Community Guide to Mental Health Crisis Response

Authored by
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Effective Law Enforcement for All

A reference guide for those seeking to understand how police can better serve the needs of individuals experiencing mental health crisis, their families, and their communities.

Effective Law Enforcement for ALL

Executive Summary

Our Mission

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

Our Team

David Douglass
President

Ashley Brown Burns, PhD
Executive Director

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This section reviews the history of mental healthcare and mental health services, demonstrating that as a result of sporadic and underfunded health response, law enforcement have become the de-facto response to mental health crisis. This broken system needs to be addressed by an 'ecosystem approach', explained as a healthy, co-operative response that considers the needs of those in crisis at each step.

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CIT

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Effective Law Enforcement For All

www.ele4a.org

outreach@ele4a.org

Locations:

New Orleans, LA

Montgomery County, MD

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This section offers recommendations that help ensure improvements are carried through to interactions in the community. It discusses the need for leadership and accountability in training and frequent review, proposes models that integrate more clinicians and case workers into calls for service, dispatch nd call centers, and jails to ensure that the needs of those in crisis are met.

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

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This guide was prepared in collaboration with Julie Solomon, MBA, LCSW. Ms Solomon's career focuses on the intersection between law enforcement and mental health. She has experience at the local and national level in reforming law enforcement crisis intervention to better reflect and meet the needs of those experiencing crisis. Ms Solomon is an Associate Monitor for Crisis Intervention in the CPD monitoring team; has served as CAO at CIT International; and gained key experience in developing a robust mental health crisis response in her many leadership roles in the CIT and Emergency Stabilization Services in Kansas City.

Working both in Wyandot Mental Health Center and on the board of the Kansas State CIT council allowed Ms Solomon to develop her approach to a successful law enforcement response in cases that involve mental health crisis: encouraging involvement from the community and considering relationships to the broader ecosystem of mental health support.

Introduction

> "This community guide's goal is to advocate that those in a community who want change ***just start somewhere***."

Those with mental health conditions are often stigmatized as dangerous when the data shows us this couldn't be further from the truth. It is important to note, despite media coverage, that only 3-5% of violent acts are attributed to people with serious mental health conditions. In fact, people with serious mental health conditions are more likely to be victims of violent crime. They are also 16 times more likely to be killed by law enforcement, making up 25% of all fatal law enforcement interactions. This injustice is evidence of a system desperately in need of progress.

Just as we've seen with the Black Lives Matter movement, communities around the country are appropriately demanding change. As a response to this growing nationwide call, creative and successful programs have sprouted and grown, represented in rural, urban, suburban and tribal communities. This white paper is intended to explore the rationale for such programs, and crucially, some of the pathways towards positive change.

While stigma poses a serious challenge for law enforcement in mental health crisis response, the challenge is compounded by the fact that response to people in mental health crisis must meet unique needs in difficult conditions. For a law enforcement response to be successful, an officer needs to be appropriately trained and supported by a robust system so that people in crisis can have their treatment needs met and their safety ensured. The truth is that policing should only be a small part of a much bigger network, and though the scope of this paper focuses on pathways towards improving mental health crisis policing, there are necessarily many references to other elements in the safety net or ecosystem that should be built up to address the needs of our communities. This 'ecosystem approach' to mental healthcare and crisis policing involves many stakeholders that will be explored, as well as suggestions to help bring diverse actors to the table when workshopping reform.

Communities can at times be overwhelmed by what needs to be accomplished and the resources change often requires, and be unclear on where to even start. This community guide's goal is to advocate that those in a community who want change ***just start somewhere***. Consider using this guide as a resource to begin searching for the places most urgently in need of reform in your community's mental health crisis response in law enforcement. Many

sections in this guide will pose questions that can be addressed to your local department, or will suggest ways to bring different stakeholders together to begin working on better models, solutions based in best practice, and approaches to the difficult problems of funding, leadership, and more. There *are* better systems out there and ways for communities of different size and resources to strive towards better mental health crisis care.

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

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

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

Ecosystem Approach

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

In a healthy ecosystem, a law enforcement response is supported by an array of other community conditions. For example, just like specific fish species require a habitat with adequate food resources, bacteria containment, temperature moderation, sunlight etc.; mental health crisis reform requires crisis center access for law enforcement, treatment advocates and family

members to divert to, law enforcement training and trauma informed response related to persons living with and affected by severe mental health conditions, 911 diversion, jail intake and diversion efforts, mental health court liaisons/programs, alternative crisis response options, hospital emergency room collaboration etc.

