Community Guide to Mental Health Crisis Response

Authored by
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Effective Law Enforcement for All

Effective Law Enforcement for ALL

Executive Summary

Our Mission

At ELEFA, our mission is in our name. We are striving for safer, more effective, and procedurally just law enforcement in every community. It's our hope that this guide can help empower you to engage with your local department, bring together stakeholders, and find a place to start improving mental health crisis response.

Our Team

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- New Recruit & Annual Inservice
- CIT
- Training Models

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Locations:

New Orleans, LA

Montgomery County, MD

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On behalf of ELE4A, we hope you are encouraged to start advocating for change. The problems in the system are massive, and can seem insurmountable, but the key is to start somewhere. The next steps can often illuminate themselves.

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Introduction

People with mental health conditions are 16 times more likely to be killed by law enforcement, making up 25% of all fatal law enforcement interactions. Increasingly, police departments and communities around the country are appropriately demanding change. As a response to this growing nationwide call, creative and successful programs have sprouted and grown, represented in rural, urban, suburban and tribal communities. This white paper is intended to explore the rationale for such programs, and crucially, some of the pathways towards positive change.

People affected by serious mental health conditions are more likely to be seen as violent, their lives more expendable and they too tend to be less likely to have the financial means to hire good legal representation. Just as young black men are killed at a far higher rate than their white counterparts, so too are people living with serious mental health conditions. These injustices are increasingly receiving the public attention they deserve, though media narratives about mental health have also contributed to the inflated sense of danger posed by this group. It is important to note, despite media coverage, that only 3-5% of violent acts are attributed to people with serious mental health conditions. In fact, people with serious mental health conditions are more likely to be victims of violent crime.

While stigma poses a serious challenge for law enforcement in mental health crisis response, the challenge is compounded by the fact that response to people in mental health crisis must meet unique needs in difficult conditions. For a law enforcement response to be successful, an officer needs to be appropriately trained and supported by a robust system so that people in crisis can have their treatment needs met and their safety ensured.

Communities can at times be overwhelmed by what needs to be accomplished and the resources change often requires, and be unclear on where to even start. This community guide's goal is to advocate that those in a community who want change ***just start somewhere***. There are many model programs that will be discussed that could scale or be adapted to fit a variety of communities. Knowledge on best practices in mental health crisis response is being developed in all kinds of places.

Starting somewhere will inform the next steps. Begin by organizing a mental health advisory committee of interested stakeholders to determine the "easiest door" to walk through—in other words, begin where there's already support. Collecting data about a community's progress, however small, can help generate momentum and illuminate the next best steps.

Tackling mental health crisis response is also often daunting because so much preventative work is missing. This guide will discuss how a broken system of mental healthcare has led to the reality that law enforcement have become a de facto mental health catch-all when their role in mental health response should be narrow and specific. That being said, this guide will primarily focus on what reforms need to happen and can happen in the space of law enforcement response, keeping in mind the reality that there are wider reforms that are required in mental healthcare.

After the murder of George Floyd, on camera for the world to watch, the time for change has never been so relevant. It is incumbent upon all of us to advocate for and in some cases demand change. It is important as advocates to educate ourselves, share our stories, offer solutions and be a part of the growing national dialogue and movement.

History

In the late 1950s and early 1960s, there was an important movement to get people living with serious mental health conditions out of state hospitals and into community-based treatment services. For years, state hospitals, often referred to as asylums, were used to house, research, and attempt to treat people living with severe mental health conditions. There are countless horror stories of individuals living in inhumane conditions, dilapidated and vastly overcrowded buildings, being severely over-medicated, isolated from family and other support systems, and used for experiments, including brain lobotomies.

Under President Kennedy, urgently needed reform was initiated with a promise to fund community based mental health services. This reform resulted in a mass exodus out of state hospitals. When Kennedy was assassinated, the funding allocated to community based mental health centers never came. Impetus for reform cooled. Consequently, the country began to see extremely sick individuals in communities without adequate resources.

Fast forward to today, community-based treatment is still vastly underfunded. Families (when involved) are often overburdened by significant health needs of their loved ones, difficult symptomology, and a broken treatment system. Unfortunately, law enforcement, jails and prisons have become the default system of "care".

Severe mental health conditions are neurological medical conditions. All too often, they are treated with a criminal justice, rather than a medical response. To make matters worse, the stigma which initially caused those with mental health conditions to be housed in inhumane asylums hasn't gone away. With many serious medical conditions (e.g. cancer), support systems show up, meals are provided, child care is offered, cards of love and support are received, prayers are offered up, good medical care is at the very least expected, if not always adequately

delivered. People diagnosed with cancer are seen as survivors, fighters, brave heroes. Events are hosted to support the cause, social media is used for additional support and often a network of people show up to support the journey. People diagnosed with severe mental health conditions are stigmatized as crazy, dangerous, or their health needs are seen as less serious than those with more visible illnesses. The stigma often leads to isolation. Typically, events are not hosted to support the cause, people do not post on social media, meals are not provided, cards of love and support are not received, and often good medical treatment is absent or inaccessible.

This system is fundamentally not fit for purpose, and requires massive reform. In its current state, it's easy to see how an inordinate burden of mental health "care" has fallen to police, as a sort of societal 'last resort'. Instead of treatment, people with severe mental health conditions are left to their own devices until a crisis occurs which is visible enough to warrant a call for 911.

