How Small Law Enforcement Agencies Respond to Calls Involving Persons in Crisis

Results from a National Survey

**NATIONAL POLICE
FOUNDATION**

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ABSTRACT

Police frequently respond to calls occasioned by people with behavioral health needs (those with mental illnesses and/or substance use disorders). These calls are often time-consuming and potentially dangerous for officers and the persons experiencing crisis. Large and medium-sized law enforcement agencies have increasingly adopted specialized police response models that entail collaboration between law enforcement, mental health agencies, and medical facilities. However, little is known about the adoption of specialized responses by small agencies with fewer resources, less occasion to see persons in crisis, and fewer nearby mental health facilities.

This report presents findings from a survey of how small law enforcement agencies respond to incidents involving persons in crisis as a result of mental health or substance abuse issues. It is based on responses of a random sample of 380 municipal police and sheriff offices with between 10 and 75 sworn officers between February and October, 2020.

The survey finds that all but twelve responding agencies had adopted some form of specialized response model for dealing with calls involving persons in crisis. More than six in ten agencies has provided some form of crisis response training to all patrol officers, and three in ten provided training to some patrol officers. Three in ten agencies had at least one officer in the agency who had been CIT (Crisis Intervention Team) certified and half of the agencies reported being part of a regional CIT partnership. The regional partnerships gave small agencies access to highly skilled law enforcement and mental health staff, but response times could be long, regional skilled staff unavailable at all times of the day, and mental health facilities a lengthy drive away. The death of George Floyd, which occurred during the administration of the survey, encouraged four in ten survey respondents to reassess their current approach to dealing with persons in crisis.

INTRODUCTION

Over the last decade, a persistent lack of community-based mental health resources available to people in crisis has resulted in frequent need for police intervention. Although police officers can respond around the clock, their core skillset and training often fail to provide adequate information about mental illnesses, proper training on de-escalating crises, and awareness of and effective connection to available services. Police encounters with people with behavioral health needs (those with mental illnesses and/or substance use disorders) are common, consuming disproportionate public safety and community health resources, and potentially dangerous. One quarter of the people killed by police each year are thought to have been in behavioral health crisis.[1]

Many experts have written about the inappropriateness of placing persons experiencing mental illness or substance abuse in jails as they wait for prosecutors to decide whether they plan to file charges and/or judges to set bail. Studies have found that individuals suffering from severe mental illness are more likely to experience co-occurring substance abuse problems and homelessness.[2] Furthermore, similar studies have found that detaining those in crisis in jail settings can often exacerbate their condition, making them more likely to reoffend.[3]

In response to this situation, law enforcement agencies (LEAs) across the country have turned to "specialized police response" models that focus on collaboration between law enforcement, mental health agencies, and advocates. Two predominant models have emerged: Crisis Intervention Teams (CIT) and Co-responder programs. Crisis intervention teams (CIT), first developed by the Memphis Police Department, are an innovative first-responder model that combines crisis intervention training and efficient access to behavioral health treatment for persons with mental disorders and/or addictions rather than subjecting them to prosecution and incarceration. It promotes safety of both responding officers and the individual in crisis. This model has been adopted by medium and large agencies across the country. According to the National Alliance on Mental Illness, it is now present in over 2,700 agencies nationwide.[4] Co-responder programs typically pair trained law enforcement officers and mental health professionals in a coordinated response to crisis calls. Sometimes the officer and mental health clinician ride

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1 https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted

2 Loveland, D., & Boyle, M. (2007). Intensive case management as a jail diversion program for people with a serious mental illness. *International Journal of Offender Therapy and Comparative Criminology, 51*(2), 130-150.

3 Moore, M., & Hiday, V. (2006). Mental health court outcomes: A comparison of re-arrest and re-arrest severity between mental health court and traditional court participants. *Law and Human Behavior, 30*(6), 659-674.

4 https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs

together in a responding vehicle, and sometimes the clinician arrives separately at the request of responding officers.[5] These models are designed to facilitate connecting people in crisis to appropriate behavioral health resources, providing follow-up case management and reducing repeated calls for service.

Implementation of these approaches varies widely. For example, the amount of training can range from minimal crisis intervention training for all patrol officers to in-depth training for a specialized crisis intervention or co-responding unit or team. The nature and extent of the involvement of behavioral health clinicians in co-responder programs can also range from having a clinician ride with a single officer for several shifts a week to officer/clinicians pairs responding for the majority of the week as well as providing follow-up to calls on an as-needed basis.

Researchers believe that comprehensive programs that comply with a series of critical elements are the best positioned to be effective.[6] For example, in CIT programs,

only a cadre of officers is trained, ideally for 40 hours to identify mental illnesses, de-escalate potentially volatile situations, and connect people in crisis to treatment or other services instead of jail where appropriate.[7] Co-responding team members receive cross-training on the expertise of each partner.[8] Extensive collaboration with a range of stakeholders is also a gold standard of all of these programs, as it allows for effective engagement of relevant resources and perspectives in model development and implementation. Other important elements of these models include 911 call-taker and dispatcher training and protocols so calls can be documented and dispatched to program responders appropriately; and specialized drop off procedures at receiving facilities.[9]

Although these efforts have proliferated and show promise in reducing negative interactions with the police and increasing appropriate assistance for those with behavioral health needs, they have largely been implemented in medium and large departments.[10] However, the vast majority of LEAs are small — more than 9 in 10 have fewer than 75 sworn staff. There

5   Shapiro GK, Cusi A, Kirst M, O'Campo P, Nakhost A, Stergiopoulos V. Co-responding Police-Mental Health Programs: A Review. Adm Policy Ment Health. 2015 Sep;42(5):606-20. doi: 10.1007/s10488-014-0594-9. PMID: 25239523.

6   Shapiro et al., ibid.

7   Watson, A.C. & Fulambarker, A.J. (2012). The crisis intervention team model of police response to mental health crises: a primer for mental health practitioners. *Best Practices Mental Health.* 2012 Dec; 8(2): 71.

8   Shapiro et al., ibid.

9   Schwartzfeld, M, Reuland, M, Plotkin, M. Improving Responses to People with Mental Illnesses: The Essential Elements of a Specialized Law Enforcement–Based Program. Council of State Governments. 2008.

10   Compton MT, Broussard B, Hankerson-Dyson D, Krishan S, Steward T, Oliva JR, Watson AC. System- and policy-level challenges to full implementation of the crisis intervention team (CIT) model. Journal of Police Crisis Negotiations. 2010;10(1–2):72–85.

is a dearth of literature on rural policing in general, and almost none on rural policing and behavioral health crisis response. In general, however, smaller agencies are often slower to adopt reforms because of smaller budgets, and police in rural communities encounter individuals experiencing behavioral health issues infrequently and often lack nearby mental health facilities.

With both resources and problems that are not on scale with larger agencies, small agencies often get left out of consideration when it comes to new technology and approaches to policing. Yet, statistics on the opioid crisis in small towns and rural America suggest that addiction is a relevant issue that must be addressed by both small agencies as well as their larger counterparts.[11] Further, although calls involving someone with behavioral health needs may be less frequent in rural communities, the amount of time officers spend on these calls still can be extensive.[12] When these small and/or rural communities address how law enforcement responds to people with behavioral health needs, they must often adapt existing models to account for limited funding and jurisdictions that cover large areas of land with a lack of public

transportation and poor access to treatment.[13]

When these small and/or rural communities address the law enforcement response to people with behavioral health needs, they must adapt existing models and innovate to account for unique characteristics: limited funding and jurisdictions that cover large areas of land with poor public transportation and poor access to treatment.[14] Nonetheless, media accounts indicate that there are many small agencies that are crafting approaches to develop constructive responses to persons with mental illness or substance use disorders. Some small agencies provide CIT training or Narcan to patrol officers. Some participate in regional consortiums where local agencies share Crisis Response Teams. Others have adopted telehealth models where experts provide advice to patrol officers in the field via audio or video conferencing: For example, the Gallia, Jackson, and Meigs County Ohio sheriff offices in rural Appalachia have allied with a mental health provider to create a regional response to behavioral health incidents. Some agencies in Minnesota are using a cell phone app that provides officers responding to crisis calls with greater situational awareness by providing them with information (name, photo,

11   Monnat, S., & Rigg, K. (2018). The opioid crisis in rural and small town America. Durham: University of New Hampshire Carsey School of Public Policy.

