

A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness

Melissa Reuland

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**By
Melissa Reuland
Police Executive Research Forum**

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Chapter 1

Introduction to the Problem

Maryland Man Shot by Officer is Mentally Ill

Mentally Ill Offenders Still Ending Up in Jail

*Mental Illness Frequently Deepens Tragedy
of Police Shootings*

The creation of community-based programs designed to serve people with mental illness did not follow the deinstitutionalization of the 1960s and 70s as intended. The headlines quoted above illustrate that law enforcement, mental health, and other community agencies continue to be challenged by situations involving people with mental illness. Over the last 15 to 20 years, law enforcement agencies nationwide have increasingly developed programs or practices designed to serve people with mental illness. This monograph is a guide for agencies embarking on this course. It addresses what law enforcement agencies are doing nationally to improve their response to people with mental illness—largely through partnerships with the mental health community—and explores how these agencies have overcome barriers to create and maintain effective programs.

1. Nature of the Problem

The source of the problem, sometimes known as the “criminalization” of mental illness, may stem in part from deinstitutionalization, inadequate or inaccessible community mental health services, and stringent involuntary commitment criteria (Newell, 1989; Lamb and Weinberger, 1998; Abram and Teplin, 1991; Richman et al., 1992; Wachholz and Mullaly, 1993; Perkins et al., 1999; Teplin, 2000; Vickers, 2000). It is clear, however, that the impact of the problem extends to law enforcement officers (Wachholz and Mullaly, 1993; Perkins et al., 1999; Lurigio and Swartz,

In this chapter:

- Nature of the Problem
- The Spread of Specialized Responses
- Monograph Overview

Research on the extent to which police interact with people with mental illness ... suggests that law enforcement must become more active in addressing the problem.

2000). One commentator has observed that “the public repeatedly calls on law enforcement officers for assistance with people who are mentally ill ... because peace officers alone combine free, around-the-clock service, with unique mobility, a legal obligation to respond, and legal authority to detain” (Finn and Sullivan, 1987). Moreover, law enforcement agencies may be aware that they are not effectively responding to people with mental illness, yet be reluctant to confront the problem out of fear they will be responsible for solving it.

Research on the extent to which police interact with people with mental illness, however, suggests that law enforcement *must* become more active in addressing the problem. For example, in New York City, the police department responds to a call involving a person with mental illness once every 6.5 minutes (Fyfe, 2002). In one year, law enforcement officers in Florida transported people with mental illness for involuntary examination (Baker Acts) over 40,000 times, which exceeds the number of arrests in the state for aggravated assault or burglary. In their case study of Birmingham, Knoxville, and Memphis police departments, Borum et al. (1998) found that, overall, officers had an average of six encounters with people with mental illness in the previous month.

While these are not the *most* numerous calls for law enforcement, encounters with people with mental illness consume a considerable amount of time. DeCuir and Lamb (1996) estimate that in 1985, the Los Angeles Police Department spent over 28,000 hours in each 28-day deployment period handling calls involving people with mental illness. Pogrebin (1986) examined data from 60 mental health calls received by a suburban Colorado police department and found that the average amount of time spent on these calls was 74 minutes. The amount of time it takes officers to address these encounters is clearly disproportionate to the percentage of the caseload they represent.

Calls to the police involving people with mental illness represent a wide range of situations—from transporting an individual to a mental health facility to situations involving potential threats to public safety. The public policy debate is often driven by those rare circumstances in which an officer is injured or force is

used to control a person in crisis who has a weapon. Tragic or ineffective outcomes can result from a lack of resources or lack of knowledge of what resources are available.

Law enforcement officers often have few options available when responding to calls involving people with mental illness. Officers may therefore leave an individual at the scene with only a short-term resolution of the crisis or take the person to jail. Based upon data from Cook County, Illinois, the prevalence rate of current severe mental disorder was 6.4 percent for male detainees entering the jail (Teplin, 1990) and 12.2 percent for female detainees (National GAINS Center for People with Co-occurring Disorders in the Justice System, 2001).

Law enforcement agencies across the country have begun to change their practices and develop innovative partnerships with the mental health community to improve their responses to people with mental illness. Data from a 1996 survey of 174 cities with populations of 100,000 or more revealed that 78 departments had a specialized response for people with mental illness (Deane et al., 1999). In this national survey, Deane and colleagues identified three types of specialized responses. The first strategy, *police-based specialized police response*, uses officers who have received special mental health training to provide crisis intervention services and to act as liaisons to the mental health system. Six of the departments surveyed used this method. Deane and her colleagues refer to the second strategy as *police-based specialized mental health response*. Under this strategy, police departments hire mental health consultants to provide on-site and telephone consultations to officers. Twenty of the agencies surveyed used this response. Fifty-two of the agencies surveyed used the third strategy, which was referred to as the *mental health-based specialized mental health response*, which often included a mobile crisis team.

2. The Spread of Specialized Responses

The Police Executive Research Forum (PERF) recently conducted a survey of 80 law enforcement agencies identified in the literature as using specialized responses to situations involving people with mental illness. PERF staff conducted telephone interviews with a subset of 33 agencies that use specialized responses meeting the criteria defined above. For

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the purposes of this monograph, 28 agencies utilizing police-based responses were analyzed. These include police-based specialized police responses, primarily using Memphis’s Crisis Intervention Team model (22), and police-based specialized mental health respons-

es (6). Law enforcement agencies that use a mobile crisis team response only are not included in this discussion because significant changes in police training or procedures have not occurred as a result. The table below provides an overview of the 28 agencies and their programs.

Table 1. Law enforcement agencies with police-based specialized responses analyzed by PERF¹

Jurisdiction	Type of response	Number of hours of special training	Number of officers	Population served	Outcomes
Akron, OH Police Department	CIT	New recruits: 16 in the academy All patrol: 8 Special teams: 40-72 Call takers/dispatch: 0	498	223,019	Good community relations; changes in perceptions both in the community and the department; decrease in officer/subject injuries; acceptance of CIT by the community. Measured by statistics, anecdotal evidence, and evaluations.
Albuquerque, NM Police Department	CIT	New recruits: 56 in the academy All patrol: 0 Special teams: 40 hours once (for CIT and SWAT) Call takers/dispatch: 10 hours	848	425,000	Police shootings, assaults and batteries and SWAT activations have decreased; good police/mental healthcare relationship. Measured by police statistics.
Arlington, TX Police Department	CIT for all officers	New recruits: 8 in the academy All patrol: 4 (sporadic) Special teams: 4 (sporadic) Call takers/dispatch: UNK	498	302,886	Increased officer knowledge of mental illness; officers have name/face recognition of liaisons; increased comfort level and willingness of officers to get help over the phone; statistics indicate APD is a leader in utilizing the mental health liaisons; no use of force dealing with people with mental illness for years; no press criticism or lawsuits.

¹ Agencies that provide CIT training to all officers indicate this training in the “New Recruit” category rather than in the “Special Teams.”

Jurisdiction	Type of response	Number of hours of special training	Number of officers	Population served	Outcomes
Athens-Clarke County, GA Police Department	CIT for all officers	New recruits:0 All patrol: 40 once Special teams: 0 Call takers/ dispatch: 40 once	210	101,000	Good public image with advocacy groups; working relationship with mental health community is good; positive public perception of department has increased; training has been well received; no problematic use of force issues; officers are supportive of the program. Measurements are anecdotal.
Baltimore County, MD Police Department	Mobile Crisis Team (police/mental health professional co-response)	New recruits: 40 in the academy All patrol: 0 Special teams: 0 Call takers/ dispatch: 0 All members are encouraged to attend training classes.	1,807	754,292	Officer (measured through surveys) and consumer satisfaction (anecdotally).
Cincinnati, OH Police Department	Mental Health Response Team (modeled after Memphis CIT). Two districts have social workers that respond with officers.	New recruits: 20 in the academy All patrol: 8 once Special teams: 40, with 8 annually Call takers/ dispatch: 0 (in planning)	1,000	364,040	Good officer and mental health worker enthusiasm. They are starting to collect statistics and introducing documentation for tracking data.
Delray Beach, FL Police Department	CIT	New recruits: 0 All patrol: 0 Special teams: 40 hours CIT Call takers/ dispatch: 0	156	55,000	Officer satisfaction. They are starting to collect statistics and introducing documentation for tracking data.

