the recommendations in this report, is intended to amplify the immense impact of the providers and responders in our community.

As a final note, the research revealed a consistently high level of professionalism, dedication, and commitment to client care across every response modality and stakeholder group. The team is grateful for the perspectives shared and believes wholeheartedly in the strength of the foundation on which this crisis response system will be built.

The work will continue beyond these recommendations. From **integrating new response modalities** to learning from quantitative insights to adapting to an evolving set of community needs, new opportunities will emerge to shepherd the Salt Lake County crisis response continuum as it matures.

OVERVIEW

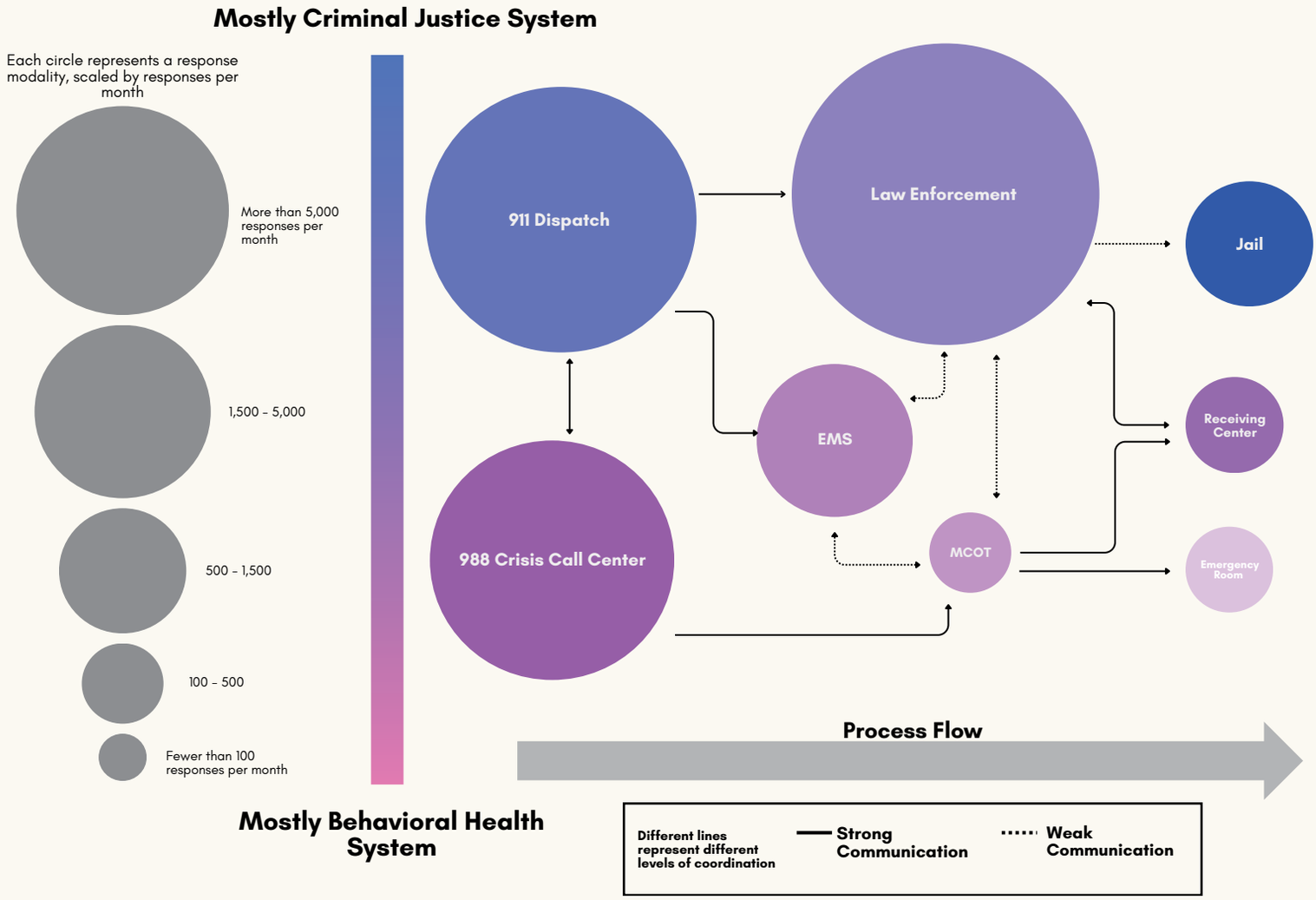
Crisis response in Salt Lake County involves behavioral health, law enforcement, and health care response modalities operating within a siloed delivery model. To illustrate, the **crisis response continuum includes:**

Modality	Purpose	Best Use	Core Challenge
DISPATCH	**Direct** appropriate and timely **resources**	Caller provides **necessary information**, and an appropriate **level** of **response** is available	**High call volume** across extremely diverse array of scenarios
LAW ENFORCEMENT	Ensure **scene safety** and individual **accountability**	Timely **mitigation** of imminent **public safety** risk	**Primary response** to a majority of crisis calls with **limited tools** to sufficiently address the crises
EMERGENCY MEDICAL SERVICES	Provide **lifesaving** on-scene **care** and **transport**	On-scene **stabilization** of life-threatening **medical conditions**	**Overused** for low-acuity crises
MOBILE CRISIS OUTREACH TEAMS	Deliver accessible, trained **de-escalation** response and **assessment**	Connect individuals with the **least restrictive** level of **care**	**Varied response times**, on-scene coordination, and transportation
CRISIS CARE CENTER	Provide immediate **stabilization** and de-escalation in a **central location**	**Divert** individuals from ER and Jail, **stabilize**, and **plan** for recovery	**Integrating** this diversion opportunity into the larger system
HOSPITALS	Provide **immediate**, life-saving **medical care** to anyone	Medical assessment to **stabilize patient** for further care	Can assess the problem, but **struggle to address** and **follow-up**
COMMUNITY-BASED PROVIDERS	Address **individual needs** for continuous care with **low/no-cost services**	**Improve lives** with need-based services	**Insufficient resources** to meet demand

RESPONSE CONTINUUM MAP

The varied crisis response systems face significant information-sharing challenges, leading to an inefficient and costly response model. At the same time, these systems struggle to limit an individual's circulation through crisis services due to the lack of coordination and follow-up care.

Each **"bubble"** represents a response modality, sized based on average responses per month. The bubbles are then connected with a line to show how information is typically shared. Bubbles are color-coded based on their alignment with criminal justice or behavioral health systems and organized left-to-right to indicate process flow.



