Enhancing Success of Police-Based Diversion Programs for People with Mental Illness

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Chapter 1. Background and Overview

Over the last 15 to 20 years, law enforcement agencies across the United States have amended policies and procedures—largely through innovative partnerships with the mental health community—to improve their responses to people with mental illness. These new approaches evolved in response to increasing numbers of people with mental illness in crisis coming to the attention of the police—often the same people repeatedly and sometimes with tragic consequences.

In 2004, the GAINS Technical Assistance and Policy Analysis (TAPA) Center for Jail Diversion published a guide for law enforcement agencies interested in managing these encounters more safely and effectively. *A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness* explores how agencies nationwide have implemented the core elements—staff training, partnership with the mental health community, and a new role for police officers—of these new approaches. The current monograph expands on the guide, addressing the ways agencies have overcome challenges and succeeded in achieving goals.

Specialized responses

Data collected by police departments and researchers make a compelling case for law enforcement agencies to become more active in examining their response to people with mental illness. The following statistics illustrate this need:

- The New York City Police Department responds to a call involving a person with mental illness every 6.5 minutes (Fyfe, personal communication, 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 1996, the Los Angeles Police Department reported spending approximately 28,000 hours a month on calls involving this population (DeCuir & Lamb, 1996).

In Chapter 1 ...

- ***background on response models***
- ***a brief review of A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness***
- ***overview of monograph topics***

Law enforcement agencies and researchers have identified three core elements of the two police-based models; these core elements enhance the effectiveness of the response:

- ***officer training***
- ***law enforcement partnerships with community mental health resources***
- ***a new role for law enforcement officers.***

In many communities, law enforcement officers confronting an individual with mental illness at the scene of a disturbance have limited options—the officers may only be able to mediate a short-term resolution of the crisis or take the person to jail. Statistics support the conclusion that many of these people are taken to jail. Data from the Cook County, Illinois, jail reveal the prevalence rate of severe mental disorder to be 6.4 percent for male detainees entering jail (Teplin, 1990) and 12.2 percent for female detainees (National GAINS Center, 2001).

The first comprehensive research aimed at understanding how law enforcement agencies respond to people with mental illness emerged from a 1996 survey conducted by Deane and colleagues of 174 United States cities with populations of 100,000 or more (Deane et al., 1999). This survey reveals that 78 departments have developed a specialized response to people with mental illness. Deane and colleagues identify three types of specialized responses:

- The *police-based specialized police response* is implemented by police officers trained to provide crisis intervention services and to act as liaisons to the mental health system. Six of the departments surveyed used this method.
- The *police-based specialized mental health response* is carried out by mental health professionals hired by, or working in partnership with, police departments to provide on-site and telephone consultations to officers. Twenty of the departments surveyed used this co-response model.
- Fifty-two departments used the *mental-health-based specialized mental health response*, in which mental health providers, often as members of a mobile crisis team, provide direct care at the scene.

Law enforcement agencies and researchers have identified three core elements of the two *police*-based models; these core elements enhance the effectiveness of the response. The elements are described in detail in The Criminal Justice/Mental Health Consensus Project report.[1] The core elements are

- officer training

1. 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.

- law enforcement partnerships with community mental health resources
- a new role for law enforcement officers.

In addition, Steadman and colleagues (2001) identified specialized crisis response sites as a core element of police-based diversion models.

The expansion of specialized responses: Findings from 2003 PERF survey

In 2003, the Police Executive Research Forum (PERF) surveyed 80 law enforcement agencies identified in the literature as using specialized responses to situations involving people with mental illness. PERF conducted follow-up telephone interviews with a subset of 33 agencies.

In *A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness,* Reuland reviews data from 28 of the 33 agencies interviewed. These agencies use police-based specialized police responses, primarily the Memphis Crisis Intervention Team (CIT) model (22), or police-based specialized mental health responses (6).[2] The agencies and the type of response program they have adopted are listed in Table 1. on page 4. (See Appendix A for a more detailed version of this chart that includes the number of officers in each jurisdiction, the number of hours of specialized officer training, and the size of the population served.) Reuland explores ways the police-based models have been implemented and strategies for planning and implementing similar programs. Data from the 2003 survey provide examples of best practices and procedures in important operational realms.

The survey demonstrates that as jurisdictions around the country adopt specialized responses, they frequently combine elements of the two police-based responses or combine a police-based response with a mental-health-based response. Further, programs have made adaptations to accommodate local circumstances. These emerging practices seek to achieve diversion of offenders with mental illness and/or co-occurring substance use disorders from the criminal justice system to community-based treatment.

Monograph overview

As agencies began to adopt the CIT models or co-response models, they faced challenges—not just in implementing the specialized approach, but in maintaining and enhancing program success. To clarify these issues, in 2004, PERF staff re-interviewed a subset of 12 of the 28 agencies interviewed previously, as well as the Framingham, Massachusetts, police department, selecting agencies with substantial experience in the specialized response models. The thirteen agencies range in size from fewer than 100 officers to several thousand, use both CIT and co-response models, and represent several regions of the country. In the current monograph, information gleaned in the 2004 interviews augments information gathered in the 2003 survey. The 13 agencies interviewed in 2004 are indicated by asterisk in Table 1. on page 4.

Chapter 2 characterizes the success of the programs, including goals; outcomes, expected and unexpected; and the keys to success.

Chapter 3 reviews data collected from the agencies on barriers to program success and on the challenges to maintaining programs over time.

Chapter 4 examines jail diversion as a prominent goal. The importance of measuring program success is also discussed. The chapter concludes with a discussion of ways to enhance the specialized response models, particularly with regard to follow-up, officer training, and committee work.

2. 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.

Table 1. Law Enforcement Agencies Included in PERF Surveys

Jurisdiction	Type of police-based response
Akron, OH	CIT
Albuquerque, NM	CIT
Arlington, TX*	CIT
Athens-Clarke County, GA	CIT
Baltimore County, MD*	Mobile crisis team (police/mental health provider co-response)
Cincinnati, OH	Mental health response team (modeled after CIT)—police/social workers co-response in two districts
Delray Beach, FL	CIT
Florence, AL	Community mental health officers (modeled after CIT)
Fort Wayne, IN	CIT
Framingham, MA**	Training for all officers; police/mental health provider co-response; and secondary mental health co-responders
Galveston County, TX (sheriff's department)	Mental health deputies from 1975—similar to CIT
Houston, TX*	CIT
Jackson, County, MO (sheriff's department)	CIT
Kansas City, MO	CIT
Knoxville, TN	Training for all officers; mobile crisis unit available for first response or co-response
Lee's Summit, MO*	CIT
Lincoln, NE	Training for all officers, emergency protective custody policy
Little Rock, AR	CIT
Long Beach, CA*	Mental health evaluation team—police/mental health provider co-response
Los Angeles, CA*	Systemwide Mental Assessment Response Team (SMART)—police/mental health provider co-response; Mental Evaluation Unit—24 hour hotline available to officers
Memphis, TN	CIT
Middletown, CT	Mobile crisis team (police/mental health co-response)
Minneapolis, MN*	CIT
Montgomery County, MD*	CIT
New London, CT*	CIT
San Diego County, CA, (sheriff's department)*	Psychiatric Emergency Response Team (PERT)—police/mental health provider co-response
San Jose, CA*	CIT
Seattle, WA	CIT
Seminole County, FL (sheriff's office)*	CIT

* Agencies re-interviewed in 2004
** While Framingham, MA, Police Department was not one of the 28 agencies originally interviewed in 2003, it was an "add on" to the 12 agencies re-interviewed in 2004.