Jurisdiction	Type of response	Number of hours of special training	Number of officers	Population served	Outcomes
Florence, AL Police Department	Community Mental Health Officers (based on Memphis CIT)	New recruits: 2 in the academy All patrol: 2 annually Special teams: 120 annually Call takers/dispatch: 2 once	91	41,000	Fewer people sent to state hospital for treatment.
Ft. Wayne, IN Police Department	CIT	New recruits: 7 in the academy All patrol: 1 annually Special teams: 40 once, with 16 annually Call takers/dispatch: 0	420	202,000	Arrest rate for persons with mental illness below national average (below 1%). Success measured through departmental statistics and public feedback.
Houston, TX Police Department	CIT	New recruits: 24 in the academy All patrol: 8 once Special teams: 40, with 8 hours annually Call takers/dispatch: 4 once	4,905	1,734,335	Increased knowledge and expertise of CIT officers; increased knowledge and proficiency of ALL officers; positive feedback from doctors, family members and consumers; 99% of people seen by CIT access help.
Jackson County, MO Sheriff's Department	CIT	New recruits: 0 All patrol: 4 once Special teams: 40 (TBD once vs. annually) Call takers/dispatch: 8 annually	100	630,000	They are starting to collect statistics and introducing documentation for tracking data.
Galveston County, TX Sheriff's Department	Mental Health Deputies (similar to CIT – around since 1975)	New recruits: 12 in the academy All patrol: 0 Special teams: 16 Call takers/dispatch: 0	380	300,000	Increased calls for service. Measured with statistics.
Kansas City, MO Police Department	CIT	New recruits: 25 in the academy All patrol: 0 Special teams: 40 once Call takers/dispatch: 1 once	1,278	435,146	Increased officer training and increased officer/community awareness of CIT; increased police/partner relations. Success measured with statistics.

Jurisdiction	Type of response	Number of hours of special training	Number of officers	Population served	Outcomes
Knoxville, TN Police Department	CIT for all officers. Mobile Crisis Unit available (mental health professionals – can be first response or co-response)	New recruits: 24 in the academy All patrol: 4 biannually Special teams: 0 Call takers/dispatch: N/A	392	174,000	Increased officer safety; no fatal shootings.
Lee’s Summit, MO Police Department	CIT	New recruits: 8 in the academy All patrol: 0 Special teams: 40 once Call takers/dispatch: 4 once	103	70,500	Downward trend in suicide or attempted suicide cases.
Lincoln, NE Police Department	CIT for all officers (started in 1970s)	New recruits: 8 in the academy All patrol: 0 Special teams: 0 Call takers/dispatch: 0	303	225,000	Improved police/mental health system collaboration; increased police/mental health communication.
Little Rock, AR Police Department	CIT	New recruits: 40 in the academy All patrol: 2 Special teams: 40 Call takers/dispatch: 0	571	181,157	Increased officer/community awareness. Track outcomes with statistics.
Long Beach, CA Police Department	Mental Evaluation Team (consists of an officer with graduate-level education and a mental health professional co-response)	New recruits: 10 in the academy All patrol: 3 annually Special teams: extensive/varies Call takers/dispatchers: 0	839	437,000	Significant cost savings to taxpayers; time savings to patrol officers; MET recognized with many honors; team has done 500 calls per year per car.
Los Angeles, CA Police Department	CIT Systemwide Mental Assessment Response Team (SMART – police/mental health professional secondary co-response) Mental Evaluation Unit (MEU – 24-hour hotline available to officers)	New recruits: 10-12 All patrol: 4, with 1 annually Special teams: 40, with 8 annually Call takers/dispatch: ¾ hour, with 1 hour annually	9,324	3,501,487	Will track outcomes in future.

Jurisdiction	Type of response	Number of hours of special training	Number of officers	Population served	Outcomes
Memphis, TN Police Department	CIT	New recruits: 10 in the academy All patrol: 1.5 (varies from 1 to 2 hours) Special teams: 40, with 8-32 annually Call takers/dispatch: 16, with 2 annually	1,900	650,100	Acceptance from the community, family members, consumers, providers, and law enforcement officers; timelier reporting of crisis events; reduced injuries; helps identify and recognize the inappropriateness of the stigma of mental illness. Success measured by statistics.
Middletown, CT Police Department	Mobile Crisis Team (usually police/mental health professional co-responders)	New recruits: 8 in the academy All patrol: 2 annually Special teams: 2 annually Call takers/dispatch: 0	100	44,000	No negative repercussions from the partnership; positive relations between partners; MCT satisfaction with police responses. Mostly measured anecdotally.
Minneapolis, MN Police Department	CIT	New recruits: 12 in the academy All patrol: 2 biannually Special teams: 40, with 12 annually Call takers/dispatch: 0	938	373,000	Decrease in MI-related fatal shootings; since June 2001 officers have made close to 4000 crisis transports; level of support for police from mental health groups increased. Measured statistically and anecdotally.
Montgomery County, MD Police Department	CIT	New recruits: 3 in the academy All patrol officers: 40 (voluntary) Special teams: 40 Call takers/dispatch: 40 (voluntary)	1,072	846,000	Decreases in repeat calls for service; decreases in officer/consumer injuries. Measured by statistics.
New London, CT Police Department	CIT	New recruits: 8 in the academy All patrol: 3 every 3 years Special teams: 40, with updates Call takers/dispatch: 0	92	26,000	Increase in officers using communications skills in situations and a decrease in restraints, physical confrontations, and liability; increased support of consumers and the agencies that support them.

Jurisdiction	Type of response	Number of hours of special training	Number of officers	Population served	Outcomes
San Diego County, CA Sheriff's Department	Psychiatric Emergency Response Team/PERT (mental health professional/police co-responders)	New recruits: 10 in the academy All patrol: 0 Special teams: 40, with 7 hours monthly Call takers/dispatch: 0	2,700	784,333	The PERT team collects information on disposition, transportation utilization, and response times. Law enforcement evaluation of PERT is positive. PERT has positive name recognition.
San Jose, CA Police Department	CIT	New recruits: 6 in the academy All patrol: 0 Special teams: 40, with 10 annually Call takers/dispatch: 4 once	1,400	909,100	Decrease in officer-involved shootings; 32% decrease in officer injuries since last year; community satisfaction; increased requests for information about their program. Measured through departmental statistics.
Seattle, WA Police Department	CIT	New recruits: 4 in the academy All patrol: 8 once Special teams: 40 Call takers/dispatch: on occasion	1,262	534,700	Officer satisfaction and positive feedback from community providers.
Seminole County, FL Sheriff's Office	CIT	New recruits: 2 in the academy All patrol: 2 once Special teams: 40 once Call takers/dispatch: 5 once	342	365,000	Reduced repeat CFS and reduced recidivism.

3. Monograph Overview

The chapters that follow provide information on these two specialized police-based models of response to people with mental illness, ways the models have been implemented across the country, and strategies for planning and implementing similar programs. Throughout this

document, data from PERF's recent survey of law enforcement agencies will be used to provide examples of best practices and procedures in important operational realms.

Chapter 2

Specialized Police-Based Models

In this chapter:

- Core Elements of Models of Specialized Responses
- Translating Core Elements into Practice
- Rationale for Choosing CIT
- Summary

As described in the first chapter, two models of police-based specialized responses to people with mental illness were identified in a 1996 survey (Deane et al., 1999). One model involves specially trained police officers that provide crisis response at the scene. The other model involves a close partnership between police officers and mental health professionals who co-respond to the scene. As jurisdictions around the country have adopted such specialized police responses, they have combined these two approaches, or combined a police-based approach with a mobile crisis team response. These emerging practices seek to achieve the goals of diversion from the criminal justice system and improved treatment for people with mental illness.

