

Small & Rural Agency Crisis Response

A National Survey and Case Studies



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EXECUTIVE SUMMARY

Police work involves dealing with myriad types of people and situations and deciding which skills and tools to use in which situation. Responding to a robbery in progress, for example, requires different skills and tools than responding to a person who has overdosed or who is rambling incoherently and wandering down the middle of Main Street.

People often call the police when a person is having a behavioral crisis even though a medical person or a social worker might be better suited to respond. However, in most situations, law enforcement is the only available first response option. That is why police officers need the skills to identify and respond to emotional behavior and know the right people to call for assistance in these situations.

Responding to a person who is experiencing a mental or behavioral crisis is challenging to all law enforcement agencies, but especially to small and rural law enforcement agencies where geographic distances are great, populations sparse, and resources limited.

Larger, more urban communities usually have speedier access to health facilities and a wider variety of resources. But smaller agencies are far more common in the United States, and there is a dearth of quantitative research about them. More than 70% of local police departments serve populations of fewer than 10,000 people. Most agencies have fewer than a dozen officers.¹

The National Police Foundation embarked on a study to understand how small and rural agencies respond to calls involving people who are in crisis. The work was supported by Arnold Ventures, a philanthropy dedicated to tackling some of the pressing problems in the United States. We began by developing and piloting a survey and selecting a random sample from the more than 7,500 small and rural agencies in the United States. We eventually received completed surveys from 380 agencies representing 44 states. Ohio had the most respondents with 33 and, in general, midwestern states were heavily represented in the sample (Pennsylvania had 20 respondents, Illinois and Michigan 18 each, Missouri had 16, and Wisconsin

¹ Hyland, Shelley S., Elizabeth Davis. "Local Police Departments, 2016: Personnel," *Bulletin*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics. (Oct. 2019, revised Jan. 2021). NCJ 252835. Available at: <https://bjs.ojp.gov/content/pub/pdf/lpd16p.pdf>

12). Other states that contributed heavily to survey completions included Texas with 21, Massachusetts with 18, and North Carolina with 16. (See “Methods” for details of the sampling process.)

After analyzing the responses, we selected eight agencies to participate in interviews that became case studies on the ways small and rural agencies respond to people in crisis, what their typical challenges are, and how they address those challenges. Six of the eight agencies were selected because they demonstrated the most effective approaches; the additional two were selected because they exemplified the difficulties small and rural jurisdictions typically face, and because they showed a strong interest in improving.

The sampling process and the drafting and piloting of the survey was done in late 2019 and early 2020. After the murder of George Floyd in May 2020, and the subsequent public demonstrations about police use of force and handling of mentally ill persons or those with substance abuse issues, we added questions designed to understand how public attention to police behavior was affecting small and rural agencies and how they might (or might not) reassess their policies and practices.

FINDINGS FROM THE NATIONAL SURVEY

The responses from the 380 randomly selected agencies clearly showed that these agencies take seriously their responsibility to respond to persons who are in mental or behavioral crisis. Nine in 10 respondents said they provided training in crisis response to at least some of their patrol officers. Six in 10 said they provided training to all patrol officers, 31% said they provided training to some officers, and 9% said no training had been provided. Of the 338 respondents who said their agency provided training, 35%

“Nine in 10 respondents said they provided training in crisis response to at least some of their patrol officers. Six in 10 said they provided training to all patrol officers, 31% said they provided training to some officers, and 9% said no training had been provided.”

said they provided officers with 40 hours of training. Half the respondents said they had access to crisis intervention training (CIT), which is a program designed to bring together a community's public services to keep people with mental illness or addictions out of jail and in treatment. CIT for officers, dispatch workers, social workers, and other emergency services providers helps the police stay focused on crime, reduces the amount of time the police spend responding to calls related to mental health and substance abuse, and gets the right kind of help for people who are mentally ill or struggling with substance abuse.

The murder of George Floyd and subsequent nationwide demonstrations calling for reform appeared to have affected the agencies that responded to the survey. 51% said they were reassessing the ways their agency handled situations involving people who are impaired due to substance abuse or mental illness. Of those who expected their agency to make changes, the most commonly expected change was increased training (93%) followed by changes to the use of force policy (46%) and increased use of cameras (43%).

Characteristics of Crisis Response

Respondents took different approaches to developing effective responses to crisis calls. They might give basic training to patrol officers, create an in-house CIT and develop a

cadre of officers with more intensive training in de-escalation methods, form partnerships with local mental health organizations, or participate in regional stakeholder collaborations. Nearly half of the respondents (49%) had access to a regional CIT while 31% reported having an in-house CIT. Almost 20% of the agencies lacked access to CIT.

Comprehensive approaches used a range of stakeholders and generally had a mix of in-house training for officers and collaboration with other stakeholders, such as hospitals, emergency medical services, regional dispatch systems, or other mental health and substance abuse service organizations.

When agencies used outside specialists, the specialists either accompanied officers in a patrol vehicle, met officers at the scene, or followed up with the person in crisis after the police had left the scene.

A small percentage of agencies said they were in such small jurisdictions that they have limited need for mental health specialists (in the same way they have limited need for other specialists, such as SWAT teams).

Biggest Challenges

The biggest concerns expressed in the survey were (1) the insufficient numbers of and access to skilled persons and facilities and (2) the lengthy time it can take to get a response from mental health services or facilities. The two primary reasons for these challenges are

limited funds and sparse population spread across large geographic areas. It is common in rural America, for example, to drive two or three hours to reach a hospital or medical facility.

Budgets for Crisis Response

Most respondents (70%) were unable to provide budget data related to their crisis response expenditures. Instead, budgets might include line items for payment to a CIT facilitator, reimbursements for mental health providers, costs for transporting persons to a hospital, or costs for producing materials to educate the public about crisis resources.

Of those who knew the amounts allotted for crisis response programs, the amounts varied widely: from \$100 to \$174,000. Most respondents (86%) did not receive any supplemental funds, such as grants, for mental and behavioral crisis response.

Use of Computer-Aided Dispatch (CAD)

Technology is common in small and rural agencies: 66% of responding agencies used CAD systems that could track calls involving individuals in crisis. Of the 207 agencies with CAD tracking abilities, more than 80% were able to track the number of calls, the nature of the calls, or identify repeat calls involving the same individual or the same location. In addition, 66% could track the final disposition

of the call through transports to hospitals, mental health facilities, or jail.

“66% of responding agencies used CAD systems that could track calls involving individuals in crisis. Of the 207 agencies with CAD tracking abilities, more than 80% were able to track the number of calls, the nature of the calls, or identify repeat calls involving the same individual or the same location.”

FINDINGS FROM THE CASE STUDIES

The in-depth look at eight agencies in the case studies section of this report illustrates the techniques successful agencies use to overcome—or at least deal with—their challenges. The challenges of limited resources, great physical distances, and sparse numbers of service providers are typical for small and rural jurisdictions.

The key factors we identified that contribute to successfully responding to people in mental and behavioral crisis are:

Creativity in Finding Funds

Keeping an open mind about where to get additional funds is essential to success and takes initiative, hard work, and persistence. The case studies show that successful agencies tend to leverage collaborations and partnerships with others in their region. They usually share resources with their neighboring service providers. They may get training funds from professional organizations, such as the state's Police Officer Standards and Training (POST) board or share the resources obtained through state and federal grant programs.

Communication Among Stakeholders

Sharing resources and training opportunities is only one of the many advantages of collaborations. Community leaders with shared interests can often devise novel approaches and introduce new thinking when they put their minds together to solve mutual problems. Collaborative groups typically include representatives from law enforcement, community mental health organizations, municipal administrators, and hospitals.

Strong Leadership

Every site in the case studies had at least one person who was a driving force for improving the way the jurisdiction handled responses to people in crisis. Having an advocate who is also in an executive position, such as the police chief or a municipal leader, can make all the difference in convincing others to take the difficult path toward applying for a federal grant or convincing someone who has not traditionally been a partner that there are benefits to joining a collaborative effort.

THE NATIONAL SURVEY

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 (such as mental illness or substance use disorders) are common, consume disproportionate public safety and community health resources, and are potentially dangerous. One quarter of the people killed by police each year are thought to have been experiencing a behavioral health crisis.²

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 to file charges 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.³ Furthermore, similar studies have found that detaining those in crisis in jail settings can often exacerbate their condition, making them more likely to reoffend.⁴

“One quarter of the people killed by police each year are thought to have been experiencing a behavioral health crisis.”

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- 2 Fuller, Doris A., H. Richard Lamb, Michael Biasotti, John Snook. “Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters.” Treatment Advocacy Center. (December 2015). Available at <https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted>
 - 3 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*, (2007) 51(2), 130-150.
 - 4 Moore, M., V. Hiday. “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*. (2006). 30(6), 659-674.

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.

CIT, first developed by the Memphis Police Department, are an innovative first-responder model that combines crisis intervention training and efficient access to behavioral

to the National Alliance on Mental Illness, it is now present in over 2,700 agencies nationwide.⁵

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 together in a responding vehicle, and sometimes the clinician arrives separately at the request of responding officers.⁶ These models are designed to help connect people in crisis to appropriate behavioral health resources, provide follow-up case management, and reduce 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

“Studies have found that detaining those in crisis in jail settings can often exacerbate their condition, making them more likely to reoffend.”

health treatment for persons with mental disorders or addictions or both 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

⁵ National Alliance on Mental Illness. Accessed Sept. 10, 2021. [https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-\(CIT\)-Programs](https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs)

⁶ Shapiro G.K., A. Cusi, M. Kirst, P. O’Campo, A. Nakhost, V. Stergiopoulos V. “Co-Responding Police-Mental Health Programs: A Review.” *Administration and Policy in Mental Health and Mental Health Services*. (Sept 2015). 42(5):606-20. doi: 10.1007/s10488-014-0594-9. PMID: 25239523.

critical elements are the best positioned to be effective.⁷ 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.⁸ Co-responding team members receive cross-training on the expertise of each partner.⁹ Extensive collaboration with a range of stakeholders is a gold standard for comprehensive 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, call-taker protocols that provide guidance to dispatchers on what information they should collect and relay

to responders, and specialized drop-off procedures at receiving facilities.¹⁰

These efforts have proliferated and show promise for positive changes in the way that police respond to calls involving persons in crisis.¹¹ However, they have largely been implemented in medium and large departments.¹² Yet, the vast majority of LEAs are small—more than 9 in 10 have fewer than 75 sworn staff. There 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 with limited budgets are often slower to adopt reforms.¹³

With resources and problems that are not on the same scale as larger agencies, small agencies often get left out of consideration

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- 7 Shapiro, et al, op.cit., see note 6 and Krider, A., R. Huerter, K. Gaherty, A. Moore. "Responding to Individuals in Behavioral Health Crisis Via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers." Policy Research Associates. (Jan. 2020). Available at <https://www.prainc.com/resources/coresponder-models/>
 - 8 Watson, A.C., A.J. Fulambarker. "The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners." *Best Practices Mental Health*. (Dec. 2012); 8(2): 71. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769782/>
 - 9 Shapiro, et al., op.cit. see note 6.
 - 10 Schwartzfeld, M., M. Reuland, M. Plotkin. "Improving Responses to People with Mental Illnesses: The Essential Elements of a Specialized Law Enforcement–Based Program." Council of State Governments. (2008) Available at: <https://csgjusticecenter.org/publications/improving-responses-to-people-with-mental-illnesses-the-essential-elements-of-a-specialized-law-enforcement-based-program/>
 - 11 Seo, C., B. Kim, N.E. Kruis. "Variation Across Police Response Models for Handling Encounters with People with Mental Illnesses: A Systematic Review and Meta-analysis." (2021) *Journal of Criminal Justice*, 72, <https://doi.org/10.1016/j.jcrimjus.2020.101752>. Also Strassle, C.G. "CIT in Small Municipalities: Officer-level Outcomes." *Behavioral Sciences and the Law*. (2018) 37:342–352. <https://doi.org/10.1002/bsl.2395>
 - 12 Compton M.T., B. Broussard, D. Hankerson-Dyson, S. Krishan, T. Steward, J.R. Oliva, A.C. Watson. "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.
 - 13 Bratina, M.P., J.A. Carsello, K.M. Carerro, M.E. Antonio. "An Examination of Crisis Intervention Teams in Rural Jurisdictions." *Community Mental Health Journal*, (2021) 7, 1388–1398. <https://doi.org/10.1007/s10597-021-00797-7>.

“Extensive collaboration with a range of stakeholders is a gold standard for comprehensive programs, as it allows for effective engagement of relevant resources and perspectives in model development and implementation.”

when it comes to new technology and approaches to policing. Yet, studies of 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.¹⁴ 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.¹⁵

There are significant challenges to small and rural agencies wanting to address the law enforcement response to people with behavioral health needs. Many states offer CIT or less rigorous courses in crisis response, but training may be held in distant cities and the department must backfill the shifts of officers away on training.¹⁶ Small and rural jurisdictions often have a scarcity of behavioral health resources in the form of mental health clinics or psychiatric hospitals.¹⁷ Co-response models may not be very practical in rural jurisdictions that encompass large areas of land with the nearest mental health staff many miles away.¹⁸

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 equip patrol officers with naloxone. Some participate in regional consortiums where local agencies share Crisis Response Teams.¹⁹ Others have adopted telehealth models where experts provide

¹⁴ Monnat, S.M, K.K. Rigg. “The Opioid Crisis in Rural and Small Town America.” *The Carsey School of Public Policy at the Scholars’ Repository*, Durham: N.H. . (2018) <https://dx.doi.org/10.34051/p/2020.332>

¹⁵ Yang, S.M., C. Gill, L.C. Kanewske, P.S. Thompson. “Exploring Police Response to Mental Health Calls in a Nonurban Area: A Case Study of Roanoke County, Virginia.” *Victims and Offenders*, (2018) 13(8), 1132–1152. <https://doi.org/10.1080/15564886.2018.1512540>

¹⁶ Compton, et al., op.cit. note 12.

¹⁷ SAMHSA. “Rural Behavioral Health: Telehealth Challenges and Opportunities.” *In Brief*. Vol 9, Issue 2 (2016). Available at <https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4989.pdf>

¹⁸ Compton, et al., op. cite. note 12.