Chapter 2. Characterizing Success in Specialized Police-Based Programs

The success of specialized police-based programs is gauged by how well goals are achieved. Stated goals of the agencies surveyed include

- safety of officers and civilians
- increased officer understanding of mental illness
- reduced numbers of people with mental illness going to jail
- improved relationships with the community, particularly with mental health professionals, people with mental illness, and family members.

In general, the agencies report success in meeting at least some goals but also observe broader impacts than had been anticipated.

In Chapter 2 ...

- ***agency goals***
- ***success in achieving goals***
- ***unintended, yet welcome, outcomes***
- ***keys to success***

Increased officer and civilian safety

Agencies most frequently note improved safety during incidents—both for officers and people with mental illness—as their goal. Many agencies cite a desire to reduce the number of incidents involving police use of force with people with mental illness.

As the Houston respondent notes, reduced use of force can be achieved through the specialized programs because, "It provides new tools for officers to de-escalate these situations. By telling officers to be less commanding, they actually have more authority over people in crisis. They can get more control over the person through communication. The more you understand, the better equipped you are to respond."

For some agencies, reducing risk in these situations has been achieved by equipping officers with hand-held TASERs, a type of stun gun that can be used at a distance (www.taser.com). Officers also use pepper spray.

Recent incidents involving TASERs, however, have been associated with injuries and even death, and some have questioned the

use of these tools (Ederheimer & Fridell, 2005). Although law enforcement agencies assert that TASERs are an improvement over previous strategies, they also agree that policies and training around their use are still evolving. In particular, training must help officers know when to use the TASERs (for example as a substitute for potentially lethal force, not as a substitute for pepper spray) (Fyfe, personal communication, 2004).

Increased understanding of mental illness

Another frequently cited goal of agencies is to provide officers with education on mental illness and how it affects people and their families. Through improved understanding, some agencies hope to raise the confidence level of officers in addressing situations involving people with mental illness or co-occurring substance use disorders and adjust police culture so that officers are aware that "someone is acting out because of a mental illness, not because he or she is a criminal." Some agencies wish to increase awareness of mental illness, not just among officers, but throughout the community.

Diversion from the criminal justice system and improved services for people with mental illness

Another of the main goals of specialized police responses is to see fewer people with mental illness enter the criminal justice system. Benefits accrue to individuals with mental illness who receive appropriate and effective treatment from community-based providers and also to the police who see a reduction in calls involving people—sometimes the same people repeatedly—with mental illness.

In San Diego County, California, where the Psychiatric Emergency Response Team (PERT) was initiated, the strategy is to provide on-scene clinical assessment and referral. Using the services of a clinician allows regular patrol deputies to stay in service to the community at large. In the past, officers spent a considerable amount of time trying to find out how to help a person with mental illness.

Providing increased opportunities for jail diversion for people with mental illness and improving community-based mental health treatment are closely linked: the only way successful diversion can be achieved is through adequate community mental health services. If services are available, diverting people with mental illness will put officers back on patrol.

Improved relationships between police and community

A strong relationship and improved communication between the police and mental health providers, consumers, and family members is an important goal for several agencies surveyed. The focus of the specialized programs is also on achieving a positive standing in the community.

How successful have programs been at achieving goals?

Almost all agencies report success in achieving at least some of their goals. The most frequently noted successes are improved relationships with the community and improved safety of officers and civilians.

Improved relationships with the community. Several police departments have found their program has improved relationships with mental health professionals and the community at large. As the Minneapolis, Minnesota, respondent notes, "We've built bridges with the mental health community and the community at large. There's an ongoing dialogue with different agencies."

In Athens-Clarke, Georgia, a good public image with advocacy groups has evolved from the program such that the mental health association honored the police captain with an award for outstanding service for mental health.

To garner citizen and mental health worker support, in Cincinnati, Ohio, the agency conducted citizen-police academies for mental health consumers and mental health workers. The demand was so high they plan to host another academy.

New London, Connecticut, notes a result of their program for people with mental illness is spill-over improvement to others in the community. "Communities must realize that when we're talking about an increase of the level of service by the police, it affects the quality of life of the entire community, not just those with mental illnesses."

Less injury and reduced use of force. For several agencies the numbers of police shootings, assaults and batteries, and "problematic use of force issues" have decreased as a result of the specialized police approaches.

One respondent notes, "Officers and consumers are safer. I sincerely believe we have saved lives." Several communities eliminated fatal incidents in the years after the program was implemented. In Minneapolis, for example, where four fatal shootings of people with mental illness had prompted the program, none had occurred since. The Minneapolis respondent notes, that it is "hard to say that CIT was the factor, but having specially trained officers making better decisions and getting people to services helps."

Increased knowledge. Two agencies stress the importance of improved officer knowledge about mental illness and mental health services. In Arlington, Texas, officers have a greater knowledge of mental health services because they have 24/7 access to mental health specialists as an element of their program. In Houston, Texas, the program has resulted in increased knowledge and expertise, not just for CIT officers, but for the entire department. While the agency has provided at least some training to every officer, CIT officers have raised the knowledge and proficiency of all officers.

Unintended consequences of programs

Respondents reflect, as well, on unforeseen consequences of the program. In some instances, these consequences please the respondents, confirming their belief that system change can have broad positive impacts.

The most frequently noted successes are improved relationships with the community and improved safety of officers and civilians.

Some respondents note their specialized program has "infected" other parts of the criminal justice system or other nearby agencies to adopt similar programs. In Albuquerque, New Mexico, for example, a post-booking jail diversion program is now up and running. "The judicial system saw how effective intervention was from the police department, so it's flowed over to the judicial system. Both the misdemeanor and felony courts work to make sure people with mental illness are diverted from jail … or that treatment is part of their sentencing."

Another community saw the establishment of a mental health court and a drug court, as well as various community programs, such as a clubhouse (consumer-oriented psychiatric treatment) program and transitional housing.

In some agencies, untrained officers have become more aware of issues pertaining to mental illness through exposure to trained colleagues. And in Florence, Alabama, "Community awareness went through the roof. More officers are educated, but we did not expect the community awareness, which is wonderful."

In Framingham, where a co-response model has been implemented, mental health clinicians have been able to learn important information about their clients by accompanying officers on calls to people's homes. The clinicians can identify aspects of living arrangements that may influence treatment plans.

In some departments, the unintended consequence of the program is the extent of change in officer attitudes about and empathy for mental illness, both as it relates to people in the community and to the officers themselves. For example, in Little Rock, Arkansas, the program brought an awareness of need for help with officers' own mental health issues. Here, "The Employee Assistance Program has jumped on this program. They're bringing in resources for us and for families. Officers are forming a Critical Incident Response Team. … It's increased overall awareness about mental health maintenance."

Another unintended consequence of the program training is that officers are translating the new skills into other policing activities. In Lee's Summit, "When you teach police officers that there are different types of people that need to be dealt with in different manners, it's a translatable skill in dealing with anyone on the street."

