Cross-Sector Collaboration in Secondary Violence Prevention

A Guide for U.S. Cities, Law Enforcement, and Mental Health/Social Work Providers

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Note on Authorship

This report was prepared for the Strong Cities Network by Gabriela Arias Torres, India Clarke, Reese Dennis, Rebecca Fainberg, Reagan Propps, and Luna Tejedor Amblar as part of a consulting practicum project at New York University's Center for Global Affairs. The views expressed herein do not necessarily reflect those of the Strong Cities Network or its members, Management Unit and partners.

Strong Cities Network

Executive Summary

This report examines how cross-sector collaboration between law enforcement and mental health/social work providers can support public health approaches in secondary violence prevention at the city-level — that is, programs and other measures that target individuals identified as being at risk of violence and seek to steer them down a non-violent path. It explores how these sectors coordinate in practice, the challenges they face, and the models and practices that can strengthen early, effective intervention.

Cross-sector collaborations in secondary violence prevention often face structural and interpersonal challenges, including resource constraints, legal and ethical requirements, and operational difficulties. These barriers can prevent service recipients from accessing the care and support they need, and may reduce communities' willingness to engage with and trust a program or partnership. Collaborators may also encounter difficulties communicating across agencies and coordinating roles and responsibilities. Issues with information-sharing procedures and a lack of clarity about what information can and cannot be shared are also common, as are cultural and linguistic differences across professions that can lead to misunderstandings, conflicting approaches, or differing expectations. It is also common to encounter problems with leadership structures, including leadership transitions, and with training, such as a lack of specialized training for legal, law enforcement, mental health, or social work professionals. Being aware of and actively planning to address these challenges and roadblocks is essential for building sustainable collaborations that meaningfully serve communities.

During the initial development stages of cross-sector collaboration, early clarity in key areas can save time and resources once the initiative starts. Several considerations when preparing for collaboration can help decision makers make intentional and informed choices to best serve their communities:

- Identifying the problem you aim to address, the available resources, and the gaps to be filled can help determine the best approach for collaboration.
- Clearly defining the collaboration's mission and scope is crucial to ensuring that those involved share a purpose and have aligned expectations for roles and boundaries, as well as to build trust and credibility with communities and participants.
- Outlining realistic and achievable goals, such as reduced arrests or increased connection to services, can help collaborators translate purpose into action. Measurable outcomes are also important for evaluation and funding applications.
- Utilizing personnel from multiple disciplines and leveraging existing community resources can promote community buy-in and facilitate wraparound support services for program participants.
- Pinpointing existing and potential new funding opportunities to support the collaboration, including acquiring staff and strengthening regular meetings, training, and information-sharing systems that match local needs.
- Understanding federal, state, and local laws related to information sharing and liability.
- Developing and disseminating clear protocols and/or MOUs for information sharing and coordination of care.

Collaborations can be operationalized through different models, depending on context and goals. They can take the form of co-response, alternative response, case management, or community-supported models, as well as crisis intervention teams or crisis stabilization centers. Many collaborations demonstrate quantitative and qualitative benefits, including reduced arrests, reduced use of force, increased service referrals, and better long-term outcomes. No single model is universally effective, and local actors should align the collaboration they select with local needs, resource availability, and long-term goals. Multi-model strategies are often the most effective, but may take a long time to develop and must take into account local capacity realities.

Effective and sustainable secondary violence prevention requires moving beyond informal collaboration to structured, coordinated systems involving law enforcement, mental health, social work, and community partners. Key components of effective implementation include referral and dispatch processes, cross-sector training, leadership and governance, relationship-building, and follow-up mechanisms. Together, these elements help communities identify risk earlier, respond more appropriately to behavioral health and social service needs, and improve coordination across agencies. Regular meetings and sustained time spent working together are critical to building trust, clarifying roles, and bridging professional differences across sectors. Local governments can play an important role here, by providing funding, delivering or facilitating training, setting clear expectations, and ensuring the necessary protocols, frameworks, and infrastructure are in place to support and sustain multidisciplinary prevention efforts.

Once in motion, cross-sector collaborations must continuously evaluate their performance to identify weaknesses and opportunities for improvement. Robust process and outcome evaluation mechanisms should therefore be established early. Systematic evaluation enables agencies and others involved in secondary violence prevention to measure the initiative's impact, improve stakeholder buy-in, identify and address gaps, and support funding acquisition. Any evaluation framework should begin with clearly defined goals, responsibilities, standardized metrics, and baseline data. Evaluation should also go beyond quantitative metrics to include internal and external feedback. This includes regular review processes with stakeholders to build trust, transparency, and continuous improvement. Local governments may face challenges in financing collaborations, especially as initiatives and the need for resources and training expand. Programs are most likely to scale when embedded in existing systems. An effective way to ensure long-term stability is through a blended financing strategy that combines public grants and resources with private-sector or foundation support. Rigorous, regular evaluation further helps evidence outcomes and thus justifies continued investment.

Local governments also have an important role to play in implementing and sustaining cross-sector collaboration. Local governments can act as conveners, coordinators, regulators, and funders. Local government can bring stakeholders together, facilitate meetings, and encourage relationship-building among the different entities involved in the collaboration. They can set expectations; mandate and support ongoing training, standards, and data collection; provide legal guidance; grant access to data; and offer technical assistance. Local governments can also provide funding, allocate non-financial resources, and invest in long-term sustainability. In setting public safety and community well-being goals, local governments should consider how best to develop and support cross-sector collaborations in secondary violence prevention within their jurisdictions.

Report Contents

Introduction

This report is designed for federal, state, county, and local practitioners responsible for the treatment of individuals at risk of violence, particularly those working across law enforcement, behavioral health, and social service systems. This includes law enforcement agencies, local public or community safety or violence prevention offices, mental health and social work providers, and community-based groups engaged in secondary violence prevention. For the purposes of this report, local government refers to municipal and county-level entities, including city or county departments, agencies, or offices, as well as related public service systems responsible for public safety and community well-being.

In practice, these actors are increasingly tasked with responding to individuals experiencing crisis, behavioral distress, or early signs of escalation, often before any violence has occurred, but after risk has already emerged. Addressing these situations requires coordination across systems that are not traditionally structured to work together. Research on prevention programming consistently shows that effective secondary violence prevention depends on multidisciplinary collaboration rather than single-agency or actor responses, particularly when addressing behaviors linked to grievance, isolation, trauma, or crisis escalation.[1,2]

This report focuses on operational models and best practices for cross-sector collaboration between law enforcement and mental health/social work providers in secondary violence prevention. The aim is to support local governments in intervening earlier with at-risk individuals, coordinating resources more effectively, and reducing reliance on responses that occur only after harm has already taken place. While this report focuses on the United States (U.S.), many of the lessons and practices identified may also be relevant to other national and local settings.

Public Health Approaches to Violence Prevention

Over the past decade, violence prevention has increasingly shifted toward a public health framework that treats violence as a preventable outcome shaped by social, behavioral, and environmental risk factors rather than solely a criminal justice issue.[3] This shift reflects a growing recognition that many incidents typically understood as security problems stem from unmet social, psychological, or community-level needs.[4] As a result, prevention strategies have shifted toward early intervention, resilience building, and coordinated care systems that address underlying vulnerabilities before crises escalate. This transition is particularly relevant in contexts where individuals may already be exhibiting concerning

behaviors, but have not yet engaged in violence. In these cases, the ability to intervene effectively often depends on coordination between law enforcement and social and behavioral health systems. Evidence from crisis intervention research demonstrates that coordinated psychological and community-based responses during emergencies significantly reduce long-term mental health harms such as PTSD, anxiety, and depression while strengthening recovery and resilience outcomes.[5] These findings reinforce a central insight of the public health approach: long-term safety outcomes depend not only on enforcement after an incident but also on the presence of trust and safety-oriented support systems in place before crises occur.

This public health framing also reflects the practical realities that many local governments face today: police are increasingly functioning as first responders to mental health crises, despite these situations often requiring clinical or social service expertise rather than enforcement solutions.[6] The average U.S. police officer receives an estimated ten hours of mental health training, while specialized crisis-trained officers may receive forty or more hours of training, but remain limited in number.[7]

This disconnect between what officers are expected to manage and the training structures available to support them has accelerated the development of collaborative response models that embed behavioral health expertise in public safety systems. Across the U.S., jurisdictions have begun to operationalize this shift through a range of cross-sector collaboration models. These include co-response teams, mobile crisis units, community-based prevention partnerships, crisis stabilization centers, and behavioral threat assessment and management (BTAM) approaches, among others. While these models vary based on local capacity and context, they share a common goal of intervening earlier and reducing escalation via coordinated, multidisciplinary responses.

> Approximately **84%** of senior law enforcement officials reported an increase in mental-health-related calls, and **63%** noted that their department is spending more time on mental illness calls.[8]

Overview of the Report

This report examines how U.S. communities operationalize cross-sector collaboration to intervene with individuals at risk of violence before escalation occurs. Specifically, it analyzes:

- The challenges and roadblocks practitioners encounter when working across law enforcement, mental health, and social work sectors.
- Key considerations for establishing and structuring cross-sector collaboration.
- Models of cross-sector collaboration used in secondary violence prevention.
- Approaches for implementing these models in practice.
- Conditions that enable the evaluation, improvement, and long-term sustainability of cross-sector collaboration.
- An appendix featuring examples of existing programs.

Rather than proposing a single model of collaboration, this report seeks to identify transferable practices that local governments, law enforcement agencies, and mental health/social work providers can adapt to their own institutional capacities and community needs. While secondary violence prevention efforts often involve a wide range of actors, this report focuses specifically on the relationship between law enforcement and mental health/social work systems within this broader landscape, as coordination across these sectors has consistently emerged as a key point of both challenge and opportunity. The goal is not to replace traditional public safety institutions, but to strengthen them by developing more integrated systems capable of addressing the complex social drivers that shape violence risk across different local contexts.