¹⁹ Skubby, D., N. Bonfine, M. Novisky, M.R. Munetz, C. Ritter, C.). “Crisis Intervention Teams (CIT) in Rural Communities: A Focus Group Study.” *Community Mental Health Journal*, (2011) 49, 756-764. DOI 10.1007/s10597-012-9517-y.

advice to patrol officers in the field via audio or video conferencing: For example, the sheriff offices in the Ohio counties of Gallia, Jackson, and Meigs 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 who respond to crisis calls greater situational awareness by giving them information on local individuals with mental health or substance abuse issues (such as the individual's name, photo, mental health conditions, behavior triggers, and de-escalation techniques).

The National Police Foundation set out to explore the specific ways in which small agencies have adapted crisis response strategies used by larger agencies to meet their unique needs. To accomplish the task, we conducted a survey of randomly sampled small law enforcement agencies throughout

the United States. The survey asked questions about officer training, access to mental health expertise, budgeting, special protocols for dispatch and hospital drop off, and partnerships with other professional organizations, all in relation to their chosen crisis response model. This section of the report outlines the results of the survey and discusses our general findings.

“The survey asked questions about officer training, access to mental health expertise, budgeting, special protocols for dispatch and hospital drop off, and partnerships with other professional organizations.”

METHODS

The National Police Foundation developed a draft survey and piloted it in December 2019 with six small law enforcement agencies. After they completed the survey, respondents were called and interviewed about survey length, burden, and difficult sections. The feedback was used to revise the survey and prepare it 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 with 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 United States. 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 12:00 p.m. EST/9:00 a.m. 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, but with the outbreak of COVID-19 in mid-March 2020 and the civil unrest in May and June of 2020, data collection was paused. At that point, after the initial invitation and one follow-up email to non-respondents, 115 surveys had been submitted. 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 invitations 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 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 responses either through physical mail returns or from the online survey (the cover letter contained a link to the online version.) 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, upon review, we found that we had received more than one response from some agencies. There were two ways the double responses could have occurred. In the first scenario, multiple responses could result from one respondent completing the survey online and another respondent within the same agency returning the survey via the 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 the Qualtrics software. After filtering all of the responses, we 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 five percentage points.

RESULTS

What Kinds of Crisis Response Programs Do Small Agencies Have?

Agencies take different approaches to develop effective responses to calls involving persons in behavioral health crisis. Whatever model they choose to follow, 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 the 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 can develop special dispatch procedures to give officers better situational awareness when responding to calls involving persons in crisis.

Of 380 responding agencies, only 12 (.03%) 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 1%).

When asked if their agency had provided basic crisis response training to patrol officers (such as PERF's ICAT²⁰ program, Mental Health First Aid, or other program), the vast majority of agencies (91%) responded affirmatively. Six in 10 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 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.

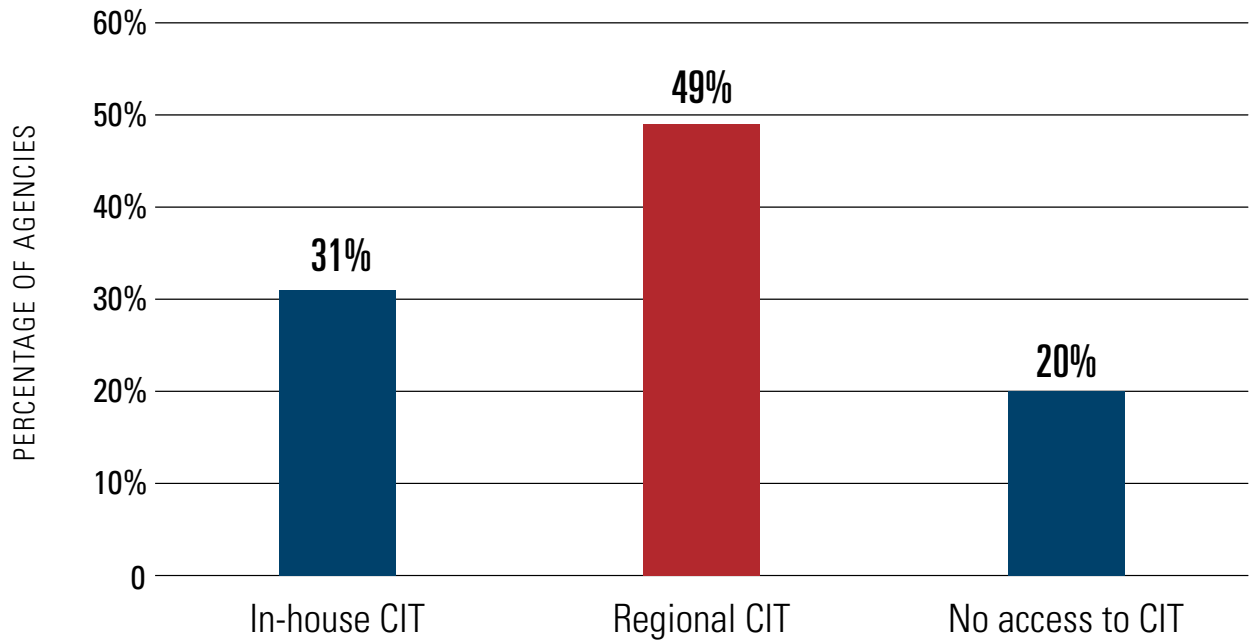
Our survey results show that the CIT model is prevalent among small agencies (see Figure 1). Nearly half of responding agencies (49%) reported access to a regional CIT while 31% reported having an in-house CIT. One in five respondents said their agency lacked a CIT program.

Municipal police and sheriffs were equally likely to have access to a CIT through a regional partnership (49% for police vs. 48% for sheriffs). 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%).²¹ Roughly half

“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.”

²⁰ Integrating Communications, Assessment, and Tactics.

²¹ p=.02

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

of agencies with 19 or fewer sworn officers and agencies with 20-75 officers stated that they had access to a regional CIT. Agencies with 20 to 75 officers were somewhat more likely than the smallest agencies to have an in-house CIT (35% vs. 27%), while the smallest agencies were somewhat more likely not to have any access to a CIT (24% vs. 16%).²²

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.

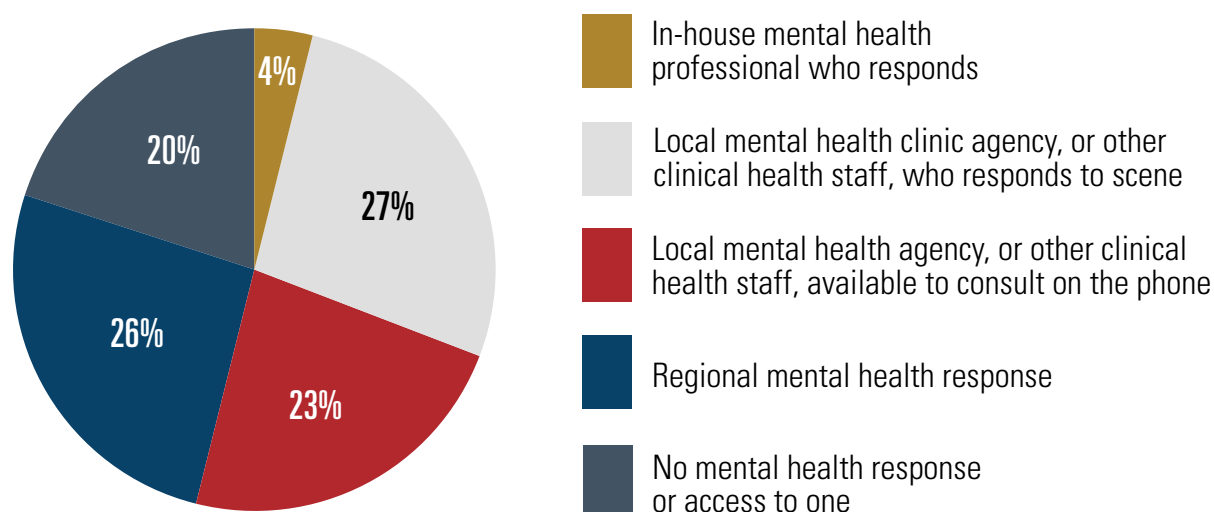
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²² p=.10

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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

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



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 (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

mandating that dispatchers contact mental health providers or other trained professionals to support law enforcement's response to the call, and use of ProQA software, which 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.

Other descriptions 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 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:

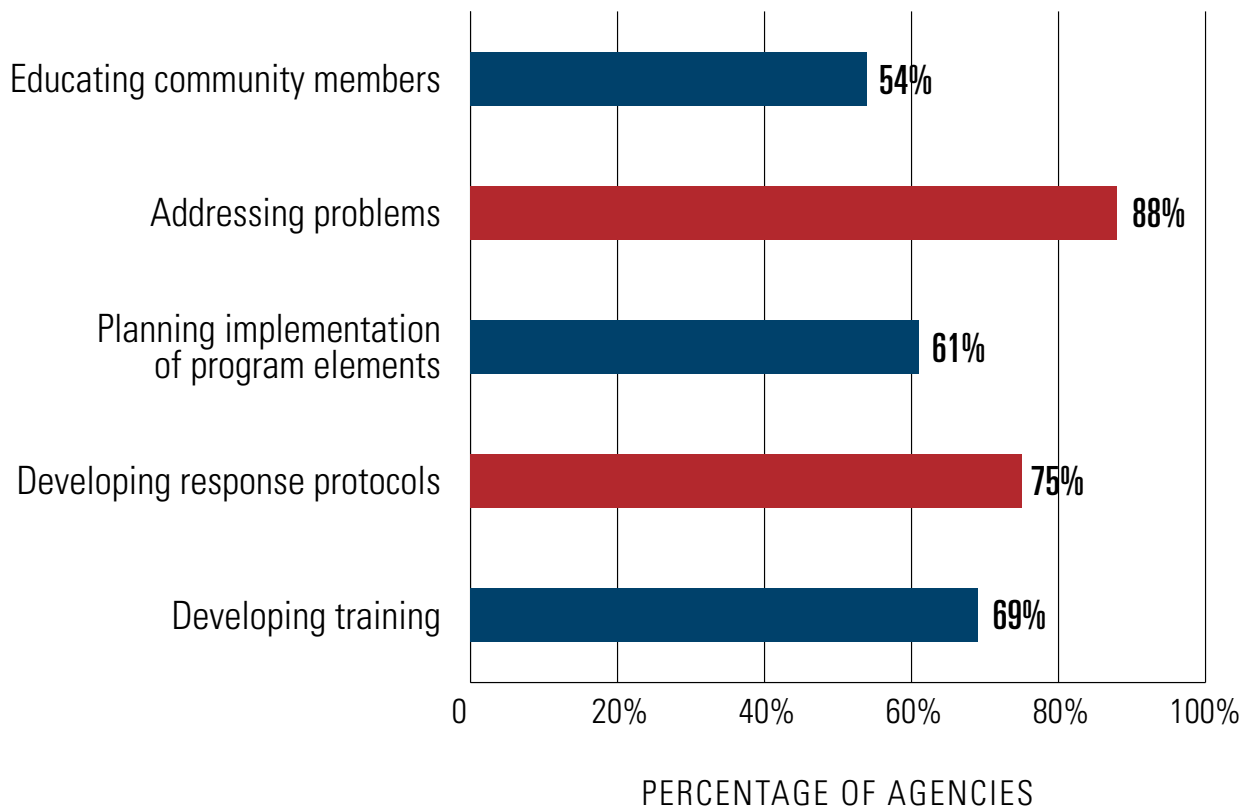
Living in rural Kansas we have the ability to get to know most of our citizens on a personal level. With that in mind our dispatchers are also well informed with individuals in crisis and we also provide shift pass down reports. We continue looking for newer methods of technology to aid us in responding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

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 group addressed problems with the jurisdiction's crisis response strategy. Other common goals that respondents named included

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

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).

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

services (for example, SWAT) does not appear frequently enough to make it practical to house services within every LEA. This is also the case for programs to respond to persons in crisis. Very small agencies may only rarely deal with mentally ill persons, so they may not see as strong a need for specialized training or programs. Moreover, mental health facilities may not be local; they may be 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.

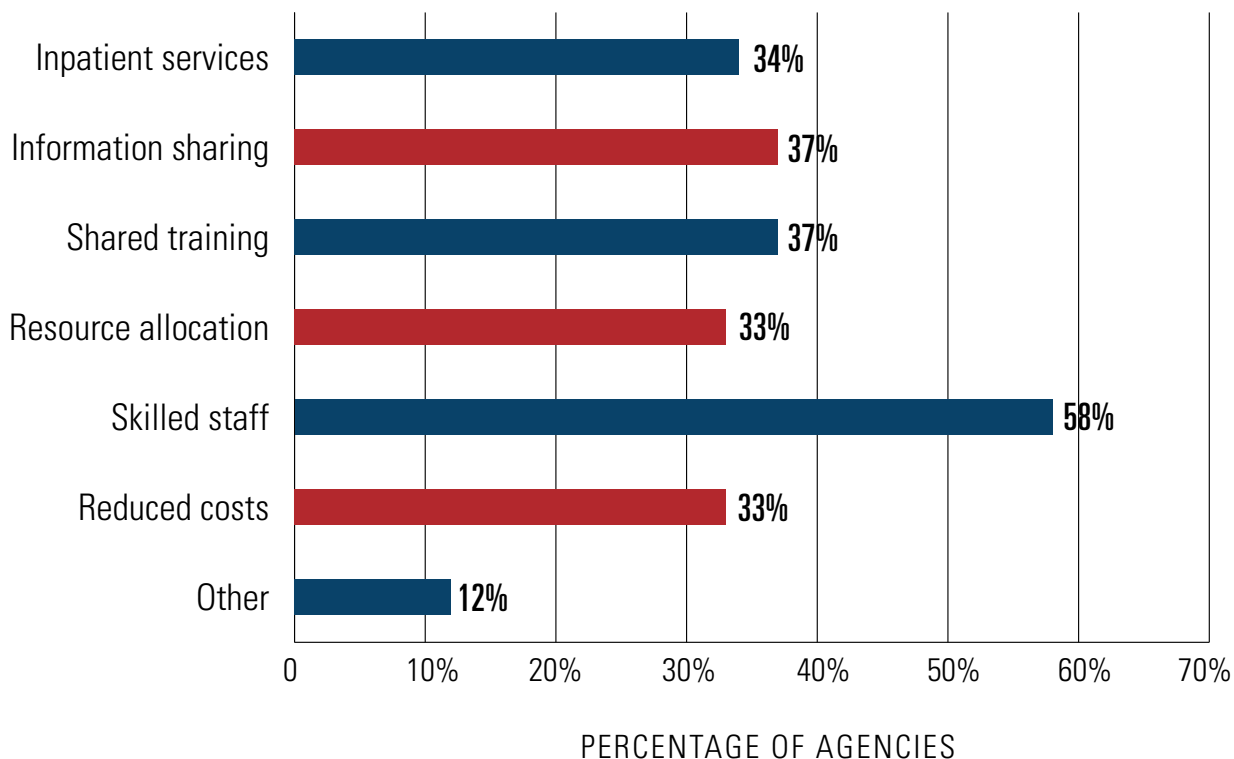
If agencies indicated that they had access to a regional CIT or access to a regional

mental health response (n=147), they became eligible for a series of additional questions about the defining features of their crisis response program. The size of regional partnerships varied 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 agency of being part of a regional approach. The answers were gathered

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 incidents involving persons in crisis (see Figure 4). Other reasons suggested by the survey's closed-ended responses were endorsed about equally as often. 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

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



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 regional 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 in their own words about other problems with a regional approach. 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.