Occasionally the program is so successful the response team will get involved in calls on issues outside their purview. In Long Beach, California, the Mental Evaluation Team has become part of a homelessness taskforce, approaching people who are homeless and asking if they would like to receive mental health services, and consults for Special Weapons and Tactics (SWAT) teams to advise them about mental illnesses.

What is the key to success?

Overwhelmingly, agencies stress the strength of partnerships formed as a result of the program as crucial to their success. Almost as important, is the commitment of agency chief executives and the core of officers and mental health service providers working in the program. Several agencies remark upon the importance of being able to show that the program achieves results, and one cites specific strategies to reward officers.

Partnership. Stakeholders in the agencies surveyed characterize their partners as "being equally invested" and "willing to work hand in hand," and termed their partnerships "an alliance." For some, partnerships are not new; they are part of an overall community-oriented policing philosophy, which fosters close working relationships with the community. Through partnership, law enforcement and mental health can bring together substantial resources and energy and can achieve more through synergy than can be achieved alone.

Within this domain of partnerships, themes emerge about what dimensions of partnerships foster success. For example, respondents comment that agencies working together cooperatively "for the

long haul" contribute greatly to program success. As the Florence respondent notes, "One agency cannot do this [alone] … You have to have all people buying in …" In terms of buy-in, the critical feature, in the words of the Middletown, Connecticut, respondents, is that "people [are] committed to the program's goals: making the community safe and providing services."

Communication is another important feature of partnership relationships. The Framingham respondent views the daily interactions between officers and clinicians as a crucial element of their successes. Respondents from several other agencies note that open communication between the law enforcement agency, service providers, and the community facilitates success in operational issues, both within the police agency and the service community.

Leadership commitment. Support from leadership within law enforcement, mental health services, and community arenas is fundamental to program success. This "buy in" and "understanding" is particularly important in the context of responses to people with mental illness because, as the Albuquerque respondent notes, "The tendency in the department is to think that the program is warm and fuzzy and to think of the involved cops as social workers. The fact that this is a priority from the top down reinforces that they are just cops doing important work."

Officer and staff qualities. Several qualities among staff involved in the specialized programs are identified as critical. Long Beach mentions the "cohesion and cooperation" between the law enforcement and mental health partners riding together to incidents involving people with mental illness. "We do therapy on each other and debrief." Arlington notes officers show "open-mindedness" and "empathy for people suffering from mental illnesses." In Minneapolis, the officer and psychiatrist involved on the team bring "credibility" to the training, and in Jackson County, Missouri, the people involved truly "care for the community."

Specific staff positions are also important to success. In Houston, skilled trainers make the courses work for the officers. In other departments, a full-time position dedicated to coordinating the program provides officers and mental health providers with someone to answer questions and address concerns.

Positive results. Several agencies indicate their ability to show program results is key to ensuring ongoing success. Some agencies compile and analyze statistics to show how the specialized program effectively deals with calls involving people with mental

Through partnership, law enforcement and mental health can bring together substantial resources and energy and can achieve more through synergy than can be achieved alone.

illness. For example, Seminole County, Florida, has seen "CFS [calls for service] reduced and reductions in ... repeat calls." They note, "With better handling, comes a better result ... It's taking a load off the system."

Reduced calls for service and better mental health assessments in the field, are not the only positive outcomes of these programs. According to the respondent in Middletown, success has helped "people feel that they've made a difference."

Officer recognition. Minneapolis makes special efforts to help officers feel appreciated for their good work. For example, the department give out "awards and recognitions to motivate officers and to communicate that they are appreciated." In addition, successes in individual cases are conveyed to the mayor, who has phoned the officer to say, "Good work, keep it up."

The strength of partnerships formed between law enforcement agencies and mental health providers is key to the success achieved by these programs.

Summary and conclusions

Short-term agency goals, such as improved officer and civilian safety at the scene of an incident, and long-term goals, such as improved relationships with the community—mental health providers, people with mental illness, and family members—have been realized. Some unintended, but welcome, consequences include expansion of program activities outside of the law enforcement arena to other parts of the criminal justice system and to nearby communities. In addition, officers use their crisis intervention skills in calls not related to mental illness.

The strength of partnerships formed between law enforcement agencies and mental health providers is key to the success achieved by these programs. Partners must communicate well and ignore turf issues to facilitate what must be a long-term focus on addressing problems. Strong partnerships are characterized by committed agency leaders as well as dedicated line staff. Agencies note, as well, that being able to demonstrate program successes can improve program longevity.

Chapter 3. Barriers to Implementing and Challenges to Maintaining a Specialized Program

Law enforcement agencies that have implemented specialized responses to people with mental illness have encountered and dealt with various obstacles to program success. These obstacles range from broad, intransigent issues that can prevent a program from really getting off the ground to narrow, fairly easily solved, logistical challenges in maintaining program success. In this chapter, barriers to success and ways to overcome these barriers are reviewed. In addition, the ways agencies have dealt with challenges to maintaining programs over time are discussed.

In Chapter 3 ...

- ***barriers to program success and ways to overcome them***
- ***challenges to maintaining programs over the long term—and solutions***

What are the barriers to success and how have they been overcome?

While it is encouraging to report that some agencies have not experienced any barriers to success, over half have. The most frequently cited barrier is funding—but not necessarily funding for the law enforcement agency. Often this barrier affects the provision of community mental health treatment (Reuland, 2004). The next most frequently noted barrier is staff attitudes, followed by staff shortages and information sharing. These are reviewed below together with strategies agencies employ to overcome them.

Funding and resources

The barrier. Eleven agencies indicate funding as an important issue affecting their ability to reach their goals. While funding is needed to expand programs, such as by training more CIT officers or by hiring additional officers to do crisis intervention work, the funding for law enforcement agencies is less often a problem than is funding for community mental health services. As the Seattle, Washington, respondent notes, reduced funding for mental health services directly impacts the situation on the street: "If social service agencies are cutting services, [people with mental illness] don't get treatment, they re-offend, and they will be arrested because there are no alternative programs in place."

Overcoming the barrier. Agencies faced with funding challenges have sought funds from public and private sources outside the agency as well as from within. For example, Akron is "working at maintaining the commitment within the department for funding." This agency also has approached the Alcohol, Drug Addiction, and Mental Health Services (ADM) Board of Summit County for assistance with people, time, and money for trainings. Other agencies have approached community stakeholders and foundations, such as the United Way, to remain viable.

Staff attitudes

The barrier. Several agencies experience difficulties obtaining officer buy-in and trust related to the program and its goals. Often, gaining this trust is difficult because it requires police officers to change their thinking about how to handle calls involving people with mental illness. In Arlington, the barrier has been in "getting officers to believe that calling the [mental health] liaisons would be worthwhile. It was difficult to show them there was value in this and that it wasn't just 'feel-good.'" The attitude problems are not just among law enforcement officers. For example, in one agency, the barrier was in overcoming mental health providers' negative conceptions.

Overcoming the barrier. Arlington notes that both persistence and the fact that "success breeds success" can convert skeptics. In Athens-Clarke, the captain advocates for the program by encouraging officers to have an "open attitude" and a "proactive approach" in dealing with these issues.

Others agencies, such as Jackson County, address attitude problems with training and education, including public education, about what to expect from people recovering from mental illness.

In Cincinnati, an active community advocate organized a consumer academy. The agency developed an award in his name that is given annually to an exemplary officer by the mental health consumers' group.