This chapter begins with a description of the core elements of the two police-based models, using Memphis, Tennessee, and San Diego County, California as the primary examples. The next section in the chapter provides detailed information on how these and other jurisdictions have put each model into practice. The chapter concludes with a discussion of the rationale for choosing a Crisis Intervention Team approach over other models.

1. Core Elements of Models of Specialized Responses

Although law enforcement agencies have experimented with ways to more effectively respond to people with mental illness since the 1970s, no model emerged until the Memphis Police Department designed the Crisis Intervention Team (CIT) model. Law enforcement agencies that have experienced tragic incidents involving people with mental illness or have become frustrated and concerned about the amount of time officers spend on these calls are increasingly adopting the Memphis CIT model. Other agencies are adopting police-based models that also

include partnerships with mental health professionals, and still others are combining the two approaches.

Law enforcement agencies and researchers have identified three core elements of the two police-based models described above. The recently released Criminal Justice/Mental Health Consensus Project report (Council of State Governments, 2002) has also outlined the essential elements[†]. The core elements of the models are believed to enhance the effectiveness of the police response used. The core elements include training, law enforcement partnerships with mental health community resources, and a new role for law enforcement officers. Each is discussed below.

1a. Training

Although the Memphis CIT program's motto is "More than *just* training," training is a key factor in the program's effectiveness. Memphis pioneered a 40-hour training curriculum for its CIT officers. Dispatchers also receive training. The curriculum includes information about mental illness, the viewpoints of people with mental illness who have been involved with the criminal justice system, and crisis intervention skills. Trainers include local mental health service providers, people with mental illness and their families, police department personnel, and attorneys. Practical experiences, such as role-play exercises, visits to mental health facilities, and dialogue with people with mental illness are a cornerstone of the CIT training approach.

The police-mental health co-response model includes a substantial commitment to training as well. For example, in San Diego County, Psychiatric Emergency Response Team (PERT) officers receive 40 hours of training as well as 7 hours of ongoing training on a monthly basis. The training includes modules on assessment of mental illness, resource networks, and the role of the clinician. The training team includes mental health professionals and police personnel.

[†] The Criminal Justice/Mental Health Consensus Project report outlines a detailed set of policy recommendations for criminal justice and mental health systems to improve their response to people with mental illness. The report can be accessed online at www.consensusproject.org.

The core elements of the models are believed to enhance the effectiveness of the police response used. The core elements include training, law enforcement partnerships with mental health resources, and a new role for law enforcement officers.

Access to additional services is also required to provide police officers with non-criminal justice system options for people who are in crisis but who do not meet the criteria for emergency evaluation.

1b. Mental Health Partnerships

Each model relies on the availability of mental health resources in the community that police can readily access on a 24/7 basis. Steadman and his colleagues (2001) identified a single point of entry, a no refusal policy, and streamlined intake for police as critical features of mental health services available to specialized police responses. The Consensus Project report has noted similar critical features (Council of State Governments, 2002). These features make the services “police-friendly,” as Steadman notes, as well as improving service delivery for people with mental illness – hopefully with the result of improved outcomes. The Memphis police have partnered with the University of Tennessee psychiatric services, which serves as the centralized drop off facility for people who need emergency evaluations.

Access to additional services is also required to provide police officers with non-criminal justice system options for people who are in crisis but who do not meet the criteria for emergency evaluation. In both Memphis and San Diego County, specially trained officers and teams make essential linkages to community-based resources such as crisis stabilization units, mobile crisis teams, homeless shelters, and detoxification facilities.

1c. Police Roles

The CIT model includes a new concept of the role of the police officer. Law enforcement officers volunteer to become CIT officers and are specially selected. In addition, the law enforcement agency works hard to make CIT officers feel like a team through the use of special pins, ceremonies, and awards and rewards officers, often monetarily, for their commitment to CIT.

Police-based response models differ from mental health-based models, in which mobile crisis teams provide a secondary response, because police officers are the only crisis responder able to arrive at the scene in 10–15 minutes. Law enforcement’s ability to provide on-scene response quickly is critical to ensuring safety of all parties involved. Although they are not mental health professionals, CIT officers conduct an initial mental health assessment at the scene. This is a unique role for law enforcement.

Many surveyed agencies indicated that although they use the term Crisis Intervention Team, their CIT officers are not a traditional specialized *team*. In these agencies, the CIT officers have specialized skills, but they have retained patrol responsibilities as well as their CIT duties. CIT officers therefore have a specialized role, but their availability to respond is not limited.

1d. Other Factors

In addition to the core elements of these models, other factors impact the efficacy of the law enforcement response to people with mental illness. These include 1) the extent to which agency command staff is committed to an effective response and 2) the degree of trust and communication between the partners. These factors are described more fully in Chapter 4.

2. Translating Core Elements into Practice

The core elements described above must be translated by individual law enforcement agencies into specific procedures and practices that address local concerns. The areas of procedure most likely to be impacted are call dispatch and on-scene responses.

2a. Call Dispatch

Several key procedural elements involved in call dispatch are required to ensure that the model responses work efficiently. One agency commander interviewed stated, "Dispatch is crucial to the success of a CIT program." PERF's recent survey sought to determine 1) how call takers assess the nature of the call, 2) how the agency tracks these encounters in the Computer Aided Dispatch (CAD) system, and 3) how calls are dispatched to special teams or officers. PERF identified several essential

procedures and practices, which are described below.

Assessing the nature of the call

The agencies PERF interviewed disagreed about how easily calls involving people with mental illness can be identified by the call taker. One agency representative stated, "Usually, mental illness calls stand out pretty clearly," while another indicated that, "Usually, no one knows that mental illness is involved until after the officer gets to the scene." One of the complicating factors is that such calls frequently come into the 911 system as disorderly conduct or even domestic violence calls, rather than with a clear statement that a person with mental illness is in crisis.

Several law enforcement agencies have addressed the difficulty of identifying calls involving people with mental illness. Agencies that have provided training to call takers and dispatchers on these issues may have less difficulty assessing the call at dispatch—approximately 13 agencies surveyed provide such training, ranging from 4 hours to 40 hours. Call takers with many years of job experience or access to specific question protocols may also be better equipped to gather the appropriate information. Several agencies PERF interviewed provide call takers with questions to define better the involvement of mental illness. For example, some agencies ask about medications use, history of mental illness, the availability of weapons, and history of dangerousness.

Some law enforcement agencies have developed protocols in collaboration with mental health crisis facilities to allow such calls to come into dispatch directly from the mental health provider through a hotline or through case workers. In Baltimore County, Maryland, for example, 30 percent of such calls come from the Baltimore County Crisis Response System, which operates a 24-hour hotline for people with mental illness who are in crisis. The

In most cases, if the call taker and dispatcher are sure the call involves a person with mental illness, they will dispatch directly to the CIT or police/mental health team.

model used in Baltimore County is a police-based specialized mental health response, which places a social worker in a patrol car with an officer. In other communities, people with mental illness and their families have become so familiar with the specialized response in use that they will call 911 and request either a "CIT" officer or a particular officer by name.

Tracking call data

Another way to facilitate dispatch of calls involving people with mental illness is to track locations that are repeatedly the scene of such incidents. The advantage to having this information in the CAD system is twofold. The dispatchers can provide important historical information to the responding officers, enabling them to arrive better prepared to address the situation. In addition, the agency can evaluate how well its specialized response is addressing the core repeat locations that are often the biggest drain on police resources. Repeated calls to a certain location can also be an indicator of a persistent problem that may require additional attention beyond the patrol response.

PERF's survey identified a range of strategies law enforcement agencies are using to track these calls in CAD systems. Many agencies flag all locations where there is a concern about dangerousness, often called a "hazard" location. Hazards, or "special needs," as they are referred to in Seminole County, Florida, often will include locations where the danger or need is related to mental illness. Several agencies, including Athens-Clarke County, Georgia, and Florence, Alabama, flag all call locations involving mental illness. Some agencies also flag mental health service provider locations or only those providers that accept inpatients through civil commitment.