12   Yang, S. M., Gill, C., Kanewske, L. C., & Thompson, P. S. (2018). Exploring Police Response to Mental Health Calls in a Nonurban Area: A Case Study of Roanoke County, Virginia. Victims and Offenders, 13(8), 1132–1152. https://doi.org/10.1080/15564886.2018.1512540

13   Compton MT, Broussard B, Hankerson-Dyson D, Krishan S, Steward T, Oliva JR, Watson AC. System- and policy-level challenges to full implementation of the crisis intervention team (CIT) model. Journal of Police Crisis

14   Compton et al., ibid.

mental health conditions, behavior triggers and de-escalation techniques) on local individuals with mental health or substance abuse issues.

The National Police Foundation set out to explore the specific ways in which small agencies have adapted crisis response strategies used by larger agencies in order to meet their unique needs. To accomplish this task, we conducted a survey with a random sample of small law enforcement agencies throughout the United States. Respondents were asked questions about officer training, access to mental health expertise, budgeting, special protocols for dispatch and hospital drop off, and their professional partnerships with other organizations, all in relation to their chosen crisis response model. The present report outlines the results of the survey and discusses our general findings.

METHOD

After development of a draft survey, in December 2019, the survey was piloted with six small law enforcement agencies. The purpose of the pilot was to gain constructive feedback on question clarity and relevance. After completing the survey, respondents were called and interviewed about survey length, burden, and difficult sections. After receiving this feedback, the survey was revised and prepared for national distribution.

The Office of Community Oriented Policing defines small law enforcement agencies as those with 50 or fewer sworn officers. For our purposes, we used a somewhat different definition of small agencies – those with 10 to 75 officers. We chose to construct a sampling frame from somewhat larger small agencies because we believe that the very smallest of agencies (under ten sworn officers) are less likely to encounter behavioral health incidents with any frequency or to have felt the need to develop innovative ways to respond. Our goal was 366 survey responses: Given the size of the population we were drawing from (7,646 agencies between 10 and 75 sworn staff), this would allow us to make population estimates within +/- 5% with 95% confidence.

In February 2020, a random sample of 1,200 agencies was drawn from municipal police agencies and sheriff offices with 10-75 officers in the National Directory of Law Enforcement Agencies' (NDLEA) list of all municipal police

agencies and sheriff's offices in the U.S.. The survey was disseminated via email to the 1,200 agencies. The email, using Qualtrics software, personalized the email body, links, and maintained metadata (contact name, type of agency, number of officers, county population, etc.) for each agency in the sample. Since the survey was sent to agencies in different time zones, the emails were prescheduled to send during weekdays at 12 pm EST/9 am PST, to ensure it was received during regular business hours. Two weeks after the initial invitation, a reminder was sent to agencies that had not responded. We hoped that this sample size would yield about one in three completed surveys, thus meeting our quota of 366. If it did not, then our plan was to draw a second random sample of 1,200.

We had intended to send additional email reminders to non-respondents. However, as a result of COVID-19 starting in mid-March 2020 and the civil unrest in May and June of 2020, data collection was paused. At that point, the initial invitation and one non-response email had generated 115 submitted surveys. The 115 surveys were analyzed for patterns and completion. This preliminary analysis led to shortening the survey because several questions had less than a 10% response. Data collection resumed in July 2020, when a final email reminder was sent to non-respondents; however, the return rate was lower than the previous two invitations, with only 34 responses.

Because we were still far from our goal of 360 completed surveys, we began conducting

additional non-response outreach through alternate contact methods. The first alternate method we tried was telephone: We conducted a test with 50 non-respondent agencies, reminding them by phone to complete the survey and offering assistance in completing the survey instrument. Each agency was called twice. Out of the 50 agencies, we were able to successfully make contact with 10 Sheriffs or Police Chiefs in total, all of whom agreed to take the survey via a new link sent to their email. We confirmed email addresses with each recipient before ending the call and forwarding the link. However, in spite of these efforts, only one survey was returned as a result of phone invites.

Next, we experimented with mail invites by distributing paper surveys via USPS to 100 of the non-respondent agencies. The "mailer," contained a cover letter with similar language as the email body and a link that could be used to complete the survey online. We also provided an additional envelope marked with return postage and a hardcopy version of the survey. Agencies were asked to respond within two weeks. The mailing yielded 11 completed responses, or around a 10% response rate. As a result, we organized a more extensive mail survey to the remaining nonresponding agencies (approximately 1,000). This distribution yielded approximately 200 surveys responses across both physical mail returns and those who elected to take the online survey using the link listed on the cover letter. Overall, we received 349 surveys for a 29% response rate (across all modes of survey

administration).

After exhausting data collection efforts on the original sample, we were still short of our 360 goal. Therefore, we drew a second random sample of 1,200 agencies from the same NDLEA universe described above. In September 2020, this sample was invited to complete the survey online using the same email methodology as the first sample. An email invitation was followed by two non-response reminders sent over six weeks. Sample #2 yielded 122 responses, just over a 10% response rate.

The final yield, including all samples and data collection strategies, was 458 responses. However, in some instances, we received more than one response from a single agency. There are two ways in which this could occur. In the first scenario, multiple responses could result from one respondent completing the survey online and another, within the same agency, returning the survey via mail. In these cases, we chose to use the response from the respondent with the higher rank. In the second scenario, respondents who took the survey online could have started the survey using the link from one email invitation or reminder, but not finished the survey, and restarted on another occasion using the link they received from a later reminder. In these cases, we opted to use the survey responses that were most complete as determined by a measure of survey progression maintained by Qualtrics. After that, we filtered all of the responses and determined that 338 unique agencies had filled out the survey in its entirety and another

42 had completed at least 20% of the survey for a total of 380 responses. At this point, having exceeded our goal of 360 complete surveys, we did not employ the additional data collection strategies (i.e., phone and mail) that we had used for the first sample.

We conducted a non-response bias analysis to determine if survey respondents differed from non-respondents. The only two useful agency characteristics that were available in the NDLEA database were type of agency (municipal police or sheriff) and number of officers. There was virtually no difference in number of sworn officers between responders and non-responders (mean = 26 for both groups). There was a significant difference between the two groups in terms of type of agency: Responders were more likely to be municipal police agencies (83%) than non-responders (78%). This difference is statistically significant (p=.03) because of the large sample size. Nonetheless, we decided not to weight the sample since the size of the difference was substantively small – just 5 percentage points.

RESULTS

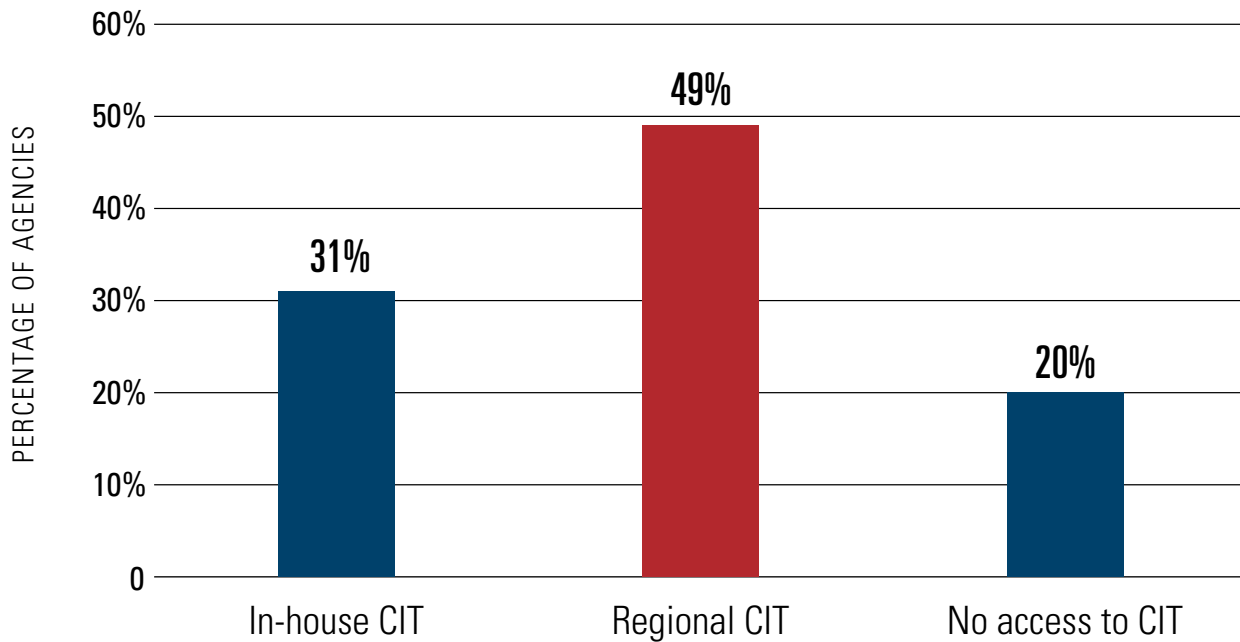## *What Kinds of Crisis Response Programs Do Small Agencies Have?*

As noted above, there are different approaches that agencies may take to develop a more effective response to calls involving persons in behavioral health crisis. Whatever model is chose, there are several important elements agencies can undertake to implement comprehensive response programs:

1. They can provide basic training to patrol officers that teaches officers to recognize signs of mental illness or substance abuse and better understand how to react in these situations to promote positive outcomes.