Montgomery County, Maryland, notes that although a small number of officers likely will never be receptive to changing their attitudes, younger officers, who constitute a large percentage of the force, may.

In San Diego County, education involves spending time on "someone else's turf." For example, mental health providers bring officers in for meetings in hospitals or go themselves to lineups on midnight or early morning shifts. It impresses officers that the mental health providers are willing to work around the officers' schedules.

Staffing shortages

The barrier. Insufficient numbers of officers trained for the specialized response program have impeded the success of programs for several agencies. Optimal staffing is articulated variously as "25 percent of the patrol force" or "two officers trained per shift per district." Not all agencies have been able to achieve this level of staffing, particularly in early years of the program. The reason for staffing shortages varies: for some agencies, the difficulty is finding officers interested in participating, for others it is a funding or an administrative obstacle. In Framingham, difficulties have arisen because program resources limit the mental health liaison's availability.

In Delray Beach, Florida, a very young department, the practice is that "officers must be off [job] probation before they can get specialized assignments." This informal policy prohibits young officers, who might be the ones most interested in taking on this new role, from being considered.

Several agencies state they would like to have more officers in their programs to "eliminate the risk of burnout" and to improve their ability to conduct "follow-up visits to make sure people are getting care."

Overcoming the barrier: Kansas City, Missouri, finds they need to "sell the CIT program success" to increase officer willingness to volunteer for the team. Having CIT officers talk to their peers in other zones is regarded as the best way to promote the program.

Framingham has arranged for other mental health professionals to assist officers when the mental health liaison is unavailable.

Sharing information

The barrier: Seminole County finds problems related to information sharing and strict regulations regarding privacy of medical information are detriments to success. They note: "Without the ability to share specifics about individuals, we have found that it's more difficult to resolve the problems."

Overcoming the barrier: Exchange of information between mental health providers and law enforcement is regulated by local, state, and Federal law. Jurisdictions should investigate the specific requirements. The Federal Health Insurance Portability and Accountability Act (HIPAA) makes some exceptions for the exchange of information with correctional facilities or law enforcement; however, local or state regulations may be stricter than HIPAA requirements. (Massaro, in press).

Law enforcement and mental health providers can establish coordinating committees to review or develop policies and procedures that facilitate communication, such as the development of a standardized release of information form that meet all Federal, state, and local requirements (Massaro, in press).

In Seminole County, mental health providers obtain signed release of information forms from their clients. This consent allows the mental health professionals to share information about some clients with law enforcement.

Guidance for working within privacy rules is contained in the Criminal Justice/Mental Health Consensus Project report Chapter V, *Improving Collaboration*, policy statement number 25 (www.consensusproject.org).

Challenges to maintaining program longevity

In general, agencies find that challenges to maintaining programs are related to training issues, limited resources, and staffing. Lack of funding—needed to obtain equipment and training as well

Agencies faced with funding challenges have sought funds from public and private sources outside the agency as well as from within.

as support community mental health services—in particular, is described as a major challenge.

Keeping training current. The rapid pace of change in treatments for mental illness is causing some agencies to struggle to keep their training material current. For example, trainers in Athens-Clarke and New London are challenged to provide officers with current information about medications. New London solved this problem by working with a drug manufacturer to update and deliver revised training.

For Akron, the challenge to remain current applies to new training techniques. Agencies have begun to expand training techniques to include more experiential learning opportunities. These techniques include personal contacts with people with mental illness and their families, as well as methods that promote understanding of what it is like to have a mental illness (such as the *Hearing Voices* training curriculum, available at http://www.power2u.org/hvtad_curriculum.html).

Managing program logistics. Several logistical issues affect program maintenance. These issues include managing accurate records, arranging monthly meetings, and conducting periodic training. These activities tend to occupy large amounts of staff time, and in Athens-Clarke, as in many other communities, the program director has many job responsibilities in addition to those required by the department's specialized-response program. Here delegating program responsibilities is recommended: "The department can't designate one person to head up the mental health response, develop the response, keep the courses organized and materials fresh." Seattle struggles with arranging periodic training because it is difficult "to bring officers all together for refresher training, as it takes many officers off the street."

Minneapolis attempts to provide quarterly retraining to "get officers back together and provide more training on new topics, as well as to debrief in a structured way and swap experiences among officers." They experience difficulties in arranging this quarterly training, however, because "taking 100 people off the street on a given day is very tough."

The ability to maintain the specialized programs depends not only on the work of specially trained officers; it also is a function of how frequently the rest of the agency turns to the trained officers for help at the scene. To offset this concern, liaison officers in Arlington attend briefings, reintroduce themselves to the patrol officers, and remind them of circumstances when they should contact the mental health liaisons (such as when transporting someone to a facility).

Doing more with fewer community resources. Some agencies have had to continue their programs in the face of decreasing resources in the community. Community-based mental health resources are critical for these specialized programs, because if officers identify that someone needs treatment, and services are not available, the officer is left without appropriate options. In Florence, "If the availability of beds is downsized, it's very frustrating. Where do you put someone [who needs] long-term treatment? We all want early intervention so that it doesn't come to the police encounter." The consequences of limited beds are far reaching. In Lincoln, Nebraska, when resources get tight in the community, "It's very time-consuming to find beds. The department spends more time on these calls than on accidents due to the time waiting in hospitals because beds aren't emptying out fast enough."

Budget cuts in mental health impact what happens with police at the scene even more directly in cities where mental health experts have historically intervened in crisis situations. In San Jose, California, for example, these experts were once available to conduct danger assessments in cases of barricaded suspects. This service has been eliminated due to mental health budget cuts.

Managing staffing. Personnel management issues that challenge agencies include inadequate staffing and staff turnover. The difficulty of providing adequate staffing is demonstrated by Fort Wayne,

Indiana's experience, where the uniform division has three shifts. "In May, we had 101 documented contacts among CIT officers. The second shift has the fewest CIT officers, but they handled 53 of the 101 contacts." For some agencies, the program has persevered through part-time supervision or staffing shortfalls. Turnover in community mental health program staff, such as newly rotating medical residents at the psychiatric hospital, can also affect the program.

Staff changes can influence the interpersonal relationships that support the smooth operation of program activities. For example, in Cincinnati, "There are so many changes in the department and the community—people in the mental health field have much quicker rotation and shorter tenure than in the department. The maintenance effort is to keep these relationships going."

Maintaining interest in the program. Given the challenges posed by staff shortages and turnover, some agencies note the importance of maintaining excitement about the program—both to motivate new officers to volunteer as well as to prevent "burn out" among officers already in the program. Some agencies work to ensure the program is institutionalized in the department, which can "prevent backsliding to the way they used to do things." For San Jose, it's a matter of "selling it," both to the community, so there is a strong supply of instructors, and to the officers, so there are enough volunteers.

Summary and conclusions

This chapter reviews data on barriers to program success and challenges to maintaining specialized police-based programs. These barriers include program funding, staff attitudes, and staff shortages, as well as issues related to trust and sharing information between partners. Challenges faced in maintaining programs over the long term are more logistical, involving improving training content, contending with budget cuts in community mental health care, and stimulating staff interest.

Even the most complex challenges can be overcome. Agencies use creativity and ingenuity to seek out nontraditional funding sources, such as foundations and corporations; training techniques, such as on-site experiences at the mental health partner's place of work; and partnership with advocates and consumers to develop forums that facilitate the exchange of confidential medical information.

