

WORKSHOP SERIES

Emergency and First Responders Partnerships: Collaborative Models of Response

February 24, 2026



Funded by the Substance Abuse and Mental Health Services Administration



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Crisis Systems Response Training and Technical Assistance Center

SAMHSA has selected Altarum to provide training and technical assistance (TTA) support to states, territories, Tribal organizations, and community partners across the 988 Suicide and Crisis Lifeline and crisis continuum of care. Along with our partners, W2 Consulting Corporation and Change Matrix, LLC, who have extensive experience with crisis services and technical assistance, the Crisis Systems Response Training and Technical Assistance Center (CSR-TTAC) was formed to support the continued growth of the 988 Lifeline and build a more robust crisis care system.



SAMHSA Team



Jill D. Mays, MS, LPC

Division Director of Crisis System Transformation for the 988 & Behavioral Health Crisis Coordinating Office (BHCCO)

Jill D. Mays is the Division Director for Crisis System Transformation for the 988 & Behavioral Health Crisis Coordinating Office at SAMHSA. She currently leads the evolutionary and collaborative work of pillars two (someone to respond) and three (a safe place for help) of the 988 Behavioral Health Crisis Continuum. Before coming to SAMHSA, Mrs. Mays served as Director of the Office of Behavioral Health Prevention and Federal Grants at the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), where she most recently oversaw all substance misuse prevention, suicide prevention, and mental health promotion, and served as principal investigator for the agency's multimillion dollar portfolio of federal grants, including 988 and CCBHC grants and as planner for the mental health block grant. Additionally, as Assistant Director of the Office of Adult Mental Health at DBHDD, she was the Project Officer for Crisis Services. Mrs. Mays previously coordinated operation of SAMHSA's Disaster Distress Helpline (DDH) Core Regional Call Center in Atlanta, serving FEMA Regions III & IV. Mrs. Mays is a Licensed Professional Counselor, with over 30 years of experience in the behavioral health field and is a person with mental health lived experience.

SAMHSA Acknowledgment



Tiffany M. Russell, MBA
Chief, Crisis and Justice Initiatives for the 988 & Behavioral Health Crisis Coordinating Office (BHCCO)

As the Chief of Crisis and Justice Initiatives with SAMHSA's 988 & BHCCO, Tiffany serves as an advisor to the 988 Director and other members of SAMHSA's senior leadership in planning and determining policy, programs, and activities that address complex challenges in coordination of 988 crisis centers with law enforcement, 911 call centers, and emergency medical service providers. She also develops, recommends, and implements programs and provisions of guidance related to improving crisis response and fair access to services for individuals with behavioral health needs that minimize unnecessary law enforcement involvement and promote diversion from the justice system.

Before joining SAMHSA, Tiffany directed the Mental Health and Justice Project which focused on improving behavioral health crisis responses in state and local governments for Pew Charitable Trusts. Prior to Pew, she served as the Director of Strategic Planning and Research Development in the District Court Administration for the Superior Court of Fulton County, Georgia, where she was responsible for building the court's capacity by developing policies, programs, and processes to enhance the administration of justice and increase access to justice for all. Tiffany also held several positions in grant management, research, strategic planning, public relations, and communications in nonprofit, government, and education organizations. Tiffany also holds a bachelor's degree in organizational leadership and a Master of Business Administration in Innovation from Mercer University.

Workstream Team



Stephanie Berzkalns



Chizoba Chukwura



Jasmine Little



Stephanie Loo



Meagan MacGregor



Manny Stegall



Elizabeth Woodford

Agenda

Position	Topic
01	Learning Objectives
02	Collaborative Response in the Crisis Continuum of Care
03	Presentation
04	Question and Answer

Learning Objectives

By the end of this workshop, participants will be able to:

Describe

Describe key components of collaborative response models and emerging practices

Identify

Identify improved outcomes associated with collaborative response models in crisis care

Apply

Apply strategies to overcome common challenges in adopting collaborative response models