It is equally important to emphasize that most police officers are good people who went into this line of work for all the right reasons. This sometimes gets lost when we have incidents around the country that are unacceptable. Like all professions, there are people who should not be in them. The difference between police officers and other professions is that law enforcement carry firearms and have the training and legal protection to shoot to kill when lives are in danger or are perceived to be in danger. Sometimes, bad judgment is made, and lives are unnecessarily lost. This is unacceptable and traumatic for so many. Law Enforcement officers are not trained clinicians and should not be expected to act as clinicians. However, law enforcement has taken an oath to treat people with dignity and respect, and to have the highest regard for human life. Because of this, it is incumbent on law enforcement and communities to work together to provide mental health training and response with a community treatment system that supports successful outcomes.

When we do not do that, and a criminal justice response is the default, trauma and tragedy are perpetuated. Handcuffs are used (usually determined by police department policy), and arrests are made (often for minor city ordinance and misdemeanor crimes) often because alternative treatment options are either not available or not easily accessible). Jails are all too often used as the default "drop off center", accounting for significant unnecessary cost to taxpayers, but more importantly disruption to continuity of medical care, with an increased risk of trauma and violence. In addition, when a jail booking occurs, a fine and court date is often incurred. People with serious mental health conditions are often unable to pay fines or get to court hearings, which leads to additional fines and court hearings and ultimately bench warrants in which the person is picked back up and booked back into the jail.

This cycle of criminal justice involvement must be addressed by community systems with a lens toward a more humane medical response to a medical condition. While the criminal

justice system certainly has an important role in transforming this response, it is also incumbent on the community ecosystem, including the community mental health system to step up collaborative innovation and response.

Ecosystem Approach

In light of a long history of failing to adequately meet both mental healthcare needs and crisis response needs, it's important to envision what a successful system would look like. Focusing on mental health crisis response, unlike some other police reforms, mental and behavioral health reform requires an ecosystem approach.

In a healthy ecosystem, a law enforcement response is supported by an array of other community conditions. For example, just like specific fish species require a habitat with adequate food resources, bacteria containment, temperature moderation, sunlight etc.; mental health crisis reform requires crisis center access for law enforcement, treatment advocates and family members to divert to, law enforcement training and trauma informed response related to persons living with and affected by severe mental health conditions, 911 diversion, jail intake and diversion efforts, mental health court liaisons/programs, alternative crisis response options, hospital emergency room collaboration etc.

In a broken ecosystem, created by a history which has sidelined mental health treatment, law enforcement are the *only* response to mental health crisis, and are isolated in their approach. Additionally, communities can create barriers that poison the ecosystem. Community organizations often operate in silos, create unnecessary turf wars, bring an unwillingness to share important data, acknowledge their own organization system failures, or focus on claiming single entity ownership for successes; all of which result in trust issues. These barriers prevent successful innovation.

Through this lens of ecosystem, successful change requires multiple entities working together, sharing data, owning mistakes, offering transparency in system barriers and their roles in it, with a commitment to put ego's aside and focus on ways to collectively address real issues. Some of these issues can be quite complex (HIPPA, State Legislation, Union etc.) With solution focused leaders up and down the chain of command in law enforcement, advocates, people with lived experience and professionals providing services on the ground and up through executive leadership, change is possible.

Many reform efforts require an ecosystem approach. In justice and behavioral health reform, this typically includes policy changes, training improvements, and operational innovation (in tandem across ecosystem organizations). This requires strong community collaboration with egos aside. Some of the operational innovation includes specialty/multi-disciplinary response

teams (both in and outside of law enforcement), proactive approaches to high frequency utilizers of first responder services, emergency communications (911) innovation, jail diversion initiatives, specialty courts, 24/7/365 crisis centers for law enforcement drop off, and collaborative data tracking to inform your own community reform roadmap.

It is not unusual when the whole ecosystem is considered that individuals, organizations, and communities can get overwhelmed by all that needs to occur to get in line with 21st century reform practices. It is not atypical to hear things like "We don't have the budget", or "this department or executive doesn't 'play well in the sandbox'", or "this issue isn't a priority for the people in power", or "we don't have data systems to do this". Some of these may be very real issues in your community. It can be helpful to equate this journey with an archaeological dig. Just start somewhere, and the data will unfold informing where the next logical step lies. This guide may help your community have some insight into where a good step for your community may be to start.

There is no one right answer. Envision a river and go in the direction that you have the strongest current. You can respond to the rocks blocking the current when you have more successes and momentum.

As law enforcement assessments are completed around the country, and with it the community ecosystem, it can be useful to approach the framework from a policy, training, operational, and accountability lens. Polices *inform* training, which *taken together support* operational practice. Accountability, internally and to the public, is essential to maintain reform and to strengthen public trust. Each of these elements are fluid and should be continuously audited and evaluated. The following sections of this guide will focus on policy, training, and operational practice with recommendations in each.

Policy

All police departments should have policies directing interactions with individuals with mental and behavioral health conditions, intellectual disabilities, and those needing special accommodations for physical limitations, deaf/hard of hearing, visually impaired, non-English speaking, gender and sexual identity etc.). In addition, a police department may have Crisis Intervention Team (CIT) and/or other alternative response policies. CIT will be discussed in greater detail later in this guide.

Unfortunately, these policies are often not updated regularly to reflect best practices, and to ensure they accurately reflect updated training and operational practices. Community

resources change, transition in department leadership occurs, there can be a disconnect between departments responsible for policy review and those actually providing program leadership and consequently, policy updates often get lost.

In a healthy community ecosystem, policies should be co-reviewed by key partners, and of particular importance, by community mental health center partners. Successful police reform in the mental and behavioral health space requires, at minimum, input from law enforcement, community mental health and people with lived experience.

