

League of Minnesota Cities, Minnesota Chiefs of Police Association,
Minnesota Sheriffs Association & the Best Practices Working Group

The background of the slide features a complex network of thin, dark lines connecting various nodes of different sizes and colors (blue, orange, and grey). Overlaid on the left side of this network is a large, semi-transparent silhouette of a human head in profile, facing right. The silhouette is filled with a gradient of colors, transitioning from a light blue at the top to a warm orange and yellow at the bottom, suggesting a brain or internal network. The overall aesthetic is high-tech and interconnected.

BEST PRACTICES IN

Law Enforcement Responses to Mental Health Crises

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Foreword and Executive Summary

In 2020, Minnesota enacted new legislation restricting the circumstances under which peace officers may use deadly force and, along the way, instructed that peace officers should use “special care” toward persons having mental illnesses and intellectual disabilities. Some law enforcement leaders expressed concern that these legal changes threatened to criminalize officers who do their best to handle volatile and unpredictable crisis situations, and voiced reluctance over continuing to send officers to crisis calls. These expressions of reluctance, in turn, gave rise to tension between law enforcement and those who rely on officers to provide service in crisis situations.

The Minnesota Chiefs of Police Association, the Minnesota Sheriffs Association, and the League of Minnesota Cities Insurance Trust responded by bringing stakeholders together to determine if best practices for law enforcement crisis response could be identified. Eight meetings were held over a span of several months, involving over 40 individuals from law enforcement, the mental health community, allied fields, state agencies, and the National Alliance on Mental Illness. The goal was to catalog the current challenges and to surface realistic solutions and approaches. This guide communicates the results of those efforts. Yet the project yielded another unforeseen benefit: a realization that people and organizations across the spectrum are all working toward the same broad goals: to keep people safe, improve lives, and reduce human suffering. Unfortunately, until recently, we have remained

somewhat in our own respective silos, unaware of the goals and efforts of co-laborers from other disciplines.

At present, many law enforcement agencies are experiencing high demand for crisis services but have no clear answers for what to do about it. The statistics are concerning: One-fifth of adults, and nearly one-half of adolescents in America live with a mental illness. Estimates hold that between 6% and 10% of all police calls involve someone with a serious mental illness. And these calls all too often end in tragedy — approximately 23% of those killed by officers in 2015 had a mental illness.

Mental health professionals and practitioners are beginning to augment and, in some cases, supplant the police as responders in some locales. But funding for these programs is insufficient and, in many places — particularly in Greater Minnesota — they struggle under the additional weights of covering large territories and an inability to attract and retain workers. These factors have combined to leave law enforcement agencies across the state facing very different realities. Some officers work alongside robust crisis teams that respond to calls promptly. Other agencies find themselves essentially going it alone, with little to no real-time help from trained mental health workers.

Despite these daunting realities, the working group also became aware of several bright spots where progress is being made. Law enforcement agencies have been collaborating with those in allied fields to create new approaches,

teams, and programs to address crises and begin attacking their root causes. In some places, law enforcement has thrown itself into larger efforts to address unmet needs for mental health, substance use, and housing services. Other agencies are embedding mental health professionals to follow up with people who have been in crisis and link them to available community-based services. Those who have been successful in taking steps forward attest that collaboration among law enforcement and other disciplines is not just helpful, it is the name of the game. While law enforcement is not directly tasked with solving problems in the areas of mental health, substance use, and homelessness, it is uniquely positioned to foster needed changes. Police chiefs and sheriffs can use their influence to bring these issues to the forefront, and to convene discussions aimed at improving services locally.

With that as background, the following are the key takeaways from the efforts of the Best Practices Working Group:

- Government entities should provide mental health crisis response services in parity with the services provided to those experiencing medical emergencies. To decline services to those with mental illness could run afoul of the Americans with Disabilities Act and other anti-discrimination laws.
- Law enforcement officers should be trained to keep everyone safe in crisis situations, to work toward non-violent resolutions, and to use force appropriately given their roles as members of the care team.

- Officers should be trained in the legal standards for imposing transport holds and their authority to conduct other seizures and searches in the mental health context, and to work cooperatively with other crisis response professionals.
- There is no one-size-fits-all approach for how crisis response services should be delivered at the community level. The best plan for response services is one that matches the resources available in a particular locale to the needs of the community.

To this last point, the differences in resources from one place to another in Minnesota can be vast. Law enforcement managers using this guide are encouraged to consider whether there are gaps or needs for improvement in the services currently being provided in their community, and to explore whether it is possible to address them through additional resources, collaboration, or training. While there is great value in this exercise, you may still find yourself without the means to take any large steps forward. Even if this turns out to be the case, this guide will hopefully help you identify some attainable improvements in how you deliver crisis services.

Introduction

Much has been written about the “broken” or “never built” mental health system in the United States, and the resulting gaps in behavioral health services. In the absence of proactive and comprehensive mental health services, law enforcement has become a type of mental health first responder, providing triage services in the streets, often with scant training and inadequate resources. In June 2020, the president of the United States issued an executive order summarizing this state of affairs and the need for more compassionate and effective means of caring for those with mental illness and substance use disorders. The executive order stated in relevant part:

Ineffective [mental health treatment] policies have left more individuals with mental health needs on our nation’s streets, which has expanded the responsibilities of law enforcement officers. As a society, we must take steps to safely and humanely care for those who suffer from mental illness and substance abuse in a manner that addresses such individuals’ needs and the needs of their communities. It is the policy of the United States to promote the use of appropriate social services as the primary response to individuals who suffer from impaired mental health, homelessness, and addiction, recognizing that, because law enforcement officers often encounter such individuals suffering from these conditions in the course of their duties, all officers should be properly trained for such encounters.¹

The needs for mental health services are vast and significantly unmet. Recent estimates are that:

- About one in five adults in the U.S. lives with a mental illness.
- About one in 20 adults has a serious mental illness.
- Almost half of adolescents aged 13-18 have a mental disorder, and over 20% have a severe impairment.²
- Six percent to 10% of all police contacts involve persons with serious mental illness.³

Most unfortunately, about 23% of the persons killed by law enforcement officers in 2015 had a mental illness.⁴

In mid-2021, the League of Minnesota Cities, the Minnesota Chiefs of Police Association, and the Minnesota Sheriffs Association assembled a working group of over 40 stakeholders from around the state with the goal of developing a best practice guide for responding to mental health crisis calls. The working group defined a mental health crisis as follows:

A mental health crisis (MHC) is a situation in which an individual's coping mechanisms are overwhelmed, causing them to have an extreme physical, emotional, or behavioral response. A mental health crisis could arise in connection with a person's mental illness, personality disorder, intellectual disability, drug or alcohol use, traumatic brain injury, or extreme circumstances that are beyond the person's capacity to manage.⁵

The stakeholders in the working group included:

- Urban, suburban, and rural representatives.
- Law enforcement executives and officers.
- Social workers, mental health professionals, and advocates.
- Persons working in crisis teams and as co-responders with law enforcement.
- Representatives of the Minnesota Department of Health, Department of Human Services, and the Department of Education.
- Emergency medical service providers.
- Risk managers.
- The Minnesota County Attorneys Association.

A key conclusion from the group's work is that there is no one-size-fits-all approach for how law enforcement agencies should respond to mental health crisis calls. In fact, there are vast differences in resources for crisis response from one locale to another. Here are some examples:

- In some places, Mobile Crisis Response Teams are staffed, operational, and often able to respond swiftly to calls for service.
- In other jurisdictions, these teams lack adequate funding, cover large areas, are hindered by staffing difficulties, and are often unable to arrive at scenes within a time frame that negates the need for a law enforcement response. Many voices in the working group advocated for increased funding for these teams.
- Some law enforcement agencies have embedded mental health workers and may contract with their Mobile Crisis Response Team to provide staff for these positions. Agencies may use these workers in dispatch, to follow up on crisis calls, co-respond, or to provide coaching and training to officers.
- Some agencies have co-responders who accompany officers on calls for service having a mental health or substance use component.
- For other agencies, the need for services of this type is sporadic and unpredictable, and even if things were otherwise, there is little or no funding available for co-responders or embedded mental health professionals or practitioners.
- Resources for children experiencing a mental health crisis also vary among schools and communities.

The working group concluded that there is not a universally applicable best way to deliver crisis response services in Minnesota at the present time. Rather, the more productive focus for local agencies should be on trying to do the best they can with existing resources while also advocating for and developing additional resources. Working group members repeatedly emphasized that collaboration with others in mental health and allied fields, and with other stakeholders, is paramount when seeking to improve services within a community. Although a local police chief or sheriff does not own the mental health issues in their locale, their position in the community affords them an opportunity to elevate these issues and convene discussions aimed at improving services.

Although there may not be a single best way to provide services, the working group was able to identify guiding principles and recommendations to help agencies maximize their effectiveness. These are discussed in this guide, along with an outline for establishing or reevaluating local service delivery models.

Goals of This Guide

The purpose of this guide is to help your law enforcement agency or community develop (or update) its **plan** for responding to mental health crisis calls. Broadly speaking, this plan will reflect all the decisions made about the goals to be attained and resources that will be used in responses, along with implementing a **policy** to guide operations going forward. This guide provides strategies and information for delivering compassionate, professional, and effective responses to situations involving persons experiencing a mental health crisis. These responses should protect the safety of the individual in crisis, the public, and officers, while respecting the rights and dignity of the individuals being served.

Definitions

Some of the terminology and related definitions in this area are relatively new and are intended to mean different things by different speakers. As used in this guide, the following terms have the meanings given:

Co-responder:

Co-responders are mental health professionals or practitioners⁶ who are deployed alongside law enforcement personnel in response to calls for service with a mental health or substance use component. Unlike Mobile Crisis Response Teams, there are no laws or regulations setting service standards for co-responders.

Embedded Mental Health Professional or Practitioner:

An embedded mental health professional or practitioner refers to one who is qualified by law to provide mental health services and works in cooperation with and from within a law enforcement agency. An embedded professional or practitioner may or may not respond to crisis calls in the field and may be tasked with following up with persons after a crisis, to connect them with and help them navigate available services. Some law enforcement agencies form agreements with their counties for an embedded professional or practitioner and might, for example, share the time and cost of the worker across two or more police departments. The embedded professional or practitioner in these cases remains a county employee and part of the county “system,” with the ability to access and create county records, and interface with county colleagues on an as-needed basis. Some law enforcement agencies enter into agreements with their local Mobile Crisis Response Team for the provision of embedded staff or services.