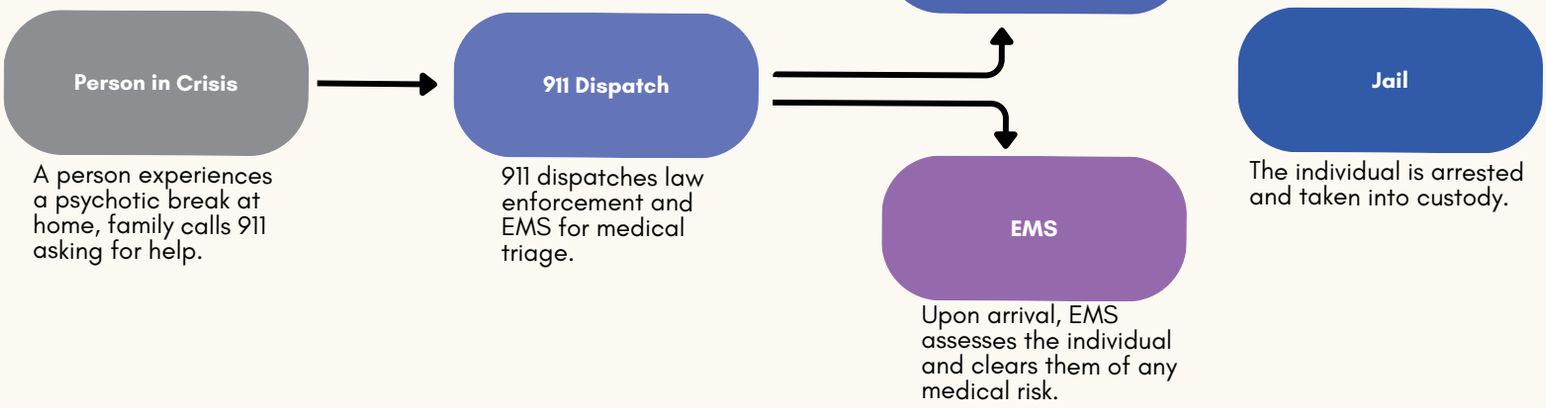
Working in concert, these response modalities aim to coordinate the care a client receives through crisis and beyond. For example, almost 50% of law enforcement responses involved embedded social workers, and many individuals are successfully stabilized in place and referred to follow-up care.

This map also highlights where breakdowns can occur. For example, the current model relies heavily on law enforcement response. Additionally, frequent communication breakdowns between law enforcement, EMS, and MCOT result in scene mismanagement and client re-escalation.

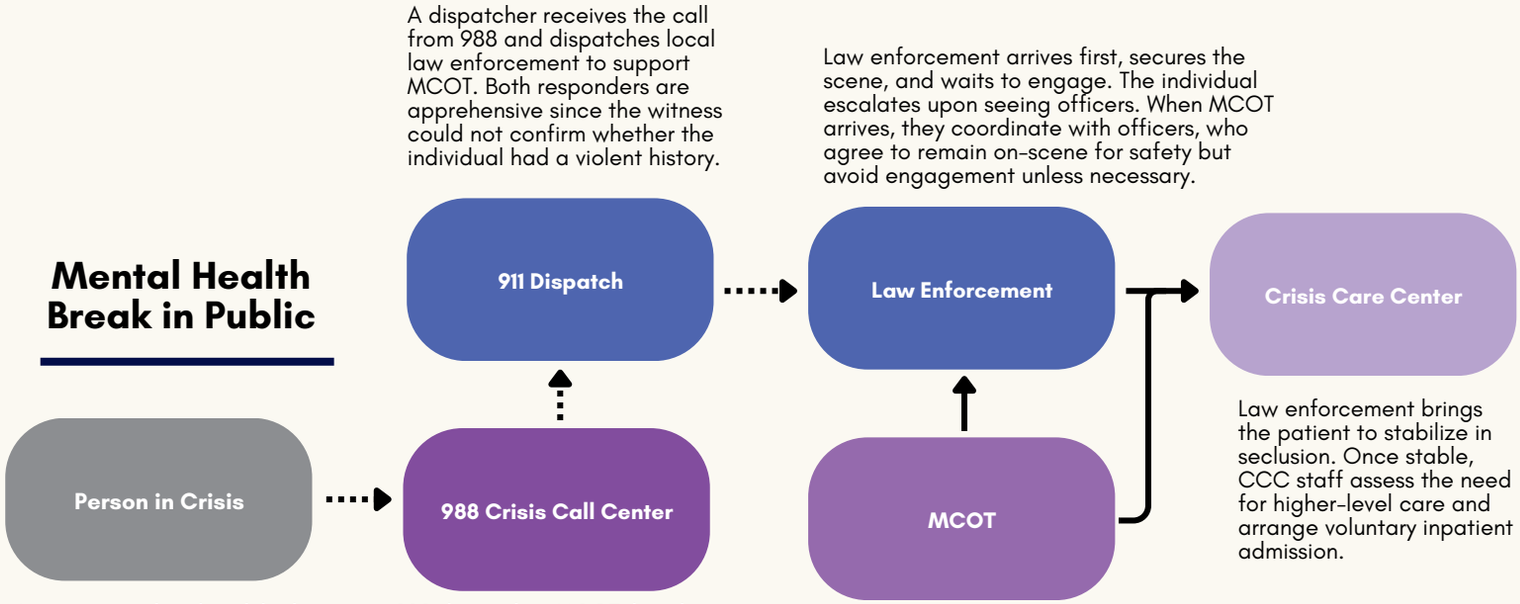
CLIENT PATHWAYS

The following case scenarios represent possible client pathways while in crisis, illustrating how different factors lead to different responders and outcomes.

Psychotic Break at Home



Mental Health Break in Public



CLIENT PATHWAYS

Suicidal Thoughts at Home

Person in Crisis

The partner witnesses the person having suicidal thoughts at home and calls 988 for help. They withhold the patient's violent history, hoping to prevent a law enforcement response.

988 Call Center

A 988 crisis worker cannot stabilize the individual and dispatches MCOT to respond to their home.

MCOT

MCOT arrives, and the individual escalates, threatening violence. MCOT calls 911 to dispatch law enforcement.

911 Dispatch

911 dispatches local law enforcement to support MCOT on-scene. 911 gathers limited information on the patient's negative interactions with law enforcement. MCOT has been with the individual for over an hour.

Law Enforcement

Law enforcement arrives on the scene, furthering escalation. MCOT deemed the individual to meet the criteria for issuing a "pink sheet." An officer transports the individual to the nearest emergency room.

Hospital

The individual is restrained and transported to the local emergency department, where they are well known due to frequent visits. The patient was discharged after two hours because the crisis worker did not complete the pink sheet properly.

Homeless Shelter Agitation

Person in Crisis

A person experiencing agitation with escalated behaviors in a shelter. Their case manager knows their history and calls 988 for help.

