Improving Responses to People with Mental Illnesses

Tailoring Law Enforcement Initiatives to Individual Jurisdictions

BJA
Bureau of Justice Assistance
U.S. Department of Justice

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

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A report prepared by the
Council of State Governments Justice Center
and the Police Executive Research Forum

for the

Bureau of Justice Assistance
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Melissa Reuland
Laura Draper
Blake Norton

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Contents

Acknowledgments v

Introduction vii

Section I—Step by Step: The Program Design Process 1

Step 1: Understand the problem 3

Step 2: Articulate program goals and objectives 6

Step 3: Identify data-collection procedures needed to revise and evaluate the program 7

Step 4: Detail jurisdictional characteristics and their influence on program responses 9

Step 5: Establish response protocols 11

Step 6: Determine training requirements 15

Step 7: Prepare for program evaluation 17

Section II—From the Field: Program Design in Action 19

Tailoring Specialized Policing Response Programs to Specific Problems 19

Tailoring Specialized Policing Response Programs to Jurisdictional Characteristics 34

Appendix A: Site Visit Information 45

Appendix B: Document Development 49

Appendix C: Program Design Worksheet 51

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- Deputy Chief Dottie Davis, Director of Training, Fort Wayne (Ind.) Police Department
- Captain Richard Wall, Los Angeles (Calif.) Police Department
- Sergeant Michael Yohe, CIT Coordinator, Akron (Ohio) Police Department

(A complete list of contributors, by jurisdiction, can be found in appendix A.)

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- Jackson County (Mo.) Sheriff's Office
- Jacksonville (Fla.) Sheriff's Office
- Kansas City (Mo.) Police Department

*Representatives' titles and agency affiliations reflect the positions they held at the time this document was published, which may differ from titles listed in appendix A.

- Lees Summit (Mo.) Police Department
- Lincoln (Nebr.) Police Department
- Long Beach (Calif.) Police Department
- Montgomery County (Md.) Police Department
- New London (Conn.) Police Department
- Portland (Ore.) Police Bureau
- Portland (Maine) Police Department
- San Diego (Calif.) City Police and County Sheriff's Department

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Introduction

A growing number of law enforcement agencies have partnered with mental health agencies and community groups to design and implement innovative programs to improve encounters involving people with mental illnesses. These "specialized policing responses" (SPRs) are designed to produce better outcomes from these encounters by training responders to use crisis de-escalation strategies and prioritize treatment over incarceration when appropriate.[1]

Effective SPRs share many common features, but programs also differ in some important ways. These programmatic variations generally stem from a community's unique needs, opportunities, and limitations. For example, officers in rural areas may have difficulty connecting people to a full range of mental health services, whereas officers in large urban areas may spend hours out of service trying to transport people to mental health facilities through traffic-congested areas. Some jurisdictions may spend tremendous resources responding repeatedly to a small number of locations or individuals. Other communities may face significant concerns about responding appropriately to particular groups of individuals, such as people with mental illnesses who are homeless.

SPOTLIGHT

Different Jurisdictions, Different Program Models

Two of the most common law enforcement-based specialized response programs are the Crisis Intervention Team (CIT) model and the co-responder model. Each program model was developed based on a jurisdiction's unique circumstances, reflecting the need for a flexible decision-making process.

Memphis (Tenn.) police leaders, mental health professionals and advocates, city hall officials, and other key stakeholders were spurred to action following a tragic incident in which an officer killed a person with a mental illness. In response, the Memphis Police Department established the first law enforcement-based CIT in 1988, which was designed to improve safety during these encounters by enhancing officers' ability to de-escalate the situation and providing community-based treatment alternatives to incarceration.

Los Angeles and San Diego (Calif.) initiative leaders recognized that officers encountered many people with mental illnesses who were not engaged with treatments and services. To address this problem, law enforcement agencies collaborated with the mental health community to form teams in which officers and treatment professionals respond together at the scene to connect these individuals with community-based services more effectively.

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1. There has been a trend toward categorizing any response in which law enforcement plays a central role in addressing people with mental illnesses as a "crisis intervention team (CIT)" approach. To avoid confusion, this publication refers to all law enforcement-based responses as "specialized policing responses" or SPRs (pronounced *spurs*). The term encompasses both "CIT "and "co-responder" approaches. Those terms can then be preserved to describe accurately the scope and nature of those models.

Law enforcement agencies have identified a variety of ways to respond that recognize the unique opportunities and limitations presented by each of their jurisdictions. Some agencies have replicated existing models from other jurisdictions—such as the Memphis CIT Model—to improve their responses to people with mental illnesses. Other agencies have determined that specific community characteristics and law enforcement resources (for example, the lack of a single mental health facility or the tremendous size of a policing agency) require adaptations and additions to existing models—such as implementing a mental health outreach team in addition to an existing CIT program.

To determine the best possible response model that will meet local needs, each jurisdiction should work through a program design process. This is not to say that they should reinvent the wheel, but rather they should not skip the critical program planning and development steps that ensure a program will reflect their unique community characteristics. Program design decisions should be made in the context of a collaborative planning process that includes a wide variety of stakeholders—a practice that most communities committed to specialized responses undertake.[2] Beyond a commitment to collaboration, however, little is known about the steps law enforcement professionals and community members take to tailor other jurisdictions' models to their own distinct problems and circumstances. This publication addresses that gap and provides guidance for jurisdictions that want to improve their law enforcement interactions with people who have mental illnesses.

About this Report

This report is the result of a project supported by the Bureau of Justice Assistance (BJA), U.S. Department of Justice. It explores the program design process, including detailed examples from several communities from across the country.[3] It is meant to assist initiative leaders and agents of change who want to select or adapt program features from models that will be most effective in their communities. To ensure that this material has practical value, staff members from the Council of State Governments (CSG) Justice Center and the Police Executive Research Forum (PERF) visited four jurisdictions with extensive experience with SPRs to examine their decision-making and program development processes (selected based on a range of characteristics such as diverse objectives, jurisdiction size, and program model type).[4] During each visit, project staff interviewed relevant stakeholders and observed

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2. Throughout this document, the term "stakeholders" is used to describe the diverse group of individuals affected by law enforcement encounters with people with mental illnesses, such as criminal justice and mental health professionals; myriad other service providers, including substance abuse counselors and housing professionals; people with mental illnesses (sometimes referred to as "consumers") and their loved ones; crime victims; and other community representatives.

3. The examples included in this guide reflect various types of efforts that involve partnerships, programs, or practices for other communities to consider as they develop responses to people with mental illnesses. By highlighting this sampling of approaches, however, the authors are not necessarily promoting them as "best practices."

4. For information on when the site visits were conducted and the personnel interviewed, see appendix A. This document also includes program examples from several other jurisdictions interviewed but not visited for this project, as well as several communities that have received grants through BJA's Justice and Mental Health Collaboration Program (JMHCP). See www.ojp.usdoj.gov/BJA/grant/JMHCprogram.html for more information about JMHCP.

initiative activities.[5] The four jurisdictions selected were Akron, Ohio; Fort Wayne, Ind.; Los Angeles, Calif.; and New River Valley, Va.

This report is divided into two sections: 1) *Step by Step: The Program Design Process,* and 2) *From the Field: Program Design in Action*. The first section articulates the seven steps involved in shaping a program that best address a jurisdiction's distinct resources and needs, and within each step provides questions to help guide the planning process. This section is

SPOTLIGHT

About the Four Sites

Akron (Ohio) provides an example of a program that has remained true to the Memphis model of a Crisis Intervention Team (CIT), transplanting it to a new jurisdiction. This agency has collected a substantial amount of data, which has shown this program to be an effective solution to its jurisdictional needs. Agency representatives identified the need to augment CIT with follow-up program activities to address a broader range of problems in their jurisdiction.

Fort Wayne (Ind.) operates a traditional CIT program with a focus on schools and juveniles. School Resource Officers (SROs) are trained to recognize and respond to a range of self-destructive behaviors (such as self-mutilation), and CIT officers coordinate with school administrators to identify youth who would be best served by mental health services rather than the juvenile justice system. Data collection processes are advanced and thorough, which allows program policymakers to evaluate the initiative's progress.

Los Angeles (Calif.) has implemented a wide variety of adaptations to address the unique needs of its jurisdiction, focusing on a co-responder model, while incorporating elements of the CIT model into patrol operations, as well as creating a new program focusing on a priority population. Their experience illustrates the difficulties some large jurisdictions have had in implementing the CIT model citywide. Due to its sheer size, both in area and in population, the CIT approach alone did not effectively address the community's problems. In response, the department believes it developed a more robust and multifaceted strategy.

New River Valley (Va.) represents a rural, multi-jurisdictional CIT program that includes fourteen different law enforcement agencies contained in four counties and one city.[6] The challenges facing these non-urban communities and the state law requiring that law enforcement take custody of a person meeting the criteria for an emergency mental health assessment have led to the need for several adaptations to the CIT model.

For more information on how these sites were selected, see appendix B.

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5. Some practitioners are concerned that law enforcement not just conduct "programs" that are a discrete set of activities, instead stressing that agencies should develop broader "initiatives" in which an agency engages in a comprehensive effort that includes meaningful partnerships with the community and other agencies. Because practitioners in the field used these terms interchangeably in interviews, this report also uses both to refer to efforts to improve responses to people with mental illnesses and instead qualifies or describes the level of agency engagement and commitment from a community.

6. The fourteen law enforcement agencies that comprise the New River Valley (NRV) CIT are the Blacksburg Police Department, Christiansburg Police Department, Dublin Police Department, Floyd County Sheriff's Office, Giles County Sheriff's Office, Montgomery County Sheriff's Office, Narrows Police Department, Pearisburg Police Department, Pulaski Police Department, Pulaski County Sheriff's Office, Radford City Police Department, Radford City Sheriff's Office, Radford University Police Department, and Virginia Tech Police Department.

most useful for policymakers and practitioners interested in learning how to design or revise a program—whether it is a CIT, a co-responder model, or some combination or variation of these models—that takes into full account the specific factors that drive their jurisdiction's problems associated with law enforcement interactions with people who have mental illnesses.

The second section provides two overview charts—one about problems that affect program design and the other about jurisdiction characteristics that can affect initiative plans. It also provides specific examples that illustrate how program design processes are translated into activities in the field, drawing on information provided during interviews and site visits. It describes how program elements are tailored to a jurisdiction's problems and specific characteristics when implemented.

The information collected from the four sites reveals a blurring of the two main models. In some cases, it is not possible to use the terms "CIT" or "co-responder" to describe the entirety of a jurisdiction's responses; communities are now implementing a combination of both approaches. This section will help individuals interested in learning more about how other agencies throughout the country have navigated the program design process to develop these evolving initiatives.

As discussed more fully below, this report delves into some of the other ten "essential elements" of a successful SPR to people with mental illnesses that are identified and outlined in a previous publication.[7] Whenever applicable, references to these elements are highlighted in the text. The material that follows also includes sidebar articles on related topics that often include references to additional sources of information.

Related Resources

This publication is just one in a series that addresses how law enforcement responds to people with mental illnesses. The Justice Center, in partnership with PERF and with support from BJA, has developed a collection of resources for law enforcement practitioners and their community partners.[8] The centerpiece of the *Improving Responses to People with Mental Illnesses* suite of materials is the publication, *The Essential Elements of a Law Enforcement-Based Program*.[9] The other documents build on this essential elements publication. For example, one of the ten essential elements describes the need for specialized officer training that is tailored to the law enforcement audience. It is a very concise description of why training is needed and highlights some key challenges to overcome. Another publication, *Strategies for Effective Law Enforcement Training,* explores these training issues in greater depth and

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7. Readers are encouraged to review *Improving Responses to People with Mental Illnesses: The Essential Elements of a Specialized Law Enforcement-Based Program* to better understand how program design and decision making fit within a broader context. To download a copy, visit www.consensusproject.org/issue_areas/law-enforcement.

8. The project and publication were completed as part of BJA's Law Enforcement/Mental Health Partnership Program. The resources developed as part of this suite of materials are available for free download at the law enforcement issues page on the Justice Center's Consensus Project website (www.consensusproject.org).

9. The ten essential elements presented in this document are Collaborative Planning and Implementation; Program Design; Specialized Training; Call-Taker and Dispatcher Protocols; Stabilization, Observation, and Disposition; Transportation and Custodial Transfer; Information Exchange and Confidentiality; Treatment, Supports, and Services; Organizational Support; and Program Evaluation and Sustainability.

raises additional matters that must be considered in training law enforcement officers. This document's focus on tailoring specialized responses provides a similar level of discussion and guidance for readers who want to drill down to the details and implementation options for the essential element that encourages thoughtful, collaborative program design. These written materials are complemented by web-based information on statewide efforts to coordinate law enforcement responses and by an online Local Programs Database.[10]

Essential Element 2

Program Design[11]

The planning committee designs a specialized law enforcement-based program to address the root causes of the problems that are impeding improved responses to people with mental illnesses and makes the most of available resources.

10. The Local Programs Database, formerly referred to as the Criminal Justice/Mental Health Information Network (InfoNet), was made possible through the leadership, support, and collaboration of key federal agencies and private foundations, including the Bureau of Justice Assistance (BJA) and the National Institute of Corrections (NIC). The database was created to foster peer-to-peer learning among agencies across the country. The database is interactive and entries include contact information to facilitate information sharing, as well as easily searchable fields on key topics. The database is available through the Consensus Project website at www.consensusproject.org and can be searched for information on other programs or accessed to create a new program profile.

11. This and other elements reflect a consensus of experts, including a broad range of policymakers, practitioners, advocates, and researchers, whose recommendations are captured in the *Essential Elements* report.

Section I

Step by Step: The Program Design Process

Designing a program specific to a community's unique needs is a complex process. Identifying and implementing a collaborative partnership is the first hurdle, but once stakeholders are involved and committed to the issue, the question remains, "What next?"

It is critical that a planning committee (and its program coordination group) develop a strong level of collaboration among stakeholders, yet the process can be fraught with significant challenges. Personnel from the four featured sites shared how they have successfully engaged people who are vested in the outcomes of law enforcement interactions involving people with mental illnesses and established lasting frameworks to maintain their programs' integrity. The keys to their success include the following:

- **Gain the support of law enforcement leaders through the involvement of other law enforcement leaders.** In deciding whether to participate in the New River Valley CIT program, the Chief of the Pearisburg (Va.) Police Department was influenced by both the chief law enforcement executive in Radford (Va.) and Major Sam Cochran, the former CIT Coordinator for the Memphis (Tenn.) Police Department, who were each able to explain—from one law enforcement official to another—the importance and benefits of specialized responses to people with mental illnesses.

Essential Element 1

Collaborative Planning and Implementation

Organizations and individuals representing a wide range of disciplines and perspectives and with a strong interest in improving law enforcement encounters with people with mental illnesses work together in one or more groups to determine the response program's characteristics and guide implementation efforts.

Keys to Collaboration

The **planning committee** is composed of leaders from each of the stakeholder agencies who have operational decision-making authority and community representatives. This executive-level committee should examine the nature of the problem and help determine the program's objectives and design.