Even the most complex challenges can be overcome.

Chapter 4. Enhancing the Success of Specialized Programs

In Chapter 4 ...

- *achieving jail diversion*
- *the importance of measuring success—quantitatively and qualitatively*
- *enhancing program success through ... follow-up of consumers diverted from jail ... booster training for officers ... joint committee meetings with community stakeholders*

The previous chapters identify agencies' goals and how successful the agencies have been at achieving them. Several steps are involved in enhancing success.

- **Agencies must have a clear understanding of what they hope to achieve.** Although few agencies specifically state diversion from the criminal justice system as a goal, it is at the heart of most goals community stakeholders and policymakers hope to achieve. For this reason, the follow-up survey posed a series of questions designed to examine how diversion is defined and how it works in the field.

- **Agencies must have a way to measure achievements.** Measuring program impacts can help agencies facilitate continuance of the program, attain program funds, and identify areas in need of modification. Consequently, the surveys asked agency respondents about the methods they use to measure success in achieving a range of goals and the difficulties encountered in doing so.

- **Agencies must have mechanisms in place to make changes if they are not meeting their goals.** This chapter concludes with an overview of three mechanisms agencies employ to enhance program success:
  - follow-up with people diverted from jail
  - booster training for officers to provide updates and reinforce skills
  - committee meetings that allow an opportunity for oversight and problem solving.

Achieving jail diversion

What is diversion? The TAPA Center for Jail Diversion defines jail diversion programs as those with dedicated personnel who identify people with mental illness and provide linkages to community-based services and supports, resulting in avoidance of arrest and incarceration—in the case of pre-booking jail diversion programs—or a substantial reduction in jail time—in the case of post-booking jail diversion programs. Agencies may consider various scenarios to be jail diversion that do not fall within this

framework. With regard to pre-booking diversion, such scenarios include situations in which the specialized response contends with mental health crises (e.g. suicide attempts) that do not involve the commission of an offense and situations in which the specialized response is believed to have prevented the commission of an offense. In fact, these scenarios may comprise a significant percentage of specialized response team encounters with people with mental illness, but they are not jail diversion.

While law enforcement agencies may have different notions or definitions of what constitutes jail diversion, most strive to place people with mental illness somewhere other than jail if possible. Whatever definitional distinctions are drawn, these important decisions about whether to arrest an individual or divert him or her to community-based treatment lie with the officers at the scene.

How do officers decide whether a person should be diverted from jail? Agencies rely on the discretion of well-trained officers to observe situations carefully, collect information from all involved parties, and make determinations about who can be diverted from jail. As part of their preparation, officers often are provided with guidelines to help them determine when it is appropriate to divert someone.

In some jurisdictions, officers are given a great deal of latitude to make these decisions. In Arlington, for example, "We train officers to be problem solvers, not just arresters, and to ask 'What's the best way to fix this?'" In New London, the policy is intentionally left "wide open" and the focus is on getting a properly trained officer to use his or her training to achieve a positive outcome. Here, officers will still make arrests if a person has been in crisis in the past, or if there is a victim who's pressing a complaint. "If there's a victim involved, they have input into what happened. One person's rights end where another person's begin."

For agencies that provide more structure, policies clearly state who can be diverted and who cannot, usually based on whether the offence is a misdemeanor or a felony. In these agencies, officers are trained to assess the nature of the crime committed and the likelihood the person has a mental illness before deciding whether to take the person to jail. In addition, the person does not have to be a danger to self or others and in need of emergency treatment to be diverted—even those less seriously ill may qualify.

In these agencies, several other factors can impact the officer's decision to divert. For example, in Houston, if someone wants to file charges, the officers are required to work with the district attorney to determine the outcome. In Long Beach and Seminole County, officers are required to determine if the misdemeanor crime committed was due to the person's mental illness. "If someone is medication compliant, has bipolar disorder and is not exhibiting signs of mental illness, and they know what they're doing, they will go to jail." Montgomery County frames the officer's assessment in terms of danger, both as it relates to the act that prompted the police intervention and the person's history of violence, in making decisions about diversion. In addition, the person must be willing to comply with treatment.

In communities where officers are paired with a mental health professional, such as in Los Angeles and San Diego, a joint decision determines who is diverted. In these communities, assessment is facilitated by the access the mental health team member has to the person's medical history. In San Diego County, "The clinician has access to mental health records, which is very valuable. That person can call here [PERT], and we can get a person's records … they then know a person's case history, etc. They can then determine if jail or diversion is appropriate."

What happens to charges related to the encounter if the person is diverted? In jurisdictions where diversion occurs prior to booking at the jail, frequently no charges are filed. In Long Beach, officers complete a "release/not booked" form to document this. In Houston, charges are not filed

While program coordinators conduct most of the data analysis themselves, some agencies have obtained grants that allow them to pay outside experts to collect and analyze their data.

for people with mental illness who are accepted into a mental health facility.

In Montgomery County, although no charges are posted for pre-booking diversion, the person is told he or she could be charged for up to a year if he or she continues to have problems or doesn't go to the crisis center. Similarly, Seminole County has an arrangement with the State Attorney's Office that if the person completes a six-month diversion program, the charges will be dropped. If the person does not complete the program, charges will be filed. The court asks consumers to sign a release that allows the community mental health facility to contact the court. Consumers cannot be diverted unless they sign this release.

Measuring success

Program evaluation is a key to the success of many agency programs. Tracking and evaluating program data ensures the program can be improved through review and feedback. Agencies can measure success in several ways, including gathering anecdotal evidence and statistical evidence through analysis of departmental data and surveys or through more informal contacts.

Agencies measure *quantitative* changes—changes in the number of certain occurrences (such as calls for service or injuries)—and *qualitative* changes—changes in the character or quality of circumstances (such as the nature of interactions between officers and people with mental illness).

Measuring quantitative changes

Many agencies determine whether they have been successful by enumerating points along their processes and selected outcomes. For example, agencies track the number of calls for service involving people with mental illness, call-outs for special teams, situation types (such as suicides or emergency petitions), disposition types (such as arrest or transport to the mental health facility), incidents involving use of force, and officer or citizen injuries.

These statistics are then compared to past years' experiences or between certain patrol areas or populations (such as people who are homeless). Agencies also use these data to measure the number of repeated contacts and the numbers of arrests. For example, a recent analysis of Houston's 1,439 CIT calls revealed that only 17 people with mental illness had been arrested. Agencies also use department figures to calculate savings to the county and

amount of patrol time saved by using the specialized response program.

While program coordinators conduct most of the data analysis themselves, some agencies have obtained grants that allow them to pay outside experts to collect and analyze their data. In Lee's Summit, for example, a local research firm examines each CIT case and attempts to determine if the program is diverting people out of the criminal justice system who normally would have entered it. Akron uses local university researchers, and Jackson County and Kansas City are using Substance Abuse and Mental Health Services Administration (SAMHSA) grant money to employ private consulting firms to perform statistical analysis of their data.

Several agencies, such as Long Beach and San Diego County, prepare periodic reports on their statistics, either monthly or quarterly, so that command staff and others outside of the law enforcement agency can observe the program's progress. Arlington prepares a quarterly report, broken down by city sector, to track how often officers use the mental health liaisons. These reports allow for communication about the program and the accountability of participants—in the community as well as within the department itself.