Mobile Crisis Response Team:

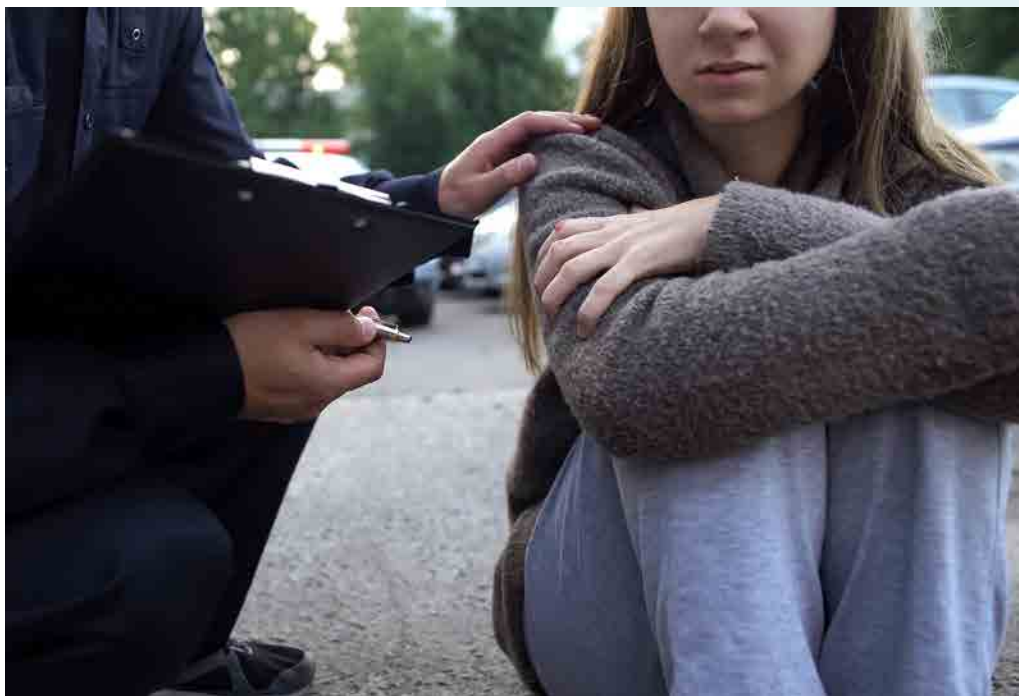
Mobile Crisis Response Teams (MCRTs) consist of mental health professionals and practitioners who provide face-to-face psychiatric services to individuals within their own homes and at other sites outside the traditional clinical setting. When available, these teams work to help persons in crisis cope with immediate stressors and lessen their suffering, avoid unnecessary hospitalization, develop an action plan, connect the person with services, and begin returning the person to their baseline level of function. Minnesota has MCRTs covering all counties across the state. These teams are required to provide services on a 24/7 basis, but services may be available at some places and times only by telephone.⁷

Why Is Crisis Response a Police Matter?

1

Before considering *how* law enforcement should respond to mental health crisis (MHC) calls, or partner with others to provide crisis services, a fair question to ask is *why* law enforcement is involved in this arena at all.

In reality, local governments have a fair amount of policy-level discretion about the services they provide to their communities. While Minnesota law obligates sheriffs to “keep and preserve the peace,” and to apprehend felons and execute process,⁸ the law is generally silent as to the specific types of services that agencies must provide. Law enforcement agencies have, over time, been tasked with meeting various community needs. The U.S. Supreme Court recognized this almost 50 years ago, noting that law enforcement officers have come to take on many adjunct duties under the broad umbrella of providing “community caretaking” services.⁹



BACKGROUND

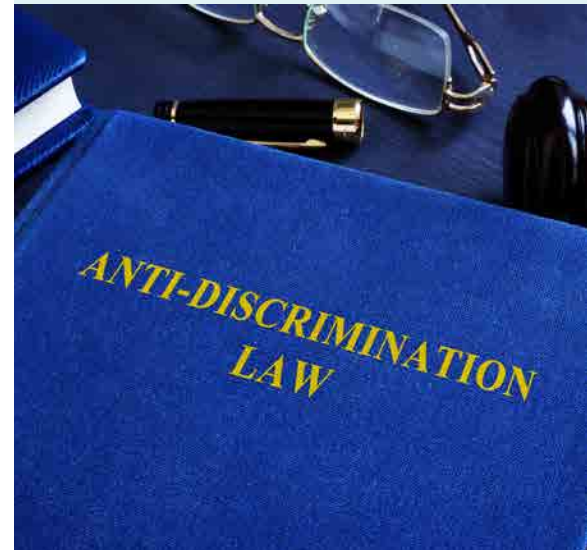
Over time, officers have stepped in to meet a wide array of community needs apart from keeping the peace and apprehending offenders. These include assisting motorists, providing medical and rescue services, conducting well-being checks, and responding to adults and children in mental health crisis. Dating back to 1967, peace officers in Minnesota have been legally authorized to take persons into custody who appear to be in imminent danger of harming themselves or others due to mental illness, intellectual disability, or drug or alcohol use, and to transport those individuals to a facility for evaluation or treatment.¹⁰ This authority is permissive in nature — it does not impose a mandatory duty. On the surface, then, it appears that local governments and their agencies have a good deal of discretion in deciding what kinds of mental health crisis services to provide.

ANTI-DISCRIMINATION LAWS

Although law enforcement agencies have discretion in determining the services they will provide, federal and state anti-discrimination laws may prohibit them from declining to respond to MHC calls. The Americans with Disabilities Act (ADA) prohibits state and local governments from discriminating against disabled individuals in the provision of benefits, services, programs, or activities.¹¹ The Minnesota Human Rights Act establishes parallel state law protections.¹² Local governments could place themselves in tension with these laws if they provide assistive services to the non-disabled but withhold such services from people with disabilities. For example, it would arguably be unlawful for a city to have a policy of sending its police, fire, or EMS personnel to help those in a medical emergency, but to refuse to serve those seeking assistance in a mental health emergency.

In addition, the U.S. Department of Justice (DOJ) has brought suits against and entered into settlements with police agencies when it has found that they have discriminated against individuals with behavioral health disabilities.¹³ The DOJ takes the position that substandard policy and training in the area of mental health responses may result in the use of excessive force against those with mental illnesses.¹⁴

The ADA requires agencies to make “reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability.”¹⁵ The DOJ’s view is that training officers how to de-escalate and safely interact with individuals with mental illnesses is a “reasonable modification” that helps ensure that disabled individuals are not subjected to unreasonable force.¹⁶ The agreements negotiated by the DOJ have variously required agencies to better train officers to respond to MHC calls, and when trained officers are available, to dispatch them to MHC calls.



The ADA requires agencies to make “reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability.”

SAFETY AND TRANSPORT

It is almost inevitable that law enforcement will respond to at least some calls of adults and youth in crisis, even if a robust Mental Health Crisis Team is serving its jurisdiction, because of two overlapping expectations. The first is that law enforcement will, at the very least, respond to requests from Mental Health Crisis Team members to keep them safe in the face of armed or violent patients or volatile circumstances at the scene. The second expectation is that law enforcement will provide for the involuntary transportation of those needing immediate care.

The Minnesota Commitment and Treatment Act (MCTA) vests peace officers *and* health officers with the authority to take persons into custody so that they may be provided with emergency evaluation and treatment in some circumstances (see the definition of “health officer” in the sidebar at right). The legal mechanism for doing this is known as a “transport hold,” and the authority for them is set forth in Minnesota Statutes, section 253B.051 (2021). Holds may be imposed on persons with a mental illness or developmental disability, or those who are chemically dependent or intoxicated in public, if the person is in danger of harming themselves or others if not promptly brought into custody.¹⁷

As noted, peace officers and health officers have co-equal authority to order transport holds. However, as more fully described in **Chapter 3**, only peace officers are trained and authorized to use force (physical restraint) for the purpose of apprehending and transporting those in a mental health crisis.¹⁹ Thus, unless a health officer has both a means of providing transportation and a willing patient, they are left to rely on law enforcement to supply these services. The transport hold statute provides that peace officers may rely on the expert determinations made by health officers and examiners that a person meets the criteria for a transport hold.²⁰

Notably, emergency medical technicians are not included among the definition of health officer. As such, they are not authorized to impose a transport hold, but may provide transportation for such a hold at the direction of a health officer or peace officer.²¹ Like health officers, emergency medical personnel may only use restraint to prevent a person in crisis from harming self or others.²²

The term *health officer* is defined in statute as:

1. A licensed physician.
2. A mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6).
3. A licensed social worker.
4. A registered nurse working in an emergency room of a hospital.
5. An advanced practice registered nurse (APRN) as defined in section 148.171, subdivision 3.
6. A mental health practitioner as defined in section 245.462, subdivision 17, providing mental health mobile crisis intervention services as described under section 256B.0624 with the consultation and approval by a mental health professional.
7. A formally designated member of a pre-petition screening unit established by section 253B.07.¹⁸



Response Goals

2

The working group strove to identify the potential goals that law enforcement agencies might pursue when establishing a mental health crisis response plan. Protecting the safety of the person in crisis, the public, and officers should be the first priority. Beyond that, there are additional objectives that an agency might seek to accomplish through the plan it develops.

The objectives and their explanations are summarized as follows:

Protecting the safety and dignity of persons in crisis.

Emphasizing the use of strategies to prevent escalation, bring calm, and minimize the use of force will serve to protect the safety of all concerned. To this end, many experts emphasize the importance of “slowing things down” at the scene so there is time to attempt resolving the crisis through the use of communications, calming, and persuasion. Next, providing respectful and dignified treatment serves to affirm the humanity of the person in crisis and, in return, increases the community’s trust and respect for law enforcement.

Providing effective, compassionate services to those in crisis.

This aligns with the statement of policy in the 2020 Presidential Executive Order. It also aligns with the equal protection-based goal of working to ensure that the most vulnerable members of our communities receive just and equitable treatment.

Maximizing effectiveness by leveraging the use of locally available resources.

Crisis services must be delivered locally, so focusing on the local resources that can be enlisted to support mental health crisis (MHC) responses is essential. Are there additional services that could be provided by the Mobile Crisis Response Team (MCRT)? What could local mental health, social service, and emergency medical providers do to improve or fill gaps in existing services? How could changes in training, procedures, or information sharing improve the coordination of services?

Diverting calls to Mobile Crisis Response Teams.

Ensuring that appropriate calls are diverted to an MCRT, when available, provides those in need of service with specially trained responders and reduces the call load on law enforcement.

Avoiding unnecessary hospitalization.



Because MCRTs can provide on-scene assessment and stabilization, using them can reduce incidents of unnecessary hospitalization.

Decreasing police time on calls.



Responding to MHC calls can be time-intensive and take officers away from providing other services needed in the community. When mental health workers can either serve as primary responders or receive warm handoffs from officers once the scene is safe, it can free up officers to perform other duties.

Reducing the risk of civil liability.



When officers rely on the professional judgment of mental health professionals and practitioners about the need for hospitalization, it should substantially reduce the liability risk an officer might face for a mistaken judgment. Likewise, when officers are trained to correctly apply the legal criteria for transport holds, it reduces the liability risk for false arrest, unlawful search, and excessive force claims.

Linking those in need with available services and supports.



Having a system in place to ensure appropriate follow-up on crisis response calls helps reduce repeat calls and can improve the quality of life of those who were in crisis. This system should provide for documentation of relevant information from each call and the routing of it to an appropriate agency or individual, to ensure an appropriate connection with or referral to resources.