The **program coordination group** is made up of staff members from stakeholder agencies. This group should oversee officer training, measure the program's progress toward achieving stated goals, and resolve ongoing challenges to program effectiveness.

In some jurisdictions, the two bodies may be the same—particularly those with small agencies, in rural areas, or with limited resources.

- **Develop a subcommittee structure within the larger planning committee or program coordination group to support targeted issue areas and make collaboration more efficient.** In addition to their participation in a multidisciplinary coalition in the New River Valley CIT program, initiative planners developed a "Law Enforcement and Mental Health Services Coalition," which meets quarterly to discuss mental health issues related specifically to law enforcement. In Fort Wayne (Ind.), a subcommittee composed of individuals from law enforcement, mental health, and advocacy meets separately to focus on training development and then to prepare and host training sessions several times each year. The training committee in Akron (Ohio), which meets twice yearly, manages the iterative process of refreshing the curriculum to ensure it reflects the most current policies and procedures.
- **Designate staff members to focus on accountability and to maintain connections among stakeholders in the collaboration.** The planning committee can designate staff members in the program coordination group to manage the logistics of partnerships. Identified personnel can ensure that there is an emphasis on collaboration from the start of the program.
- **Exchange meaningful information to measure outcomes and foster necessary program changes.** Stakeholders will be more likely to maintain their involvement if they find the meetings provide meaningful information and accomplish specific tasks. In Los Angeles, the police department shares information with its mental health advisory board about their use-of-force trends and reports, for example.

What Next, After Collaboration?

This section outlines seven key steps involved in the collaborative program design process. Each step includes a series of questions designed to help planning and coordination groups structure their discussions and advance their thinking about related issues.[12]

Step 1: Understand the problem

Step 2: Articulate program goals and objectives

Step 3: Identify data-collection procedures needed to revise and evaluate the program

Step 4: Detail jurisdictional characteristics and their influence on program responses

Step 5: Establish response protocols

Step 6: Determine training requirements

Step 7: Prepare for program evaluation

In each of the four jurisdictions—Akron, Fort Wayne, Los Angeles, and New River Valley—initiative leaders found that the challenges their community faced were inter-related, multilayered, and required similarly complex and nuanced responses. In addition, those

12. For a worksheet that provides the questions that guide the design process without the narrative explanation, see appendix C.

who had created programmatic responses found that it was an iterative process, rather than a simple linear approach. Accordingly, the steps recommended in this guide are designed to be revisited as needed to fine-tune efforts and remain responsive to conditions and resources in a jurisdiction. Program design does not end when the seven steps are complete, but rather requires an *ongoing* effort to evaluate and adjust program responses as the community's landscape changes.

Step 1: Understand the problem[13]

Program development is often initiated in reaction to a terrible tragedy in the community, impending litigation, or another event. Partners involved in the collaboration should start the program design process by researching and then moving beyond the initial impetus to develop a common and comprehensive understanding of the legal, clinical, and community circumstances that make it so challenging to effectively respond to people with mental illnesses encountered by law enforcement officers.

It is important to stress from the outset that research does not support the stereotype that people with mental illnesses are more violent than individuals in the general population.[14] Accordingly, police use of force is usually not needed. Yet even though the occurrence is infrequent for there to be law enforcement shootings involving people with mental illnesses, the impact of such events on the officer, the individual's family, and the community—and even on other communities not directly involved—is profound and

> *"We ask ourselves, and other agencies ask, too, would these terrible incidents have happened [where someone is shot and killed] had this program been in place at that time? We paid a terrible price. Why would an agency choose to do otherwise? How could they see what has happened here and in LA County and knowingly choose not to do this program? It makes no sense to me."*
>
> **—Assistant Chief Earl Paysinger**
> Director, Office of Operations,
> Los Angeles (Calif.) Police Department

13. Gary Cordner's report "People with Mental Illness" also emphasizes the need for decision-makers to understand the problem in their local community to design an effective response strategy. He provides detailed questions that planners should ask to better understand the impact of incidents, stakeholders, victims, offenders, and locations/times. Gary Cordner, "People with Mental Illness," *Problem-Oriented Guides for Police Problem-Specific Guides Series*, Number 40, U.S. Department of Justice (Washington, DC: Office of Community Oriented Policing Services, 2006), www.popcenter.org/problems/mental_illness.

14. For a scholarly review, see A. Harris and A.J. Lurigio, "Mental illness and violence: A brief review of research and assessment strategies," *Aggressive and Violent Behavior* 12(5) 2007: 542–51. Several large-scale research projects found a weak statistical association between mental illness and violence (M.C. Angermeyer, B. Cooper, and B.G. Link. "Mental disorder and violence: Results of epidemiological studies in the era of deinstitutionalization," *Social Psychiatry and Psychiatric Epidemiology* 33(13) 1998: S1–S6). The association becomes stronger, however, when a person with a mental illness has a co-occurring substance use disorder and/or is not taking his or her medication (H.J. Steadman, E.P. Mulvey, J. Monahan, P.C. Robbins, P.S. Appelbaum, T. Grisso, L.H. Roth, and E. Silver, "Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods." *Archives of General Psychiatry* 55 1998: 393–401; M.S. Swartz, J.W. Swanson, V.A. Hiday, R. Borum, H.R. Wagner, and B.J. Burns. "Violence and severe mental illness: The effects of substance abuse and nonadherence to medication," *American Journal of Psychiatry* 155 1998: 226–31).

far-reaching. The following questions can prompt planners to investigate the scope and nature of the challenges officers face in incidents involving people with mental illnesses and design appropriate responses.

Question 1: *What forces are driving current efforts to improve the law enforcement response to people with mental illnesses?*

Stakeholders should contribute their individual perspectives to answer this question. Law enforcement line staff may voice concern about the many challenges they face during encounters involving people with mental illnesses—many agree that these calls are often time-consuming and frustrating. Patrol officers may spend long periods of time attempting to link a person in crisis to an appropriate mental health resource, and also may find themselves responding repeatedly to the same individuals without seeing any improvement in the outcomes. From another perspective, consumers of mental health services and their families might identify the need for change because of the limited treatment and response options for people with mental illnesses at risk of criminal justice involvement. They may not have any other options when a loved one is in crisis, but are disappointed by the results of law enforcement engagement. Both stakeholder groups would likely agree that the person's mental health and related calls for service are not improved through the more *traditional* interactions with police. It is important both to recognize the legitimacy of each argument and the need to reach consensus around the issues influencing the reasons for change. (Section II of this report provides more detail about the specific problems and the contributing factors that various jurisdictions have encountered.)

Question 2: *What data can planning committee members examine to understand the factors influencing law enforcement responses to people with mental illnesses?*

Effective program design hinges on accurately identifying the causes of the problems communities face. For example, if a community is responding to a tragic incident, stakeholders must explore the circumstances that led up to and occurred during the incident. They will also want to look for more systemic issues that go beyond those involved in the particular incident. This exploration may include interviews with the involved parties and a review of law enforcement and mental health system protocols and procedures (including response practices and training), as well as an assessment of resource gaps that may be hindering better responses to people with mental illnesses.

Among the law enforcement data that should be considered when defining the scope and nature of the problem are the number and types of calls related to people with mental illnesses, duration of the responses, and related use-of-force information. It may be important to note whether officers are responding repeatedly to the same individuals and locations to determine if interventions are needed to produce better results. One option is to examine computer-aided dispatch (CAD) data. If possible, efforts should be made to understand outcomes of calls for service through forms used to track the disposition of calls.

Valuable information should also be gleaned about the mental health system response. For example, planners can review the number and type of admissions at the receiving psychiatric facilities, and gather feedback on this process from officers, mental health professionals, family members, and consumers that has been collected through focus groups, surveys, or interviews.[15] Data should be collected on how long officers spend at the mental health facility and problems experienced in transferring custody as well. It is also important to catalog the types of services provided by community mental health centers and other providers, their availability, and their capacity to address the individuals' needs. Together, this information can then inform needed changes in responses.

(Problems that are related to *community and agency characteristics,* such as lack of mental health resources uncovered by cataloging the number and kind of available providers and their admission criteria, are addressed in Step 4: Question 2.)

Question 3: *What are the data limitations, and how can they be overcome?*

Stakeholders should identify the limitations of various data sources, such as the scant reporting on perceived mental illness in CAD databases or the failure of mental health intake records to account for the involvement of law enforcement. Law enforcement and community stakeholders should explore why officers may not be reporting encounters they resolve at the scene, what system limitations there are that make it difficult to capture relevant information when clearing a call or ending a field interaction, and other problems with gathering information on these interactions. Efforts should be made to resolve these issues and gain a better understanding of whether repeat calls for service, or particularly difficult incidents, center on a particular subgroup of individuals, such as people in a particular beat, men with substance abuse problems, or women who are homeless.

A critical component of the program design process is to ensure that goals, objectives, policy and practice reforms, and measures of success are all data-driven and tailored to a particular jurisdiction's distinctive needs. Because of problems with underreporting and other collection barriers mentioned previously, data should be interpreted with these limitations in mind. They are, however, still useful sources of information that provide a starting point for program design. To enhance the reliability of the information, stakeholders should consult multiple sources of data.

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15. "Receiving psychiatric facilities" include all medical facilities that will receive, assess, and treat someone in a mental health crisis, including hospital emergency rooms, psychiatric hospitals, and crisis drop-off centers. Most medical information is protected under federal and state privacy laws. If stakeholders wish to examine protected health information during this process, they should take into account laws governing this information exchange. For an overview of the federal laws, see John Petrila, "Dispelling the Myths about Information Sharing between the Mental Health and Criminal Justice Systems," National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness (February 2007). Petrila also participated in a webinar, "HIPAA: Myths, Facts, and Cross-systems Collaboration" (March 23, 2009). The associated presentation is available at www.consensusproject.org/features/hipaappt.

Step 2:

Articulate program goals and objectives

Once the collaborative planning group has a firm grasp on the challenges facing the community, they should establish the program's goals and objectives. Program goals capture the "big picture" of the good that the effort is meant to achieve, whereas objectives outline program activities that, if achieved, would meet those goals. A shared statement of the program goals will advance the discussion around program design. The objectives will not only detail the mechanisms for achieving a program goal, but will also provide a framework for developing evaluation measures. Program planners should articulate realistic goals and objectives, and avoid terminology that suggests problems will be "eliminated" or that all individuals will benefit from improved responses. It is advisable to establish both short- and long-term goals and objectives to help ensure early successes and sustainability.

Question 1: *What are the program's overarching goals?*

The program's goals reflect the desired outcome of the initiative on the primary problems identified by the planning group and other stakeholders in the community. For example, if the community is responding to a tragic incident involving law enforcement and a person with mental illness, the program goals might include improving officer and community safety. The goals should be well-articulated in writing and shared among all partners and the community, and should be reviewed periodically.

Other goals might include reducing arrests for minor offenses, lowering the number of repeat calls for service involving people with mental illnesses, decreasing the use of force by law enforcement, incurring fewer injuries among all involved at the scene, increasing the numbers of people diverted to mental health treatment when warranted, or cutting law enforcement agency costs.

Question 2: *What are the program's objectives?*

Objectives capture the specific program activities needed to achieve the stated goals. For example, if stakeholders identify improved safety as the program goal, providing effective agency training on de-escalation will be a key program objective. Objectives should be as specific as possible. In this example, the objective could be to train a certain proportion of the primary and secondary responders or a particular subset of individuals.[16] If the goal is to address strains on law enforcement resources, one objective might be reducing the amount of time officers spend attempting to link people with mental illnesses to mental health services to a target number (for example, 15–30 minutes).

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16. Examples that include specific numbers or percentages included in this section are not intended as recommendations, but are included only to highlight the value of setting specific goals within the agency to monitor improvement and to evaluate the extent to which the program is implemented.

STEP 3:

Identify data-collection procedures needed to revise and evaluate the program[17]

Once program goals and objectives are set, law enforcement and their partners can use them to identify what information they should collect and how they should collect it.[18] Data collection practices should take into account both process and outcome measures. Evaluating a program's *process* will allow coordinators to assess whether the proposed activities are being carried out (how many individuals were trained, how many calls were answered by an officer with training, and more) so planners can revise day-to-day program functioning and the reach of the initiative. It is also critical that the evaluation determine whether the activities are having the intended *outcome* (that is, the impact that planners hoped to achieve for people with mental illnesses, officers, and the community)—information needed not only to assess true advances, but also to secure funding and ensure program sustainability over time.

Question 1: What data will be collected to measure whether goals and objectives have been achieved?

Once goals and objectives have been articulated clearly, determining what information is required to measure them will be generally straightforward. For example, if a goal is to increase safety, an agency would want to collect data on injuries or deaths, use of force, and citizen complaints to see if that has been attained. If a related objective is to train all recruits, the agency or its partners will need to track the number of recruits who complete the curriculum or successfully pass a test. Most initiatives will want to address many of the issues raised previously that relate to using scarce law enforcement resources to better identify and safely serve people with mental illnesses—particularly those who should appropriately be diverted to the mental health system. Accordingly, the collaborative planning group and other stakeholders will want to collect data such as the frequency of calls for service involving people with mental illnesses, including how many are to the same individuals or locations; the types and frequency of disposition decisions; the percentage of calls that specially trained personnel handle and the portion that involve routine responses, and the duration of those responses; and any injuries or fatalities suffered during law enforcement encounters involving people with mental illnesses.

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17. Cordner's "People with Mental Illness" provides additional information on measures that could be used to evaluate the effectiveness of the SPR. Cordner, "People with Mental Illness." For a detailed guide to program evaluation, consult such resources as Richard A. Berk and Peter H. Rossi, *Thinking about Program Evaluation 2* (Thousand Oaks, CA: Sage Publications, 1999); Robert H. Langworthy, ed. *Measuring What Matters: Proceedings from the Policing Research Institute Meetings*, (Washington, DC: U.S. Department of Justice, National Institute of Justice, 1999); Kristin Ward, Susan Chibnall, and Robyn Harris. *Measuring Excellence: Planning and Managing Evaluations of Law Enforcement Initiatives* (Washington, DC: U.S. Department of Justice Office of Community Oriented Policing Services, 2007).

18. Law enforcement agencies may want to partner with a local college or university to assist with identifying what data to collect. Academic partners should be included from the beginning of the planning stages to provide guidance during this step.

Question 2: *What data collection strategies will be used?*

Many existing data sources—such as CAD data, Emergency Medical Services (EMS) logs, and Emergency Room records—can provide useful information. These data systems typically were designed, however, to capture information for purposes other than law enforcement/mental health program improvement or evaluation. As a result, specialized law enforcement-based programs almost always require collecting new information, and often from different sources or in novel ways.