2. They can create a Crisis Intervention Team (CIT) to deploy a cadre of officers with more intensive training in de-escalation methods to calls involving person in crisis.

3. They can create partnerships with local mental health organizations to have psychologists or social workers available to co-respond in person or by phone or video link to assist officers with crisis calls.

4. They can develop protocols with local hospitals to facilitate drop off of persons in crisis.

5. They can participate in a stakeholder collaboration group that meets to create policies for dealing with persons having a mental health or substance abuse crisis.

6. They may develop special dispatch procedures to give officers better situational awareness when responding to calls involving persons in crisis.

Of 380 responding agencies, just 12 did not meet any of the above criteria for having a crisis response program. More than 3 in 4 respondents (78%) indicated that their agency's crisis response program was focused on responding to both individuals with mental illness and those with substance abuse problems. Nineteen percent of the programs were targeted only at persons with mental illness and very small percentages focused exclusively on substance abuse (2%) or homelessness (less than one percent).

PERF's ICAT (Integrating Communications, Assessment, and Tactics) program is perhaps the best-known training. ICAT is designed for situations when officers encounter persons who are unarmed or are armed with weapons other than firearms, and who may be experiencing a mental health or other crisis. When asked if their agency had provided ICAT or other basic crisis response training to patrol officers such as Mental Health First Aid, the vast majority of agencies (91%) responded affirmatively. Six in ten agencies said that training had been provided to all patrol officers, while 31% said training had been provided only to some officers. Just 9% of those responding

Figure 1: Prevalence of Crisis Response Teams (n=367)

stated that no training had been provided. Of the 338 respondents who stated their agency did provide training, most often (35%) these agencies had provided officers with 40 hours of training. Other respondents reported hours of training ranging from 1 to as many as 700 hours.

Our survey results show that the CIT model is also prevalent among small agencies (see Figure 1). Nearly half of responding agencies (49%) reported access to a regional CIT while 31% reported having an in-house CIT. One in five respondents said their agency lacked a CIT program.

Municipal police and sheriffs were equally likely to have access to a CIT through a regional partnership (49% vs. 48%, respectively). However, municipal police were more likely than sheriffs to have an in-house CIT (24% vs. 21%), and less likely to have no access to a CIT (17% vs. 32%, respectively).[15] Similarly, roughly half of agencies with 19 or fewer sworn officers and agencies with 20-71 officers stated that they had access to a regional CIT. Nonetheless, agencies with 20-75 officers were somewhat more likely than the smallest agencies to have an in-house CIT (35% vs. 27%), while the smallest agencies were more likely not to have any access to a CIT (24% vs. 16%).[16]

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[15] p=.02
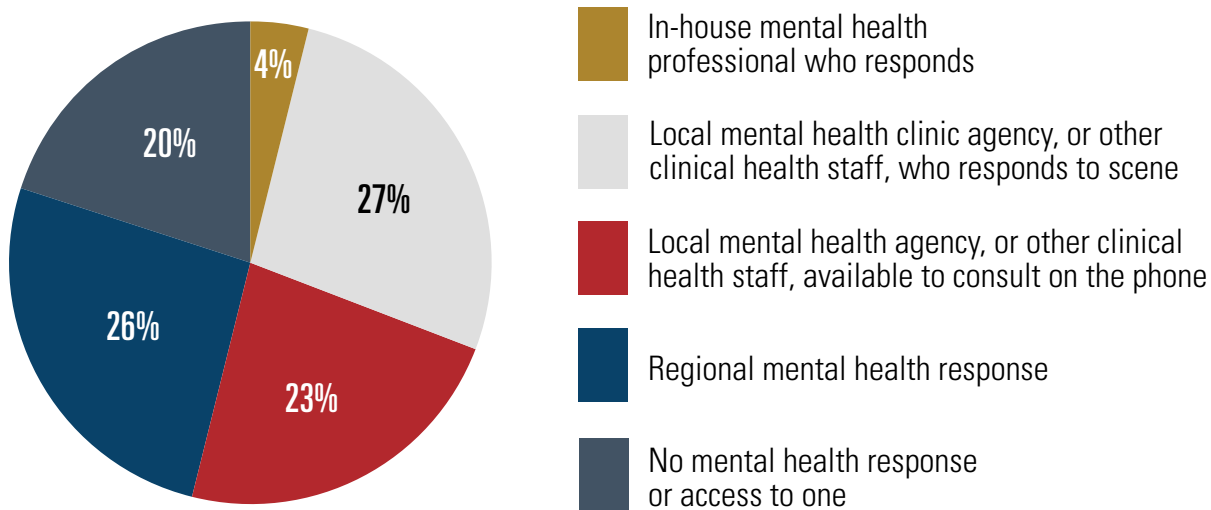[16] p=.10

Respondents were asked if their agency had an agreement with mental health providers or county staff to assist in responding to incidents involving persons in crisis (see Figure 2). A few agencies (4%) actually had in-house mental health professionals available to respond. More commonly, agencies had an agreement with a local mental health agency to provide staff who respond to the scene (27%), had access to regional mental health staff (26%), or had a local mental health agency that is available to consult over the phone (23%). Roughly one in five respondents did not have access to mental health experts to assist on calls.

(58%) indicated that they did have an agreement in place.

We asked whether agencies had developed special dispatch procedures for calls involving persons in crisis. One in three respondents (33%) were unsure of dispatch procedures because these were under control of a regional or county-wide dispatch system. The remaining two-thirds were just about evenly split between agencies that had developed specialized procedures (34%) and agencies that had not (32%). Procedures frequently mentioned included specialized crisis response training provided to dispatchers, protocols mandating that dispatchers contact mental

Figure 2: Agencies on their Partnerships with Mental Health Professional (n=369)

- 4% — In-house mental health professional who responds
- 27% — Local mental health clinic agency, or other clinical health staff, who responds to scene
- 23% — Local mental health agency, or other clinical health staff, available to consult on the phone
- 26% — Regional mental health response
- 20% — No mental health response or access to one

Respondents were asked if their agency had an agreement with a local hospital or mental health facility for a special process for officers to drop off people in crisis. Most respondents

health providers or other trained professionals to support law enforcement's response to the call, and use of ProQA software (ProQA aids dispatchers in quickly identifying an

appropriate code for each call, displays the response configuration specifically assigned to the code by the local agency, and guides dispatchers in providing arrival instructions to responding officers.) Some other examples of dispatch procedures include:

> *Our Communications Section Standard Operating Procedures require that all of our communication technicians (dispatchers) receive over 20 hours of CIT training, which is then utilized in the call-taking and dispatching functions regarding persons in crisis. This training ensures technicians react appropriately to situations involving mental illness or developmental disability.*

> *CAD systems are equipped with all points of contact for our mental health care provider to include other resources within the state. HIPPA precludes flagging individuals names within CAD; however, our tele-communicators have been trained to be perceptive when speaking with individuals who may be in crisis and are trained at the Academy Level on proper call response (telephone) while speaking with a consumer.*

Some agencies (n=46) reported using innovative technology in responding to crisis calls, including tracking software, customization of their CAD system, or emergency medical dispatch. One respondent indicated that they flag "frequent flyers" in their CAD system:

> *If you have a trained person assigned to review dispatch logs and police incidents they will find people with mental illness*

"*Our embedded Behavioral Health unit monitors radio traffic and will often contact responding officers direct or call them on the radio or phone if they are aware of a history or triggers.*„

> *related challenges. Police departments are full of very valuable information that can be used for guardianship.*

> *We also have survival kits for anyone who wants one. The kits have Naloxone and Fentanyl Test Strips in them. The kits also have recovery support information in them which includes telehealth prescriber information.*

Another respondent noted that their agency has staff dedicated to monitoring radio traffic:

> *Our embedded Behavioral Health unit monitors radio traffic and will often contact responding officers direct or call them on the radio or phone if they are aware of a history or triggers.*

Finally, we asked respondents if their agency had any additional programs or strategies in place for responding to crisis calls. One in four said that they did. One respondent said his agency was starting an "Angel" program. (In an Angel program, individuals are guided through a professional substance use

disorder assessment and intake process to ensure proper treatment placement.) Another talked about a "partnership with local peer advocates to assist with those in crisis related to addiction. The advocates can respond or be available if needed." A third said that the agency had instituted "follow-up procedures to address the needs of the individual and the family after the initial call." And a fourth told us that his county had implemented CIMS (Critical Incident Management System), a software product to support police programs documenting all overdose incidents within county jurisdictions and facilitating the transition of those experiencing drug overdoses to treatment.