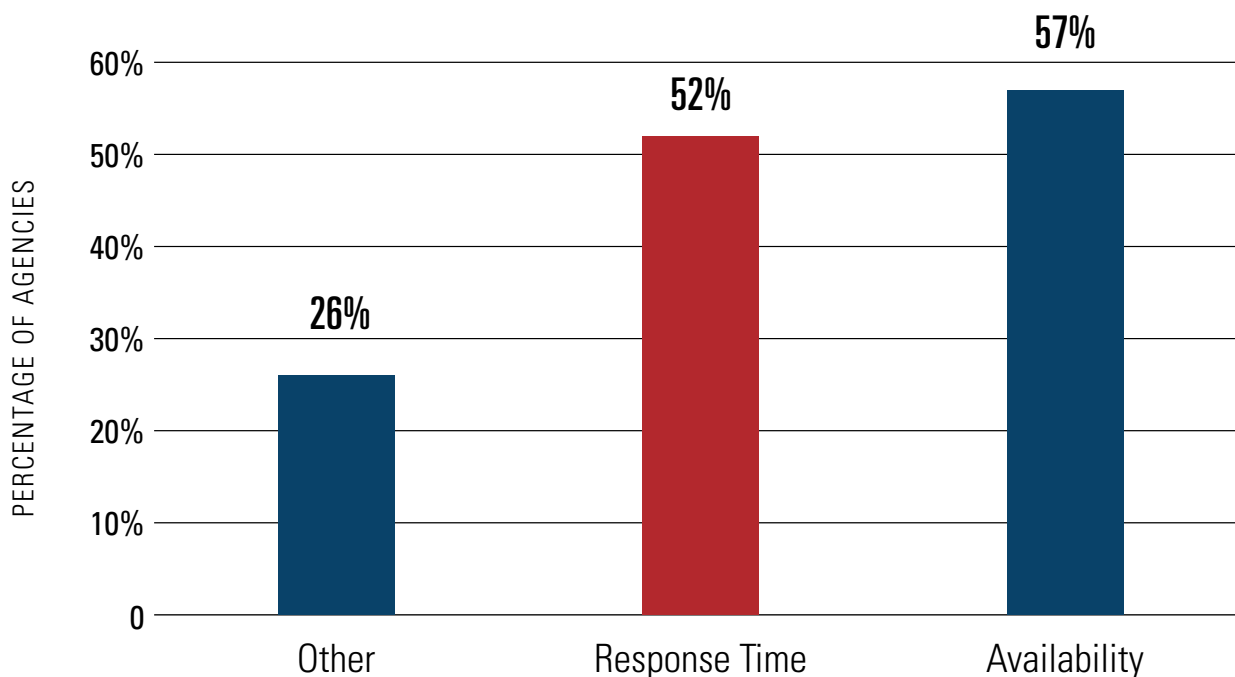
One other problem mentioned by survey respondents was the drain on officer time involved in interfacing with mental health staff. One respondent put it this way:

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.

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, eight allocated funds for mental

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



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 said their crisis response programs were fully funded by grants, and they therefore 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).²³

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.

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

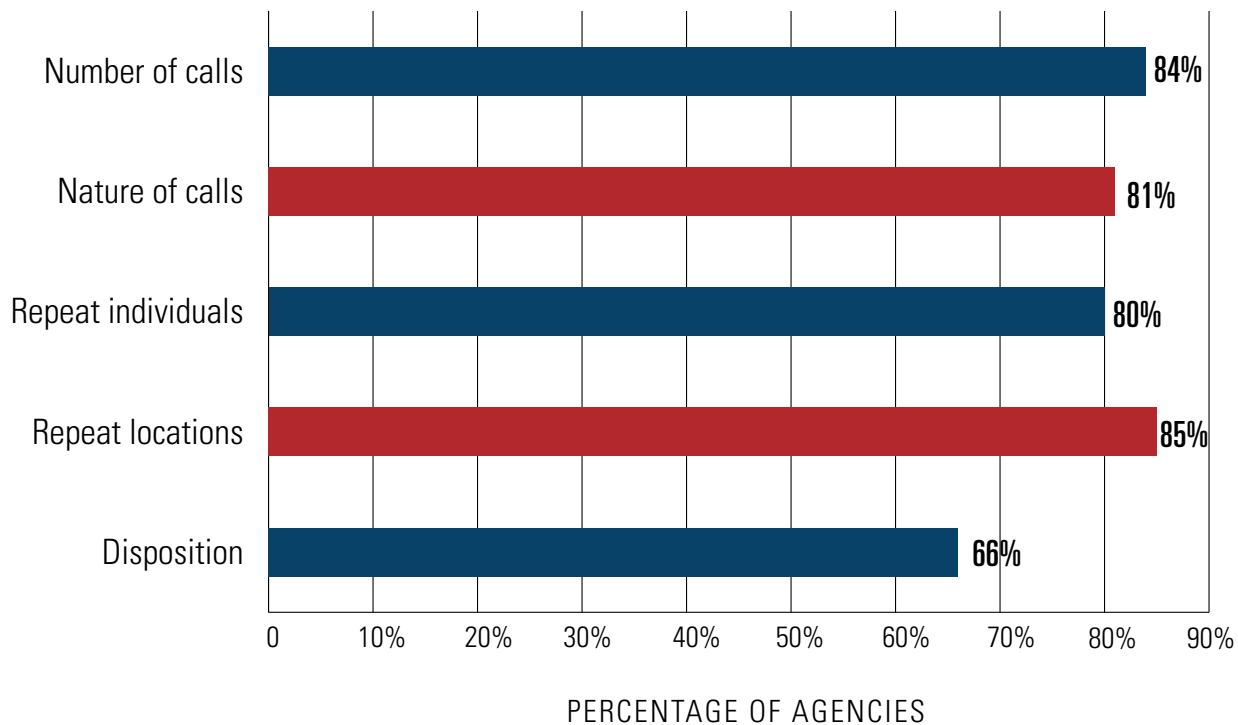
Table 1: Average Amount Budgeted for CIT Training and Related Programs (n=102)²³

	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

²³ 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.

²⁴ These values are based on agencies who reported budgeted amounts in at least one of the four areas above \$0.

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



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 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).

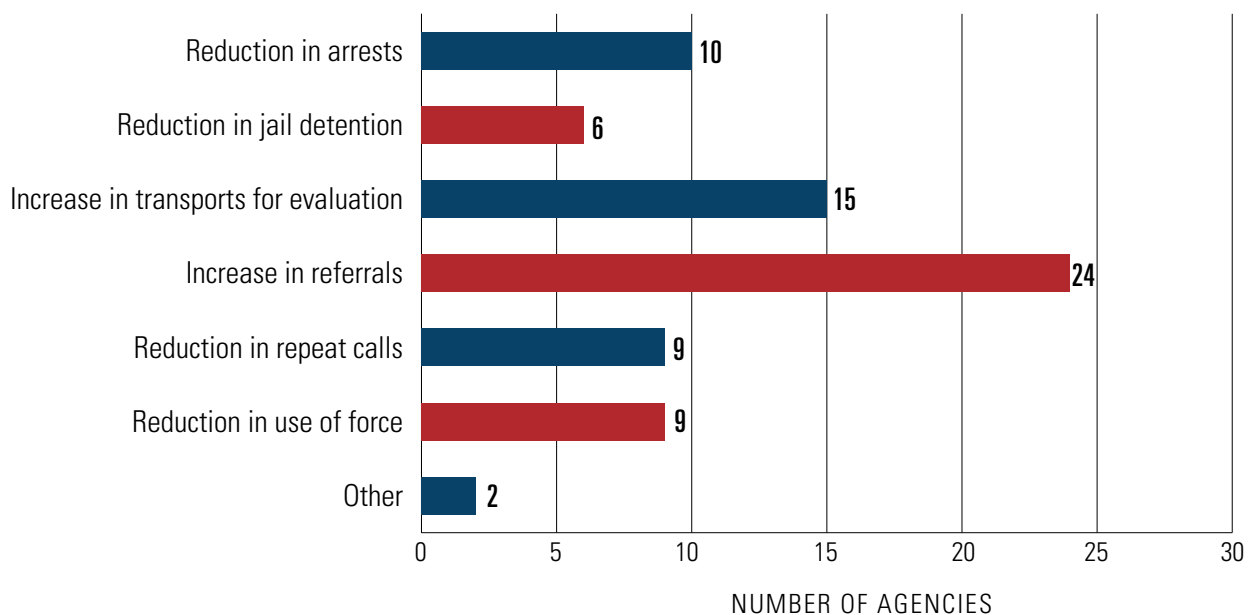
Respondents were also invited to provide a free text response outlining their findings. Only two respondents provided a text response. One of the two was especially detailed:

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.

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

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



possible to put together a successful program without a lot of resources:

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.

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.

“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.”

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.

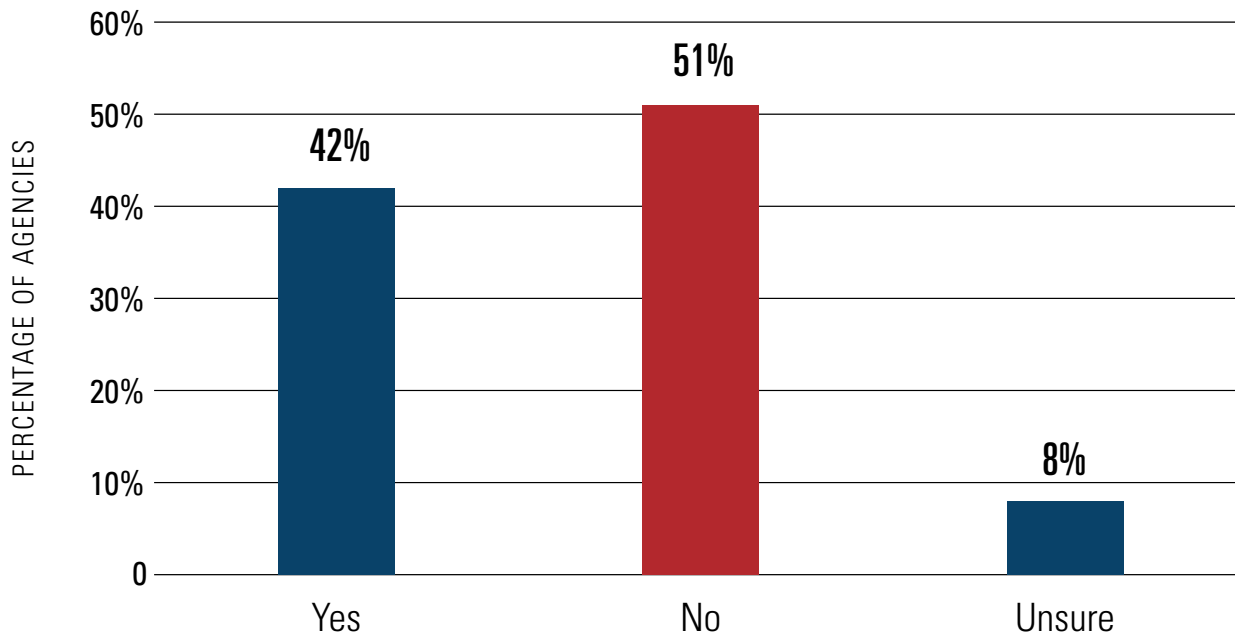
Finally, a couple of respondents were very direct, and just said that their need for a crisis response program was a low priority for their agency: “Our crisis program is not robust [but] our need is not frequent enough.” Others stressed that their program was a work in progress and still developing:

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 murder of George Floyd occurred after we had paused the survey due to the COVID-19 pandemic. The circumstances of Floyd’s murder 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 was restarted asking if and how the murder of Floyd and other African Americans by police had led them to reassess how their agency responded to situations involving persons with mental

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



illness or impairment due to substance abuse.