> *"Every time there is a CIT encounter, there is a stat sheet completed. This is a police department document, which can be shared internally and also with mental health partners. These sheets are used to identify problems so we can address them."*
>
> **—Dr. Mark Munetz**
> Chief Clinical Officer, Summit County (Ohio) Alcohol, Drug Addiction and Mental Health Services Board

Collecting the necessary information has proven difficult for many agencies. Each of the four agencies featured in this report had varying levels of success capturing data consistently from both law enforcement officers and mental health providers. The two major limitations are 1) inconsistency in call identification and 2) paperwork noncompliance. Most agencies do not have a reliable method to label calls for service involving people with mental illnesses at the time of dispatch, nor an ability to update the codes in the CAD system retroactively to reflect new information relating to mental health status.[19] In terms of noncompliance with record-keeping or reporting practices, law enforcement officers have an enormous amount of paperwork to complete for all incidents, particularly those involving serious crimes or arrests, and may feel that the time needed to complete an additional form is in conflict with their other policing duties. Both of these factors can result in missing or incomplete data in law enforcement systems. Mental health providers may also experience problems with trying to maintain updated, accurate information in their systems given their often overwhelming caseloads. Departments must be creative and persistent in overcoming these challenges.

PROGRAM EXAMPLE: Addressing barriers to data collection, Philadelphia (Pa.)

In 2006, Philadelphia received a Justice and Mental Health Collaboration Program (JMHCP) grant from the Bureau of Justice Assistance. Initiative leaders decided to use this funding to plan and implement a CIT program in the Philadelphia Police Department—pilot-testing the program in a single division and addressing any challenges before expanding it department-wide.

According to coalition members, one of the main difficulties the planners faced was obtaining information directly from the CIT officers about their encounters with people with mental illnesses. In response, they decided to change their data-reporting system from a paper-based system to a call-in system. At this writing, officers call the CIT coordinator to complete the necessary form by phone, and then the coordinator collects and files the reports.

For more information about Philadelphia's program, see the program entry in the Local Programs Database available at www.consensusproject.org.

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19. The majority of police action related to people with mental illnesses in the four sites studied was based on responding to calls for service rather than incidents observed during the course of routine patrol.

Step 4:

Detail jurisdictional characteristics and their influence on program responses

For this discussion, "jurisdictional characteristics" refers to those aspects of a community that are difficult to change, often requiring long-term efforts. Based on information gathered during the site visits, project staff found these characteristics fall into four categories relating to 1) the law enforcement agency, 2) the mental health system, 3) state laws, and 4) geography and demography. Each of these categories should be considered when designing a program.

Question 1: What characteristics of the law enforcement agency are relevant in planning a specialized response to people with mental illnesses?

The planning group and stakeholders should consider the following during the design stage:

- **Agency resources**, which include staffing levels, data management structures, training expertise and capacity, and availability of less-lethal technologies.
- **Relevant policies and regulations**, such as use-of-force guidelines, discretion in making arrests, policies on diversion, reporting requirements, information-sharing policies, and requirements for handcuffing during custodial transport.
- **Leadership styles**, which may dictate the number of officers a program seeks to train, either focusing on a small self-selecting group or providing training to an entire department. Some law enforcement executives believe a subset of officers must become "specialists" who are dedicated to particular areas of expertise (such as domestic violence) because the additional information they obtain will help them respond to those situations more effectively. Other chiefs or agency executives believe all officers should be prepared to respond to all situations they will encounter. Leadership must believe there is a compelling need to prioritize limited resources to address this issue. And they must be willing to designate someone within the agency to help provide oversight and support to the effort, to work collaboratively with the mental health community, and to garner support among policymakers to ensure sustainability. The agency should have leaders who are willing to even reconsider officer evaluation criteria that is

> *"I talk about the three Cs of program success: compassion, constitutionality, and consistency. Compassion is brought by people who want to be [in a specialized assignment]. Constitutionality and consistency are greatly enhanced when the department provides resources."*
>
> **—Chief William Bratton**
> Los Angeles (Calif.) Police Department

> *"Working on the CIT Outreach Team provides great satisfaction, but it should remain voluntary—it requires a certain kind of officer who is internally motivated."*
>
> **—Officer Forrest Kappler**
> CIT Officer, Akron (Ohio) Police Department

more in keeping with community policing principles—in which officers are reviewed for their problem-solving and de-escalation skills instead of the number of arrests they make.

***Question 2:** What mental health system characteristics are relevant in planning a specialized response to people with mental illnesses?*

As part of the program design process, stakeholders should catalog available mental health resources in the community, identify the criteria for or any restrictions to accessing them, and describe their capacity and availability. For example, if there are no twenty-four-hour facilities to receive people with mental illnesses except emergency rooms, and officers are required to wait hours with the individual to be seen, alternatives can be explored. And if facilities will only accept individuals who meet specific eligibility criteria, such as only individuals not under the influence of drugs or alcohol, it becomes clear that other options must be indentified to support officers when they encounter these individuals.

The planning group and relevant stakeholders should then identify service gaps. Community mental health resources might include emergency departments, inpatient and outpatient treatment programs, crisis response services, emergency receiving centers, family support programs, telephone hotlines, clubhouses and other peer-to-peer supports, and ancillary services such as housing assistance and income and entitlement support.[20] Throughout this review, the planning group should work with policymakers and other key groups to examine the structure of the mental health system and understand variations in catchment areas (municipal vs. county) and revenue sources (private vs. public). These variations may affect law enforcement responses by impacting where officers can transport a person in crisis.

Beyond identifying available mental health resources, stakeholders should become familiar with the avenues available to law enforcement officers to access these services (whether in person, by telephone, or through a referral mechanism), understand the requirements for medical clearance, and clarify existing protocols or procedures for voluntary and involuntary admissions for mental health evaluations and assessments.

***Question 3:** What state laws are relevant in planning a specialized response to people with mental illnesses?*

State laws can address a range of issues relating to the law enforcement response. For example, they can mandate law enforcement training and dictate the criteria that must be met and the protocols that must be followed for an emergency mental health evaluation. Local law enforcement officers can play a critical role in this process. In Nebraska, for

20. According to the International Association of Clubhouse Development, a clubhouse is "a community intentionally organized to support individuals living with the effects of mental illness. Through participation in a clubhouse people are given the opportunities to rejoin the worlds of friendships, family, important work, employment, education, and to access the services and supports they may individually need." More information is available at www.iccd.org.

example, a sworn law enforcement officer is required to determine if a person meets the criteria for involuntary emergency evaluation, to maintain custody of the person, and to transport the person to the mental health receiving facility. In other states, a magistrate or clinician might be required to make the commitment determination. States may have outpatient commitment laws that can be enforced prior to consumers becoming dangerous to themselves or others. Consumers may develop advance directives that provide instructions for how they wish to be treated if they decompensate. These mandates and regulations can present both an opportunity and a burden on law enforcement officers, and should be considered fully by planners.

Question 4: *What demographic and geographic community characteristics are relevant in planning a specialized response to people with mental illnesses?*

A jurisdiction's population, population density, land area, and crime patterns can present important constraints or benefits to developing specialized response programs. For example, a jurisdiction whose only emergency mental health resources are located far from particular law enforcement beats or districts will require officers to spend long periods out of service transporting individuals, particularly if they have to pass through densely populated, traffic-congested areas. Rural and urban areas may have very different problems that will affect dispatch and response times. Some rural areas may be dependent on only phone access to mental health professionals who can direct emergency evaluations. Further, an area that is populated primarily by seniors may have very different needs than those that are generally young families with children, or that have a large number of homeless individuals. Although jurisdictions of every size can struggle with inadequate resources (especially when budget cuts directly impact state and community mental health services), these considerations should be addressed carefully when shaping a law enforcement initiative.

Step 5:
Establish response protocols

At this stage of design, the planning group will understand how law enforcement, mental health, and other community-based providers are currently responding to people with mental illnesses who are at risk of criminal justice involvement. Based on the community's characteristics, it should be possible to see how these can be better integrated and shaped to address identified problem areas and service gaps. Program development decisions at this point in the process should focus on which law enforcement and mental health responses are needed, both individually and collectively, and what resources are needed to support them.

Question 1: *What law enforcement responses are necessary?*

There are three main categories of law enforcement first-responder activities that require consideration and planning—call-taker and dispatcher protocols; on-scene activities

(stabilization, observation, and disposition); and transportation and custodial transfer.[21] Planners must decide which personnel will serve as primary responders to scenes involving a person in a mental health crisis, and how they will be dispatched. Based on the review of the law enforcement/mental health problems and community characteristics, they may choose to train a subset of officers for this responsibility, train all officers, or pair officers with mental health clinicians or caseworkers. In addition to these activities, planners may also choose to involve law enforcement officers in follow-up activities not generated by a call for service.

> *"There are immeasurable benefits to officers who travel with mental health professionals on the SMART teams both for the officers and the clinicians in terms of information exchange and awareness."*
>
> **—Commander Harlan Ward**
> Assistant Commanding Officer of Valley Bureau, Los Angeles (Calif.) Police Department

Question 2: *What mental health system responses are necessary?*

Mental health personnel may be involved in a variety of ways, including providing information to dispatchers, co-responding to calls for service involving a person with mental illness, acting as a remote resource if no on-scene professional can be available, helping to train or cross-train personnel, and coordinating a follow-up effort, particularly with people

Essential Elements 4–6

Essential Element 4—Call-Taker and Dispatcher Protocols
Call takers and dispatchers identify critical information to direct calls to the appropriate responders, inform the law enforcement response, and record this information for analysis and as a reference for future calls for service.

Essential Element 5—Stabilization, Observation, and Disposition
Specialized law enforcement responders de-escalate and observe the nature of incidents in which mental illness may be a factor using tactics focused on safety. Drawing on their understanding and knowledge of relevant laws and available resources, officers then determine the appropriate disposition.

Essential Element 6—Transportation and Custodial Transfer
Law enforcement responders transport and transfer custody of the person with a mental illness in a safe and sensitive manner that supports the individual's efficient access to mental health services and the officers' timely return to duty.

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21. Each of these three categories represents one of the ten elements in *The Essential Elements of a Specialized Law Enforcement-Based Response*. For more information, see http://consensusproject.org/jc_publications/le-essentialelements.pdf.

identified as high utilizers of emergency mental health services. Collaboration for certain activities may be best achieved through co-location of law enforcement and mental health coordinators or such mechanisms as merged or integrated databases that are consistent with privacy laws.

As the Justice Center's *Essential Elements* publication indicates, individuals with mental illnesses often require an array of services and supports, which can include medications, counseling, substance abuse treatment, income supports and government entitlements, housing, crisis services, peer supports, case management, and inpatient treatment. Planners of the SPR program should anticipate the treatment needs of the individuals with whom law enforcement will come in contact and work with service providers in the community to ensure these needs can be met and coordinated.

> *"We need to create drop-off stations at the hospital to receive people in crisis. This requires not only trained law enforcement staff, but also an appropriate space—a space where we can safely manage the behavior of people who are out of control."*
>
> **—Marie Moon Painter**
> Clinical Team Leader for CONNECT, Carilion St. Albans Behavioral Health, Virginia

Because many individuals with mental illnesses who come into contact with law enforcement have co-occurring substance use disorders, the availability of integrated treatment approaches is essential to achieve clinical and public safety objectives. Accordingly, stakeholders should consider how the program can help connect individuals with co-occurring disorders to integrated treatment and should advocate for greater access to this and other evidence-based practices.[22] Histories of trauma and post-traumatic stress disorder are common in criminal justice-involved populations. As such, both the on-scene response of law enforcement and subsequent clinical responses must be trauma-informed. Planners should pay special attention to the service needs of racial and ethnic minorities and women by making culturally competent and gender-sensitive services available to the extent possible.

Stakeholders should also identify ways to improve the efficiency of access to needed services. This may entail broader system changes and agreements, such as streamlining the custody transfer process at a mental health intake facility through memoranda of agreement (MOAs) and revised protocols. Law enforcement should have within easy reach twenty-four-hour drop-off facilities or emergency room(s) designated to expedite the transfer of custody to ensure the individual receives swift mental health services and allow officers to return quickly to duty.[23]

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22. Evidence-based practices (EBPs) are mental health service interventions for which consistent scientific evidence demonstrates their ability to improve consumer outcomes. R.E. Drake, H.H. Goldman, H.S. Leff, A.F. Lehman, L. Dixon, K.T. Mueser, and W.C. Torrey, "Implementing Evidence-Based Practices in Routine Mental Health Service Settings," *Psychiatric Services* 52 (2001): 179–82. Other EBPs include assertive community treatment, psychotropic medications, supported employment, family psychoeducation, and illness self-management, see Fred C. Osher and Henry J. Steadman: "Adapting Evidence-Based Practices for Persons with Mental Illness Involved with the Criminal Justice System," *Psychiatric Services* 11 (2007), 1472–78.

23. For more information about the role of specialized crisis response sites, see Henry J. Steadman, Kristin A. Stainbrook, Patricia Griffin, Jeffrey Draine, Randy Dupont, and Cathy Horey. "A Specialized Crisis Response Site as a Core Element of Police-Based Diversion Programs," *Psychiatric Services* 52 (2001): 219–22.

Question 3: *What other responses or resources are necessary?*

While law enforcement agencies and mental health professionals can provide the majority of responses that the planners will prioritize, other partner organizations and their resources may be required to address the problem faced by the community. For example, consumer- or advocate-led organizations, such as clubhouses, can provide essential support to people in crisis and supplement limited mental health resources. Non-law enforcement criminal justice professionals, such as judges, magistrates, and jail personnel, can play an important role in identifying and assessing individuals who may be in need of emergency mental health evaluations.

The planning committee also should identify the availability of community and government resources that focus on critical issues that disproportionately tend to affect people with mental illnesses (such as housing, employment, education, substance abuse treatment, and veterans' services). An assessment of their accessibility in the community should be part of the planning process.

SPOTLIGHT

Systemwide Solutions

The 2002 landmark *Consensus Project Report*—written by Justice Center staff and representatives of 100 leading criminal justice and mental health policymakers, practitioners, and advocates from across the country—provides policy guidelines and practical recommendations for improving the criminal justice system's response to people with mental illnesses. The policy statements and recommendations span the entire criminal justice continuum, from the law enforcement encounter, through court involvement and incarceration, to the individual's reentry into the community. The success of recommended efforts is dependent on collaboration and partnership among the full range of criminal justice agencies and their community partners. It recognizes that law enforcement, courts, or corrections officials' actions have ramifications for the rest of the criminal justice system.

This interconnectedness highlights the value of creating a systemwide commitment to change, in which reforms at each point of contact between the individual with mental illness and a different criminal justice agency are woven together. There is a wide variety of program models that focus on a different point of intercept in the criminal justice system, including the following:

- **Law enforcement specialized responses,** which use specially trained law enforcement officers to de-escalate incidents involving people with mental illnesses and divert them to services when appropriate.
- **Mental health courts,** which are specialized dockets that link defendants with mental illnesses to court-supervised, community-based treatment in lieu of traditional case processing when warranted.
- **Post-booking jail diversion programs,** which screen and assess people with mental illnesses in the jail, and divert them to community-based services when suitable.
- **Specialized probation caseloads,** which integrate community corrections supervision strategies with community-based mental health treatment and services through a variety of methods.