Collaborative Response within the Three Pillars of Crisis Care

THREE PILLARS OF CRISIS CARE



Collaborative Response Models

Model	Core Components	Primary Partners	Evidence-Based Outcomes
Co-Responder Teams	Law enforcement and mental health clinician respond together	Police, behavioral health clinicians 🚔 ♂ 🩺	Reduced arrests, improved de-escalation, fewer hospitalizations, increased access to care
Mobile Crisis Teams	Behavioral health professionals respond independently (or with) Emergency Medical Services (EMS)	EMS, behavioral health specialists 🚑 🩺	High success in resolving crisis on site, reduced Emergency Room (ER) visits, warm-handoffs improve follow-up connection
Crisis Intervention Team (CIT)	Specialized training for law enforcement to support individuals in crisis with referrals pathways to clinicians	Police, behavioral health agencies 🚔 ♂ 📄	Increased officer confidence in de-escalation, reduced use of force, improved diversion to treatment
Community Responder Programs	Non-police teams (social workers, peers, etc.) respond to low-risk behavioral health calls	Social workers, peer specialists, EMS 🧑 🏠 🚑	Reduced arrests, improved community trust in agencies, reduced reliance on law enforcement for crisis response

Collaborative Response Models References

1. Bakko, M., Swanson, L., Zettner, C., Kok, K., Fukuzawa, H. and Kubiak, S., 2025. A comparison of behavioral health crisis response models in meeting behavioral health goals and improving criminal legal diversion. *Community Mental Health Journal*, pp.1-11.
2. Policy Research Associates 2020, *Responding to behavioral health crises via crisis response models*, Policy Research Associates, Delmar, NY
3. Center for Justice Innovation. (2024) *Audio-visual crisis response report*. New York: Center for Justice Innovation.
4. Center for Police Research and Policy, The University of Cincinnati. (2021) *Assessing the impact of co-responder team programs: A review of research. Academic training to inform police responses best practice guide*. March 2021. Cincinnati, OH: Center for Police Research and Policy, The University of Cincinnati.
5. Pope, L.G., Patel, A., Fu, E., Zingman, M., Warnock, A., Ellis, S., Ashekun, O., Watson, A., Wood, J. and Compton, M.T., 2023. Crisis response model preferences of mental health care clients with prior misdemeanor arrests and of their family and friends. *Psychiatric Services*, 74(11), pp.1163-1170.

Best Practices in Collaborative Response

Strong cross-system partnerships

- Establish formal agreements between first responders and behavioral health providers
- Cross-training opportunities in de-escalation, trauma-informed care, and cultural awareness

Integration with the care continuum

- Coordinate with 988 Lifeline and community-based services for follow-up
- Conduct warm hand-offs to community services and/or peer support programs

Flexible models

- Ride-along teams
- On-call clinicians dispatched
- Post-crisis follow-up teams

Data collection and evaluation

- Collecting data on metrics like arrest diversion, repeat crisis calls, and linkage to services
- Use data to refine protocols

Key Outcomes

Public Safety
& First
Responders

Emergency
Department
(ED)
Utilization

Linkage
to Care

Suicide Risk

Cost and
Performance

Public Safety and First Responder Outcomes

- Arrests are associated with a higher future crisis recurrence and poorer health outcomes. Collaborative response shifts focus to stabilization rather than criminalization.
- Reduction in arrest rate for individuals in behavioral health crisis
- Reduced reliance on punitive responses
- Shorter call resolution times
- Increased officer confidence addressing behavioral health
- Improved perception of safety for all parties

Pisani, Anthony R, and Edwin D Boudreaux. Systems Approach to Suicide Prevention: Strengthening Culture, Practice, and Education. *Focus (American Psychiatric Publishing)* vol. 21,2 (2023): 152-159. doi.org/10.1176/appi.focus.20220081



ED Utilization

Collaborative response teams are more likely to resolve cases on scene or divert to community-based services.

- Lower rates of ED transport
- Reduced repeat ED visits

Inagaki, M., Kawashima, Y., Yonemoto, N., & Yamada, M. (2019). Active contact and follow-up interventions to prevent repeat suicide attempts during high-risk periods among patients admitted to emergency departments for suicidal behavior: A systematic review and meta-analysis. *BMC Psychiatry*, 19, Article 44. doi.org/10.1186/s12888-019-2017-7



Linkage to Care Outcomes

- Collaborative response allows for rapport-building, referrals in real-time, and on-site safety planning.
- Higher engagement through care transitions
- Increased follow-up attendance

Doupnik SK, Rudd B, Schmutte T, et al. Association of Suicide Prevention Interventions With Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: A Systematic Review and Meta-analysis. *JAMA Psychiatry*. 2020;77(10):1021–1030.

