Appendix A:
Developing Your Interagency Workgroup

How to Structure and Set Up Your Interagency Workgroup

The exercise below prompts project coordinators to fill in items that help them determine who they should invite to be partners in the interagency workgroup. It may be completed by the project coordinator prior to the first convening of the interagency workgroup, or in the early planning stages in consultation with the interagency workgroup, chairperson, and any additional key PMHC stakeholders that have already been identified, such as representatives from behavioral health, law enforcement, and community organizations.

Step 1:

Establish who will be on your interagency workgroup.

Use the following templates to list out the planning and implementation team members and their roles in the interagency workgroup. Add additional lines if needed.

Planning Team

Name	*Title*	*Organization*	*Specific Role on Interagency Workgroup*	*Signed Letter of Agreement Committing to Involvement in Project?*
John Doe	Director, Client Services	ABC Treatment Provider	Provides clinical support to ABC Treatment clients and provides workgroup information around availability of and how to implement crises services	☐ Yes ☐ No
Jane Smith	Director, Training Initiatives	Anywhere Police Department	Oversees the training subcommittee and helps develop new training curricula for the PD	☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Implementation Team

Name	*Title*	*Organization*	*Specific Role on Interagency Workgroup*	*Signed Letter of Agreement Committing to Involvement in Project?*
John Doe	Director, Client Services	ABC Treatment Provider	Provides clinical support to ABC Treatment clients and provides workgroup information around availability of and how to implement crises services	☐ Yes ☐ No
Jane Smith	Director, Training Initiatives	Anywhere Police Department	Oversees the training subcommittee and helps develop new training curricula for the PD	☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Step 2:

Establish the structure of your interagency workgroup.

Answer the following questions to help formalize your workgroup's structure and determine what subcommittees are needed to plan and implement the PMHC.

Structure of the Interagency Workgroup
Is a task force, advisory, or interagency workgroup already in place to oversee the PMHC? If no, what plans are in place to assemble a group and who will oversee that effort?
Answer:
Has the interagency workgroup identified a mission, vision, guiding principle, or statement of purpose as it relates to the PMHC? If not, will the interagency workgroup create any of these?
Answer:
Has the interagency workgroup established a clear leadership and decision-making structure that details whether the project coordinator can make decisions without input from the larger group, if unanimous agreement is required, if certain decisions will be made by specific members of the workgroup, etc.?
Answer:
Where, when, and how often will the interagency workgroup meet?
Answer:

Structure of the Interagency Workgroup

Is there a set length of time for these meetings? If so, what is it?
Answer:
Has the group defined the roles and responsibilities of the project coordinator and chairperson (e.g., when does the project coordinator report out to the group as a whole and to the chair, when and to whom does the chair report to, who initially develops agendas, who runs the meetings, etc.)?
Answer:
Who will be responsible for reporting progress and activities to the executives and other organizing bodies? How often? In what format? To whom?
Answer:

Developing Subcommittees

Will the interagency workgroup develop subcommittees?
Answer:
What kind of subcommittees do you anticipate creating?
Answer:
How will you staff the subcommittees? Can people volunteer for subcommittees, or will they be assigned?
Answer:
How will subcommittees report back to the main group and how often?
Answer:
Who will chair each of the subcommittees?
Answer:

Step 3:

Determine how your interagency workgroup connects with the community.

Answer the following questions to determine how your workgroup is connected to the broader community. These answers will help to fully develop the workgroup that will be instrumental in planning and implementing the PMHC.

