Research Update: CIT & Other Models of Crisis Response

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Melissa Reuland, M.A.
Amy Watson, Ph.D.
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Acknowledgements: Serving Safely Research & Evaluation Committee

- We prepared a *Literature Review* with input from members of the Research & Evaluation Committee of Serving Safely. As part of its charge, we then developed a *Research Agenda* for BJA and other federal agencies that considers the current research base, identifies gaps in knowledge, and lays out scalable research and evaluation options.

- In order to complete this goal, the Research & Evaluation Committee first identified existing models of partnership between police/law enforcement and mental health and developmental disability service providers to include in a comprehensive review of the literature. We then drafted the literature review. The Committee members reviewed the draft and provided written feedback through virtual convenings. All feedback was then integrated into the final report.
The Context

Police contact with persons with mental illnesses and intellectual/developmental disabilities
Police contact with persons with serious mental illnesses: The extent of involvement

• 6-10% of all police contacts with the public involve persons with serious mental illnesses (Livingston, 2016)

• 29% of persons with serious mental illnesses in the U.S. had police involved in a pathway to care (Livingston, 2016)

• At least 1 in 4 individuals fatally shot by police had a serious mental illness (Fuller et al., 2015; Lowrey et al., 2015)

• Over 1 million arrests of persons with mental illnesses per year in the U.S.
Police contact with individuals with I/DD

- Research is very limited, and varies in terms of focus on ID/DD/Autism, and much is from outside of the U.S.

- Research from Australia (Fogdan et al. 2016) suggests similar rates of overall offending compared to community samples, but higher rates of violent and sexual offense perpetration and victimization (ID)
  - Co-occurring mental illness doubled the risk of perpetration and victimization

- Research on adults with autism found that during a 12-18 month period, 16% of the sample had a police contact. The most common reason was aggressive behavior (Tint et al. 2017)

- In the U.S., almost 20% of youth with autism report having police contact by age 21, almost 5% had been arrested (Rava et al. 2017)
Police contact with individuals with I/DD

- Estimates on how often police come into contact with persons with IDD vary:
  - On average, officers in Victoria (Australia) came into contact with 3 individuals with I/DD per week, most considered vulnerable or at risk (Henshaw & Thomas 2016).
  - Survey of Florida officers found that only half believed they had any contact in past 12 months (Gardner et al. 2018).

- Surveys of officers find that while they are confident in identifying individuals with I/DD, many lack basic knowledge of characteristics of this population.
Police contact with individuals with I/DD

Surveys suggest mixed experiences with police among persons with I/DD

- Study of adults with autism (and parents) with police contacts (in the U.K.) found that a majority of adults (69%) and parents (74%) rated interactions with police as unsatisfactory (Crane et al. 2016)
- In a Canadian survey, parents indicated that police helped calm the situation and they were “somewhat satisfied” with the response (Tint et al. 2017)

Study of 138 behavioral crisis events among adults with ID (Rava et al. 2017, in Ontario, Canada)

- 1 in 10 resolved with arrest
- 55% transported to ED
- 33 resolved on scene

This research lags behind the research on persons with mental illnesses & police contact / criminal justice involvement
CIT AND RELATED MODELS & STRATEGIES
MODELS to improve (LE) response to mental health crisis

- CRISIS INTERVENTION TEAM
- MOBILE CRISIS TEAMS
- CO-RESPONDER TEAMS
- EMS/AMBULANCE-BASED RESPONSE
- FLAGGING SYSTEMS
- STAND-ALONE TRAINING PACKAGES
- CASE MANAGEMENT/ HIGH UTILIZER TEAMS (MH/LE)
- I/DD-SPECIFIC MODELS/ STRATEGIES
CRISIS INTERVENTION TEAMS: MODEL DESCRIPTION

Ongoing Elements

- Partnerships: Law Enforcement, Advocacy, Mental Health
- Community Ownership: Planning, Implementation & Networking
- Policies and Procedures