[doi:10.1001/jamapsychiatry.2020.1586](https://doi.org/10.1001/jamapsychiatry.2020.1586)



Suicide Risk Outcomes

Collaborative response models function as a critical access and engagement mechanism within evidence-based suicide prevention systems.

- Active contact during crisis can reduce repeat suicide attempts up to 50% within 6 months of crisis encounter.
- Collaborative response models that support warm hand-offs and continuity of care are associated with lower suicide attempt rates across all health systems.

Inagaki, M., Kawashima, Y., Yonemoto, N., & Yamada, M. (2019). Active contact and follow-up interventions to prevent repeat suicide attempts during high-risk periods among patients admitted to emergency departments for suicidal behavior: A systematic review and meta-analysis. *BMC Psychiatry*, 19, Article 44. doi.org/10.1186/s12888-019-2017-7

Cost and Performance Outcomes

- While there are initial costs to implementing collaborative response models, they show promise in cost avoidance and system efficiency.
- Cost of collaborative response shows cost offset from reduced ED utilization, fewer involuntary holds, and decreased jail utilization.
- Systems that embed collaborative response across the crisis continuum of care show better performance metrics than siloed programs.
- Collaborative response models typically include data-sharing systems leading to better reporting on interactions and outcomes.

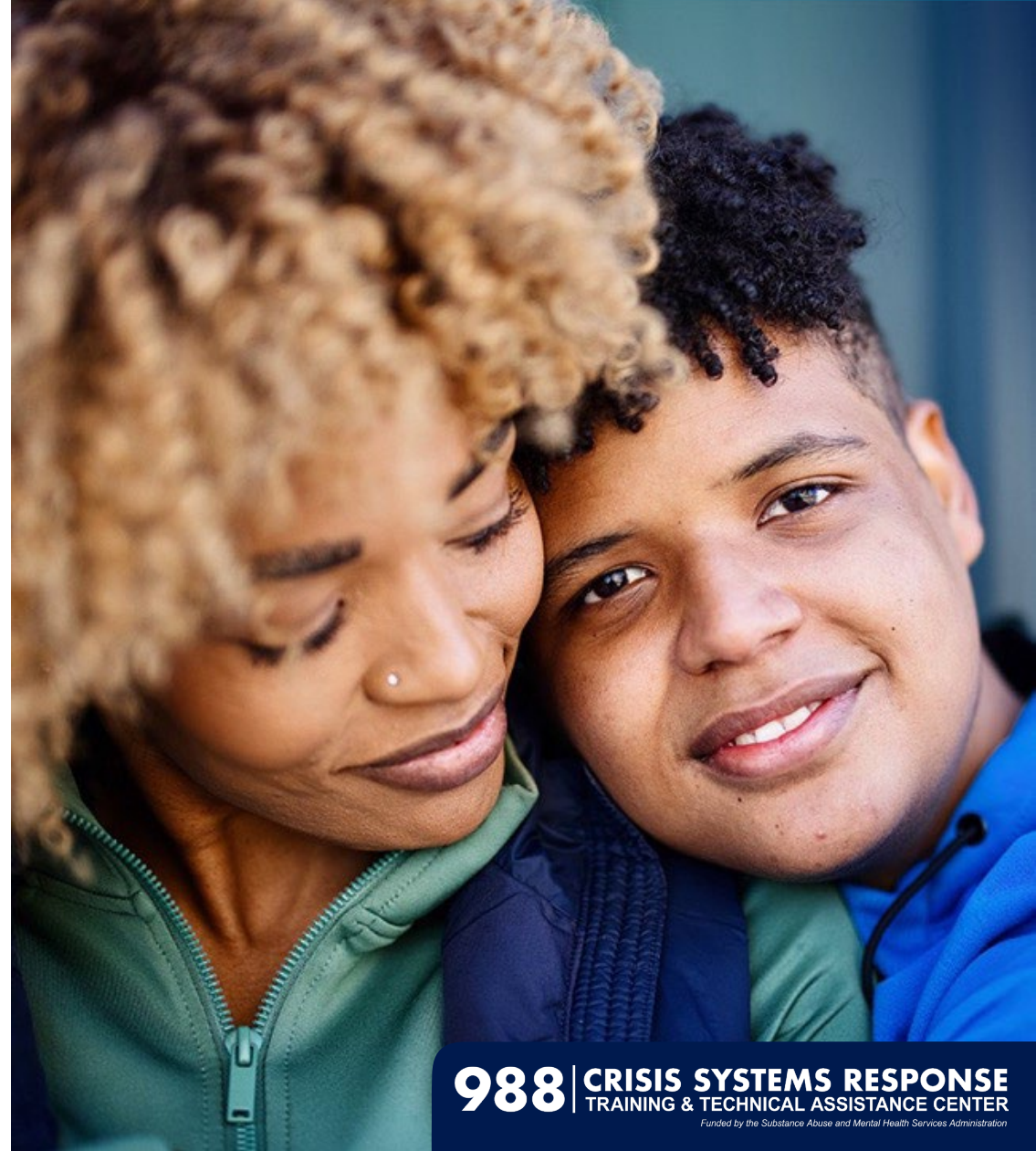
Substance Abuse and Mental Health Services Administration. (2025). *National guidelines for a behavioral health coordinated system of crisis care* (HHS Publication No. PEP24-01-037). U.S. Department of Health and Human Services.