988 Call Center

988 crisis worker is unable to render adequate support and dispatches MCOT.

MCOT

MCOT arrives within the hour to assess and provide crisis intervention techniques. The individual voluntarily agrees to further stabilization at the receiving center.

EMS

MCOT requests EMS transport to the receiving center for additional supportive services.

Crisis Care Center

Staff assigned the individual to a recliner for 12 hours of additional stabilization. They provide new clothes and a warm meal and schedule a follow-up appointment.

CRISIS RESPONSE BEST PRACTICE

To identify opportunities for system integration, it is helpful to understand nationwide best practices and assess how the county has integrated these standards into current models.

In 2020 The Substance Abuse and Mental Health Services Administration **(SAMHSA)** published the National Guidelines for Behavioral Health Crisis Care Best Practices to help states assess their crisis systems[23]. **The guidelines recommend three core services, which are now available in Salt Lake County:**

Regional Crisis Call Centers:

A 24/7 facility staffed by clinicians that provides crisis intervention through phone calls, text messages, or online chat. Clinically trained staff conduct risk assessments and can coordinate crisis response and dispatch additional resources when necessary[23].

Crisis Mobile Team Response:

A mobile response team that addresses individuals in crisis within the community promptly, either independently or in support of first responders. The team's structure should consist of two members: a clinician and a certified peer support specialist. Services provided by the team include assessments, de-escalation interventions, coordination with medical and behavioral health services, crisis planning, and connecting individuals with follow-up services[23].

Crisis Receiving and Stabilization Facilities

A 24/7 facility offering de-escalation and stabilization services for individuals experiencing a behavioral health crisis. The facility accepts all referrals, regardless of the clinical condition or age of the individual. Adopting a no-wrong-door approach, it welcomes referrals from law enforcement, emergency medical services, and walk-ins, aiming to reduce the impact on emergency rooms and promote diversion from the justice system[23].

ANALYSIS

A qualitative analysis informed by **fifty (50) interviews** and **twelve (12) focus groups** yielded two distinct sets of challenges. The first is how different response modalities interact, called the **'response continuum.'** The second is how each response modality experiences gaps within its own system, called **'system gaps.'**

Response Contiuum

Challenges across the **response continuum** impede the effectiveness and cohesion of response modalities. Insights from the interviews and the focus groups indicate communication and collaboration breakdowns, hindering information sharing and leading to fragmented responses with suboptimal outcomes. Initial collaborative efforts produced patchwork coordination across some response modalities but remain absent from a comprehensive, countywide systemic strategy. These systemic gaps, further exacerbated by limited resources, prevent efficient coordination and disrupt the continuity of care for individuals during, after, and across crises.

Over the past decade, significant investments have been made in developing a coordinated behavioral health response to crises, guided by SAMHSA's best practices. Key investments include a **crisis call center**, **mobile crisis outreach teams** (MCOT), and a **receiving center** in Salt Lake County. The aim is to divert individuals in crisis from law enforcement and emergency services to appropriate supportive resources. While these programs have shown positive outcomes, reliance on law enforcement remains high, with officers responding to an average of **202 crisis calls daily**, or over **6,000 monthly**[14]. By contrast, MCOT handles an average of **370** crisis calls per month[17]. Despite high utilization, law enforcement still lacks sufficient resources to address behavioral health crises effectively. As a result, individuals cycle through the criminal justice system and experience barriers to recovery and stability.

The following example illustrates the lack of cohesion across the response continuum:

> *"A Holladay Detective was assigned a case involving an individual in crisis. This individual was brought to Salt Lake County by Tooele law enforcement to receive medical care at the hospital. After being discharged from the hospital, the individual had multiple law enforcement interactions that were crisis or drug related, but these interactions were not flagged for mental health to route a proper detective, causing this case to get lost in the system. As the detective was investigating the case, no follow-up had been completed other than "attempted phone contact" on a disconnected line, with nothing further. By the time the detective was able to establish accurate information it was too late, the person had passed away from an overdose in another jurisdiction."*

When interviewed for this report, the detective expressed frustration, believing that if information had been accessible and comprehensive, appropriate resources could have been offered, potentially preventing a tragic outcome. Cases like this one are common and highlight the need for systematic coordination across the response continuum.

ANALYSIS

Our crisis response continuum lacks a coordinated approach. Unclear roles and responsibilities contribute to fractured trust, deterring collaboration. Many agencies respond to crises in our community, but limited data sharing, insufficient resources, and system inefficiencies lead to the repeated cycling of individuals without meaningful intervention. Administrative burdens and compliance with state and federal privacy laws further restrict information sharing, making it more challenging for officers to access client histories and connect individuals to appropriate resources. Instead of a streamlined approach, officers must navigate multiple systems to piece together crucial information, placing additional strain on law enforcement and reducing the effectiveness of crisis intervention.

System Gaps

In Salt Lake County, crisis call responders vary based on location, capacity, context, and jurisdiction. Individual system gaps have a **downstream impact** on effective coordination and collaboration.

The **primary objective** of crisis response is to divert individuals who do not pose a public safety risk from the criminal justice system. Resource constraints further interfere with timely access to ongoing supportive services for individuals, disrupting continuity of care. **Coordination challenges** and **limited resources** undermine consistent, timely, and quality care for the community.

First, coordination challenges among law enforcement agencies hinder the collection of critical information, often resulting in officers repeatedly gathering the person's history for each crisis event. This redundancy **increases** the **time burden** on officers, resulting in **unnecessary re-traumatization** for clients.

Second, communication breakdowns among law enforcement, MCOT, and EMS obstruct on-scene coordination, support, and patient transport. Since MCOT lacks transport capabilities, they rely on EMS or law enforcement, creating further challenges.

Third, several municipalities, including Salt Lake City and Millcreek, use co-response teams, integrating social workers alongside law enforcement. Salt Lake City's police and fire departments also embed social workers to provide immediate crisis intervention and short-term case management. While these initiatives have shown success, coordination remains challenging.

West Valley City's CIT Unit and the Salt Lake County Sheriff's Office Metro Mental Health Unit were **disbanded** due to funding limitations and systemic barriers. The absence of behavioral health professionals on-scene negatively affects community outcomes, as law enforcement alone may not be the most effective response to behavioral health crises. In addition, law enforcement will occasionally request MCOT for on-scene support, but lengthy response times dissuade collaboration.

ANALYSIS

Finally, Salt Lake County lacks a standardized system for crisis training, communication, and operations. While many agencies require **Crisis Intervention Team** (CIT) training, the two primary providers—CIT Metro and CIT Utah—differ in their training approaches and participation requirements. CIT equips officers with essential skills to understand behavioral health conditions, de-escalate situations, and reduce the use of force while ensuring scene safety. Officers often **struggle to retain and apply** these skills due to the sheer volume of information covered. Regular **follow-up training** is essential to reinforce evidence-based practices and improve long-term effectiveness[27].