To capture data that cannot be maintained in the computer-aided dispatch (CAD) system, several agencies ask their CIT officers to complete a form that captures information about incidents involving people with mental illness. Examples of forms used by these agencies are included in Appendix B. Typically, these forms document gender, race, and substance use of the person who is the subject of a call; use of a weapon; injury to civilian or officer; and final disposition of the contact (whether the person was left at scene or taken to mental health facility, for example). Some agencies, such as Lee's Summit, include a space for a narrative explanation of the incident.

Given the large number of forms some officers are required to complete in the field, agencies may encounter difficulty retrieving completed forms. To facilitate data collection, Houston officers complete the form on laptop computers. The information is conveyed to a database, which is downloaded regularly. The goal in Los Angeles is to have officers complete the form on a Web-based system. In other agencies, officers complete the form in the field and submit it to a coordinator, who enters the data into a database and analyzes it. Seminole County deputies complete a "hazard" form for people deemed to be a threat to themselves or others. Although not a tracking form per se, the hazard form is entered into the CAD system so the information will appear on the screen if a call comes in again regarding that person. This information allows the agency to prepare responding officers for potentially violent situations.

Measuring qualitative changes

Some agencies assess the satisfaction of law enforcement officers, mental health professionals, consumers, and family members qualitatively. Some agencies use structured means to measure these attitudes. San Diego County, for example, sent out consumer satisfaction surveys, and in Minneapolis, the mental health community surveyed consumers and their family members. Baltimore County has surveyed officers in areas where the mobile crisis team operates.

For other agencies, qualitative data are derived from anecdotes that program coordinators hear about through informal channels, such as meetings and conversations with stakeholders. Program coordinators also receive feedback from officers and mental health crisis workers. Some agencies, such as New London and Arlington, have received awards or other public accolade for their efforts. And, in Arlington, department members have been invited to serve on community-wide advisory panels addressing mental illness.

In Houston and Baltimore County, informal contacts with people with mental illness and their families have revealed how impressed these community

members are by the officers' empathy and knowledge of medications. In some areas, a lack of negative media coverage or poor feedback from partners is regarded as a sign of program success.

Published resources are available to assist agencies in collecting and analyzing data ... and local university research staff can be a tremendous resource.

Measurement difficulties. Several agencies identify difficulties in measuring and interpreting their data. Baltimore County notes an important consideration when analyzing calls-for-service (CFS) data: "We have found the CFS are spiking because of awareness, so it's driving the numbers higher." Increases in calls for service involving people with mental illness may also simply be due to the way the data are coded in the CAD system; as agencies improve the questions call takers ask, the number of calls coded as being related to mental illness will likely increase.

At the same time, relying on calls-for-service data to measure program success may be flawed because many calls that do not at first appear to be related to mental illness are determined as such when officers arrive on scene. And, if the calls do not get recoded in the CAD system to reflect the mental illness component at disposition, Knoxville points out, "It's hard to track what's what."

New London points to another basic difficulty in the ability of agencies to assess the impact of these programs—it is not possible to count prevented events. "We feel confident we've saved lives, but we may never know.."

The complexity of the situation involved in responding to people with mental illness can also hinder the ability to understand exactly which circumstance is causing which outcome. In Little Rock, for example, coordinators have had to look more closely at "rival causal" factors that affect the admission of people with mental illness to the jail. Here: "The jail simply isn't taking people showing mental illness because there are fewer beds for everyone. If we wanted to track this as a diversion, we could declare victory, but it would be a false conclusion."

These difficulties are not unique to measuring success in police-based response programs; they are issues that affect program evaluation of all types. It is important that agencies be aware of these limitations and attempt to account for them when presenting program outcomes. Published resources are available to assist agencies in collecting and analyzing data (for example, Chapter VIII in the Criminal Justice/Mental Health Consensus Project report: www.consensusproject.org), and local university research staff can be a tremendous resource.

Enhancing success

To learn more about how agencies enhance their specialized responses to people with mental illness, the PERF survey asked representatives about three program elements that may increase the likelihood of success: conducting follow-up with people who have been diverted from jail, conducting booster training, and participating in multidisciplinary committee meetings.

Conducting follow-up. Ensuring linkage and follow-up can be an important part of a program geared toward crafting long-term solutions for problems faced by people with mental illness. Reaching out to people who have come into contact with police and who have been diverted into mental health treatment can allow for evaluation of whether the person's needs are being met—essentially whether the program is having its intended impacts. If not, the follow-up contact provides an opportunity to fine tune services and supports to the person's needs.

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The agencies PERF surveyed are involved in conducting follow-up in a variety of ways. Some agencies conduct their own follow-up, some work in partnership with mental health providers, and in some communities only mental health providers will carry out follow-up. These arrangements are either formal and informal.

In four agencies—Arlington, Framingham, Minneapolis, and San Diego County—mental health providers undertake the follow-up, not the police. In Arlington, for example, providers conduct follow-up with people who are involved in the police-based program and provide a quarterly report on the results (for example, the number of people who entered into treatment or counseling, the number that returned to taking their medication, and the number that could not be located).

Other agencies note that their officers do follow-up, but that it is informal, typically involving only a few officers who check up on people they know well in the community. In two agencies, officers keep track of people who repeatedly come into contact with police and follow-up with them. CIT officers and CIT coordinators may also track consumers who are a particular safety concern to themselves or others.

Some agencies work together with their mental health partners on follow-up in an informal way. In Lee's Summit, "We get a heads-up from providers that we haven't seen person X, or they were off their meds and [we] want them to stay on them." In Seminole County, deputies will conduct follow-up at the request of the

The opportunity to learn more about topics related to responding to people with mental illness or to be reminded of critical skills helps officers maintain interest in their work, improves officer knowledge and ability to respond, and rewards officers for their commitment to the program.

treatment facility to identify whether people or their families are in need of services, or to see if deputies can help people continue with their treatment program.

Law enforcement may not conduct follow-up because of call load and because police access to mental health information is limited by privacy regulations and concerns. San Jose struggles with "how much information can we get from people and how do you do it in a way that's not being intrusive?" Montgomery County notes that mental health providers are very careful about privacy rights of the consumers and must receive written consent to share specific information, particularly with law enforcement. "The key for us to remember is that individuals who are diverted have been determined to be suffering from a health condition and are not 'criminals.'"

Conducting booster training. Several agencies, including Los Angeles and Minneapolis, conduct routine retraining to "refresh" material covered in initial training, as well as to update officers on "new laws, new resources, new theories, new thoughts." Houston mandates an eight-hour refresher class every year for CIT, the content of which changes based on what needs to be covered. Some agencies use monthly meetings to conduct training based on the needs and interests of staff.

Houston offers voluntary off-site training for CIT officers to spend one shift at the main mental health facility. "Officers can observe what goes on, ask questions, and go out with the Mobile Crisis Outreach team. It helps strengthen their relationship with the mental health community. Also, the officer goes [to off-site training] on the shift they work, so … they have better relationship with [mental health] staff working that shift. Reciprocally, staff can ride along with CIT officers."