Dispatching to special teams or officers

In most cases, if the call taker and dispatcher are sure the call involves a person with mental illness, they will dispatch directly to the CIT or police/mental health team. Most law enforcement agencies have a roster available to dispatchers that identifies which CIT officers are on patrol at any time. If the situation is unclear, dispatchers will follow normal procedures and dispatch to available patrol. Once patrol officers identify the situation as involving a person with mental illness they will contact dispatch and request the CIT or special team as a secondary response. Some agencies, such as San Jose, California, always dispatch

to beat officers, who then request CIT if certain conditions are met.

An important concern for people with mental illness and their families is the language used by dispatchers to communicate the nature of the call to the responding officers. Many law enforcement agencies still use 10 codes. For instance, 10-96 is used in Athens-Clarke County for a situation involving a person with mental illness. Other agencies use plain language to describe these calls, including general terms such as “situation found” or “check on the welfare of.” Memphis uses the terminology “mental disturbance call.” Some agencies have chosen language that focuses on the nature of the police response, rather than the behavior of the person. For example, Cincinnati and Jackson County, Missouri, use “MHRT”, which stands for mental health response team, “MHRTV” to include “violence”, or “CIT call.” Some agencies are sensitive to using non-stigmatizing language to describe the behavior of persons with mental illness, and dispatchers are careful to avoid derogatory terms.

2b. On-Scene Responses

Three issues are critical to the on-scene response of law enforcement agencies to situations involving people with mental illness: assessment of the involvement of mental illness, availability and accessibility of mental health services, and transportation to mental health facilities.

Assessing mental illness involvement

Most law enforcement agencies, particularly those that use the CIT model, train officers to assess the involvement of mental illness on the scene. The scene must be stabilized by officers prior to assessing the involvement of mental illness, however. CIT officers are carefully trained in de-escalation techniques to reduce the level of crisis and promote a calmer environment. Officers do not then *diagnose* mental illness, but are trained instead to recognize the signs and symptoms of the most common types of mental illness, and medications used to treat them. Officers are also trained to seek information from family members, friends, and neighbors to help clarify the person’s behavior and history.

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Police-based models that include a mental health professional as part of a team response—one that occurs most frequently as a secondary response to a traditional patrol response—have the advantage of on-site mental health expertise. Such teams often include a social worker or crisis worker who performs the mental health assessment as well as conducting crisis intervention counseling. The mental health professional often has access to historical mental health information that helps clarify the current situation.

In Long Beach, California, the mental evaluation team (MET) pairs a uniformed patrol officer with a mental health professional from the county to co-respond to calls, either when requested to do so by the responding officer or when a call is overheard on the radio. This team only responds to calls involving a mental health crisis. The team focuses on being non-threatening by riding in an unmarked car and using an approach that is conversational and calm. In the team's experience, the person in crisis will often respond favorably to at least one person on the team, who will then take the lead.

In some communities, providers of mental health services are available to law enforcement officers by telephone on an emergency basis. In jurisdictions that have combined a CIT with a mental-health based response, health care professionals are available to come to the scene if requested by the CIT officer. These professionals may have access to privileged information about the person's mental illness. If acceptable within the confines of confidentiality requirements, these professionals may offer information about the best way to approach an individual.

Accessing mental health resources

Once the determination has been made by law enforcement officers at the scene that mental illness is involved, officers can refer or transport a person with mental illness to services.

To do so, officers must know what mental health services are available, which services are appropriate for which patient populations, and be confident that facilities will evaluate the person in a reasonable amount of time.

If an individual meets the criteria for emergency evaluation, police officers will take the person into custody. Steadman et al. (2001) have identified the importance of a "specialized crisis response site" to police-based diversion programs. PERF's survey found that in many communities police have agreed in advance for one or more psychiatric emergency rooms to conduct the evaluations. For example, in Arlington, Texas, and Florence, Alabama, centralized psychiatric emergency rooms in nearby hospitals employ streamlined drop-off procedures. In some jurisdictions, such as Akron, Ohio, police can access emergency psychiatric services in two or three hospitals, based on availability of beds. In Lee's Summit, Missouri, two hospital facilities are available; police choose one over the other based on whether the admission is expected to be involuntary or voluntary.

If the person does not meet criteria for emergency evaluation, law enforcement officers use a variety of strategies. CIT officers will often make referrals or provide information about local mental health services. In some communities, crisis workers come to the scene to provide counseling or take people to shelters or counseling centers. For example, in Delray Beach, Florida, and Montgomery County, Maryland, mobile crisis teams come to the scene to assist with mental health assessments. In other communities, law enforcement officers take people to needed services and shelters (e.g., Athens-Clarke County, Baltimore County, and Kansas City, Missouri) or inform mental health service providers that the CIT has encountered an individual in need (e.g., Florence, Alabama).

Transportation

For people in crisis with few resources, a major barrier to accessing mental health services may be obtaining transportation to a mental health facility. Some law enforcement agencies can provide transportation to a treatment facility, under certain circumstances. Factors that an agency may consider to determine whether to transport include the individual's medical condition, behavior and potential for violence, and willingness to be transported. An agency may take an individual into protective custody in order to provide transport to a mental health facility for emergency evaluation.

Some jurisdictions have formed partnerships with a mobile crisis team or other mental health service provider that include arrangements for the service provider to transport people in crisis to needed services. Other jurisdictions provide people with cab vouchers or request an ambulance to transport to services.

3. Rationale for Choosing CIT

PERF asked law enforcement agencies that have implemented the CIT model why they chose CIT. Many agencies noted that the CIT model is both efficient and realistic. A respondent from the Houston Police Department stated, "It makes sense to focus on the first responders. It's the first few seconds of these interactions between law enforcement and people with mental illness that determines if it's going to be a bad or good situation. It's good to de-escalate a situation at the beginning. By providing training to people in all divisions and shifts, we have coverage everywhere. Calling in to a specialized central team would take too long, and there is a lot of down time associated with centralized units."

One reason for agencies to choose a CIT model or other police-based response over a mental health-based response, such as a mobile crisis team, is the importance of the police role in controlling potentially violent situations. This rationale was noted by a respondent from the Los Angeles police: "Law enforcement will always be the first ones there. There will never be a mental health response that takes 10 minutes or less. We must reduce the potential for violence. Law enforcement will always

One reason for agencies to choose a CIT model or other police-based response over a mental health-based response, such as a mobile crisis team, is the importance of the police role in controlling potentially violent situations.

On-scene response procedures must focus on assessing the involvement of mental illness, accessing mental health services efficiently, and transporting individuals to those services safely.

be there in situations that are unsafe. Responding in the field is by definition non-clinical. The CIT model is the only model that addresses that scenario. Law enforcement officers are the only ones who will be there first and the only way to get mental health crisis expertise in a situation that's unsafe for clinicians."

A respondent from the New London, Connecticut, police summed up that agency's choice, stating, "Basing it in uniformed response made sense. For example, if it's 3 AM on a Sunday morning, we're the ones out there."

4. Summary

This chapter reviewed core elements of the specialized police-based responses to people with mental illness, including training, law enforcement partnerships with mental health services, and new police roles. It described how the agencies PERF surveyed translated these elements into practice in two procedural areas—call dispatch and on-scene responses. Call dispatch procedures must include accurately assessing the nature of the call, tracking call information in a data system, and dispatching the call to specialized officers or teams. On-scene response procedures must focus on assessing the involvement of mental illness, accessing mental health services efficiently, and transporting individuals to those services safely. The next chapter provides guidance on planning and implementing a police-based response model.

Chapter 3

Planning a Police-Based Specialized Response Program

The path that leads to implementation of a police-based specialized response to people with mental illness is not necessarily linear, nor is it uniform. Law enforcement agencies often experience a precipitating event—frequently a tragic event—that propels the agency to change the way it responds to calls involving people with mental illness. This chapter outlines the factors that provided an impetus for change in the agencies PERF surveyed, sets forth the steps involved in program implementation, and describes program goals that can frame program implementation efforts.