Care Beyond Crisis

Resource limitations, communication breakdowns, and the **complexity of crisis response** create a critical gap in post-crisis care. While agencies can connect individuals to treatment, a centralized program post-crisis and beyond is not available. This lack of longer-term, post-crisis services leaves individuals without care continuity, increasing the risk of repeated crises.

Additionally, a shortage of behavioral health professionals further restricts treatment availability and increases program wait times. Without proper coordination, individuals often cycle through the crisis response continuum without addressing the root causes of their crises, highlighting the need for post-crisis follow-up services.

Looking Forward

The crisis response continuum lacks a **unified approach** to responding to and preventing crises in Salt Lake County. Currently, there is no systematic coordination of response modalities, leading to an **overreliance on law enforcement** despite substantial investments in behavioral health diversion.

Coordination and **communication breakdowns** between law enforcement, MCOT, and other service providers impede timely and effective responses. Furthermore, resource limitations, inconsistent training, and a lack of continuity in post-crisis care prevent individuals from accessing **ongoing supportive services**.

The following section presents a set of key **recommendations** to address these challenges, facilitate coordination, enhance collaboration, and improve the continuity of care for an **effective** and **integrated** crisis response continuum.

> *"The burden is on law enforcement to respond to crisis calls; Law enforcement is not the right fit for it, but the '**solution**' is to cite a person enough times, and then he goes to jail. I recognize it isn't the best option, but fines on the person are not necessarily helping either."*
>
> *Police Officer*

RECOMMENDATIONS

To address crisis response challenges, the Office of Homelessness and Criminal Justice Reform has developed six targeted recommendations. Taken together, these recommendations will enhance the crisis response continuum and prevent future crises by coordinating and ensuring an efficient, data-driven, and person-centered approach.

Recommendation	Purpose
Salt Lake County Crisis Response Coordinating Task Force	Establish a governing task force, co-led by law enforcement and behavioral health, to support and advise the coordination of the crisis response continuum.
Centralized Post-Crisis Care Program	Establish a centralized post-crisis care program that supports individuals after the crisis with ongoing services and system navigation.
Cross System Data Integration & Information Sharing	Enhance macro-level data integration across systems through comprehensive analysis to inform programs and policies. Improves micro-level real-time information sharing for first responders when working with a person in crisis.
MCOT Transportation Services	Facilitate MCOT's ability to transport low acuity, voluntary patients to a higher level of care.
Enhanced Co-Response Coordination	Address coordination gaps between law enforcement, MCOT teams, and police-based social workers. Enhance on-scene collaboration, coordination, and communication.
Enhanced First Responder Training	Develop training that: • Support knowledge retention and reinforce key techniques for crisis response. • Are tailored to the trends and situations officers experience. • Include information about community resources.

1 SALT LAKE COUNTY CRISIS RESPONSE COORDINATING TASK FORCE

Conversations with key stakeholders highlighted a willingness to collaborate across response modalities and the absence of a clear avenue. To meet this need, this report recommends establishing a Salt Lake County Crisis Response Coordinating Task Force. Meeting regularly and supported by County staff, this body will provide an implementation structure for system improvements and dynamically identify gaps and opportunities.

Whereas the Utah Behavioral Health Crisis Response Committee helps establish a statewide standard of care in crisis scenarios, the Coordinating Task Force will focus on integrating services within Salt Lake County's unique delivery model. Crucially, there are no statutory barriers to creating this body, and existing staff resources can be deployed to establish proof-of-concept and secure long-term budgetary support.

Beyond the recommendations in this report, the Task Force will identify and pursue further opportunities to promote consistent, compassionate responses to individuals in crisis by building sustainable partnerships with each response modality.

The Coordinating Task Force will comprise thirteen stakeholders, co-led by law enforcement and behavioral health representatives. Convening monthly to start and redetermine the meeting schedule as necessary.

Membership will include at least one representative from each of the following areas of expertise:

Law Enforcement	**Behavioral Health**
Lived Experience	**MCOT**
Crisis Care Center	**Hospitals**
Mental Health Provider	**Substance Use Provider**
EMS	**County Jail**

It is ideal to have a dedicated staff member to support the coordination, operations, and initiatives of the Task Force. The Utah Behavioral Health Commission utilizes this staffing model to advance the commission's work.[28]

The Task Force will address various topics to strengthen Salt Lake County's crisis system, including:

- *How to triage between law enforcement and MCOT responses adequately*
- *Conduct a community needs assessment*
- *Diversion opportunities*
- *Protocols to work across response modalities*
- *Cross-system data analysis*
- *Evaluation of the crisis response continuum*
- *Create open lines of communication with Utah Behavioral Health Crisis Response Committee*

Establishing a governance framework will give stakeholders a formal mechanism for **effective dialogue** and **timely decision-making** to address critical gaps. This collaborative approach will foster trust and promote the development of an integrated crisis response continuum.

Evidence To Support a Crisis Response Coordinating Task Force

1) SAMHSA and CIT International recommend a localized advisory board

The advisory board should foster partnerships between law enforcement, advocates, and behavioral health professionals to create localized solutions and ensure sustainable coordination of the crisis system.[23]

Additionally, CIT International recommends that a regional body provide oversight, analyze data, and monitor programs, enabling leaders to make informed recommendations to improve the crisis continuum of care.[27]

2) SAMHSA's 2025 guidelines outline how to build an integrated, comprehensive behavioral health crisis system

The SAMHSA guidelines recommend clear oversight structures for a crisis response continuum to facilitate system implementation and smooth transitions between services.[24]

SAMHSA emphasizes that services should be localized to address community needs, ensuring not only a variety of crisis services but also an interconnected system that meets local demand.[24]

3) The *National Council for Mental Wellbeing's* 2021 report recommends creating a high-level "accountable entity" to coordinate crisis systems[6]

This report suggests creating an "accountable entity" to focus on local areas through a collaborative system approach to provide essential quality improvement functions for the crisis system. [6]

4) The CSG Justice Center, in partnership with the Bureau of Justice Assistance (BJA), developed the Police-Mental Health Collaboration Framework

Their recommendations for a successful law enforcement and behavioral health collaboration include an interagency workgroup to discuss data sharing and inform improvements to crisis response, reducing repeat encounters.[21]

They suggest forming a formal community workgroup with law enforcement, behavioral health, government, and community-based providers to plan, implement, and evaluate collaborative efforts.[21]

> ***"It's about compassion, sustainability, and real partnership across systems — making sure that every person in crisis gets the right response at the right time, from people who are trained, connected, and committed to working together."***
>
> *Community Member*

2 CENTRALIZED POST-CRISIS CARE PROGRAM

Centralized post-crisis care is a critical gap in our crisis response continuum. Prevention of future crises hinges on which response modalities are engaged, the crisis outcome, and the individual's established connections to community-based services. Frequently, individuals do not receive post-crisis services due to the lack of integration and capacity constraints. Thus, we recommend a centralized post-crisis care program to prevent future crises through adequate follow-up care.