Challenges and Roadblocks to Collaboration

A number of challenges and roadblocks typically arise when law enforcement and mental health/social work providers seek to work together in secondary violence prevention. It is crucial to be aware of these, as they influence the effectiveness of cross-sector collaboration at different stages. Understanding these potential challenges is the first step toward building successful partnerships that can contribute to secondary violence prevention. The table below identifies the most common barriers based on previous practice. Subsequent sections of this report will discuss strategies to help overcome them when preparing for, implementing, and sustaining cross-sector collaboration.

Collaboration Barrier	**Description of the Problem**
Resources and Funding	Limited resources or funding to support effective collaboration or service provision, especially in rural areas.[1,2,3,4]
Inadequate Infrastructure	Lack of accessible mental health and/or social work infrastructure, including continuity of care, outpatient capacity, and treatment pathways.[4,5,6]
Ethical Standards	Ethical differences across sectors regarding privacy and confidentiality, particularly when balancing public safety and client protection/trust.[3,7,8]
Information Sharing	Absence of clear information-sharing procedures across sectors and agreement on what kinds of information needs to and can ethically be shared.[1,3,4,8,9,10,11]
Legal Gaps	Lack of understanding of federal and state laws regarding information-sharing and duty-to-report requirements (e.g., HIPAA, NASW Code of Ethics, FERPA), as well as liability and protection laws for providers.[8,12]

Collaboration Barrier	Description of the Problem
Credibility	Mental health/social work providers losing credibility when working with law enforcement due to community distrust of criminal justice organizations, especially the police.[1,9,13,14]
Occupational Culture	Distinct knowledge and cultural foundations that affect perspectives and approaches.[1,4]
Language	Linguistic differences across professions and unfamiliarity with certain terminology and/or definitions.[1,3,10,11]
Trust	Lack of cross-sector trust at the organization, unit, and personal level.[1,3,4,7,8,9,10,11]
Role Delineation	Lack of clearly defined roles and understanding of specific responsibilities and boundaries.[1]
Leadership	Absence of clear leadership of initiatives and plan for leadership transitions.[1,3]
Training	Lack of practitioners across sectors (legal, law enforcement, mental health, social work) with specialized training, and lack of receptiveness to broader training across fields or more specific training within one's field.[3,4,7,9,10]
Knowledge Gaps	Limited knowledge of how to connect individuals to specialized services and the resources available.[4,5,6]
Participation	With the exception of threat of arrest or charges, community-based partnerships for secondary violence prevention often lack clear enforcement mechanisms or incentives for individuals to participate compared to school or workplace settings, which have clearer structures and compliance mechanisms.[9,17,18]
Data Collection and Evaluation	Unclear success metrics and evaluation gaps, disagreement on what constitutes a success, and a lack of standardized outcome measures. Lack of expertise and agreement in data collection processes.[9,19,20,21,22,23]

Key Considerations when Preparing for Collaboration

From initial conception to execution, those developing a collaboration between law enforcement and mental health/social work providers in the secondary prevention space need to consider a number of important elements. Adequate and thoughtful preparation will help key stakeholders avert some of the challenges and roadblocks highlighted in the previous section and effectively support participants. Establishing the necessary infrastructure for effective collaboration early on also ensures that there is minimal confusion and that processes are in place to address potential points of contention or inefficiencies once operations begin. This section provides key considerations and promising practices for preparing collaborations between law enforcement and mental health/social work providers.

Assessing Community Needs, Resources, and Response Gaps

There is no one-size-fits-all approach to setting up a multidisciplinary partnership or developing an initiative between law enforcement and mental health/social work providers in the secondary violence prevention space. Differences in the nature of collaboration generally stem from variations in community needs, available resources, and existing gaps.[1] The answers to the following questions can assist with determining how to approach a collaboration between law enforcement and mental health/social work providers (see the Types of Cooperation section for information on specific models).

What problem are you aiming to address?

Clearly defining the problem can help shape the goals and structures of a collaboration and ensure it is targeted and appropriate.[1] Communities may be seeking to address one or more specific forms of violence, such as gun, gang, youth, and/or domestic violence, or violent extremism. In other cases,

concerns may include high numbers of arrests or hospitalizations following police interaction. Another issue could be that police departments are facing resource constraints and need support.

What resources are already available?
Given limited funding sources, it is crucial to identify existing efforts and infrastructure. For instance, a community organization may already be working with the target population, and rather than launching a new initiative, a secondary violence prevention component could be integrated into their work.[2] Consulting community members, hospitals, schools, universities, and other public health stakeholders can help identify resources and avoid duplicating efforts.

What gaps need to be filled?
After mapping existing resources, find what is missing. Law enforcement agencies may lack specialized training, or mental health/social work providers may need more tailored education on violence prevention approaches or working with specific populations. In these cases, a training component may be necessary. If sufficient training already exists, efforts can instead focus on addressing other gaps, such as obtaining legal guidance or pursuing funding opportunities. In some contexts, especially in rural areas, it may be necessary to recruit additional mental health or social work providers or identify local or remote providers to which individuals can be referred.

Local government can provide support at this stage by:

- Engaging with community stakeholders to assess needs and releasing assessment reports that outline key gaps and services needed.
- Collecting and providing access to data that can be used to identify needs and response gaps.
- Organizing and potentially leading meetings or working groups that bring relevant actors together to engage in consultations.

Define Mission & Scope

Once aims, resources, and gaps are identified, it is important to clearly define a collaboration's mission and scope. It may be beneficial to develop these components collectively in spaces where diverse voices from different entities and professionals from different disciplines are represented, so that all involved understand the purpose and parameters of the work and cross-sector trust begins to build.[3]

Specifying the mission can help participating stakeholders align around a shared purpose and work towards the same goals. As an example, the mission of the Wichita Police Department Homeless Outreach Team (HOT) is to "divert people experiencing homelessness from jail by linking them to behavioral health and housing resources".[4]

Determining and clearly specifying the scope can help manage expectations about what a collaboration will and will not do and clarify the specific roles and boundaries of those involved. The scope should outline the target population, the activities or services to be conducted, and where and when the work will take place. In the Wichita Police Department HOT, the target population is those experiencing homelessness; the services they provide include crisis response and behavioral health referrals; and the work takes place in the city of Wichita, Kansas, with officers operating on 4 to 10-hour shifts.[4,5]

These components not only make cross-sector collaboration more effective, but a clear mission and scope may also help build trust with relevant communities and participants. This is important as mistrust of law enforcement may make community members hesitant to engage with multi-disciplinary teams or other cross-sector collaborations.[6] When the mission and scope are clearly defined and publicly communicated, these collaborations can better meet community concerns and establish credibility.[6]

Local government can provide support at this stage by:

- Facilitating multi-stakeholder meetings.
- Setting expectations for cross-agency cooperation and helping align departments around prevention priorities.
- Providing recommendations to help align the mission and scope with existing public safety priorities, policies, or strategies.

Clarify Goals

Clarifying the collaboration's goals is crucial for guiding decision-making and shaping the program's design. While the mission describes the overall purpose, goals translate that purpose into concrete and achievable outcomes. Some examples of goals include reduced arrests, reduced repeated 911 calls, reduced use of force, and/or increased connection to services or treatment.[7] To ensure goals are realistic and achievable, it is important to keep community size, service capacity, and overall needs in mind.

When possible, goals should be specific and measurable so progress can be monitored and assessed. These assessments and a plan for systematic evaluation of the collaboration's impact can also be helpful for securing funding (see the Evaluating, Improving, and Expanding section for more information on evaluation mechanisms and funding possibilities).

Local government can provide support at this stage by:

- Helping define measurable indicators of success by sharing recommendations and knowledge from relevant practice or key partners.
- Requiring clearly defined and measurable indicators of success as a mandated criteria of operation and funding.
- Providing transparency around external funding application requirements so that goals can be set with appropriate criteria in mind.

Identify Key Personnel & Community Partnerships

The physical composition and staffing of multidisciplinary partnerships and other forms of collaboration are critical to effective secondary prevention efforts. While each community operates within its own capabilities and constraints, and different models may require varying levels of involvement from specific sectors, the importance of having a diverse, multidisciplinary collaboration is that it provides fresh perspectives and support options for the participants' prevention plans.[8] For example, a faith leader or work supervisor in a participant's life may have more insight into their attitudes and behaviors than a social worker or law enforcement officer, given that they are meeting the participant under different circumstances and contexts and more frequently. The participant may also have greater trust and rapport with such an individual.

Some models for collaboration also utilize an ad hoc approach to participation, in which not all partners are involved at every stage of engagement (for example, facilitating a meeting between law enforcement and a participant's therapist, but not with the community partners involved with the participant). This method allows collaborative partnerships to be mindful of the information they are sharing about a participant in group settings, while also creating precedent for more private meetings where sensitive information can be discussed if necessary.

Community-led programs, as another example, may include law enforcement presence during individual case discussions, but not in the full execution of engaging individuals. While these programs do not involve direct law enforcement support, their work supplements and supports law enforcement's overall public safety efforts. Further, community-led interventions can assist with calls that do not require law enforcement presence, and allows officers to focus on other key tasks. [9,10] Due to the trust and rapport needed to execute them, these programs can create shared understanding between local law enforcement and the community.

Examples of key personnel and community partnerships include:

- Legal Counsel
- Medical Personnel
- Social Workers
- Law Enforcement
- Mental Health Providers
- Relevant Community Connections for Participant (Faith Leaders, Co-Workers, Teachers, After-School Program Leaders, Coaches)

Collaborations can draw on different community resources and programs depending on each participant's needs.

Creating a list of available resources and building relationships with key contacts in advance can help initiatives maximize wraparound services for participants. These relationships could also help establish lasting support for the participant beyond their time in formal prevention programming.

Additionally, as resources continuously fluctuate and organizations change within communities, a process is needed to maintain and update accurate information for accessing available resources. Points of contact may also change over time. Ensuring that resource information and contacts are regularly kept up to date may not only save time when addressing participants' needs, but will also help establish relationships with key contacts early on, resulting in stronger, more durable partnerships and trust within the community.