> "In a healthy ecosystem, a law enforcement response is supported by an array of other community conditions."

In a broken ecosystem, created by a history which has sidelined mental health treatment, law enforcement are all too often the *only* response to mental health crisis, and are isolated in their approach. Without strong community mental health clinics, the warning signs of crises go unaddressed, leading to more preventable crises that overburden an already stretched-thin system. Without strong hospital care and crisis clinics, jails can become the de-facto place to bring someone in a crisis, which creates a vicious cycle of further trauma, and can disconnect a person with a mental health condition from their medication or the care they need. A lot of this probably sounds familiar because the state of mental healthcare in the US much more often resembles a broken ecosystem than a healthy one. The history of mental healthcare in the US has been characterized by patchwork reform, often missing funding and creating huge gaps for people to fall through.

Additionally, communities can create barriers that poison the ecosystem. Community organizations often operate in silos, create unnecessary turf wars, bring an unwillingness to share important data, acknowledge their own organization system failures, or focus on claiming single entity ownership for successes; all of which result in trust issues. These barriers prevent successful innovation.

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

Many reform efforts require an ecosystem approach. In justice and behavioral health reform, this typically includes policy changes, training improvements, and operational innovation (in tandem across ecosystem organizations). This requires strong community collaboration with egos aside. Some of the operational innovation includes specialty/multi-disciplinary response teams (both in and outside of law enforcement), proactive approaches to high frequency utilizers of first responder services, emergency communications (911) innovation, jail diversion initiatives, specialty courts, 24/7/365 crisis centers for law enforcement drop off, and collaborative data tracking to inform your own community reform roadmap.

Individuals, organizations, and communities can get overwhelmed by all that needs to occur to get in line with 21st century reform practices. It is not atypical to hear things like "We don't have the budget", or "this department or executive doesn't 'play well in the sandbox'", or "this issue isn't a priority for the people in power", or "we don't have data systems to do this". Some of

these may be very real issues in your community. It can be helpful to equate this journey with an archaeological dig. Just start somewhere, and the data will unfold informing where the next logical step lies. This guide may help your community have some insight into where a good step for your community may be to start.

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

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

Departmental policy can often be difficult to parse for a layperson, but there are some very simple places to start looking at your local police department's policies. All police departments should have policies directing interactions with individuals with mental and behavioral health conditions, intellectual disabilities, and those needing special accommodations for physical limitations, deaf/hard of hearing, visually impaired, non-English speaking, gender and sexual identity etc.). In addition, a police department may have Crisis Intervention Team (CIT) and/or other alternative response policies. CIT will be discussed in greater detail later in this guide, but it's certainly worth noticing whether your department has CIT policy, and whether policies are extensive, specific, and useful.

Unfortunately, these policies are often not updated regularly to reflect best practices, and to ensure they accurately reflect updated training and operational practices. Community resources change, transition in department leadership occurs, and as a result there can be a disconnect between departments responsible for policy review and those actually providing program leadership and. Consequently, policy updates often get lost or deprioritized.

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

> "Successful police reform ... requires, at minimum, input from law enforcement, community mental health and people with lived experience."

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

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

This can be a difficult place to start when demanding reform, because often policies *will* include at least some promising language. If your community's policy does seem lacking, ask why. If the policy looks good but isn't reflected in the lived experience of community members who have interacted with law enforcement during a crisis, this can be a good indicator that the gaps your community needs to address are somewhere else. How well do officers adhere to policy? How is policy reflected in training and accountability so that mental health crisis policing follows these best practices?

Training

Equipping officers with the right skills and mindset is essential for the safety both of the person involved in a crisis and for the officers themselves. With only about 4% of police calls for service ending in use of force, departments often have a heavy imbalance of training focused on proper use of force, tiered levels of force and custodial escort techniques (handcuffs, leg irons etc.). While this is critically important training, and police safety training should never be sacrificed, it is often at the expense of an equal or greater amount of training on a range of

de-escalation practices and tactics; which are more aligned with how the majority of calls for service end.