library.samhsa.gov/national-guidelines-crisis-care-pep24-01-037.pdf



Bottom Line Up Front

Collaborative, follow-up-oriented responses save lives and reduce system strain.



PRESENTATION

Collaborative Models of Response

Jon Ehrenfeld

Mobile Integrated Health Program Manager
Seattle Fire Department

Guest Speaker



Jon Ehrenfeld has served as the program manager for the Seattle Fire Department's Mobile Integrated Health program since 2016. He oversees the program's co-responder team, Health One, which comprises specially-trained firefighters and civilian case managers. He has a background in program management, disaster preparedness and recovery, and holds a Master's Degree in International Relations. Jon served as a paramedic in Montgomery County, MD and lives with his family in Seattle, WA.

Jon Ehrenfeld

**Mobile Integrated Health
Program Manager
Seattle Fire Department**

SFD – MOBILE INTEGRATED HEALTH PROGRAM

Partnering with Emergency and First
Responders: Collaborative Models of
Crisis Response



City of Seattle

The mission of the Mobile Integrated Health (MIH) program is to alleviate the strains placed on Seattle Fire Department Operations companies by high utilizers, behavioral, chronic medical, or social crises, and lower acuity alarms while providing response and case management services to those individuals in need.

Program History

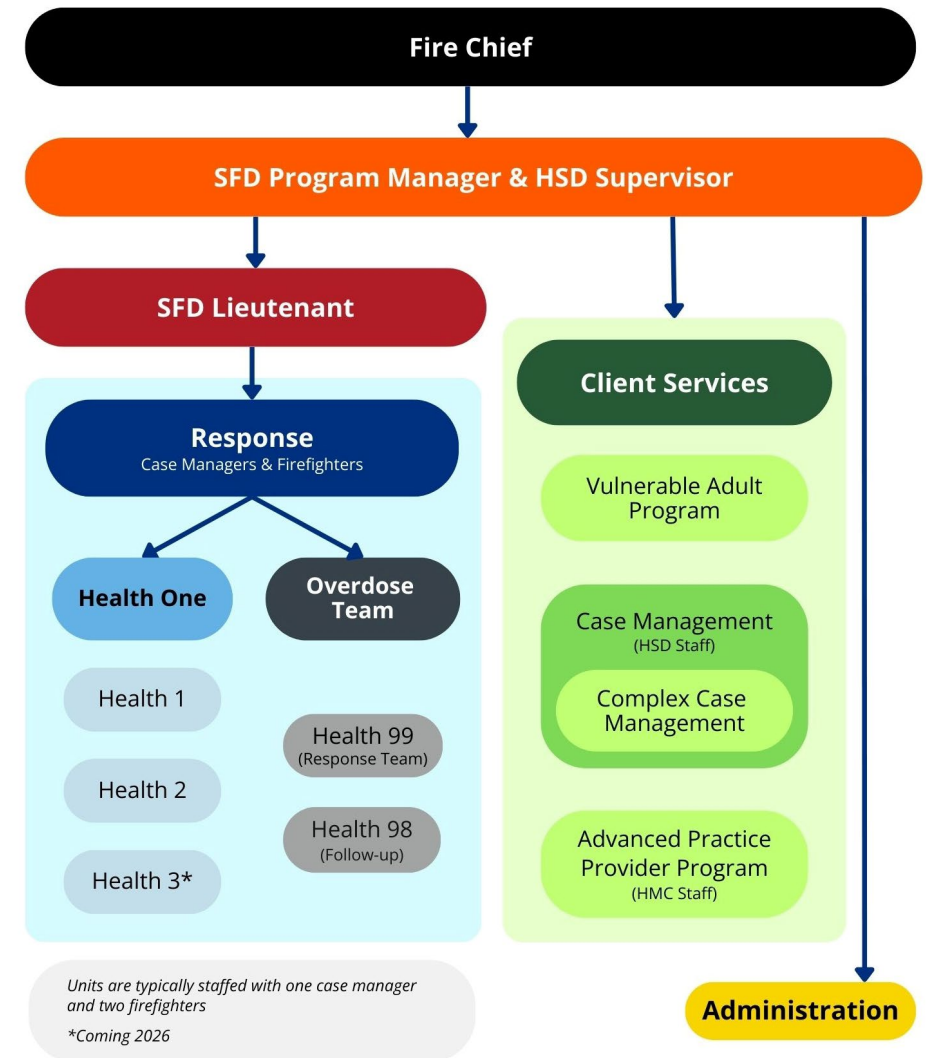
- 2011 – Vulnerable Adult Program (with Seattle Human Services Department (HSD))
- 2016 – Low Acuity Alarm Program (later renamed MIH)