1. Program Impetus

PERF's survey asked law enforcement agencies to describe the events leading up to program development. A tragic incident involving a person with mental illness often preceded the decision by law enforcement agencies to change their response to people with mental illness. Thirteen of the 28 agencies PERF interviewed cited this reason as the main impetus for developing a specialized police response program. The tragic incidents included police killings of people with mental illness, many of whom were suicidal and/or barricaded in their homes. In other agencies, law enforcement officers had been killed by people with mental illness. In examining these incidents, the law enforcement agency involved often found that police officers had previously encountered the person with mental illness. The agency then developed a specialized response program to enable officers to intervene more effectively in situations involving people with mental illness, perhaps preventing future tragic events.

Another frequent program impetus was the realization that police were increasingly encountering people with mental illness. The same individuals were often repeat-

In this chapter:

- Program Impetus
- Program Implementation Steps
- Setting Goals and Collecting Data
- Summary

Once there is an agreement that a problem exists and something must be done about it, law enforcement agencies must go through a series of steps to design and implement a program.

edly encountered, an indication that the agency was not adequately meeting their needs. These agencies sought to develop a more comprehensive, long-term solution to the problem. Some agencies sought to shorten the amount of time it took to execute emergency protection orders. In other communities, people with mental illness and their family members found the tactics used by some untrained officers troubling.

Program implementation was often aided by pre-existing relationships between police personnel and people in the mental health community. For example, in Akron, Cincinnati, and Delray Beach, police personnel who sat on mental health committees or were board members of mental health service providers began a dialogue about the issues. A shared understanding of the problems faced by both systems in responding to people with mental illness who encounter the criminal justice system could then be formulated. In some cases, mental health service providers reached out to police to offer their help. In two jurisdictions, the law enforcement agency learned about an effective program in a nearby jurisdiction.

2. Program Implementation Steps

Once there is agreement that a problem exists and something must be done about it, law enforcement agencies must go through a series of steps to design and implement a program. This process can take many months; in some cases it has taken years. For example, in Lee's Summit, the CIT "was the culmination of two years worth of research and planning – from identifying the need to moving it to a regional concept where other agencies are now participating."

The program implementation steps PERF identified are outlined below in a logical sequence. The experience of the surveyed departments has shown, however, that some steps occur simultaneously, some occur in a slightly different order, and some may not happen at all. These steps are offered as suggestions for communities to consider as they move forward in designing and implementing their own programs.

2a. Examining Available Models

Nearly all of the agencies surveyed began the process of program development by considering model approaches that had already been developed—particularly the CIT program in Memphis. Law enforcement agencies chose Memphis for a variety of reasons: it had developed the CIT model, the model seemed achievable without major added expense, and CIT was seen as successful in reducing problem encounters. Some agencies were impressed that the CIT model doesn't take officers away from patrol assignments. Further investigation of the model occurs after someone in the agency has shared the program idea with others, often including the chief executive, to persuade them of the need for the program and to obtain permission to explore the options.

The available models were often examined in a collaborative, committee, or work group setting. Committees included a wide range of stakeholders, including advocates, mental health service providers, people with mental illness, law enforcement personnel, and corrections personnel. The goal of the meetings was to build consensus about what the new program should include, as well as to gain community members' support and contributions to the new approach. For instance, the mental health community may be asked to donate time or space for training.

Some agencies made site visits to other departments, including Memphis, Los Angeles, and Portland. The site visit teams included advocates for people with mental illness, often from the National Alliance for the Mentally Ill (NAMI); officers and supervisors from the police department; and staff from the community-based mental health service provider. Site visit activities included participating in training and meeting with program staff.

2b. Adapting the Model to the Locality

Most agencies adapted the model program chosen to their jurisdiction's conditions and circumstances. The Memphis CIT model, or agencies that had adapted the Memphis model, such as Albuquerque, Seattle, and San Diego, often guided program development. Other agencies also investigated programs in Houston, Los Angeles, and Long Beach. The kinds of adaptations made by the agencies PERF surveyed are detailed below.

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Law enforcement agencies have adapted training curricula and materials from other programs to local circumstances, policies, and laws.

Mental health services adaptations

As noted above, Steadman et al. (2001) identified the importance of a centralized drop-off site to which police can bring an individual in need of psychiatric assessment and of a no-refusal policy for police referrals. Law enforcement agencies have struggled to implement such services in their communities and have adapted the concepts to local circumstances. Agencies must first identify appropriate local mental health services and develop formal relationships with service providers. Such partnerships provide advantages for the community. In the opinion of a respondent from Middletown, Connecticut, “When you form partnerships, you win by gaining officer safety and an increased quality of life for citizens.” Some agencies that adapted the Memphis model developed partnerships with more than one central drop-off location. In Ft. Wayne, Indiana, because of concerns about bed space, a second drop-off location was added so as not to overburden any one hospital. Some agencies have added additional resources for officers to access. For example, Albuquerque added Health Care for the Homeless as a resource, partly to make sure no resource felt “slighted” and partly to increase the “opportunity to serve the community.”

In some communities, creative approaches were developed to find alternative resources or stretch existing services to meet community needs. For example, in Little Rock, Arkansas, relations between the police department and the emergency room were strained by the perception that hospital personnel were unhappy about serving people with mental illness who were in crisis. The role of the emergency room was clarified by utilizing the Crisis Stabilization Unit (CSU)—the ER was now only responsible for medical stabilization, rather than more extensive supervision of individuals in crisis.

Training adaptations

Law enforcement agencies have adapted training curricula and materials from other programs to local circumstances, policies, and laws. Curriculum development involved creating lesson plans, choosing appropriate topics, and determining training length. Some agencies reduced the total time spent in training due to funding constraints or changed the proportion of time spent on individual topics. For example, in Seattle, one 8-hour training covers suicide prevention, and another 8-hour training covers communication. In Athens-Clarke County, the curriculum addresses

Post Traumatic Stress Disorder (PTSD) to help officers understand police stress. The San Jose Police added training about developmental disabilities and traumatic brain injuries.

In addition, agencies identified the training audience (some included school resource officers, police corps members, and dispatchers) and selected and trained trainers from a range of disciplines. As was the case in program selection, some agencies developed the curriculum and identified trainers in a collaborative environment. Advocacy groups, social service providers, people with mental illness, and government personnel were included in this process.

In Houston, mandatory refresher training was added to provide officers with an opportunity to keep informed on current issues and to help commanders stay in touch with CIT officers. Houston also holds a CIT practicum, where officers spend a shift at the crisis center to enhance mutual learning. The opportunity for “ride alongs” with mental health workers and officers grew out of the practicum. Athens-Clarke County allows groups of officers to visit mental health facilities. Cincinnati includes a “shadowing experience as part of the 40-hour training where officers spend two days going out with caseworkers to understand their roles and to network.”

Response protocol adaptations

Some law enforcement agencies have adapted response protocols from earlier models. In Athens-Clarke County, department leadership decided to train everyone because their agency was smaller than Memphis. The response was not specialized per se—everyone in the department was trained on the response protocols. Agencies that chose to train all officers did so because they wanted to “have everyone trained so you don’t have an instance where an officer is waiting for a specially trained officer—they have the skills themselves to take the appropriate action.”

Some agencies PERF surveyed adapted the chosen model by implementing responses that were secondary to the on-scene response. Planners in Baltimore County, for example, felt the CIT model was missing an important follow-up component. This jurisdiction “developed a hybrid model that includes Memphis training, the Los Angeles pairing of clinician and officer, and an at-home intervention” response. The in-home portion of the program “provides fol-

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low-up for 10 days for people that are in crisis and need short term visits to stabilize them, hopefully to decrease the risk of unnecessary hospitalization.” Seattle and Albuquerque also use police personnel to do follow-up on non-criminal cases. In Seattle, officers also work closely with the municipal mental health court and the state Department of Corrections. Officers review records of prison inmates with mental illness before their release to evaluate their eligibility to receive services.

Rather than pairing a mental health professional in a patrol car with a police officer, as is done in San Diego County and Baltimore County, Los Angeles and Cincinnati have specially trained officers who respond as a traditional CIT would, but who can also request that a trained mental health professional respond on-scene if needed.