Ensuring proper handling of calls involving children in crisis.



Involving law enforcement in children's mental health crisis situations can have a stigmatizing effect. Officers should recognize when not to become involved in behavioral and disciplinary matters with youth and should be aware of other local or school-based resources to which such matters may be referred.

Guiding Principles

There are several guiding principles that agencies may wish to consider when establishing or revising their mental health crisis (MHC) response plan.

GUIDING PRINCIPLE #1

MHC RESPONSE SERVICES SHOULD BE PROVIDED IN PARITY WITH OTHER RESPONSE SERVICES.

As alluded to earlier **on page 10**, the level of services provided to those in a mental health crisis should at least be on par with the services offered to persons experiencing a medical emergency. Basically stated, it would run afoul of anti-discrimination laws to refuse services to people based on a mental disability.

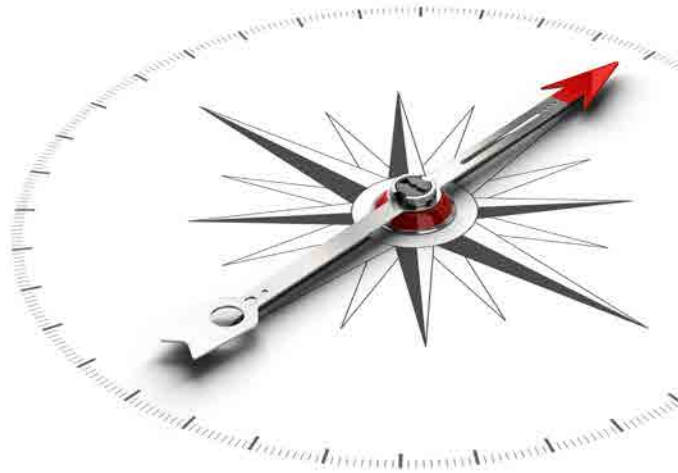
The comparison to medical responses is a useful way to think through the parity principle and the application of anti-discrimination laws. Just as officers would not be expected to rush into an exceedingly dangerous situation to give aid to a medical victim, they would not be legally required to abandon cover and approach an armed, suicidal man who could quickly turn his gun on another. Assuming the officer did not create the hazard, the officer would not be expected to take actions in either situation that would appear to create a serious risk of injury to themselves or the person in need of help.

GUIDING PRINCIPLE #2

TRAIN OFFICERS TO KEEP EVERYONE SAFE AND USE FORCE APPROPRIATELY IN THE CONTEXT OF MHC RESPONSES.

Keeping the person in crisis, the public, and officers and other responders safe from harm is the paramount concern when responding to MHC calls. In view of recent legal developments and emerging public expectations, officers should take steps to affirmatively minimize the risk of situations escalating, and to minimize any force being used to bring the person in crisis under control. In terms of mindset, officers who respond to MHC calls are not there to enforce the law so much as they are present as a member of the care team, to help the individual who is experiencing a health concern.

3



3: GUIDING PRINCIPLES

Several developments have contributed to the expectation that officers will emphasize safety and work to minimize force when responding to crisis situations. In 2020, the Minnesota Legislature added a provision to the state law governing the use of deadly force by peace officers. It now provides that officers should use “special care” when interacting with people having known disabilities, because these disabilities could affect their ability to understand and comply with officers’ commands.²³ In 2021, the Minnesota Board of Peace Officer Standards and Training (POST) issued learning objectives that require training for officers in “best practices for safe and effective resolution of mental health crises.”²⁴

Current POST learning objectives for use-of-force training require instructing officers in de-escalation and conflict management strategies to reduce the need for force.²⁵

Next, federal courts have held that when officers are sent to help nonthreatening people in crisis, resorting too quickly to using force that causes pain or injury can be at odds with the government interests at issue.²⁶ That is, the government justification for using force that causes pain or injury is reduced in a situation where a nonthreatening person is known to be experiencing a mental health crisis.²⁷ Federal courts have also been critical of officers for using control techniques where the subject has not been given an adequate time to comply with an officer’s commands.²⁸ In addition, the U.S. Department of Justice has taken the position that training officers how to de-escalate and safely interact with individuals experiencing mental illness may be necessary to help ensure they are not discriminated against by the use of unreasonable force.²⁹

There are three key takeaways from all of this that could be said to constitute “best practices”:

- 1** First, officers should look for ways to work with the person in crisis that will mitigate any evident risk of rapid escalation. Managing access to weapons, and using barriers and distance, can protect officers from assault, and against the risk of being suddenly provoked into using significant force.
- 2** Second, in *control situations* (see [page 17](#)), techniques likely to cause pain or injury should be used reservedly, when reasonably necessary to protect the person in crisis against a greater harm, or when efforts at persuasion have failed or would be futile.
- 3** Third, in situations involving weapons or other significant threats, where there are no bystanders in the zone of danger, it may sometimes be appropriate for officers to fall back and abandon immediate efforts at face-to-face intervention. This might be the case if officers reasonably determine that the person cannot be approached without a risk of significant escalation or injury to officers, the person in crisis, or others. In such cases, the best course of action could well be to attempt phone contact with the person in crisis, or to try to arrange for a mental health professional or practitioner to make phone contact with the person. This protects officers in both a physical sense and a legal sense.



Deciding on the appropriate response

As illustrated in the discussion of parity, officers are not required to attempt a rescue in either medical or mental health emergencies when doing so would place them in significant danger. In settling on what to do in risky situations, officers should weigh the likelihood of a safe and successful rescue against the dangers of the attempt, without letting the fear of becoming civilly liable for inaction drive the decision. This is because law enforcement generally has no legal duty to rescue people from circumstances that officers had no role in creating.³⁰ If the circumstances cannot be rendered safe against the risk of assault or needing to use significant force, then avoiding direct contact may be appropriate.

One request made of the working group was to provide officers with clear guidance on when and how much force can be used when responding to persons in crisis. Providing definitive guidance is not possible because of the infinitely variable circumstances that officers will confront, and because what is expected of officers is changing. Nevertheless, some general guidance and best practices can be identified.

To be sure, officers are facing an increasing expectation that they will try to manage mental health crisis situations without using force that injures people or causes them pain.

Understanding control situations versus defense situations

As a general matter, when officers use force in any situation, it is for the purpose of either defense or control. The law, for example, permits officers to use reasonably necessary force to achieve control over someone who is struggling against the placement of handcuffs, and also permits officers to use force to defend themselves or another against an oncoming attack.

Differentiating between defense and control situations is imperative when gauging how much force to use when responding to a mental health crisis. This is because a person's mental health status is less relevant in defense situations than in control situations. Federal appellate courts have held, for example, that the Fourth Amendment may permit officers to use deadly force to stop someone advancing with a bladed weapon, because "mental illness or intoxication does not reduce the immediate and significant threat [that such] a suspect poses."³¹ But where the person poses no realistic threat, the force calculus is different. In another case, a man under a mental health commitment resisted apprehension by grabbing on to a signpost. Officers resorted to using a Taser when they could not pry his hands loose. Noting that there were a number of officers and hospital security guards present, the court held that the use of a Taser was excessive. The court explained, "[O]fficers who encounter an unarmed and minimally threatening individual who is exhibiting conspicuous signs that he is mentally unstable must de-escalate the situation and adjust the application of force downward."³²

CONTROL SITUATIONS

When officers use force for purposes of *control*, it is generally to stop someone's physical movement or to bring the person into physical custody, such as for a transport hold. Pure control situations do not involve a realistic, near-term threat to the officer or bystanders. In practical terms, the expectation officers face when these situations involve someone in a mental health crisis is that they will attempt to obtain control by nonviolent means, such as by using communication and persuasion skills to calm the person and obtain their compliance. In nonthreatening situations, courts have been critical of officers for resorting "too quickly" to force without attempting less intrusive means first, or without being able to demonstrate reasonable grounds for believing that communications and persuasion would not have worked.³³

DEFENSE SITUATIONS

Defense situations are those in which the person in crisis is engaging in conduct that threatens the officers or others. When courts evaluate the force officers have used in response to immediate threats, their inquiry tends to focus on the threat itself, as opposed to the mental health status of the person posing the threat. This is logical in the sense that being stabbed by a person experiencing a mental health crisis is no less harmful than being stabbed by a person who is not in crisis. So, for example, courts have held that officers may use even deadly force — if it is a proportional response to the threatening behavior — without regard to the subject's mental health status.³⁴

However, the shift in training doctrine that has occurred over the last several years, and the recent legislative emphasis on exercising special care, speak to how officers *approach* threatening and potentially threatening situations involving persons in crisis. Current POST in-service learning objectives, for instance, point officers toward using time, distance, physical barriers, and cover to minimize the opportunities available to the person in crisis for escalating the situation.³⁵ This, in turn, theoretically provides officers with more time and opportunity to work toward a nonviolent resolution.

Risk of rapid escalation

As officers assess situations, particularly those involving people with weapons or having the ability to inflict serious harm, it is foreseeable that some circumstances could appear to be so rife with the potential for rapid, unmanageable escalation that disengagement may be proper. For example, if a man is alone in his garage with a gun and threatening suicide, the circumstances could be such that the officers would be placing themselves at risk of being shot — and at the same time placing themselves at risk of having to shoot in response to the man's behavior — if they remain. It could be reasonable for officers in such circumstances to disengage after taking steps to get others out of harm's way. If disengaging, officers should consider what steps could be safely taken in an effort to assist the person in crisis. Measures could include contacting the person by phone, having a mental health worker make contact by phone, and following up with the person after the threat has dissipated to check on their welfare and offer access to mental health services.

Training

The factors discussed above make the case for ensuring that use-of-force and mental health crisis intervention training are not delivered in entirely separate silos, but that some degree of integration is accomplished. Current Minnesota POST training requirements likewise advance the case for integration. The learning objectives for use of force now require instruction in communications approaches that should be used alongside “tactical de-escalation strategies in volatile situations,” which would encompass mental health crisis calls.³⁶ The learning objectives for crisis intervention training require instruction in de-escalation and strategies for reducing tension and emotional intensity in mental health crisis situations.³⁷ These factors leave the slate wide open for the use of training scenarios that are not foreordained as mental health or use-of-force situations, but instead require officers to diagnose the issues and respond to them appropriately, whether through some combination of communications and tactics, or disengagement. As above, this training should also include differentiating between defense and control situations as an element of determining an appropriate response.

GUIDING PRINCIPLE #3

TRAIN OFFICERS IN THE LEGAL ISSUES PERTAINING TO TRANSPORT HOLDS.

A transport hold is a legal mechanism by which officers may take people into custody and deliver them to a care facility for emergency evaluation and treatment. These holds are authorized by Minnesota Statutes, section 253B.051. Because they involve a loss of liberty that is legally similar to an arrest, officers must also comply with Fourth Amendment requirements.³⁸

Who may impose and effectuate?