- 2018 – Concept development and Council funding
- 2019 – Health One launch (November)
- 2021 – 2nd unit goes live
- 2022 – 3rd unit goes live
- 2023 – H99 goes live
- 2024 – Advanced Registered Nurse Practitioner (ARNP) program launches (in partnership with Harborview Medical Center (HMC))
- 2025 – H98 goes live
- 2026 – Weekend service launches

MIH Organization and Oversight

Key Players

- Executive Sponsor (Fire Chief)
- Key Partners: HSD/Harborview
- Steering Committee (FD departments, HSD, external partners, rank-and-file)
- Labor
 - IAFF Local 27
 - PROTEC Local 17
- Seattle Fire Department (SFD) Medical Direction

ORG CHART



Processes and Information Sharing

- Broad reliance on coordination of care (exceptions for 42 CFR) = many informal relationships
- New compliance with HIPAA
- Pre-shared returns on investment (ROIs) with high-utilizer groups
- Memorandum of Understanding (MOU) with hospital system, full electronic medical record (EMR) access
- Real-time access to program data via MIH software platform
- Establishing county-wide MOUD data-sharing platform

Staffing

- 11 Full-time employed (FTE) case managers (14 by 2027)
- SFD/HSD managers, 2 admin staff
- Pool of about 32 firefighter (FF)/EMTs (48 by 2027)
- 1 Admin FF lieutenant
- 1 Harborview ARNP (soon, 2)
- Daily full Health One staffing: 4 Case Managers (CMs), 7 FF/EMTs

Deployment

- Health One units typically 2 FF/EMTs, 1 CM
- H1 out of Pioneer Square
- H2 out of Belltown
- H99/H98 out of Pioneer Square
- H3 (later this year) out of Northgate/SODO

MIH Operations (continued)