Connection to the Broader Community
Are there other criminal justice, behavioral health, or similar advisory boards active in the jurisdiction? Will the same stakeholders attend both groups and, if so, how will you eliminate duplication of efforts between these groups?
Answer:
Does the interagency workgroup report to the law enforcement and behavioral health executives, or another body, organization, or group (i.e., other groups mentioned in Step 2)?
Answer:
Are there any local "champions" for mental health and criminal justice issues in your community?
Answer:
Are these local "champions" involved or connected to the PMHC?
Answer:

Connection to the Broader Community

Is there a plan in place to engage them to support the PMHC if they are not already involved?
Answer:
What are the names of local champions?
Answer:
What agencies or community groups do they represent?
Answer:
Who are the additional stakeholders you would like to join the interagency workgroup to ensure there is systems-wide representation?
Answer:

Appendix B:
Part 1. Assessing Your Current Policies and Procedures

The checklist below is designed to help project coordinators assess the current status of the PMHC's policies and procedures and to identify where gaps may exist, and adjustments are needed. One clear indicator of a gap is if certain scenarios below are not covered by policies and procedures in your jurisdiction or the policies and procedures are outdated. By using this checklist, project coordinators will have a better sense of which new policies and procedures need to be developed and which ones need updates.

Instructions:
Check the box reflecting the current status of your policies and procedures for each item, indicating whether a certain activity is (1) in place and current; (2) underway; (3) in the planning stages; or (4) outdated or not in place.

Activities	Implementation Status			
	Yes	Underway	Planning	No
All policies and procedures define frequently used terms, common acronyms, and other key information so that they are clear, transparent, and accessible to all readers.				
Policies and procedures consider and outline any relevant statues or local legislation that will impact the PMHC.				
Written policies and procedures describing each selected response model are up to date.				
Job descriptions and responsibilities for PMHC staff include critical information about knowledge, skills, and the abilities required for each position.				
Performance evaluations for PMHC staff reflect the duties of their positions as described in job descriptions.				

Activities	Implementation Status			
	Yes	Underway	Planning	No
Training protocols include ways to provide mental health and de-escalation/stabilization training at each of the following levels: recruit, in-service, and specialized.				
Policies and procedures are in place to guide in-service trainings about the PMHC for managers, supervisors, and field training officers and to ensure awareness and utilization of the PMHC.				
Training protocols include ways to provide mental health and de-escalation training for call-takers and dispatchers.				
Policies and procedures guide 911 personnel,[5] including dispatchers, call takers, and other staff on how to gather descriptive information when answering mental health crisis calls.				
Policies and procedures ensure that 911 personnel, dispatchers, and other call takers know which officers, teams, or mental health co-responders exist to respond to calls that may involve a person who has a mental health need.				
Policies and procedures direct 911 personnel, other call takers, and dispatchers to create and check off Records Management System (RMS) flags or notify officers of repeat addresses associated with mental health calls for service, people who have mental health needs who are repeatedly in contact with law enforcement, and people who pose a verifiable threat to officers.				
Policies and procedures guide responding officers on how to de-escalate situations. The policy may outline actions that may be taken on scene, such as assessing whether a crime has been committed, determining whether the person's behavior indicates that a mental health need may be a factor, ascertaining whether the person appears to present a danger to self or others, and ensuring that the officer uses skills that safely de-escalate the situation if it involves someone in crisis.				

5. Deirdra Assey, *Tips for Successfully Implementing a 911 Diversion Program* (New York: The Council of State Governments Justice Center, 2021), https://csgjusticecenter.org/publications/tips-for-successfully-implementing-a-911-dispatch-diversion-program/.

Activities	Implementation Status			
	Yes	Underway	Planning	No
Policies and procedures outline the actions an officer may take as it pertains to the disposition of the call.[6] This may include resolutions such as diverting the person to a mental health, crisis, or diversion center when behavior appears to result from a mental health need; arrest of the person when a serious crime has been committed; connection to the person's current mental health care provider, a mobile crisis team, or other mental health crisis specialists; or connection to a friend or family member, peer support group, or treatment crisis center when no formal action (i.e., emergency evaluation or arrest) is taken.				
Policies and procedures outline when to use restraints while detaining people in a crisis situation.				
When jail diversion, crisis, or receiving centers are available to officers, program policies and procedures specify the criteria established by the center for accepting referrals from officers. These can include items such as eligibility criteria and intake procedures, including obtaining information about the person's observable behaviors from officers.				
Policies and procedures govern the exchange of information between law enforcement personnel and mental health program partners.				
Policies and procedures specify which law enforcement personnel are responsible for collecting and analyzing PMHC program data, and where that information is housed or saved.				