Either a peace officer or health officer may impose a transport hold under the MCTA. However, only peace officers have the statutory authority to use physical force to apprehend and transport someone involuntarily. This is because Minnesota Statutes, section 609.06, which governs the use of force, differentiates between those who are and are not public officers. The statute grants persons who are not peace officers only the authority to restrain persons having mental illness for the purpose of preventing them from harming self or others.³⁹ In contrast, peace officers are authorized to use force for carrying out any duty imposed upon them by law, which includes apprehension and transport under the MCTA.⁴⁰

Circumstances warranting a transport hold

Officers must comply with both the MCTA and Fourth Amendment requirements when imposing a transport hold.⁴¹ The statutory conditions warranting a transport hold are specified in Minnesota Statutes, section 253B.051, and include mental illness, developmental disability, intoxication in public, and chemical dependency. Under the Fourth Amendment, an officer must not only have grounds for believing that one of these conditions is present, but also have probable cause that the person poses an “emergent danger” to self or others.⁴²



3: GUIDING PRINCIPLES

An emergent danger is not the same as one that is imminent or immediate.⁴³ If a reasonable officer would expect harm to come to the individual in the not-too-distant future unless taken into custody, then the situation probably qualifies as emergent. However, if there is time to petition a court for a commitment order (which could take weeks), then the situation is not emergent in a legal sense, and it would not be appropriate for a peace officer or health officer to take a person into custody without a court order.⁴⁴ In cases where intoxication furnishes the basis for concern, courts consider the objective indicators as to the degree of impairment, combined with the hazards the person would face if not taken into custody.⁴⁵

One provision of section 253B.051 appears to be out of sync with Fourth Amendment requirements. Subdivision 1(3) provides that peace officers may take persons into custody — who are chemically dependent or intoxicated in public and *do not* present a danger to self or others — and transport them home. But recent federal case law requires that officers have probable cause to believe a person poses an emergent danger to self or others before taking them into custody, and reliance on subdivision 1(3) is not advised.⁴⁶ To avoid liability under the Fourth Amendment, officers should give intoxicated and chemically dependent people a ride home only based on the consent of the person transported. Along this same line, if an individual agrees to be transported to a hospital or treatment center, then officers need not rely on their authority to impose a transport hold.

Transporting at the request of a health officer

The MCTA also grants peace officers permissive authority to apprehend and transport individuals based on a written statement from a health officer or examiner, provided the statement meets the enumerated statutory criteria.⁴⁷ Some or all of those serving on a Mobile Crisis Response Team may qualify as health officers who can impose a transport hold and request peace officer assistance in transporting the individual. It is foreseeable that law enforcement will be receiving more transport hold requests from health officers as MCRTs respond to more calls.

While accommodating these requests is permissive rather than mandatory, a health officer's determination that someone meets the criteria for a transport hold is entitled to deference given their specialized training. Reasonable reliance on determinations made by mental health professionals and practitioners may also serve to insulate law enforcement officers against claims that they arrived at mistaken judgments.⁴⁸

Detaining to investigate or stabilize

The 8th U.S. Circuit Court of Appeals has observed that officers dealing with mental health crisis situations may briefly detain a person to ensure their safety, and the safety of others, based on a reasonable belief that an emergency exists requiring an officer's attention.⁴⁹ This permits something akin to an investigatory stop in the criminal context, and can likewise evolve into a custodial "arrest" as more information is obtained.⁵⁰

Entering a home to contact someone in crisis

The general rule is that law enforcement officers may not enter the home of another without consent or a search warrant. But circumstances could arise while responding to mental health crises that will authorize a warrantless entry.

Previously, warrantless entries in mental health situations were thought to be authorized by the Fourth Amendment's community caretaking doctrine.⁵¹ But in 2021, the U.S. Supreme Court held in *Caniglia v. Strom* that the community caretaking doctrine does not extend to homes.⁵² A concurring opinion in the case suggested that home entries in crisis situations should instead be analyzed under the emergency aid exception to the warrant requirement.⁵³



Under the emergency aid exception, officers may enter a home without a warrant to provide emergency assistance to someone who is injured or to protect an occupant from imminent injury.⁵⁴ The Minnesota Supreme Court clarified the application of the emergency aid exception in a 2018 decision, *Ries v. State*.⁵⁵ The court held that entry into a home is permissible when:

- 1** Officers have reasonable grounds to believe there is an emergency at hand and an immediate need for their assistance for the protection of life or property;
- 2** There is some reasonable basis, approximating probable cause, to associate the emergency with the area or place to be searched; and
- 3** The warrantless search is strictly confined to addressing the emergency that justified the entry.⁵⁶

This last factor means that officers may enter and search areas as necessary to address the emergency, but not any further.⁵⁷ Once the emergency situation has been defused, a warrant or valid consent will be necessary to perform any additional search.

GUIDING PRINCIPLE #4

TRAIN OFFICERS IN THE SPECIAL CONSIDERATIONS APPLICABLE TO CHILDREN AND ADOLESCENTS.

According to federal statistics:

- More than one in three high school students have reported experiencing persistent feelings of sadness or hopelessness.
- About one in six reported making a suicide plan in the past year.
- Students who identify as gay, lesbian, or bisexual, and those unsure of their sexual identity were far more likely to report considering suicide than their heterosexual counterparts.⁵⁸

Other researchers reported that almost 16% of those aged 12 to 17 have experienced a major depressive episode,⁵⁹ and an approximately equal number received inpatient or outpatient care in a mental health specialty setting.⁶⁰



Youth are at high risk of experiencing mental health crises, yet their unique circumstances are often not considered in “standard” crisis response training.

Giving in-depth treatment to the topic of responding to youth in crisis is beyond the scope of this guide. However, some general “best practice” principles to consider are as follows:

Avoid stigmatization. Having the police respond to a mental health crisis has the potential to be stigmatizing for anyone, yet even more so in a school or other setting where a youth is surrounded by their peers. Agencies may wish to consider meeting with schools on a periodic basis to discuss when officers will be summoned to school grounds and classrooms, and to advocate against calling officers to deal with behavioral or mental health incidents that would be more appropriately handled by teachers, school support personnel, others within the school system, or by a local mobile crisis team.

If officers must respond to a crisis in a school or other setting where peers are present, they should strive to resolve them with low-restraint, non-stigmatizing tactics. Federal courts have observed that taking children into custody in such settings can be humiliating and demeaning and have long-lasting effects on the psychological well-being of the child.⁶¹

Provide special training for officers who work with youth. The goal of crisis intervention with children and adolescents is the same as with adults — to safely lead the person in crisis to a state of calm and to resolve or stabilize the situation at hand. However, the dynamics and strategies can be different, and agencies may wish to consider specialized training for school resource officers (SROs) and others with youth-oriented assignments. Youth act and react differently than adults due to having different developmental and cognitive abilities and different psychological pressure points. In addition, the community-based supports and services that are most effective for youth may be different than those that work best for adults. The National Alliance on Mental Health (NAMI) recommends having a specialized Crisis Intervention Team (CIT) for youth training⁶² and that law enforcement agencies work closely with school-linked mental health providers and school support personnel.

3: GUIDING PRINCIPLES

Reserve use of restraint for only certain circumstances. The use of handcuffs and other forms of physical restraint are seizures under the Fourth Amendment. The 8th U.S. Circuit Court of Appeals has acknowledged that using handcuffs to restrain children in school settings may be unreasonable in some circumstances. Children in school settings should not be handcuffed automatically as an incident of being detained or taken into custody. Rather, the use of handcuffs should be reserved for situations where the officer has grounds to believe the child will flee or pose a threat to self or others if not restrained. Handcuffs should be removed promptly once the need for them has subsided.⁶³

GUIDING PRINCIPLE #5

CRISIS RESPONSE PLANS SHOULD BE DEVELOPED AT THE LOCAL LEVEL.

A point that became abundantly clear from the working group's discussions was that crisis response and mental health resources varied widely among jurisdictions. For example, although all counties in Minnesota are served by mobile crisis teams, their response times vary from place to place. The reality is that some teams are both understaffed and responsible for covering large areas, which has essentially left officers on their own when responding to most or nearly all crisis calls.

Given this variation in resources, as well as differences in local needs, it is not possible to say there is a single best approach for how agencies should respond to crisis calls. The best approach in a given jurisdiction will be one that seeks to meet its community's needs by leveraging and coordinating the efforts of available service providers. Here are some questions a community might want to consider when developing its response plan:

- What types of calls are you wanting assistance with? Frequent utilizers of services, people who are homeless, mental health crisis situations, suicides?
- What types of services do you want to provide? Assessment, intervention, safety planning, stabilization, connection to resources?
- What types of training should someone have to respond to crisis situations?
- What types of records should be kept?

In many areas, law enforcement will continue to be the only provider responding to crisis calls for the foreseeable future. Here are some reference points that may bear consideration as your agency seeks to develop or refine its local response plan:

- Law enforcement *a/ways* has a potential role in responding to crisis calls, even in areas served by robust crisis teams. At the very least, officers will be called upon to safeguard the patient, mental health workers, and the public in dangerous situations, and to physically detain and transport those who are in need of services but do not voluntarily cooperate.
- When, where, and if mobile crisis teams are available and adequately staffed, it may be appropriate for law enforcement to fall into a supportive, gap-filling role. That is, the MCRT could be considered the primary responder, with law enforcement providing support and answering calls on its own when the MCRT is not available.



3: GUIDING PRINCIPLES

- Where co-responders will respond to calls with officers, then the agency and co-responders will need to determine the respective roles of the officers and mental health workers. Key issues to address will include who will decide whether a transport hold should be imposed, who will decide whether it is safe for the mental health worker to remain on the scene without officers present, and what records will be generated by officers and co-responders.
- In agencies where some officers have received advanced training in crisis intervention and others have not, it may make sense to prioritize dispatching the trained officers to crisis calls, if feasible.
- Even if law enforcement has access to MCRTs, co-responders, or officers with advanced training, they should plan for times when these resources will not be available.

Framed differently, a sensible approach might be to anticipate that every officer will at times be required to respond to MHC calls, and to then look for local opportunities to add additional layers of service and support. These layers could come through partnering with MCRTs, bringing on co-responders, or establishing relationships with providers that could supply telehealth support or real-time consultation to officers in the field.

GUIDING PRINCIPLE #6

INVOLVE POLICYMAKERS IN ESTABLISHING YOUR RESPONSE PROGRAM.

Agency decisions about what resources to provide for mental health responses should involve the governing bodies. For the law enforcement executive, elevating this decision to the governing body reinforces the message that mental health response services are in large part a resource issue affecting the entire community. When the governing body deliberates over and decides on the resources and funding to be devoted to these services, it can provide important legal immunities.