Still, most of the responses we received did not highlight additional strategies, but rather elaborated on training, mental health partnerships, and the need for new funding sources to maintain ongoing partnerships with mental health agencies. One response highlighted a significant difference between small agencies and large ones in dealing with individuals repeatedly involved in calls for service:

> Living in a rural Kansas we have the ability to get to know most of our citizens on a personal level. With that in mind our dispatchers are also well informed with individuals in crisis and we also provide shift pass down reports. We continue looking for newer methods of technology to aid us in responding to those in need. We are actively working with Motorola Technologies and Spillman Technologies to assist us.

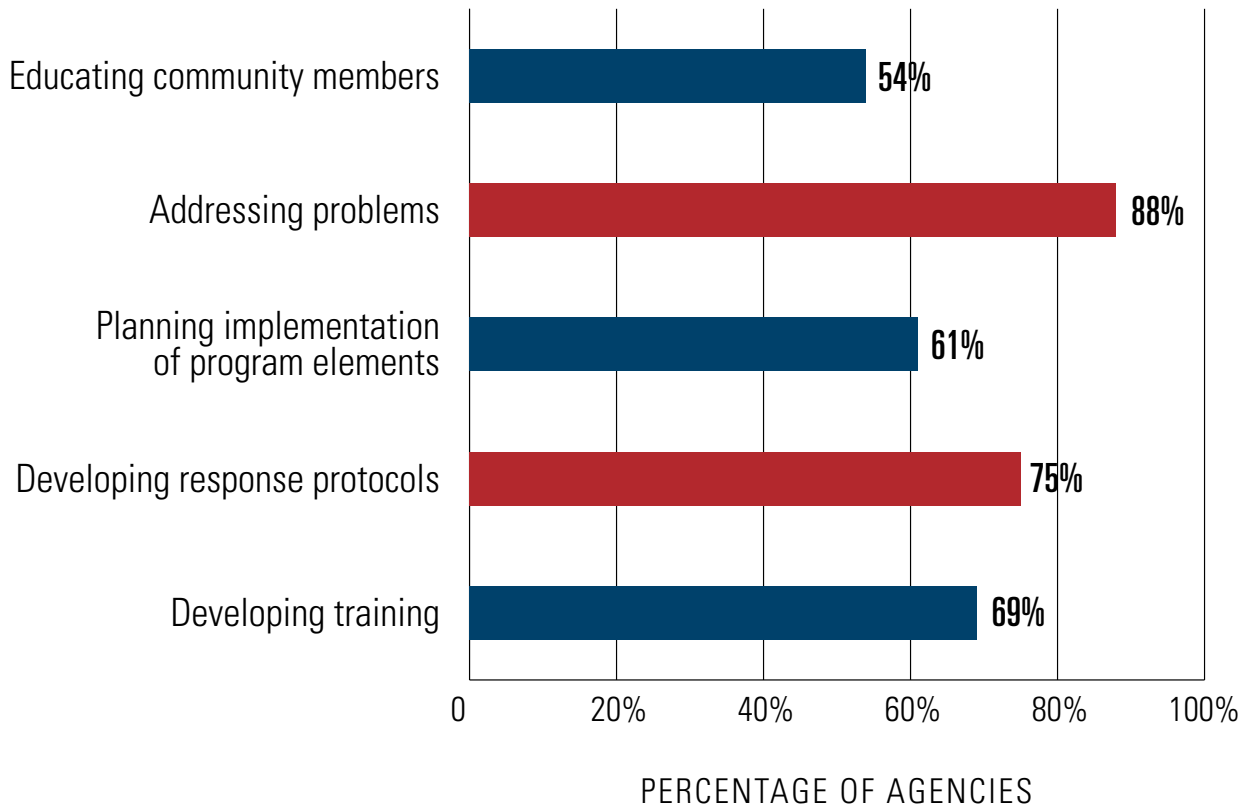## How Was the Local Crisis Response Model Formulated?

Respondents were asked whether other local organizations participated in the process of choosing a crisis response model and planning its implementation. (Respondents were able to select multiple responses to a list of possibilities.) Sixty-two percent worked with a local mental health facility, 32% partnered with a regional police agency, 26% partnered with a local advocacy organization, 20% partnered with a local government organization, and 8% partnered with another type of agency, ranging from hospitals to non-profits.

Forty-six percent of respondents indicated that their agency was involved in an ongoing stakeholder collaboration group that met regularly to address issues concerning law enforcement's response to people in crisis. Nine in ten of those responding affirmatively reported that their stakeholder collaboration was part of a regional effort. Those agencies that reported participating in a stakeholder group were asked a series of follow-up questions about the specific goals of their group (see Figure 3). Responses indicate that these groups had multiple purposes. Nearly all responding agencies (101 of 115, or 88%) reported that their groups addressed problems with the jurisdiction's crisis response strategy. Other common goals that respondents named included developing crisis response protocols (86 of 115 responding agencies); developing

training (79 of 115 agencies); planning implementation of program elements (70 of 115 agencies); and educating community members (62 of 115 agencies).

services (e.g., SWAT) does not appear frequently enough to make it practical to house services within every LEA. This is the case for programs to respond to calls involving persons in crisis as well. Very small agencies may only rarely deal with mentally ill persons, so they

Figure 3: Agencies on the Goals of their Stakeholder Collaboration (n=115)

PERCENTAGE OF AGENCIES

- Educating community members — 54%
- Addressing problems — 88%
- Planning implementation of program elements — 61%
- Developing response protocols — 75%
- Developing training — 69%

What Is the Experience of Agencies That Participate in a Regional Response Model?

Small agencies often do not have the kind of funding for special programs that larger agencies enjoy since the need for specialized
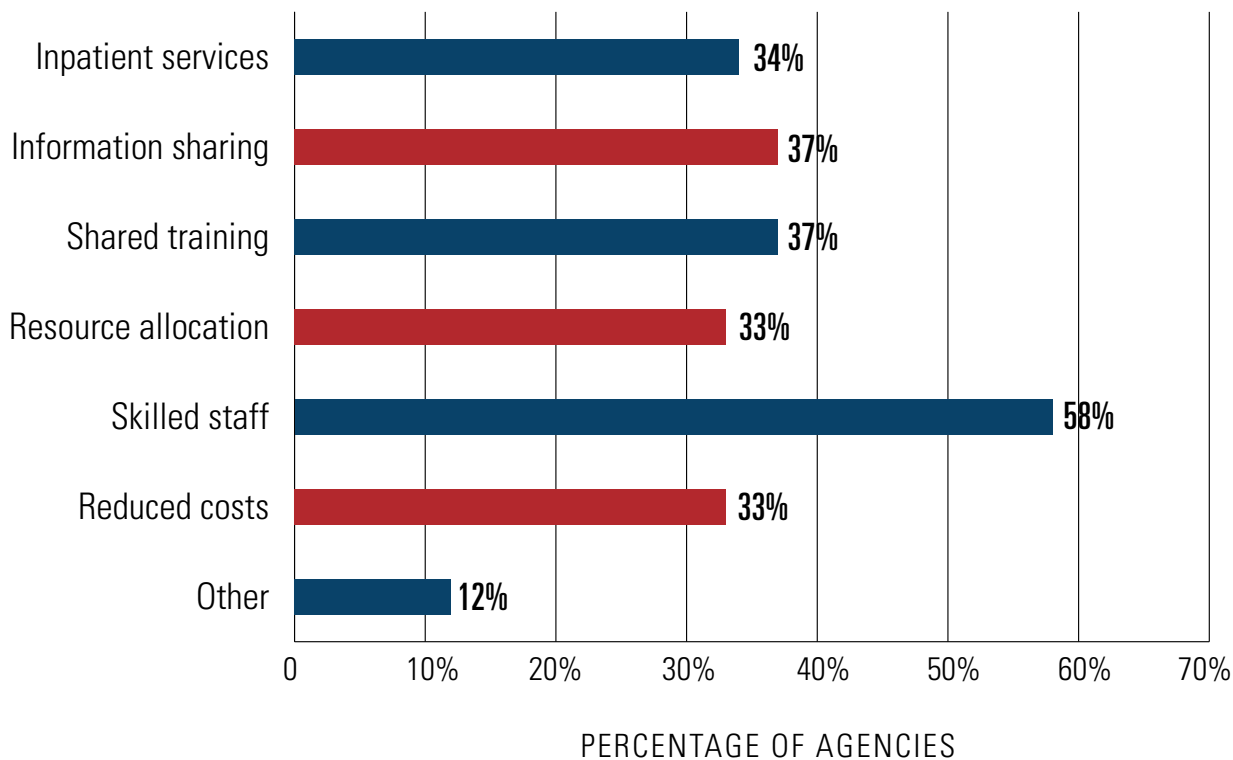
may not see as strong a need for specialized training or programs. Moreover, mental health facilities may not be local, but rather on the other side of a large county, a lengthy drive away. For small agencies then, participation in a regional program may make good sense.