Potential Community Resources		
Access To Healthcare & Insurance Coverage	Food & Clothing Pantries	Supportive Employment Programs
Volunteer, Youth, or Extracurricular Groups	Supportive Housing Opportunities	Community Mental Health Services
Low-Income Legal Aid	Rent & Utility Support	Other Mutual Aid Organizations

Local government can provide support at this stage by:

- Maintaining or contributing to the list of community resources and partners available.
- Raising community awareness through, for example, informational sessions, providing information via libraries, government websites, or via community partners about secondary violence prevention initiatives to encourage involvement and support.
- Increasing funding to community partners who participate.
- Facilitating initial meetings between collaborators and community partners to establish rapport and working relationships.

Initial Financing

Most initiatives between law enforcement and mental health/social work providers in the secondary violence prevention space will require some funding. It is important therefore to identify any existing funding sources or solicit additional internal funding to support collaboration and successfully launch initiatives. Stakeholders should map existing funding sources and assign them to relevant programming steps before seeking alternative or additional external funding.

Behavioral and public health departments or existing initiatives may have the necessary funds available if requested.[11] The Massachusetts Area Prevention Network, for example, has historically provided funding to support partnerships with schools, enabling them to establish their own threat assessment teams.[12] More broadly, the Edward Byrne Memorial Justice Assistance Grant may be an option, as it provides funding for local governments to expand mental health services.[13]

Communities with smaller populations, often in rural areas, tend to have more limited tax bases, which can constrain the funding available for programs.[13] In these contexts, it is important to clearly assess local capacity and minimize costs by leveraging existing infrastructure and available staff when possible (see the Evaluating, Improving, and Expanding section for additional information on funding).

Local government can provide support at this stage by:[14]

- Prioritize funding for these initiatives in local government budgets and leverage existing city or local grant programs.
  - Assess the current level of local government funding that is available for whom, and under what circumstances.
  - Provide dedicated financial support for communities to build intentional partnerships to effectively and productively plan and implement collaboration in the secondary violence prevention space.
  - Review and streamline data collection and reporting requirements.
  - Identify and apply for federal grants.
- Utilize eligible reimbursement mechanisms, where applicable, to recoup federal matching funds to improve access to services across the continuum of care.
- Engage community and other place-based foundations and as well as other, private philanthropic foundations.
- Advocate for provisions on law enforcement and mental health/social work collaboration in state policies in order to increase access to behavioral health care and other supports.

Identifying Legal Frameworks

Given the dense legal and potentially high-risk environment in which cross-sector secondary violence prevention operates, any effort at collaboration must identify relevant legal frameworks at the federal, state, and local levels. These are essential for not only understanding and addressing liability and the participant's privacy, but for outlining when and what kinds of data and information about participants can be shared across sectors.

Key legal frameworks

Federal Laws

Federal laws help determine what information mental health and social work providers can share about participants with law enforcement (and others), and under what circumstances certain types of information may be shared.[12]

- The Health Insurance Portability and Accountability Act (HIPAA) requires mental health practitioners to safeguard protected health information and prevents its disclosure to law enforcement without a court order. It contains an exception, however, that allows information sharing to prevent or lessen a threat to health and safety, as determined by a covered healthcare professional using their professional judgment.[15]
- The Family Educational Rights and Privacy Act (FERPA) protects education records and covers information-sharing questions for grades K-12 and higher education. Since FERPA has its own safety and emergency exceptions, any collaboration operating in an educational setting or in conjunction with an educational partner needs to design procedures that focus on satisfying federal requirements, especially around law enforcement liaison work.[12] Some examples include the health or safety emergency exception, which allows for the disclosure of information of a student's education records without consent during situations where students might face impending danger to their personal health or safety.[16]

State Laws

State statutes also play a critical role in determining what mental health/social work providers and other practitioners can and cannot do when working in the secondary violence prevention space. Likewise, pre-arrest diversion and crisis response strategies depend on enabling statutes enacted at the state level. These strategies not only authorize non-criminal pathways for individuals in crisis situations but also define the options available beyond arrest in cases where multidisciplinary collaboration is involved.[17]

- HIPAA is supplemented by state privacy statutes and professional-licensing rules that vary by jurisdiction and profession, meaning confidentiality obligations and exceptions depend on both the practitioner's role and state laws.[12]
- Several states, such as New York under the NY SAFE Act, impose mandatory reporting duties for certain firearm-related threats and authorize information sharing in the context of extreme risk protection orders or similar proceedings.[12]
- Forty-nine states and Washington, D.C., authorize short-term civil custody for individuals experiencing acute mental health crises, especially when they pose a danger to themselves or others, or if they are gravely disabled. However, statutes differ on who can initiate such custody, and the evidentiary thresholds, eligible facilities, and maximum duration.[17]
- All states allow officers to issue citations instead of making an arrest for certain offenses, though eligibility, exclusions, and whether citations are mandatory or discretionary vary widely. Nevertheless, strong citation authority, combined with local diversion options can help law enforcement de-escalate many lower-level incidents and route individuals to alternatives to jail.[17]
- Some state EMS regulations require transport only to hospital emergency departments, while others allow a wider range of destinations, such as crisis-stabilization centers or sober units. These rules play a key role in determining whether teams can rely on specialized non-emergency department destinations as part of their diversion pathways.[17]

Local Laws, Ordinances, and Regulations

In addition to federal and state laws, there are a number of legal frameworks by which counties, cities, and municipalities shape the legal landscape even when the underlying authority is set by the state.[18] These vary widely even across jurisdictions that may be proximate to one another. Adequate preparation for collaboration requires that key stakeholders and practitioners are familiar with not only relevant federal and state, but also local laws, ordinances and regulations in the areas in which they operate.

Developing Protocols for Information Sharing

In order to comply with the aforementioned legal frameworks, clear guidelines need to be put in place for how information is shared among partners involved in the collaboration. In many cases, barriers to cooperation arise not because information cannot legally be shared, but because practitioners are uncertain about when and how sharing is appropriate, particularly when balancing privacy with risk assessment needs.[18,19] Misunderstandings about confidentiality and legal thresholds can prevent agencies from effective coordination.[18,19]

In order to encourage information sharing within the ethical bounds, local governments and authorities and other key stakeholders should focus on explaining these concepts to law enforcement and mental health/social work providers through plain language guidance during, ideally, the early stages of preparation for collaboration. This strategy is important in multidisciplinary teams and crisis response teams, where their members (namely clinicians, law enforcement, community partners, among others) may operate under different confidentiality rules and reporting obligations. Information sharing should therefore be guided by clear protocols that balance individual privacy with public safety. Establishing these protocols early helps build confidence among partners and reduces hesitation during case coordination.

Key considerations for information sharing:

- *Clarify legal frameworks governing confidentiality:* Mental health and social work professionals operate under confidentiality rules such as HIPAA and state privacy laws, which may limit disclosure of patient information. However, most jurisdictions include exceptions for situations involving serious and imminent threats of violence or other public safety concerns.[18]
- *Identify profession-specific confidentiality obligations:* Different professionals may operate under different legal and ethical standards. Psychologists, psychiatrists, and social workers face distinct reporting obligations depending on their professional licenses and state law.[18]
- *Engage legal counsel early:* Consult legal advisors who understand state confidentiality laws and can help clarify permissible information sharing.[18]
- *Develop written agreements:* Memoranda of Understanding (MOUs) or written protocols can help formalize expectations about information sharing and ensure that participating agencies understand their responsibilities.[18]

- *Establish clear protocols for case communication*: Partners should define how information should be shared during case discussions, who has access to what information, and how decisions are documented. This may include sharing behavioral warning signs, observed changes in behavior, prior interactions with law enforcement or service providers, compliance or engagement with services, and risk-related concerns. At the same time, protocols should clarify what should not be shared (e.g., detailed clinical notes or unrelated personal history) unless legally permitted and necessary.[18,19] Without clear procedures, important information may remain siloed across agencies.[19]
- *Create structured procedures for transferring relevant information between sectors*: When cases move between law enforcement and mental health and social work providers, agencies should establish processes for sharing key updates such as current risk level, recent incidents or triggers, service engagement status, and recommended next steps, while protecting confidential details.[12,19]
- *Set expectations with participants*: Programs working directly with clients should clearly communicate what information may be shared and under what circumstances. Transparency about confidentiality boundaries can help maintain participant trust while allowing necessary coordination.[20]

- *Provide training on confidentiality and information-sharing thresholds*: Both law enforcement and mental health/social work professionals may misunderstand what information can be shared. Training can help address these misconceptions and build confidence among partners.[20]
- *Maintain ongoing communication*: Information-sharing practices are strengthened when teams communicate regularly and develop a shared understanding of roles and responsibilities.[21]

Local government can provide support at this stage by:

- Providing clear, practical guidance on what information can be shared under federal and privacy laws, including real-world examples to reduce confusion among practitioners.[18,19]
  - Have city/county counsel turn relevant federal and state rules into plain-language guidance and flowcharts for teams.
  - Require MOUs that spell out who can share what, when (schools, clinicians, advocates, police).[12]
  - Commission a concise "legal map" of relevant laws for all team roles and embed it in training.
- Creating standard tools and protocols (e.g., templates, checklists) that help agencies know what information to share, with whom, and in what situations.[18]
- Investing in secure systems that allow agencies to share information safely and quickly, rather than relying on informal or inconsistent communication methods.[19]
- Setting clear rules for how information is handled, including who can access it, how it is documented, and how it is stored and protected.[19]
- Treat "legal readiness" as a core design element, not an afterthought.[12] Make local government counsel standing advisors to teams and fund regular cross-sector legal training.
- Supporting hands-on training using real-world scenarios so practitioners understand what they can and should share in practice, not just in theory.[18,20]
- Encouraging regular communication across agencies and other relevant stakeholders so partners can build trust, clarify expectations, and improve how they share information over time.[21]
- Regularly review and improve information-sharing practices by identifying where confusion or breakdowns occur and updating protocols as needed.[18,19]