This program will assign a **peer support specialist** and a **case manager** to follow up with individuals after a crisis and coordinate with service providers and response modalities.

This post-crisis team will follow up within 24 hours of the crisis event and prioritize **trauma-informed**, **human-centered care.** Program activities will include assisting clients with resource navigation, individualized case planning, and stabilization.

To implement this program in Salt Lake County, a comprehensive, **cross-system analysis** of crisis response data will **inform program scope** and staffing goals. Next, a **grant-funded program pilot** with three (3) post-crisis teams supported by a program logic model will be utilized to **develop protocols** and **establish validity**. After the pilot is evaluated for sustainability and scalability, a **long-term host** will be selected and **funding sources** identified.

Potential funding sources include: **Medicaid billing** for peer support and case management services, state and county general funds, and **federal grants**.

Investing in **centralized post-crisis care** is the primary means of **crisis prevention**. It is a key step towards promoting healthy, long-term outcomes for clients and reducing the burden on the crisis response continuum.

Additionally, this program shows **strong alignment** with the strategy outlined in **The Salt Lake County Human Services, Homelessness, and Criminal Justice Reform Action Plan**.

Evidence For a Centralized Post Crisis Care Program

1) SAMHSA recommends Community Outreach Teams (COTs) to support post-crisis care

These teams offer crisis-related services in prevention and post-intervention and support the individual with additional needs, such as housing, ongoing behavioral health care, and employment. COTs support an individual's needs, promote resiliency, and connect clients to ongoing services.[24]

These teams can serve as follow-up care post-crisis and be a complimentary service to MCOT, first responders, and hospitals to provide a missing link for post-crisis care.[24]

2) Olympia, Washington: Crisis Response Unit

These teams both respond to crises with behavioral health expertise and work closely with law enforcement to follow up with individuals who cycle through the system.[1]

The peer navigators, operated by a local nonprofit, conduct outreach to familiar faces: individuals who have had multiple encounters with first responders in the past month.[9]

These peer navigators offer wrap-around supportive services individualized and tailored to each client to address their needs.[1]

The Crisis Response unit, familiar faces program, and other community stakeholders meet weekly to coordinate case management and access to care.[18]

3) BJA and CSG Justice Center Report

This report introduces a police-mental health collaboration framework, which includes a case management team consisting of a case manager and peer to provide follow-up, outreach, and ongoing support to high-utilizers.[21]

4) Law Enforcement-Assisted Diversion (LEAD)

LEAD is a community-base safety program that diverts individuals whose **offenses stem** from **poverty** or **behavioral health** issues into supportive services rather than jail, connecting them to intensive case management and wrap-around services.[15]

It emphasizes continuity across services, using a client-driven approach to reduce system involvement and promote stability and self-sufficiency.[15]

5) Duluth, Minnesota: Centralized Post-Crisis Care

The Duluth Police Department hosts a Substance Use Response Team (SURT), a peer-led outreach program that works alongside law enforcement to offer supportive services for individuals who have a substance use disorder or are post-overdose response.[20]

The collaboration creates opportunities for diversion and access to treatment. Its success exemplifies the importance of peer support coordination with law enforcement to facilitate long-term recovery and stability.[20]

3 CROSS SYSTEM DATA INTEGRATION & INFORMATION SHARING

This recommendation addresses the gap in **information exchange** and **data integration** between crisis response modalities. Enhancing access to timely, accurate data will **improve** real-time and long-term **decision-making**.

Without a data-sharing framework, the system continues to operate with **information gaps**, requiring individuals in crisis to **repeatedly recount** their personal information to each agency.

Data integration and information sharing, a two-pronged recommendation:

First, analyzing cross-system crisis data allows for a comprehensive analysis that informs the development of policies and programs to meet the crisis population's needs and address systemic challenges. Stakeholders will:

- Analyze data trends across all disciplines responding to crises
- Establish protocols and the implementation plan for data integration

Second, real-time data sharing across agencies for first responders when responding to a crisis event will improve coordination and reduce redundancy. Informing responding officers of an individual's service utilization will help create a targeted intervention plan that engages system providers and directs appropriate resources.

According to the Department of Health & Human Services Health Insurance Portability and Accountability Act (HIPAA) Guide for Law Enforcement,[12] individuals' personal health information (PHI) can be shared without client consent during a crisis. Using this information will allow officers and EMTs to administer the most appropriate and timely response. Due to HIPAA protections, data sharing protocols should be implemented only after in-depth legal analysis and guided by the Crisis Response Coordinating Task Force.[8]

To initiate data sharing, the task force will conduct a system needs assessment to define data coordination and integration requirements. This effort will require time, collaboration, and coordination across the crisis response continuum. The investment will result in a coordinated crisis response continuum where individuals are served across modalities seamlessly.[8]

Salt Lake County Mayor's **Systemic Coordination Initiative** also supports analyzing system-level data and improving cross-system data integration. Once the Coordinating Task Force establishes data integration objectives, the two bodies can work to **align implementation** strategies.

Evidence For Data and Information Sharing:

1) SAMHSA recommends effective state and local data coordination

SAMHSA emphasizes the need to coordinate oversight to enhance data sharing, improve service quality, and reduce duplication in crisis response systems. They recommend that the governing body analyze how individuals move through the system, ensuring no gaps in care.[24]

The report recommends a comprehensive needs assessment to map out the crisis response system components and identify improvement needs.[24]

2) The Data-Driven Justice Playbook

The Vera Institute of Justice provides a framework to help stakeholders establish cross-system data sharing while remaining compliant with federal and state laws. The process begins by fostering collaboration to define shared data measurement goals.[31]

After reaching a consensus, stakeholders determine how to share information across the various systems.[31]

3) Berkeley, California: 2021 Crisis Response Model Report

This report references the SAMHSA 2020 National Guidance on Crisis Services, which recommends that law enforcement and behavioral health agencies share aggregate data outcomes. This data helps identify trends that agencies can address collaboratively.[12, 24]

4) Bernalillo County, New Mexico: Cross-System Data Integration

Bernalillo County is leading a cross-system data integration project to improve outcomes for individuals frequently interacting with the criminal justice and behavioral health systems.[3]

To comply with federal and state privacy laws, Bernalillo County established a data-sharing agreement across system providers, supported by a universal release of information (UROI) that enables clients to consent to information sharing across agencies. A memorandum of understanding (MOU) between the county, city, criminal justice, behavioral health, and homeless service providers further strengthens coordination and data sharing.[4]

The county partnered with Tyler Technologies through a data use agreement to develop a secure, cloud-based database as part of this initiative. This system, accessible to all MOU partners, enables real-time tracking of high utilizers across systems.[4]

4 MCOT TRANSPORTATION SERVICES

Transportation is an ongoing challenge in Salt Lake County's crisis response continuum. These teams are highly effective at on-scene de-escalation and support, but cannot transport a patient to a higher level of care. As a result, MCOT relies on one of three transportation options: **a patient's family member**, **an ambulance**, or **law enforcement**.