If agencies indicated that they had access to

a regional CIT or access to a regional mental health response (n=147), they were eligible for a series of questions aimed at obtaining more information regarding the defining features of their crisis response program. The size of regional partnerships varied

agency of being part of a regional approach through a series of dichotomous survey items. The most common answer, endorsed by 58% of agencies in regional partnerships, was that being in a regional partnership gave them access to highly skilled staff to respond to

Figure 4: Benefits of Regional Program (n=147)

PERCENTAGE OF AGENCIES

from 1 to 100 agencies in the partnership. Not all respondents gave numeric answers (for example, a common response was that all agencies in the county participated in a regional partnership). Of those that did give numeric responses, the median number of agencies in the regional partnerships was between 5 and 6.

Respondents were asked about benefits to their

incidents involving persons in crisis (see Figure 4). Other reasons suggested by the survey in the closed-ended items were endorsed about equally often by those agencies that were part of a regional approach. These included information sharing (37%), shared training (37%), in-patient services (34%), directing limited resources to areas most in need (33%), and reduced costs (33%). We also allowed respondents to provide their own response

in text form. Some of the most interesting benefits that respondents wrote in included:

> *Better access to advanced training and the ability to train a larger number of officers*

> *A CIT Advisory Board meets monthly and includes each agency's CIT Coordinator and agency head or designee. This really helps maintain the flow of information on transient consumers…and creates networking with other agencies in the region.*

> *We have our local…multidisciplinary team comprised of a police officer, nurse, mental health professional, and peer support specialist. We provide warm hand-offs to the team by way of police information that indicates mental illness-related challenges…We share information with neighboring communities…if we come across people…that reside in other communities. We connect people to services in their communities if they intersect with our team and want the help.*

One agency had a proactive program:

> *We have developed a local response team that proactively gets involved in helping people that are identified by way of police data. These people are found and asked if they need community based wrap around services provided by our C.L.E.A.R. Team. If they agree, they are immediately connected to our team for multidisciplinary support services. Our team is connected to more regional support options and organizations*

> *to help minimize any drawbacks related to a purely reginal approach.*

We also asked respondents about drawbacks to a regional crisis response approach, specifically whether they viewed lengthy response times or lack of availability of skilled staff as a problem. A majority of respondents viewed lengthy response times (52%) and lack of availability of skilled clinical staff at times when they were needed (57%) as problems. We also allowed respondents to tell us about

"*A CIT Advisory Board meets monthly and includes each agency's CIT Coordinator and agency head or designee. This really helps maintain the flow of information on transient consumers…and creates networking with other agencies in the region.*„

other problems with a regional approach in their own words. Several respondents took the time to tell us about issues they faced. The most common of the write-in complaints about regional partnerships centered on lack of resources or insufficient skilled personnel. For example, one respondent said:

Our mental health care provider does a really good job overall; however, the region covering eight (8) counties does sometimes tax resources. Sometimes LEOs get hung up waiting on an evaluator who may be responding after hours from a long distance.

Another complaint was limited availability or coverage. One respondent said:

There is limited availability, particularly at certain hours. After 11 PM they are not available, and this is the most likely time when these services are needed. We are exploring the possibility of having more direct access to social workers and potentially hiring one to work with the police.
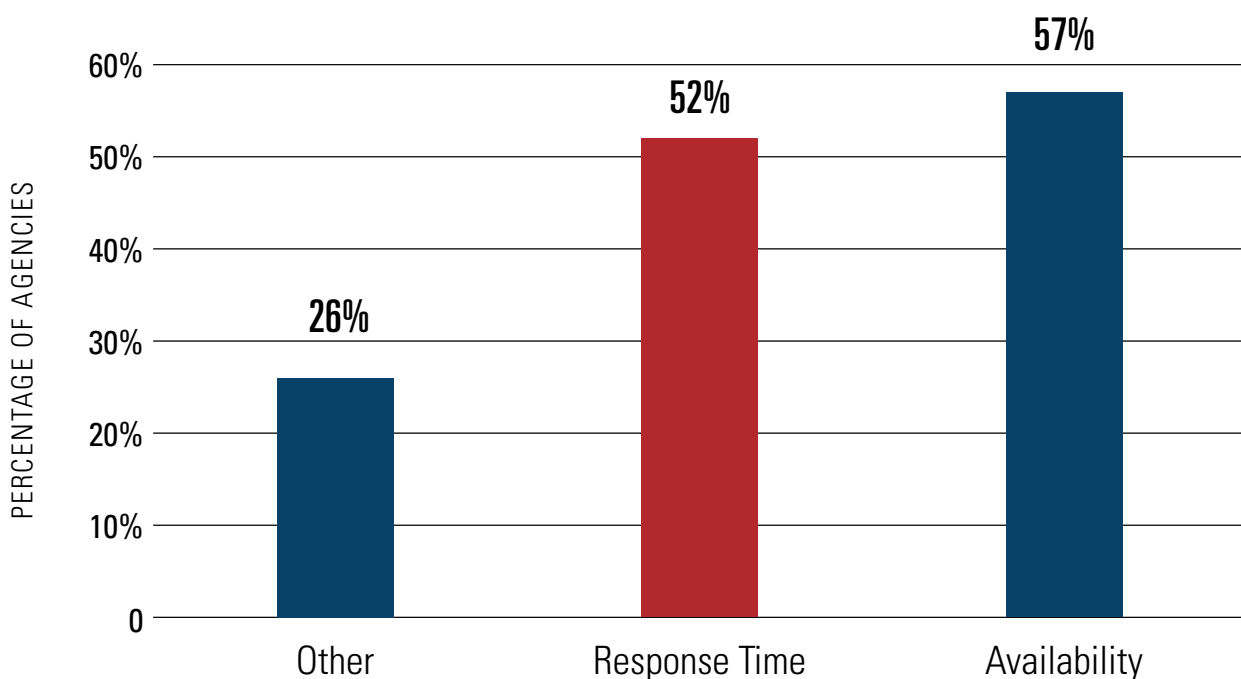
In the same vein, another said:

The regional response is not available in all areas of the County. The rural portion of the County is only partially covered.

One other problem mentioned by survey respondents was the drain on officer time involved in interfacing with mental heath staff. One respondent put it this way:

We usually have to remain on scene or transport the individual to a mental health facility. This is a problem because at times we might only have one or two officers on-duty.

Figure 5: Drawbacks of Regional Approach (n=144)

What Are Small Agencies Spending on Crisis Response Programs?