6. "988: A Shared Opportunity for Criminal Justice and Behavioral Health Partners," CSG Justice Center, accessed October 25, 2023, https://csgjusticecenter.org/projects/988-a-shared-opportunity/.

Appendix B:
Part 2. Identifying and Reviewing Information-Sharing Policies and Procedures

This exercise prompts project coordinators to indicate what information is currently being shared between behavioral health and law enforcement partners, and then determine where gaps exist in sharing and coordination that can impact PMHC outcomes. It will also help project coordinators begin to identify the barriers that contribute to difficulties in the sharing of information in their community and develop a process for regularly reviewing these policies and procedures in consultation with legal counsel.

Instructions:

Answer the following questions about what information can be legally shared between behavioral health care providers and law enforcement for your community, without a signed authorization or verbal consent from the person who encounters law enforcement. For each scenario below, indicate the amount of information that can be shared. The options are:

a. No information (i.e., no information about the person's behavioral health care or criminal justice involvement can be shared);
b. Minimal information (i.e., limited information can be shared if the person has had contact with the behavioral health care or criminal justice system); or
c. Maximal information (i.e., most or all information that can be shared,[7] as allowed by law, to de-escalate a crisis and determine final disposition or to improve access to behavioral health care in a non-crisis-situation).

For those questions where no or minimal information is selected, also indicate what barriers are preventing you from sharing information.
Examples of barriers may include:

- There is no information-sharing agreement in place.
- A partnership has not yet been established with that stakeholder.
- There are no staff designated to provide the information during a crisis call.
- There are laws specific to your jurisdiction that prevent this type of information sharing.
- There are agency restrictions that prevent this type of information sharing.

7. "Most or all-information" can include mental health, substance use, or other medical diagnoses; family member and treatment provider names and contact information; and other protected health information that can provide the officer insight into how to respond and resolve a mental health call for service.

1. To de-escalate a crisis and determine final disposition when the person presents as a threat or danger to self or others:

What can **behavioral health care providers** share with law enforcement officers?

☐ No information
☐ Minimal Information
☐ Maximal Information

What can **law enforcement officers** share with behavioral health care providers?

☐ No information
☐ Minimal Information
☐ Maximal Information

Optional: What barriers are preventing you from sharing information?

2. If no or minimal information was selected for the previous question, what barriers exist that may be preventing the sharing of information?

Answer:

3. When a person does not present as a threat or danger to self or others, what can agencies share to de-escalate a crisis and determine final disposition:

What can **behavioral health care providers** share with law enforcement officers?

☐ No information
☐ Minimal Information
☐ Maximal Information

What can **law enforcement officers** share with behavioral health care providers?

☐ No information
☐ Minimal Information
☐ Maximal Information

Optional: What barriers are preventing you from sharing information?

4. If no or minimal information was selected for the previous question, what barriers exist that may be preventing the sharing of information?

Answer:

5. To connect people to behavioral health care in a non-crisis situation, what information can be used to identify and proactively engage people with frequent calls for service:

What can **behavioral health care providers** share with law enforcement officers?

☐ No information
☐ Minimal Information
☐ Maximal Information

What can **law enforcement officers** share with behavioral health care providers?

☐ No information
☐ Minimal Information
☐ Maximal Information

Optional: What barriers are preventing you from sharing information?

6. If no or minimal information was selected for the previous question, what barriers exist that may be preventing the sharing of information?

Answer:

Appendix C.
Defining the PMHC Training Program

The exercises below are designed to help project coordinators inventory their current training for law enforcement and behavioral health personnel, as well as track the implementation progress on new training programs that are aligned with the PMHC's goals. Steps 1 and 2 should be completed in consultation with the law enforcement training manager and/or interagency workgroup, as well as representatives from relevant stakeholders (such as dispatchers, PMHC specialists, etc.). These should also be reviewed and updated periodically (e.g., yearly).

Step 1:
Inventory your training program.