Health One Response

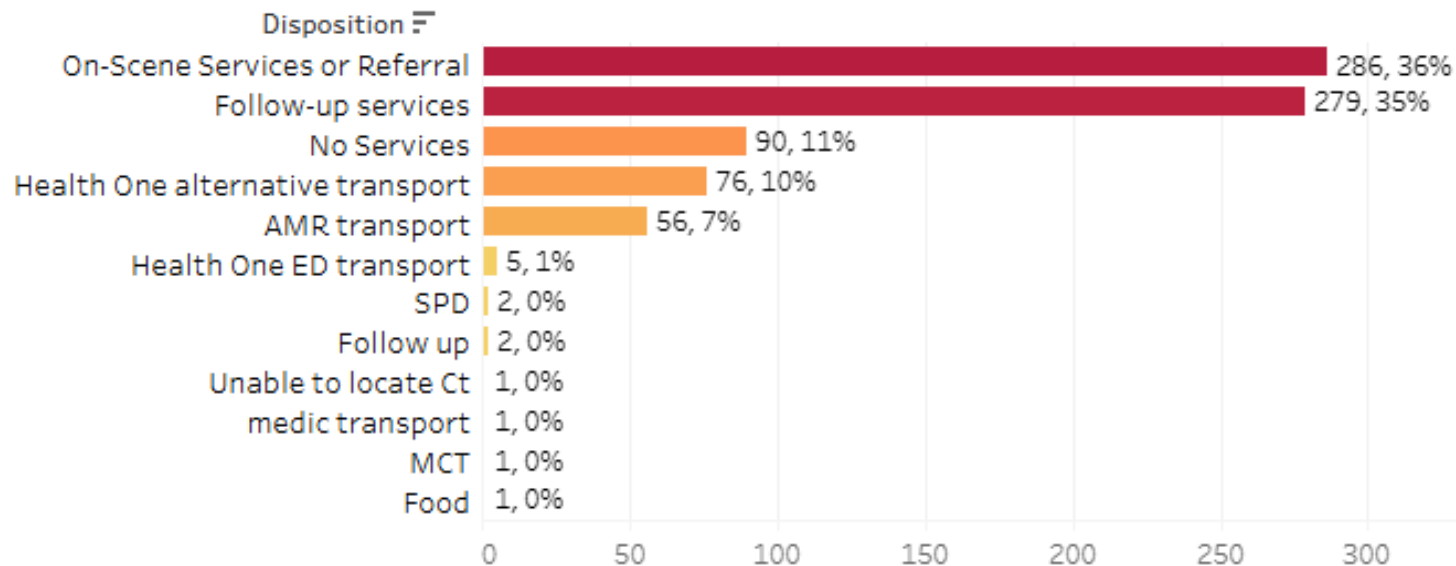
- Citywide operations
- Monday – Sunday, 9-7pm
- Code Yellow response (Health One), Code Red (H99)
- Apparatus: crew cab pickups, Americans with Disabilities Act (ADA) wheelchair van, passenger car, ambulance
- Full EMS equipment, food, clothing

Response Types

- Direct 911 dispatch: Behavioral health crisis and suicidality
- Live operations requests
- Self-dispatch (overdose, new referrals, or existing clients)

Health One on Scene

- Average scene time: 42 minutes
- Wide array of alternate transport destinations
- 1,234 dispatches in 2025
- Capabilities: wheelchair transport, essential items, crisis intervention, EMS, phones, warm handoffs



Clients and Case Management

- **All** MIH responses presume short-term case management
- Case management allows MIH to move from **episodic, incident-driven** interactions to **longitudinal, client-centered relationships**
- HSD case managers have access to state-level benefits and long-term care databases, plus hospital records (with documentation)
- MIH team directly receives all SFD Adult Protective Services reports—vulnerable clients not typically seen by other teams/services
- ★ New in 2025: complex case management
- 2025: 1,564 non-duplicated clients
- **Average 76% reduction in 911 call volume, 69% reduction in ED utilization**



Clients and Case Management (continued)

- Deliberate focus on at-risk, under-prioritized populations, impact on operations
- Mean client age 67 (17% of H99 clients are geriatric)
- 95% of clients on public insurance
- Disproportionately serve clients experiencing homelessness, in supportive/low-income housing, minorities
- Large number of “unseen” clients: housed, poorly-served, only interfacing with EMS