Types of Collaboration

After assessing your locality's needs and resources, it is important to determine what type of partnership, team, or general collaboration to establish that best aligns with these factors. There are a number of existing models of collaboration between law enforcement and mental health/social work providers in the secondary prevention space. Depending on community needs and available resources, certain models may be more appropriate than others. In some cases, a tailored approach that combines elements from multiple models might be more effective than drawing on a single model. The table below serves as a guide of different models based on previous practice, and their documented strengths and limitations. Examples of each collaboration model have been included in the Appendix.[1]

Model	Description	Strengths	Limitations
Co-Response Team	Law enforcement officers with specialized training and mental health professionals respond to mental health-related calls as a team. Typically, they ride together in the same vehicle throughout the shift, but in some cases, the mental health professional meets the officer directly at the scene.[2,3,4]	• Decreased use of force by officers suggests co-response teams are effective at crisis de-escalation • Increased referrals to community services and management of cases by social network • Increased ability to follow up reduces the likelihood of another crisis • Creation of improved and more immediate responses to crises, including more accurate on-scene needs assessments.[4,5]	• If resources are limited, the outcomes may be different/less successful; decision-making processes change or are limited by resource availability • Often, there is limited officer buy-in and a lack of trust in "outsiders" • Potential for confusion over the roles of mental health providers and officers if there are no clear guidelines.[5,6]

Model	Description	Strengths	Limitations
Case Management Team	Law enforcement officers collaborate with mental health/social work professionals and other relevant stakeholders, if necessary (e.g., pretrial officers), to provide coordinated care for individuals who may be at risk of engaging in violence. A common approach involves officers referring individuals to mental health care and/or social services at a partner facility.[7,8]	• Facilitates long-term relationships that keep individuals connected to service providers • Enables proactive intervention rather than just crisis response • Reduces unnecessary law enforcement involvement • Provides a more holistic approach to individual situations, with more options for wraparound care.[2,7]	• Requires significant coordination between mental health/social work providers and law enforcement, and predetermined roles and guidelines • Success is often determined by availability of resources.[2]
Behavioral Threat Assessment and Management (BTAM) Teams	Multidisciplinary teams (composed of law enforcement, mental health/social work providers, and other key stakeholders) are formed to identify, assess, and remediate potential risk behaviors among individuals. Although a number of local governments at the state, county, and city levels are developing BTAMs, the model is primarily used in school and workplace settings, where multiple avenues of support are available to individuals in need of care, while also providing them with an incentive to engage.[9,10,11]	• Supports collaboration with practitioners and community stakeholders relevant to the participant's needs and strengths (e.g., faith leaders, volunteer coordinators, peer support, etc.) • Establishes participant connection with external services beyond the team to promote long-term participant stability.[12,13]	• Potentially less effective when working with participants lacking incentive to engage and/or multiple avenues of support • Requires strong partnership and trust among collaboration members before a case needing a BTAM team is brought forward.[10,11]

Model	Description	Strengths	Limitations
Embedded Clinician	A licensed mental health professional or social worker is integrated directly within a law enforcement agency. The clinician works alongside officers, often providing support during co-response while embedded in the office's daily operations. A clinician can participate in long-term case management and proactive identification of individuals at risk.[14]	• Reduction in use of force • Resolution without need for medical hold, which reduces number of officer transports • Embedded social worker can follow up without need for a police response • Increases diversions from hospital emergency rooms and frees up capacity.[14]	• If boundaries are not clearly defined, risks ambiguity in role and scope of clinician • Tension between clinician and law enforcement ethics and knowledge • Requires consistent funding to integrate long-term into police departments.[15]
Alternative Response/ Mobile Crisis Team	Teams of mental health professionals that respond to law enforcement or mental health-related calls and help stabilize individuals. The main goal is to prevent unnecessary arrests and/or hospitalizations. The teams also conduct follow-up visits to encourage connections to care.[2,8]	• Increases diversion from jail and emergency services • Decreases mental health detentions and individual re-referral rates • General improvement of joint decision-making and information sharing among agencies • Can respond without police presence in certain situations, freeing up law enforcement capacity and reducing costs.[2]	• In rural communities, travel times may be too long to fully de-escalate the risks • Organizational culture often defaults to sending police first • Officers may struggle with the transition to new roles, policies, and procedures • Liability and safety concerns remain major barriers • Underutilization of such response teams, even in large cities.[16]

Model	Description	Strengths	Limitations
Alternative Response - 911 Triaging	Aside from responding to 911 calls collaboratively, law enforcement officers and mental health/social work providers may also collaborate with 911 call centers. In these cases, 911 operators receive specialized training and dispatch alternative response teams (i.e., non-police responders) to mental health-related calls.[16]	• Frees up law enforcement capacity and reduces costs • Ensures that the most relevant actors are sent to respond to crises.[17]	• A poor system may result in inappropriate agencies being dispatched • Very limited specialized training on alternative response programs and diversion decision-making • 911 dispatchers often default to sending police first due to potential security concerns.[16]
Crisis Stabilization Centers	Facilities that provide short-term emergency mental health care. Law enforcement can transport individuals to these centers, which serve as an alternative to arrests and emergency room visits.[7,8]	• Fills a gap for immediate stabilization of crisis scenarios • Reduces transfer to emergency room or jail.[2,7]	• Often, short-term solutions to larger, complex problems • These centers alone may not have a vast impact.[18]
Crisis Intervention Team (CIT)	Law enforcement officers volunteer to receive specialized training from mental health clinicians and community and police stakeholders. The training equips them to better respond to mental health-related calls and to support officers without CIT training.[2,19]	• Reduced arrests • Increased diversion to mental health services • Increases in calls properly identified as mental health-related • Decreased use of force among CIT-trained officers • Improved officers' confidence in identifying and responding to persons with mental illness • Training-based model rather than structural reform, making its implementation cheaper and easier.[2,19]	• Does not enhance treatment access if community resources are limited • No guarantee officers will implement it within their department, especially if there is cultural resistance or it is not mandated • Although there are examples of the model producing results, there is no systematic evidence or evaluation, and outcomes vary for each program.[18,19]

Model	Description	Strengths	Limitations
Community Violence Intervention (CVI)	These programs involve members of the affected community in the provision of services to reduce violence. This model requires a localized strategy to identify individuals who are most likely to engage in violence through community contacts or voluntary participation, and then linking them to relevant community resources. CVI often includes street outreach and mentorship, utilizing existing relationships and credible messengers to provide support and refer individuals to specialists who are experienced in violence prevention.[20,21]	• Addresses the root cause of violence and offers community members an opportunity to access education and forge relationships • Improves access to wraparound services, which support long-term stabilization of at-risk individuals • Proven to reduce gun violence and homicides • May complement law enforcement work without directly altering their process or requiring them to take on more responsibilities.[20,22,23]	• Requires strong community ties and willingness to assist, including training and certification • Requires close management of relationship with law enforcement, while maintaining community trust • May be difficult to maintain consistent community engagement without structured frameworks • Success is often dependent on availability of external service providers.[20,24,25]

How to decide which model to use?

Choosing which type of collaboration to implement is often difficult. Ideally, a mix of methods would yield the strongest collaboration, but depending on each community's needs and resources, certain models may be more suitable and effective. An understanding that these collaborations are a long process that may take years of building trust, partnerships, and opening pathways in communities is critical.[26] The following questions should be considered when making this decision, as they are also laid out in the preparation phase:

- What are the main issues related to secondary violence prevention that you wish to tackle: mental health crises, repeat crisis contacts, issue-specific crises (extremism, domestic violence, gun violence)?
- Are the challenges more related to crisis response or long-term prevention?
- What agencies will be involved in the response? Are adequate mental health and social services already available? Are they being utilized effectively?
- What are the main goals?
- What specific outcomes will define success (goal setting)?
- Are officers being asked to respond to problems that would be better handled by mental health/social work providers?

Local government can provide support at this stage by:

- Mandating CIT training for a certain number of officers per municipality. Providing resources to make this training available could help improve law enforcement's response to crises.
- Encouraging connections with universities can provide helpful resources for general or specialized training for mental health/social work and law enforcement providers. Governments could create programs that connect these resources, particularly in areas with a shortage of providers, or where a community-based partnership is being established.
- Providing funding and/or allocating time on the job to relevant providers and staff. Cities and communities are often left with limited options when choosing a type of cooperation due to a lack of financial resources or time to allocate to organizing these initiatives, training, or recruiting additional providers.

Implementation

Carrying out secondary violence prevention through multidisciplinary collaboration requires more than establishing partnerships. It requires clear processes, defined roles, and consistent coordination across agencies. While informal collaboration between law enforcement and mental health/social work providers already exists in many local contexts, that collaboration often struggles to translate that into trusted, structured, reliable, and replicable systems. This section outlines key components for implementing collaboration between law enforcement and mental health/social work providers in the secondary prevention space, which can help overcome these struggles. These include establishing referral and dispatch processes, workforce preparation, leadership structures, relationship-building, and follow-up mechanisms, to help communities move from informal collaboration to coordinated, systematic practice.

Referral & Dispatch Decision Processes

Emergency call and dispatch systems represent a critical decision point in determining how communities respond to crises, particularly incidents involving behavioral health or social service needs.

When a 911 call is received, dispatch personnel must rapidly determine which agency - law enforcement, fire, emergency medical services, or specialized response units - should respond and what type of intervention is most appropriate. This decision has become increasingly complex as many jurisdictions now operate multiple response options, including crisis intervention teams, mobile behavioral health units, co-response teams, and community responder programs. Dispatchers, therefore, function as the first gatekeepers in determining whether a situation warrants a traditional police response or a more specialized intervention.[1]

A key tool guiding these decisions is the call triage protocol, sometimes referred to as a processing guide, decision tree, or flowchart. These protocols provide structured guidance for dispatch personnel by outlining the roles and responsibilities of call takers and specifying criteria for determining which responder type to deploy. By standardizing how behavioral health calls are identified, risk is assessed, and incidents are routed, triage protocols reduce reliance on ad hoc decision-making and ensure that alternative response programs are integrated into the broader emergency response system.