Respondents were asked to estimate the amount of money their agency budgeted for training and programs related to crisis response, including engaging a CIT or crisis facilitator and reimbursement to mental health providers. Most respondents (70%) reported a budgeted amount of $0 or simply left the question blank. Nevertheless, 41 respondents reported using funds toward a CIT training facilitator, 63 reported using funds for a general crisis response training facilitator, 8 allocated funds for mental health provider reimbursement, and 30 allocated funds for other related programs. The "other" programs listed by respondents included additional training, officer salaries, transportation costs, and the production of materials related to crisis resources for distribution to the community. Interestingly, some respondents wrote in that their crisis response programs were fully funded by grants and so they were not concerned with budgeting funds. The amounts allocated toward these programs among those that entered non-zero amounts varied substantially from $100 to $174,000 (see Table 1).[17]
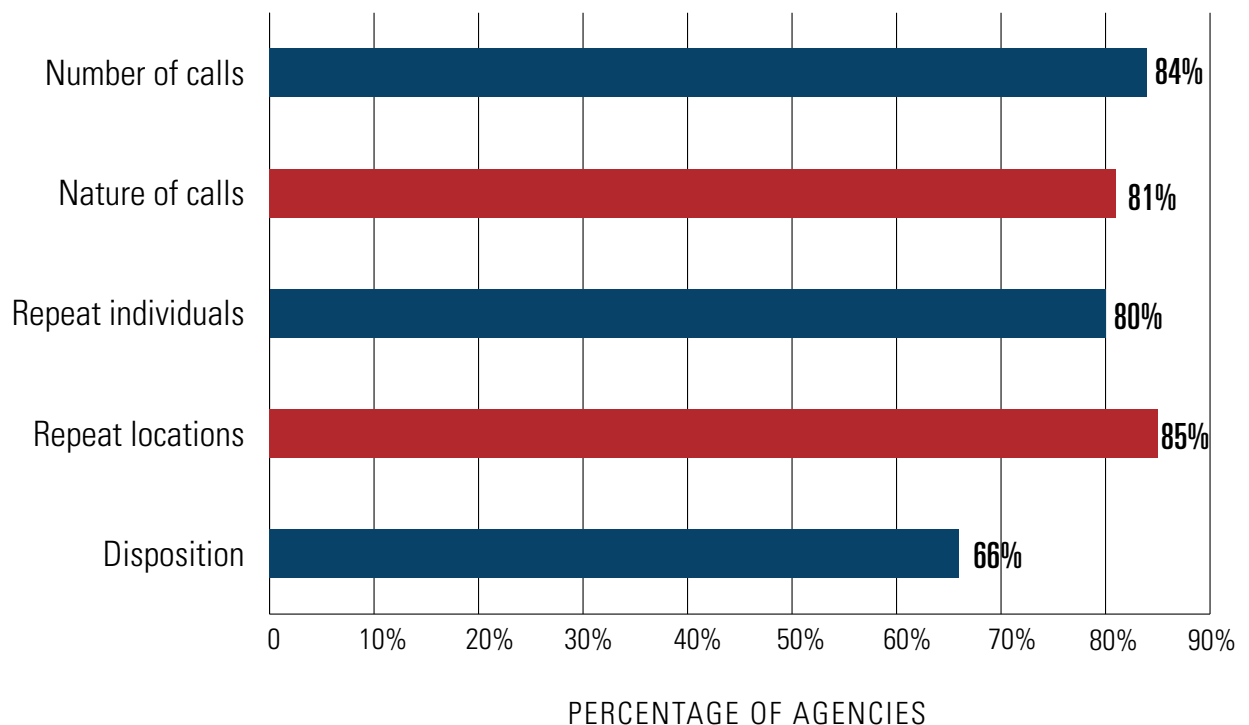
Respondents were also asked whether their agency received supplemental funds from state or federal grants to cover the cost of their crisis response program. A majority of respondents (86%) reported that their agency did not receive supplemental funds; only a small percentage (14%) reported that they did.

Table 1: Average Amount Budgeted for CIT Training and Related Programs (n=102)[18]

	CIT Facilitator (n=41)	Crisis Facilitator (n=63)	Mental Health Provider Reimbursement (n=8)	Other (n=30)
Median amount spent	$1,500	$2,000	$4,000	$4,750

[17] Some respondents reported extreme values outside this range, such as $10 for a CIT training facilitator all the way up to $2.3 million for mental health agency reimbursement We chose to exclude these values from the overall range as they appeared to be atypical outliers.

[18] These values are based on those who reported budgeted amounts in at least one of the four areas above $0.

Figure 6: Tracking Abilities of Agencies' CAD Systems (n=207)

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Do Small Agencies Have the Capability to Track Crisis Calls?

We were surprised to learn that 63% of responding agencies indicated that their CAD systems have abilities to track calls involving individuals in crisis (see Figure 6). Of the 207 agencies with CAD tracking abilities, 84% were able to track the number of calls, 81% were able to track the nature of those calls, 80% were able to track repeat calls involving the same individual, 85% were able to track repeat calls involving the same location, and 66% were able to track the final disposition of the call (through transports to hospitals, mental health facilities, or jail).

As we had expected, few agencies reported that their systems were integrated with others: 9% reported integration with court data systems, 3% with a hospital system, 2% with behavioral health systems, and 3% reported integration with both behavioral health and court data systems.

Survey respondents who reported CAD tracking ability were also asked whether their agency had ever analyzed their CAD data in order to assess the impact of their crisis response program. Just 31 (14%) of those responding answered affirmatively. Of the 31 agencies asserting that they had analyzed CAD data, 10 reported a reduction in arrests, 6 found a reduction in the number of days individuals spent detained in jail, 15 found an increase
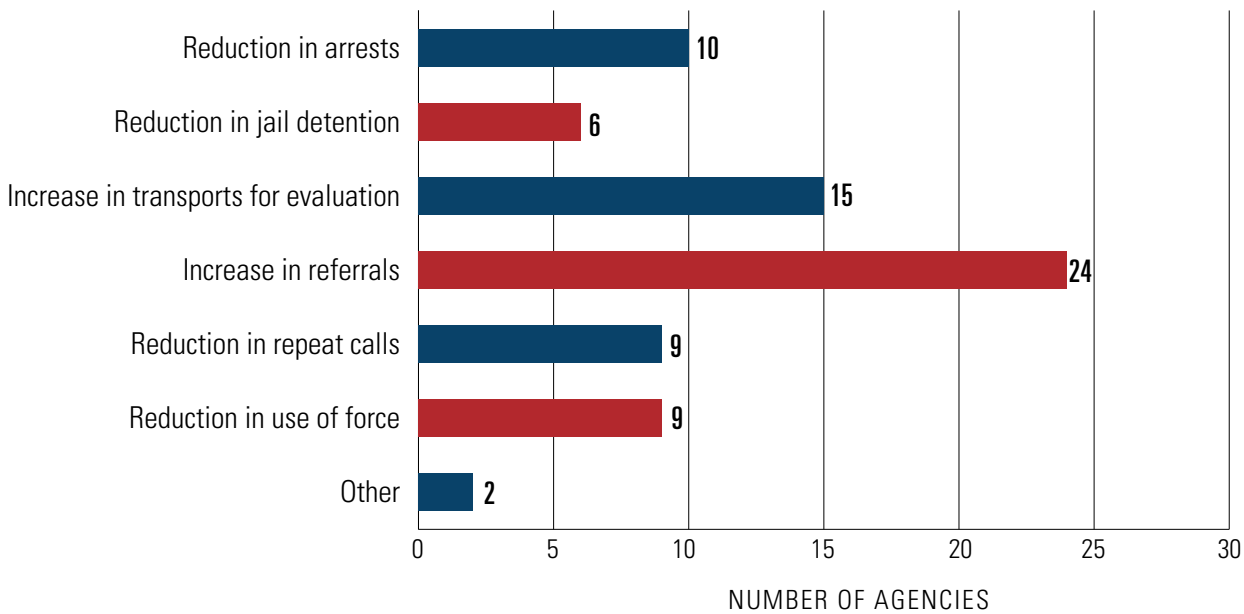
in transports to emergency departments for evaluation, 24 found an increase in referrals to community-based substance abuse or mental health treatment services, 9 saw a reduction in repeat calls, and 9 observed a reduction in related use of force incidents (see Figure 7).

Respondents were also invited to provide a free text response outlining their findings. Only two respondents provided a text response; One of the two was especially detailed:

We have been able to review data collected by our team which indicated the community is very receptive to being connected with the C.L.E.A.R. Team. 70% of people found agree to be connected with the team. We

have also calculated a projected savings of over $5000.00 for every emergency medical transportation that is not required because contact and support from the C.L.E.A.R. team was successfully implemented. Since March of this year, we have found and connected over 70 people to the CLEAR Team by phone outreach alone due to the COVID emergency making in person on site follow up and outreach not possible. We have dropped off or mailed over 20 survival kits that have Naloxone and Fentanyl Test Strips in them.