Verbal de-escalation and strategies that support reducing the need for force should be of paramount importance and should be reflected in training priorities. Strategies like tone of voice, physical stance, using time as tactic, use of physical barriers, distance, cover, and verbal/non-verbal communication strategies are measurable tactics that should be integrated into scenario-based training at all levels, reinforced, audited, evaluated, and included in policy, training, and operational compliance.

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

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

> "Use of Force scenario-based training ... can train officers to *expect* force rather than expect to de-escalate a situation."

In addition, it is important to consider how many hours are dedicated to scenario-based training, which is essential. Use of Force scenario-based training all too often is made up of scenarios ending in force, rather than successful de-escalation. This can train officers to *expect* force rather than expect to de-escalate a situation. Scenarios involving people in mental health crisis should also be integrated. In a mental health crisis, slowing things down; using distance; cover; body language; single command voice; and softer interpersonal communication buys invaluable time to de-escalate and gain additional resources as needed. Try to find out what proportion of scenario-based training involves use of force as opposed to de-escalation; *and* what proportion involves a mental health component. Ask if this proportion is reflective of the reality of policing in your community.

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

De-Escalation: Combining Training and Review

De-escalation is a crucial tool in law enforcement. An officer should be thinking about how to de-escalate using skills like positioning, body language, and tone of voice in order to achieve their objectives. Failure to de-escalate tense situations often means putting the officer and those on the scene in more danger, and as a scenario escalates, it becomes harder to gather information and resolve conflict. Good de-escalation skills are useful in not just mental health crisis calls for service but most of the day-to-day operations of police officers. It is something that needs to be clear and codified in the minds of officers, as a result of both training and strong reinforcement. Keep de-escalation training from becoming a tick-box exercise by refreshing frequently and tying training concepts to frequent review.

Training and review should ask whether time; space; tone; cover; stance; asking open ended questions versus commands; calling for specialized units; and other de-escalation strategies are being used appropriately. There are tangible ways to assess use of de-escalation strategies, which reinforces to officers what the department means when they are prioritizing "de-escalation".

"Training and review should ask whether time, space, tone, cover, stance, asking open ended questions versus commands, calling for specialized units, and other de-escalation strategies are being used appropriately."

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

Sergeants trained in CIT, or another equivalent mental and behavioral health training is an essential element to understanding what is being taught and in adequately supporting their patrol officers in utilizing these skills and resources in the field. Police departments should consider mandating all Sergeants and any newly promoted Commanders be trained in CIT or another robust mental health training, which with attrition and promotion, will build capacity and a culture of understanding the importance of the CIT program, mental health response and reform efforts. Mandating Field Training Officer (FTO) certification (officers who are paired with new officers in a mentor type role) should also be strongly considered, as new officers coming into the field can be unduly influenced by FTO's who do not have the training or context of a CIT program or mental health response.

Crisis Intervention Team (CIT)

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

CIT has been widely adopted and many communities already use the CIT model, but even in those communities it can be important to examine the individual mechanisms of the model to constantly seek improvement. Like with de-escalation, departments can't rest on their laurels after having initiated a CIT program but instead need to continually reassess and reinforce ideas from CIT training to ensure they don't stagnate or become a tick-box exercise.

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

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

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

A "train all" model can become diluted if not done carefully. This negates the specialized nature of CIT officers, and allows officers who may *not* be a good fit to be called to respond without the personality or skill set required. This can be dangerous. It is highly recommended in a mandated model that there is a "bumped up" specialized team of voluntary CIT certified officers who receive advanced training, are vetted for their interest and skill set, and would respond to higher level calls for service involving a mental health component. This voluntary cadre of officers can also make up a specialized unit (behavioral health units) and are central to

expansion efforts including Mobile Crisis Response Teams, follow up teams, high frequency utilizer initiatives, homeless outreach, co-responders etc. (see Portland PD, Houston PD, LAPD, San Diego models). These bumped up specialized officers would wear CIT pins (not mandated officers) and would be prioritized for dispatch. In this model, it elevates all officers to receive critically important, in depth training, with important exposure to community-based resources, yet still maintains the specialized nature of voluntary CIT officers with the skill set and interest to be prioritized for response.