Beyond emergency dispatch, a clearly defined referral process is foundational to effective multidisciplinary prevention systems. Prevention systems are most effective when referrals are triggered by behavioral concerns rather than waiting for crisis-level behavior.[2] This approach aligns with threat assessment research demonstrating that individuals who engage in violence often exhibit observable warning signs beforehand.[3,4] Systems that require a crisis before referral risk missing opportunities for early engagement and supportive intervention.

Accessible referral pathways should therefore extend across multiple sectors, including law enforcement, mental health/social work providers, schools, and community partners. Expanding referral authority allows systems to respond proactively rather than reactively, increasing the likelihood that individuals receive support early on.

Structured referral protocols also promote consistency in how concerns are evaluated and addressed, reducing reliance on informal judgment and improving coordination across agencies.[2,4]

Referral and triage processes should also account for age- and gender-specific needs and contexts that may shape both risk and appropriate intervention pathways. Practitioners note that women may present with different behavioral indicators or underlying needs, including caregiving responsibilities or experiences of trauma, which may not be fully captured in standard screening approaches.[5] Incorporating screening assessment considerations that account for gender and age into triage protocols, can improve identification of appropriate interventions and ensure that responses are tailored to the individual's circumstances.

Local government can provide support at this stage by:

- Supporting the development and implementation of standardized call triage protocols across dispatch systems.[1]
- Funding and integrating alternative response programs into emergency response infrastructure.[1]
- Expanding and formalizing cross-sector referral pathways to enable early intervention across agencies.[2,4]
- Raising awareness of referral pathways and how community members can make referrals, including outreach in schools, libraries, and community centers.
- Promoting coordination between dispatch, law enforcement, mental health/social work providers, and community organizations.[1]
- Supporting the development and use of age- and gender-responsive screening and assessment tools within dispatch and referral systems to ensure responses reflect individuals' lived circumstances and needs.[5]

Recruiting & Training

Professional cross-sector training

Effective multidisciplinary secondary prevention requires preparation within each profession and coordinated cross-sector training. Law enforcement officers, clinicians, social workers, and mental health providers often approach risk, crisis response, and intervention from different frameworks. Without deliberate preparation and shared understanding, these differences can create barriers to coordination, effective treatment, and referral. Training should therefore focus on both profession-specific competencies and cross-sector collaboration.

Training for law enforcement should include:

- Recognizing the behavioral warning signs related to secondary violence prevention.[6]
- Crisis stabilization and de-escalation techniques to safely manage behavioral health crises.[7,8]
- Trauma-informed approaches to recognize trauma, minimize re-traumatization, and support engagement.
- Familiarity with local mental health and social service systems and how to connect individuals to appropriate care and community resources.[6]
- Working with clinicians and social workers during joint responses and through referrals.[9]
- Referral pathways rather than relying solely on law enforcement responses.[4]
- Information-sharing regulations and processes, including what information can be shared, under what conditions, and how to document and communicate that information appropriately.[4,6]
- Familiarity with coordination mechanisms across agencies, including how to participate in multidisciplinary case discussions and ongoing follow-up processes.[9]

Training for mental health and social work providers should include:

- Behavioral threat assessment and risk factors for violence in community settings.[10]
- Crisis response and de-escalation approaches for community-based and co-response settings.[9]
- Familiarity with referral pathways, including how to coordinate care and connect individuals to appropriate supports.[4,6]
- Information-sharing regulations, including what can be shared with law enforcement and other partners while maintaining confidentiality.[4,6]
- Collaboration with law enforcement during joint responses while maintaining a focus on clinical assessment, care planning, and continuity of services.[9]

Joint cross-sector training

- Cross-sector training involving law enforcement and mental health/ social work providers can improve communication and clarify professional roles during interventions.[6] When partners train together in advance, they are better able to anticipate each other's roles and decision-making processes, reducing confusion and tension during live incidents.[11]
- Joint training can help establish a shared understanding of behavioral warning signs and referral pathways across agencies.[9] Scenario-based training can also prepare partners for situations where conditions escalate, ensuring both responders know how to coordinate if de-escalation is not possible.[11]
- Collaborative training can bridge cultural, linguistic, and professional differences and build cross-sector trust.[10] Joint preparation can also increase law enforcement trust in mental health partners' understanding of safety protocols, and help mental health providers feel prepared to operate in dynamic or high-risk environments.[11]

Tailored training for local risk contexts

- Training programs should be tailored to reflect local patterns of violence and community risk factors.[9]
- In some jurisdictions, training may need to include specialized knowledge on gang violence, firearm-related threats, youth violence, violent extremism, or targeted violence.[10]
- Scenario-based training grounded in local risk patterns can improve professionals' ability to recognize warning signs and coordinate interventions.[9]

The average U.S. police officer receives approximately **10 hours of mental health training,** despite increasingly serving as first responders to behavioral health crises.[12]

Local government can provide support at this stage by:

- Mandating and funding cross-sector training initiatives involving law enforcement and mental health/social work providers.[6]
- Coordinating partnerships across agencies and other relevant secondary prevention actors to support joint training and collaboration.[6]
- Establishing shared training standards and continuing education expectations.[6]
- Institutionalizing training requirements to ensure sustainability.[6]

Leadership & Regular Engagement

Multidisciplinary collaboration functions best when leadership roles and decision-making authority are clearly defined. Uncertainty about who leads the team, manages cases, or determines next steps can slow coordination and delay responses.[13] Clarifying leadership responsibilities early helps teams move cases forward and maintain consistent coordination across participating agencies.

Regular meetings are also essential for maintaining coordination across partners. Structured, consistent meeting schedules allow team members to share updates, review cases, and align on next steps, reducing the risk of gaps in assessment or response.[3,4] Consistent interaction across agencies also helps develop a shared understanding of risk and responsibilities and fosters trust.

Good practice includes:

- Clarify decision-making roles early, including who manages cases, who leads interventions, and how next steps are determined.[13]
- Designate a clear team lead or coordinating agency responsible for convening meetings and guiding case discussions.[13]
- Hold regular multidisciplinary meetings to review cases, share updates, and coordinate interventions across agencies.[4]
- Document meeting structures, procedures, and decision-making processes to maintain continuity across personnel or leadership changes.[2,13]
- Ensure responsibilities are shared across agencies where possible, allowing the team to continue functioning during leadership transitions.[2]
- Develop and maintain written protocols, policies, and operational guidance to ensure institutional knowledge is retained and does not depend on a single individual.[5,11]
- Plan proactively for leadership transitions by identifying potential successors, cross-training staff, and ensuring multiple team members understand core functions.[11]
- Engage incoming leaders early (e.g., newly appointed or elected officials) by involving them in stakeholder meetings and program briefings prior to transition to support continuity.[11]
- Build broader institutional and community support for the program to help sustain it through political or leadership changes.[11]

Clear leadership structures also support accountability. When roles and responsibilities are formally defined, teams are better positioned to coordinate interventions, track follow-up actions, and maintain continuity of care with individuals of concern.[13]

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Communities should also consider the tradeoffs involved in determining which agency leads multidisciplinary efforts. Shared or co-leadership models can help balance perspectives across sectors and reinforce collaboration.

Alternatively, designating a single lead agency (e.g., public or community safety or violence prevention offices or law enforcement), can provide clear decision-making authority and operational structure. Some practitioners note that this approach can also increase predictability and comfort for mental health/social work partners by clarifying roles and responsibilities and reducing liability.[14] Local leaders should select a model that aligns with their operational context, partner capacity, and existing interagency relationships.

Local government can provide support at this stage by:

- Establishing governance structures and clarifying leadership roles across participating agencies.[13]
- Determining and formalizing a leadership model (e.g., single-agency lead or shared leadership), taking into account local capacity, partner relationships, operational needs, and community trust and credibility, with leadership roles assigned to agencies that have strong relationships and legitimacy within the community.[14]
- Designating or supporting a coordinating body responsible for convening multidisciplinary teams.[13,14]
- Convening regular interagency meetings and establishing accountability and transparency mechanisms.[4]
- Providing institutional backing and succession planning to maintain continuity during leadership or personnel transitions.[2,11]
- Requiring documentation of policies, procedures, and program operations to reduce disruption during leadership turnover.[11]
- Facilitating onboarding and early engagement of incoming leadership to sustain program continuity and alignment with local priorities.[11]

Establishing Trust & Building Relationships

Building trust between law enforcement, mental health/social work professionals, and other partners is critical for cross-sector collaboration in secondary violence prevention. Collaboration often improves when agencies have opportunities to work together regularly, understand each other's roles, and jointly review cases.[2,15] Trust tends to develop through sustained interaction and shared experience rather than formal agreements alone.

Regular communication and joint problem-solving are important in the early stages. Agencies that create structured opportunities to review cases, discuss response decisions, and share lessons learned can strengthen working relationships and improve trust and coordination over time.[15]

Good practice includes:

- Create regular opportunities for interaction, such as multidisciplinary meetings, case reviews, and joint incident debriefs. These help partners understand each other's capabilities and decision-making processes.[15]
- Conduct joint reviews of response decisions, including examining missed diversion opportunities or cases where law enforcement was deployed by default. This helps refine protocols and build trust.[15]
- Use co-response models as a bridge for collaboration. When officers and clinicians respond together, they gain firsthand experience of each other's roles and develop confidence in shared decision-making.[15]
- Co-response or other opportunities for interaction help providers understand linguistic and cultural differences across professions.
- Involve legal and risk-management staff early on in program design and implementation. Addressing liability concerns upfront can reduce hesitation among partners and build confidence in the approach.[13,15]

Local government can provide support at this stage by:

- Facilitating structured opportunities for cross-sector collaboration, such as meetings, case reviews, and co-response programs.[6,15]
- Supporting and mandating systems for shared accountability, including review of missed diversion opportunities.[15]
- Encouraging the early inclusion of legal and risk-management stakeholders in program design.[13,15]
- Investing in sustained infrastructure that allows for sustained collaboration rather than investing in one-off initiatives.[6]

Follow-Up Mechanisms

Effective secondary violence prevention requires sustained engagement beyond initial intervention. Responsibility for follow-up must be clearly assigned to ensure continuity.[2] Without defined ownership, cases may stagnate or fall outside coordinated oversight. Threat assessment literature reinforces that an individual's risk is dynamic and should be reassessed over time.[3] Monitoring and documentation help support accountability and enable teams to adapt interventions as circumstances evolve.[4] Ongoing follow-up also provides opportunities for learning and improvement. Structured monitoring ensures that prevention efforts remain responsive and aligned with emerging needs.