MIH referral reasons, 2025

Automation: Multiple Falls Calls - 50+	879
MH/SUD	847
High utilizer	825
Low acuity medical	720
Living conditions	593
Homeless	556
Neglect/abuse/no self-care	551
Falls	497
Vulnerable Adult	306
Other	223
Grand Total	3,528



Overdose Program: H99

- Launched summer 2023 by Executive Order
- Modeled on other FD programs
- 2 FF and 1 CM or ARNP
- Citywide self-dispatch (M-F), focus on high-volume areas (3/Pike, 12th/Jackson)
- Training: OUD, medications for OUD, overdose risk and response services, trauma-informed care
- November 2024: first-in-USA EMT buprenorphine program
- 133 admins, 0 adverse outcomes to date
- About 80% post-overdose (OD) ED diversion rate
- About 1,000 responses in 2025



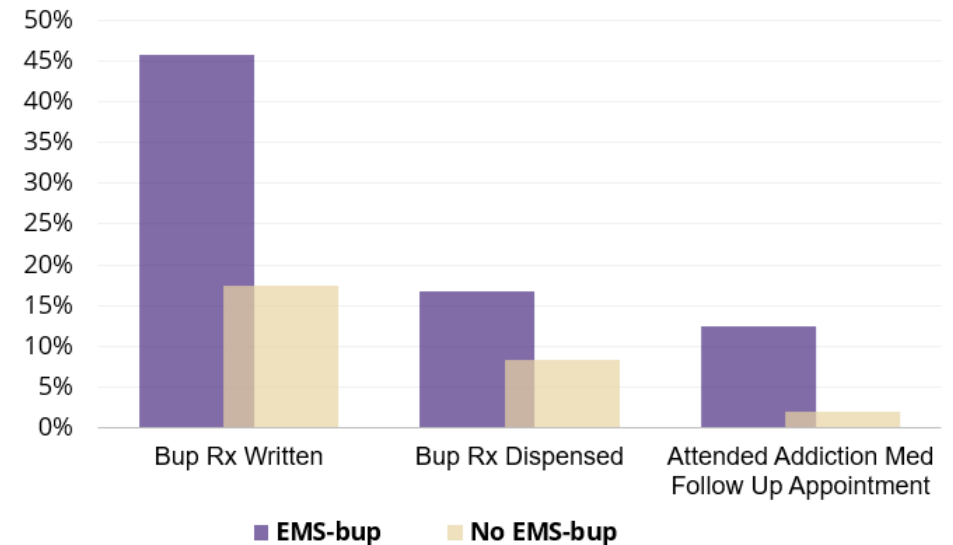
Overdose Program: H98

- Post-OD outreach, follow-up, and case management: hours/days post OD
- Goals: connection with ongoing MOUD (focus on long-acting injectable (LAI) buprenorphine), general case management, referrals
- About 300 outreaches since 2025, higher rates of engagement
- Reliance on partners: Downtown Emergency Service Center (DESC), REACH, Ryther, Let Everyone Advance with Dignity (LEAD), etc.
- Strong/growing partnership with DESC Opioid Recovery & Care Access (ORCA):
 - Daily coordination call
 - Almost all post-OD transports
 - Real-time client navigation, follow-up



ED Impact

Fig 6. Comparing Buprenorphine Prescription & Linkage to Care 30 days from Index Overdose for Cohort of Patients Who Received EMS-Buprenorphine vs Patients Who Did Not Receive EMS-Buprenorphine 03/2024 – 07/2024



Gressman et al.: Prehospital Buprenorphine: Facilitators, Barriers and Impact Using a Systems Analysis and Improvement Approach (SAIA)

Advanced Practice Provider Program

- Partnership with HMC Hobson Clinic
- Currently 1 ARNP – time split between Health One and H99
- Clients/bodies of work:
 - Complex illness management (e.g., CHF, COPD)
 - Street medicine
 - Intakes/assessments/referrals
 - Med admin/new prescriptions
 - Support for H99
- Initially funded by Rep. Smith CDF, now city-funded
- Planning 2nd position

UW Medicine

HARBORVIEW
MEDICAL CENTER



Future Growth, Challenges, and Gaps

Growth

- Lieutenant starting 2026
- 2nd ARNP
- Expansion of complex case management
- Expansion of ORCA partnership
- Expansion of H98 capability
- Additional north/south end coverage
- More vehicles (ambulance, van, pickup, car)

Challenges/Gaps

- Shelter capacity
 - General population
 - High-acuity needs
 - Families with children
- Post-overdose stabilization: shelter, tiny homes
- Crisis options
- PSH and low-income housing capacity

Questions?