Figure 7: Agency Findings from CAD Data Analysis (n=31)

Would Agencies Recommend Their Crisis Response Program to Others?

When asked if they would recommend their program to another jurisdiction, a bit less than two-thirds (61%) said they would. Some of the respondents were clearly proud of the crisis response initiative that they had put together. One respondent said, "On the occasions that we used the Crisis Team, it worked perfectly. The team responded by phone and addressed and took care of the subject immediately." Another averred, "Success of the project has clearly increased the efficiency and effectiveness of officer response to those with special needs and improved access to services." Still another asserted that it is possible to put together a successful program without a lot of resources:

"We have had many success stories (qualitative research) showcasing the effectiveness of our Crisis Intervention Team. While our program isn't large, or even the best, we have learned to use it successfully in our small community with little resources."

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But other respondents blamed lack of funds for their inability to develop a strong program for responding to incidents involving persons in crisis. One respondent bluntly stated:

We do not have the budget to have an in-house program and we do not have the manpower. When your police budget is cut every year and your manpower is cut every year, you are handcuffed by what you can do and how much time you can spend on the call.

Another respondent similarly complained that:

We don't have the money or the means to deal with these cases. We pick people up that are suicidal and send them to the hospital. Then we take them to a rehabilitation center an hour away. If they aren't suicidal we talk to them and leave.

That respondent hit on another common theme among those who did not think they had a program they could recommend – the lack of accessible mental health services. A respondent lamented:

Our state had virtually no mental health resources. We have no one to collaborate with beyond the medical (i.e., hospital) on,

so our programs do not address the issues. They're merely bandaids.

A common complaint of agencies in a regional partnership was that regional law enforcement CIT officers or mental health personnel were often slow in responding to calls for assistance with persons in crisis. One respondent said about his program, "It's the best we have but it is not sufficient due to response times of up to 2 hours." Another comment in the same vein was:

Instead of mental health personnel responding, officers are responding to the calls. When people in crisis are taken to the local hospital or jail, the response time for them being assessed by a mental health worker can be up to a day or longer.

Some respondents said that a significant issue for them was that mental health staff often left them in the dark regarding dispositions of individuals handed off to them. Some examples are:

Our local approach is merely a temporary band-aid to the crisis. We refer individuals for help and then we are left in the dark as to what their outcome is.

The flow of information is slow or nonexistent between police and healthcare systems. Resources are very low and not available at all hours.

There were other reservations about the quality of crisis response programs as well,

including:

- Agency does not have a CAD system that tracks histories of persons in crisis

- Local responding officer or agency has no say in what happens to an individual once the case is handed off to regional law enforcement or mental health personnel

Finally, a couple of respondents were very direct, and just said that their need for a crisis response program was a low priority for their agency: "Our crisis program is not robust [but] our need is not frequent enough." Others stressed that their program was a work in progress and still developing:

We are in our infancy in this and using what we have. We are in the beginning of a pilot project to have an embedded social worker to help with these types of calls.
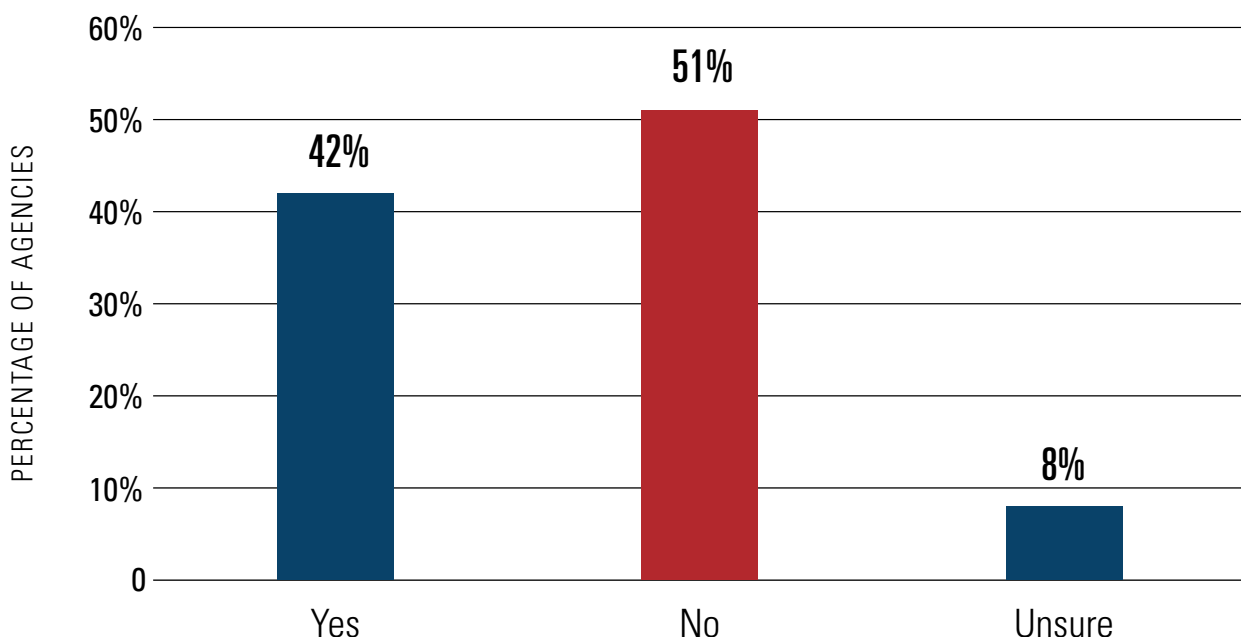
Have Current Developments in Policing Led Agencies to Reassess Their Response to Calls Involving Persons in Crisis?

The death of George Floyd occurred after we had stopped the survey due to the pandemic. The circumstances of his death were very relevant to the topic of how police respond to persons in crisis. Therefore, we thought it would be useful to add a question to the survey once it started up again asking whether the

death of Floyd and other police-involved deaths of African Americans had led them to reassess how their agency responded to situations involving persons with mental illness or impairment due to substance abuse.

incidents were asked what kind of changes they thought the reassessment might lead to (multiple responses were allowed). More than 9 in 10 of those responding indicated they thought it likely that there would be

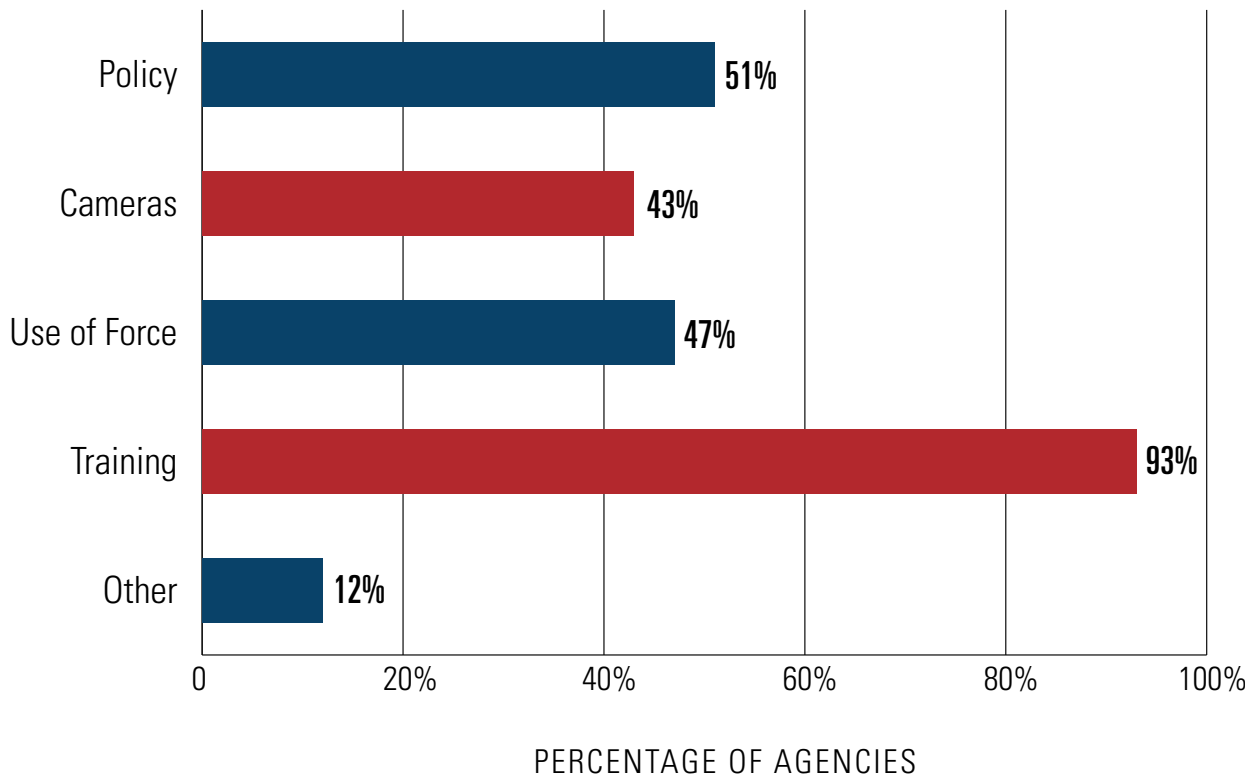**Figure 8: Agencies Anticipating Change in Crisis Response in Wake of George Floyd Death (n=280)**