> "[A]ny training, and especially mental and behavioral health training for law enforcement, cannot be a "one and done". *All training models should include refresher training.*"

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

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

Because of the nature of CIT training, which requires diverse community-based experts to deliver the curriculum, constraints on outside resources will need to be addressed. A collaborative approach, rather than siloed efforts to meet individual community needs is recommended. Some communities have been successful pooling resources and combining law enforcement from jails, courts, and outside police departments in one CIT class, along with key behavioral health personnel into one training. While there may be distinctions among the needs of different law enforcement agencies and behavioral health partners, a community can address this by, for example, including stronger emphasis in areas that make up the composition of the class (e.g.: youth mental health focus for School Resource Officer (SRO) participants, scenario's specific to jail based settings for jail detention personnel etc.). There are successful and creative ways to accomplish this.

Another useful framework which incorporates CIT training is the IACP's One Mind Campaign. They recommend combining CIT training and Mental Health First Aid (MHFA) for law enforcement. MHFA is an 8-hour course endorsed not only by the International Association of Chiefs of Police (IACP) "One Mind Campaign" but is also a good overall educational tool to

orient officers to signs and symptoms of mental health conditions, and responses that are often different from traditional police training.

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

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

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

Developing a Training Model Around CIT

Whatever model your community chooses, there are a minimum of six training areas that should be considered:

1. Recruit academy
2. Annual in-service for all officers
3. Pre-service promotion training
4. Refresher training.
5. Voluntary specialized mental health training and response options

and/or

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

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

like TNC. The hours allocated to training vary, but should be prioritized, which generally means the more dedicated hours, the higher the priority.

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

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

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

"Don't let the perfect be the enemy of the good: develop a CIT model within your department's means and ensure that there's leadership that is passionate about the program."

As discussed when assessing CIT, the two predominant models are a voluntary or a mandated model. However, both of these models can be tweaked to best fit their purpose in a community. The One Mind Campaign advocates that 20% of a department's sworn members be trained in CIT or equivalent qualification. If your community can't afford to do that in one year, locate and prioritize officers to train. Consider what support they're going to need. Is it more worthwhile to train a few non-sworn staff, such as dispatch staff? Don't let the perfect be the enemy of the good: develop a CIT model within your department's means and ensure that there's leadership that is passionate about the program.

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

These six elements are a basic framework to be built on. Consideration should also be given to additional law enforcement and non-law enforcement mental health response options like: multidisciplinary response teams (with or without law enforcement); police co-responders

(mental health clinician paired with CIT officer); mobile crisis teams; 911 telecommunication call diversion (embed a clinician inside telecommunications); jail diversion program (embedding case managers in the jail to divert for minor city ordinance or misdemeanor crimes); mental health court liaison; justice involved case management teams; etc.

Alternative responses will be discussed further in the following 'Operations' section, but they need to be integrated into training to be successful. Just like with de-escalation, officers need to approach a call for service with a strong awareness of what resources are at their disposal and what solutions would be the most appropriate in different scenarios.

Operations

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

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

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

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

In addition to clear and passionate leadership, an allocated budget, and incentives to improve, operations need to codify the structure of mental health response. The following subsections include recommendations on different elements of operations and how they can best prioritize mental health crisis response.

Alternative Response and System Integration Models

Alternative responses at their best should be bridges to other elements in the mental health 'ecosystem', to help ensure that those in crisis are connected to the most appropriate, effective solutions. This way, officers' time and resources can be better spent in the community and people experiencing crises can receive care.

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

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

- Embed community mental health center case manager(s) inside the jail to crosscheck the daily jail booking report with the client database at the community mental health center. This allows for identification of active clients who are booked into the jail, for what crimes, how long they are in jail and at what cost to the city. These basic data points help inform areas for diversion, rapid communication with jail mental health staff regarding medications the individual is on for continuity of care inside the jail, assists with coordinating a warm handoff at release from the jail with either a family member, their assigned case manager or a person with lived experience, and identifies high frequency utilizers to connect with justice involved case management teams for proactive outreach.
- These same case managers can also be assigned to the mental health dockets for continuity between jail, judges, attorney's, psychiatric services, and client case managers.
- Develop justice involved case management teams who have the role of proactively serving the high frequency utilizers of law enforcement and first responder calls and jail bookings.
- Embed a clinician(s) inside telecommunications (citizen facing) to divert non-urgent 911 calls from Law Enforcement response at all, while also utilizing a warm hand off as necessary to a resource line or community mental health hotline.
- Consider variations of dedicated co-response teams that can include combinations of a paramedic, clinician, law enforcement (recommend soft uniform) and PEER (person with lived experience). These teams often present opportunities to move away from law enforcement focused response and law enforcement transport (criminalizing mental

health conditions), and toward a medical response providing an unmarked vehicle with locked seat belt restraints or EMS transport instead of handcuffs and a marked police unit.