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 George Floyd's murder and subsequent nationwide demonstrations were 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 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 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, 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 in crisis. For example:

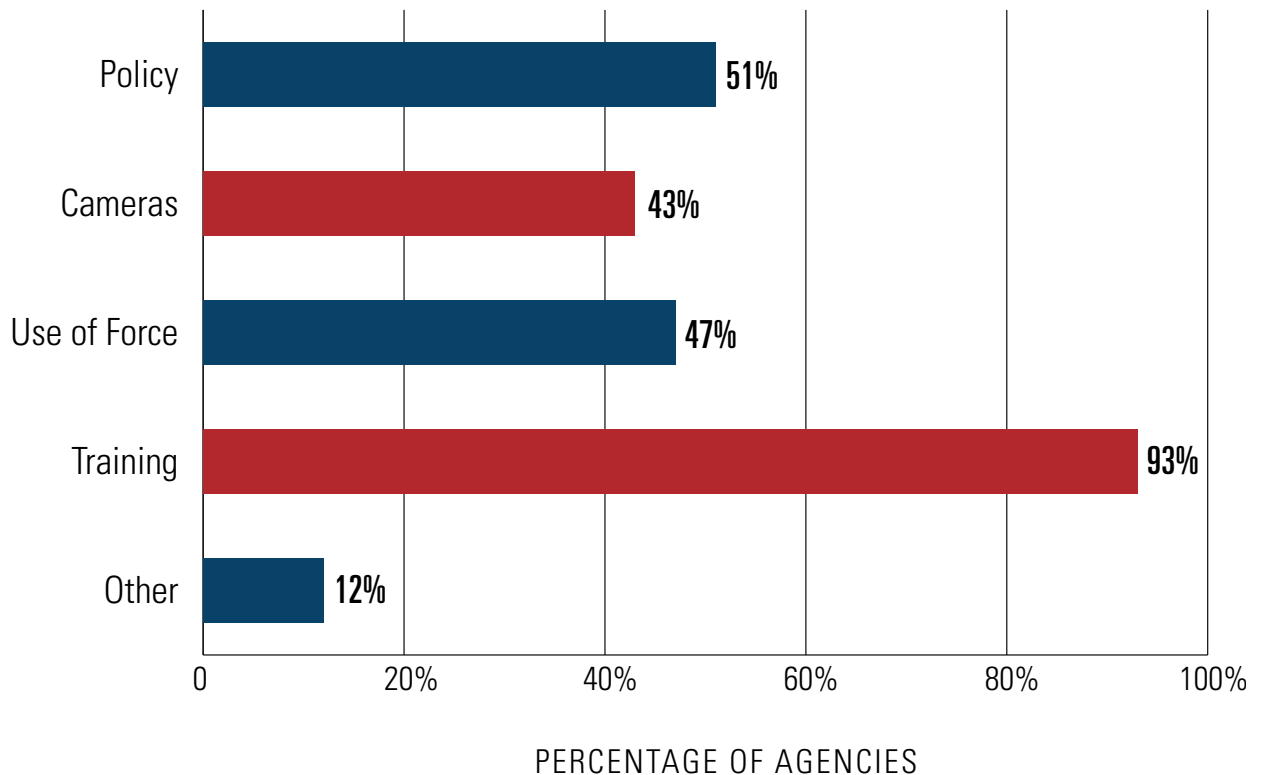
Having more mental health workers available and trained to go to the original call. Take LE out of the equation.

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.

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



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, only 12 (.03%) 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% of respondents 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 10 agencies also had assistance 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 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.

Respondents volunteered additional ways they had created to respond to people in crisis. 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

“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 or that dispatchers had at their fingertips points of contact for mental health providers.”

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

“Two in three survey respondents said they would recommend their program to others. 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.”

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 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 such 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. The small number of agencies (n=46) that reported using innovative technology in responding to crisis calls said they used tracking software, customized their CAD system, used emergency medical dispatch, and added staff to review call data and monitor radio traffic. These efforts are primarily conducted to better use the data the agency has access to and represent best practices in rural agencies.

Two in three survey respondents said they would recommend their program to others. 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 10 agencies said that they were reassessing their ways of dealing with persons in crisis as a result of the murder of George Floyd and subsequent public demonstrations. These agencies were considering seeking additional training for officers, changes to use of force and other policies, and purchase of body cameras.

THE CASE STUDIES

Surveys are useful for describing broad issues and trends but are blunt instruments for providing details or depth of the phenomenon under study. We used the national survey results to select individual small and rural agencies that exemplified particular approaches to responding to calls involving persons in crisis. The resulting set of case studies illustrate the common challenges and solutions small agencies have had as they work to successfully respond to people in crisis.

METHODS

The eight case studies in this report are drawn from in-depth, in-person interviews with eight agencies that participated in a larger, written survey of 380 randomly selected agencies.

The departments asked to participate in the case studies were chosen through a multi-stage selection process. First, project staff reviewed written survey responses from the 380 agencies to identify jurisdictions that were engaged in best practices and innovative programs or strategies. The staff then selected six agencies that were diverse in terms of agency size, region of the country, and distance from urban centers (i.e., suburban

or rural). The six chosen included Winthrop, Massachusetts; Bath, Maine; Mason County, Michigan; Groton, Connecticut; North Reading, Massachusetts; and Davidson, North Carolina. Two additional agencies—Elko, Nevada; and Brush, Colorado—were selected to illustrate the significant obstacles agencies face in developing more robust responses to persons in crisis.

In accordance with the terms of the Institutional Review Board's clearance, the study's team conducted semi-structured interviews with police chiefs and other key staff at each of the eight sites. The team first identified the generic topic areas to discuss in every in-person interview (such as crisis intervention training and dispatch procedures). Then they created a unique set of questions for each site based on that agency's responses to the written survey. For example, when the agency's written responses indicated that it was part of a regional program, the staff filled in that information on the interview form. Additional questions were designed to fill in gaps and probe for more information.

In each jurisdiction, the interviews started with the chief law enforcement executive, and, based on that interview, the project staff decided which other persons were key

to drawing a complete picture of the site's strengths and challenges. Depending on the site, the interviews might be with agency staff directly involved in the crisis response program, dispatch staff, or in-house clinicians. In addition to members of the agency, the interviews might also have been with community mental health partners and heads of regional response programs. All interviews were tailored to confirm previously gathered information and fill in gaps.

Interviews were conducted using Zoom. The audio was recorded with permission of the interviewee. In most cases, two members of the research staff attended, one as the primary interviewer and the other as primary note-taker. The interviews lasted 15-45 minutes. Those with agency heads were the longest, and subsequent interviews were typically shorter. Two staff collaborated on producing each case study report based on the written transcript and notes taken during the call. A list of persons interviewed at each site is included in [Appendix A](#).

LESSONS LEARNED

Characteristics of Effective Crisis Response

By analyzing interview responses, the study team identified strategies successful agencies use to help overcome their challenges and implement an effective crisis response. The strategies they held in common were:

- Crisis intervention training
- Automated dispatch procedures
- The use of multiple types of on-scene responses
- Follow up with the households or persons in crisis
- Engaging community mental health efforts

The interviews also revealed features common in all the case study sites that contributed to their success. These key features were:

- Leadership from an energetic advocate of reform
- Clear communication among traditional service providers, including police and medical and behavioral health providers
- Involvement of community partners

Each feature and strategy is discussed broadly in this Lessons Learned section and in more detail in the individual case studies.

Crisis Intervention Training

All eight sites selected to be in the case study project had at least some officers who had received an 8-hour course to learn how to respond to crisis calls. All eight sites had at least some officers who had received full 40-hour crisis intervention training (CIT).

Paying for a 40-hour crisis intervention curriculum can be a burden if left to individual agencies, especially small agencies. In all but one of the sites, the cost was covered by the state and trainers came from the state's Peace Officer Standards and Training Council (POST), the state health department, the National Alliance on Mental Illness, or other non-profit organizations.

*“Historically, police have tended to view these calls as **incidents** best resolved in the criminal justice system while mental health professionals focus on stabilizing and rehabilitating the **individual** involved in the incidents.”*

Even when agencies did not have to pay the direct costs, there were other significant impediments. For an agency with 10 sworn officers, for example, backfilling shifts so that one or two officers can be absent for a week-long training can be daunting and usually includes significant overtime costs. In addition, for many rural agencies, officers must travel large distances and stay overnight, adding more costs.

Differences in professional values sometimes cause animosity between law enforcement and mental health staff over how to handle persons with mental illness.²⁵ Historically, police have tended to view these calls as *incidents* best resolved in the criminal justice system while mental health professionals focus on stabilizing and rehabilitating the *individual* involved in the incidents.²⁶ During the interviews, the study team heard about disagreements between police officers and behavioral health specialists over the most appropriate course of action, examples of poor interactions, and stories that illustrate the perception that the behavioral health system does not make it a priority to help law enforcement manage situations involving persons who are experiencing a mental crisis.

An ancillary benefit of CIT can be greater cooperation between the law enforcement and mental health communities. In Mason County, for example, initial differences in

²⁵ Skubby, et. al., (2011) op. cit. note 19.

²⁶ Skubby, et. al. (2011) op. cit. note 19.

approach eventually were replaced by a successful partnership after community leaders participated in several facilitated conversations involving stakeholder groups. Eventually the stakeholders were able to settle their differences and establish several memoranda of understanding.

Dispatch and CAD Systems

Dispatchers, too, can benefit from CIT. The curriculum teaches them the types of questions to ask so they can increase the situational awareness of responding officers. However, as difficult as it is to cover the shifts for officers who attend CIT, the challenges can be even greater for dispatchers because dispatchers are so few in number. The absence of even one can cause a significant gap in coverage. One solution adopted in some jurisdictions is to send dispatchers to an abbreviated training.²⁷

Another tactic related to dispatch involves flagging the names of officers on the daily roster who have completed CIT so officers with the right skills can be matched to the situation.²⁸

Another important tactic is the ability to identify “frequent flyers.” Having a computer-aided dispatch (CAD) system that can track repeat callers, link those callers to addresses, and list the outcomes of the calls is key

to enhancing the situational awareness of responding officers and to developing post-call follow-up services.

CAD systems should also systematically prompt dispatchers to ask callers relevant questions and share key information with responding officers. See, for example, the case study from Bath where dispatchers who identify a call as a potential crisis call can activate software that leads the dispatcher through a script that prompts a series of questions to assess the safety of the first responder, the caller, and the patient on the scene. Bath’s system also allows the agency to enter collaborative crisis plans into the system so that officers can respond to plans developed with community providers and family. CAD systems, such as those in North Reading, Bath, and Groton, that prompt

“Dispatchers, too, can benefit from CIT. The curriculum teaches them the types of questions to ask so they can increase the situational awareness of responding officers.”

²⁷ Compton, et al., op.cit. note 12.

²⁸ Compton, et al., op.cit. note 12.

“The difficulty of providing a prompt co-response by mental health professionals underscores the importance of having officers who are fully trained in crisis intervention.”

dispatchers to ask the right questions may be especially useful when dispatch staff have not completed crisis intervention training.

Small communities have another challenge related to dispatch: 911 is often shared with other public safety agencies. In these cases, taking calls from persons in crisis and dispatching first responders may be determined by an outside agency—one that may or may not be willing or able to capture data of interest to the police. The Mason County Sheriff’s office worked to solve such a challenge by developing a good working relationship with the Mason-Oceana Dispatch Center. In Mason County, the dispatch system retains information gleaned from prior police contact, including, for example, information on the presence of weapons and whether an individual has a dedicated case worker assigned through the local mental health service provider.

On-Scene Response

Comprehensive Policies. All sites in the case studies had well-developed, comprehensive policies and procedures regarding how to respond to crisis calls. All sites instructed officers to assess whether unusual behavior may be the result of mental illness and determine if individuals pose an immediate danger to themselves or others. All agencies also required officers to act and talk in non-threatening ways, offer reassurance, and gather information from family members or acquaintances. Sites also had specific policies that were unique to them. North Reading, for example, requires officers to call for a supervisor to help make a decision about whether someone should be taken into custody for emergency evaluation.

Co-Response with Mental Health Providers. Several agencies had access to mobile mental health specialists who could respond along with the police officer. Round-the-clock coverage for mental health co-responders, however, may not be available in many small and rural communities. Even when it is available, response times may be lengthy due to travel distances or call volume. Some agencies connect to mental health services remotely via the telephone or hold video conferences using iPads. The difficulty of providing a prompt co-response by mental health professionals underscores the importance of having officers who are fully trained in crisis intervention.

Accessing Mental Health Services.

Having a co-responder available on a timely basis may be beyond the fiscal means of many small agencies. Two agencies in the case studies obtained municipal or grant funds to hire an in-house mental health specialist. Other models are being tried as well. In Davidson, the chief is forming a collaborative with two neighboring municipalities to set up a mental health unit composed of clinicians and law enforcement officers. Together the three municipalities plan to use a portion of their budgets to fund a dedicated unit all the municipalities can use when needed. In Bath, leaders from the police department and the National Alliance on Mental Health lobbied the state legislature for a statute that would allow 911 operators to divert crisis calls to mental health services when appropriate rather than dispatching the police.

Dispositions of Crisis Calls. For most agencies in the case studies, officers had the choice of releasing the person who was in crisis, providing a referral for behavioral or social services, transporting the person to the local emergency center for evaluation, or taking the person into police custody. All agencies in the case studies considered arrest to be the least appropriate alternative.

Most of the case study sites were fortunate to have hospitals with psychiatric services, but few rural communities have a psychiatric emergency facility within a reasonable

distance or an adequate supply of state hospital beds, so the local jail, which very rarely has treatment staff, becomes the last-resort alternative.²⁹

Agencies reported a variety of strategies for effectively managing their transportation challenges. Often, EMS and police share responsibilities for transporting people in crisis depending on the situation. In Bath, EMS transports people who are experiencing a drug overdose or who are suicidal, and in Elko, they can also transport people who are non-violent.

When deputies in Mason County respond to a crisis call during normal business hours, they can transport the person to a community mental health facility for evaluation and outpatient clinical services. But they may also need to drive up to six hours to reach the right services.

Following Up on Crisis Calls

Follow up can be done in several ways. One way is to regularly contact the households where the crisis call originated to assess changes and help prevent future crises. Another option, when a clinician did not co-respond with the police, is to have a mental health specialist follow up after the encounter with police. The chief in North Reading, for example, noted a decline in the number of same-person repeat calls, which he attributed

²⁹ Compton, et. al., op. cit.

to the clinician's follow-up to crisis calls.

Finding the funds for dedicated staff who are skilled at making follow up calls and offering clinician services is a challenge. Winthrop braided together two grant funds to create and sustain their Community and Law Enforcement Assisted Recovery (CLEAR) program. The grants came from the Massachusetts Department of Health and Human Services and the U.S. Department of Justice's Justice and Mental Health Collaboration Program, which is managed by

“All agencies in the case studies considered arrest to be the least appropriate alternative.”

the Bureau of Justice Assistance.³⁰ CLEAR involves direct follow up first by a lieutenant in the police department who, if an individual accepts his offer of assistance, can connect the individual with the department's full-time peer recovery counselor or with a licensed clinician. The work the peer does may last several months and is free of charge.

Collaboration with Professional and Community Groups

Several departments in our case studies participated in local community mental health collaborations, which are essential components of success. For example, in response to a high number of calls related to suicide, the chief in Davidson developed a multidisciplinary mental health committee composed of community stakeholders, school practitioners, law enforcement personnel, and members of mental health and suicide advocacy groups in and around Davidson. In Brush, the department collaborated with high school leadership to better understand a spike in youth suicide attempts.