Complete the following table to indicate who is receiving which kinds of training and for how many hours. Fill in additional personnel where needed.

Personnel	**Type of Mental Health or De-escalation Training (e.g., Crisis Intervention Team [CIT] Training, Mental Health First Aid [MHFA], etc.)**	**Number of Hours**		**Percentage of Staff Trained**
		Entry-Level/ Recruit Training	In-Service Active Duty Officer Training	
Law enforcement officers				
Law enforcement supervisors/ management				

Personnel	Type of Mental Health or De-escalation Training (e.g., Crisis Intervention Team [CIT] Training, Mental Health First Aid [MHFA], etc.)	Number of Hours		Percentage of Staff Trained
		Entry-Level/ Recruit Training	In-Service Active Duty Officer Training	
Behavioral health care providers				
911 call-takers/dispatchers				
Paramedics/EMTs				

Step 2:

Track your implementation progress on new training curricula.

Check the box reflecting the current status of your mental health and stabilization/de-escalation training program for each item, indicating whether a certain activity is (1) in place and current; (2) underway; (3) in the planning stages; or (4) outdated or not in place.

Activities	Implementation Status			
	Yes	Underway	Planning	No
Your agency has a training plan to provide mental health and de-escalation/stabilization training at each of the following levels: recruit, in service, and specialized.				
Training curricula for the PMHC is collaboratively developed among the following partners and stakeholders: mental health care providers, advocacy groups, and people who have mental health needs and who have had previous contact with law enforcement.				
Aside from law enforcement personnel, trainers also include: ● Mental health program partners; ● People who have mental health needs and/or their family members; and ● Advocates.				
A plan is in place to train or hire a group of instructors, especially if the department does not have the resources or expertise internally. This plan includes: ● Investigating train-the-trainer courses; ● Coordinating training with other law enforcement agencies to reduce or share costs; ● Selecting trainers that are credible and have sufficient experience in mental health crises and law enforcement; and ● Collaborating with community partners on trainer selection.				
Law enforcement personnel who specialize in responding to people who have mental health needs receive extensive knowledge and skills training (e.g., a 40-hour advanced course).				

Activities	Implementation Status			
	Yes	Underway	Planning	No
An advanced training course in in place and includes, at a minimum, instruction on: ● Mental illnesses and their impact on individuals, families, and communities; ● Signs and symptoms of mental illnesses; ● Stabilization and de-escalation techniques; ● Trauma-informed responses; ● Active listening; ● Use of force; ● Disposition options and the corresponding procedures; ● Legal criteria for emergency mental health evaluation and involuntary commitment; ● Community resources; and ● Data collection and information sharing.				
The training also includes any of the following additional topics. *(Please select all that apply.):* ☐ Cultural competency ☐ Gender responsivity ☐ Implicit bias ☐ Substance use responses ☐ Trauma-informed policing				
The training curricula includes hands-on, experiential learning, with:				
● Scenario-based role playing				
● Simulations/ virtual reality training				
● Presentations by advocates				
● Site visits such as to mental health facilities and ride-alongs with police officers				
● Group problem-solving exercises				

Activities	Implementation Status			
	Yes	Underway	Planning	No
Call takers and dispatchers receive training that addresses:				
• The structure and goals of the PMHC program.				
• Procedures for receiving and dispatching calls involving people with mental health needs.				
• How to recognize and assess a mental health crisis, including appropriate questions to ask callers.				
• How to identify and dispatch appropriately trained officers.				
• Procedures for documenting mental health calls for service and information about the callers.				
Leadership (e.g., managers, supervisors, and field training officers) receive, at a minimum, awareness training about the PMHC.				
Other professionals in a support role (e.g., SWAT officers, hostage negotiators, EMT/paramedics, firefighters) receive, at a minimum, awareness training about the PMHC.				
Mental health professionals who work within the PMHC receive training on law enforcement policies and procedures.				
Mental health professionals who work within the PMHC receive training or hands-on experience on topics such as law enforcement policies and procedures, 911 call-taking and dispatching functions, and booking and jail intake procedures.				
Your PMHC has a process for reviewing and evaluating mental health and de-escalation training (e.g., evaluation forms, post-training focus groups or interviews with staff, course observations).				
The training manager administers pre- and post-tests to evaluate knowledge and skills acquired from the training.				
The training manager has a process in place to modify the training curricula based on evaluation findings and other developments in the field.				