Upcoming 988 CSR-TTAC Events



[Upcoming Events](#)
[\(SAMHSA CSR-TTAC\)](#)

- **Leveraging the Skills of Older Adults and Tribal Elders to Strengthen the Crisis System Response**
 - February 26, 2026
 - 1:00pm ET
- **The Work After the Work: Embedding Long-Term Recovery in CYF Crisis Systems**
 - March 19, 2026
 - 2:00pm ET
- **Trusted Messengers: Faith Community Partnerships to Strengthen the 988 Crisis System**
 - March 31, 2026
 - 2:00pm ET

Free 1:1 Technical Assistance (TA) Available

The CSR-TTAC was developed to provide TA to States, Territories, Tribes and Tribal organizations, and community partners. All CSR-TTAC supports are provided at no cost (funded by SAMHSA) and are available to any U.S.-based program, agency, or group working within the crisis continuum.



What Is CSR-TTAC TA?

Individualized support to help programs/organizations strengthen capacity and implement best practices for behavioral health crisis response. An assigned CSR-TTAC team member works collaboratively with requestors to define desired outcomes, identify conditions for successful change, and select the appropriate methods for TA delivery.

Our TA is tailored to each request and may include:

- 1:1 consultation and subject matter guidance
- Skills, knowledge, and capacity building
- Facilitation and step-by-step guidance for implementation
- Webinars, workshops, and meeting presentations
- Small group or cohort-based learning opportunities
- Online resources, written tools, and digital products
- Customized resource development

REQUEST TA

- Email: support@988crisisttac.org
- Call (toll-free): 844-464-8338
- [Request TA through the web](#)
- Scan the QR code:



Free 1:1 Tribal Grantee-Specific TA Available

- Assist 988 Tribal Grantees with system mapping, relationship-building, and collaboration with community stakeholders.
- Identify needs and support connections to resources and subject matter experts.
- Develop specific trainings, curricula, and/or programs.
- Sustain and expand services beyond the period of grant funding.
- Any additional topics, identified by the Tribal Grantee, related to developing and implementing 988 crisis systems and services.



Tribal Grantee TA Elements

Monthly Individualized 1:1 TA Calls

- Identify TA needs and respond to specific requests

Monthly Group TA Calls

- Peer-to-peer learning and relationship building between grantees through open discussion and information sharing on common challenges and successes

Webinars

- Presentations by subject matter experts on high priority topics

Resource Development and Sharing

- Create/disseminate fact sheets, strategy guides, and sample policies and procedures

Site Visits (if needed, and as budget allows)

- Facilitate planning sessions
- Train on specific topics
- Conduct a system assessment with partners
- Facilitate and convene working sessions with 988 stakeholders

REQUEST TRIBAL GRANTEE TA

Please contact **Caley Small**,
Andy Hunt, and **Taryn Patterson**
at: support@988crisisttac.org

We Value Your Feedback!

Please take a minute to complete the evaluation poll on your screen.



Certificate of Attendance

[Available by Request](#)



988 CRISIS SYSTEMS RESPONSE

TRAINING &
TECHNICAL
ASSISTANCE
CENTER

SAMHSA
Substance Abuse and Mental Health
Services Administration

Funded by the Substance Abuse and Mental Health Services Administration

Thank you for attending!

Have additional questions? Email us!

support@988crisisttac.org

This project is supported by SAMHSA, the agency within HHS that leads public health efforts to advance the behavioral health of the nation. The CSR-TTAC works in conjunction with the 988 Suicide & Crisis Lifeline. In 2020, Congress designated the new 988 dialing code to be operated through the existing National Suicide Prevention Lifeline. SAMHSA sees 988 as a first step towards a transformed crisis care system in America. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of SAMHSA or the 988 Suicide & Crisis Lifeline.