Ultimately the final decision on *police* policy usually rests with the department, but good policy should reflect best practice language, integrate well with partner policy and operational practice, and should be informed by lived experience. It is of equal importance that key community partners, for example the community mental health centers, engage the police department(s) and persons with lived experience in the review/revisions of their relevant policies. The final decision on these policies rests with their organization but just like police policy, should include partner review and input. All collaborating entities need to be aware of and have input into what their organization/department directs them to do. This will help ensure policies are in sync with one another, and provide an opportunity to address areas that may create operational barriers.

These entities should ensure policies integrate well with other department policies, as well as telecommunicator policies, Fire/EMS policies and community mental health/crisis response policies. If a community has a CIT program, the designated CIT coordinator should be centrally involved in the revision process. Policies should be reviewed annually and updated as needed based on training, operational changes, best practices, and community input.

Training

With only about 4% of police calls for service ending in use of force, departments often have a heavy imbalance of training focused on proper use of force, tiered levels of force and custodial escort techniques (handcuffs, leg irons etc.). While this is critically important training, and police safety training should never be sacrificed, it is often at the expense of an equal or greater amount of training on a range of de-escalation practices and tactics; which are more aligned with how the majority of calls for service end.

Verbal de-escalation and strategies that support reducing the need for force should be of paramount importance and should be reflected in training priorities. Strategies like tone of voice, physical stance, using time as tactic, use of physical barriers, distance, cover, and

verbal/non-verbal communication strategies are measurable tactics that should be integrated into scenario-based training at all levels, reinforced, audited, evaluated, and included in policy, training, and operational compliance.

All of us naturally do what we are best trained for and repeatedly practiced. Departments all over the country would do well to train, practice, evaluate and reinforce proper use of de-escalation tactics as much as they do force tactics.

One good place to begin driving change could be to ask what types of training and certification are available in your community, who is receiving training, how often, and whether there are any standardized mechanisms to hold trained officers accountable, ensuring that training is reflected in operations.

Defining De-Escalation

In most police departments, the required response to resistance and use of force documentation, along with body worn camera review does not include a tangible assessment of "de-escalation" strategies. As indicated previously, measuring whether time, space, tone, cover, stance, asking open ended questions versus commands, calling for specialized units etc. are important to evaluate. There are tangible ways to assess use of de-escalation strategies, which reinforces to officers what the department means when they are prioritizing "de-escalation". Otherwise, the word becomes diluted, and the response is often seen as a "check box".

Departments should consider a requirement for Sergeants to randomly audit a specific number of BWC events after or during each shift, including those that were identified as having a mental health component. This is important not only for overall accountability and coaching, but also to assess de-escalation skills utilized, and resources accessed. It is also one of the reasons Sergeants should be prioritized to be trained in CIT or another equivalent mental and behavioral health training—to increase awareness of what strategies and tactics are supported by best practice. See the Further Resources section at the end of this guide for an example of De-Escalation Assessment.

Sergeants trained in CIT, or another equivalent mental and behavioral health training is an essential element to understanding what is being taught and in adequately supporting their patrol officers in utilizing these skills and resources in the field. Police departments should consider mandating all Sergeants and any newly promoted Commanders be trained in CIT or another robust mental health training, which with attrition and promotion, will build capacity and a culture of understanding the importance of the CIT program, mental health response and reform efforts. Mandating Field Training Officer (FTO) certification (officers who are paired with new officers in a mentor type role) should also be strongly considered, as new officers

coming into the field can be unduly influenced by FTO's who do not have the training or context of a CIT program or mental health response.

New Recruit & Annual Inservice

One way to gauge a police department's balance in use of force, mental health and de-escalation training is to review *both* the New Recruit and Annual Inservice Training and consider the number of hours allocated to mental health training, de-escalation, communication, crisis negotiation training (etc) compared to the number of hours dedicated to defensive tactics, firearms and other weapon training, active shooter, custodial escort techniques etc.

In addition, it is important to consider how many hours are dedicated to scenario-based training, which is essential. Use of Force scenario-based training all too often is made up of scenarios ending in force, rather than successful de-escalation. This can train officers to *expect* force rather than expect a de-escalated situation. Scenarios involving people in mental health crisis should also be integrated. In a mental health crisis, slowing things down, using distance, cover, body language, single command voice and softer interpersonal communication buys time to de-escalate and gain additional resources as needed. Most departments are severely out of proportion with other training topics upon close review of new recruit and annual in-service training

All scenario *evaluations* should include not just the officer's response - but also how it affects the public. Unfortunately, law enforcement around the country need to work hard to change the narrative of being seen largely as threatening to being seen as supporting and protecting. This is often referred to as the "guardian" rather than the "warrior" mentality.

Departments who have CIT programs should strongly consider integrating the CIT coordinator and/or CIT program key personnel into recruit and annual Inservice training to better integrate the policies, and practices from the beginning of an officer's time with the department and to regularly reinforce the importance of the program and its resources to more seasoned officers.

Annual Inservice training should require robust refresher training on mental health signs, symptoms and response as well as robust training on de-escalation, verbal/non-verbal communication, negotiations and overall crisis response, with scenario based exercises. Most departments require annual firearm and CEW (conducted electrical weapon—or taser) re-certification, but most do not require annual de-escalation strategies/tactics as part of an annual recertification. This can seem like radical change, but given the data on calls for service, use of force, lethal force and community trust, it certainly warrants strong consideration.

Crisis Intervention Team (CIT)

Crisis Intervention Team (CIT) training/program was developed in 1988 in Memphis TN after a fatal shooting involving a person in mental health crisis. The training became a gold standard model and includes a 40-hour training taught in one week by a multidisciplinary team of professionals, including law enforcement. Training matrices are fairly consistent across the nation covering a wide range of topics. A successful CIT program must include community partnerships, with local law enforcement, community behavioral health and people with lived experience and advocates key to success. More information on CIT can be found here: https://www.citinternational.org/.