The Bath Police Department participates in a regional partnership, which is instrumental in learning about up-to-date methods for responding to crisis calls. There, regional mental health meetings with chief law enforcement officers and sheriffs and the National Alliance on Mental Illness (NAMI) are working to conduct more training, collect more data, and identify weaknesses in the system.

30 See details about the Bureau of Justice program at <https://bja.ojp.gov/program/justice-and-mental-health-collaboration-program-jmhcp/overview>

Creating Databases to Evaluate Outcomes

Leveraging technology is another element of success. Databases and, as discussed earlier, dispatch systems that can recognize patterns and store information are vital tools. Regional databases can help pinpoint available hospital beds and community mental health resources. A database can also create the possibility of evaluating effectiveness of CIT training and other aspects of police crisis response. The Bath Police Department is using a dataset, created by NAMI, that contains crisis calls from 50 participating law enforcement agencies. The agencies record crisis calls, dispositions, and officer training.

Using Jail Diversion

In places without good psychiatric options for mentally ill persons, the local jail becomes the default facility. However, especially in small jurisdictions, jails rarely have mental health staff who are skilled in stabilizing individuals. In both small and large jurisdictions, prosecution is unlikely to be the best disposition for these cases. Diversion programs and substance abuse counseling in jail are better alternatives to prosecution. The Mason County Sheriff claimed that his federally funded jail diversion program has reduced recidivism, but empirical data supporting the claim so far are lacking.

“In places without good psychiatric options for mentally ill persons, the local jail becomes the default facility. However, especially in small jurisdictions, jails rarely have mental health staff who are skilled in stabilizing individuals.”

INNOVATIVE PROGRAMS

WINTHROP, MASSACHUSETTS

Background

The Town of Winthrop, Massachusetts, is a very small (1.98 mi²) but densely populated (n=18,554) beach community on the outskirts of Boston. The population is primarily white (93%) with small percentages of people who identify as Black and Asian. The percentage of people who identify as Hispanic is 10%. The median household income sits at \$74,069 with a per capita income of \$44,642 and a

“The lieutenant who manages the CLEAR program, estimated about half of the calls Winthrop received in 2020 were tied to mental illness or substance use in one way or another.”

poverty level of 9%, just below the national average. ³¹The Winthrop Police Department (WPD) employs a total of 30 sworn officers.

Winthrop does not have designated call codes for substance use or mental health. Therefore, unless a final disposition is written and the phrase ‘mental health’ is specifically used by the responding officer in their report narrative, the call cannot be identified as relating to mental health by the data system. However, because the lieutenant in charge of the Community and Law Enforcement Assisted Recovery (CLEAR) reviews call logs daily, the agency was able to provide an accurate tally of calls for service related to behavioral health crisis. In 2020, Winthrop received 23 calls for service related to overdoses, and 12 calls for services where mental health was mentioned in an officer’s report. The lieutenant who manages the CLEAR program, estimated about half of the calls Winthrop received in 2020 were tied to mental illness or substance use in one way or another. In a two-month period in the spring of 2021, he noted 83 cases were scheduled for outreach, successful connections were made with 44 community members, and 27 survival kits were distributed (containing Narcan, test drug strips, and additional resources).

31 U.S. Census Bureau, <https://www.census.gov/quickfacts/winthroptowncitymassachusetts>

Why This Site?

WPD was selected as a case study site due to its access to regional behavioral health response through Boston Medical Center's Boston Emergency Services Team (BEST) in addition to its own multi-disciplinary CLEAR Program. WPD has also signed the One Mind Pledge, an IACP campaign that requires participating agencies to establish a partnership with a community health organization, develop and implement a policy addressing law enforcement response to persons in crisis, and train 100% of sworn officers in some form of crisis response training.

Crisis Training for Officers

Nearly all officers have received 40 hours of Crisis Intervention Training (CIT) and 8 hours of Mental Health First Aid Training (MHFA) through the Commonwealth of Massachusetts' Sommerville Training Center. Officers also receive 40 hours of re-training annually. Funding for the training is provided by the Commonwealth.

Procedures for Responding to Crisis Calls

WPD has extensive policies in place outlining officer response to persons with mental health and substance use issues. If officers determine that a person in crisis is in need

of a specialized response, they have two key resources at their disposal.

First, as part of a regional response, WPD can access the BEST team based out of Boston Medical Center. This team provides a masters-level clinician to respond to the scene, and when safe to do so, conduct a mental health evaluation. The service, funded by the Commonwealth of Massachusetts, is available 24 hours a day/7 days a week. Response time, however, can range from one to two hours because the service is a regional resource. Alternatively, officers have the option of contacting the mental health counselor who works for the local jail diversion program under Winthrop's CLEAR program.

Officers can contact EMTs for transport to Boston's Massachusetts General Hospital for a mental health assessment. In response to overdoses, the department equips officers with and trains them to use Narcan (naloxone), a commonly used medical drug for counteracting the effects of opioid overdose.

Engaging Community Resources

In 2013, communities north of Boston began to experience an increasing number of deaths related to opioid overdose. In response, Winthrop and community partners in the neighboring towns of Revere, Chelsea, and Saugus formed the Winnisimmet Regional Opioid Collaboration (WROC). The primary

“The primary goal of the collaboration was to reduce the number of overdoses in the community by connecting members with peer recovery coaches who have lived-experience related to substance use and the recovery process.”

goal of the collaboration was to reduce the number of overdoses in the community by connecting members with peer recovery coaches who have lived-experience related to substance use and the recovery process. Funding for the collaboration was supplied by the Massachusetts Department of Public Health’s Bureau of Substance Abuse Services. A grant of \$100,000 was split among the four communities. Winthrop used their funds to hire two part-time peer recovery coaches.

An officer began to review dispatch logs on a weekly basis, flagging calls for follow up and making contacts with community members as needed with the assistance of the peer recovery coaches. A funding stream became available after successful grant applications were coordinated by Winthrop’s Director of Public Health and Clinical Services. In 2016, with funding from town, county, and state sources, the CLEAR program was formally established. The additional funding was fully

allocated by 2019 and allowed Winthrop’s CLEAR Team to employ a peer recovery coach and a jail diversion counselor in addition to fully funding a full-time position in the Police Department dedicated to addressing mental health and substance use issues in the community.

The CLEAR team meets weekly to discuss on-going cases and next steps for program development. The lieutenant in charge reviews dispatch logs, flags cases for follow up, and assigns cases to team members. Team members connect individuals with programs and resources and use a harm-reduction approach with those who are not yet ready to completely abstain from substance use. The peer recover coach typically serves 20-30 clients at any given time with the number of clients reaching its peak around the holidays. Having peer recovery counselors has created an environment in which law enforcement officers have more opportunity to learn about and discuss substance use issues and gain a better understanding of the role of law enforcement in responding.

The CLEAR team also maintains a connection with the local detention center, allowing them to contact individuals before they are released back to the community to aid their transition and reduce recidivism. The jail diversion counselor maintains an active caseload of approximately 20 clients. Some of these cases require the counselor to hold weekly check-ins, but others are referred to services, such as peer support groups, counseling, family, or individual therapy.

Summary

Winthrop has been able to develop a multi-disciplinary crisis response program that leverages law enforcement, mental health, and peer resources to deliver a collaborative response and followup. The CLEAR and jail diversion programs have predominantly been the result of grants. The Winthrop case study illustrates the value of having strong advocates for changing the way that law enforcement responds to persons in crisis. The movement toward CIT and Mental Health First Aid training can in large part be attributed to the lieutenant in charge of the CLEAR program who first took notice of the mental health and substance use challenges facing Winthrop in 2014. The lieutenant as well as the chief of police and the chief city mental health officer were also instrumental in obtaining grants to fund the CLEAR and jail diversion positions.

The CLEAR program manager is currently working to improve the police department's data tracking capabilities to more accurately document the number of crisis cases and the services they are providing to the community. The city is also looking into purchasing case management software to assist with this process. The development of this data system will allow Winthrop to advocate for additional funding and resources for those in the community.

INNOVATIVE PROGRAMS

BATH, MAINE

Background

Bath, Maine, is a town of 8,300 people located on the coast, about 30 minutes north of Portland, and is part of the Portland metropolitan statistical area. It is the county seat of Sagadahoc County. The city is popular with tourists due to its 19th-century architecture. The population is 97% white; 2% identify as Hispanic. The median household income is \$36,000.³² The town has been gradually losing population over recent decades. Bath is served by the Bath Police Department (BPD). According to the police chief, the department is staffed by 19 sworn officers and five civilians supported by a budget of \$1,589,507. Also, according to the police chief, the department has received 88 calls for service involving an individual with mental health issues by the time of our interview in mid-May in 2021, or about 20 calls per month.

Why This Site?

The BPD was included in the case studies because of the unique partnership the department has had with the Maine affiliate

³² U.S. Census Bureau, <https://www.census.gov/quickfacts/ME>

of the National Alliance on Mental Illness (NAMI). The BPD was among the first agencies in Maine to partner with NAMI, and the NAMI spokesperson praised the Bath chief for showing the initiative and willingness to find ways to backfill shifts for officers who attend the CIT training and for his interest in attending regional council meetings.

Crisis Training for Officers

BPD's CIT program was the result of a partnership between the state of Maine and NAMI. The state provides the funds for training, and NAMI organizes regional training sessions. The core of the training is drawn from CIT International's recommendations with modifications and updates developed by NAMI. Nine Bath Police Department officers have completed a 40-hour CIT course while eight other officers have had basic crisis response training through the police academy.

To gain feedback on the effectiveness of the training, NAMI conducts a three-month followup survey of all officers who participate in CIT to see if and how they have altered their interactions with individuals and to understand their perceptions about their ability to recognize symptoms of mental illness and to de-escalate situations. A NAMI spokesperson estimated the cost of delivering a CIT training at \$8,000.

NAMI also offers mental health first aid courses, de-escalation training, and CIT refresher courses. Recognizing that police

officers are at high risk of suicide, post-traumatic stress, divorce, and substance use disorders, NAMI also conducts officer wellness trainings that emphasize to officers the importance of taking care of themselves so they can respond effectively to persons in crisis in the community.

Procedures for Responding to Crisis Calls

Dispatch. The BPD participates in a regional dispatch system. Dispatchers are initially trained and certified through the International Academies of Emergency Dispatch, as mandated by the state of Maine. Refresher classes are held once or twice a year and dispatchers also often attend additional crisis intervention classes either in person or online.

Once a call is identified as a potential crisis call, dispatchers activate the International Academies of Emergency Dispatch Emergency Medical Dispatch software, which leads the dispatcher through a series of questions to assess the safety of the responder/caller and the patient at the scene. The dispatch software can tag repeat callers and addresses with a special alert so dispatchers are aware and can relay the information to the responding officer. The software also can store collaborative crisis plans that give officers background about past events so they can continue to implement strategies developed with community providers and family. It also stores contact information so

officers can proactively make plans and work with an individual's natural and community supports.

Policies. The BPD has an extensive written policy on dealing with persons who are mentally ill. It requires that a minimum of two officers are assigned to calls pertaining to persons with mental illness, including one CIT-trained officer, if available. Officers are instructed to assess whether unusual behavior may be the result of mental illness and determine whether the individual poses an immediate danger to themselves or to others. The policy stresses that officers should employ de-escalation measures, including acting and talking in non-confrontational ways, offering reassurances to the individual, and gathering information from family members or acquaintances if possible. For persons not taken into custody, officers are encouraged to provide referrals to community mental health resources. If circumstances dictate that an individual must be taken into custody, officers are advised to transport the individual to Mid Coast Hospital for psychiatric evaluation. After the individual is evaluated by psychiatric staff, he or she may be released, committed on a voluntary or involuntary basis, or—if a crime has been charged—held in custody by the police officer or issued a summons to appear in court. Policy requires that officers write reports for every incident involving a person in a mental health crisis, including probable cause for holding the individual in protective custody or arrest.

BPD policy also incorporates Maine law

“The dispatch software can tag repeat callers and addresses with a special alert so dispatchers are aware and can relay the information to the responding officer.”

allowing officers to petition a court to order that weapons be temporarily removed from persons who present a danger to themselves or others. Moreover, if a police officer has probable cause to believe that a person may be mentally ill and presents a threat of imminent and substantial physical harm to himself or others, the officer may take the person into protective custody.

Procedures. When officers arrive at the scene of a call involving someone in crisis, they try to gather information about the situation and the mental state of the person. Officers speak to the individual to gauge if they are a risk to themselves or others. BPD is part of a regional partnership that includes access to a crisis counselor over the phone. However, due to limited state funding of regional community mental health providers, counselors are often unavailable at the hours when most crisis calls occur.

Officers are instructed to avoid incarceration of persons experiencing crisis if at all possible. For persons who are suicidal or overdosing, officers partner with EMTs to transport them

to the emergency department in the next town over, about eight miles away. In most cases the officer can leave once the person is in the hands of hospital staff; on occasion if the person in crisis is aggressive, the officer may stay for a period of time. The department has a partnership with the addiction resource center at the local hospital.

For people in crisis who are not transported to the emergency room, officers try to connect them with resources in the community. The major community provider is Sweetser Mental Health Services. Sweetser has an Assertive Community Treatment team, which uses a community-based team approach to promote rehabilitation and recovery. The team is composed of a psychiatrist, nurse, employment specialist, and a counselor.

Engaging Community Resources

The Bath Police Department participates in a regional partnership. According to the chief, the partnership is important to incorporating modern crisis response methods:

We have regional mental health meetings with chief law enforcement officers and sheriffs as well and along with NAMI-Maine, we're trying to do more training, more data collection, and trying to find out where the weaknesses are in the system.

NAMI aims to bring together regional mental health providers, the police department,

families and peers, advocates, and other community resources to provide a more collaborative and robust response to mental health crises in the community. The NAMI subject matter expert who does regional CIT training for police officers has become a community resource for the department—someone officers can connect with who can provide resources for persons who do not require involuntary commitment.

Data Collection

Working with NAMI, the department keeps a dataset containing information on mental health calls for service. The NAMI dataset tracks mental health calls and dispositions including:

- Who made the call to 911?
- Was the individual stabilized at the scene?
- Was he or she brought to a hospital or emergency room?
- Was he or she able to get a community response?
- Was he or she diverted to our mobile crisis system?
- Was anyone brought to jail?
- Was anyone arrested and charged?
- Was there injury to individuals or the officer?
- How long did the officers spend on the call?
- What overtime costs were associated with the call?