Appendix D: Assessing Behavioral Health Care and Community Resources

This exercise helps project coordinators inventory the behavioral health care services and resources available in your community. It can also help project coordinators better understand what barriers need to be addressed, what additional services are needed, and who can best help to fulfill the need. It should be completed in coordination with the interagency workgroup and updated once a year.

Developing an inventory such as this is not an easy undertaking; it requires gathering information from a variety of agencies, organizations, and people. As such, your interagency workgroup might consider designating a specific subcommittee to work with the project coordinator to carry out this task. Ultimately, completing this inventory will help your interagency workgroup identify the existing services in your community and determine where there may be treatment and service gaps across systems. Note: just because your community lacks a specific program or service doesn't necessarily mean that it is needed. This will depend on your community's needs and other local contextual factors.

For each service listed in the charts below, fill in the information under each category. The last two columns only require yes or no responses. Definitions for the categories below:

Admission, Eligibility, or Access Requirements: the requirements an agency may have to serve an individual, including location of residence, age, gender, language spoken, diagnosis, criminal justice history, etc.

Capacity Limits: the number of people a facility can treat, how many beds are available, or how many beds are designated for people in contact with the criminal justice system.

Availability Issues: the time a facility is open (or closed), distance an officer needs to travel to the facility, how often services may be offered and where, and ability for the facility to accept custodial transfers (e.g., limited security on staff).

Waiting times: time it takes for a facility to accept, screen, assess or admit the client. For some services, wait times can create a barrier that prohibits the service from being a viable disposition option.

Dedicated Law Enforcement Liaison: refers to a dedicated drop-off point, assigned number of beds, or staff member to accept the individual and ensure custodial transfer is complete. A facility or program with a dedicated law enforcement liaison may assign a dedicated staff member to work with officers and their clients.

LE Familiarity and Understanding: refers to whether officers are familiar with this service/program, if it is part of a roster of referral sources, and whether they understand the admission requirements and how to access the services/program (i.e., is training provided around how to use this service or program).

Crisis Prevention

	Admission, Eligibility, or Access Require-ments	Capacity Limits	Availability Issues	Waiting Times	Dedicated LE Liaison (Yes/No)	LE Familiarity and Under-standing (Yes/No)
Emergency departments						
Crisis/diversion/stabilization center						
Hotline/warmline						
Mobile outreach						

Outpatient Services

	Admission, Eligibility, or Access Require-ments	Capacity Limits	Availability Issues	Waiting Times	Dedicated LE Liaison (Yes/No)	LE Familiarity and Under-standing (Yes/No)
Assertive community treatment						
Assisted outpatient treatment						
Counseling services/medication management						
Day treatment						
Educational services						
Employment/vocational services						
Intensive outpatient						
Victim/survivor services						
Walk-in clinic						

Residential or Other Long-Term Services

	Admission, Eligibility, or Access Require-ments	Capacity Limits	Availability Issues	Waiting Times	Dedicated LE Liaison (Yes/No)	LE Familiarity and Under-standing (Yes/No)
Detox facilities						
Housing for people who have behavioral health needs						
Partial hospitalization						
Rehabilitation						
Residential substance addiction treatment						

Additional Services

	Admission, Eligibility, or Access Require-ments	Capacity Limits	Availability Issues	Waiting Times	Dedicated LE Liaison	LE Familiarity and Under-standing
Intellectual and development disability programs						
Programs that are trauma informed						
Translation and interpretation services						
Traumatic brain injury services and treatment facilities						
Faith-based wraparound services						
Benefits Navigator						

Appendix E:
Collecting and Analyzing Data

Scanning Data Resources

Instructions:
Answer the following questions to identify what types of data your PMHC collects and tracks, what mechanisms are in place, and what gaps need to be addressed in order to accurately measure the PMHC's progress. These should be answered in consultation with the data specialist or chairperson of the data subcommittee; primary users of the jurisdiction's data management system (if there is one); and any law enforcement, behavioral health, or other partners that the PMHC has established data and information-sharing agreements with. Once you have completed the exercise, consider bringing the interagency workgroup together to develop a plan to fill the identified gaps.