Minnesota law establishes immunity from civil liability for “planning level” decisions by government entities.⁶⁴ This immunity could help insulate a city or county against claims for failing to have co-responders, failing to have more training than is required by statute, or failing to provide additional mental health resources. Planning level decisions, according to the Minnesota Supreme Court, are those based on “the evaluation of factors such as the financial, political, economic, and social effects of a given plan or policy.”⁶⁵ When asserting this immunity, the burden is on the government body to show that it engaged in “protected policymaking.”⁶⁶

As a result, the decision-making process should be well documented. An example of this documentation would be a proposal and cost estimate for embedding a mental health professional or providing all officers with 40 hours of crisis response training, together with the record of the governing body’s deliberations and decisions on the matter.

Developing Your Local Approach

4

Mental health crisis (MHC) response plans should be developed on the basis of need and in view of the resources available in each community.

ASSESSING NEEDS

As of now, there are no agreed-upon metrics for identifying when a community needs more crisis response resources, or modifications to its existing plan for delivering services. Commonsense rationales for increasing or taking steps to improve services include:

- An uptick in or high level of crisis calls.
- Other community needs are being left unmet because of the workload in responding to crisis situations.
- Law enforcement is responding to repeat calls involving high users of crisis services, with few referrals to mental health or other services — which may indicate that persons in crisis are not receiving care or being linked to resources between episodes.
- Referrals to resources are not being made because officers are not expected to or they lack time or awareness of resources.
- Community members, crisis teams, EMS, or other stakeholders are providing feedback that services are lacking or inadequate.
- Gaps in training, procedures, resources, or follow-ups are evident from reviewing how crisis calls are presently handled.
- People are being placed into custody in lieu of providing other services to “solve” immediate problems relating to mental health issues.



Photo by Clint Austin

INVESTIGATING RESOURCES

Making improvements to services and how they are delivered is not an all-or-nothing proposition, nor does it have to involve starting from scratch. A fair starting point in developing or evaluating your crisis response plan is to investigate whether there are any untapped, locally available resources that could be brought to bear on mental health issues. Finding untapped resources is not the same as a decision to use them, but instead involves assessing whether they could contribute something of value to how your agency and community responds to mental health issues. Places to check could include:

- Your county social services, human services, or mental health departments.
- The mobile crisis team serving your area.
- Certified Community Behavioral Health Centers.
- Local EMS services and hospital emergency departments.
- Local mental health services and providers.
- Homeless service providers.
- Other social service organizations or charities that could assist with services or emergency housing.
- Schools, including school support personnel and mental health professionals.
- Veteran services.
- Substance abuse providers.
- Domestic abuse agencies.

DESIGNING A LOCAL PLAN

Just as there is no single approach to delivering services that will work for every community, there is also no linear pathway for how to go about assessing needs, finding resources, and designing and implementing your plan. The diagram at right (Figure 1) illustrates one conceivable pathway for developing a local plan or reevaluating one already in place.

This model assumes that you will develop or update your plan after identifying what service providers beyond law enforcement are presently available in your jurisdiction, or that can be obtained to augment the law enforcement response. From there, you will determine the hours and days of the week other providers are available; what services or assistance they can supply when available; and how dispatch and officers will coordinate with these other services.

Just as there is no single approach to delivering services that will work for every community, there is also no linear pathway for how to go about assessing needs, finding resources, and designing and implementing your plan.



Figure 1: Planning Model

Improving coordination and awareness

In the course of researching your local plan, opportunities can arise for improving coordination with and awareness of other resources. Connections made with crisis teams, mental health professionals, and others can give rise to opportunities to consider what each could potentially contribute to the improvement of services delivered to those experiencing a mental health crisis.

These efforts could produce, at the very least, a pocket-sized list of locally available resources for officers to carry and to be referenced when referrals are being considered. In addition, connections with crisis teams or EMS could yield ideas for joint training. Discussions with staff at schools might lead to clearer expectations about the role of law enforcement in school-based crisis situations. Conversations with emergency room staff could produce a better understanding of hospital procedures and the admission criteria being applied.

Follow-ups

One key to improving the quality of life of those who have experienced crisis, and reducing their future reliance on crisis services, is conducting appropriate follow-ups to link them with needed community-based services. An important step in the planning process is to consider whether anyone is available to help in establishing this link, and how they will receive the information needed.

Some agencies, for example, have a special crisis report form that officers complete and route to an embedded professional. Another possibility is that the crisis team serving your area would be willing to triage and conduct follow-ups on calls your agency has handled. In the absence of someone being designated to triage crisis reports, officers should be aware of when matters are appropriate for referral to child and adult protection authorities.

Reporting

Consider tracking MHC calls through the use of a special tracking form, or an electronic form in your records management system. These reports may help in tallying the number of crisis calls being handled, identifying high users of crisis services, and prompting officers to gather information that could be useful in resolving future crisis situations. For data practices reasons, the form should be structured so as *not* to capture information on 911 callers or subscribers, so that it can be shared with whoever may be designated to follow up on crisis calls.⁶⁷

Connections made with crisis teams, mental health professionals, and others can give rise to opportunities to consider what each could potentially contribute to the improvement of services delivered to those experiencing a mental health crisis.

Caring for those in custody

Although the needs of incarcerated persons who have a mental illness are beyond the scope of this guide, agencies should give consideration at the planning stage to circumstances where crisis response and custodial situations may intersect.

Officers who are delivering a person to jail who has been in crisis, or is believed to have a mental illness, should alert custody staff to these circumstances as soon as possible. While mental health screening will be administered as part of the intake process,⁶⁸ this may not occur for some time, and the person being booked may not be entirely forthcoming about their condition and history. Law enforcement officers should be trained to provide custody staff with any information known to them pertaining to suicidality; mental health concerns or mental health history; prescribed medications and the use of any other drugs or intoxicants; and behaviors or statements tending to indicate a crisis situation or mental illness.

Local plans should include consideration of circumstances when law enforcement will be called to a jail to assist with an incarcerated person who is in crisis. Plans could delineate, for example, when a crisis team or other mental health professionals or practitioners will be summoned; the respective roles of custody staff, law enforcement officers, and mental health workers who will respond; protocols to be followed if a transport hold will be imposed; and any special safeguards that will be utilized.

Jails may wish to consider developing a local plan for working and collaborating with mental health providers and crisis response teams.



ILLUSTRATIONS

City A is in Greater Minnesota, and the police chief determines that it is a good time to reevaluate her department's plan for responding to mental health crisis calls. City A is served by a mobile crisis team that covers 10 counties. Due to resignations from the team and a labor shortage in the mental health workforce, the team has been unable to recruit new professionals and has had to cut its service hours. As a result, the team probably will not be able to respond in a timely manner to many of the crisis calls occurring in City A. The team advises the chief, however, that a mental health professional is available 24/7 by telephone to confer with officers in the field and to speak with those in crisis. In checking with the local human services director, the chief has learned that the agency is unwilling to provide a social worker to serve as a co-responder based both on budget considerations and the unwillingness of staff to take on this workload. A phone call to the local EMS provider confirms that their service will provide transportation for transport holds, but staff will only enter a crisis scene after officers have rendered it safe.

Based on this survey of available resources, it appears that City A's plan will need to assume that officers will continue serving as primary responders who are only occasionally augmented by the MCRT. City A should consider, in view of other competing budget priorities, whether this makes the case for additional mental health response training for its police officers. In formulating the response plan, the chief should also consider: (1) when to contact the crisis team for a response, support, or follow-up; and (2) under what circumstances call information should be routed to others for follow-up.

City B is a regional hub that is covered by a mobile crisis team. However, due to the volume of crisis calls, the MCRT is able to respond to only about 20% of the city's calls. An uptick in repeat crisis calls in City B is straining the police department's resources. City B works out an arrangement with the county for a social worker to be "embedded" on a part-time basis with the agency. Although the social worker will not respond to calls in the field, he reviews all reports generated from crisis calls, and works to connect people with resources to reduce their need for crisis care going forward.

County C is in the metro area and is served by a crisis team. During peak hours, the county has a mental health professional in its 911 dispatch center. Calls involving mental health issues are routed to this worker, who triages them and determines whether a crisis team, law enforcement, or both should be sent. The mental health professional also answers questions from and consults with officers in the field.



DISPATCH, CALL HANDLING, AND OFF-RAMPING

In developing a local plan, it may also be appropriate to consider what kinds of circumstances warrant a law enforcement, EMS, or crisis team response. One group in Minnesota has proposed a *Sequential Intercept Model*, included as **Appendix A**, for triaging crisis calls and determining who should respond. This model proposes criteria for call takers at 988 centers to utilize, and identifies different potential outcomes such as referral, stabilization, or transport to a care facility. One goal of this work is to avoid unnecessary involvement of the criminal justice system in mental health issues.

As has been true for some time, persons seeking crisis services may call mobile crisis teams directly by dialing the team's 10-digit phone number, calling 911 in certain tribal areas, or by dialing **274747 from a mobile phone.⁶⁹ In 2020, the Federal Communications Commission designated 988 as the new nationwide dialing code to reach suicide and mental health related crisis support. Dialing and texting to 988 will be operational by July 16, 2022.⁷⁰ The 988 calls will operate through the existing National Suicide Prevention Lifeline,⁷¹ connecting individuals to localized support and resources when appropriate. Guidance on 988 and 911 interactions in Minnesota are under development. Also, Minnesota lawmakers enacted "Travis's Law" in 2020.⁷² This law adds to 911 system requirements. It provides that in addition to dispatching police, fire, and EMS services, the 911 system shall also include a "referral to mental health crisis teams, where available." Statewide guidance on what must be done to comply with this new enactment is not yet available.

It is too soon to tell what these developments will mean for how law enforcement agencies respond to MHC calls. However, these new pathways for accessing and dispatching crisis teams increases the likelihood that crisis responses will be occurring in communities without law enforcement's knowledge or involvement. It is not unrealistic to expect that 911 operators and officers may be unaware of crisis responses in their community until calls come into 911 from crisis team members facing dangers at the scene, or who need law enforcement assistance in transporting a person in need of hospitalization. Agency plans and training should account for these possibilities.

Another innovation in uncoupling criminal justice from mental health issues is the idea of *off-ramping*, which basically involves analyzing calls received through 911 centers and by police agencies to determine if a law enforcement response is appropriate. Without appropriate policies and active triaging, 911 dispatchers may believe they must send law enforcement to every 911 crisis call. Officers who are dispatched on these calls might likewise believe they must respond and see the matter through to a conclusion. Off-ramping responds to this by providing public safety dispatchers with criteria and the authority to determine whether a response by someone other than the police should be initiated, and by providing officers with guidance and discretion for determining when they should not respond, or otherwise terminate their involvement.



Examples and Initiatives

5

CARVER COUNTY

The Carver County Sheriff's Office, in collaboration with the Carver County 24/7 mobile Mental Health Crisis Program, implemented two innovative programs in 2020. First, telephone crisis response and screening practitioners from the Mental Health Crisis Program were co-located in the 911 Dispatch Center in Chaska. The practitioners are available during peak evening and weekend hours to consult with dispatchers, join a 911 call, or take over calls when appropriate. Practitioners are also authorized to dispatch a mobile crisis therapist, with or without law enforcement, as dictated by the circumstances. Carver County believes use of this model meets and exceeds the requirements of Travis's Law.