2c. Educating the Community

A few law enforcement agencies marketed the new program to people with mental illness and their families, through NAMI or other resources. The education component was designed to assure the community that the department had become better equipped to handle calls involving mental illness and that individuals should feel free to call a CIT officer if needed.

2d. Obtaining Necessary Reviews and Approvals

Changes in law enforcement procedures for emergency mental health evaluations often required approval by various state, county, and local officials. Notifications had to be made to the governor, county commission, or the city council in some jurisdictions to inform them of the program. In other communities, the city attorney and the department’s professional staff reviewed the program to ensure appropriate procedures were in place.

2e. Setting Logistics and Administration

The next step in implementing a new program is establishing appropriate roles and responsibilities. Law enforcement and mental health agencies developed general orders and policies regarding the response, including establishing dispatcher roles, and patrol and supervisor responsibilities. In some cases, standard operating procedures were developed based on a pilot project, which implemented the specialized response in a subset of police districts. In addition, the roles of non-police personnel were defined clearly and communicated to staff. For example, nurses at the hospital chosen as the receiving facility for emergency evaluations were informed of the program and introduced to the police personnel. Agencies also recruited and selected their CIT officers during this stage.

Some agencies formally assigned an oversight responsibility either to a person who filled a liaison role or to a committee before the program was fully implemented. In Delray Beach, the oversight committee determined whether CIT was used properly and ensured that proper documentation was completed. In Little Rock, the psychiatrist from the medical center assisted in overseeing operations at the hospital.

Finally, before the program was fully implemented, agencies addressed such details as the design of special pins used to designate CIT officers and approval of the pin by the uniform committee. Just before program start up, several agencies began informational campaigns. CIT members attended departmental operations meetings to introduce the program to agency command staff.

3. Setting Goals and Collecting Data

All program development—including police-based specialized responses to people with mental illness—should ultimately be guided by the goals communities wish to achieve through the specialized response. The agencies PERF surveyed delineated a wide range of program goals, which are described in detail below. Some of the goals were lofty—to reduce crime and drug abuse—and some were very practical—to conduct training for all officers.

In addition to articulating program goals, agency partners in the response must develop ways to assess whether the program is achieving its goals. Program evaluation requires a commitment of resources to data collection and analysis.

3a. *Improved Services to People with Mental Illness*

Law enforcement agencies PERF surveyed often articulated a broad systemic goal. For example, communities want to help people with mental illness who are in crisis, reduce unnecessary inpatient hospitalization, and provide improved treatment options. They believe that the delivery of appropriate treatment to individuals in crisis can be achieved through collaboration by the mental health and criminal justice systems. Early intervention through an improved police response increases the likelihood that individuals in crisis will receive appropriate treatment before a situation gets out of hand. Responses that include an on-scene mental health assessment and on-scene crisis intervention are designed to get people help as quickly as possible. Some agencies also seek to reduce the need to bring people to psychiatric emergency rooms for emergency evaluation.

3b. *Improved Efficiency of Law Enforcement Response*

Communities also seek to improve the overall efficiency of the police response. For example, agencies aim to reduce the amount of time police spend on calls with individuals who are in crisis by streamlining the drop-off process at emergency rooms. Ensuring that an adequate number of CIT officers are on each shift to respond to calls involving

Early intervention through an improved police response increases the likelihood that individuals in crisis will receive appropriate treatment before a situation gets out of hand.

Many law enforcement agencies have identified the goal of diverting people with mental illness from jails which are often poorly equipped to meet their needs.

mental illness can also reduce waiting time at the scene. Goals for improved efficiency of police response also include relieving and assisting routine patrol, allowing officers to access specialized teams and quickly return to responding to radio calls.

3c. Improved Effectiveness of Law Enforcement Response

According to one respondent, improving the effectiveness of the law enforcement response to people with mental illness decreases the revolving door of repeat offenders who are committing crimes because of their illness. To improve response effectiveness, agencies believe part of their role is to provide individuals with the best possible disposition of the situation. For some agencies, this process involves setting a “standard of excellence” with respect to the way people with mental illness are treated by law enforcement officers and developing a “coordinated emergency response system” that connects people with appropriate community-based treatment.

3d. Diversion from the Criminal Justice System

Many law enforcement agencies have identified the goal of diverting people with mental illness from jails, which are often poorly equipped to meet their needs. As one respondent put it, “If you can have success by keeping people out of jail that don’t belong there and protect public safety at the same time, you’ve achieved your goals.”

3e. Reductions in Officer and Civilian Injuries

Almost all law enforcement agencies aim to improve the safety of officers, citizens and individuals with mental illness. Specialized police-based responses enhance the safety of officers and protect individuals with mental illness in two ways: by providing training on appropriate de-escalation techniques and by promoting the use of less-than-lethal weapons. The goal is not simply to save lives, however. Many communities seek to reduce injuries to officers and citizens when responding to these calls. Strategies for minimizing injuries include shortening the contact between law enforcement officers and the person in crisis and having trained officers at the scene who can access community resources.

3f. Improved Officer Knowledge About Mental Illness

The training that is the cornerstone of police-based specialized responses provides law enforcement officers with information about mental illness and tools to successfully resolve encounters with people with mental illness. Training curricula prepare officers to make informed assessments about taking individuals into custody. Some agencies have deemed the information in the training so critical that they have delivered the 40-hour course to all officers.

3g. Effective Partnerships with the Mental Health Community

Without careful attention paid to relationships and formal partnerships with stakeholders in the mental health community, specialized responses would be nothing more than an altered patrol response. Building strong, positive working relationships with mental health service providers and productive relationships with advocacy groups is a critical goal for many communities. The advantages include streamlining mental health service provision. Another goal is educating mental health service providers about police procedures and police about mental health. This exchange of information also provides the foundation for close working relationships that foster informal contacts and assistance. As a respondent from Kansas City remarked, “The goal was to create a face-to-face understanding of each other so they can just pick up the phone and call someone.”

Some agencies wished to improve relationships with people who have mental illness, much as they have done with some crime victim groups. In this way, people with mental illness know, as a respondent from Ft. Wayne described, that the department “is there to help, not hurt them, and that officers have a sincere interest in getting people help.”

4. Summary

This chapter describes the reasons law enforcement agencies PERF surveyed implemented specialized responses to people with mental illness and the steps these agencies have taken toward program implementation. The steps taken include examining existing models, adapting the model to the local jurisdiction, educating the community, obtaining necessary approvals, and setting logistics. The final section details the kinds of goals agencies set, which most frequently address improved safety and service to the community. The final chapter offers lessons learned by the agencies PERF surveyed as they have encountered challenges to program implementation.

Chapter 4:

Making It Work: Operational Lessons Learned

In this chapter:

- Overcoming Challenges to Program Implementation
- Selecting Personnel Using the CIT Model
- Marshalling Resources
- Avoiding other Agencies' 'Worst Mistakes'
- Summary

The preceding chapters describe the core elements of a specialized police-based response to situations involving people with mental illness, identify steps involved in program implementation, and articulate program goals. The experiences of the law enforcement agencies surveyed nationwide were used to illustrate each model and the steps communities have taken to implement it. Many agencies have also encountered and overcome difficulties when implementing the program. This chapter provides further information about how the agencies PERF surveyed overcame challenges, selected personnel, garnered resources, and avoided costly mistakes.

1. Overcoming Challenges to Program Implementation

Law enforcement agencies that have implemented a police-based specialized response model have had to overcome many challenges to program implementation. PERF has grouped these challenges into two categories: *personnel* challenges and *logistical* challenges. Personnel challenges include getting “buy-in” from both police and mental health professionals and gaining trust within the partnership. Designing training curricula and dealing with cross-jurisdictional resource issues are two examples of logistical challenges. These challenges and the strategies for overcoming them are described in greater detail below.