CIT has been widely adopted and many communities already use the CIT model, but even in those communities it can be important to examine the individual mechanisms of the model to constantly seek improvement.

Under the traditional CIT model, officers volunteer to be certified through the 40-hour training and are considered a voluntary, specialized response. CIT officers would apply to become certified, demonstrating the right skills and interest to be considered a specialized officer. In a true CIT model, an application process would be developed with disciplinary history checked and the CIT coordinator would consult with the officer's supervisor to ensure a good fit. It is generally recommended that 20-25% of patrol is certified, and efforts are made to mirror the percent of CIT officers assigned to a district/shift to reflect the percent of Calls for service (CFS) involving a mental health condition in that district/shift. CIT officers often wear CIT pins on their lapels so they can be identified by community members as CIT certified and would be prioritized for dispatch to calls involving a person in crisis. Clearly, this model requires a mechanism by which mental health calls to 911 are able to be identified as a mental health call and dispatchers are aware of which officers are CIT certified in order to prioritize dispatch. This is another example of why ecosystem collaboration is essential.

Since 1988, communities and police departments have recognized the exceptional training that CIT provides, and many communities are moving to a mandated rather than voluntary model. In this model, some communities are mandating the training at the end of recruit training, some after field training, or after two or more years on the job, others choosing methods that meet their community and department needs.

There are pros and cons to each of these methods, and it is important for your community to educate yourselves and decide what is the best fit for you. It is important to remember that CIT is not just a one-off training, it requires an ecosystem collaborative approach to be successful, along with a regular cadence of refresher training.

A "train all" model can become diluted if not done carefully. This negates the specialized nature of CIT officers, and allows officers who may *not* be a good fit to be called to respond without the personality or skill set required. This can be dangerous. It is highly recommended in a mandated model that there is a "bumped up" specialized team of voluntary CIT certified officers who receive advanced training, are vetted for their interest and skill set, and would respond to higher level calls for service involving a mental health component. This voluntary cadre of officers can also make up a specialized unit (behavioral health units) and are central to expansion efforts including Mobile Crisis Response Teams, follow up teams, high frequency utilizer initiatives, homeless outreach, co-responders etc. (see Portland PD, Houston PD, LAPD, San Diego models). These bumped up specialized officers would wear CIT pins (not mandated officers) and would be prioritized for dispatch. In this model, it elevates all officers to receive critically important, in depth training, with important exposure to community-based resources, yet still maintains the specialized nature of voluntary CIT officers with the skill set and interest to be prioritized for response.

Of course, in some communities with fewer resources, having all officers go through a CIT or alternate robust mental health training is an improvement from limited to no training, and therefore an inability to create a behavioral health team, or "bumped up" model should not dissuade from increased training/awareness for all officers.

It is also important to remember that any training, and especially mental and behavioral health training for law enforcement, cannot be a "one and done" training. *All training models should include refresher training.* Annual refresher training is recommended, typically accomplished with annual in-service, but certainly should occur no less than every 2-3 years. Refresher training is critically important to practice skills in scenario-based training, to keep abreast of changing community resources and programs, refresh best practices on identifying common signs and symptoms of persons living with severe mental health conditions and how best to interact with and use tactics that support de-escalation and diversion from the criminal justice system whenever possible. It is recommended that if in-person annual inservice refresher training on mental health conditions and response can only occur every 2-3 years, that an annual on-line refresher course is identified and required for all officers in the years in between in-person refresher training.

Because of the nature of CIT training, which requires diverse community-based experts to deliver the curriculum, constraints on outside resources will need to be addressed. A collaborative approach, rather than siloed efforts to meet individual community needs is recommended. Some communities have been successful pooling resources and combining law enforcement from jails, courts, and outside police departments in one CIT class, along with key behavioral health personnel into one training. While there may be distinctions among the needs of different law enforcement agencies and behavioral health partners, a community can

address this by, for example, including stronger emphasis in areas that make up the composition of the class (e.g.: youth mental health focus for School Resource Officer (SRO) participants, scenario's specific to jail based settings for jail detention personnel etc.). There are successful and creative ways to accomplish this.

Another useful framework which incorporates CIT training is the IACP's One Mind Campaign. They recommend combining CIT training and Mental Health First Aid (MHFA) for law enforcement. MHFA is an 8-hour course endorsed not only by the International Association of Chiefs of Police (IACP) "One Mind Campaign" but is also a good overall educational tool to orient officers to signs and symptoms of mental health conditions, and responses that are often different from traditional police training.

The IACP's One Mind Campaign calls for communities to:

- Establish a clearly defined and sustainable partnership with one or more community health organizations.
- Develop and implement a model policy addressing law enforcement response to people in crisis and/or with mental health conditions.
- Train and certify 100 percent of sworn officers (and selected non-sworn staff, such as dispatchers) in mental health awareness courses by:
    - Providing Mental Health First Aid training (or equivalent) to 100 percent of officers (and selected non-sworn staff); and,
    - Providing CIT or equivalent crisis response training to a minimum of 20 percent of sworn officers (and selected non-sworn staff).

More information on the One Mind Campaign can be found here:
https://www.theiacp.org/projects/one-mind-campaign

Training Models

Background
Whatever model your community chooses, there are a minimum of six training areas that should be considered:
1. Recruit academy
2. Annual in-service for all officers
3. Pre-service promotion training
4. Refresher training.

5. Voluntary specialized mental health training and response options
and/or

6. Mandated specialized training for all officers, with bumped up voluntary, advanced mental health training and response options.