For more information on the Consensus Project report and the many program models, see www.consensusproject.org.

Step 6:

Determine training requirements

Once planners determine which types of responses are best suited to their local needs and resources (such as a specially trained unit, co-responder model for a subset of officers, or all officers who respond with special unit backup), the group can begin developing a training curriculum and schedules. Both law enforcement and mental health agencies or providers will have concerns about their ability to afford and prepare quality training, including how to address such issues as compensation for trainers, continued education accreditation, and covering shifts for officers in training or fitting it into already packed recruit training schedules. These concerns need to be factored into decisions about how many and how often first-responders are trained.

Question 1: How much training will be provided and to which law enforcement personnel?

How much training is not only a question of hours spent in the classroom, but also of the number of officers trained and of how often training is held. Many agencies with specialized law enforcement-based response programs require that 20 percent of the department's officers receive forty hours of training.[24] However, there are other approaches that planners can consider, including increased training on mental health issues for recruits or ongoing education requirements for all officers. Dispatchers and call takers will also require training on the program model, to help them identify calls for service that may involve a person with mental illness and then to dispatch the correct personnel to the scene. They may also be able to ask questions that can help officers who arrive at the scene, and to collect information about

> *"Some law enforcement agencies only send officer volunteers to attend the training, while others send all officers. There are always some officers at the training who don't want to be there. After a day or two, though, even reluctant officers understand that this program is about officer safety."*
>
> **—Patrick Halpern**
> Executive Director, Mental Health Association of the New River Valley, Inc., Virginia

Essential Element 3

Specialized Training

All law enforcement personnel who respond to incidents in which an individual's mental illness appears to be a factor receive training to prepare for these encounters; those in specialized assignments receive more comprehensive training. Dispatchers, call takers, and other individuals in a support role receive training tailored to their needs.[25]

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24. The CIT Center at the University of Memphis has released the "Crisis Intervention Team Core Elements" (available at http://cit.memphis.edu/CoreElements.pdf), which outlines their suggestions for length of training (forty hours) and the number of officers trained within an agency's patrol division (20 to 25 percent). The guide provides detailed information about the Memphis CIT Model.

25. To learn more, download *Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training* from www.consensusproject.org/issue_areas/law-enforcement.

the disposition of calls involving people with mental illnesses to help administrators determine the number and effectiveness of specialized responses.

Question 2: *What topics should training cover?*

Training curricula should be geared toward the particular law enforcement personnel (line-level, special teams, dispatchers) and include information specific to the jurisdiction (for example, state commitment laws and local resources). Although there is no single curriculum that will address the needs of all jurisdictions, several training topics form the foundation of a comprehensive training program. These include understanding mental illness, statutory authorities governing law enforcement responses, the law enforcement response to calls for service, community policing/problem solving, and use of force.[26] The training is not intended to turn law enforcement officers into diagnosticians, but rather to train them to look for behaviors associated with mental illnesses and determine the best way to address those behaviors. Specific skills training may include a combination of verbal de-escalation techniques and suicide prevention methods.

> *"Because of the limitations posed by our jurisdiction's size, in addition to forty hours of training for officers on our special teams, we decided to provide twenty-four hours of online training to all of our officers on mental health de-escalation techniques."*
>
> **—Commander Harlan Ward**
> Assistant Commanding Officer of Valley Bureau, Los Angeles (Calif.) Police Department

> *"It is important to provide training to all officers on encounters with people with mental illnesses, and e-learning has an important place in the picture."*
>
> **—Mark Gale**
> Member, Board of Directors, NAMI–California

Question 3: *Who will provide the training?*

Training for law enforcement officers on effective responses to people with mental illnesses must draw on a diverse range of expertise and perspectives to cover a broad range of topics, from recognizing signs of mental illness to understanding the state's emergency evaluation laws. Many of these topics may be better taught by experts from disciplines other than law enforcement. For example, signs of mental illnesses may be taught by a psychiatrist or mental health clinician, whereas de-escalation techniques may be best taught by a seasoned law enforcement officer who can provide real-life examples. Consumers and family members can provide a face and a voice for people struggling with mental illnesses, and they are uniquely qualified to promote a compassionate response from officers who often see people with mental illnesses only when these individuals are in crisis. Training coordinators might not know who would be a good fit to teach all modules, so it is important that coordinators reach out to community partners to collaborate on identifying trainers or facilitators.[27]

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26. This list is drawn from *Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training*, "Appendix B: Suggested Training Topics," page 41.

27. For more information on how to identify trainers, see "Chapter 1: Identifying Trainers" on page 8 of *Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training*.

Question 4: *What training strategies will be employed?*

Effective training strategies are critical to a specialized law enforcement-based program. These strategies may include short lectures that focus on behaviors and plain language rather than diagnoses and medical terms; site visits to some of the mental health facilities where they will do custodial transfers or refer individuals for treatment or support; role plays to engage officers in real-life interactions that can be acted out and corrected in a safe environment; and question-and-answer sessions to prompt officers to consider and discuss their own experiences, preconceptions, and concerns. Traditional classroom-style training is invaluable, but as a supplement, many agencies have started to develop e-learning platforms to engage personnel who work nontraditional hours and to increase access to specialized training topics.[28]

> *"We trimmed the forty-hour training curriculum by determining what course content the officers really needed. We had a four and one-half-hour block on psychopharmacology, and while it is important to understand what these drugs are, the reason the police officer is there is because the person is NOT taking their medications. We now tell officers what these medications are, what they do, and give them a card to refer to."*
>
> **—Dr. Luann Pannell**
> Director of Police Training and Education, Los Angeles (Calif.) Police Department

Step 7:

Prepare for program evaluation

It is not enough to simply identify what information will be collected (as outlined in Step 3) to ensure effective evaluations will be conducted. It is important for planners to prepare for a program evaluation as part of the design process. As previously mentioned, the program evaluation should contain both a process assessment as well as an assessment of outcomes. This evaluation will be needed to make revisions to the activities that may be experiencing difficulties and to enhance those that are effective, as well as to provide proof of the program's success to foster sustainability.

Question 1: *What resources need to be set aside or identified for an evaluation?*

A thorough program evaluation will require the allocation of resources to analyze the data collected. Agencies with planning and research divisions may want to identify department staff and allocate a percent of their time during the program design phase to coordinate or conduct these evaluations. Agencies without research capacity may benefit from outside assistance in aggregating, deciphering, and interpreting the data to determine program effectiveness. Because of the challenges associated with data collection, as well as the difficulties in analyzing often incomplete data, many law enforcement agencies partner with a local college or university to assist with this process. Academic partners may require compensation for which law enforcement agencies may need to find sources of support,

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28. For more information on training strategies, see "Chapter 2: Effective Training Techniques" on page 22 of *Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training*.

including submitting joint grant proposals. If the department chooses to engage an external research partner, these outside teams will need to work closely with law enforcement and their collaborators during the evaluation process, and this staff time commitment should be considered at the planning stage.

Question 2: *Are there individuals designated to oversee the evaluation?*

Law enforcement agencies should designate a staff person who will work with a subcommittee on evaluation issues. In addition to helping to ensure that all agencies that are contributing data are using sound and accurate collection and reporting practices, this group can determine how the evaluation results will be used, how they will be disseminated, and who should be brought to the table during the evaluation process to review interim reports and the interpretations of the data.

Conclusion

The seven steps to program design summarized in this section may seem straightforward. They are not. Law enforcement agencies and their community partners are struggling to navigate the many issues that are involved in making the proper decisions at each stage in the process. And as new information is made available, it is necessary to revisit previous steps. To fully grasp the challenges in following these design steps, policymakers and planners interested in exploring a specialized policing response to people with mental illnesses must operate within a framework defined by two complex forces—the nature of the problem and the jurisdiction's distinct characteristics.

Though the *problem* frequently relates to safety concerns and strains on police resources that do not result in good outcomes for law enforcement, the individual, or the community, jurisdictions may find that data and discussions lead them to other issues or sub-issues that need particular attention. Crafting the solutions to these problems—including changes to law enforcement training, policies, and procedures—cannot be shaped in a vacuum. Training officers on diversion and other strategies, for example, will be ineffective if mental health resources in the community are not available or lack the capacity to support increased referrals and placements. Accordingly, jurisdictions will be limited by the resources they have or believe they can create or expand.

The following section explores how various problems and community characteristics have shaped responses in the agencies studied and how other jurisdictions might expect these factors to influence their own program design and enhancements.

Section II

From the Field: Program Design in Action

This section provides practical advice on how to consider common problems as experienced by the four sites studied. It also considers various law enforcement, mental health, and other community characteristics, and their relative impact on program design. Examples from the field are included to illustrate how these problems and characteristics are reflected in program implementation.

> *If you want it to be collaborative, you need to be flexible and adapt this program to your local community."*
> **—Sgt. Michael Yohe**
> CIT Coordinator, Akron (Ohio) Police Department

Tailoring Specialized Policing Response Programs to Specific Problems[29]

The three most commonly encountered problems found in the four communities studied were unsafe encounters, frequent arrests of people with mental illnesses and the strains on law enforcement resources, and high utilization of emergency services. It is important to note that this separation of problems into distinct categories is somewhat artificial, as they often overlap and relate to one another. Other communities may find their data lead them to identify different problems beyond these three types. The chart that follows provides an overview of how the four sites tailored their responses to their community's problems.

> *CIT is a godsend. The community of people with mental illnesses was getting badly treated and CIT has been an undisputed success. There are very few situations where the response is poor."*
> **—Tom**
> Consumer, Carriage House (Fort Wayne, Ind.)

> *It may well take a tragedy to mobilize the resources…."*
> **—Assistant Chief Jim McDonnell**
> 1st Assistant Chief, Chief of Staff, Los Angeles (Calif.) Police Department

> *I feel that CIT changed our understanding of what the police officers are capable of doing with de-escalation and compassion."*
> **—Jim Randall**
> President, NAMI–San Fernando Valley (Calif.)

29. Cordner's guide, "People with Mental Illness," outlines a variety of response strategies that decision-makers can consider when choosing how to best respond to the problem they are facing in their local community. These response strategies are also summarized in a table that presents the response type, how it works, when it works, and additional considerations to take into account.

The Impact of Problem Type on SPR Programs[30]

Problem Type	Jurisdictions	SPR Program Activities
Unsafe Encounters	Los Angeles, Calif. Akron, Ohio Fort Wayne, Ind. New River Valley, Va.	Officers trained on mental health issues respond to the scene when dispatched. (In the LAPD, a call can also be triaged to dispatch a special co-response unit. See box below.) Related issues are addressed during training for officers on mental health topics. Training is provided for dispatchers.
Frequent Arrests and Strains on Police Resources	Los Angeles, Calif.	Co-responder teams are dispatched to the scene when requested by a first-responder. Crisis mental health clinicians also respond to the scene. Additional dispatch capability is used to "triage" incidents requiring the co-response team.
	Akron, Ohio Fort Wayne, Ind. New River Valley, Va.	Related issues are addressed within the forty hours of training for officers. Emergency psychiatric facilities streamline intake procedures for law enforcement.
High Utilization of Emergency Resources	Los Angeles, Calif. Akron, Ohio	Follow-up teams of law enforcement personnel and mental health clinicians work on case management for referred cases, including cases brought to their attention by involved stakeholders.

> "*Relatives of consumers are now less reluctant to involve the police because family members realize that a compassionate officer will respond to the call. Consequently, families do not wait until the situation has escalated, and officers now respond to less threatening calls. This allows them to intervene at an earlier point. No CIT officer has been injured when responding to a person with mental illness.*"
>
> **—Lieutenant Mike Woody (ret.)**
> Law Enforcement Liaison, Ohio Criminal Justice Coordinating Center of Excellence

30. Many of the "SPR Program Activities" listed here address more than one problem. In practice, these responses often straddle the goals of improving safety, reducing frequent calls for service, and decreasing the use of emergency resources.

Problem: *Unsafe outcomes of encounters between law enforcement and people with mental illnesses*

When communities experience a tragedy related to a law enforcement encounter involving a person with mental illness, there is often a flurry of activity to determine what factors contributed to that outcome and to ensure it will not happen again. Several factors seem to affect safety at the scene. Many community members interviewed for this project noted that when consumers have had previous negative encounters with law enforcement, they become fearful and distrusting during subsequent interactions. A person's fear can then be exacerbated by the officer's uniform and an authoritarian approach. Even individuals in crisis with no previous contact with officers may have extreme reactions to being crowded or subjected to officers' commands.

Community members interviewed also recognized that traditionally trained law enforcement officers often lack information about mental illnesses, particularly information about strategies to calm crisis behavior and avoid use of force. Without adequate training, officers may also be fearful of individuals with mental illness and may misperceive them as more dangerous, affecting officer posturing and reactions. It is important to recognize that much of an officers' academy training is oriented toward taking control of a situation and resolving it as quickly as possible—which may run counter to specialized response strategies. These factors, together with dynamics such as the level of access to mental health supports, guidelines on less-lethal weaponry and tactics, and whether the individual is taking medications or is abusing drugs or alcohol, can all contribute to concerns about the safety of all those involved in these encounters.

Tailored Responses

Based on the sites visited and related project research, programs designed to respond to safety concerns during these encounters were found to be aimed primarily at officer education and quick, on-scene de-escalation of crisis behavior. Other responses include the training on and use of less-lethal weapons, helping call takers and dispatchers get the best possible information to the

> *"One of the largest complaints by NAMI and other advocates was the lack of understanding by the officers of how to communicate with people with mental illnesses."*
>
> **—Commander Harlan Ward**
> Assistant Commanding Officer of Valley Bureau, Los Angeles (Calif.) Police Department

> *"There are times when the police must run from call to call. But there will come a time when an officer's compassion will be necessary to resolve a situation, and the officer will need to step up and come through."*
>
> **—Bernie**
> Mental Health Consumer (Akron, Ohio)

> *"Injury on the job could lead to job loss—therefore, any opportunity to learn additional officer safety techniques is a plus."*
>
> **—Officer Lori Natko**
> CIT Officer, Akron (Ohio) Police Department

> *"CIT provides the opportunity to really sit and listen more than talk. Usually we just tell people what we are going to do. I plan to try to volunteer for as long as I can—I see different things all the time."*
>
> **—Officer Mark Bieker**
> CIT Officer, Fort Wayne (Ind.) Police Department

Akron Tailors Response to Safety Concerns and Repeat Calls for Law Enforcement and Mental Health Services*

Quick Facts

Government type: Municipal	**Number of sworn personnel in 2006:** 451
Jurisdiction type: Urban	**Number of civilian personnel in 2006:** 43
Population in 2007: 207,934 (estimate)	**Program name:** Crisis Intervention Team (CIT)
Area of Akron in square miles: 62.4	**Program start date:** 2000

Overview

The Akron (Ohio) Crisis Intervention Team (CIT) was one of the first agencies to replicate the Memphis CIT Model. Although this community maintains fidelity to the model, they have made several adjustments to the core elements. For example, CIT Officers in Akron have access to four emergency resources, rather than the single point of entry available in Memphis. This adaptation was made to ease the burden on any single mental health facility. Akron has also modified the CIT training to include a segment about being a CIT officer, including safety issues, duties, and officers' experiences.