Operational Elements

- CIT: Officer, Dispatcher, Coordinator
- Curriculum: CIT Training
- Mental Health Receiving Facility: Emergency Services

Sustaining Elements

- Evaluation and Research
- In-Service Training
- Recognition and Honors
- Outreach: Developing CIT in Other Communities

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**Core Elements**

**The University of Memphis**

School of Urban Affairs and Public Policy

Department of Criminology and Criminal Justice

CIT Center

September, 2007

Randolph Dupont, PhD

University of Memphis

Major Sam Cochran, MS

Memphis Police Services

Sarah Pillsbury, MA

University of Memphis

**Contributors**

**Ohio**

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NAMI Board of Directors

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* Mr. Pillsbury is currently with the U.S. Department of Justice Federal Bureau of Investigation (FBI).
RESEARCH ON CIT
Aim 1: Scale development and testing
Aim 2: Cross-sectional study of ~500 (~250/~250) officers
Aim 3: Longitudinal data collection on encounters

Sample: 586 officers (251 CIT officers at a median of 22 months since CIT training, and 335 Non-CIT officers) in 6 urban and suburban police departments in Georgia

Study Design: cross-sectional survey, with many instruments linked to two in-depth vignettes
The Six Police Departments Studied in Georgia
The Police-Based Crisis Intervention Team (CIT) Model: I. Effects on Officers’ Knowledge, Attitudes, and Skills

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Amy C. Watson, Ph.D.

Objective: Individuals with serious mental illnesses are very likely to interact with police officers. The crisis intervention team (CIT) model is being widely implemented by police departments across the United States to improve officers’ responses. However, little research exists on officer-level outcomes. The authors compared officers with or without CIT training on six key constructs related to the CIT model: knowledge about mental illnesses, attitudes about serious mental illnesses and treatments, self-efficacy for deescalating crisis situations and making referrals to mental health services, stigmatizing attitudes, deescalation skills, and referral decisions. Methods: The sample included 586 officers, 251 of whom had received the 40-hour CIT training (median of 22 months before the...
## CIT versus Non-CIT Group Differences in Scales Measuring the Six MOLEC Constructs

<table>
<thead>
<tr>
<th>Variable</th>
<th>251 CIT Officers</th>
<th>335 Non-CIT Officers</th>
<th>t</th>
<th>p</th>
<th>d</th>
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<tbody>
<tr>
<td>Knowledge about mental illnesses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Knowledge (% correct)</td>
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<td>335 54 15</td>
<td>4.32</td>
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<tr>
<td>Attitudes about mental illnesses and their treatments</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Opinions about Mental Illnesses</td>
<td>249 4.24 0.45</td>
<td>331 4.01 0.40</td>
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<td>.54</td>
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<td>332 2.96 1.49</td>
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<tr>
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<td>333 3.42 1.58</td>
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</table>
Knowledge about Mental Illnesses

• 33-item *Multiple-Choice Knowledge of Mental Illnesses Test* (MC-KOMIT)
• questions on schizophrenia/psychosis, depression, bipolar disorder/mania, personality disorders, posttraumatic stress disorder and other anxiety disorders, developmental disabilities, suicide, child/adolescent psychiatric disorders, alcohol and drug addiction, and Alzheimer’s disease/dementia
3a. Which of the following community services is especially important for people with dementia and their families?
A. Detoxification programs for those with alcohol abuse
B. Hygiene programs for those with grooming problems
C. Memory retrieval programs for those with memory loss
D. Re-orientation programs for those who are disoriented
E. Safe return programs for those who become lost

D5b. A man is evaluated by a psychiatrist, who tells him that psychotherapy is much more important for his problems than any medications. Which of the following disorders is he most likely being seen for?
A. Bipolar disorder
B. Dependent personality disorder
C. Dyslexia
D. Heroin withdrawal
E. Paranoid schizophrenia