1. Recruit Academy, 2. Annual In-service, 3. Pre-service Promotion and 4. Refresher Training:

In recruit academy, annual in service, pre-service promotion training and refresher training, it is recommended to include an overview of common signs and symptoms of severe mental and behavioral health conditions, scenario-based training on best practices for de-escalating and interacting with persons in crisis, incorporate video scenarios from across the country (readily available and some options listed in appendix A), and expand on de-escalation strategies including Time, Cover, Distance, Tone, Stance, etc. These training topics can all be easily re-purposed from existing training content if your department already has CIT. There is no need to reinvent the wheel. Departments around the country are generally glad to share their slide decks and lesson plans. Additionally, pre-packaged training like Mental Health First Aid (MHFA) for Law Enforcement can be considered along with on-line training from companies like TNC. The hours allocated to training vary, but should be prioritized, which generally means the more dedicated hours, the higher the priority.

Pre-service promotion training should also include supervisor responsibilities for review of body worn camera (BWC) and should have a requirement to randomly select and review calls involving a mental health component.

Finally, whenever possible, communities should include key community partners and subject matter experts in these trainings along with a site visit to key community resources like drop off center(s). This helps not only to build important relationships with providers but also to inform responding officers on where to take individuals in crisis rather than the jail or hospital ER.

5. Voluntary specialized mental health training and response options
and/or
6. Mandated specialized training for all officers, with bumped up voluntary, advanced mental health training and response options.

As discussed when assessing CIT, the two predominant models are a voluntary or a mandated model. However, both of these models can be tweaked to best fit purpose in a community. Two example policies below can be thought of as a base framework to start from.

A voluntary specialized mental health training and response model:

1. ALL officers (mandated) complete a 3-day intensive mental health training which covers some of the essential topics typically contained in a 40-hour CIT course, and include

Scenario Based Training (SBT) and Site Visit(s). This serves as a foundational training for all officers.

2. Then, develop a process for Identifying appropriate voluntary specialized officers (Consider a Notice of Job Opportunity—NOJO-- which includes an application, interview, review of disciplinary and performance history, supervisor recommendation etc.).
3. Seek Goal of 20-25% across districts/shifts, but most importantly based on the percent of Calls for Service for individuals in mental health crisis across districts/shifts. The percent of mental health calls for service in each district and shift should roughly equate to the number of certified CIT officers in that district and shift.
4. Prioritize these specialized officers to be certified in the 40-hour CIT course or another equivalent specialized training. The FBI crisis negotiations training is a nice complement to specialized mental health training. Note: If your department already has CIT, be sure to re-certify specialized officers if it has been more than three years since they first received the 40-hour training and have had little or no refresher since.
5. As a community, develop an Advanced Training (Youth, Veteran etc.) to continue to strengthen specialized training for CIT certified officers.
6. Identify a "CIT District Level" Position(s), who is/are the primary point person for CIT in their district. They will be responsible for Roll Call Trainings on relevant topics, educating the district on any Alternative Response programs the community may have, share data on Mental Health calls for service (CFS) in their District, be a point person for High Frequency Utilizer notification, serve as a liaison with community partners, and track important call for service data etc.
7. Prioritize Research of National Models to continue best practices.
   Note: Consideration should be given to additional law enforcement and non-law enforcement mental health response options like: multidisciplinary response teams (with or without law enforcement); police co-responders (mental health clinician paired with CIT officer); mobile crisis teams; 911 telecommunication call diversion (embed a clinician inside telecommunications); jail diversion program (embedding case managers in the jail to divert for minor city ordinance or misdemeanor crimes); mental health court liaison; justice involved case management teams etc.

A mandated specialized training for all officers, with bumped up voluntary, advanced mental health training and response options:

1. For departments/communities moving toward all officers being mandated in the 40-hour CIT (or equivalent), you may want to consider offering the 40-hour CIT course one or two years after field training as opposed to extending academy. This permits officers to bring with them appropriate street experience, and reduces the training exhaustion that often comes with recruit academy. An alternative for departments wanting to extend academy for this purpose, consider offering a shortened, for example 20-hour, brief CIT training covering the most important topics, with the full 40-hour training as capacity allows one to two years post field training. There will need to be a strategy developed for how to prioritize veteran officers for training as well, not just new officers. This is a mistake many departments make.
2. It is useful in a mandated model for communities to broaden their pool of trainers to increase capacity while not burning presenters out. Many community experts (for

example on VA, Autism, Intellectual Disabilities, PTSD, Mental Health, Substance Use) are eager to assist with this important community training and program.
3. Implement steps 2-7 for the "bumped up" cadre of voluntary, specialized officers, an essential component of a mandated model.
4. Ensure annual refresher (or at minimum every 2-3 years) for *all* officers, and with additional advanced training for specialized officers. Advanced CIT for Youth, Veterans and the FBI Crisis Negotiations Team are good options.

Two mistakes departments frequently make is 1. not providing annual refresher training for all officers on identification and response to mental health crisis with robust de-escalation strategies and tactics included and 2. Providing the 40-hour CIT training years ago with no refresher training provided since. This would not be a specialized response. If more than three years have passed since receiving the 40 hour CIT training with no refresher since, it would be recommended for these officers to re-take the 40 hour CIT training and then pick up the regular cadence of refresher training. While refresher training can take the form of on-line e-learning one year, it should always include in-person classroom training with scenario based exercises on off years. Inclusion in annual in-service training is recommended.

These six elements are a basic framework to be built on. Consideration should also be given to additional law enforcement and non-law enforcement mental health response options like: multidisciplinary response teams (with or without law enforcement); police co-responders (mental health clinician paired with CIT officer); mobile crisis teams; 911 telecommunication call diversion (embed a clinician inside telecommunications); jail diversion program (embedding case managers in the jail to divert for minor city ordinance or misdemeanor crimes); mental health court liaison; justice involved case management teams etc.