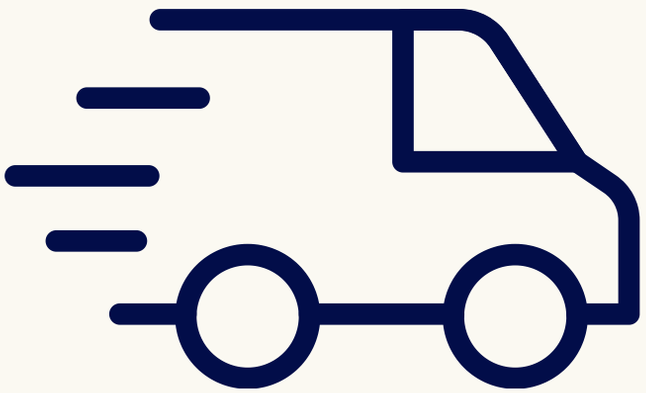
Each option presents its own set of difficulties. For instance, when an ambulance is called, the patient accrues a significant **out-of-pocket cost,** further burdening individuals experiencing financial hardships. **Likewise**, relying on law enforcement may escalate the situation and often requires officers to intervene physically, which can be distressing for the individual in crisis.

According to 2024 MCOT data, the teams responded to **4,323** crisis outreach **events**. Of these, **34%** required a **higher level of care,** and **25%** met the criteria for a **temporary involuntary commitment.**[17]

An initial review of the Utah Code **suggests no changes** are necessary to allow MCOT transportation under **specific parameters**. If there is no public safety risk or immediate medical emergency (§53-2d-101), **transportation is allowable** (§26B-5-331(4)(b)). The local mental health authority must approve the MCOT's designation to provide transport services before implementation (§53-2d-403).[29]

We recommend that MCOT address the challenges and strategize an implementation plan to support the transportation of low-acuity patients. The goal is to improve patient care coordination by limiting unnecessary agency involvement, promoting diversion opportunities, and ensuring safety through clear protocols.

A Medicaid reimbursement rate can circumvent some costs, with additional financial options to explore.



Evidence to Support Transportation Service

1) Eugene, Oregon: Crisis Assistance Helping Out on the Streets (CAHOOTS)

The program deploys two-person teams—a medic and a crisis worker—to support individuals and connect them to appropriate services. The CAHOOTS Model uses vans to transport patients.[2]

The agency retrofitted vans with a plexiglass barrier between the front and back seats for safety. While intended as a safety measure, the plexiglass could contribute to stigma, and may not be necessary for voluntary transports. The vehicles also include radios for dispatch and tablets for data entry.[12] Each vehicle costs approximately $40,000, with an additional $30,000 for customizations such as technology, a plexiglass barrier, and other features.[32]

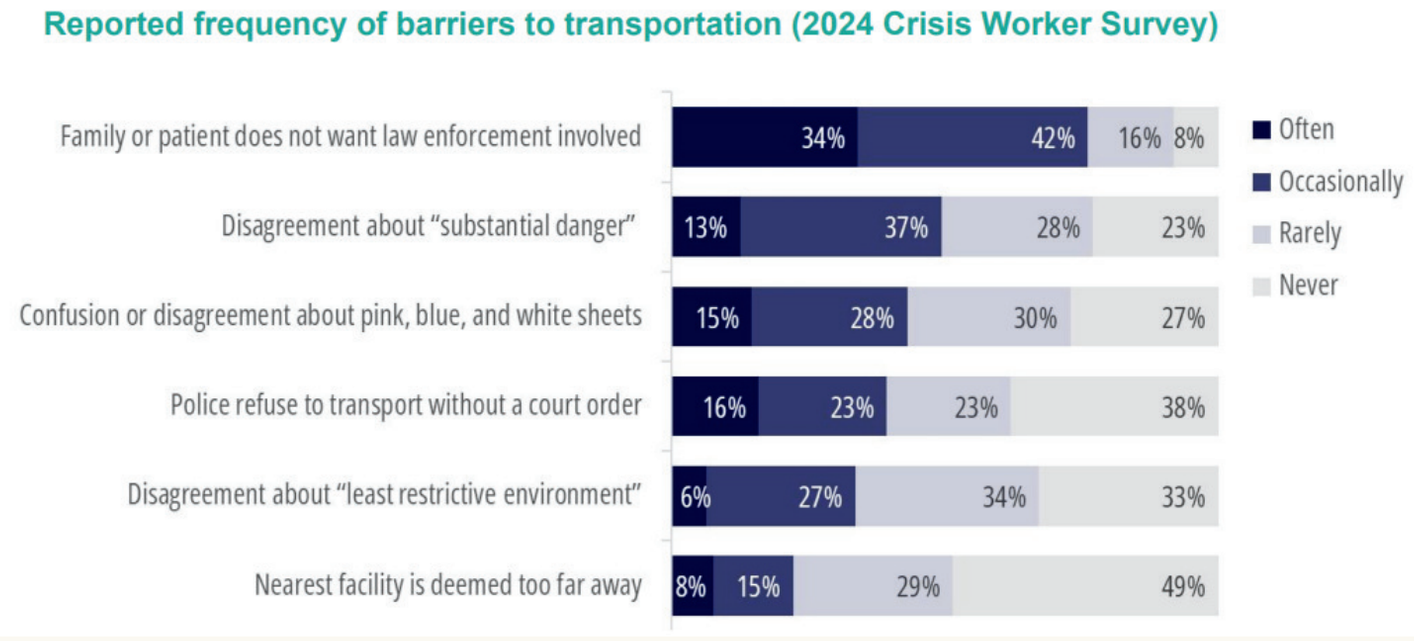
Adaptations of this model should consider designing a transport vehicle that is accessible and supports clear safety protocols. Program designers should determine whether the vehicle's markings are discreet or visible.[32]

2) Utah statute 53-2d-101 Permits MCOT to Transport in Defined Circumstances

Approved entities like MCOT may transport patients voluntarily to facilities such as crisis receiving centers, hospitals, or community-based programs. Transport to the individual's home is prohibited. The individual must be medically cleared to qualify for non-emergency transportation[29].