In Montgomery County, officers receive advanced ongoing training to emphasize the way to assess dangerousness and de-escalate crisis situations, two of the most complex and important skills officers must have. Other topics are presented on an as-needed basis. In New London, officers requested information about drug treatment regimens and side effects and the effects of not taking medications. For this training, "We teamed up with Pfizer, who took us into their training room and provided us with a doctor to talk about these issues." When officers noted a lack of resources for children, "We brought in the state child advocate who told officers about a new program—a mobile crisis service for children and adolescents."

The opportunity to learn more about topics related to responding to people with mental illness or to be reminded of critical skills, helps officers maintain interest in their work, improves officer knowledge and ability to respond, and rewards officers for their commitment to the program. In these ways, booster training re-focuses officers on program goals and enhances the likelihood they will achieve them.

Participating in committees. All of the surveyed agencies have participated in a multidisciplinary committee at some point. These committees, which typically meet monthly or quarterly, serve a variety of important functions and can enhance success by providing a platform for discussion about progress and an opportunity for developing solutions to problems that arise. Committee size ranges from 10 to more than 30 participants. Members include police officials, mental health representatives, people with mental illness, advocates (such as NAMI representatives), government attorneys, public defenders, jail administrators, court representatives, school psychologists, and social workers. Most committees focus on including diverse stakeholders representing a wide range of backgrounds and services. The Lee's Summit respondent noted, "It's important to have advocates remind us of why we're doing this and of the importance of keeping people on track. The program tends to sustain itself better."

These committees take on a wide range of tasks, depending on program structure and how long the program has been in existence. These tasks include modifying practices and procedures that are not working well; reviewing progress statistics and identifying the successes and failures of the program; identifying specific training needs; soliciting assistance from partners to solve problems; conducting research; reviewing individual cases (within confidentiality requirements) to assess danger, reveal ineffective solutions, and brainstorm remedies; advocating for (or against) legislation; and addressing information sharing strategies.

In the absence of a formal committee, agencies still find ways to discuss progress. In Houston and New London, frequent communication with mental health partners, either during on-scene conferencing or by telephone, allows coordinators to identify problems (within the law enforcement or mental health agency) and address concerns or complaints immediately and directly.

Summary and conclusions

Agencies are challenged to maintain, and even improve upon, the practices and procedures they implement to divert people with mental illness from jail. To achieve the goal of diversion, these agencies must clearly define what they mean by diversion and how officers can achieve it in the field. Predominantly, agencies surveyed for this monograph define diversion to mean directing people who have committed minor offenses to community mental health treatment services rather than taking them to jail.

To measure how well agencies are achieving diversion, as well as other program goals, agencies conduct both quantitative and qualitative assessments. Although agency personnel must interpret these data carefully, this information provides a necessary understanding of how program activities impact the police department's processes (calls for services and arrest, for example), the mental health system processes (the number of people who come in for treatment, for example), and the circumstances of the lives of people with mental illness (how many are staying on medication or feel more comfortable with the police).

PERF asked respondents to provide details on three elements of their programs that may enhance their success: conducting follow-up, providing booster training, and participating in committees with community stakeholders. These elements provide opportunities to evaluate and strengthen program activities and better gauge program impact on people with mental illness who come into contact with police.

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Appendix A

Law enforcement agencies with police-based specialized responses analyzed by Police Executive Research Forum in 2003 and/or 2004

Jurisdiction	Type of response	Number hours of special training	Number 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 in community and department; decrease in officer/civilian injuries; acceptance of CIT by 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 once (for CIT and SWAT) Call takers/dispatch: 10	848	425,000	Decrease in police shootings, assaults and batteries, and SWAT activations; good police/ mental healthcare relationship. Measured by department 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 with liaisons; increased comfort level and willingness of officers to get help over the phone; statistics indicate APD is a leader in utilizing mental health liaisons; no use of force dealing with people with mental illness for years; no press criticism or lawsuits.
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; good working relationship with mental health community; 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: 40 Call takers/dispatch: 0 All members encouraged to attend training.	1,807	754,292	Officer (measured by surveys) and consumer satisfaction (anecdotally).

* Agencies re-interviewed in 2004
** While Framingham, MA, Police Department was not one of the 28 agencies originally interviewed in 2003, it was an "add on" to the 12 agencies re-interviewed in 2004.

Law enforcement agencies with police-based specialized responses analyzed by Police Executive Research Forum in 2003 and/or 2004 *continued*

Jurisdiction	Type of response	Number hours of special training	Number officers	Population served	Outcomes
Cincinnati, OH, Police Department	Mental Health Response Team (modeled after Memphis CIT). Two districts have social workers who 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.
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.
Fort 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 by departmental statistics and public feedback.
Framingham, MA, Police Department**	Training for all officers, police/ mental health co-response, secondary mental health responders)	New recruits: 3 (in the academy) All patrol: 4 annually Special teams: Call takers/dispatch: 4 annually	125	66,000 (daytime population higher)	Increased respect between police and crisis teams; fewer "repeat players," as people are referred to appropriate mental health services. Measured by statistics (www.framinghampd.org).
Galveston County, TX, Sheriff's Department	Mental Health Deputies (similar to CIT—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 by statistics.
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 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.
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 by statistics.

Law enforcement agencies with police-based specialized responses analyzed by Police Executive Research Forum in 2003 and/or 2004 *continued*

Jurisdiction	Type of response	Number hours of special training	Number officers	Population served	Outcomes
Knoxville, TN, Police Department	Training 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	Training for all officers; emergency protective custody policy	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. Outcomes tracked by statistics.
Long Beach, CA, Police Department*	Mental Evaluation Team (officer with graduate-level education and mental health professional co-response)	New recruits: 10 (in the academy) All patrol: 3 annually Special teams: extensive/varies Call takers/dispatch: 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*	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.
Memphis, TN, Police Department	CIT	New recruits: 10 (in the academy) All patrol: 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 community, family members, consumers, providers, and law enforcement officers; more timely reporting of crisis events; reduced injuries; helps identify and recognize the inappropriateness of the stigma of mental illness. Success measured by statistics.

Law enforcement agencies with police-based specialized responses analyzed by Police Executive Research Forum in 2003 and/or 2004 *continued*

Jurisdiction	Type of response	Number hours of special training	Number officers	Population served	Outcomes
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 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 6/2001 officers have made close to 4000 crisis transports; support from mental health groups increased. Measured statistically and anecdotally.
Montgomery County, MD, Police Department*	CIT	New recruits: 3 (in the academy) All patrol: 40 once (voluntary) Special teams: 40 Call takers/dispatch: 40 (voluntary)	1,072	846,000	Decrease 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; decrease in restraints, physical confrontations, and liability; increased support of consumers and the agencies that support them.
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	PERT team collects data on disposition, transportation utilization, 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 2003; community satisfaction; increased requests for information about program. Measured by departmental statistics.
Seattle, WA, Police Department	CIT	New recruits: 4 (in the academy) All patrol: 8 once Special teams: 40 Call takers/dispatch: sporadic	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.