The department is working with NAMI to use the data from Bath and other departments across Maine to highlight weaknesses in the system and pinpoint where more mental health hospital beds and community mental health resources are needed. NAMI is also using the database to evaluate the effects of CIT training by examining whether graduates have reduced their use of incarceration or whether injuries to officers or civilians have declined—two primary goals of CIT.

Involvement with NAMI on Legislative Initiatives

According to the NAMI spokesperson, a research study conducted in several major cities found that a large percentage of all calls routed by dispatchers to police departments involved non-criminal, non-emergency issues, such as noise complaints, civil complaints, wellness checks, or substance use concerns. The Bath Police department worked with NAMI in lobbying for a statute to allow 911 operators to divert crisis calls to mental health services when appropriate rather than dispatching the police. The proposed legislation would have allowed local and mobile crisis services to be recognized as emergency services and thus be dispatched in situations where the risk of violence is negligible—for example, calls from parents who are worried about their child being suicidal. The bill failed, but the NAMI spokesperson still retained the hope that:

What we can start doing is really looking at funding of mental health systems appropriately and then sending the clear message that mental health is not a criminal matter, that it is a medical matter.

Summary

The Bath Police Department and several other small departments in Maine have partnered with NAMI to provide better crisis services in their communities. That partnership has resulted in a high proportion of CIT-trained officers and better access to the community's mental health resources. A comprehensive database offers a unique opportunity for program evaluation.

INNOVATIVE PROGRAMS

MASON COUNTY, MICHIGAN

Background

Mason County, Michigan (495 mi²) sits on the east coast of Lake Michigan with a population of roughly 29,144. The population is predominantly white (95%); 5% identify as Hispanic. Just under 25% of the population is aged 65 or older. The median household income sits at \$51,725 with a per capita income of \$29,549 and a poverty level of 14%.³³ The Mason County Sheriff's Office (MCSO) serves as the county's primary law enforcement agency, employing 18 sworn officers. The county is also served by Michigan State Police, Scottsville PD, and Ludington PD. In 2020, the Mason County Sheriff's Office responded to 78 mental health calls, 113 suicide calls, 79 drug-related calls, and 727 checks coded as "check on well-being."

Why This Site?

The Mason County Sheriff's Office was selected as a case study site because of

their access to a regional mobile crisis unit through a program run by the West Michigan Community Mental Health (WMCMH) System, and because they were one of the few Sheriff's Offices in the national survey that reported a more developed crisis response program.

Crisis Training for Officers

All officers receive eight hours of mandatory crisis response training funded by the Sheriff's Office and have the option of completing an 8-hour autism awareness training provided by the state. Correctional officers must complete an 8-hour mental health awareness training annually, and 911 operators undergo behavioral health training and have the option to complete CIT training as a method of obtaining continuing education credits. The MCSO recently acquired a three-year \$750,000 grant from the U.S. Department of Justice to implement CIT training and a regional jail diversion program. Although they have a regional training center in the county, CIT training is typically based out of Lansing, a three-hour drive south of Ludington (where MCSO is headquartered). The process of getting all officers CIT certified is challenging because of the small number of patrol deputies. Training usually means officers are either taken off the street or their shifts are backfilled by other deputies who receive overtime pay.

33 U.S. Census Bureau, <https://www.census.gov/quickfacts/fact/table/masoncountymichigan/PST045219>

Procedures for Responding to Crisis Calls

Dispatch. Mason County shares a regional 911 center with their neighboring Oceana County. Although certain dispatch procedures differ between the two counties, the center maintains many consistent procedures. The 911 center recently transitioned to a new CAD system. Previously, behavioral health calls were tracked only if they related to suicides and checks on a person's well-being. The new CAD system has distinct codes for calls related to mental health, suicide, substance use, and general checks on a person's well-being.

Upon receiving a call for service related to a behavioral health crisis, the Mason-Oceana Dispatch Center gathers information on known available weapons, medications, and whether the individual has a case worker through WMCMH, information that may be documented due to prior contact with the police. Improvements to the CAD system now allow dispatch to track repeat callers and addresses linked to multiple calls for service. Deputies can access the information through the Michigan Law Enforcement Information Network.

Procedures. If the dispatcher acquires enough information from the caller to indicate that additional support is required, they will contact WMCMH's mobile crisis unit (MCU) after dispatching officers to the scene. The dispatcher will then relay the officer contact

info to the MCU so they can be connected. If officers arrive on the scene and discover that the person in crisis requires a specialized response and there is no imminent safety risk, they will contact the MCU themselves. The MCU is available 24 hours a day, seven days a week, and is staffed by at least two on-call WMCMH clinicians at any given time. Because the MCU covers Mason County, Lake County, and Oceana County, response times can be slow due to travel time but some officers have iPads that allow MCU staff to conduct telehealth assessments when they cannot make it to the scene in-person.

Officers responding to a call during normal business hours also have the option of transporting a person who is in crisis to the local WMCMH Office for outpatient clinical services. If the person poses a threat to himself or others, officers will transport them to the local hospital's emergency room for psychiatric assessment. In extreme cases this may result in hospital stays of 5-6 days.

Clinicians often have difficulty locating in-patient facilities with available beds. Although the nearest facility is in Muskegon (approximately an hour's drive from the typical county location), it is not unusual for a person in crisis to be transported to Detroit for service, which is a five- to six-hour drive, or even out of state to Indiana. In instances where EMS is unavailable to transport someone, the responsibility falls to the responding officer. This places a heavy strain on the resources of the MCSO and other local law enforcement agencies. Jail detention is only used when an

individual has committed a crime.

Engaging Community Resources

The mobile crisis unit was formed in 2018 by WMCMH with a subset of funding from a \$4 million grant awarded to West Michigan Community Mental Health by SAMHSA to become certified as a CCBHC (Certified Community Behavioral Health Clinic). One of the service expansions was the creation of a Mobile Crisis Service available 24 hours a day, seven days a week. WMCMH is contracted

“The three-county region currently shares a substance abuse counselor who spends two days a week in each jail and organizes individual and group meetings for inmates to prepare them for life after incarceration.”

through the Lakeshore Regional Entity, which is contracted through Michigan’s Department of Community Health to provide behavioral health care services to Mason, Lake, and Oceana counties.

Law enforcement’s regional collaboration with WMCMH began in large part because of leadership from the chief of the Pentwater (Michigan) Police Department (who was formerly with the Mason County Sheriff’s Office). In 2018, the Pentwater chief and a WMCMH administrator began a Jail Diversion Collaborative group consisting of local law enforcement agencies, courts, hospitals, and mental health practitioners across the three-county region. Initial disagreements about the most appropriate course of action for responding to people in crisis eventually were resolved and memoranda of understanding were signed.

Later in 2018, the collaborative group applied for a grant from the U.S. Department of Justice. Their first application was rejected; their second one was successful, and in 2021 they received a three-year, \$750,000 grant for strategic mental health planning. As of June, 2021 the funds had not yet been released, but the top priority is hiring two clinicians and one case manager across the three local jails to assist with post-release planning for inmates with mental health and substance use issues.

The three-county region currently shares a substance abuse counselor who spends two days a week in each jail and organizes individual and group meetings for inmates to prepare them for life after incarceration. Mason County Jail also offers inmates access to peer recovery coaches who meet one-on-one with detainees who have a history of substance use to provide them with

additional support and resources that may prove beneficial to their recovery. During their stay many inmates undergo detox because of drug withdrawal. According to the jail administrator, Mason County has seen a noticeable decline in the number of repeat offenders cycling through the jail since the program began. Mason County Jail has two staff members certified as CIT trainers; an additional training was planned for 2020 but it was postponed due to COVID-19.

In addition to improvements to jail resources, Mason County's regional partnership also plans to fund CIT training for all officers and expand telehealth services using the funds from their Department of Justice grant. The delay in the release of grant funds has put many of these plans on hold. The Mason County sheriff also has established a successful working relationship with a state senator who has expressed support for reforming law enforcement response to mental health. Through this connection it may be possible for Mason County's regional partnership to obtain additional state funding to support its continued growth.

Summary

Mason County's regional crisis response collaboration has taken several steps to improve the ability of law enforcement officers to respond to people who are in crisis and divert those with behavioral health issues from jail. As the sheriff puts it, "being a small community there are a lot of personal

connections. A lot of times officers will know the families of the people they're responding to and these officers take the issue seriously." Within the next 5-10 years the sheriff and others would like to see the establishment of more regional treatment centers for those struggling with substance use and mental health. The jail administrator stated that "helping individuals with mental illness will take a lot of stress off officers."

Overall, Mason County has established a multi-disciplinary collaboration that has a great deal of potential to reform the way in which local law enforcement is able to respond to those in crisis. Nevertheless, there is a need for additional infrastructure in the region to remedy the lack of local in-patient treatment facilities.

INNOVATIVE PROGRAMS

GROTON, CONNECTICUT

Background

The Town of Groton, located in New London County, Connecticut, is a relatively small town comprised of 45.29 mi², and home to approximately 38,692 people. Groton's population is 77% white, 7% Black, and 14% Hispanic. Groton has a median household income of approximately \$66,657 and an unemployment rate of 10%.³⁴

Groton is served by the Town of Groton Police Department (GPD). As of mid-2021, the GPD had 70 sworn and 20 civilian employees, and an annual budget of approximately \$9.9 million.³⁵ Out of the roughly 28,136 calls for service GPD receives per year, about 120 involve individuals in crises and result in emergency committals. Quantitative data were not available, but the chief estimates that the agency typically receives several crisis calls each day that require officers to transport individuals to a local emergency room: "I'd say on average it happens probably at least once a day, and it seems more so now

than ever before."

Why This Site?

The GPD was chosen as a case study site due to its reported commitment to providing officers with CIT training and its use of the ProQA Dispatch Software that assists dispatchers give officers greater situational awareness when they respond to crisis calls.

Crisis Training for Officers

Thirty-two of the 42 GPD patrol officers have received 40 hours of CIT training provided through the Connecticut Alliance to Benefit Law Enforcement (CABLE). CABLE is a nonprofit research and education collaborative composed of active and retired law enforcement, mental health professionals, people with mental illness, and family members. CABLE is supported by funding from the Connecticut Department of Mental Health and Addiction Services.

Procedures for Responding to Crisis Calls

Dispatch. Dispatchers go through the same 40-hour CIT training as patrol officers. There are currently no annual updates to this

³⁴ U.S. Census Bureau, <https://www.census.gov/quickfacts/fact/table/grotontownnewlondoncountyconnecticut/IPE120219>

³⁵ Information provided by the Police Chief.

training. Dispatchers utilize ProQA Dispatch Software, which assists dispatchers in providing relevant post-dispatch and pre-arrival instructions, as well as important case completion information.³⁶ When the dispatcher is assisting in a call, the ProQA prompts the dispatcher to ask important case-specific questions. For example, if the case concerns a suicide attempt, ProQA prompts dispatchers to ask the caller questions such as “Have you ingested anything?” or “Do you have a firearm or a weapon?” The dispatcher then relates this information to the responding officer. GPD dispatchers reported being satisfied with the ProQA software, finding it easy to use as well.

Policies. In 2019, the GPD issued a general order outlining their policy and procedures for handling individuals in crisis and those experiencing homelessness. The GPD’s policy states that, “Mental illness or homelessness is not a crime and does not, in itself, justify or require police intervention....When persons appear to be mentally ill, however, the department’s primary concern shall be to protect the mentally ill person and other citizens.” The policy reiterates Connecticut’s General Statutes Section 17a-503, which states that officers are allowed “to take into protective custody individuals who require treatment if the officer has reasonable cause to believe that a person is mentally ill, and, who as a result of that mental illness, is a danger to himself or herself or others or gravely disabled, and in need of immediate

care and treatment.”

According to the GPD’s protocol, officers are not expected to make judgments of mental or emotional disturbances, but rather to recognize potentially dangerous or destructive behaviors to self or others. The protocols provide officers guidance on how to recognize potential mental health issues in an individual and the types of behaviors that may signal danger. If an officer has any doubt as to whether the individual is a “person requiring treatment,” the officer is expected to request

“Mental illness or homelessness is not a crime and does not, in itself, justify or require police intervention...When persons appear to be mentally ill, however, the department’s primary concern shall be to protect the mentally ill person and other citizens.”

a supervisor be dispatched to the scene to help determine whether the individual requires treatment. The officers provide a written request for emergency examination,

³⁶ Priority Dispatch Corp website: https://prioritydispatch.net/discover_proqa/

which includes an explanation of why the individual was taken into custody. The policy states that individuals should not be locked up or be registered on an arrest ticket. The GPD also provides officers with a list of available local community mental health resources.

Procedures. Officers are trained to first assess for safety concerns and engage with the person in crisis through de-escalation tactics. Officers are expected to approach the situation with calmness, avoid topics that may agitate the individual, and avoid deceiving them. If deemed necessary, Connecticut's involuntary commitment law gives police officers the authority to take into custody any individual the officer believes meets the criteria for commitment (i.e., individuals with psychiatric disabilities who are dangerous to themselves or others or are gravely disabled). GPD officers may take the individual to the local emergency room for examination, typically accompanied by an EMT. The individual must then be examined within 24 hours and released within 72 hours unless detained and committed on an emergency basis.

Due to the growing need for a reliable mental health co-response, the police chief proposed hiring a full-time in-house social worker in the GPD's 2021 municipal budget. If hired, the social worker will provide follow-up services and make referrals as well as assist in responding to crisis calls when appropriate.

Engaging Community Resources

The GPD often contacts a Mobile Outreach team through their regional partnership ran by Connecticut's Department of Mental Health. The Mobile Outreach team is located in Norwich (approximately 20 miles from Groton) and conducts on-site assessments as well as follow up services to ensure the individual receives the mental health needed. The team is available during the day and sometimes during the weekend. The Mobile Outreach team is a state agency that serves about 13 other communities, and its capacity is very limited.

According to the Groton police chief, the GPD is invested in community efforts to address mental health, substance use, and homelessness. Since 2015, the GPD has been involved with grassroots organizations in Groton that target opioid and other addictions, where the guiding philosophy is not to arrest individuals struggling with these issues but rather looking for solutions that may have long-term effects. Consistent with their "a community spreads out" philosophy, the GPD works with local groups to refer individuals with substance use disorders when appropriate.