Tailored Responses

Once CIT was implemented, Akron stakeholders determined the need for a supplemental program to address the needs of their "at-risk" population—those individuals who are repeat clients of both the criminal justice and mental health systems and who often fall through the systems' cracks. The "CIT Outreach Program" consists of a group of officers who team up with an outreach worker from Community Support Services (CSS). Officers in uniform ride together with a CSS worker in a marked cruiser to contact referrals and attempt to engage people in services. Akron reported that pairing a law enforcement officer with a case worker to conduct follow-up can also facilitate information sharing, locating individuals, and increasing the safety of encounters.

Outreach teams can refer individuals to mental health and other services, such as elder care and drug addiction services. When the team encounters someone who does not qualify for an involuntary commitment order, they are often able to persuade the person to voluntarily go to CSS, where they are welcomed in the back door with dignity and discretion.

Unique Program Features

The CIT program coordinator in Akron maintains his patrol duties, which lends credibility to the program and assists in soliciting officer involvement. When the outreach team transports an individual in a marked cruiser, he or she rides without handcuffs in the back seat with the mental health case manager. The person may meet criteria for emergency mental health evaluation, but the officer allows the person to ride without handcuffs when the situation is under control. If the person is at risk of harming him- or herself or others, or attempts to leave, the police will then use handcuffs and transport as needed.

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* Dates and figures in this sidebar are consistent with the most recent information available at the time of this writing.

Fort Wayne Tailors Response to Safety Concerns and Problems in Schools*

Quick Facts

Government type: Municipal	**Number of sworn personnel 2006:** 435
Jurisdiction type: Urban	**Number of civilian personnel 2006:** 100
Population in 2007: 251,247 (estimate)	**Program name:** Crisis Intervention Team (CIT)
Area of Fort Wayne in square miles: 79.12	**Program start date:** 2001

Overview

Fort Wayne (Ind.) operates a traditional CIT program. Law enforcement plays a primary role in the program, but it is also shaped by mental health consumers, available resources, and a strong NAMI presence. Fort Wayne made several adjustments to the traditional CIT model. CIT officers in Fort Wayne have access to two hospitals and a transitional care center, where Memphis has only a single point of entry to mental health emergency services. This change broadens the range of services available to CIT officers, and the hospital and transitional care center staffs assist in transporting consumers to the hospital where they may have received services in the past. Fort Wayne also added training topics on problems of concern that were not required in the Memphis curriculum, such as a unit on autism.

Tailored Responses

After implementation of the CIT program, Fort Wayne identified several problem behaviors among middle and high school students. In some cases, self-mutilating behavior was detected, and in other cases, schools were struggling to manage the behavior of "bad kids." Their only options at that time were to expel these students or have police arrest them for such acts as vandalism.

To address these school problems, CIT program planners began providing CIT training to all of the School Resource Officers (SROs). In addition, a CIT-trained officer has helped identify high school students who might benefit from mental health services. This officer's training enabled him to recognize that some students were not simply acting out, but may have serious mental health problems. On more than one occasion, this officer used his training to gain a student's trust, so the student could talk openly about what was happening in his or her life and get help.

Unique Program Features

Fort Wayne is fortunate to have the extensive involvement of a judge who reviews all civil commitment hearings and participates in officer training. Their program also uses a "stat sheet" to collect information on the number of calls the police get, how many are diverted at the scene, how many are brought to the hospital for twenty-four-hour observation, and how many are kept for seventy-two-hour holds. The form also collects data on the presence of weapons and whether the case involved a suicide attempt. This stat sheet then follows the consumer through the mental health system. If he or she is brought to the emergency room and a need for detention is identified, the stat sheet becomes the "face sheet" for the seventy-two-hour hold and is faxed to the judge for review. All face sheets are retained in the police department's records, are analyzed on a monthly basis to track program responses, and are reviewed by the Judge and CIT Sergeant for accuracy. Summary data are shared appropriately to keep all stakeholders routinely informed about program progress.

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* Dates and figures in this sidebar are consistent with the most recent information available at the time of this writing.

officers suited to address the situation, developing means for capturing information that will improve safety for repeat calls for service, and involving a secondary mental health response.

Programs that respond to safety concerns emphasize specialized training on policies and practices designed to help law enforcement officers take adequate time and steps to identify the signs and symptoms of mental illnesses. These programs reflect the understanding that these behaviors may be the result of an illness, draw on effective communication and behavioral strategies, and familiarize officers with less-lethal force options. Training includes the opportunity for role-play scenarios that enable officers to practice and hone their skills in addressing "real-world" crises before applying them in the field. These skills include those involved in maintaining the safety of all involved and determining whether the person meets the criteria for emergency mental health evaluation. Specially trained law enforcement officers apply their new skills in the field to determine if the situation involves a person who may have a mental illness. If it does, officers are trained to de-escalate the person's behavior and to connect him or her to treatment when appropriate. When safety concerns involve educational institutions, additional personnel may receive specialized training. In Fort Wayne, for example, the department requires that all school resource officers (SROs) attend CIT training.

Specialized training for call takers and dispatchers is critical to officer and consumer safety. This training provides tools for call takers to identify calls that may involve a person with a mental illness, gather important information about the situation from the caller (for example, when possible, the person's previous reactions to law enforcement, the person's medication status, any history of violence) and provide that information to responding officers. Dispatchers follow specific protocols to help ensure that specially trained officers respond quickly to incidents they believe may involve a person with a mental illness.

Call takers clear calls and make notations in the CAD system about the involvement of weapons or violence to enhance safety should this location draw future calls for service. For example, in Akron, dispatchers

> *"The police response has become seamless and is totally accepted. Consumers even call police themselves now, which would not have happened prior to CIT."*
>
> **—Jane Novak**
> Member, NAMI-Indiana

> *"Our dispatchers are trained in verbal de-escalation and can sometimes avoid dispatching the police by talking down the individual on the phone."*
>
> **—Lorie Witchey**
> Dispatcher, Akron (Ohio) Police Department

> *"I was a practicing public defender for ten years and saw how many clients had real issues with mental health and co-occurring substance use disorders. I knew these people would benefit from treatment and should not be in jail. Once they were in jail, they got stuck there."*
>
> **—Victoria Cochran**
> Chair, State Mental Health, Mental Retardation and Substance Abuse Services Board

> *"Don't let anyone tell you we did not have a problem with arresting people who were mentally ill. Our people didn't realize they had a mental illness and we were putting them in jail when they were sick."*
>
> **—Officer Danny Ratcliffe**
> CIT Officer, Pearisburg (Va.) Police Department (NRV)

review incident reports and flag locations relating to a person with mental illness, focusing on the presence of a weapon or specific strategies that may have proven successful in de-escalating an encounter with the subject of the call for service. This information can be used to improve the dispatching and response of officers for any future calls to that location.

When tailoring a response program to safety concerns, the interviewed sites only included on-scene mental health experts as a secondary response. For example, in the agencies studied, a mental health professional might come to the scene, but only after the

> *"People were going to jail when they should not have. If you are mentally ill, jail is not the solution."*
>
> —**Amy Tyler**
> Director of Behavioral Health,
> St. Joseph Hospital (Fort Wayne, Ind.)

New River Valley Tailors Response to Safety Concerns in Rural and Small Communities*

Quick Facts†

Government type: County, Municipal
Jurisdiction type: Rural, multi-jurisdictional
Population in 2007: 172,255 (estimate)
Area of New River Valley in square miles: 1,469 (estimate)
Program name: New River Valley Crisis Intervention Team
Program start date: 2002

Overview

In response to growing concerns about the number of people with mental illnesses in the criminal justice system, program planners in New River Valley, Va., developed a multi-jurisdictional CIT that involves fourteen different law enforcement agencies within four counties and one city in a largely rural area. These agencies have found it difficult to implement state mandates that people with mental illnesses who qualify for emergency assessment must remain in the custody of law enforcement officers until an emergency service clinician can complete the assessment, and if necessary arrange for mental health services. Prior to the site visit, law enforcement custody could last up to four hours and individuals could not be placed in jail. (Legislation in 2008 increased the mandatory custody up to six hours to provide sufficient time for the provision of medical clearance.) Mental health resources are limited and the rural nature of the community requires emergency service clinicians and law enforcement officers to travel long distances to conduct assessments and then transport individuals to available inpatient facilities. The Mental Health Association (MHA) in Blacksburg, Va., funds a CIT coordinator, whose responsibilities include arranging for CIT training.

continued on next page

* Dates and figures in this sidebar are consistent with the most recent information available at the time of this writing.

† Population and area figures of the New River Valley are aggregate numbers for the jurisdictions that make up the "valley:" Montgomery County, Pulaski County, Floyd County, Giles County, and the independent City of Radford. Given the multi-jurisdictional structure of the region, data were not available on the number of law enforcement personnel.

New River Valley continued

Tailored Responses

The New River Valley CIT brought together fourteen jurisdictions that all fell within one of Virginia's mental health catchment areas. The goal of bringing the smaller, rural communities together was to capitalize on shared resources. For example, agencies created agreements to allow officers to cross jurisdictions and serve each other's residents, and developed a plan to provide CIT training to approximately 25 percent of the total number of patrol officers from the combined forces to have sufficient coverage of shifts and locations.

To address the burdens placed on law enforcement and emergency service clinicians who must travel long distances and spend hours maintaining custody of people who are in crisis, program planners also intend to streamline procedures so that law enforcement officers can take a person in crisis to a mental health facility and transfer custody to another designated law enforcement officer stationed at the hospital. The hospital would then arrange for appropriate assessment and placement if needed.

Unique Program Features

Stakeholders in the New River Valley note the profound impact the Virginia Tech shooting in April 2007 had on mental health resources, particularly on inpatient hospitalizations. According to the director of the New River Valley Community Services, there was a 99 percent increase in hospitalization rates for children and youth after the shooting incident. Another significant outcome of this tragic event was the enactment of new legislation that increased—from four to six hours—the amount of time a person in mental health crisis could be detained. To offset the demand this placed on law enforcement, the new legislation also allows "trained security officers" to accept people who have an emergency custody order and to do paperwork for emergency custody orders.

Due to differences in staffing and leadership styles, the participating law enforcement agencies vary in their perspectives about how many—and which—officers in their agencies should get CIT training. Consequently, the MHA trains some officers who do not volunteer for the assignment and trains all officers from some of the agencies. The MHA director notes that although some participants appear reluctant at the outset of training, two strategies tend to transform them. First, even people who don't want to participate in the CIT program have a very different attitude about mental health consumers once they have been to the site visits, where they meet with people who have mental illnesses who are doing well. Second, information that stresses the impact of the CIT approach on officer safety can change the minds of trainees who are otherwise disinclined to support a SPR.

> *"The biggest problem with small departments is if we get taken on a call where the person needs placement in a hospital, the officer will be off-road for a whole shift. Oftentimes, we may only have a total of two or three officers on a shift."*
>
> **—Officer Danny Ratcliffe**
> CIT Officer, Pearisburg (Va.) Police Department (NRV)

person's behavior is stable and the officer is in control of the situation. Typically in these response models, officers will transport the person to a mental health facility where mental health experts can conduct further assessment if needed. Individuals interviewed in the studied sites underscored that it is essential that these facilities allow law enforcement officers efficient access to a wide range of services.

> *Law enforcement officers felt isolated from other service providers before CIT, and their knowledge of available resources was limited."*
>
> **—Sgt. Michael Yohe**
> CIT Coordinator, Akron (Ohio) Police Department

Problem: *Frequent arrests of people with mental illnesses and strains on police resources*

Officers typically have three options when they encounter someone with a mental illness whose behavior is erratic—they can arrest the person if there is evidence a crime was committed, transport the person to a mental health facility in accordance with applicable legal mandates, or stabilize the situation and leave the person at the scene. Community members in each of the four sites identified several problems related to the limited options available for officers when encountering people with mental illnesses. Some stakeholders believed officers arrested people with mental illness who had committed minor offenses much too frequently. In most of these cases, individuals reported that the person's behavior may have been too disruptive for the officer to leave him or her alone at the scene, and the officer did not have adequate information about—or efficient access to—available mental health resources.

In other communities, stakeholders noted problems that occur when an officer must either remain with the person in crisis until a mental health professional arrives to conduct an assessment or transport the person to an emergency room, where they may spend additional hours waiting for the assessment to take place.

> *Before CIT, officers were frustrated they had to wait a long time before transferring custody. With CIT, they could drop their paperwork off and scoot."*
>
> **—Amy Tyler**
> Director of Behavioral Health, St. Joseph Hospital (Fort Wayne, Ind.)

> *Our CIT program has diverted a fair number of people from jail to the mental health system, which is improving the balance between the legal system and the mental health systems."*
>
> **—Deb Richey**
> Nursing Director of Emergency Services, Parkview Hospital (Fort Wayne, Ind.)

Tailored Responses

Programs developed in response to inefficient access to mental health resources use strategies to make these facilities more "officer-friendly." In Fort Wayne, for example, the receiving facilities' administrators adapted their procedures to prioritize intake for consumers who officers bring to the facility, allowing the officers to complete paperwork quickly and return to other

> *Since CIT was implemented, fewer people are going to jail. The contacts are better and there are fewer arrests."*
>
> **—Andy Wilson**
> Executive Director, Carriage House (Fort Wayne, Ind.)

duties. In addition to minimizing the strain on law enforcement time and resources, these efficiencies can decrease the number of people who may otherwise be taken to jail for minor offenses. When coupled with officer training on local mental health resources and de-escalating behaviors that might otherwise result in more serious charges against the individual, these changes can improve outcomes for the person with mental illness and the law enforcement first-responders.

Law enforcement responses that address poor knowledge about and limited access to mental health resources can also pair a law enforcement officer and mental health service provider to respond together to calls involving someone with a mental illness. In most cases, co-responder teams are dispatched as a "secondary" response. For example, in Los Angeles, patrol units are dispatched to calls based on priority, as is the usual practice.[31] Once the patrol officer gets to the scene, he or she will make a determination about whether mental illness may be a factor and if the co-response team is needed. When the co-responder team arrives, the initial responding patrol officer manages safety concerns. The co-response team—both the law enforcement officer and the mental health clinician—focuses on the person with mental illness, making decisions about an assessment, referral for service, and placement.[32]

In Los Angeles, an additional layer of dispatch is in place to facilitate this model. Law enforcement first-responders can ask patrol dispatchers for a Systemwide Mental Assessment Response Team (SMART); the dispatchers then route their call to the "Triage Center" of the Mental Evaluation Unit (MEU), where an officer assesses when to send out teams. This triage officer can access the MEU database to gather information on the criminal justice history for the subject of the call for service. The forensic nurse, who is co-located in this unit, can access the Department of Mental Health (DMH) records. Both

> *"It is the chief's responsibility to balance resources, which involves practice, vision, and creativity. There is a resource benefit to the co-responder model: pairing a civilian with a sworn officer frees up other two-officer cars."*
>
> **—Chief William Bratton**
> Los Angeles (Calif.) Police Department

> *"Officers in [the CIT] program come to recognize the weaknesses in the mental health system and how to navigate them to benefit the consumer."*
>
> **—Ron Rett**
> Member, NAMI-Ohio

> *"Through the partnership, police officers often learn to mirror the techniques that the mental health practitioners use in handling situations with people with mental illnesses."*
>
> **—Dr. Tony Beliz**
> Deputy Director, Emergency Outreach Bureau, Department of Mental Health, Los Angeles County (Calif.)