1. Does your PMHC track baseline data on the number of mental health calls for service?

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2. Does your PMHC track baseline data on the four key outcomes:

☐ Increased connection to resources
☐ Reduced repeat encounters with law enforcement
☐ Minimized or lower rates of arrest
☐ Reduced use of force

3. If so, what general patterns and individual demographic characteristics in mental health-related calls for service have you been able to track or identify, if any?

General Patterns

Time of Day	Day of Week	Patrol Sector	Address/Location of Call

Individual Demographic Characteristics

Age	Race	Ethnicity	Gender

4. Does the law enforcement agency collect data on the mental health characteristics of people who come into contact with officers, such as diagnosis, whether the person has an existing case manager, previous treatment connections, hospital transfers, etc.?

5. Has the interagency workgroup defined what constitutes a frequent encounter?

6. Have you been able to identify people who have frequent encounters with law enforcement?

7. Are you planning to track subsequent encounters for the people who have been identified as having frequent encounters with law enforcement and also have mental health needs?

8. Has the interagency workgroup defined use of force in your community?

9. Does your law enforcement agency track use of force?

10. Is use of force tracked for people who have mental health needs?

11. Does your law enforcement agency track final dispositions for mental health calls for service?

12. Does your law enforcement agency offer and track multiple disposition code options for mental health calls for service, such as transfer to hospital, crisis center or diversion facility, outpatient treatment facility, or hand-off to family/friend, etc. rather than just “non-arrest”? (Please list.)

13. Does the law enforcement agency track where, what facility, or to whom an individual was transported, or where a hand-off occurs?

14. Does the agency track the time a call takes, and are they able to separate out this data for mental health calls for service?

15. Has the group established any other key outcome data or benchmarks for success for the PMHC that are important to the community or in service of a grant, funder, or funding opportunity? If so, please enter below:

What type of data is being collected? *(e.g., number of officers trained, number of mental health calls for service, etc.)*	Who is collecting the data? *(Title of position/agency)*	What is the data source? *(e.g., incident report or other form, database, survey, etc.)*

Records Management System:

Answer the next set of questions about the PMHC's records management system.

16. How is program data stored (e.g., in paper files, shared drive, network databases, etc.)?

17. Is there an information management system in place to collect behavioral health data?

18. Is there an information management system in place to collect criminal justice data?

19. List the name of the data system(s) used for your PMHC and which agencies have access to it.

20. Does the information management system allow users to change or re-code calls for service? Can users track how often this occurs?

21. Are there improvements to the information management system that would expand the capacity of the PMHC to collect and analyze data?

Information Sharing and Data Reports:

Answer the next set of questions about sharing information to create data reports.

22. Who (what staff members) have access to the information management system and any protected or confidential data that are stored there?

23. Does your PMHC have data-sharing agreements that outline which staff have access to the information management system and personal identifiable information?

24. Has the PMHC established data-sharing processes for criminal justice and behavioral health agencies to share data and information? If so, what are they?

25. Logistically, how is that data shared between systems (e.g., how is it protected, in what format is it shared in, how often is it shared, and who receives the data)?

26. Are staff available to analyze data and develop reports based on the four key outcomes?

27. Are there established timeframes (e.g., daily, weekly, monthly, semi-annually) for how often reports are generated?

28. Who receives these reports, both internally (i.e., the interagency workgroup and data collection subcommittee) and externally, and how often are they generated for these individuals?

Appendix F:
Part 1. Conducting a PMHC Performance Review

Use this checklist to assess the progress of your PMHC's efforts regularly. It should help project coordinators evaluate the effectiveness of the PMHC, and then gauge which external stakeholders to engage to continuously improve upon these efforts. Complete this checklist in consultation with the data specialist or data subcommittee, primary users of the of the jurisdiction's data management system (if there is one), and any law enforcement, behavioral health, or other partners that the PMHC has established data and information-sharing agreements with.