Summary

The GPD has taken several steps toward equipping its officers for responding to

individuals in crisis. The majority of GPD officers have received 40 hours of CIT training, and dispatchers rely on the ProQA Software to guide them in obtaining useful information to relate to responding officers. In the future, the GPD plans to hire a full-time, in-house social worker. The police chief also is discussing the possibility of having a Mobile Outreach counselor affiliated with GPD for a certain amount of time each week, thus allowing for more consistent accessibility. It is uncertain, however, whether the Mobile Outreach team's small number of counselors will allow for this option. Despite limited access to regional resources, the GPD appears to be making progress toward the continued development of effective ways for officers to respond to those with behavioral and mental health issues.

INNOVATIVE PROGRAMS

NORTH READING, MASSACHUSETTS

Background

The Town of North Reading, Massachusetts, is a small town (13.51 mi²) located 30 miles north of Boston. It is home to approximately 15,865 residents, of which 91% identified as white, 5% Asian, and 2% Hispanic.³⁷ North Reading is a relatively affluent area; the per capita income is \$56,981, and 3% of its population are experiencing homelessness.³⁸

North Reading is served by the North Reading Police Department (NRPD). As of mid-2021, NRPD had 31 sworn officers and three civilian employees.³⁹ The NRPD receives an estimated 20 calls for service per month related to mental health or substance abuse. In response, the NRPD has made notable efforts to properly equip the staff to handle such calls.

³⁷ U.S. Census Bureau: <https://www.census.gov/quickfacts/fact/table/northreadingtownmiddlesexcounty/massachusetts/RHI225219#RHI225219>

³⁸ U.S. Census Bureau <https://www.census.gov/quickfacts/fact/table/northreadingtownmiddlesexcounty/massachusetts/INC910219#INC910219>

³⁹ Information provided by the Police Chief.

Why This Site?

The NRPD was chosen as a case study site primarily because the department has a full-time mental health clinician who is funded through the municipal budget. The clinician conducts follow-up with people after their encounter with police to assess social service needs and make referrals.

Crisis Training for Officers

The NRPD provides all officers with 40 hours of CIT training, funded by the Massachusetts Department of Public Health. According to NRPD's chief, officers and dispatchers are expected to respond to crisis calls following CIT standards and procedures.

Procedures for Responding to Crisis Calls

Dispatch. When a call for services comes in, typically dispatchers try to get as much information as possible about the situation from the person who called, dispatch officers to the scene, and notify the Fire Department's dispatch to have them on standby. Dispatchers maintain constant communication with the caller and provide the responding officer with relevant updates as they approach the scene. The police chief noted that because of their dispatch protocol and the level of information shared between dispatchers and officers, NRPD officers are able to arrive at the scene

with a good amount of situational awareness.

Policies. NRPD has detailed, written policies for responding to mental health related calls. The policies guide officers on how to recognize when individuals may be suffering from a mental illness, assess potential risk factors for violence, determine officer safety, attempt to establish a dialogue with the individual, apply effective listening skills, and interact with the individual in crisis. The protocol provides step-by-step guidelines on how to take an individual in crisis into custody or an involuntary commitment.

Procedures. Upon arrival, officers first assess the scene for safety concerns. The officer then talks to the caller to confirm the dispatchers information and get updates before approaching the person in crisis. Most individuals are released at the scene or are released to caretakers. In cases in which an individual voluntarily requests a mental health evaluation, the officer notifies dispatch to make arrangements for the individual to be transported to the appropriate hospital for evaluation. Less frequently, officers may pursue an involuntary mental health commitment. According to NRPD policy, if an officer has reason to believe that, under the circumstances, failure to hospitalize a person would create a likelihood of serious harm, the officer may restrain the person and apply for their hospitalization for up to three days at a public or private facility authorized by the Massachusetts Department of Mental Health. The officer stands by the individual until he or she is transported by the fire department or by

private ambulance. Very rarely are individuals taken to jail.

The NRPD relies primarily on its officers to respond appropriately based on their CIT and de-escalation trainings. On the few occasions when the NRPD requires further help during a call, they can contact Eliot Community Human Services, which operates a crisis team that is available 24 hour a day, seven days a week. The crisis team can conduct in-person mental health assessments to determine if the person in crisis needs involuntarily commitment. The Elliot team's response time to the scene depends on their availability; they can arrive at the scene immediately (after approximately 20 minutes of travel time) or it can take a couple of hours. Officers remain on the scene until the crisis team arrives; EMS also stands by with the individual in crisis during the wait.

In 2018, NRPD hired a full-time, in-house mental health clinician. According to the police chief, his interest in hiring an in-house mental health clinician began in 2017, when he noticed that the same individuals were in contact with police over and over again:

We didn't have the proper training, and we probably didn't have the same empathy that mental health clinicians have when talking to people in crisis a lot of the things that police officers are taught may not be for situations involving mental health. I just felt having a professional here that could help the public but also help our officers understand and work through dealing with people in crisis would be the most

beneficial thing that I could do.

The chief's initiative received immediate support from North Reading's Town Administrator and the position was created with funding from the town's budget.

The clinician contacts people after their encounter with police, rather than responding to crisis calls with the officer. The police chief explained that one of the biggest advantages of an in-house mental health clinician is this follow up; even if people refuse clinical services, just having a clinician talk to them has been effective in preventing future crisis calls. He noted a decline in the amount of same-person repeated calls, which he attributed to the clinician's involvement. Prior to the COVID-19 pandemic, the clinician would follow up at a person's home but, currently, most of her work is conducted over the phone. The clinician updates case outcomes in the department's CAD system and keeps HIPPA-protected information confidential. The NRPD's CAD system is not integrated with behavioral health, hospital, or court data systems.

Engaging Community Resources

The NRPD participates in a stakeholder collaboration team. The North Reading Community Impact Team is a partnership between the NRPD, Youth Services, Elder Services, School Department, Parks & Recreation, Fire Department, Board of Health,

the Director of the Drug Free Communities grant, and the Board of Selectmen. The Impact Team works to identify factors that negatively affect the quality of life of all community members and implement solutions that solve the underlying problems. The Team focuses on informing the North Reading community about mental health and drug use issues, conducts prevention work in those areas, and organizes community events, such as the National Night Out, to promote engagement and partnerships among community leaders, stakeholders, and members.

Summary

NRPD has made proactive efforts to address persons in crisis in their community. CIT training, an in-house clinician, and preventative community efforts that promote

education and engagement have been implemented over the last recent years. NRPD's police chief believes their crisis intervention efforts have been successful, noting the reduced number of same-person repeat calls, an improved department-wide understanding of mental health, as well as more structured and efficient procedures in place for responding to crisis calls.

One of the limitations the NRPD has grappled with is its inability to engage in a regional partnership, which limits the number of resources they have available. The clinician noted that because North Reading does not fall in the catchment area of the closest regional partnership, they are unable to take part in some of the discussions and the sharing of expertise from clinicians in the regional programs. Transportation was also mentioned as a limitation in North Reading: Some individuals without cars have difficulty gaining access to treatment.

“We didn’t have the proper training, and we probably didn’t have the same empathy that mental health clinicians have when talking to people in crisis a lot of the things that police officers are taught may not be for situations involving mental health.”

INNOVATIVE PROGRAMS

DAVIDSON, NORTH CAROLINA

Background

Davidson, North Carolina, is a small township (5.75 mi²) about 20 miles north of Charlotte, North Carolina. Davidson is home to approximately 13,054 residents, a majority of whom are white (91%); 6% identify as Black, and 6% as Hispanic. Davidson is also home to Davidson College, a small liberal arts college with roughly 2,000 students. The median household income sits at \$128,651, with a per capita income of \$56,981 and a poverty level of 3.2%.⁴⁰

The Town of Davidson has experienced significant growth over the past several years, and the department is growing to meet those needs. The Davidson Police Department (DPD) employs 25 sworn officers.

DPD's ability to estimate the number of calls involving persons in crisis is limited. Most of these calls are categorized in the CAD system under a general "check the welfare" code, making it impossible to obtain a separate count of calls for service that ultimately

involve a behavioral health component. DPD does, however, have data on the number of calls their officers respond to concerning threatened, attempted, and completed suicides. From 2018-2020, DPD responded to 89 calls for service related to suicide, 42 of which involved individuals ages 10-20. Every year there are spikes at the start of the school year (July-September).

Why This Site?

DPD was selected as a case study due to its access to Charlotte-Mecklenburg County's regional behavioral health response program and the integration of its CAD system with both behavioral health and court data systems.

Crisis Training for Officers

Of the total 25 officers, 21 have received 40 hours of CIT training and all officers have received 8 hours of Mental Health First Aid (MFHA). The push to have all officers CIT-trained began in 2017. The greatest obstacle DPD faced in getting all officers trained was the difficulty ensuring shift coverage during the training period and the lack of available training in the past year because of the COVID-19 pandemic.

⁴⁰ U.S. Census Bureau, <https://www.census.gov/quickfacts/davidsontownnorthcarolina>

Procedures for Responding to Crisis Calls

Dispatch. DPD officers are dispatched through a regional call center shared with the Charlotte-Mecklenburg Police Department and other nearby jurisdictions. Calls for service are initially received by CIT-certified 911 call takers who gather as much information as possible on the person in crisis. The call takers then relay that information to 911 dispatchers who contact DPD officers and EMTs, when necessary, to respond to the scene. These behavioral health calls are typically assigned one of three codes in the CAD system: “check the welfare,” “suicide threat,” or “suicide attempt.”

Policies. DPD has an extensive written policy outlining the approach officers should take when responding to someone with a potential mental illness or developmental disability. Their written policy includes key elements from the IACP’s model policy on this topic and builds upon it to include guidance for responding to individuals with autism. DPD policy requires that a CIT-trained officer respond to these calls for service when one is available. Given most officers in the department are CIT trained, typically one is available.

Procedures. Upon arriving at the scene officers attempt to de-escalate the situation. In cases where the person in crisis appears to be suicidal or appears to exhibit a degree of distress beyond the level that the officer

is equipped to handle, officers have the option of contacting the Mecklenburg County Mobile Crisis Response Team (MCMCRT) for a licensed mental health counselor or EMS to request transport to the local hospital. In all other cases, the alternative is jail detention.

The MCMCRT is funded through the state of North Carolina and provides licensed mental health counselors, available 24 hours a day, seven days a week to take crisis calls throughout Mecklenburg County. Prior to 2015, the MCMCRT funding was limited, which made it difficult to maintain sufficient staffing; waiting time could be as long as two or three hours. According to the Police Chief, this caused officers to hesitate about contacting the MCMCRT. After 2015, the state increased funding, and the MCMCRT increased the availability of their services. The additional funding, however, was short lived. In 2019, the state reduced funding for mental health, the number of licensed mental health counselors went down, and, according to the Police Chief, officers rarely call upon the MCMCRT now because of the significant delay in response time.

Engaging Community Resources

In response to a high number of calls related to suicide, the police chief recently helped develop a multidisciplinary mental health committee whose members will attempt to fill gaps in service for those in need of

mental health care services. The committee is composed of community residents, school practitioners, law enforcement personnel, and members of mental health and suicide advocacy groups in and around Davidson. The committee is exploring the possibility of using volunteer clinicians to respond to crisis calls alongside the officer when it is possible and safe to do so.

One of the primary members of the committee is Davidson Lifeline, an advocacy group that was formed in response to a growing number of teen suicides. Davidson Lifeline actively provides QPR (question, persuade, refer) training to staff of Davidson's local middle and high school. The QPR training is a nationally recognized, evidence-based program designed to "teach lay and professional 'gatekeepers' the warning signs of a suicide crisis and how to respond."⁴¹ Ultimately, these prevention efforts in schools may reduce the need for police service. Davidson is also developing a Local Outreach for Survivors of Suicide (LOSS) Program for community members who have been affected by suicide. Members of the police department provide information on how to engage the LOSS program.

Summary

The Police Chief is currently working with the three neighboring municipalities in Mecklenburg County to form a collaborative

mental health unit comprised of clinicians and law enforcement officers. According to the Chief, two of the neighboring police chiefs have also expressed interest in providing a specialized response to persons in crisis. Together the three municipalities would allocate a portion of their budgets to employ mental health counselors and dedicated sworn personnel to respond to crisis calls across the three municipalities. The Police Chief currently plans to allocate department funds to kickstart this program for the 2022-2023 fiscal year.

DPD has taken substantial steps to develop its crisis response model and is currently in the process of engaging in several collaborative partnerships with community organizations and other small law enforcement agencies in the area to further improve their response to persons in crisis. Despite challenges arising from budgetary constraints and limited access to regional resources, the Chief and community members appear to be making substantial progress toward the continued improvement in the response of law enforcement to those with behavioral health issues.

⁴¹ The Suicide Prevention Resource Center, <https://www.sprc.org/resources-programs/qpr-gatekeeper-training-suicide-prevention>. Accessed Sept. 2021.

AGENCIES FACING CHALLENGES

ELKO CITY, NEVADA

threats, 5 calls coded as suicide attempts, and 884 calls categorized as “check the welfare” (general welfare checks also include calls that do not involve behavioral health issues).

Background

Elko City (17.64 mi²) sits in the northeastern portion of Nevada, four hours east of Reno and three hours west of Salt Lake City, Utah. Elko City has a population of roughly 24,000, of which 87% identify as white, 3% Native American, 2% Asian, and 27% Hispanic. The median household income sits at \$79,205 with a per capita income of \$35,270 and a poverty level of 14%.⁴² Elko City is also one of several jurisdictions in Nevada where licensed brothel prostitution and land-based commercial casinos are both legal and prevalent.

The Elko Police Department (EPD) serves as Elko City’s primary law enforcement agency. The city is also home to the Elko County Sheriff’s Office, which operates the local jail.⁴³ As of mid-2021, EPD is staffed by 43 sworn officers.⁴⁴ In 2020, EPD responded to 244 calls coded as drug and alcohol related, 40 calls coded as overdoses, 113 calls categorized as psychiatric, 136 calls coded as suicidal

Why This Site?

The EPD was selected for two reasons. First, due to the unique characteristics surrounding their jurisdiction, including housing a sizable mining migrant community and the proliferation of alcohol and substance use in the area, the EPD is faced with some unique challenges when responding to crisis calls. Second, EPD was chosen due to the challenges they have faced with kickstarting a regional crisis response program. The Elko police chief and a sergeant have worked to improve the state of law enforcement crisis response in their area for several years, following an officer-involved shooting of a veteran believed to have had behavioral health issues. Limited access to resources has prevented the implementation of a formal crisis intervention team.