Next, the Carver County Sheriff's Office funded a full-time licensed mental health professional position as a law enforcement co-responder, who is officed with law enforcement. Either dispatch or deputies may summon the co-responder, who provides direct assessment of the current crisis, intervention, and brief stabilization services. This position is also credentialed with the hospitals in Carver County and is able to follow a client from the community to the hospital to complete an assessment if needed. The co-responder also follows up on prior law enforcement contacts having a mental health or substance use component and provides education on mental health topics to sheriff's personnel as requested. On 23% of the calls, officers were freed up for other tasks while the co-responder continued engaging with the person in crisis. Of those evaluated in the field, 56% were able to remain in their homes, thereby avoiding ambulance and emergency department visits.

For more information on these programs, contact Melanie Warm at (952) 221-5153.

Practitioners are also authorized to dispatch a mobile crisis therapist, with or without law enforcement, as dictated by the circumstances.

ST. PAUL POLICE DEPARTMENT COMMUNITY OUTREACH AND STABILIZATION (COAST)

A 2015 assessment showed that mental health calls to the St. Paul Police Department had doubled over the preceding decade and had come to account for 15% of all calls for service. In 2018, the department launched the Community Outreach and Stabilization (COAST) program, which pairs clinicians with sworn officers to respond to persons in crisis. The unit also follows up with persons reported to be suffering from mental illness, to connect them with needed resources and thereby reduce their likelihood of future police interactions. In response to needs highlighted by the opioid epidemic, the department launched the Recovery Access Program (RAP) in 2021. The RAP pairs licensed alcohol and drug counselors with sworn officers to serve people following non-fatal overdose events. The RAP teams conduct chemical health outreach and coordinate care for individuals afflicted by addiction.

Since its inception in 2018, COAST has received over 5,000 cases, resulting in more than 1,500 referrals to services, more than 500 mental health diagnostic assessments, and more than 100 chemical health diagnostic assessments. Learn more about the COAST Unit on the [St. Paul website](#).

THE YELLOW LINE PROJECT, BLUE EARTH COUNTY

Blue Earth County launched the Yellow Line Project (YLP) in 2016 as a cooperative effort between law enforcement, human services, and a private mental health provider. Since then, the county has seen a 20% decrease in its cost for detox services, and an 86% decrease in costs for state hospital services. YLP began as a jail diversion project to provide an early response to individuals with acute or chronic mental or chemical health problems who have become involved with law enforcement and are not a risk to the community.

Officers in Blue Earth County have the option of referring offenders to the YLP either in lieu of or in addition to charges. Beyond officer referrals, a community-based coordinator conducts pre-booking screenings to determine if offenders are in need of services and eligible for the YLP. The coordinator works with willing participants to develop a plan with actionable short-term goals and to connect them with community-based resources. Recently, the YLP was expanded to include street-level intervention with people who have committed no offense or non-jailable offenses, when officers are concerned about mental health or substance use issues. Officers can coordinate with the Mobile Crisis Response Team to initiate proactive interventions. Learn more about this initiative on the [YLP website](#).

THE NW8 ADULT MENTAL HEALTH INITIATIVE

The NW8 Adult Mental Health Initiative serves Kittson, Mahnomen, Marshall, Norman, Pennington, Polk, Red Lake, and Roseau counties. Through its crisis grant, NW8 offers crisis intervention training to law enforcement officers throughout the region. Local agencies have sent many or all of their officers through this training, resulting in relationship building and strong collaboration between law enforcement, the two local mobile crisis teams, and hospital emergency staff.

Learn more about this initiative on the [NW8 website](#).

COMMUNITY OUTREACH SPECIALIST PARTNERSHIP (ROCHESTER/OLMSTED COUNTY)

In 2017, the Rochester Police Department began partnering with Olmsted County social workers to bring a co-responder model online, with RPD providing office space for one social worker. Given early successes and broad acceptance, four community outreach specialists (COSs) are now embedded within and co-respond to calls having a mental health or substance abuse component. The specialists provide assessment, advice, diversion, and resources; respond to phone inquiries from officers seeking advice; and follow up on completed calls. Their services include assisting persons experiencing homelessness to address short- and long-term needs. In 2021, the COS team expanded its partnership with RPD's Police Assisted Recovery (PAR) Program. This program provides non-arrest pathways to treatment for individuals living with substance use disorders. It has been instrumental in the effort to reduce overdoses through providing follow-up to incidents, as well as outreach, peer support, and immediate recovery options to those in need.

In 2021, the COS team responded with officers to over 1,000 dispatched calls, with 85% being related to mental health or substance use, and with approximately 50% resulting in follow-ups. One 22-year patrol veteran described the partnership with social workers as a “game changer” and the “best addition to the PD in at least a decade.” Although data is still being collected, officers believe that the COS follow-ups have eliminated future crisis calls. As another officer put it, “I can’t imagine doing this job without them.”

For more information, contact Lt. Jennifer Hodgman at JHodgman@rochestermn.gov.

STEARNS COUNTY COMMUNITY ACTION TEAM

The Stearns County Community Action Team (CAT) is a collaboration between local law enforcement, probation, social services, the Central MN Mental Health Center, CentraCare, and the St. Cloud Veterans Administration Health Care System. It is aimed at assisting “active utilizers” of deep-end services such as hospital emergency departments and detox, and those who become enmeshed with the criminal justice system through contacts with law enforcement or being jailed. Each partner represented in CAT had a problem that it could not solve on its own. For law enforcement, it was the number of holds and detentions, for the health care provider it was the number of emergency room visits, and for the county it was the cost of jail days and detox.

The CAT reports that it has seen significant reductions in high-cost services to individuals and more efficient coordination of services, in addition to improving the health and lives of the population being served. CAT team members meet weekly to plan care and intervention for active utilizers, with the goal of coordinating care and efforts around persons who are identified as either active utilizers or being on the path to becoming one. The jail, for example, refers individuals to CAT and serves as a stabilization and intervention location for people who have begun receiving services. Social workers coordinate services and assist with appropriate placement and housing for individuals. Probation agents collaborate with CAT to connect individuals to needed services. Central MN Mental Health provides mobile and residential crisis programs and detox services. Clinical social workers from the VA’s Homeless Team coordinate care for veterans that CAT is working with, and often have familiarity with their circumstances.

VOLUNTARY ENGAGEMENT LEGISLATION

Voluntary engagement is an innovative and promising idea that, unfortunately, has not yet gained appreciable traction. Legislation passed in 2020 authorizes counties to encourage people to voluntarily engage in treatment to avoid the need for civil commitment or ending up in jail.⁷³ In order to be eligible for engagement services, the person must be at least 18 years old, have a mental illness, and either (1) be exhibiting the signs of a serious mental illness; or (2) have a history of failing to adhere with treatment for their mental illness that has been a key factor in the past for a hospitalization or incarceration, and the person is now showing the symptoms that may lead to hospitalization, incarceration, or court-ordered treatment.

Families and others can contact pre-petition screening at the county to ask for help. Engagement services include making assertive attempts to engage the individual in mental health treatment; engaging the person’s support network; and meeting the person’s immediate needs for food, housing, medication, income, disability verification, and treatment for medical conditions. Engagement services must consider a person’s personal preferences and can last for up to 90 days. Services end if the person meets the criteria for civil commitment or if the person agrees to voluntary treatment. When an individual agrees to treatment, the engagement team must facilitate the referral to an appropriate mental health provider, including help obtaining insurance. These services can be provided by either county staff or a contracted agency, such as members of a mobile crisis team, certified peer specialists, and homeless-outreach workers. NAMI encourages agencies to speak with their counties about offering these services in appropriate cases.

Resources

INFORMATION

From the International Association of Chiefs of Police (IACP):

**Assessing the Impact of Co-Responder Team Programs:
A Review of the Research (pdf)**

From IACP:

Responding to Persons Experiencing a Mental Health Crisis (pdf)

**Minnesota Department of Human Services, Mobile Crisis
Mental Health Services**

**Bureau of Justice Assistance, Police-Mental Health Collaboration
(PHMC) Toolkit**

From Substance Abuse and Mental Health Services Administration:

**National Guidelines for Behavioral Health Crisis Care Best Practice
Toolkit (pdf)**

From NAMI Minnesota: Dealing with a Mental Health Crisis:

Information and Resources for First Responders (pdf)

TRAINING

At present, Minnesota training requirements are that officers receive a minimum of six continuing education credits for crisis intervention and mental illness training during each licensing cycle. In addition, officers must also complete four credits each licensing cycle in safer interactions between peace officers and persons with autism. The Minnesota POST Board maintains a list of instructional providers and courses that will help fulfill these training requirements.