1a. Personnel Challenges

Many agencies experienced sharp resistance from law enforcement and mental health professionals to adopting new program practices, which went beyond the usual resistance to change. For some agencies, the resistance of

officers was related to the perceived program impetus. For example, in Cincinnati, some officers and community members believed that the only reason the department was implementing the new program was due to pressure from the Department of Justice. One community experienced difficulty getting buy-in from hospitals that believed, because they were already serving people in crisis, additional funding should be made available. The community's partnership had chosen to invest money in community-based resources instead.

Resistance by law enforcement was sometimes based on historically poor encounters with people with mental illness, for example, on encounters that involved long waits at receiving facilities. Some officers believed that a specialized jail diversion approach is inconsistent with what they considered "traditional" policing. As one respondent put it, "part of the police culture is that our job is to put people in jail." In Montgomery County the resistance was in "transitioning police into the mental health role. At the beginning, many people thought, 'We're cops, not social workers!'" In other communities, some officers with many years of experience in policing felt there was nothing the new approach could teach them.

Building officer confidence in the program by demonstrating its success was one strategy used to avoid or overcome resistance to a new program. As stated by one respondent, "Probably the most difficult part was to generate officer interest by showing program success. We needed to allow enough time to show people that there is merit to the program." Demonstrating program success in a small patrol area initially, before expanding, was another solution to officer resistance. In one community, the first round of trainees became "the best salesmen for the training, which really worked well to convince the other officers of the program's value."

Agencies that didn't experience much resistance credited the early involvement of officers, law enforcement unions, and supervisors in program development. The involvement of officers was particularly important. Agencies demonstrated that the program was intended to improve safety and to "make [the officers'] job easier." One respondent stated this point clearly, "It's critical to get low-level buy-in at the earliest stages because it makes it easier to get these things accomplished. Never forget the contribution that officers on the street make. They are your most

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important resource: if you don't tap it, you're missing an important ingredient."

Developing strong working relationships between officers and mental health service provider staff was another important challenge. Misconceptions held by police and mental health partners over many years often had to be overcome. In part, overcoming misconceptions held by program partners involved defining participants' roles clearly. For example, in Minneapolis, Minnesota, "Although some advocates felt the police should never be sent because their uniforms are upsetting to people, a psychiatrist said sometimes the formal police role is exactly what's needed to control a situation."

Fostering close relationships between law enforcement officers and mental health service provider staff was also critical. In Seminole County, Florida, the challenge was in "[g]etting to know each other within the partnership, understanding where each of us is coming from and getting to know each other at another level." In Middletown, Connecticut, an important part of partnership was "understanding the limitations and abilities of each partner. For instance, someone on the [Mobile Crisis Team] would ask an officer to go in someone's home and get someone. Naturally, the officer couldn't do this because he/she didn't have probable cause. Once the partners were able to better understand each other's roles and responsibilities, the partnership came together."

Overcoming mutual distrust between police and the mental health community was often a significant challenge for the agencies PERF surveyed. Focusing on shared program goals, such as diversion from incarceration, was one solution. According to the Albuquerque respondent, "Everybody has a war story where they've been burned. It was an issue of moving forward and trying to make this better for everyone—the consumer, the officers, and the providers."

Some communities sought to build trust between program partners by promoting effective communication between law enforcement and mental health providers. In San Diego County, for example, the Psychiatric Emergency Response Team (PERT) coordinator had two concerns related to trust. The first concern was the community's perception that the program was worthwhile. The second concern was the potential reluctance of law enforcement officers to have a clinician ride with them in their patrol cars. The PERT team therefore "started some forums with law enforcement, clients, and mental health workers to get people talking. The mechanics are easy; it's the trust and communications that can be an issue. These you have to build gradually."

Law enforcement agencies that developed their specialized response after an incident involving the use of force by officers against an individual with mental illness often faced a great deal of anger toward police from people with mental illness and their families. The police officers' reaction to the community anger was complicated by their own reactions to the tragedies. In Minneapolis, for example, "The officers who knew the officers involved in the shootings knew it had profound effects on them. They were in somewhat of a defensive mode; they had kind of a 'siege' feeling." In these communities, the challenge often was getting officers to volunteer for a new program. The first class of officers to be trained often consisted of risk takers.

1b. Logistical Challenges

Managing cross-jurisdictional or regional programs was a significant logistical challenge to some law enforcement agencies. Coordinating regional or countywide programs can involve complex political concerns and negotiation between city and county law enforcement agencies. Mental health professionals who partnered with law enforcement often had little experience with these political reali-

ties. Another logistical challenge faced was integrating a new program with existing law enforcement responses. According to the Minneapolis respondent, “What could have been a program killer was getting it integrated in the department. The possibility of misuse of the program, that it might not get used because of territorial issues (i.e., this is my sector, I can handle these things myself). There was also the risk of CIT getting called on every [call involving an intoxicated person] (i.e., he’s [intoxicated] and acting strangely, I’d better call CIT).” After officers saw CIT officers using their new skills, however, resentment towards CIT officers diminished quickly.

Several law enforcement agencies encountered challenges in developing a training curriculum and arranging for instructors. Mental health providers were often very receptive to volunteering their time to teach, but when one agency sought to include people with mental illness and advocates in the curriculum, there was concern that the officers might be alienated. When officers realized the consumer and advocacy groups hadn’t come to “grind axes, but to help the officers,” resistance declined. One agency had difficulty limiting a new curriculum to 40 hours because of the amount of information to cover.

Other logistical challenges law enforcement agencies faced in implementing new responses included: managing large call volumes, getting policy approvals, and instituting technology changes, such as showing CIT officers on duty in the CAD system. Two agencies mentioned obtaining funding was a challenge. One agency noted that the new program was not a major cost consideration for the police department, but obtaining funding was a major endeavor for their mental health partners.

2. Selecting Personnel Using the CIT Model

Voluntary participation by law enforcement officers is the key to selecting CIT officers under the Memphis CIT model. The agencies PERF surveyed agreed that assigning staff “does not work” and that people who chose to be CIT officers were better team members. As Long Beach noted, “The best of all worlds is to get officers who are interested and not forced into it.” When CIT members volunteer,

Voluntary participation by law enforcement officers is the key to selecting CIT officers under the Memphis CIT model.

[CIT o]fficers who apply go through an extensive screening and selection process. Screening includes interviews with the officer ..., reviews of records of past performance ..., discussion with the officer's current supervisors ..., education requirements, or requirements of a number of years of experience working patrol.

they are more cooperative, particularly because CIT can be viewed as being "more work." CIT volunteers may also be more qualified and motivated by the "rewards of doing a better job impacting the lives of those who suffer from mental illnesses."

Nonetheless some agencies PERF surveyed initially assigned officers to the CIT team. For example, in Ft. Wayne, command staff selected the first group of officers to go through training "based on how well they dealt with a crisis hostage situation" that had motivated the agency to adopt the specialized approach. Subsequent classes were volunteers who had been recruited by the first group trained.

Recruitment for CIT positions is generally through standard job announcements. Officers who apply go through an extensive screening and selection process. Screening includes interviews with the officer (that can include assessing the officer's knowledge of mental illness), reviews of records of past performance (including probationary status and complaints), discussion with the officer's current supervisors (to learn how he or she has interacted with people with mental illness in the past), education requirements, or requirements of a number of years of experience working patrol. In Kansas City, partners from the mental health community participate in interviews with officers who have applied for CIT membership. In San Diego County, the officer must have his or her supervisor's approval to apply.

The law enforcement agencies PERF surveyed identified the knowledge, skills and abilities, and personality characteristics they look for when selecting CIT officers. Calls involving people with mental illness can be complex and emotionally demanding. The agencies therefore looked for officers with a unique set of qualities that are described below. The respondent from Houston summed it up well: "Responding to these calls is different than the typical law enforcement response to criminal issues. Officers must switch to a less controlling physical response in these cases sometimes to avoid flustering a person. Consequently, patience is important, as is the ability to approach these situations from a different perspective than officers normally do."