As can be seen in Figure 8, nearly half of agencies responded affirmatively. The remainder said either that they had not reassessed their agency's response 51% or were unsure (7%). Our data indicate that the Floyd death and following anti-police demonstrations are having a significant effect on departments—even those that are not in large cities and have not experienced the same type of unrest.

Respondents who said that their agencies were reassessing their response to crisis

additional training of officers (see Figure 9). Half of those responding thought that the reassessment might lead to a change in policy about responding to persons in crisis, 46% thought it might lead to a change in use of force policy, or and 43% to deployment of body or dash cameras.

Respondents were offered the option to suggest other changes that might result from the reassessment. A number of these responses centered on better mental health assistance available for responding to persons

Figure 9: Anticipated Areas of Change (n=115)

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in crisis. For example:

> *Having more mental health workers available and trained to go to the original call. Take LE out of the equation.*

> *Hiring of a mental health manager to help us develop our own program. Train all officers in Mental health first aid. Train some officers in more extensive courses.*

Several respondents' answers highlighted two of the biggest challenges to small agencies in developing effective ways to respond to persons in crisis—cost and lack of close-by mental health services:

> *Like most agencies we don't have enough funding for deployment of body/dash cams for everyone. I would like to see more grants offered. We also need more Professional Mental Health responders in Western Kansas. Extremely hard to pay someone to move out west and more importantly find someone who is willing to live in western Kansas with a degree and move away from larger cities.*

DISCUSSION

We found that small law enforcement agencies are taking seriously the issue of how best to respond to calls involving persons in crisis. Of 380 responding agencies, just 12 did not meet any of our six criteria for having a crisis response program. Nine in ten survey respondents said that they had provided basic crisis response training to at least some of their patrol officers and 35% indicated they had provided 40 hours of training The 40-hour training is the gold standard for CIT programs and thus likely represents the actual number of CIT programs among our sample. Additionally, another 49% said that they had access to a regional CIT program, which considerably expands the availability of a specially-trained officer for crisis calls in the surveyed rural communities.

Eight in ten responding agencies also had assistance with persons in crisis from mental health providers: 31% have an in-house (4%) or local professional (27%) who co-responds. Another 23% can access a provider by telephone. This represents a significant amount (54%) of inclusion of professional expertise in these calls. The ability to have a clinician available by phone may be of particular importance to agencies covering large rural areas. Six in ten agencies had agreements with local hospitals for a special process to drop off persons in crisis.

About half of the agencies that used local call dispatch said that they had given dispatchers special training in identifying calls involving persons in crisis and/or that dispatchers had at their fingertips points of contact for mental health providers. These practices represent another important step in implementing an effective approach, and appear possible for small agencies to accomplish. Some went so far as to have staff go over dispatch logs to identify "frequent flyers" so that dispatchers could be aware when calls involving those persons came in.

In addition to these, respondents volunteered other responses that they had engineered. One had sponsored an "Angel" program, which guided individuals through a professional substance use disorder assessment and intake process to ensure proper treatment placement. Another had developed a partnership with local peer advocates to assist with persons experiencing addiction issues. And another agency had created a protocol to follow up with the families of persons in crisis.

As expected, regional partnerships were a common option for agencies – slightly over half of our respondents had banded together with other agencies in their county or region to combine resources. Of the agencies involved in stakeholder partnerships, almost all (91%) were part of regional or county-wide efforts. In rural areas, regional partnerships make a lot of sense since each individual agency may only infrequently receive crisis calls and mental health facilities may be few and far between. Advantages touted about being part of a regional team included having access to

highly skilled staff, shared training, sharing of information across agency boundaries, and reduced costs. However, regional partnerships also had drawbacks, especially lengthy response times and unavailability of clinical staff at critical times.

The most common goal of these collaborative groups was to address problems (85%), followed by developing response protocols (72%). Effective collaboration with stakeholders is a key way to resolve problems. Both of these goals demonstrate a dedication to making the collaboration have practical, operational impacts.

Given that 70% of respondents recorded zero dollars spent or left the questions blank, we believe that cost questions were too complicated or burdensome for agencies to answer thoroughly on a survey. The budget numbers we did get varied widely and were most frequently spent on training, which seems consistent with other literature on program costs. More specific questions about funding and sources will be explored during the second phase of this research.

More than six in ten agencies reported having the ability to track calls involving persons in crisis, which was surprising given that CAD data are notoriously inaccurate. It is possible these systems have a code for "mental health crisis" or similar, but it isn't known how accurate it is. Most of these agencies said they were able to track individuals or repeat locations across calls. Two-thirds were able to track calls through call dispositions at hospitals, mental health facilities, or jails, which is interesting

because this data collection can be daunting. Perhaps the regional partnerships enable this kind of data tracking.

The ability to track information and analyze it are two distinct practices. Although not all respondents received the question about whether and why they analyzed CAD data, the vast majority of those that answered the question (86%) said they had never done analysis. This is not surprising given difficulties with data accuracy and the need for analysis expertise, which may be common challenges in smaller agencies. Those small number of agencies (n=46) that reported using innovative technology in responding to crisis calls, cited using tracking software, customizing their CAD system, using emergency medical dispatch, and adding staff to review calls data and monitor radio traffic. These are primarily efforts to better use the data the agency has access to and represent best practices in use in these rural agencies.

Two in three survey respondents said they would recommend their program to others. However, the remainder said that their programs were less than ideal because of budget issues, lack of nearby mental health services, and slow regional partnership response times. More than four in ten agencies said that they were reassessing their ways of dealing with persons in crisis in light of the death of George Floyd and subsequent public outcries. These agencies were considering seeking additional training for officers, changes to use of force and other policies, and purchase of body cameras.

CONCLUSION

Our results indicate that the vast majority of small agencies have taken some measures to develop more effective ways to handle calls involving persons in crisis. Furthermore, the death of George Floyd seems to have spurred thinking about additional steps that could be taken. Over 90 percent of agencies responding to the survey had provided some form of crisis response training to all or some of their patrol officers. Eight in ten agencies had access to a skilled CIT response, either in-house or, more commonly, as part of a regional partnership. While the regional partnerships gave small agencies an inexpensive way to have access to skilled crisis response staff, there were drawbacks including sometimes slow response times, unavailability of skilled staff at odd hours, and distant mental health facilities.

In addition to highlighting the kinds of practices rural communities are able to implement, we also see value in the survey as highlighting some of the challenges that small agencies face in implementing these programs—insufficient funds, sparse mental health service providers, and lengthy response times from regional mental health staff or CIT-certified officers. These challenges are very real, but the fact that many agencies reported rethinking their capabilities in the wake of the recent national discussion about policing gives hope that progress will continue to be made, even if programs developed are not perfect.

The results should be viewed while keeping in mind that most agencies did not accept our invitation to take the survey: We achieved a 29% response rate for the first sample and 10% response rate for the second sample where we only issued two invitations by email and no mail follow-up. The rate of survey completions is not surprising: Small agencies are typically not nearly as responsive to surveys as larger ones and, moreover, the data collection occurred during a pandemic and anti-police agitation. Indeed, had we not taken the exceptional step of sending out mailed surveys, the response rate would have been considerably lower. Because most agencies did not respond, we cannot know for sure whether we have captured the true proportion of small agencies that have developed some form of response to calls involving persons in crisis. Those agencies that did respond are more likely to have had some form of crisis response program, and thus be more interested in the topic and willing to take the survey.