**See mandated training approved entities and sponsors on the POST
Board website**

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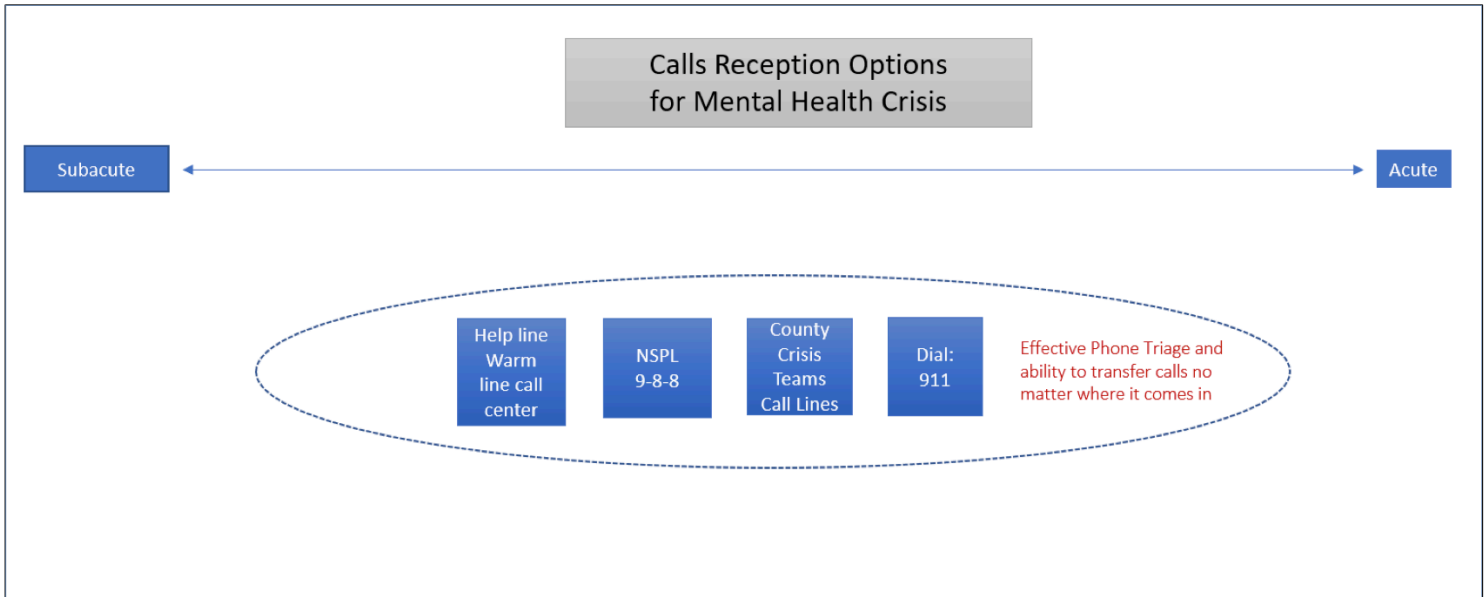
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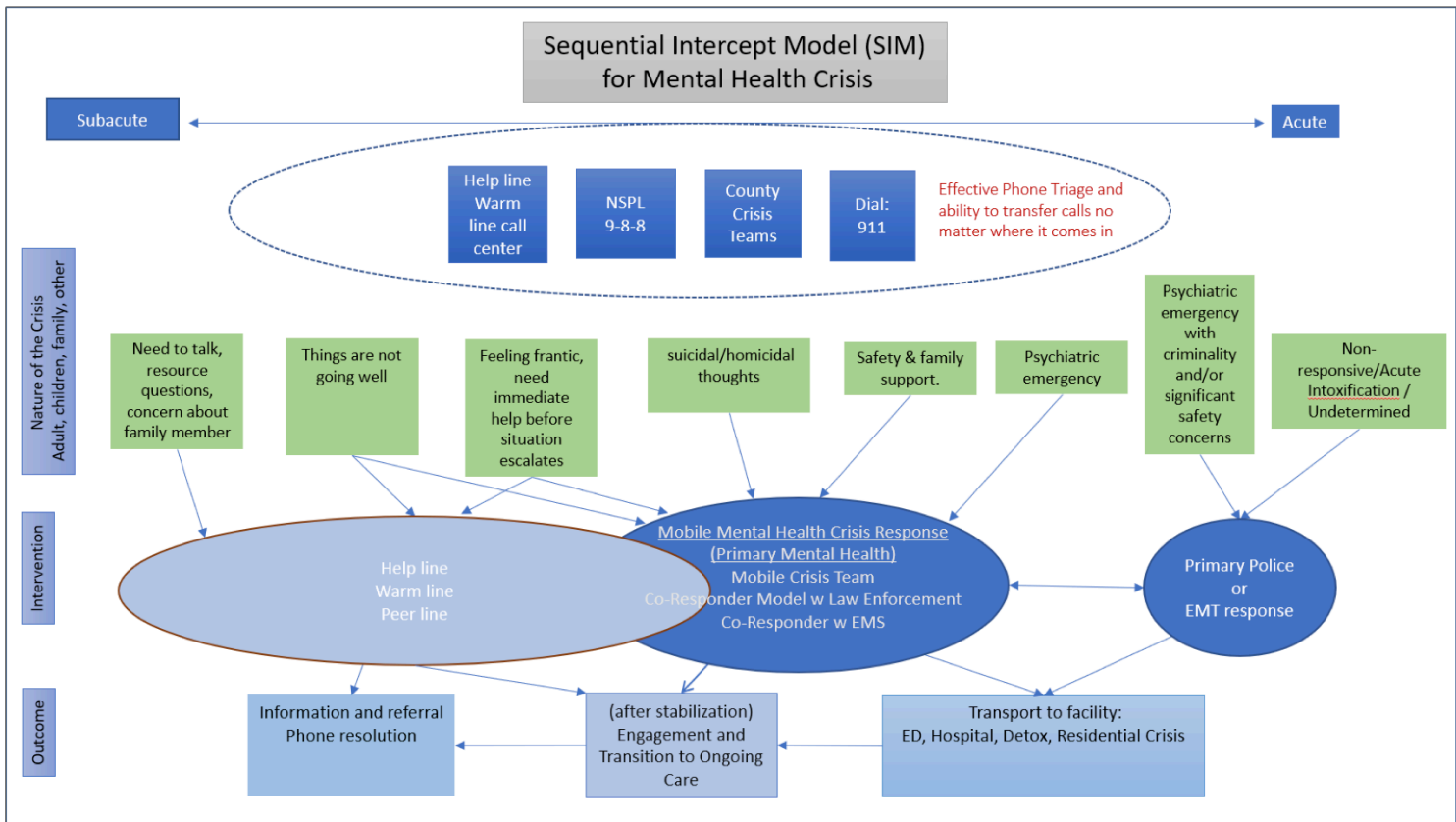
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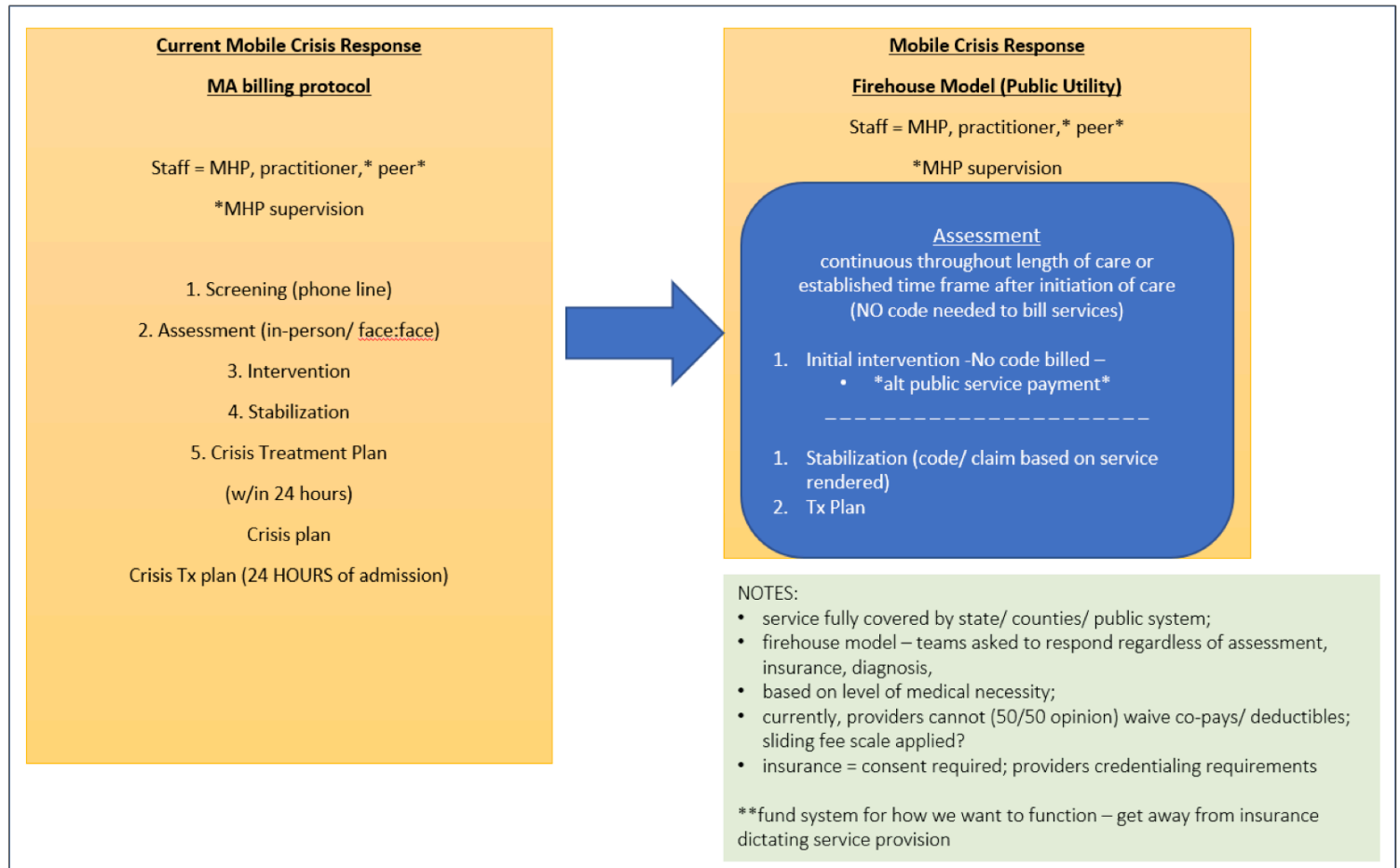
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APPENDIX A – Sequential Intercept Model



*Model provided courtesy of the Central Minnesota Mental Health Center.





FOOTNOTES

¹ Exec. Order No. 13929, 85 Fed. Reg. 119 (June 16, 2020), *available at* <https://www.govinfo.gov/content/pkg/FR-2020-06-19/pdf/2020-13449.pdf>.

² *Mental Illness*, NATIONAL INSTITUTE OF MENTAL HEALTH (Jan. 2022), <https://www.nimh.nih.gov/health/statistics/mental-illness>; A. C. Watson & J. D. Wood, *Everyday Police Work During Mental Health Encounters: A Study of Call Resolutions in Chicago and Their Implications for Diversion*, BEHAVIORAL SCIENCES & THE LAW, Vol. 35(5-6), at 442-455 (2017) (hereinafter “Watson & Wood”).

³ Watson & Wood, *supra* n. 2.

⁴ A. Z. Saleh, P. S. Appelbaum, X. Liu, T. S. Stroup, & M. Wall, *Deaths of People with Mental Illness During Interactions with Law Enforcement*, INT’L J. OF LAW & PSYCHIATRY, Vol. 58, at 110-116 (2018).

⁵ This definition avoids clinical terminology and is intended to enable officers to readily identify those who are or may be in crisis for purposes of their response to the situation. A more formal definition of “mental health crisis” is set out in Minnesota Statutes, section 256B.0624, subdivision 2(j) (2021). That section defines a “mental health crisis” as a “behavioral, emotional, or psychiatric situation that, without the provision of crisis response services, would likely result in significantly reducing the recipient’s levels of functioning in primary activities of daily living, in an emergency situation under section 62Q.55, or in the placement of the recipient in a more restrictive setting, including but not limited to inpatient hospitalization.”

⁶ Minnesota law differentiates between Mental Health Professionals and Mental Health Practitioners. *Compare* Minn. Stat. § 245.462, subd. 17 (2021) (defining mental health practitioner), with Minn. Stat. § 245I.04, subd. 2 (defining mental health professional).

⁷ Crisis Services, MINN. DEP’T OF HUMAN SERVS., <https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/crisis-services/>.

⁸ Minn. Stat. § 387.03 (2021).

⁹ *Cady v. Dombrowski*, 413 U.S. 433, 441 (1973).

¹⁰ 1967 Minn. Laws Ch. 638, sec. 4 (codified at Minn. Stat. § 253A.04 (1967)).

¹¹ 42 U.S.C. 12132 (2018).

¹² Minn. Stat. § 363A.12, subd. 1.