Jurisdiction: Seminole County, FL, Sheriff's Office

Crisis Intervention Tracking Form

Agency Case #: _____

Subject:	Date of Birth:	Race:	Sex:
Home Address:		Times: / / /	
City:	State:	Zip:	Phone:
Enrolled in Medical Security Program (MSP)? Yes ☐ No ☐ Unk ☐			
Diagnosis (if known):			

Call Dispatched ☐ Referred By: _____ Self-Initiated ☐ Other: _____

Nature of Incident *(check all that apply)*

☐ Disorderly/disruptive behavior
☐ Neglect of self-care
☐ Public Intoxication
☐ Nuisance (loitering, panhandling, trespassing)
☐ Theft/other property crime
☐ Drug-related offenses
☐ Suicide threat or attempt
☐ Threats or violence to others
☐ Other / specify:
☐ No Information

Threats/Violence/Weapons

Did subject use/brandish a weapon?
☐ Yes ☐ No ☐ Don't Know
If YES –
Type of weapon (*check all that apply*):
☐ Knife ☐ Gun
☐ Other / specify:

Did subject threaten violence toward another person?
☐ Yes ☐ No ☐ Don't Know
If so, to whom? (*Partner, Law Enforcement, Stranger, Etc)*

Did subject engage in violent behavior toward another person?
☐ Yes ☐ No ☐ Don't Know
If so, to whom? (*Partner, Law Enforcement, Stranger, Etc)*

Did subject injure or attempt to injure self?
☐ Yes ☐ No

Prior Contacts *(check all that apply)*

Known person (from prior police contacts)
☐ Yes ☐ No ☐ Don't Know
Repeat call (within 24 hours)
☐ Yes ☐ No ☐ Don't Know

Drug/Alcohol Involvement

Evidence of drug/alcohol intoxication
☐ Yes ☐ No ☐ Don't Know
If YES –
☐ Alcohol
☐ Other Drug / specify:
☐ Don't Know

Medication Compliance
☐Yes ☐ No ☐ Don't Know

Specify if known:

Complainant Relationship

(check one)
☐ Partner/spouse
☐ Boyfriend/girlfriend
☐ Parent
☐ Sibling
☐ Friend/acquaintance
☐ Business owner
☐ Other family member
☐ Police Observation
☐ Other Stranger
☐ Don't Know

Behaviors Evident at Time of Incident *(check all that apply)*

☐ Disorientation/confusion
☐ Delusions – *specify if known*:
☐ Hallucinations – *specify if known*:
☐ Disorganized speech (freq. derailment, incoherence)
☐ Manic (elevated/expansive mood, inflated self-esteem, pressured speech, flight of ideas, distractible)
☐ Depressed (sadness, loss of interest in activities, loss of energy, feelings of worthlessness)
☐ Unusually scared of frightened
☐ Belligerent or uncooperative (angry or hostile)
☐ No information

Incident Injuries

Were there any injuries during incident?
☐ Yes ☐ No ☐ Don't Know

If so, to whom? (*Partner, Law Enforcement, Stranger, Etc)* _____

Disposition *(check all that apply)*

☐ No action/resolved on scene
☐ On-scene crisis intervention
☐ Police notified case manager or mental health center
☐ Outpatient/case management referral
☐ Transported to treatment facility
Facility Name:
☐ Baker Act ☐ Marchman Act

☐ Arrested
If YES, most serious charges:

Mental health referral ☐ Yes ☐ No

☐ Other – *specify*:

Prior to CIT, would you have taken this individual to jail? ☐ Yes ☐ No

What would the charges have been? _____

_____

Signature of Officer: _____

Printed Officer Name: _____

Badge/ID #: _____

Agency: _____

Date: _____

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LEE'S SUMMIT POLICE DEPARTMENT
CRISIS INTERVENTION TEAM REPORT

INCIDENT INFORMATION

Reporting Officer(s): _____
CIT No. (Cad Call No.): _____ Date: _____
Event No. (Report No.): _____ Day: _____
Time: _____
Location Of Incident: _____ Time Cleared: _____

CONSUMER INFORMATION

Name: _____
Date Of Birth: _____ Height: _____ Sex: _____
Social Security Number: _____ Weight: _____ Race: _____
Address: _____
Address: _____
City / State / Zip Code: _____
Home Phone: _____
Mobile Phone: _____
Currently Under Mental Health Treatment ☐ Yes ☐ No

If "Yes" Case Worker: Contact Number:
Treatment Facility: _____

REASON FOR CONTACT

☐ Suicide Threat ☐ Vehicle Stop ☐ Check The Well-Being
☐ Suicide Attempt ☐ Vehicle Check ☐ Call For Service / 3rd Party Call
☐ Probate Warrant ☐ Pedestrian Check ☐ Threat / Attempt To Harm Others
☐ Self-Initiated ☐ Citizen Contact (CIT) ☐ Threat / Attempt To Harm Police Or Fire
Other: _____

If A Suicide Threat / Attempt:
☐ Firearm ☐ Hanging ☐ Overdose
☐ Edged Weapon ☐ Carbon Monoxide ☐ Jumping
☐ Suicide By Cop ☐ Jump In Oncoming Traffic ☐ Other: _____

If A Threat / Attempt to Harm Police Or Fire
☐ Physical Force ☐ Edged Weapon ☐ Firearm
☐ Other: _____

INJURIES TO CONSUMER

	Yes	No	Unknown
Prior To Police Contact:	☐	☐	☐
Due To Use Of Force By Police:	☐	☐	☐
Injury To Bystander / Witness:	☐	☐	☐
Injury To Police / Fire By Consumer:	☐	☐	☐

LEE'S SUMMIT POLICE DEPARTMENT
CRISIS INTERVENTION TEAM REPORT pg. 2

MENTAL HEALTH EVALUATION

- ☐ Truman Medical Center At Lakewood
- ☐ Rediscover
- ☐ Western Missouri Mental Health
- ☐ Lee's Summit Community Hospital
- ☐ Research Hospital
- ☐ Two Rivers
- ☐ Truman Medical Center West
- ☐ _____

CONSUMER MENTAL HEALTH HISTORY

- ☐ Bi-Polar
- ☐ Depression
- ☐ Delusional
- ☐ Borderline (Personality Disorder)
- ☐ Oppositional Defiant
- ☐ Substance Abuse
- ☐ Antisocial
- ☐ ADD
- ☐ Dementia
- ☐ Sleep Disorder
- ☐ Panic / Anxiety
- ☐ OCD
- ☐ Schizophrenia / Schizoaffective
- ☐ Other: _____
- ☐ Alzheimer
- ☐ Eating Disorder
- ☐ PTSD

SUBSTANCE USE ON SCENE

- ☐ Alcohol
- ☐ Cocaine / Crack
- ☐ Opiates (Pain medications, herion, etc.)
- ☐ Methamphetamine
- ☐ Marijuana
- ☐ Other: _____

PRESCRIBED MEDICATIONS

_____

_____

CIT RESOURCES USED TO RESOLVE INCIDENT (Check All That Apply)

- ☐ Advice From Mobile Crisis (816-864-2008)
- ☐ Rediscover Mobile Crisis Responded To Scene
- ☐ Self-Admit To Mental Institution
- ☐ Calmed & Left / Resolved at Scene
- ☐ NAMI Packet
- ☐ Medical Treatment At Hospital
- ☐ Other: _____
- ☐ Arrest
- ☐ Arrest With Referral To L.S. Mental Health Court
- ☐ Expansion Capacity Grant (816-864-2008) Or Email
- ☐ 96 Hour Hold
- ☐ Later Appointment With Rediscover
- ☐ Medical Treatment By EMS / Fire

REPORTING OFFICER NARRATIVE

CIT Officer, Badge No.	CIT Coordinator, Badge No.

*The formatting and graphics of tracking forms reproduced here may be modified slightly; the content is unchanged.