Instructions:
Check the box reflecting the current status of your PMHC for each item, indicating whether a certain activity is (1) in place and current; (2) underway; (3) in the planning stages; or (4) outdated or not in place.

Activities	Implementation Status			
	Yes	Underway	Planning	No
Program evaluations are conducted at least once a year to assess the impact of the PMHC.				
The results of the program evaluation are used to implement changes in the PMHC's efforts (e.g., revising data collection if results show these are not adequately tracking progress).				
Written MOUs with external agencies, such as the 911 dispatch center or a mental health agency, are reviewed annually to identify any gaps in procedures for their roles and responsibilities to provide PMHC program data, including: Data sources; Data storage; Quality control; and Data analysis.				

Activities	Implementation Status			
	Yes	Underway	Planning	No
If an outside evaluator is used, a contract outlining roles, type of deliverables and a timeline for reporting results is developed for any external evaluators, academic institutions, or other parties conducting the evaluation.				
Outcome measures are evaluated at least once a year to determine if there are new outcome measures, in addition to the four key outcomes, needed to assess performance of the PMHC.				
Your PMHC meets with community leaders, the media, key public officials, and other policymakers to update them on program performance.				
Officers and mental health specialists are regularly surveyed to assess the PMHC's utility and opportunities for improvement.				
Performance management meetings, with PMHC staff and patrol supervisors, are held to discuss items such as workload, process, outcome measures, and rewards staff for progress.				
Process and outcome measures are used to inform budget decisions, such as whether to expand programmatic capacity by geographic area or time of day, add staff positions, fund additional training, shift resources across the agency, etc.				
Reports on progress toward meeting the PMHC's goals are regularly provided to the interagency workgroup, chairperson, and key staff from all PMHC partner organizations.				
The PMHC response model is assessed at least annually and this information is used to make policy decisions in support of the PMHC.				
The PMHC response model is assessed at least annually and this information is used to make budget decisions in support of the PMHC.				
Community services capacity and utilization are assessed at least annually and this information is used to make policy decisions in support of the PMHC.				
Community services capacity and utilization are assessed at least annually and this information is used to make budget decisions in support of the PMHC.				

Appendix F:
Part 2. Developing A Sustainability Plan

This exercise prompts the project coordinator to answer a series of questions to identify key response model elements that are important to sustain long term, potential funding sources, and what champions and other stakeholders will be instrumental in helping ensure the response model's long-term health and sustainability. It should be completed in consultation with the chairperson of the interagency workgroup and revisited in conjunction with any annual, semi-annual, or other periodic reviews the law enforcement agency conducts to elevate their policies.

1. What funding sources can sustain the program long term (e.g., foundation, federal, state, local, private donation, etc.)?

2. Who is responsible for securing funds for program sustainability?

3. Has your interagency workgroup identified the key components that are essential to sustain the response model (e.g., program-specific staffing, treatment interventions, policies, or practices), and which would need to be cut if you do not receive additional funding?

4. Who are the key partners to help sustain your program?

5. Have additional leaders and stakeholders, whose buy-in would facilitate the successful implementation of the PMHC sustainability plan, (e.g., community leaders, agency administrators, service providers, or elected officials) been identified?

6. Which of the following measures will be taken to maintain or attract interest from the key stakeholders (select all that apply):

- ☐ Program e-mails or newsletters about the PMHC and successes
- ☐ Individual meetings with key stakeholders
- ☐ Program fact sheets or brochures
- ☐ Special events and meetings/conferences
- ☐ Media (e.g., local newspapers, radio stations, television stations, online news sources and websites)
- ☐ Promotion targeting professional groups, associations, and key constituents
- ☐ Program tours for community leaders, executives, and other stakeholders
- ☐ Other

7. What additional PMHC response model(s) and community services are you looking to develop or sustain?