> *"Patrol commanders and those who respond to critical incidents are learning that mental health components are regularly an issue, and therefore, they recognize the value of MEU on these scenes."*
>
> **—Lt. Michael Albanese (ret.)**
> SWAT Commander, Los Angeles (Calif.) Police Department

31. When a call for service involves a person or place that has generated a high volume of previous police responses, the dispatch system flags any mental health issues and the dispatcher shares that information with the responding officers.

32. The Los Angeles County Department of Mental Health not only coordinates response teams with the Los Angeles Police Department, but also with agencies in Long Beach and Pasadena.

sources of information can guide the triage and ensure the responding team will have a more comprehensive history on the individual. When SMART is dispatched, the first-responder officers stay at the scene until the person in crisis has been stabilized. This provides support and backup to the SMART officer and the mental health clinician.

Even in agencies where there is no co-location of law enforcement and mental health personnel, co-responder teams can improve linkages to mental health or substance abuse treatment. Because the mental health professional has access to the person's mental health history, the team may be able to reconnect the person to a clinician who has previously treated him or her. In addition, mental health professionals working with law enforcement are knowledgeable about a wider range of services and supports, so they can find the most suitable mental health approach to the individual's needs. According to those interviewed for the project, co-responder teams can also assist in transportation to a mental health facility for a greater range of situations than law enforcement could alone. For example, the team may have more time to transport people who meet the criteria for involuntary evaluation to the mental health facility, which frees the first responding officer to return to patrol. In addition, because of the involvement of a mental health professional at the scene, co-responder teams may be able to transport people voluntarily to services and supports that would otherwise rely on a family member or public transportation.

Problem: *High utilization of emergency resources*

Many communities experience a large number of law enforcement calls to the same locations, involving the same people with mental illnesses without positive effect. Many of these same individuals have been found to also repeatedly need emergency medical services. This small group of consumers, often referred to as "high utilizers" of emergency services, typically represents people who are difficult to keep connected with nonemergency services, including continuous treatment that is effective in relieving their symptoms. In some cases, these individuals have co-occurring substance use disorders, are homeless, or both. They may cycle in

> *"Law enforcement leadership must know how to apply the necessary resources to solving crimes [and disorder]. The best way to apply limited resources is to focus on the 10 percent of the population that uses the greatest amount of resources."*
>
> **—Chief William Bratton**
> Los Angeles (Calif.) Police Department

> *"One challenging population is [the group of individuals] who are drug- or alcohol-dependent. They are only at our hospital for a short period of time and a large group does not follow through with treatment recommendations. This can result in a revolving door. The officer goes to the scene, brings the person in, we end up admitting them, and discharge them two to three days later. When they do not follow through with treatment, they will be back."*
>
> **—Patsy Hendricks**
> Director of Clinical Services, Parkview Behavioral Health (Fort Wayne, Ind.)

> *"I believe it is in part because of our CAMP program that L.A. hasn't had [a mass shooting incident]. Once we identify someone who has mental illness [that puts them at risk of criminal justice involvement] and put them in the CAMP program, we monitor them to make sure they get medications, have housing, go to work, and can take care of themselves."*
>
> **—Captain Ann Young**
> Commanding Officer, Detective Support and Vice Division, Los Angeles (Calif.) Police Department

Los Angeles Tailors Response to Safety Concerns and High Utilization of Emergency Services*

Quick Facts

Government type: Municipal
Jurisdiction type: Urban
Population in 2007: 3,834,340 (estimate)
Area of City of Los Angeles in square miles: 498.3
Number of sworn personnel: 9,883
Number of civilian personnel: 3,263

Program names: Systemwide Mental Assessment Response Teams (SMART) and Case Assessment Management Program (CAMP)
Program start dates: 1993 and 2005, respectively

Overview

Los Angeles has implemented several complementary program responses to address the complex needs of the jurisdiction. Los Angeles was one of the first communities to develop the police/mental health co-responder teams (SMART) in 1993. This program was designed to better link people with mental illnesses with appropriate mental health services. When the department came under a U.S. Department of Justice consent decree in 2001, one provision directed the agency to improve safety for all involved in officer encounters with people with mental illnesses. At that time, the department also began implementing a CIT program in pilot locations. However, due to its sheer size, both in area and in population, training the recommended 20 percent of its officers in CIT protocols could not effectively cover rapid responses. As a result, department leaders chose to prioritize CIT training for officers most likely to come in contact with people in a mental health crisis, although the training is not limited to these officers.

Tailored Responses

After implementation of CIT training and the SMART teams, a serious problem remained. A group of people with mental illnesses who called the police repeatedly, or were the subject of many calls for service, were costing the city millions of dollars in emergency resources. Further, a large percentage of SWAT call-outs involved someone with a mental illness. The police department developed the Case Assessment and Management Program (CAMP) to identify and track the subjects of these repeat calls, and construct customized responses to their problems. The program co-locates a police detective with psychologists and social workers from the county mental health agency in the police department facility. This team develops long-term solutions to an individual's needs on a case-by-case basis. In particularly complex situations, team members have conducted home visits on a daily basis, linked a person to service provision in his or her home, provided transportation assistance, or made appointments for services or treatment. The team members focus on developing trusting relationships with people in need and few resist the help.

The CAMP program receives referrals from both SMART officers and mental health professionals. When CAMP receives a referral, the psychologist reviews the information, accesses the Department of Mental Health (DMH) records, and reviews the person's history with the police. The psychologist makes the determination about whether the person qualifies for CAMP. For example, someone may qualify if incidents with the police have been high profile, if the person is accessing more than three emergency resources, or the person has a large number

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* Dates and figures in this sidebar are consistent with the most recent information available at the time of this writing.

Los Angeles continued

of calls to the police over a short period. CAMP cases are worked by the psychologist, a detective, and a police officer. At this initial stage (level 1) the team develops and implements a plan for mental health treatment and strategies for managing services. When the person stabilizes (level 2), the case shifts to periodic monitoring. For example, the detective may contact some clients every week to check in, or stop by once a month. If the person remains stable and the family does not need help, the case becomes inactive (level 3) and is filed.

Unique Program Features

The department formed the "Mental Evaluation Unit (MEU)" to oversee all of these programs and manage points of intersection. The MEU contains a triage unit that fields calls from patrol officers who have questions about what to do in certain situations involving people with mental illnesses. In these circumstances, the triage officer consults the MEU database (separate from the CAD system and protected from access outside the unit) to learn this person's history with the police. A triage mental health nurse sits alongside this officer and can check the DMH databases to determine the person's case manager, psychiatrist, or treatment centers. The triage staff determines together whether to send out a SMART team or have the officer take the person directly to a mental health facility. If the triage unit determines that this person has repeatedly contacted police (or been the subject of frequent calls for intervention), they will refer the person to the CAMP coordinator for follow-up.

and out of treatment, and many do not follow through with treatment plans independently, including taking prescribed medications.

Tailored Responses

In Los Angeles, repeat calls for service led to the creation of the Case Assessment and Management Program (CAMP), which is a response strategy that focuses on proactive efforts to resolve the issues that generate repeat calls to police and others, including mental health case management and rigorous follow-up. CAMP teams include detectives from the police department and mental health clinicians, who work together to create customized plans for identified individuals. The CAMP team, which is located in the MEU area of the police department, receives referrals from many sources, including SMART officers, the Los Angeles Fire Department, school police, other city police officers, other LAPD detectives/investigators, and from mental health department personnel.

> *"The outreach team allows officers to see people when they are not in crisis—to see them as people. It also allows the consumers to have a positive and compassionate experience with the officers."*
>
> **—Helen Reedy**
> Member, NAMI-Ohio

> *"There is pressure to handle a high volume of calls for service, and short-term fixes are often a reality. The outreach team follow-up with a consumer allows the police to start implementing longer-term solutions."*
>
> **—Sgt. Michael Yohe**
> CIT Coordinator, Akron (Ohio) Police Department

In Akron, a similar experience with "repeat callers" prompted the creation of CIT Outreach Teams, which consist of a law enforcement officer who partners with a mental health case manager to conduct follow-up with consumers in the community. This is not a routine assignment for the officers; they must choose it as an off-duty assignment. Outreach Team assignments come from referrals from mental health service providers, probation officers, and from law enforcement officers who identify individuals who would benefit from follow-up visits. The CIT coordinator at Community Support Services (CSS) prioritizes the referrals based on mental health and criminal justice history. A list of repeat call locations is also provided for follow-up and prevention efforts. Follow-up visits can result in a transport to CSS, where psychiatrists or case workers can provide additional treatment and support, or directly admit the individual to a hospital.

PROGRAM EXAMPLE: Responding to homelessness, Fort Lauderdale (Fla.)

Given that a large number of homeless individuals suffer from mental health issues, Fort Lauderdale (Fla.) created a Homeless Outreach Unit to bring shelter, assistance, and understanding to the homeless population. The outreach team includes an officer and a mental health worker who try to address the myriad needs of the "homeless mentally ill population." The officer's assignment is voluntary because participating in the program requires a sincere compassion and commitment to assist people in crisis. The team's officer confirmed that "these people have complex problems, they need medications they cannot afford, and the team needs to empathize with them."

The team gets referrals from law enforcement officers, but also establishes a pick-up location for three hours each day to assist people who are homeless or have just been released from long-term programs. The officer interviews them and tries to link them with social services and shelters.[33]

> *I have responded to fewer CIT calls over time because of the positive effect of the outreach teams in decreasing repeat callers."*
>
> **—Officer Lori Natko**
> CIT Officer, Akron (Ohio) Police Department

> *The outreach teams served as a natural complement to the CIT program. Referrals did not only come from mental health service providers, but also from officers who identify individuals that would benefit from follow-up visits."*
>
> **—Ragan Leff**
> CIT Coordinator, Community Support Services (Akron, Ohio)

> *CAMP team members develop responses on a case-by-case basis, and they range considerably. For complex cases, we conduct home visits—as often as daily—to link the person to services, in their home if needed, and obtain consent for our clinicians to speak to the person's psychologist to check on whether the person is making and keeping appointments."*
>
> **—Detective Teresa Irvin**
> CAMP Coordinator, Los Angeles (Calif.) Police Department

33. The information presented in this program example was developed based on a phone interview conducted during the information-gathering phase of this project. For more information about the Fort Lauderdale Homeless Outreach Unit, see the profile available on the Local Programs Database at www.cjmh-infonet.org/main/show/2071.

The Impact of Jurisdictional Characteristics on SPR Programs

Characteristic	Specific Jurisdictional Characteristics	Jurisdictions	SPR Activities
Law Enforcement Agency	Leadership style is consistent with "specialist" approach	Akron, Ohio Fort Wayne, Ind. Los Angeles, Calif. New River Valley, Va.	A subset of self-selected law enforcement officers are assigned to teams.
	Leadership style is consistent with "generalist" approach	Los Angeles, Calif. New River Valley, Va.	All officers receive training in basic de-escalation and recognizing mental illness.
	Conducted Energy Devices (CEDs) are used broadly as part of departmentwide use-of-force protocols	Akron, Ohio	Only CIT officers are provided with CEDs.[34]
	Conducted Energy Devices (CEDs) are used infrequently as part of departmentwide use-of-force protocols	Fort Wayne, Ind.	CIT officers are not provided with CEDs.
Mental Health System	Medical clearance is required before admission to a mental health facility	Fort Wayne, Ind.	Hospital emergency room protocols provide quick medical and mental health assessments in a secure area.
	Mental health resources are extremely limited/inaccessible	New River Valley, Va.	Officers are trained to identify better those in need of emergency mental health assessments.
State Laws	Involuntary emergency mental health assessment requires extended police custody	New River Valley, Va.	Officers are trained on de-escalation to enable them to manage safety concerns during custodial period. Law enforcement officers can be stationed at an emergency psychiatric facility to receive custody from patrol, freeing them to return to routine duties.
Demography and Geography	Large, urban jurisdictions	Los Angeles, Calif.	SMART units are assigned specific areas of responsibility and work in conjunction with the more than 800 officers who receive some mental health training to provide citywide coverage. All officers receive some online training.
	Small, rural jurisdictions	New River Valley, Va.	The forces of multiple jurisdictions are combined to increase the number of trained officers who can respond to a large area.
	Medium, urban jurisdictions	Akron, Ohio	Department trained 19 percent of total sworn personnel in the department to respond.
		Fort Wayne, Ind.	Department trained nearly 20 percent of total sworn personnel in the department to respond.

34. Although accurate at the time of the interviews in 2007 and 2008, both the Akron Police Department and Fort Wayne Police Department have since revised their respective policies on CEDs. See page 35 for more information about the evolution of these changes.

Tailoring Specialized Policing Response Programs to Jurisdictional Characteristics

As distinct from the previous discussion about *problems* and their impact on the specialized response program, *jurisdictional characteristics* are largely static features in a community or agency, which policymakers and planners must consider in program design and implementation. (These are reviewed briefly in Section I.) The following discussion examines how the jurisdictional characteristics, such as those outlined in the summary chart on the previous page, shaped program responses. These factors include law enforcement agency characteristics (such as leadership and use-of-force protocols), mental health system characteristics (such as resources and medical clearance requirements), state law (such as those regarding emergency custody orders), and demographics and geography.

Jurisdictional characteristic: *Law enforcement agency leadership*

The predominant law enforcement agency characteristic that affected program development in the four studied sites was leadership style. According to those interviewed at the study sites, at the foundation of these preferences are law enforcement chief executives' opinions about the necessity of particular personality traits among personnel for carrying out specific tasks. For example, many in the field report that there are senior law enforcement officials who believe that officers trained for the specialized response, particularly special units, should be volunteers, self-selected to have compassion for people with mental illnesses. Others may feel that all first-responders should be educated about mental illnesses and trained to de-escalate crisis situations using appropriate procedures. Still others believe that some basic training for all first-responders is in order, with more intensive preparation for voluntary special unit personnel. Though concerns about training budgets, priorities for limited resources, size of jurisdiction, and other factors may be considered in determining who is trained and dispatched, many of the individuals interviewed in the study sites felt that the perspective of the agency's leaders largely determined how the response would be shaped.