- Traditional co-responder model (clinician riding with a mental health trained officer or deputy)
- Mobile crisis response teams typically formed by community mental health centers to respond to calls not requiring police presence. Response times (as quickly as possible) are important as individuals and families in crisis are more likely to call 911 if response times are too long. These mobile crisis response teams can sometimes also be successfully utilized for police call outs by officers on scene of a call not requiring law enforcement response.

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

Considerations in Alternative Response Models:

- A clear line of supervisory chain of command is essential, particularly for the clinicians/case managers. If a clinician or case manager is housed inside a police department or paired with an officer, agreement must be clear in advance and written into MOU's and job descriptions. Typically the clinician reports up to their mental health center supervisor with the officer reporting to the CIT coordinator, however there must be trust and strong communication between the supervisors to quickly respond to any issues that arise.
- Consideration should be given to where clinicians and case manager are housed, within the Police Department or Mental Health Center. Often, housing clinicians inside Police Headquarters, or at police district offices allows rapport to be built with officers and allows an ongoing opportunity to promote the program to officers.
- Alternative uniforms and vehicles should be strongly considered. Stigma is exacerbated when marked police vehicles and regular police uniforms show up on scenes where someone is calling for help due to a mental health crisis. Not only are people embarrassed to have a police car in front of their homes, but uniformed police can also escalate a situation with someone in behavioral health crisis. A "softer" approach through non-traditional uniforms and vehicles is a good approach to consider.
- The job description, selection and hiring of the co-responder/alternative response positions should be carefully and thoughtfully considered and should be co-developed and co-interviewed minimally between the Law Enforcement and Community Mental Health Center. It is imperative that both organizations agree that the person(s) is a good match for the role.
- Consider internal versus external clinical hires. It is a steep learning curve just to learn the services, agency protocols, and accessibility guidelines within the organization you work for, let alone attempt to do it as a part of a new pilot program that needs to be successful early on. If officers see that clinicians do not know where to take someone, what paperwork will need to be completed to access those services, who to call in the organization etc., officers will often give up on the use of it. This is difficult to rebound from. Typically, seasoned clinicians are hired internally, who already have strong familiarity with the organization operations.

- A data analyst should be considered, either internal, or externally contracted- typically with a local University for a more robust community analysis of data.
- SAMHSA's Sequential Intercept Mapping (SIM), and the Sequential Intercept Model are good resources and training for communities to help identify gaps in community systems.
- CIT training and specialized programs should be highlighted on the police department and mental health centers websites. When absent, it is often an indication of both how CIT may be viewed by the department, and sometimes the overall disjointedness of the program itself. When CIT and Alternative responses becomes an embedded community program, as intended, it should be identified on the website like any other specialized response.

24/7/365 Law Enforcement Drop Off Centers

> "If it's quicker to book someone into jail than to bring them to the crisis center, the crisis center is going to be unsuccessful."

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

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

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

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

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

enforcement are benefiting. More about the importance of data, and what can and should be collected, will be discussed in the section on data.

Community Mental Health Advisory Committee

A Community Mental Health Advisory Committee is a multidisciplinary team that serves as a foundation to innovation and successful community response to persons in crisis. The Advisory Committee should openly share data/information, explore alternative approaches to law enforcement response, identify gaps in service, and be deliberate on how best to respond to them, etc. The Advisory committee should meet monthly and is a critical foundation to any successful community program. This is one great way to start formalizing cooperation and communication between elements of our 'ecosystem'. Bringing everyone to the table will help illuminate the key areas for improvement and produce a virtuous cycle of improvement.