¹³ *United States v. Police Dep’t of Baltimore*, No. 1:17-cv-00099-JKB (D. Md. Apr. 7, 2017); *United States v. City of Cleveland*, No. 1:15-cv-01046-SO (N.D. Ohio May 26, 2015).

¹⁴ U.S. DEP’T OF JUSTICE, *Investigation of the Baltimore City Police Department*, at 80-85 (April 10, 2016), *available at* <https://www.justice.gov/opa/file/883366/download> (hereinafter “Baltimore Report”).

¹⁵ Nondiscrimination on the Basis of Disability in State and Local Gov’t Servs., 28 C.F.R. § 35.130(b)(7)(i) (2016).

¹⁶ Baltimore Report, *supra* n.14, at 81.

¹⁷ Minn. Stat. § 253B.051.

¹⁸ *Id.* § 253B.02, subd. 9.

¹⁹ Minnesota law does not provide health officers with the full authority necessary to apprehend and transport persons in crisis who physically resist those attempting to provide care. Rather, health officers seemingly have authority only to intervene in the moment to restrain those in crisis from causing harm to self or others. *Compare* Minn. Stat. §§ 609.06, subd. 1(1) (peace officers may use reasonable force in executing any lawful duty), with *id.* subd. 1(9) (individuals may restrain those with a mental illness or developmental disability from harming self or others).

²⁰ Minn. Stat. § 253B.051, subd. 1(e).

²¹ *Id.*

²² See *supra*, n. 19.

²³ 2020 Minn. Laws Ch. 1, secs. 9, 10 (2d Special Session) (codified at Minn. Stat. 609.066, subd. 1a(4)).

²⁴ MINN. BD. OF PEACE OFFICER STANDARD & TRAINING, *Peace Officer and Part Time Peace Officer In-service Learning Objectives for Crisis Intervention and Mental Illness Crises (CIMIC) Training* (dated Mar. 2021), *available at* <https://dps.mn.gov/entity/post/Documents/Crisis%20Intervention%20and%20Mental%20Illness%20Crises%20In-service%20Learning%20Objectives.pdf>.

²⁵ MINN. BD. OF PEACE OFFICER STANDARD & TRAINING, *In-service Use of Force Learning Objectives for Peace Officers and Part-time Peace Officers* (approved Jan. 28, 2021), *available at* <https://dps.mn.gov/entity/post/Documents/Crisis%20Intervention%20and%20Mental%20Illness%20Crises%20In-service%20Learning%20Objectives.pdf>.

²⁶ *Estate of Armstrong ex rel. Armstrong v. Village of Pinehurst*, 810 F.3d 892, 900 (4th Cir. 2016).

²⁷ *Vos v. City of Newport Beach*, 892 F.3d 1024, 1034 (9th Cir. 2018).

²⁸ *Karels v. Storz*, 906 F.3d 740 (8th Cir. 2018).

²⁹ Baltimore Report, *supra* n.14; *United States v. Police Dep't of Baltimore City, et al.*, No. 1:17-cv-00099-JKB (D. Md. Jan. 12, 2017) (consent decree), available at <https://www.justice.gov/crt/case-document/file/959321/download>.

³⁰ E.g., *Dahlheimer v. City of Dayton*, 441 N.W.2d 534, 537-38 (Minn. Ct. App. 1989) (general duties owed to entire public rather than specific class of persons cannot form the basis of negligence action); *Cracraft v. City of St. Louis Park*, 279 N.W.2d 801, 806 (Minn. 1979) (law prohibits negligence claims based on general duty, but lawsuit can be based on special duty to protect specific person or classes of persons); *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 195, 199-201 (1989) (Fourteenth Amendment imposes no general obligation to protect others, but there are exceptions to this rule for persons in custody and state-created dangers); *Wood v. Ostrander*, 879 F.2d 583, 588 (9th Cir. 1989) (trooper had duty to protect woman after arresting driver and impounding vehicle she was in, because woman was left alone in high crime area miles from her home); *Riordan v. City of Joliet*, 3 F. Supp. 2d 889, 894-95 (N.D. Ill. 1998) (officers had duty to protect intoxicated man they removed from hotel room and may have violated that duty by dropping him off on the street in cold weather).

³¹ *Sok Kong Tr. for Map Kong v. City of Burnsville*, 960 F.3d 985, 993 (8th Cir. 2020), *cert. denied sub nom. Kong v. City of Burnsville*, Minnesota, 141 S. Ct. 2839 (2021).

³² *Estate of Armstrong*, 810 F.3d at 900 (cleaned up).

³³ See, e.g., *Estate of Armstrong*, 810 F.3d 892 at 900; *McReynolds v. Schmidli*, 4 F.4th 648, 653 (8th Cir. 2021) (“[P]rior to using force officers must allow a reasonable opportunity to comply with their commands.”).

³⁴ *Hayek v. City of St. Paul*, 488 F.3d 1049, 1055 (8th Cir. 2007) (“Knowledge of a person’s disability simply cannot foreclose officers from protecting themselves, the disabled person, and the general public when faced with threatening conduct by the disabled individual.”); *Sok Kong ex rel. Map Kong v. City of Burnsville*, 960 F.3d 985, 993 (8th Cir. 2020) (“[T]he cases establish that mental illness or intoxication does not reduce the immediate and significant threat a suspect poses.”), *cert. denied sub nom. Kong v. City of Burnsville*, 141 S. Ct. 2839 (2021).

³⁵ See POST Use of Force Learning Objectives, *supra* n. 25.

³⁶ *Id.*

³⁷ See POST Crisis Intervention Learning Objectives, *supra*, n. 24.

³⁸ “[A] seizure of a person for an emergency mental health evaluation raises concerns that are closely analogous to those implicated by a criminal arrest, and both are equally intrusive.” *Graham v. Barnette*, 5 F.4th 872, 884 (8th Cir. 2021) (quoting *Pino v. Higgs*, 75 F.3d 1461, 1468 (10th Cir. 1996)), *reh’g denied* (Aug. 20, 2021).

³⁹ Compare Minn. Stat. § 609.06, subd. 1(1) (peace officer authority) with *id.*, subd. 1(9) (restraint of person with mental illness).

⁴⁰ *Graham v. Barnette*, No. 17-CV-2920 (JNE/SER), 2018 WL 6592666, at *9 (D. Minn. Dec. 14, 2018) (officer’s use of force in restraining woman prior to transport was reasonable), *aff’d* 970 F.3d 1075 (8th Cir. 2020), *cert. granted and judgment vacated*, 141 S. Ct. 2719 (2021), *opinion vacated and superseded*, 5 F.4th 872 (8th Cir. 2021).

⁴¹ *Graham v. Barnette*, 5 F.4th 872, 886 (8th Cir. 2021), *reh’g denied* (Aug. 20, 2021) (holding that the Fourth Amendment imposes the probable cause requirement and emergent danger standard).

⁴² *Id.*

⁴³ *Id.* at 890-91.

⁴⁴ *Id.*

⁴⁵ *Meehan v. Thompson*, 763 F.3d 936 (8th Cir. 2014).

⁴⁶ *Graham*, 5 F.4th at 886.

⁴⁷ Minn. Stat. § 253B.051, subd. 1(c).

⁴⁸ See *McRaven v. Sanders*, 577 F.3d 974 (8th Cir. 2009) (holding that prison officials may rely on a medical professional’s opinion if such reliance is reasonable).

⁴⁹ *Graham*, 5 F.4th at 885.

⁵⁰ *Id.*

⁵¹ E.g., *Graham v. Barnette*, 970 F.3d 1075, 1085 (8th Cir. 2020).

⁵² *Caniglia v. Strom*, 141 S. Ct. 1596, 1599-1600 (2021).

⁵³ *Id.* at 1602-05 (Kavanaugh, J., concurring).

⁵⁴ *State v. Lemieux*, 726 N.W.2d 783, 787 (Minn. 2007); *Brigham City, Utah v. Stuart*, 547 U.S. 398, 403 (2006).

⁵⁵ 920 N.W.2d 620 (Minn. 2018).

⁵⁶ *Id.* at 629-31.

⁵⁷ *Lemieux*, 726 N.W.2d at 788; *State v. Johnson*, No. A07-1796, 2009 WL 982003, at *3 (Minn. Ct. App. Apr. 14, 2009); *Ries v. State*, 920 N.W.2d at 633-34.

⁵⁸ *Mental Health: Poor Mental Health is a Growing Problem for Adolescents*, Centers for Disease Control and Prevention, <https://www.cdc.gov/healthyyouth/mental-health/index.htm> (May 12, 2021) (hereinafter “CDC Adolescent Mental Health”).

⁵⁹ S. Abuse, U.S. DEP’T OF HEALTH AND HUMAN SERVS., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*, at 4 (2020), available at https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-07-01-001-PDF.pdf (hereinafter “SAMHSA Report”).

⁶⁰ SAMHSA Report, *supra* n. 59, at 5.

⁶¹ *Scott v. City of Albuquerque*, 711 F. App’x 871, 882 n. 9 (10th Cir. 2017) (collecting cases).

⁶² NAT’L ALLIANCE ON MENTAL HEALTH, *Step 4 Planning a CIT for Youth Training*, available at [https://www.nami.org/getattachment/Get-Involved/Crisis-Intervention-Team-\(CIT\)-Programs/CIT-Programs-for-Youth/Responding-to-Youth-with-Mental-Health-Needs_NAMI.pdf](https://www.nami.org/getattachment/Get-Involved/Crisis-Intervention-Team-(CIT)-Programs/CIT-Programs-for-Youth/Responding-to-Youth-with-Mental-Health-Needs_NAMI.pdf).

⁶³ *K.W.P. v. Kansas City Public Schools*, 931 F.3d 813 (8th Cir. 2019).

⁶⁴ *Holmquist v. State*, 425 N.W.2d 230, 231-32 (Minn. 1988).

⁶⁵ *Id.*

⁶⁶ *Conlin v. City of Saint Paul*, 605 N.W.2d 396, 402 (Minn. 2000).

⁶⁷ See Minn. Stat. § 13.82, subd. 17(f) (certain data pertaining to 911 calls in mental health emergencies is not public).

⁶⁸ Minn. Stat. § 641.15, subd. 3a.

⁶⁹ *Get Help*, MINN. DEP’T OF HUMAN SERVS. (July 10, 2017), <https://mn.gov/dhs/people-we-serve/adults/health-care/mental-health/get-help/>.

⁷⁰ Press Release, Fed. Commc’ns Comm’n, FCC Approves Text-to-988 to Expand Access to the Suicide Prevention Hotline (Nov. 18, 2021), available at <https://docs.fcc.gov/public/attachments/DOC-377987A1.pdf>.

⁷¹ National Suicide Hotline Designation Act of 2020, Pub. L. No. 116-172 (2020), available at <https://www.congress.gov/116/plaws/publ172/PLAW-116publ172.pdf>.

⁷² Minn. Stat. § 403.03, subd. 1(b).

⁷³ Minn. Stat. § 253B.041.