Crisis Training for Officers

⁴² U.S. Census Bureau, <https://www.census.gov/quickfacts/fact/table/elkocitynevada/EDU635219>. The Census counts Latinos as individuals of any race who self-identify as Hispanic.

⁴³ U.S. Census Bureau, <https://www.census.gov/quickfacts/elkocountynevada>

⁴⁴ Information provided by the Police Chief.

Ten of the Elko Police Department's 43 sworn staff received CIT training in 2019 through a local training facilitated by coordinators from the regional CIT training center based in the Reno-Carson City area, which is nearly 5 hours southwest of Elko City. The distance greatly limits the ability of EPD to access the training center's regional resources.

Procedures for Responding to Crisis Calls

Dispatch. EPD shares a regional dispatch center with the Elko County Sheriff's Office. The dispatch center is staffed by 14 dispatchers, two of whom have received CIT training made possible with funds from the dispatch authority's budget for the purpose of post-call debriefing. Dispatchers, who double as call-takers, utilize telephone software that automatically prompts the dispatcher to ask questions related to the nature of the call, specifically those involving suicidal threats. The software, which was purchased by the city, requires that dispatchers complete a refresher training course every two years. Beyond the training to use the software, there are few opportunities for continued crisis response training. Nevertheless, the dispatch center does have dedicated codes for calls related to behavioral health issues, which greatly assists with their data tracking capabilities.

Upon receiving a call for service related to a behavioral health crisis, the Elko Central

Dispatch Authority does its best to obtain as much information as possible about the person who is in crisis. The center then dispatches two officers to the scene and relays all necessary information. If the CAD system detects numerous calls to the same address or phone number from past records, this information will also be relayed to officers. Officers then have the ability to view previous call records on their mobile terminals to receive additional background on the nature of past law enforcement contacts with the individual in crisis.

Procedures. Officers are trained to use verbal de-escalation tactics and do their best to assess the situation at the scene. In the absence of any serious offense, officers encourage people who are in crisis to accept transport to the local hospital for evaluation. If the person accepts transport and displays no indications of violent behavior, EMS handles the transport. Once at the hospital, the person is evaluated by a hospital counselor and, unless the individual expresses suicidal thoughts, the hospital will discharge the individual back into the community. If individuals require inpatient services, the nearest facility is in Reno.

In the early 2000s, the local hospital staffed a dedicated behavioral health unit, but after the hospital was privatized, the behavioral health unit was shut down. According to a sergeant, it is not uncommon for officers to re-encounter the same individuals still struggling with the same issues. Many officers have expressed the feeling that "they're not getting

anywhere,” as calls for service involving the same persons-in-crisis have become a repetitive cycle.

EPD uses the Overdose Detection Mapping Application (ODMAP) system, which tracks overdose incidents on a shared data platform across police agencies and across the country. First responders can log an overdose into the centralized database in real time and share the information with others. As explained by ODMAP: “As the overdose death toll across the country continues to rise, the ODMAP tool gives law enforcement agencies powerful and unprecedented real-time information about overdose occurrences and trends that allow them to shape a more effective opioid response.”⁴⁵

“A major challenge faced by EPD in attempting to establish a regional crisis response program has been the lack of local community resources and buy-in from nearby law enforcement agencies.”

Engaging Community Resources

A major challenge faced by EPD in attempting to establish a regional crisis response program has been the lack of local community resources and buy-in from nearby law enforcement agencies. According to the EPD staff we interviewed, there are approximately 12 certified mental health counselors in the region; only one specializes in juvenile populations. Elko does have access to a Certified Community Behavioral Health Clinic through Vitality Unlimited. However, the facility focuses on outpatient services and is often inundated with privately insured individuals, which limits the facility’s availability for those without private insurance.

According to the EPD’s chief, Elko County suffers from limited tax revenue to fund expanded behavioral health programs. Most of the local mines are physically located in Eureka County, but many of the migrant workers live in Elko for the duration of their employment. This means that Eureka County benefits from the mine’s tax revenue, but Elko is left responsible for providing services to the migrant population.

⁴⁵ “ODMAP: A Digital Tool to Track and Analyze Overdoses, Notes from the Field,” U.S. Department of Justice, National Institute of Justice. Accessed Sept. 2021. <https://nij.ojp.gov/topics/articles/odmap-digital-tool-track-and-analyze-overdoses>

Summary

The lack of mental health resources and regional collaboration, long distances to facilities, and a large transient population pose significant challenges to developing new strategies and programs. Elko's Central Dispatch Authority possesses a CAD system capable of tracking calls for service related to behavioral health issues through the use of dedicated call codes. Elko PD may be able to leverage this data to pursue federal or state funding, since there are a number of grants available to law enforcement agencies seeking to enhance their crisis response capabilities.

AGENCIES FACING CHALLENGES

BRUSH, COLORADO

Background

The Town of Brush, Colorado, is small (2.47 mi²) with a population of 5,463.⁴⁶ The population increases by approximately 300-500 during the summer as migrant agricultural workers arrive. The population is primarily white (93%); 25% of residents identify as Hispanic. The median household income is \$43,824 with a per capita income of \$23,293 and a high poverty level of 19%.⁴⁷

The Brush Police Department is budgeted for 13 officers; at the time of the case study interviews, 11 were on the force. The Chief estimates his officers respond to an average of four to six calls relating to behavioral health every month during the winter and an average of 20 calls per month in the summer. Before COVID-19, calls usually related to substance use. After COVID-19, more calls relate to mental health crises; youth suicide attempts began "skyrocketing." In spring 2020, the department received almost one call a day relating to a youth suicide attempt.

⁴⁶ U.S. Census Bureau, <https://www.census.gov/quickfacts/fact/table/brushcitycolorado/AGE775219>

⁴⁷ U.S. Census Bureau, <https://www.census.gov/quickfacts/fact/table/brushcitycolorado,US/PST045219>

Why This Site?

The Brush Police Department was chosen for case study to illustrate the challenges small agencies face in responding to people in behavioral health crisis in communities with few mental health resources. Further, the goal was to document ways to connect officers remotely with mental health specialists.

Crisis Training for Officers

All officers have completed 40-hour CIT training, a process that occurred over several years. CIT training is offered at Colorado's Police Officer Standards and Training (POST), which has 10 regional training groups. The Brush Police Department funded the CIT training through a grant from the state POST. The overtime costs for backfilling officers who were in training was paid from the agency's budget. Regarding the agency's budget allocation, the chief noted: "They just needed to carve it out. It was a matter of priorities." His goal is to have his officers trained as instructors. In addition to CIT training, all officers receive 16 hours from the Colorado POST and four hours of training through an online PoliceOne Academy course.

Procedures for Responding to Crisis Calls

All calls are dispatched through Morgan County's Communications Center. Responding

officers determine as best they can whether the situation involves mental health crisis, drug overdose, domestic violence, or other contributing factors. There are currently no readily available mental health crisis resources to assist them on scene, which is partly why the Chief prioritized the CIT training for all officers. People who meet the criteria for emergency custody are transported, ideally by ambulance, to the nearby hospital where staff from the Centennial Mental Health Center are called to conduct an assessment. Banner Health Hospital has a "safe room" where people can stay as they wait for a mental health evaluation. An officer stays with individuals who may be acting aggressively. The Chief and the CEO of East Morgan County Hospital (a Banner Health Hospital), indicated their relationship is strong.

Centennial Mental Health Center (CMHC) is the regional provider of crisis mental health services for a 10-county area in Colorado, which includes Brush. CMHC has had some form of mobile crisis response coordination with law enforcement since 1979. This response has necessarily evolved over time as the community's needs and the funding have fluctuated. Currently, mobile mental health crisis staff are called in by law enforcement or emergency department staff to assess whether the person meets criteria for an "M1," which is for a 72-hour hold. Most often, these staff meet the individual who is in crisis at the emergency department for assessment. If the individual meets the criteria, CMHC staff find a bed and arranges for transportation to

the hospital. Typically, transportation is done by CMHC.

A mental health crisis team can respond on site, but it is a limited response that can take a long time to arrive. In 2018, CMHC began connecting to law enforcement through the use of iPads to streamline their ability to connect people to needed resources, including hospitalization. The iPads were funded through the regional crisis contract that was in place at that time. The police chief said that having a crisis specialist available by teleconference to conduct an assessment of dangerousness alongside the officers at the scene also helped to reduce the number of people police brought to the emergency department. The iPads were especially important during the height of the COVID-19 pandemic when in-person co-responders were unavailable.

Engaging Community Resources

The Police Chief has participated in periodic regional discussions to find ways to pair a mental health professional with a police officer to enhance the response to crisis calls. These discussions have occurred at the bi-monthly regional Chief's and Sheriff's Association meeting. There have been discussions with CMHC about how to use grant funds for a co-responder model, but funds are not currently available. The Chief noted that competition for limited funds is a

challenge. He also noted a collaboration with the local high school to better understand and address suicide attempts among high school students.

Summary

The Brush Police Department has confronted difficult situations involving behavioral health crises, including seasonal increases in related calls due to a migrant labor force and a spike in suicide attempts. Their response to these challenges has been to collaborate with CMHC and school leadership. Given the paucity of on scene behavioral health responses, the chief prioritized funds to ensure all officers have CIT training. The key to achieving this was to spread out the training over the course of several years, and to obtain grant funds. Although there has been a lapse in the use of iPads to support the police response to people in crisis, there is a plan to reinstate their use and reestablish communication between the partners.

CONCLUSION

Most agencies did not accept our invitation to take the national survey: We achieved a 29% response rate for the first sample and a 10% response rate for the second sample, which included only 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 national reckoning with race and policing. Indeed, had we not taken the exceptional step of mailing paper copies of the survey, the response rate would have been far lower.

“Interviews with representatives from the case study agencies identified several key aspects associated with successfully responding to individuals in mental health crisis: creativity in finding funding, effective communication among stakeholders, and strong leadership.”

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. In other words, the survey results likely overestimate the proportion of small and rural agencies that have adopted alternative ways of dealing with calls involving persons in crisis.

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 numbers of 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 murder of George Floyd gives hope that progress will continue to be made, even if programs developed are not perfect.

Interviews with representatives from the case study agencies identified several key aspects associated with successfully responding to individuals in mental health crisis: creativity

in finding funding, effective communication among stakeholders, and strong leadership.

Creativity in Finding Funding

Funds are needed for a great many elements of an improved crisis response: training for officers and dispatch staff; advanced technology, such as CAD systems and iPads; and the services of mental health specialists and facilities. Finding the funds takes initiative, hard work, and an open mind that can see opportunities in unlikely places.

Many states are now providing CIT training in a consistent way through their regional training centers and POSTS or through training that is paid for by the state's department of public health.

Funding for mental health resources to follow up and offer counseling may sometimes be provided by municipalities or regional collaborations, such as those in Winthrop and North Reading. For most small and rural agencies, however, local funding for crisis response efforts so far has been a difficult sell. Federal government funding through the Bureau of Justice Assistance's Justice and Mental Health Collaboration Program can be a source of funds, but applying for federal funds requires staff who are sophisticated in grant writing.

Communication Among Stakeholders

Both the national written survey and the case study interviews revealed that many small and rural agencies create regional collaborative groups to effectuate change. These groups may consist of representatives from the municipal police, county sheriff, community mental health organizations, municipal administrators, and others. The collaborations help promote new thinking about responding to crisis calls, how to share resources, and how to apply for grant funds. Small agencies also can collaborate with local chief and sheriff's associations to develop program ideas and seek funding. The personal relationships that characterize small and rural communities can facilitate formation and effectiveness of these groups. In several sites, personal relationships between individual stakeholders and among stakeholders and city or county leaders fostered an agency's ability to develop a program and find funding. When the chief in Winthrop wanted to get a program going, he was able to simply walk into his city councilmember's office to make his case. When the chief in Davidson wanted to start a dedicated unit to respond to crisis calls, she contacted chiefs she already knew from nearby small towns to see if they would join the effort.

Strong Leadership

Successful sites often have a strong advocate for change, a person who can pursue a variety of state and federal funding opportunities and build local coalitions. Every site in the case studies had at least one person who was the driving force behind their crisis response efforts. Agencies reported that it was particularly useful to have both the chief and other members of the executive staff contributing to the effort.

Significant change came about when someone in the agency took the initiative to motivate local partners to apply for federal grants to create programs like in-house social worker positions and jail diversion programs.

APPENDIX A

PERSONS INTERVIEWED AT EACH SITE

Bath (Maine) Police Department

Chief Michael Field

Hannah Longley, NAMI Maine Director of Community Programs

Brush (Colorado) Police Department

Chief Derek Bos

Linda Thorpe, CEO, East Morgan County Hospital (a Banner Health Hospital)

Dr. Elizabeth Hickman, Executive Director, Centennial Mental Health Center

Cindy Audia, LPC, Director of Crisis Services, Centennial Mental Health Center

Davidson (North Carolina) Police Department

Chief Penny Dunn

Corporals Joe Calandra and Meghan O'Brien

John Brunelle, Clinician

Jaletta Desmond, Community Member

Melissa Marino-Sharp, Dispatcher

Lakeshia Ginn, Mobile Crisis Unit Lead

Amy Rudisill, Cardinal Innovations Team Member

Elko (Nevado) Police Department

Chief Tyler Trouten

Sergeant Jeremy Shelley

Director of the Elko Central Dispatch Authority

Groton (Massachusetts) Police Department

Chief Louis Fusaro

Captain James Bee

Mason County (Michigan) Sheriff's Office

Mason County Sheriff Kim Cole

Josh Snyder, Chief Clinical Officer

Kenny VanSickle, Jail Administrator

Mason-Oceana 911 Center Administrator

Chief Laude Hartrum, Pentwater Police Department

North Reading (Massachusetts) PD

Chief Michael Murphy

Mrs. Laura Miranda, mental health clinician

Winthrop (Massachusetts) PD

Chief Terence Delehanty

Lieutenant Sarko Gergerian

Jane Rupp, LMHC

Chip McHugh, Peer Recovery Coach

Meredith Hurley, Public Health & Clinical Services Director

Sarah White, Public Safety Analyst