Operations

Training shouldn't exist in a vacuum. It should be part of a robust CIT program, reinforced by policy and procedure, and should be reflected in the field. A robust CIT program involves chain of command leadership and recognizes CIT certified officers who are doing outstanding work in the field. Having chain of command leadership (usually captain and above) serve as the program coordinator helps ensure enough rank both up and down chain of command to implement change.

Whenever possible, have the Chief, Deputy Chief or Major speak at the beginning of CIT classes. This helps to demonstrate their support and commitment to the program, set expectations, and helps ensure that officers will give utmost attention to presenters (not be on phones/computers/leave the room etc.).

There must be leadership, usually in the form of a CIT coordinator, who helps lead the program. It is important to develop a strong Position Description (with key stakeholder input), requiring an application, vetting skill set, interviewing applicants, speaking with supervisors, and adding considerations with rank, education, experience, disciplinary and performance history. Interviews should include key community partners (minimally the community mental health center designee), just as clinicians working alongside the police department should have police involved in writing job descriptions, interviewing, and selecting candidates. When both law enforcement and community stakeholders agree on a candidate, there is less opportunity for pointing fingers when something does not work out. Additionally, for programs to be successful, there must be buy-in from all entities that it is a good cultural match.

If there is no budget allocated to CIT (or equivalent) training, consider allocating that. If it is not possible, organizations involved in CIT could consider sharing budget allocations, either direct line-item contributions, and/or donations (space, food, CIT pins/resources, a designated coordinator etc.). This has been successful in many communities when budget is a barrier.

Alternative Response and System Integration Models

It is estimated that between a quarter and a third of 911 calls are considered low-priority or non-urgent calls, not requiring armed law enforcement response. Some of these calls include trespassing, noise complaints, pets, loitering, non-urgent medical needs including mental health. Law enforcement response including lights, sirens, uniforms, commands, guns, and arrests often serve to escalate the situation. With that said, when individuals call 911, it is police duty to respond. So, we must do a better job of providing alternatives and educating the public.

A wide array of alternative responses, inside and outside of police departments, have developed in recent years. Some of them will be identified below for your community consideration.

- Embed community mental health center case manager(s) inside the jail to crosscheck the daily jail booking report with the client database at the community mental health center. This allows for identification of active clients who are booked into the jail, for what crimes, how long they are in jail and at what cost to the city. These basic data points help inform areas for diversion, rapid communication with jail mental health staff regarding medications the individual is on for continuity of care inside the jail, assists with coordinating a warm handoff at release from the jail with either a family member, their assigned case manager or a person with lived experience, and identifies high frequency utilizers to connect with justice involved case management teams for proactive outreach.
- These same case managers can also be assigned to the mental health dockets for continuity between jail, judges, attorney's, psychiatric services, and client case managers.

- Develop justice involved case management teams who have the role of proactively serving the high frequency utilizers of law enforcement and first responder calls and jail bookings.
- Embed a clinician(s) inside telecommunications (citizen facing) to divert non-urgent 911 calls from Law Enforcement response at all, while also utilizing a warm hand off as necessary to a resource line or community mental health hotline.
- Consider variations of dedicated co-response teams that can include combinations of a paramedic, clinician, law enforcement (recommend soft uniform) and PEER (person with lived experience). These teams often present opportunities to move away from law enforcement focused response and law enforcement transport (criminalizing mental health conditions), and toward a medical response providing an unmarked vehicle with locked seat belt restraints or EMS transport instead of handcuffs and a marked police unit.
- Traditional co-responder model (clinician riding with a mental health trained officer or deputy)
- Mobile crisis response teams typically formed by community mental health centers to respond to calls not requiring police presence. Response times (as quickly as possible) are important as individuals and families in crisis are more likely to call 911 if response times are too long. These mobile crisis response teams can sometimes also be successfully utilized for police call outs by officers on scene of a call not requiring law enforcement response.

There are many combinations of these models that are successfully utilized in communities, and an internet search will give additional models to consider.

Considerations in Alternative Response Models:

- A clear line of supervisory chain of command is essential, particularly for the clinicians/case managers. If a clinician or case manager is housed inside a police department or paired with an officer, agreement must be clear in advance and written into MOU's and job descriptions. Typically the clinician reports up to their mental health center supervisor with the officer reporting to the CIT coordinator, however there must be trust and strong communication between the supervisors to quickly respond to any issues that arise.
- Consideration should be given to where clinicians and case manager are housed, within the Police Department or Mental Health Center. Often, housing clinicians inside Police Headquarters, or at police district offices allows rapport to be built with officers and allows an ongoing opportunity to promote the program to officers.
- Alternative uniforms and vehicles should be strongly considered. Stigma is exacerbated when marked police vehicles and regular police uniforms show up on scenes where someone is calling for help due to a mental health crisis. Not only are people embarrassed to have a police car in front of their homes, but uniformed police can also escalate a situation with someone in behavioral health crisis. A "softer" approach through non-traditional uniforms and vehicles is a good approach to consider.
- The job description, selection and hiring of the co-responder/alternative response positions should be carefully and thoughtfully considered and should be co-developed and co-interviewed minimally between the Law Enforcement and Community Mental

Health Center. It is imperative that both organizations agree that the person(s) is a good match for the role.