2a. Knowledge

Law enforcement personnel who have accurate information about mental illness as well as an understanding of the stigma that surrounds people who have mental illness are an asset to CIT programs. An officer with experience responding to situations involving people with mental illness in crisis or working with community resources will often have a good understanding of the issues involved. In many cases, officers have personal experiences with people with mental illness who are family members or friends. For example, Kansas City found that “[m]any officers we interview say they volunteered because they have someone in their family with mental illness or have a background in sociology/psychology.”

2b. Skills and Abilities

Survey respondents repeatedly mentioned communication skills, including active listening and effective interviewing skills, as key qualities for CIT officers. These skills are essential to an officer’s ability to deescalate a crisis situation. The ability to “consciously display a demeanor that shows caring and concern rather than one that is authoritarian,” being observant, and recognizing subtle behaviors are also essential skills to deescalating crises.

Respondents noted that CIT officers must be “independent thinkers” who can find “the most reasonable non-confrontational avenue to take to resolve the problem peacefully and bring it back to a pre-crisis level.” The ability to slow down the traditional police response is also important. As the respondent from New London noted, “Police officers are trained to take control quickly and forcefully if needed.” Officers must be able to “unlearn” this type of response.

At the same time, though, CIT officers must be willing to ask for and accept help from a variety of community-based resources. Officers must be able to work cooperatively with many people in the community.

2c. Personality Characteristics

Respondents described a wide range of personality characteristics that typify officers suitable for CIT. Most

CIT officers must be willing to ask for and accept help from a variety of community-based resources. Officers must be able to work cooperatively with many people in the community.

Many of the agencies PERF surveyed have used government funding and non-financial government resources to implement a new program.

frequently, agencies look for people who are patient and calm. These characteristics are particularly useful because situations involving people with mental illness can be time-consuming and frustrating. Individuals who have a high threshold for anger and a high level of restraint are better able to avoid inappropriate responses to provocative comments by individuals with mental illness they encounter. As the respondent from Ft. Wayne noted, officers must “have thick skin, and not take racial epithets or questioning of their man/womanhood seriously. They need to let it roll off their back.”

Creativity, flexibility, open-mindedness, and respect for the dignity of people with mental illness are other important qualities identified by survey respondents. Many respondents also noted the importance of kindness and empathy and of a desire by the officer to help people with mental illness.

3. Marshalling Resources

The law enforcement agencies PERF surveyed reported using a variety of resources to support development of a new program. Most agencies reported using in-house resources in the form of equipment, personnel, and academy and in-service training about responses to people with mental illness. For example, the Houston Police Department has a partially self-sustaining program in that the resources, staff, and psychologists used to train officers are all in-house. Some departments, including Ft. Wayne and Houston, provide CIT officers with additional pay for taking on the challenging CIT role. Law enforcement agencies also provide assistance to colleagues in other jurisdictions. The Jackson County Sheriff’s Department uses the Lee’s Summit Police Department facility for CIT training.

Many of the agencies PERF surveyed have used government funding and non-financial government resources to implement a new program. Several respondents receive funds from local mental health agencies and from state agencies such as State Departments of Mental Health. Federal funding is also available through Local Law Enforcement Block Grants and Substance Abuse and Mental Health Services Administration and other Health and Human Services Department grants. Government agencies also provided personnel, including clinicians for a paired police-mental

health professional response, and service locations, including hospitals and mental health centers.

Some respondents also reported securing nongovernmental funding or resources from the United Way, private foundations and hospitals, and NAMI. NAMI in particular has assisted departments in obtaining instructors for trainings, food for training participants, and training materials. The Los Angeles Police Department receives private donations for CIT officer pins. Pharmaceutical companies provide equipment to the Akron Police Department to assist with training. Using a unique funding strategy, money for officer training is raised by the Forensic Interagency Consortium (FIC) in Albuquerque—a group of doctors, directors at University Mental Health, and people with mental illness and family members that meets weekly.

Finally, many agencies, including Minneapolis and San Diego County, receive donations of time, expertise, and/or funds for training officers from instructors and mental health agencies. Some departments, such as Cincinnati, are able to offer reimbursement of some trainer expenses.

4. Avoiding Other Agencies' "Worst Mistakes"

PERF asked each law enforcement agency surveyed to offer key advice to other agencies considering developing a specialized response to people with mental illness. Respondents were asked, "What is the worst mistake a police department could make when developing a specialized response to this population?" Answers addressed many of the themes discussed in this monograph—from the core program elements of police roles, training, and partnerships to the department's commitment to the program. This advice is detailed below.

4a. Police Roles

Several agencies reiterated the critical importance of not "forcing" officers to become CIT members. They stressed the need to "solicit interest and take only those who are interested." Officers who are assigned to CIT will lack the desire and skills required to respond effectively to people with mental illness. A respondent from Jackson County

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remarked, “If they’re not in it heart and soul, they’re not going to do justice to people in crisis.” Some agencies believed that voluntary participation in the CIT program is so important that programs that rely on training all officers cannot work. A respondent from Akron stated, “Officers need experience, that doesn’t come from training.”

4b. Training

Although many agencies do not recommend training all officers to respond as a CIT officer, several noted that all officers should be trained on basic issues related to mental illness and ways to deescalate crisis situations. This is considered part of basic departmental support and commitment to the program.

4c. Partnerships

The most frequently noted mistakes were related to the failure to partner with mental health service providers. Respondents warned other departments considering a specialized response not to “go it alone.” A respondent from Arlington noted, “It’s a terrible mistake not to use outside resources and handle [situations involving people with mental illness] purely as a law enforcement problem.” Departments urge other jurisdictions to work with mental health service providers to address the problem so law enforcement can handle cases more efficiently and provide a better service to the community.

No law enforcement agency can assume it “knows all of the answers.” As a Middletown respondent noted, “This is a very bad mistake. A more responsible approach is to identify the problem, get community-level feedback to define the problem, and check out what social service agencies are out there. Then, set up a meeting and work together to come up with the best solution. If you go it alone and don’t look at a problem consensually, you’ll

have problems.” In addition, the worst mistake from Montgomery County’s perspective would be “[d]eveloping a program without investigating and getting help from [agencies] that have already done it.”

A related mistake noted by several respondents was a failure to involve mental health advocacy groups and incorporate their feedback into the specialized approach early on in program development. The goal of including advocacy groups is twofold—to gather information and input on what the problems are in the community and to gain program support. In this regard, a respondent from Lee’s Summit pointed out, “Generally there’s a vast untapped amount of energy in advocacy groups. Make contact with them, brainstorm solutions, and let them help you.”

4d. Department Commitment

Some mistakes are caused by the agency’s lack of commitment to the program. Agencies cannot succeed without a commitment to the goal of community service. A respondent from Little Rock noted, “If you look at it like you’re simply trying to immunize yourself from liability, you will not be able to develop a mental illness response.”

Respondents also note difficulties that result from a lack of commitment, or “buy-in,” from the full range of stakeholders, including the department chief, mental health service providers, people with mental illness and their family members, and the community. In addition, problems will arise if agencies do not introduce the program throughout the department. For example, “If dispatch isn’t aware of it and supervisors aren’t aware of the specialized training, dispatch will improperly dispatch officers and supervisors will not understand the concept and not use CIT to full capability.” Additional mistakes noted by survey respondents included being too inflexible in thinking about the program, adopting

a program model from another jurisdiction without adapting it to their community's needs, or understaffing the initiative at the outset.

Finally, some agencies felt that the worst mistake is to ignore the problem altogether or to give up after a program is started. In Kansas City, CIT is viewed as "problem solving. The worst thing a department could do is to ignore a special segment of their population and let it settle itself." Agencies noted that the problem of people with mental illness becoming involved with the police is not going to go away—it must be addressed. "The thing required to address this is persistence," noted the Los Angeles respondent. "The tendency under a crisis management situation is to think there's a one-time cure, but it takes a long-term approach to really make progress."

5. Summary

This chapter focused on lessons learned in the process of program implementation by the law enforcement agencies PERF surveyed. The first section described personnel and logistical challenges. Next, the importance to program development of selecting personnel and marshalling resources were addressed. The chapter concludes with "worst mistakes" identified by the agencies surveyed as they relate to the core components of specialized approaches—police role, training and partnerships.

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