3) Weber County, Utah: MCOT Transport

An informational interview with Weber Human Services indicated that their MCOT teams have purchased two standard vehicles to respond to crisis calls and transport voluntary patients according to established protocols. Strong communication among law enforcement agencies and MCOT ensures effective transportation coordination for each call.



Source: Utah Behavioral Health Commission Strategic Plan Presentation[28]

5 ENHANCED CO-RESPONSE COORDINATION

Across Salt Lake County, some law enforcement agencies have chosen to embed social workers in their agencies; **some agencies work with MCOT**, and others have **CIT teams that respond without behavioral health support**. Broadly, agencies see more success when behavioral health professionals are present to provide enhanced mental health support for the individual and officer on scene.

There are two approaches to enhance co-response in Salt Lake County. Each jurisdiction within Salt Lake County should explore what approach will support improved access to on-scene behavioral health support. In addition, coordination across the county to streamline co-response policies and procedures will build sustainable partnerships and trust across the crisis response continuum.

Enhancing coordination is a two-pronged approach:

> **First responder agencies may embed social workers alongside law enforcement officers or paramedics to provide on-scene support during crisis response.**

> **Agencies partner with mobile crisis response teams (MCOT) for on-scene behavioral health response support.**

Recently, West Valley City Police Department disbanded its CIT unit, but its three-tiered approach can be examined by agencies to be implemented. First, all Officers have gone through the 40-hour CIT training. The second-tier officers, part of the CIT Unit, were also given forty hours of additional training. The 3rd tier has two dedicated CIT detectives who respond to mental health calls, co-respond with the embedded social worker, and conduct case follow-up. Clients could participate in the West Valley Mental Health Justice Court to have their charges dismissed upon treatment completion. With the disbanding of both programs, increased reliance on patrol for crisis calls is anticipated.

Salt Lake County crisis response modalities must have clear protocols for working with behavioral health professionals in crisis response. Each agency should consider whether to embed social workers or collaborate better with MCOT. The Coordinating Task Force will facilitate stakeholder dialogue to build sustainable partnerships and develop solutions for enhancing co-response in Salt Lake County. Improving communication between law enforcement and MCOT will reduce on-scene mismanagement and increase diversion opportunities and individuals' access to services.

Evidence to Support Co-Response Coordination

1) SAMHSA Recommends Co-Response Teams as Additional Support

SAMHSA recommends prioritizing a behavioral health response team that can operate independently of law enforcement but collaborates with them as a co-response team for individuals in crisis.[24]

Research demonstrates that an on-scene behavioral health professional reduces the harm associated with a law enforcement-based response,
emphasizing the importance of enhanced co-response support in improving outcomes across jurisdictions.[24]

""We need more integrated, countywide solutions that help us connect people to care—not just move them around."

Community Advocate

"There's a growing need, especially in the south end of the valley, and fewer resources to meet it. That's putting more pressure on patrol."

Police Officer

2) Roanoke County, Virginia: Co-Response Effectiveness

In "*Evaluating the Effects of Co-Response in Reducing Subsequent Hospitalization: A Place-Based Randomized Controlled Trial*," S.M. Yang and Y.F. Lu explore the impact of co-response teams on individuals with mental illness who frequently encounter law enforcement.[33]

The study involved four police departments and integrated two mental health professionals who responded alongside CIT officers, guided by 911 call data analysis. The data identified geographic hotspots with the highest volume of mental health-related events, which enabled the targeted deployment of the co-response teams.[33]

Compared to a police-only response, the findings revealed reduced hospitalizations and temporary commitment orders when co-responders were involved.[33]

The authors emphasized that establishing a co-response team requires thorough oversight and interagency evaluation. The study demonstrated that concentrating resources based on data-driven geographic needs can optimize support in a resource-limited system.[33]

6 ENHANCED TRAINING FOR FIRST RESPONDERS

We recommend a **three-pronged approach** to develop a robust training toolkit to increase training opportunities for all officers and first responders.

These approaches include:

Reinforce key techniques for crisis response

This training focuses on officers who recently completed CIT or are interested in crisis intervention. After applying their skills in the field, officers will participate in a follow-up session to reflect on their responses and reinforce skills.

Training tailored to the trends and situations officers experience

This training would be available to all officers but developed based on call-for-service response trends. For example, some officers have reported higher rates of calls from individuals who have autism spectrum disorders. Tailored training will result in less reliance on the use of force and promote better outcomes.

Resource information session

Officers need updated information about the latest resources and how to access them. Enhancing officers' understanding of resources will create more opportunities for diversion. Developing a first responder community resources directory will improve officers' ability to facilitate diversions and referrals.

Implementing this three-pronged approach will supply more expansive training opportunities for first responders, reinforce intervention techniques, and equip officers with updated community resources. Expanding training for officers and first responders supports countywide standardization, best practices, and expands diversion opportunities.

Evidence for Enhanced Training:

1) Crisis Intervention Team (CIT) Program

The Crisis Intervention Team (CIT) Program trains officers in mental health crisis interventions and de-escalation strategies, preparing them to respond effectively.[27]

The 40-hour course includes presentations, scenario-based role-plays, and site visits to community resources.[27]

The trauma-informed, evidence-based curriculum aims to reduce the use of force, increase officer empathy, and enhance diversion opportunities.[27]

2) Utah's Mental Health Crisis Intervention Council Recommendations

In 2022, S.B. 47 established the Mental Health Crisis Intervention Council, which made six recommendations to improve CIT training in Utah.[16]

The report recommends implementing a 16-hour basic de-escalation intervention training for first responders. This training provides officers with essential de-escalation techniques and can serve as an alternative for those unable to attend a Crisis Intervention Team (CIT) Program.[16]

The program incentivizes officers to attend the 16-hour training, ensuring they gain critical skills in managing crises effectively.[16]

3) Crisis Response Intervention Training (CRIT)

CRIT adapted the CIT curriculum to develop a 40-hour alternative training, grounded in evidence-based research, to address a broader range of crises for officers. The expanded training combines in-person, online, and scenario-based learning, equipping officers to respond to intervention techniques for mental health crises, individuals with intellectual or developmental disabilities, and other situations.[10]

4) CSG Justice Center Recommends Versatile Training

The Council of State Governments (CSG) Justice Center recommends implementing de-escalation policies and training for all roles within emergency response systems.[13]

Additionally, it emphasizes the importance of scenario-based and interactive follow-up training for officers to reinforce and reapply de-escalation techniques.[13]

5) State of Michigan: First Responder Training

In 2021, the Michigan Mental Health Diversion Council, in collaboration with the Center for Behavioral Health and Justice, offered recommendations to enhance training for Michigan first responders.[26]

Subject-matter experts developed these recommendations to address law enforcement and first responders' unique needs when interacting with individuals experiencing behavioral health crises.[16]

The Council developed the Behavioral Health Emergency Partnership (BHEP) program to provide a 2.5-day training, combining in-person, online, and scenario-based learning.[16]

The curriculum covers various topics, including diversion strategies, de-escalation techniques, crisis identification and response, and cross-system collaboration.