- Consider internal versus external clinical hires. It is a steep learning curve just to learn the services, agency protocols, and accessibility guidelines within the organization you work for, let alone attempt to do it as a part of a new pilot program that needs to be successful early on. If officers see that clinicians do not know where to take someone, what paperwork will need to be completed to access those services, who to call in the organization etc., officers will often give up on the use of it. This is difficult to rebound from. Typically, seasoned clinicians are hired internally, who already have strong familiarity with the organization operations.
- A data analyst should be considered, either internal, or externally contracted- typically with a local University for a more robust community analysis of data.
- SAMHSA's Sequential Intercept Mapping (SIM), and the Sequential Intercept Model are good resources and training for communities to help identify gaps in community systems.
- CIT training and specialized programs should be highlighted on the police department and mental health centers websites. When absent, it is often an indication of both how CIT may be viewed by the department, and sometimes the overall disjointedness of the program itself. When CIT and Alternative responses becomes an embedded community program, as intended, it should be identified on the website like any other specialized response.

24/7/365 Law Enforcement Drop Off Centers

For successful community programs, it is essential to have a 24/7/365 drop off crisis center for law enforcement to divert from the criminal justice system; having somewhere to take individuals rather than jail and hospital emergency rooms.

The turnaround time for officers to drop off and return to duty is essential. There should be a brief standardized report that captures important data, and an officer should be in and out within 15 minutes. It is always nice to have coffee and small snacks available for officers as well! Making it an "officer friendly" environment helps improve utilization.

Remember, if it is quicker to book someone into jail than to bring to the crisis center, a system is not as functional as it needs to be! And, if a crisis center has too many restrictions (officers must go somewhere else if the individual is using alcohol or drugs, or talking about suicide etc.), it will not be used effectively. Law enforcement should be able to drop individuals off (with reasonable limitations) and crisis center staff be responsible for arrangements for transport elsewhere if needed.

A robust 24/7/365 drop off center for law enforcement officers (that typically can also be accessed by individuals and families themselves) is essential and should be funded and supported. (See San Antonio, Phoenix).

If your community is too small for a robust 24/7/365 drop off crisis center, consider collaborating with surrounding regions, or partnering with your local hospital. Once a community starts to see results, there can be a chance to expand smaller programs towards the ideal 24/7/365 crisis center. This is also why gathering data at the center is key: find out who is being diverted from jails and how both their experience is improving and other elements of law enforcement are benefiting. More about the importance of data, and what can and should be collected, will be discussed in the section on data.

Community Mental Health Advisory Committee

A Community Mental Health Advisory Committee is a multidisciplinary team that serves as a foundation to innovation and successful community response to persons in crisis. The Advisory Committee should openly share data/information, explore alternative approaches to law enforcement response, identify gaps in service, and be deliberate on how best to respond to them, etc. The Advisory committee should meet monthly and is a critical foundation to any successful community program.

At *minimum,* participants should include representative(s) from:

- Police Department(s)-usually the CIT coordinator
- Community Mental Health-usually the emergency services director
- Sheriff's office-usually the unit commander that oversees involuntary commitments and/or a CIT deputy on a co-response team; and/or a CIT deputy who serves involuntary commitment petitions
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- Jail-usually the jail administrator and/or the mental health nurse and/or a ranking deputy assigned to the mental health pod or to booking
- Hospital ER's-usually the psychiatric nurse or psychiatric case manager
- Judiciary-usually the judge who oversees the probate court docket (mental health docket)
- Advocacy groups like National Alliance on Mental Illness (NAMI) and/or persons with lived experience
- Telecommunications
- Fire/EMS

This critically important advisory committee should always include cross discipline collaboration, including both on the ground expertise and high enough rank/executive leadership to make and implement decisions. The advisory group should be small enough to encourage rich dialogue and data sharing, but large enough to include at least one committed designee from each key stakeholder entity.

A functional, outcome oriented advisory committee must be able to put ego's aside, with full transparency, engagement, and trust building, including shared decisions, data collection and analysis to identify gaps in the overall system, while working collectively to find solutions including informing program expansion. Beyond building or strengthening a CIT program; a Behavioral Health Unit; and other Alternative Response efforts, this group can also make recommendations on jail diversion programs, specialty court collaboration, intensive case management teams for justice involved individuals and other key response and diversion programs for people in crisis.

Many states and communities have both a County and State Steering Committee, with the county steering committee made up of entities like those listed above, and a state steering committee made up of a designee from each participating county across the state. This can be very helpful to legislative change, collaborating on CIT and other alternative response efforts, and learning from one another's successes and challenges.

911 Call Takers & Dispatch

All too often, telecommunications (and Fire/EMS) can get forgotten in the overall ecosystem of a successful community program. They are both critical partners.

Telecommunications are often the first point of triage. Many communities have robust Mental Health Awareness or CIT training specifically for telecommunications. This is a critical component of a robust program call takers are the individuals identifying the calls, gathering crucial information, triaging and dispatching the correct response. The information gathered for responding officers can literally be life saving information. Some recommendations and best practices include:

- Develop Telecommunication Specific Mental Health Awareness or Crisis Intevention Team training (ex: 8 hour or up to 3 Days) or include Telecommunications in the 40-hour CIT program (or equivalent). Ensure there is also regular, robust, ongoing refresher training for telecommunications.
- Prioritize Response of CIT officers to Calls for Service involving a mental health component.
- Establish clear criteria for telecommunications to identify the call for diversion to an alternate resource, a co-response or non-law enforcement response where appropriate.
- Ensure there is a coordinated effort and strong relationship between the CIT coordinator, telecommunications and the mental health center to cross train on Mental Health related efforts. Each need to have thorough awareness of respective program(s) and resources. It is critically important to have a streamlined approach.
- Establish call codes that best capture overall calls for service (CFS) that involve a mental health component. Some departments limit call codes to things like "suicidal" or "Mental Health". It is important to develop a strategy for identifying a way to uniformly track incoming calls that involve a mental health component. While this will not always

be perfect, since many calls have overlapping characteristics, there should be a designation that triggers an automated set of triage questions at call intake. It is recommended that telecommunications have designated pop-ups in their digital system capable of asking basic triage questions that can then be transmitted over the air and via Computer Aided Dispatch (CAD) to responding officers. For example, known mental health condition (given by caller); behaviors present; weapon present (including type); triggers that can escalate behavior etc.