> *"Not all officers can be CIT officers, because it requires a personal commitment and compassion that cannot be taught or forced. Still, because the skills are so generalizable, they can be applied, in part, on calls such as responding to people with mental retardation and developmental disabilities, domestic violence calls, or people who are intoxicated—all officers should have a basic understanding of them."*
>
> **—Lt. Richard Edwards**
> Public Information Officer, Akron (Ohio) Police Department

Tailored Responses

Each of the four jurisdictions developed training approaches that were consistent with the agency leader's style. This was most notable in the regional New River Valley CIT program, where variation exists among the police leadership in the fourteen jurisdictions involved in the program. Each jurisdiction determines which and how many of its officers will be trained, resulting in differences among them. Leaders in the Los Angeles Police

Department chose to provide some training on mental health issues to all patrol officers (twenty-four hours) because all officers must be prepared to handle the wide range of calls to which they respond. This agency also provides a full forty hours of "specialized" training to officers involved in its MEU, SMART, and CAMP strategies, and officers who receive CIT training for use in designated areas of the city.

Jurisdictional characteristic: *Law enforcement agency use-of-force protocols*

Department policies and practices on the use of force, particularly less-lethal technologies, also can play a role in program design. Police agencies must develop policies on how and when officers use a range of force options through a complex and careful process that takes into account factors such as officer training and the circumstances during the encounter. Many communities are grappling with the use of conducted energy devices (CEDs), such as Tasers,™ during encounters with people with mental illnesses as a way to reduce the likelihood of serious injury or death during these incidents.

Tailored Responses

These policies differed significantly across jurisdictions visited for this study. For example, at the time of the site visits, the Akron Police Department provided CEDs *only* to CIT-trained officers, and the Fort Wayne Police Department *never* provided them to CIT officers. These policies have since changed, but the thinking behind these early policies on CEDs can be instructive for other agencies. Akron believed that the training provided to CIT officers uniquely positioned them either to use the device very judiciously or to de-escalate a situation so that a CED would not be needed. (Since the time of the visit, Akron has extended the use of CEDs to other officers with proper training.) In contrast, Fort Wayne believed that officers trained in CIT would be the least likely to need the device due to their training in de-escalation and that backup could be provided by another patrol officer on the scene. Fort Wayne Police Department leaders have since decided that

> *"Tasers™ are critical to the success and safety of CIT. Although applying CIT knowledge and communications skills are highly effective at de-escalation, no technique is 100 percent reliable. Having a less-lethal option available to CIT officers is an obvious way to increase everyone's safety in handling many crisis calls. This is especially true considering that a significant number of these calls involve suicides-in-progress, and Tasers™ may provide one of the few options to safely stop individuals from harming themselves. The conversation about less-lethal devices must be tied in with the CIT conversation."*
>
> **—Sgt. Michael Yohe**
> CIT Coordinator, Akron (Ohio) Police Department

> *"Though the Fort Wayne Police Department did not prioritize Tasers™ for CIT officers, in part because they could be provided backup by other officers, they now have the same opportunity to request and train for the use of these less-lethal devices."*
>
> **—Deputy Chief Dottie Davis**
> Director of Training, Fort Wayne (Ind.) Police Department

CIT training will not be a determining factor when selecting who in the department will be issued a CED.

If a department's leadership team decides that CEDs can make situations involving people with mental illnesses safer for all involved, law enforcement should work with their partners to develop protocols and policies, appropriate training, and supervision.[35]

Jurisdictional characteristic: *Mental health resources*

Specialized policing response programs hinge on the availability of mental health resources to serve as an alternative to criminal justice system involvement when warranted. Although some communities manage to increase the available mental health resources, or shift them, many communities must work with what resources are available in their jurisdiction. As a consequence, stakeholders must develop strategies to manage increases in volume that result from law enforcement transports or referrals. Among the issues to be considered are whether any changes can be made in triaging to ensure the highest levels of care match those most in need, evaluating admission criteria and accessibility issues, easing contact and increasing efficiency for law enforcement personnel, and addressing any commensurate increases in costs related to caring for people with mental illnesses at risk of continued criminal justice involvement, many of whom are uninsured.

Tailored Responses

In Los Angeles and New River Valley, specialized policing response programs reduce some demands on limited mental health resources by relying on

> *"The main problem in Los Angeles is a lack of available resources—even trained officers have nowhere to transport individuals. Not only can the officers not transport anyone, there are no services to recommend to family members anymore. Psychiatric emergency rooms and psychiatric inpatient units are located in the county hospital, and one county hospital has closed completely."*
>
> **—Nancy Carter**
> Executive Director, NAMI–Urban Los Angeles (Calif.)

> *"The number of scenarios that involve custody was a lot more before the CIT training. Officers can now better identify people who need to be taken into custody because they know what to look for. Fewer people are taken into custody, and more people are taken appropriately."*
>
> **—Officer Danny Ratcliffe**
> CIT Officer, Pearisburg (Va.) Police Department (NRV)

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35. For more information about standards and guidelines for CED use, the Police Executive Research Forum (PERF), with support from the Office of Community Oriented Policing Services (COPS Office), has created a resource on the topic. See James M. Cronin and Joshua A. Ederheimer, *Conducted Energy Devices: Development of Standards for Consistency and Guidance* (Washington, DC: U.S. Department of Justice, Office of Community Oriented Policing Services and Police Executive Research Forum, 2006), www.ojp.usdoj.gov/BJA/pdf/CED_Standards.pdf.

well-trained officers and effective information-gathering to help properly assess individuals' need for emergency evaluations, and whenever possible, connect people with care providers outside of the emergency response networks. As mentioned previously, in Los Angeles, the SMART officers work with their triage unit to access a database with an individual's history while the forensic nurse in this unit can access the mental health records. In the New River Valley, CIT officers are trained to screen people for the need for hospitalization, so fewer people are taken into custody. In both jurisdictions, law enforcement is working with the mental health community to make the most of limited resources.

In one hospital in Fort Wayne, the volume of mental health patients increased significantly as a result of the implementation of the CIT program. The number of twenty-four-hour mental health assessment holds brought to the hospital by police doubled—from 600 in 1998 to 1,200 in 2007. The stakeholders in this community also eventually determined that a subgroup of people had been invoking a seventy-two-hour hold repeatedly when they did not have a mental illness. These individuals had primary substance abuse issues and many were attempting to avoid arrests for DUI. The facility arranged with the judge who oversees the commitment hearings to limit the number of times a person could be admitted consecutively based on an emergency custody order to eliminate those who were not in need of mental health treatment. This resulted in increased availability of services for those who appropriately needed mental health care.

To manage costs, the inpatient mental health providers in Fort Wayne have developed a mechanism to enroll people in benefit programs, such as Medicaid. The hospital contracts with a for-profit business that charges a fee to enroll qualified individuals in Medicaid programs. The contractors working at Parkview Behavioral Health have converted 52 percent of the people who were admitted without insurance to become covered by Medicaid, which has significantly reduced the hospital's burden of providing uncompensated care.[36]

> *"Clinicians now recognize the CIT officer and take more stock in what a CIT officer is saying. The clinicians also recognize the added benefit that the officer provides by de-escalating the situation before the clinician gets there."*
>
> **—Deputy Chip Shrader**
> Montgomery County (Va.) Sheriff's Office (NRV)

> *"The biggest fear was that this was going to cost more money. Parkview became creative with funds and implemented programs—with social workers getting . . . Medicaid for clients—to get the ball rolling."*
>
> **—James White**
> Service Coordinator/Security Lead Staff, Park Center Inc. (Fort Wayne, Ind.)

> *"The other issue that providers need to be aware of is that this will impact their payer mix—many people in this population are underinsured or not insured. If you are using the ER as the access point, this can be costly."*
>
> **—Chuck Clark**
> Executive Director, Parkview Behavioral Health (Fort Wayne, Ind.)

36. For more information about connection to federal benefits, particularly for people with mental illnesses who are returning to the community from prison or jail, see www.reentrypolicy.org/issue_areas/reentry_federal_benefits.

Although the communities visited were not able to create entirely new mental health resources, they were successful in maximizing the use of existing resources through two particular strategies: First, planners stretched resources by training officers and others to identify more accurately those people who needed emergency mental health services. Second, planners developed strategies to enroll qualified individuals in benefits programs to improve payment of needed mental health services. In the New River Valley, law enforcement agencies also shared resources throughout the region, making it easier to access and sustain them.

> *"The biggest challenge is bringing all the people in through the ER. The ER was identified as the access point for all psychiatric patients; it is expensive and not best for patients to have to wait three or four hours for an assessment."*
>
> **—Chuck Clark**
> Executive Director, Parkview Behavioral Health (Fort Wayne, Ind.)

Jurisdictional characteristic: *Medical clearance requirements*

In the New River Valley and in Fort Wayne, mental health system stakeholders were hesitant to accept someone into a mental health facility who might have a medical condition that requires priority treatment. This concern is shared by many communities across the country, and program models typically require law enforcement officers to transport the person in mental health crisis first to a hospital emergency room for medical clearance. In these cases, mental health services are provided after a physician determines the person is well enough for psychiatric assessment.

The necessity of medical clearance requires program planners to develop procedures to guarantee a safe and timely medical assessment, to ensure the safety needs of other patients and staff, and to create a smooth transition to the appropriate mental health resource.

Tailored Responses

In Fort Wayne, law enforcement officers bring the person in crisis to the emergency room of the local hospital through the ambulance entry to one of three secure rooms. This allows privacy and security. The individuals in the care of officers get priority treatment and officers talk directly with the mental health counselors. Once the physician determines the individual's medical condition is stable, the mental health clinicians assess the needed level of care.

To enable officers to return to other duties, the hospitals in Fort Wayne employ security staff to monitor the patient's safety and the safety of others in the emergency room. The hospital worked with their legal counsel to develop clear guidelines on holding, restraining, and detaining patients, and to make sure that hospital security is not held liable for injuries that may result. Although the goal in these hospitals is to err on the side of protecting patients from harming themselves or others, their care, dignity, and privacy were considered in developing these guidelines.

Jurisdictional characteristic: *State laws*

Requirements in state laws regarding law enforcement officers' role in emergency mental health evaluations must be addressed in designing and implementing specialized policing responses. These laws may affect program design by mandating certain types or the scope of training. They can also spell out under what circumstances officers are permitted to transport or take into custody individuals with mental illnesses who meet specific standards (such as imminent harm to themselves or others).

Among the many state mandates that can affect program design, the one that was most at issue in the four-site study involved officers taking custody of individuals with mental illnesses for emergency evaluation. As described, in Virginia, for example, a law enforcement officer is authorized to determine if a person meets the criteria for an "emergency custody order" (ECO) without taking the person in front of a magistrate. The ECO lasts up to six hours (previously mandated at four hours), and state law requires that the officer maintain custody of the person with mental illness while they wait for a mental health crisis worker to arrive and complete a mental health assessment, and find a treatment bed if needed. Officers may not detain the person in jail during this time, which means law enforcement agencies must designate a place where the officer can stay with the person in crisis until a clinician arrives. Oftentimes, this space becomes a multipurpose room (the same area may serve as a waiting area for a person who has been served a warrant and for someone who has come to the department to report a crime). If the six-hour period elapses without an assessment or an available place for treatment, the person must be released.

During the ECO time period, crisis workers assess the person's status, gather collateral information, and decide if the person meets the criteria to be committed. If the criteria are met, the clinician tries to facilitate an admission to an inpatient facility—either into a public or private facility—or diverts the individual back to the community to receive services and supports. The majority of the calls are handled within the six-hour period.

> *"In 2008, hospitals were faced with national patient safety goal #15, which requires a system for screening patients for suicide risk. They must be screened appropriately and the hospital must provide 'continuity of care' so that when the person returns to the community it must be with a safety net in place.*
>
> *Mental health clients are no longer what we do at the end of the day when we are done with everything else. This hospital is now making psychiatric services a priority and we are committed to quality services."*
>
> **—Deb Richey**
> Nursing Director of Emergency Services, Parkview Hospital (Fort Wayne, Ind.)

Tailored Responses

One goal of the New River Valley CIT program is to address the strain on law enforcement personnel created by this law. At this writing, there is legislation in place in Virginia that would allow for a CIT officer to be stationed in the hospital emergency room to accept custody of the incoming person in mental health crisis, and allow the transporting officers to return to patrol. Alternatively, if the hospital has a police or security department of its own,

the new legislation allows "willing and able" hospital security staff to extend their duties to include managing the ECO process.[37]

For law enforcement officers in Fort Wayne, the ECO under state law has been limited to a twenty-four-hour hold and it has been an effective tool for reducing the time officers spend waiting at community facilities with people who need a mental health assessment. This statute was originally underutilized because officers were not comfortable making decisions regarding mental health assessment criteria. Now that they have received specialized training on the issue, they are more likely to invoke the ECO law that authorizes them to transport that person to the emergency room without the officer needing to retain custody. Although this ECO is designed primarily for medical observation, it can be converted into a seventy-two-hour commitment for mental health evaluation upon judicial order.

> *There was a statutory twenty-four-hour hold on the books since 1969. The reason it was not used was because police officers were not trained. Before CIT, officers had to wait hours with the person in crisis until a mental health professional could come and conduct the assessment. Now, along with CIT, we are using this hold so that officers have the authority to take the person to a mental health facility for assessment, where better procedures reduce the amount of time officers must wait with the person. This has added a great efficiency to our processes."*
>
> **—James White**
> Service Coordinator/Security Lead Staff, Park Center Inc. (Fort Wayne, Ind.)

PROGRAM EXAMPLE: Working collaboratively to meet legal guidelines, Lincoln (Nebr.)[38]

In Nebraska, law enforcement and correctional officers are the only authorities who can take people into emergency protective custody (EPC) for involuntary mental health evaluation. Within thirty-six hours, a county attorney will determine whether to proceed with the involuntary commitment process. Nebraska is divided into six regions, each of which has a dedicated facility to receive people placed into EPC by law enforcement. Police officers in the City of Lincoln have round-the-clock access to mental health professionals in their region to assist them in deciding whether the person warrants custody or to determine an appropriate alternative. The Lancaster County Mental Health Agency, which serves Lincoln, is available 24/7 either by phone, in-person in the field, or at the police station. The officer can also take individuals directly to the mental health agency during business hours.

The City of Lincoln has also created a new process that has reduced by half the number of EPC orders officers do in a year. The key is to provide information to officers in the field about consumer involvement in programs like Assertive Community Treatment (ACT) to maintain their connection to these programs. Consumers can sign a waiver to put their participation in ACT in a police database. When officers conduct a routine warrant search, they get a message to contact the person's case manager, rather than taking the person into the emergency mental health system, where they will have to start over.

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37. At press time, this legislation had been passed and the leadership in New River Valley were working toward implementing this practice.

38. The information presented in this program example was developed based on a phone interview conducted during the information-gathering phase of this project. For more information about the Lincoln Police Department's efforts, see the profile available on the Local Programs Database at www.cjmh-infonet.org/main/show/2103.

Jurisdictional characteristic: *Demography and geography*

A jurisdiction's population size and density, land area, traffic patterns, and crime problems present important constraints on specialized responses. Jurisdictions of all sizes, particularly those at either end of the range, struggle with the adequacy of community-based resources, the ease of accessing them, and the allocation of officers to work with them.