Michigan demonstrates effective coordination by creating a training system for first responders grounded in evidence-based practices.[16]

CONCLUSION

System stakeholders have made significant strides in implementing innovative responses while following best practices in the crisis response continuum. A lack of behavioral health workforce, underfunded community-based providers, and limited collaboration undermine system progress.

We recommend establishing a framework to integrate and coordinate the crisis response continuum, building a more **data-driven** and **person-centered** model.[25] This framework will help ensure each response modality functions independently and collectively in the crisis response continuum.

This collaborative approach lays the groundwork for lasting improvements, ensuring that all individuals in crisis can access the care and support they need anywhere, anytime. To be effective and support the long-term stabilization of individuals, these recommendations require an investment in **community-based resources, affordable housing options**, and behavioral health professionals for a **coordinated** crisis response continuum and timely supportive services.

Successful implementation will require engagement of stakeholders and decision-makers to build sustainable partnerships, address growth opportunities, learn from data, and commit necessary resources. As we work to implement these recommendations, the County and its partners can lead the way in creating a resilient, equitable, and engaged crisis response continuum that truly meets the needs of our community.

APPENDIX A

Salt Lake County System Overview:

SAMHSA's best practices inform Salt Lake County's crisis response, including regional crisis call centers, crisis mobile team response, and receiving and stabilization centers. In addition, the county also has specific response models related to law enforcement, including co-response models and Crisis Intervention Training (CIT). These systems comprise the core parts of our crisis response continuum.

Regional Crisis Call Center

988

- A national alternative to 911 for people experiencing crises to connect with a certified crisis worker who will provide crisis intervention techniques and connection to meet each caller's needs.
- Available 24/7, 365 days per year.
- Coordinates with 911 dispatchers to connect an individual experiencing a crisis to the best level of care needed for the crisis
- Operated by Huntsman Mental Health Institute (HMHI)

Utah Crisis Line

(**1-800-273-3000)** Operated by HMHI

- Free service is available to a caller in a mental health crisis to seek support from a certified crisis worker.
- Available to the community 24/7/365
- Coordination of the appropriate service needed for the person in crisis, including:
- Dispatch of Mobile Crisis Outreach Team (MCOT)
- Referrals, education, and suicide prevention

Utah Warm Line

(**801-587-1055**) Operated by HMHI

- A step-down line from the crisis line is staffed by a certified peer support specialist who supports the caller.
- Available 7 days a week, 8 am - 11 pm
- Coordinates with Utah Crisis Line and MCOT to get the person to the correct level of support.

Crisis Mobile Team Response

Mobile Crisis Outreach Team (MCOT)

- Operated by HMHI
- Alternative response to law enforcement for a behavioral health crisis. Two-member team with a mental health professional and a certified peer support specialist. Salt Lake County currently has 14 MCOT teams. MCOT is a free service to the public and available 24/7/365 for people experiencing a behavioral health crisis. The goal is to dispatch MCOT to people in the community, assess their needs, use de-escalation techniques, and connect the individual to support services.
- MCOT teams are dispatched from the Crisis line, 988, 911, or in coordination with law enforcement, depending on who is first to the scene and the safety risk level.

APPENDIX A

An urgent psychiatric care center for adults is designed to help people in crisis de-escalate, stabilize, and connect them to community resources.[16] The Huntsman Mental Health Institute (HMHI) Crisis Care Center has a no-refusal policy when a first responder brings an individual to the center for a facility. The center will serve as a key diversion opportunity for law enforcement and first responders. The center's goal is to reduce the over-utilization of jail and hospital emergency departments for behavioral health crises.[24]

Crisis Receiving & Stabilization Center

Crisis Care Center

Operated by HMHI, opened March 2025 in South Salt Lake.

- Programs offered:
  - 30 Recliners for de-escalation & stabilization; patients can stay for up to 23 hours
  - Linkage to supportive services
- 24-bed acute care unit for short-term stabilization
- Detox area for substances
- Medication-assisted treatment clinic
- Mental health treatment
- Substance use Intensive outpatient treatment
- Community partners on-site

Peer Respite Center

Operated by Mental Health America, Utah, located in South Jordan.

- A crisis stabilization center staffed by certified peer support specialists is operated 24/7 and free of charge.
- To utilize a client must:
  - Be 18 years or older
  - Pass a criminal background check
- A person can stay up to 7 days after a mental health crisis.
- Peer support works with the client to develop a recovery action plan, connection to support groups, and a crisis plan.

Law Enforcement Crisis Response Models

Police-Based Social Worker

- A Co-Responder Model - A specialty two-member team staffed by a law enforcement officer and a mental health professional to respond to a person experiencing a crisis.
- Salt Lake County has five jurisdictions with at least one mental health professional staffed at a law enforcement agency.
- Salt Lake City Police Department Community Connection Center
  - It is staffed by eight social workers and six case managers who offer short-term case management and therapeutic interventions.
- Department of Public Safety
- Millcreek Police Department

APPENDIX A

Law Enforcement Training Models

Crisis Intervention Team (CIT) Program

- CIT is a community program involving law enforcement, mental health professionals, and advocates that aims to improve responses to mental health crises.
- The four main goals of a CIT program are to improve safety for all during the crisis incident and lessen police response to mental health calls, strategically utilize law enforcement for crisis calls, increase the role of mental health professionals on the scene, and reduce trauma for the person experiencing a crisis as they are connected to long-term support services.[27]
- 40-hour training for law enforcement officers to learn about mental health, substance use disorders, and how to de-escalate situations.[27]

CIT Utah

- A statewide organization that facilitates training for agencies and advocates for better community response to mental health.
- Utilizes CIT International curriculum
- Trains officers who opt into the program

CIT Metro

- A Salt Lake City-based CIT training program used by:
- Salt Lake City, West Valley City, and Utah County
- Utilizes CIT International curriculum
- Mandatory training for officers in the academy

First Responder Embedded Social Worker

Community Health Access Team (CHAT)

- Operated by Salt Lake City Fire Department
- Three two-person teams pair a social worker with a paramedic responding to a crisis call in Salt Lake City.
- The CHAT team's response includes:
  - Mental health
  - Substance use
  - Social service needs
  - Linkage services

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