In addition to ongoing monitoring, systems should establish clear transition and exit protocols. Not all individuals will require long-term multidisciplinary management, and partners should define criteria for when a case can be stepped down, closed, or transferred to another provider. Exit planning should include warm handoffs to appropriate services (e.g., outpatient mental health care, social services, or community-based supports), ensuring that individuals continue to receive care even after case management ends. Clearly defined transition pathways help prevent service gaps, reduce the likelihood of re-escalation, and support long-term stability.

Local government can provide support at this stage by:

- Requiring clear assignment of follow-up responsibility across agencies, including shared responsibility where appropriate, to ensure continuity of care.[2]
- Supporting systems for ongoing case monitoring, documentation, and reassessment.[3,4]
- Establishing and funding transition and exit protocols, including criteria for case closure and step-down from multidisciplinary management.[4]
- Facilitating connections to long-term care and community-based services (e.g., mental health, housing, social services) to ensure continuity beyond initial intervention.[6]
- Promoting data-sharing frameworks that support continuity, coordination, and accountability across agencies as well as evaluation.[4]

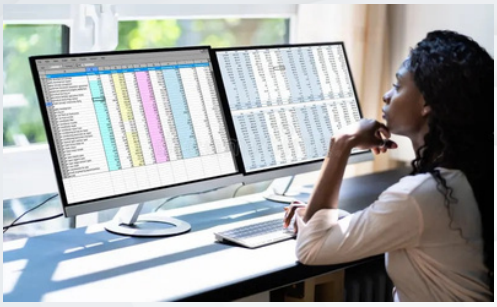
Evaluating, Improving, and Expanding

Evaluation

A framework for evaluating the successes and failures of any cross-sector collaboration is essential for identifying strengths and weaknesses, improving effectiveness, and informing future practice. Research consistently highlights that there is a lack of attention to rigorous, scientific evaluation due to complications with information sharing, a lack of infrastructure, and limited resources.[1,2,3,4] However, data collection and regular evaluation are crucial for effective multidisciplinary collaborations, and for sustaining them. These mechanisms should be designed ideally, prior to the onset of collaboration, and implemented at the earliest stages.

***Why evaluation matters*:**

- Effectiveness of program: A strong data collection and evaluation system allows both law enforcement and mental health/social work providers, as well as professionals from other relevant sectors, to gauge the effectiveness of their collaboration in their community. It also assists in determining community needs and how they are being met by evaluating pre- and post-intervention metrics.[5]



- Support and buy-in: Showing concrete data to a variety of stakeholders, such as staff, local officials, legislators, peers, and community partners, can garner internal and external buy-in to a project.[6] This support is essential to keep those working within the partnership motivated and to engage potential future partners for expansion efforts.

- Identify gaps: One of the most effective ways to determine high-need areas and tailor response models is through data collection, including both official data, and data collected through community surveys and other means that capture the needs and priorities of local residents. This can determine where current efforts require modification to bridge gaps and provide context for the typical encounters that the program is, or should be, addressing.[6]

- Funding and budget decisions: Chances of funding are strengthened by a strong study design and are often linked to demonstrating positive outcomes, which requires methodologically sound evaluation mechanisms to be in place.[7] Data can inform budget decisions to decide where additional funding would be most necessary and most effective.

Framework

TIER 1: IDENTIFY PROGRAM GOALS RESPONSIBILITIES & KEY METRICS

- Explicitly laying out the goals each partner intends to achieve through the program and agreeing upon a set of shared goals between agencies are crucial first steps. It is important to tailor goals to the specific needs of the community. However, many police-mental health collaborations use the following four key outcomes as a starting point for evaluation:[6]
  - Increased connections to resources
  - Reduced repeat encounters with law enforcement
  - Minimized arrests
  - Reduced use of force

- Baseline measures must be established at the beginning of any collaboration to allow a comparison of the program's effectiveness. This includes considering and collecting any data that officers, mental health/social work teams, or other partners already collect. This enables communities to tailor response models from the outset.[7]

- Standardizing and agreeing upon definitions must be completed before data collection begins, so each partner understands what the data tells them.[8,9.] Definitions will vary across programs, but may include
  - What counts as a "handoff"?
  - What qualifies as a "mental health call"?
  - What is a "repeat incident"?

- Mechanisms for how partners share data need to be established. The most effective way to complete data-sharing agreements is through formal, written agreements that comply with federal, state, and local laws.[6] Data sharing across systems is also critical to prevent gaps or unnecessary overlap between agencies. Some questions to consider may be:
  - What data will be shared?
  - Who is responsible for collecting different data points?
  - What systems will the data be uploaded onto and accessed through?

- Roles and responsibilities for the data collection and evaluation process should be outlined before the process begins. Nominating a project coordinator helps to standardize data collection and

review processes.[8] Partnering with other organizations, such as universities, community groups, foundations, or think tanks that have research experience, can also be helpful here. At this stage it is important to consider what data is feasible for each agency to collect and store in the given time frame.[9]

TIER 2: PROCESS & SHORT-TERM OUTCOMES

Once the initial goals, definitions, baseline measures, and responsibilities have been decided, data can be collected. Data should relate directly to the program's core goals. It would also be helpful to have a dedicated database to review the outcomes in each community.[10] Below are examples of data that could be collected.[2,6,7,11]

Process:

- Number of officers trained in mental health crisis response
- Number of encounters with individuals facing mental health crises
- Number of calls received by a trained officer
- Response time to calls
- Time spent on the scene
- Hand off rate to other services

Safety outcomes:

- Number of instances where force was used
- Injury to officers
- Injury rates to individuals

System outcomes:

- Arrest rates
- Number of crises resolved on scene
- Number of voluntary transports to treatment
- Number of involuntary transports to treatment

Post-response:

- Number of emergency department drop-offs
- Crisis center admissions
- Short-term crisis recurrence (in 90-day period)
- Initial referral appointment scheduled/attended

TIER 3: LONG-TERM OUTCOMES

Many types of collaboration, such as case management, BTAMs, and community violence interventions, follow individuals' progress and interactions with police and mental health/social work providers over a longer time period. Therefore, long-term metrics need to be tracked and evaluated. Below are examples of data that could be collected.[6,7,11]

Repeat encounters:

- Repeat calls (12-months)
- Repeat arrests (12-months)

Continuity of care:

- Treatment engagement (12-months)
- Individual case studies - what worked, what did not work, changes in individual behaviors
- Removal from law enforcement monitoring systems

Finances:

- Costs of program (staff and resources)
- Money saved by arrest diversion
- Money saved by decreased hospitalization

TIER 4: INTERNAL & EXTERNAL FEEDBACK

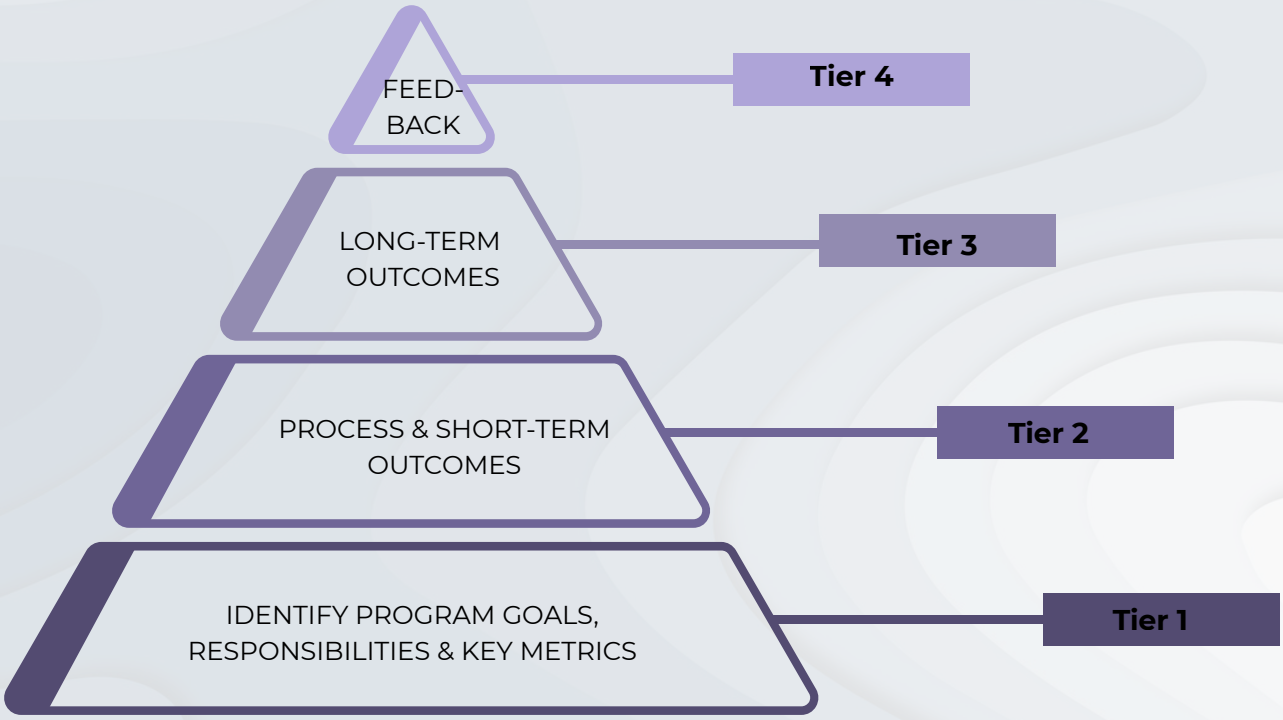
Feedback and a review process are key components for identifying where performance is not aligned with goals and where changes are needed.[12] Creating a feedback mechanism, which internal and external agencies are able to respond to and implement is important.[6] The review may reveal if the response model needs to be scaled and how to tackle any future problems that may arise. Most importantly, any refinements to the program should be driven by results-based data.

