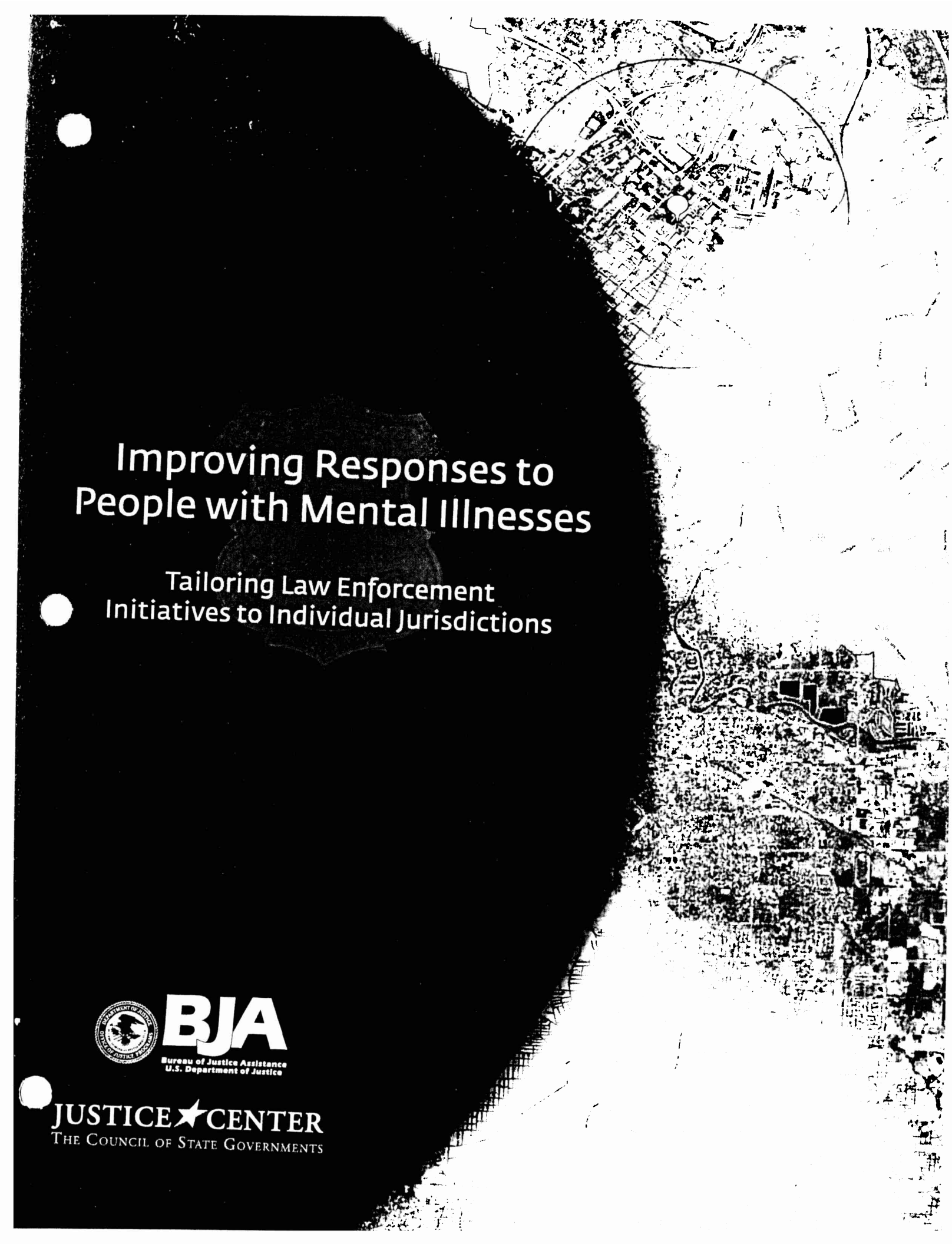
Improving Responses to People with Mental Illnesses

Tailoring Law Enforcement Initiatives to Individual Jurisdictions



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Section II

From the Field: Program Design in Action

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

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

Tailoring Specialized Policing Response Programs to Specific Problems[29]

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

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

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

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

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

The Impact of Problem Type on SPR Programs[30]

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

Relatives of consumers are now less reluctant to involve the police because family members realize that a compassionate officer will respond to the call. Consequently, families do not wait until the situation has escalated, and officers now respond to less threatening calls. This allows them to intervene at an earlier point. No CIT officer has been injured when responding to a person with mental illness."

—**Lieutenant Mike Woody (ret.)**
Law Enforcement Liaison, Ohio Criminal Justice Coordinating Center of Excellence

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

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

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

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

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

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

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

Tailored Responses

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

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

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

Quick Facts

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

Overview

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

Tailored Responses

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

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

Unique Program Features

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

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

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

Quick Facts

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

Overview

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

Tailored Responses

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

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

Unique Program Features

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quick Facts†

Government type: County, Municipal
Jurisdiction type: Rural, multi-jurisdictional
Population in 2007: 172,255 (estimate)
Area of New River Valley in square miles: 1,469 (estimate)

Program name: New River Valley Crisis Intervention Team
Program start date: 2002

Overview

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

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

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

New River Valley continued

Tailored Responses

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

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

Unique Program Features

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

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

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

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

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

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

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

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

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

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

Tailored Responses

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

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

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

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

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

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

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

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

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

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

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

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

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

Law enforcement leadership must know how to apply the necessary resources to solving crimes [and disorder]. The best way to apply limited resources is to focus on the 10 percent of the population that uses the greatest amount of resources."

—Chief William Bratton
Los Angeles (Calif.) Police Department

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

—Patsy Hendricks
Director of Clinical Services, Parkview Behavioral Health (Fort Wayne, Ind.)

Problem: *High utilization of emergency resources*

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

I believe it is in part because of our CAMP program that L.A. hasn't had [a mass shooting incident]. Once we identify someone who has mental illness [that puts them at risk of criminal justice involvement] and put them in the CAMP program, we monitor them to make sure they get medications, have housing, go to work, and can take care of themselves."

—Captain Ann Young
Commanding Officer, Detective Support and Vice Division, Los Angeles (Calif.) Police Department

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

Quick Facts

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

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

Overview

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

Tailored Responses

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

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

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

Los Angeles continued

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

Unique Program Features

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

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

Tailored Responses

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

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

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

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

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

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

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

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

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

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

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

The Impact of Jurisdictional Characteristics on SPR Programs

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

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

Tailoring Specialized Policing Response Programs to Jurisdictional Characteristics

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

Jurisdictional characteristic: Law enforcement agency leadership

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

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

Tailored Responses

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

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

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

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

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

Tailored Responses

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

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

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

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

Jurisdictional characteristic: Mental health resources

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

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

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

Tailored Responses

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

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

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

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

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

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

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

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

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

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

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

Jurisdictional characteristic: *Medical clearance requirements*

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

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

Tailored Responses

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

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

Jurisdictional characteristic: State laws

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

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

In 2008, hospitals were faced with national patient safety goal #15, which requires a system for screening patients for suicide risk. They must be screened appropriately and the hospital must provide 'continuity of care' so that when the person returns to the community it must be with a safety net in place.

Mental health clients are no longer what we do at the end of the day when we are done with everything else. This hospital is now making psychiatric services a priority and we are committed to quality services."

—Deb Richey
Nursing Director of Emergency Services, Parkview Hospital (Fort Wayne, Ind.)

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

Tailored Responses

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

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

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

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

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

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

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

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

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

Jurisdictional characteristic: *Demography and geography*

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

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

Tailored Responses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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