> *[One] reason larger cities are challenged to maintain CIT is because geography and the sheer number of calls to which they must respond can prohibit relationship-building. With three county hospitals, CIT police officers are unable to form necessary relationships with hospital personnel because they are limited by time."*
>
> **—Linda Boyd**
> Manager of Law Enforcement Mental Health Programs, Department of Mental Health, Los Angeles County (Calif.)

Tailored Responses

In Los Angeles, one of the strategy impetuses was concern over safety for all individuals involved in police encounters, which resulted in recommendations to implement CIT. However, the size of the police department limited the agency's ability to train the recommended benchmark of 20 percent of the officers to work full time on crisis intervention calls.[39] The jurisdiction's large geographic area also made deploying the CIT-trained officers difficult. They found during pilot testing in one area that the 20 percent of the officers they were able to train in just that district still were only able to respond to 20 percent of the calls involving people with mental illnesses. In large part, this occurred because transportation to psychiatric emergency centers kept CIT officers in the hospital for three to four hours, unable to respond to other mental health calls.

> *My officers can spend up to twelve hours on night shift dealing with a call involving a mental health assessment. This is the biggest problem our small department faces. If we get taken on a call like that, a whole shift is off-road all night and we may only have two or three deputies on duty."*
>
> **—Chief Jackie Martin**
> Pearisburg (Va.) Police Department (NRV)

In response, LAPD tailored its strategy to focus on the co-response model—increasing the number of personnel assigned to SMART and expanding the hours of operation. The co-responder teams are assigned to patrol areas with overlapping response protocols, which ensures citywide coverage. The linchpin to this strategy is the MEU "triage desk," with staff that provides advice to primary responders, dispatches SMART units, controls the flow of individuals who have received law enforcement responses to county psychiatric emergency departments, and maintains a database of law enforcement contacts. In addition, Los Angeles decided to train all officers with twenty-four hours of online training on crisis intervention tactics, and the department offers a CIT course each quarter that is open to all first-responders, although priority is given to those officers most likely to encounter people with mental illnesses. This training

39. The recommendation to train 20 to 25 percent of a law enforcement agency is proposed by the CIT Center at the University of Memphis in the "Crisis Intervention Team Core Elements," http://cit.memphis.edu/CoreElements.pdf.

is a key component of LAPD's strategy because any officer may encounter someone whose mental illness is a factor in the call for police involvement. The department's leaders believed all officers would benefit from knowledge of these techniques. So the LAPD based its decisions to build a multi-tiered response model on the size of the jurisdiction, data that identified a particular geographic area that generated repeat calls for service, leadership style, and many of the other characteristics discussed previously.

The New River Valley CIT brought together fourteen jurisdictions in its area because they all fell within one of Virginia's mental health catchment areas.[40] The goal of bringing the smaller, rural communities together was to capitalize on shared resources. For example, agencies created agreements to allow officers to cross jurisdictions and serve each other's residents, and planned to train 25 percent of the total number of patrol officers from the combined forces to have sufficient coverage of shifts and geography.

In New River Valley, these communities have focused on developing better relationships between law enforcement and consumers of mental health services. Because of the CIT program and officer training, stakeholders note that consumers are less reluctant to interact with law enforcement officers, are less fearful of officers, and even recognize CIT officers as helpful. Although this improved relationship may not change the fact that law enforcement must stay with the person for up to six hours, and may not have a nearby facility to take them, it does help officers communicate with consumers and understand how to resolve problems. According to those interviewed in the study site, the improved rapport and trust between officers and clinicians, consumers, and citizens who call for assistance has also boosted the credibility of law enforcement observations in the eyes of mental health professionals.

> *"One of the advantages to large jurisdictions is that there are many resources to tap and many community members to assist and many officers committed to working with this population."*
>
> **—Chief William Bratton**
> Los Angeles (Calif.) Police Department

> *"The very nature of the rural community creates challenges—the distances are long and there is almost no public transportation [to help people access services easily]."*
>
> **—Harvey Barker**
> Director, New River Valley (Va.) Community Services (NRV)

> *"It used to be mental health on one side, law enforcement on the other. They looked at us as yanking people out, and we looked at them and thought: I've had to fight this guy to get him to the department and you want to be all touchy feely. The trip we all took to Memphis brought us together and created a lasting bond. We gained a lot of respect for each other during that time."*
>
> **—Deputy Chip Shrader**
> Montgomery County (Va.) Sheriff's Office (NRV)

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40. Because mental health services are organized along different geographic lines than law enforcement services, it can be difficult to develop coordinated service delivery strategies. Jurisdictions need to consider their respective catchment areas when setting up collaborative initiatives.

PROGRAM EXAMPLE: Tailoring to a large rural region, Piscataquis County (Maine)[41]

Piscataquis County (Maine) is the only "frontier county" east of the Mississippi. According to Sgt. Robin Gauvin of the Portland, Maine, Police Department, this equates to a population density of less than one person per square mile. This county has three municipal police departments that determined a need to improve their response to people with mental illness in this rural area. This program has focused on creating force multipliers to boost the law enforcement response capacity.

For example, in 2003 the law enforcement agencies began partnering with Emergency Medical Services so that ambulances co-respond with police on situations involving someone with a mental illness. When an area has only one deputy in charge of 400 square miles, this agreement translates to the addition of three or four emergency medical technicians who can be called upon to assist. The involvement of the ambulance staff assists with de-escalation and transportation. The officer can arrive at a scene within ten minutes and an ambulance can arrive in twenty to thirty minutes, but mobile crisis workers would take more than an hour to reach most areas. Call takers and dispatchers are also part of expanding capacity to respond. They are now trained to ask for more information, give options to help, and ask questions once thought dangerous to ask a caller expressing thoughts of suicide.

Conclusion

SPR program development should be guided by both the problem in the community and the specific characteristics of the jurisdiction. There is no "one-size-fits-all" response that will work in every community. It is vital that leaders in law enforcement, mental health, and consumer advocacy understand what obstacles there are to providing sensitive and appropriate responses to people with mental illnesses, and then assess what resources and agency strengths can overcome them.

The program activities presented in this guide hint at the efforts being made around the country to improve law enforcement responses to people with mental illnesses. They should not be considered a complete catalog of all possible options, but rather are included to highlight common themes and promising approaches to problems faced by agencies with varying demographics. The examples from the sites, and the discussions of selected problems and factors that should influence program planning, are provided to underscore the need to truly understand what responses will make the most sense in a particular jurisdiction. It is hoped that policymakers and planners from any agency can use this guide as a starting point to design or enhance a SPR program that will result in better outcomes for people with mental illnesses, a more effective and rewarding use of law enforcement resources, and improved safety of all involved in these encounters.

41. The information presented in this program example was developed based on a phone interview conducted during the information-gathering phase of this project. For more information about the Piscataquis Sheriff's Office Crisis Intervention Team, see the profile available on the Local Programs Database at www.cjmh-infonet.org/main/show/3137.

Appendix A

Site Visit Information

Titles and agency affiliations reflect the positions held at the time the interviews were conducted.

Akron (Ohio)

Site Visit Dates: December 5–7, 2007

Interviews Conducted

- Chief Michael Matulavich, Akron Police Department
- Lieutenant Richard Edwards, Public Information Officer, Akron Police Department
- Lieutenant Mike Woody (retired), Law Enforcement Liaison, Ohio Criminal Justice Coordinating Center of Excellence
- Sergeant Michael Yohe, CIT Coordinator, Akron Police Department
- Officer Lori Natko, CIT Officer, Akron Police Department
- Officer Forrest Kappler, CIT Officer, Akron Police Department
- Ms. Lorie Witchey, Dispatcher, Akron Police Department
- Dr. Mark Munetz, Chief Clinical Officer, Summit County (Ohio) Alcohol, Drug Addiction and Mental Health Services Board
- Kim Shontz, Director of Outpatient Services, Community Support Services
- Joan "Ragan" Leff, CIT Coordinator, Community Support Services
- Ron Rett, Member, NAMI–Ohio
- Mel and Helen Reedy, Members, NAMI–Ohio
- Bernie, Consumer

Fort Wayne (Ind.)

Site Visit Dates: February 20–21, 2008

Interviews Conducted

- Deputy Chief Dottie Davis, Director of Training, Fort Wayne Police Department
- Officer Mark Bieker, CIT Officer, Fort Wayne Police Department
- Teresa Hatten, President, NAMI–Indiana
- Jane Novak, Member, NAMI–Indiana
- Deb Richey, Nursing Director of Emergency Services, Parkview Hospital (Fort Wayne)
- Marcy Malloris, Transitional Care Services Manager, Park Center Inc. (Fort Wayne, Ind.)
- James White, Service Coordinator/Security Lead Staff, Park Center Inc. (Fort Wayne, Ind.)

- Chuck Clark, Executive Director, Parkview Behavioral Health (Fort Wayne)
- Patsy Hendricks, Director of Clinical Services, Parkview Behavioral Health (Fort Wayne)
- Amy Tyler, Director of Behavioral Health, St. Joseph Hospital (Fort Wayne)
- Joe Louraine, Assessment Specialist, St. Joseph Hospital (Fort Wayne)
- Andy Wilson, Executive Director, Carriage House (Fort Wayne)
- Tom, Consumer, Carriage House (Fort Wayne)
- John, Consumer, Carriage House (Fort Wayne)
- Joe, Consumer, Carriage House (Fort Wayne)

Los Angeles (Calif.)

Site Visit Dates: December 11–14, 2007

Interviews Conducted

- Chief William Bratton, Los Angeles Police Department
- Assistant Chief Jim McDonnell, 1st Assistant Chief, Chief of Staff, Los Angeles Police Department
- Assistant Chief Earl Paysinger, Director, Office of Operations, Los Angeles Police Department
- Commander Harlan Ward, Assistant Commanding Officer of Valley Bureau, Los Angeles Police Department
- Captain Ann Young, Commanding Officer, Detective Support and Vice Division, Los Angeles Police Department
- Lieutenant Rick Wall, Mental Evaluation Unit, Los Angeles Police Department
- Lieutenant Michael Albanese (ret.), SWAT Commander, Los Angeles Police Department
- Detective Teresa Irvin, CAMP Coordinator, Los Angeles Police Department
- Dr. Luann Pannell, Director of Police Training and Education, Los Angeles Police Department
- Dr. Tony Beliz, Deputy Director, Emergency Outreach Bureau, Department of Mental Health, Los Angeles County
- Linda Boyd, Manager of Law Enforcement Mental Health Programs, Department of Mental Health, Los Angeles County
- Nancy Carter, Executive Director, NAMI–Urban Los Angeles
- Jim Randall, President, NAMI–San Fernando Valley
- Mark Gale, Member, Board of Directors, NAMI–California

New River Valley (Va.)

Site Visit Dates: March 6–7, 2008

Interviews Conducted

- Victoria Cochran, Chair, State Mental Health, Mental Retardation and Substance Abuse Services Board
- Chief Jackie Martin, Pearisburg Police Department
- Chief Gary Roche, Pulaski Police Department
- Lt. Brad St. Clair, Montgomery County Sheriff's Office
- Deputy Chip Shrader, Montgomery County Sheriff's Office
- Officer Danny Ratcliffe, CIT Officer, Pearisburg Police Department
- Patrick Halpern, Executive Director, Mental Health Association of the New River Valley, Inc.
- Dr. Harvey Barker, Executive Director, New River Valley Community Services
- Marie Moon Painter, Clinical Team Leader for CONNECT, Carilion St. Albans Behavioral Health

Appendix B

Document Development

This document was developed based on information gathered in several communities throughout the country, which were selected to represent a range of characteristics—diverse objectives, jurisdiction sizes, and program models. The site selection process began with an in-depth review to identify jurisdictions with an active law enforcement-based specialized response program—including mining the Local Programs Database, examining literature published on existing programs, and consulting with national experts. Once a comprehensive list was compiled, programs were screened for inclusion based on three important features—the program had to be *law enforcement-based,* in existence for at least *five years,* and designed *independently* based on the jurisdiction's *specific circumstances*.

Why these three characteristics?

1) Many communities have developed teams of community mental health professionals, such as mobile crisis or assertive community treatment teams, to assist officers at the scene. Although these models are undoubtedly a valuable resource for many communities and departments, they do not require significant policy and procedural changes in the law enforcement agency, and therefore are not *law enforcement-based* and are not within the scope of this document.
2) Anecdotal evidence suggests that during the first five years of an initiative, program practices and policies undergo an iterative process of development, building on the program's successes and failures over time. Based on this finding, jurisdictions needed to have an operational program for at least five years to be considered.
3) Several state governments have coordinated efforts to proliferate a specific model throughout jurisdictions in their state. These states should be applauded for these efforts, but jurisdictions that selected and implemented a program based on state policymakers' influence did not go through an independent program design process. Because the intention of this report is to identify and describe the various methods of program design, only jurisdictions that designed the program based on *specific circumstances and characteristics* were included.

The initial screening process left a short list of jurisdictions that fit the three primary criteria. Interviews were conducted with representatives from the remaining programs, and were centered on four main questions:

1. How was the program developed?
2. Is there a priority population involved in the strategy?
3. What is the nature and strength of the criminal justice/mental health collaboration?
4. How are data collected and analyzed?

Information gleaned from these telephone interviews was considered in the context of remaining selection criteria: variation in program model and jurisdiction type (e.g., demographic features and geography), mental health delivery styles, field familiarity (e.g., highlighting less-known programs), and usefulness and applicability to the field. Based on this review process, Akron (Ohio), Fort Wayne (Ind.), Los Angeles (Calif.), and New River Valley (Va.) were selected to be visited for this report.

Appendix C

Program Design Worksheet

Step 1: Understand the problem

1. What forces are driving current efforts to improve the law enforcement response to people with mental illnesses?
2. What data can planning committee members examine to understand the factors influencing law enforcement responses to people with mental illnesses?
3. What are the data limitations, and how can they be overcome?

Step 2: Articulate program goals and objectives

1. What are the program's overarching goals?
2. What are the program's objectives?

Step 3: Identify data-collection procedures needed to revise and evaluate the program

1. What data will be collected to measure whether goals and objectives have been achieved?
2. What data collection strategies will be used?

Step 4: Detail jurisdictional characteristics and their influence on program responses

1. What characteristics of the law enforcement agency are relevant in planning a specialized response to people with mental illnesses?
2. What mental health system characteristics are relevant in planning a specialized response to people with mental illnesses?
3. What state laws are relevant in planning a specialized response to people with mental illnesses?
4. What demographic and geographic community characteristics are relevant in planning a specialized response to people with mental illnesses?

Step 5: Establish response protocols

1. What law enforcement responses are necessary?
2. What mental health system responses are necessary?
3. What other responses or resources are necessary?

Step 6: Determine training requirements

1. How much training will be provided and to which law enforcement personnel?
2. What topics should training cover?
3. Who will provide the training?
4. What training strategies will be employed?

Step 7: Prepare for program evaluation

1. What resources need to be set aside or identified for an evaluation?
2. Are there individuals designated to oversee the evaluation?

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