- An internal review process that is transparent to staff and the public, when appropriate and, of course, anonymized, is critical to the evaluation process.[6] Review meetings can be conducted on a quarterly or yearly basis. The review should collaboratively assess performance on key outcomes, including as many relevant stakeholders as possible.

- Externally, community members and peers should be given the opportunity to give feedback on the program.[13] Community trust is an important aspect of this, and how they may perceive improvements to trust or safety. Individuals with firsthand experiences of the collaboration can also be given the opportunity to provide feedback. This often takes place through an informed consent procedure, ensuring that comments will be confidential and not affect future service provision to clients.[7]

A survey revealed that **73 percent of police officers** claimed that their embedded clinician program reduced the number of times when force would have been needed during crisis calls.[12]

- Both internally and externally, annual reports of data can be made available. This can help to determine where there are gaps in data collection and ensure all stakeholders are receiving the necessary information.[14] Sharing results across agencies may also present an opportunity to increase collaboration. This may also reveal the different types of data that important stakeholders, such as funders, view as essential, informing future reporting practices that could secure financing.[9]



Tiers of Evaluation

Local government can provide support at this stage by:

- Conducting community needs assessments by engaging with community stakeholders to evaluate program effectiveness, and formalizing these assessments into public reports that outline service gaps.
- Facilitating access, for stakeholders, to relevant data that can be used to support evaluation efforts.
- Coordinating multi-stakeholder meetings or interagency groups that bring together key actors to engage in consultation and program evaluation.
- Mandating clear and measurable performance metrics and mechanisms for review to ensure programs are aligned with policy objectives and funding requirements.

In Practice: The LAPD's Mental Evaluation Unit

The Los Angeles Police Department's (LAPD's) Mental Evaluation Unit (MEU), with 105 officers and 50 Los Angeles Mental Health Department clinicians, is a good example of a multilayered approach. Since 1948, the LAPD began offering basic guidance for officers handling mental health-related incidents; it has now evolved into one of the most comprehensive models in the nation.

The MEU's responsibilities are clearly and extensively laid out, utilizing a **multilayered, multiagency approach**.

- The MEU's mission statement is the first step, with goals including: preventing unnecessary incarceration and/or hospitalization, providing alternate care in the least restrictive environment, and facilitating the speedy return of police patrol units to patrol activities.
- Its triage desk collects data on calls and dispatch, which are documented in **Mental Evaluation Incident Reports (MEIR)**. This is a structured tool, with its data available in real time to staff and leadership, whilst still being protected from outside access, to maintain individual privacy.
- Weekly reports are generated on the number of calls, types, location and resolution methods.
- Dedicated data analysts present monthly reports during **COMPSTAT meetings.** COMPSTAT is an organizational management tool used by police departments to map patterns, analyze trends and evaluate progress against set performance metrics.
- Every three months data is presented to the **Mental Health Crisis Program Advisory Board** for a more in-depth exploration. The board engages and updates community partners on the program.
- **Senior lead officer community/mental health liaisons** were added in 2016 to fortify external feedback mechanisms with the community, service providers, and other key stakeholders to assist with problem-solving, and other obstacles encountered by the strategy.

Even after these strategies were implemented, a fundamental problem remained: a lack of effective or measurable outcomes for individuals who were repeatedly in contact with law enforcement. As a result of this, the LAPD developed the **Case Assessment and Management Program** (CAMP), which pairs law enforcement with mental health and/or social workers to identify and monitor individuals as well as develop long-term solutions for the client's needs. Without the initial implementation of a robust evaluation mechanism, this gap may not have been recognized and resolved, highlighting the importance of **continuous, rigorous monitoring and review**.

Maintaining and Seeking Additional Funding

As local governments work to build, sustain, and expand their initiatives, securing reliable and flexible funding beyond their initial, typically internal or seed funding, becomes one of the biggest challenges. In order to strengthen these initiatives and ensure sustained funding, decision-makers should opt for a blended approach aiming to receive reimbursement from federal sources where possible, government grants, and support from the private sector and foundations.

Local governments can leverage a range of sources to support the financing of initiatives. For instance, funding may be provided through state-administering agencies or state specific legislation, including mental health and substance abuse agencies that pass through federal block grant funds.[17] Information can be obtained by searching on platforms like Grants.gov for federal grants and SAM.gov for assistance listings depending on the eligibility clauses for each program. Leveraging relationships with the private sector or philanthropic foundations for matching funds or investments should also be considered.

Continuous, rigorous evaluation is critical for maintaining and seeking additional funding. Turning evaluation findings into funding arguments can enhance program sustainability. While chances of obtaining funding are strengthened by a strong study design for monitoring and evaluation and consistent stakeholder engagement, demonstrating positive outcomes through evaluation can further secure ongoing support for the project.[18]

Examples of local funding

Kitsap County Treatment Sales Tax	Funds the Poulsbo, Washington Police Department partnership with behavioral health navigators in the city's Behavioral Health Outreach Program.[16]
Grants from the Community Health Endowment and the Nebraska Department of Correctional Services	Funds the Mental Health Association of Nebraska.[16]
Marijuana Tax Cash Fund, Community Mental Health Services Block Grant dollars, Medicaid, and local community mental health centers	Funds Colorado's co-responder programs.[16]

Expanding and replicating initiatives

Clearly defined roles, durable infrastructure, and alignment with broader public health and safety policies are needed to institutionalize cross-sector collaboration. Embedding successful pilots into existing systems that possess core municipal functions helps not only ensure future continuity but allows for trust to develop among partners. In order to achieve this, programs should aim to be rooted in or supported by multiple agencies and stable funding sources, so that state and local decision-makers can reinforce institutionalization. This will allow them to remain consistent with broader public health priorities and to position cross-sector cooperation as an integral component of policy-backed infrastructure for long-term violence prevention and crisis response.

Building sustainable cross-sector partnerships helps foster enduring collaborations across law enforcement agencies, several behavioral and mental health agencies, and community organizations. This helps promote public health approaches to crises as a reliable tool and makes their replication across other localities easier. Successful examples demonstrate how programs can evolve from pilots to scaled models backed by several state and non-state actors and institutions.

Examples of How Programs Expand Over Time

- **Virtual-Mobile Crisis Intervention (Springfield, Missouri):** Introduced by the Springfield Police Department and Burrell Behavioral Health in 2012. Known as the "Springfield Model," it expanded across southwest and central Missouri, including St. Louis County.[16]
- **Community Response Team (Colorado Springs, Colorado):** Born as a collaboration in 2014 between the Colorado's Police Department, the Colorado Springs Fire Department (CSFD), and with AspenPointe. Following the program's launch, the CSFD received three Colorado Springs Health Foundation grants, which supported the expansion of the Community Assistance, Referral & Education Services (CARES) program in 2016, staffing for a Tiered Response Community Medicine unit in 2017, and continued operations plus expansion into new program areas in 2020.[19]
- **Plymouth County Outreach (Plymouth County, Massachusetts):** Launched in 2016 as a collaboration between the District Attorney's Office, the Sheriff's Department, all 27 county police departments, 5 major hospitals, recovery coaches, the Department of Children and Families, District Court, probation services, and community-based coalitions. In November 2023, it was awarded a $1.6 million federal grant to expand services through 2026 and fund a youth recovery coach, judicial system support, and the creation of an Overdose Fatality Review team.[20]

Appendix

Examples of Collaboration

Co-Response Team

- Boulder Early Diversion Get Engaged (EDGE) Program: The EDGE program was a collaboration between the Boulder Sheriff's Department, the City of Boulder, and Mental Health Partners in Colorado. Specially trained clinicians from mental health providers listened to police radio and rode along with officers. They then transferred clients to crisis centers, made referrals, and provided follow-up services. The program had 10 licensed mental health workers, 2 peers, and 2 post-graduate clinicians. The program was funded by a SAMHSA grant and a Denver Foundation Grant, and estimated $3 million in annual savings from reduced emergency room and jail diversion. More information can be found here.

- Crisis Response Unit (CRU) in Missouri: Behavioral Health Response (BHR), a trauma-informed agency in Missouri, provides Crisis Response Units (CRU), which use a street triage co-responder model. A police officer and a behavioral health clinician work together to de-escalate situations and divert individuals from arrest or hospitalization to regional care systems and community partners.

- Los Angeles Police Department (LAPD) Systemwide Mental Assessment Response Team (SMART): The Mental Evaluation Unit (MEU), within the LAPD's Crisis Response Support Section (CRSS) in California, consists of several subunits that assist officers with mental health-related calls. The Systemwide Mental Assessment Response Teams (SMART), co-supported by the Los Angeles County Department of Mental Health (LACDMH), involve a police-mental health co-responder program that helps officers respond to crises and connect individuals with needed mental health services. There are 12 to 14 SMART Units operating on a 24/7 basis.

Case Management Team

- Los Angeles Police Department (LAPD) Case Assessment Management Program (CAMP): Another subunit within the LAPD's MEU is the Case Assessment Management Program (CAMP). This program in California uses a case management approach to coordinate individualized long-term interventions and reduce violence and repeated first-responder encounters. Police detectives are paired with providers from the LACDMH, including psychologists, nurses, and social workers.

- Palm Beach County Sheriff's Office's Behavioral Services Division (BSD): The Behavioral Services Division (BSD), within the Palm Beach County Sheriff's Office (PBSO) in Florida, conducts field assessments and identifies individuals at risk for violence and showing signs of behavioral health concerns. BSD then makes referrals to the Southeast Florida Behavioral Health Network (SEFBHN), where individuals can receive services for mental health, substance abuse, and housing. More details about the cooperation between PBSO and SEFBHN are available here.