As a recommendation, participants should include representative(s) from:

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

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

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

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

911 Call Takers & Dispatch

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

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

- Develop Telecommunication Specific Mental Health Awareness or Crisis Intevention Team training (ex: 8 hour or up to 3 Days) or include Telecommunications in the 40-hour CIT program (or equivalent). Ensure there is also regular, robust, ongoing refresher training for telecommunications.
- Prioritize Response of CIT officers to Calls for Service involving a mental health component.
- Establish clear criteria for telecommunications to identify the call for diversion to an alternate resource, a co-response or non-law enforcement response where appropriate.
- Ensure there is a coordinated effort and strong relationship between the CIT coordinator, telecommunications and the mental health center to cross train on Mental Health related efforts. Each need to have thorough awareness of respective program(s) and resources. It is critically important to have a streamlined approach.
- Establish call codes that best capture overall calls for service (CFS) that involve a mental health component. Some departments limit call codes to things like "suicidal" or "Mental Health". It is important to develop a strategy for identifying a way to uniformly track incoming calls that involve a mental health component. While this will not always be perfect, since many calls have overlapping characteristics, there should be a designation that triggers an automated set of triage questions at call intake. It is recommended that telecommunications have designated pop-ups in their digital system capable of asking basic triage questions that can then be transmitted over the air and via Computer Aided Dispatch (CAD) to responding officers. For example, known mental health condition (given by caller); behaviors present; weapon present (including type); triggers that can escalate behavior etc.
- In addition, many communities have a designation (ex: alpha character z) that is added to any call, regardless of how it was dispatched, that officers can close out the call to indicate it involved a mental health component. For instance, if an officer is dispatched to a domestic call, but once on scene, it clearly involves a mental health component, the call can be closed out adding the alpha character z to the formal call code. This then allows data to be pulled to reflect calls more reliably that contained a mental health

component. While CFS involving "trespassing", "loitering" "person down", etc. are important call codes to monitor these do not always involve and may not be appropriate to include in data collection for calls with a mental health component.

- Embed a Citizen Facing Social Worker(s) in telecommunications to divert non-emergency calls.
- Telecommunications should have a shift roster of CIT officers on duty where law enforcement response is needed to ensure there is an automated way to prioritize dispatch of Mental Health calls for service to CIT trained officers or behavioral health units. This should be part of an overall robust strategy.

Data Recommendations

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

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

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

Police Department:

CIT Report:

- Calls that are closed out as calls involving a mental health component should require a CIT report be completed. The CIT report should include such information as name, address, mental health condition (if given by the person themselves or a family member on scene); characteristics indicating a mental health condition (talking to themselves or others, hearing things that you do not hear, rapid speech, depressive characteristics, odd behavior etc.); whether or not a weapon was involved, and if so, what type (knife, firearm, other object etc.); use of force and type by officers, Disposition of the call, including: resolved in community, referred to community based services; transport to services (voluntary or involuntary); arrest (city ordinance, misdemeanor, felony), referral to alternative response team etc. These data reports should be routed through

the CIT coordinator and his/her team to track trends, including high frequency utilizers that can be referred to additional alternative response and support services.

- Data indicating overall calls for service, of those, number of calls for service involving a mental health component (ex: alpha character z), of those, how many were responded to by a CIT certified officer (primary or assist), of those, disposition of the call.
- Percent of CFS that involve a mental health component by district/watch (shift).
- Time from arrival on scene to close out of call (this is good to monitor distinctions -if any- for CIT calls vs non-CIT calls).
- Percent use of force and types for CIT and Non-CIT officers.

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

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

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

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

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

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

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

Public Education Campaigning

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

Specialized program liaisons and officers should consider attending community meetings, carrying resource cards to give to families, promoting the programs on website and community policing initiatives, through NAMI and other advocacy organizations, and other robust efforts to actively promote the program.

There are many opportunities to educate the community. Methodology should strongly consider the size of a community and budget resources. It's certainly vital that people; particularly those who experience mental health crises and those in their support networks such as family, friends, coworkers and neighbors; know what resources are available to them, or even the best developed crisis response will see some gaps.

However, a cohesive mental health and alternative response strategy needs to be developed before extensive community education. This is a great *late-stage* step in the journey towards a better mental health crisis response, but shouldn't be prioritized above or before data, training, policy and operations; which are the areas that help earn and build community trust.

Conclusion

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

ELE4A advocates for safe and effective policing for all communities, and recognizes the invaluable importance of engaged citizens in leading the call for change.

Effective Law Enforcement for ALL