- In addition, many communities have a designation (ex: alpha character z) that is added to any call, regardless of how it was dispatched, that officers can close out the call to indicate it involved a mental health component. For instance, if an officer is dispatched to a domestic call, but once on scene, it clearly involves a mental health component, the call can be closed out adding the alpha character z to the formal call code. This then allows data to be pulled to reflect calls more reliably that contained a mental health component. While CFS involving "trespassing", "loitering" "person down", etc. are important call codes to monitor these do not always involve and may not be appropriate to include in data collection for calls with a mental health component.
- Embed a Citizen Facing Social Worker(s) in telecommunications to divert non-emergency calls.
- Telecommunications should have a shift roster of CIT officers on duty where law enforcement response is needed to ensure there is an automated way to prioritize dispatch of Mental Health calls for service to CIT trained officers or behavioral health units. This should be part of an overall robust strategy.

Data Recommendations

As part of the "archeological dig" referenced in this guide's introduction, reliable data is essential to inform next steps and overall success or areas for improvement. Listed below are data recommendations to consider.

It is imperative that data collection and analysis is coordinated at all levels, including partnering organizations, to inform program assessment, identify gaps, reduce silos and ensure strategic planning/alignment. Data reporting should be shared with the mental health advisory committee regularly and used to inform system gaps and needs.

While this is not exhaustive, and should be community driven, listed below are some of the primary suggested data collection:

Police Department:

CIT Report:

- Calls that are closed out as calls involving a mental health component should require a CIT report be completed. The CIT report should include such information as name, address, mental health condition (if given by the person themselves or a family member on scene); characteristics indicating a mental health condition (talking to themselves or others, hearing things that you do not hear, rapid speech, depressive characteristics, odd behavior etc.); whether or not a weapon was involved, and if so, what type (knife, firearm, other object etc.); use of force and type by officers, Disposition of the call, including: resolved in community, referred to community based services; transport to services (voluntary or involuntary); arrest (city ordinance, misdemeanor, felony), referral to alternative response team etc. These data reports should be routed through the CIT coordinator and his/her team to track trends, including high frequency utilizers that can be referred to additional alternative response and support services.
- Data indicating overall calls for service, of those, number of calls for service involving a mental health component (ex: alpha character z), of those, how many were responded to by a CIT certified officer (primary or assist), of those, disposition of the call.
- Percent of CFS that involve a mental health component by district/watch (shift).
- Time from arrival on scene to close out of call (this is good to monitor distinctions -if any- for CIT calls vs non-CIT calls).
- Percent use of force and types for CIT and Non-CIT officers.

To measure overall department wide buy-in and culture re: CIT efforts:

- Number/Percentage of active sworn officers trained in CIT.
- Number/Percentage of active SGT's Sergeants trained in CIT.
- Number/Percentage of active Commanders trained in CIT.
- Number/Percentage of active FTO's trained in CIT.
- Advanced and Refresher Training for all officers.

This is best accomplished through a digital system like LMS (learning management system)

<u>Community Mental Health Center:</u>

- Number of persons dropped off at the crisis center by law enforcement
- Circumstances for drop off (ex: intoxication, psychosis, homeless, trespassing, etc.)
- Time for police "turnaround"—drop off to back on the street
- Number of persons "turned away" from law enforcement drop off and why
- Length of Stay for person in crisis
- Linkage to Services at discharge, and what services
- Involuntary Commitment and if so, transported to what location
- If not brought to the drop off center, would the person have been arrested and for what charge? (should be included in the law enforcement drop off paperwork)

<u>Mobile Crisis Call Outs by distinct teams (inside and outside of law enforcement response):</u>

- Number of persons outreached (by location)
- Type of Outreach (clinical assessment; jail release; hospital release; follow up check in etc),
- Who requested the outreach (self-initiated, request by law enforcement on scene or off scene, family member, service provider, community member, 911 dispatch etc,)
- Time from request to arrival on scene
- Time on scene
- Disposition of call (involuntary transport to treatment, resolved in community, voluntary transport to treatment; crisis center drop off, hospital drop off etc.)

Public Education Campaigning

The community should be educated on Mental Health resources, and how to access them for both crisis and non-crisis situations. If your community has a CIT program, the community should be made aware of how to request a certified CIT officer and/or other alternative responses available to persons in behavioral health crisis. They should be able to identify the officer by the CIT pin or badge they wear on their uniform, or the soft uniform of specialized response (with or without law enforcement).

Specialized program liaisons and officers should consider attending community meetings, carrying resource cards to give to families, promoting the programs on website and community policing initiatives, through NAMI and other advocacy organizations, and other robust efforts to actively promote the program. There are many opportunities to educate the community, however a cohesive mental health and alternative response strategy needs to be developed before extensive community education.

Conclusion

It is our hope that this community guide has offered some relevant information for you to consider for your own community's journey on 21st century practices to responding to persons in behavioral health crisis. This is by no means meant to be comprehensive, as there are growing innovations occurring all over the country. Our 'further resources' section at the end of this guide may provide more stepping-off points that can generate discussion. As noted in the introduction, the key is to ***start somewhere***, even if it's your own living room. People with passion for change and a commitment to improvement can get started by bringing each other together and asking questions around a table.

On behalf of ELE4A, we wish you the best of luck.

Effective
Law Enforcement
for ALL