- The Massachusetts Area Prevention Program (MAPP): Boston Children's Hospital offers a series of prevention and intervention programs. The Massachusetts Area Prevention Program (MAPP) brings together a multidisciplinary team of providers who support youth under the age of 18 who are at risk for violence. Referrals for MAPP can come from law enforcement, probation, schools, community healthcare providers, and families. After an initial assessment of strengths, risks, and needs, the MAPP team provides recommendations for specific care and support. Families may then opt into MAPP's second-phase program, which includes therapy, coaching, advocacy, and/or case management.

- Wichita Police Department Homeless Outreach Team (HOT): The Homeless Outreach Team (HOT) at the Wichita Police Department in Kansas aims to divert individuals experiencing homelessness away from jail by helping them access behavioral health and housing resources. HOT is made up of two to four CIT-trained officers who respond to 911 calls or community referrals, and once at the scene, refer individuals to one of their behavioral health and housing agency partners. More details about the HOT are available here and here.

Behavioral Threat Assessment and Management (BTAM)

- Virginia's BTAM Team: The Behavioral Threat Assessment and Management Team (BTAM) in Virginia works to prevent targeted violence. This multidisciplinary team is located within the Virginia State Police Criminal Intelligence Division (CID) and receives support from the Virginia Fusion Center (VFC). The Behavioral Threat Assessment process involves identifying threats, gathering and assessing information, and managing the individual or situation.

- Wood County Alcohol, Drug Addiction, and Mental Health Services Board (WCADAMHS): The WCADAMHS Board has begun working with Wood County schools in Ohio to establish BTAM teams to address potential threats. More information on this program can be found here.

Embedded Clinician

- Hodgenville Police Department: The police department in Hodgenville, Kentucky, hired a full-time civilian social worker. The police social worker joins uniformed officers in various calls, including sexual assault, domestic violence, child abuse or neglect, and others. More information on this program can be found here.

- USC's Social Work and Public Safety Program: The Social Work and Public Safety Program at the University of Southern California (USC) provides Master of Social Work (MSW) students in California with internship opportunities within police departments and other public safety organizations. More information can be found here.

- Police Department in Bainbridge Island (Washington): A social worker is embedded within the local police department through the Community Health Navigator program. This co-response specialist helps provide education to police officers on behavioral health and supports individuals experiencing mental health or other issues to access resources that are beyond the criminal justice system. More information on this program in Washington state can be found here.

Alternative Response/Mobile Crisis Team

- Albany County Crisis Officials Responding and Diverting (ACCORD): The ACCORD program in Albany County, New York, is a team made up of social workers, paramedics from the Sheriff's Office, and peers who respond to nonviolent emergency calls, which are triaged from 9-1-1 calls. The teams are also stationed in rural areas to fill important service gaps to behavioral health and medical services. The ACCORD team focuses on de-escalation, assessing individual needs, and offering referral services for care. More information can be found here.

- Mobile Crisis Team Brooklyn: The Mobile Crisis Team in Brooklyn, New York, operates through the Certified Community Behavioral Health Clinics (CCBHC) and provides 24/7 emergency counseling, support, and stabilization services for individuals experiencing a crisis or mental health distress. After receiving a call to their own crisis line, licensed professionals can evaluate the situation and determine the most suitable intervention.

- Philadelphia's Community Mobile Crisis Response Teams (CMCRT): The CMCRT, available 24/7 citywide in Philadelphia, Pennsylvania, provides de-escalation and resolution-focused interventions to individuals in crisis, as well as connecting and/or transporting to needed treatment or services. The CMCRT also offers follow-up within 72 hours after stabilization. Children's Mobile Crisis Teams are also available.

Alternative Response - 911 Triaging

- Behavioral Health Emergency Assistance Response Division (B-HEARD): Launched in 2021 as a pilot initiative, B-HEARD sends teams composed of the Fire Department of the City of New York (FDNY) emergency medical technicians and a licensed mental health professional from NYC Health + Hospitals to respond to certain nonviolent 911 calls involving individuals experiencing mental health crises.[1] These teams are trained to de-escalate situations, conduct mental and physical health assessments, and connect individuals with appropriate services or community-based care.[2] The program was designed to treat mental health emergencies in New York as public health issues rather than public safety problems, reducing unnecessary police involvement and improving access to behavioral health support.[3] However, a May 2025 audit by the NYC Comptroller found that 35% of eligible calls did not receive B-HEARD services and that coverage extended to only 31 of New York City's 78 precincts, prompting a November 2025 announcement that the program would be restructured under NYC Health + Hospitals in spring 2026, with teams staffed by a nurse, a social worker, and an ambulance driver in place of FDNY EMTs.[4,5]

- Denver Support Team Assisted Response (STAR): The STAR program is an alternative response team that includes behavioral health clinicians and paramedics, responding to low-risk calls for individuals experiencing mental health distress. STAR is dispatched through Denver, Colorado's 9-1-1 Communications, and civilian call takers are trained to triage the calls and send the most appropriate responses. When the STAR mobile unit arrives, the team provides direct clinical de-escalation, aiming to resolve the crisis without police presence. The program also includes a Community Partner Network, which provides referrals to appropriate community care resources. More information can be found here.

- Holistic Empathetic Assistance Response Team (HEART): Introduced in 2022, in Durham, North Carolina, the program was designed to respond to nonviolent crises, such as behavioral health emergencies, substance use, and quality-of-life concerns, through a public health-oriented approach rather than relying solely on law enforcement.[6] The HEART model operates through a layered response structure integrated with the city's 911 dispatch system. Behavioral health clinicians are embedded in the call center to help triage crisis calls and determine whether situations can be resolved over the phone or require an in-person response. When in-person assistance is needed, dispatchers can send Community Response Teams composed of a clinician, peer support specialist, and emergency medical technician. In higher-risk situations, co-response teams, including both a clinician and a police officer, may be sent.[7]

- Mediation Response Unit (MRU): The MRU sends trained mediators, not police, to handle low-emergency 911 calls involving disputes such as neighbor conflicts, noise complaints, youth disturbances, or minor quality-of-life issues.[8,9] The program operates under the Dayton Mediation Center in Ohio and responds to calls referred through 911 dispatch, police, fire/EMS, or a direct community hotline. Mediators are trained in de-escalation, conflict resolution, and crisis response, and their role is to facilitate dialogue, help parties reach voluntary agreements, and connect individuals to community resources when needed.[10]

Crisis Stabilization Centers

- AltaPointe's Behavioral Health Crisis Center (BHCC): The Behavioral Health Crisis Center (BHCC) in Mobile, Alabama, offers short-term supervised residential care with 23-hour observation beds and a dedicated crisis stabilization unit for psychiatric emergencies. Psychiatrists, psychiatric nurses, and other mental health providers work at the center and provide care for those with mental illness and/or substance use disorder. Individuals may access services voluntarily, arrive with family members, or be referred and transported by a Crisis Response Team or law enforcement.

- Treatment & Recovery Center (TRC) of Douglas County, Kansas: The Treatment & Recovery Center (TRC) provides behavioral health or substance use care in three stages: urgent care, treatment, and recovery. EMS and law enforcement can transport individuals to the TRC rather than to jail, detention centers, or the hospital emergency department. The Observation and Stabilization units provide treatment and stabilization, as well as outpatient therapy and/or medication management if needed. Before leaving the center, individuals will be connected with additional community support to help with their recovery.

Crisis Intervention Team (CIT)

- Memphis Police Department CIT Program: The Memphis Police Department, in collaboration with the Memphis Chapter of the National Alliance on Mental Illness (NAMI), mental health providers, the University of Memphis, and the University of Tennessee, implemented a CIT program comprising a specialized unit of trained officers for mental health crisis response. Officers from every Uniform Patrol Precinct volunteered to receive CIT training and are then called to respond to crises relating to mental illness. There are approximately 268 CIT officers who maintain 24/7 coverage.

- Phoenix Police Department CIT: The Phoenix Police Department in Arizona has several hundred CIT-trained officers serving as first responders. There are also two full-time CIT squads who collaborate with behavioral health partners to connect community members to crisis services. Their mission is to provide law enforcement-based crisis intervention by assisting individuals with a mental illness.

- Salt Lake City Police Department CIT: Salt Lake City's CIT in Utah operates across multiple counties and provides 40-hour training for patrol- and corrections-based academies. The police department works with CIT Metro, which assists agencies in developing their own CIT programs that meet their specific needs. The department also operates a dedicated unit known as the CIT Investigative Unit. If a case is identified as involving a person with a mental illness, a detective in this unit will review the report, determine whether additional follow-up would be beneficial, and, if so, connect them with relevant services. The program also has a co-response team connecting the CIT with a Community Connection Team. More information on this program can be found here.

Community Violence Intervention (CVI)

- North Carolina Youth Violence Prevention Center: The North Carolina Youth Violence Prevention Center (NC-YVPC) works to reduce youth violence, aggression, delinquency, bullying, and victimization through prevention and intervention programs. They have developed several initiatives, including the Robeson Community-Based Crime Reduction (CBCR), which brings together law enforcement and other community/public health stakeholders to develop crime-reduction strategies.

- Richmond Office of Neighborhood Safety (ONS) Program: The Richmond ONS program in California focuses on individuals at the highest risk of involvement in gun violence. It provides and coordinates targeted intervention services to likely perpetrators of violence. Law enforcement and health providers play an important role in this program through referrals and service provision. The main goal is to work to build consistent relationships with community members, offering them resources and opportunities to reduce their involvement in violence. Richmond has many other programs, which support this community-led approach to violence intervention, such as the Operation Peacemaker Fellowship, the Beyond Violence Initiative, and the Richmond Community Wellness Collaborative.

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Challenges and Roadblocks to Collaboration

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Types of Collaboration

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