3a. People who have had an episode of major depression are at most risk for which of the following?
A. Becoming addicted to anti-depressant medicines
B. Being diagnosed with migraines
C. Developing schizophrenia
D. Experiencing flashbacks about their depression
E. Having another episode of depression

E2a. Which of the following is a common symptom of obsessive-compulsive disorder?
A. Fear of social situations
B. Intrusive thoughts or impulses
C. Ongoing concern about having a panic attack
D. Overeating and weight gain
E. Thinking that others are watching or following

F3b. A woman brings her 16-year-old son to a psychologist for an evaluation of failing grades. In order for the psychologist to ensure that this young man does not have mental retardation, which of the following questions is he likely to ask?
A. Did any of his family members have learning problems?
B. Do his classmates make fun of him?
C. Does he also have unusual beliefs?
D. When did his learning difficulties first begin?
E. Which class does he currently like the least?

11b. A 35-year-old woman has been court-ordered to see a psychologist for problems stemming from her alcohol and cocaine use. Which of the following is the psychologist likely to be working to change?
A. Avoidance
B. Denial
C. Pessimism
D. Violence
E. Withdrawal
### CIT versus Non-CIT Group Differences in Scales Measuring the Six MOLEC Constructs

<table>
<thead>
<tr>
<th>Variable</th>
<th>251 CIT Officers</th>
<th>335 Non-CIT Officers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge about mental illnesses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge (% correct)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge (%)</td>
<td>N</td>
<td>M</td>
</tr>
<tr>
<td>Knowledge (%)</td>
<td>251</td>
<td>59</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Attitudes about mental illnesses and their treatments</th>
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<tbody>
<tr>
<td>Opinions about Mental Illnesses</td>
</tr>
<tr>
<td>AQ Personal responsibility-Psychosis</td>
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<tr>
<td>AQ Personal responsibility-Suicidality</td>
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<tr>
<td>AQ Help-Psychosis</td>
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<tr>
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<tr>
<td>AQ Coercion-segregation-Psychosis</td>
</tr>
<tr>
<td>AQ Coercion-segregation -Suicidality</td>
</tr>
</tbody>
</table>
Attitudes about Mental Illnesses

- Opinions about Mental Illnesses (OMI) scale from the 1960s
- Opinions about Psychiatric Treatment (OPT) scale that we developed
1. Psychiatric medicines are more commonly needed for people who are not very smart.

<table>
<thead>
<tr>
<th></th>
<th>strongly agree</th>
<th>agree</th>
<th>not sure but probably agree</th>
<th>not sure but probably disagree</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
</thead>
</table>

2. Psychiatric medicines help people with serious mental illnesses move beyond problems or symptoms.

<table>
<thead>
<tr>
<th></th>
<th>strongly agree</th>
<th>agree</th>
<th>not sure but probably agree</th>
<th>not sure but probably disagree</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
</thead>
</table>

3. Anyone in psychotherapy should not be an elementary school teacher.

<table>
<thead>
<tr>
<th></th>
<th>strongly agree</th>
<th>agree</th>
<th>not sure but probably agree</th>
<th>not sure but probably disagree</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
</thead>
</table>

4. Being in psychotherapy indicates one is trying to succeed in life.

<table>
<thead>
<tr>
<th></th>
<th>strongly agree</th>
<th>agree</th>
<th>not sure but probably agree</th>
<th>not sure but probably disagree</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
</thead>
</table>

5. Day treatment programs are needed to keep people with serious mental illnesses busy.

<table>
<thead>
<tr>
<th></th>
<th>strongly agree</th>
<th>agree</th>
<th>not sure but probably agree</th>
<th>not sure but probably disagree</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
</thead>
</table>

6. Day treatment programs can help people with serious mental illnesses move toward a better life.

<table>
<thead>
<tr>
<th></th>
<th>strongly agree</th>
<th>agree</th>
<th>not sure but probably agree</th>
<th>not sure but probably disagree</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
</thead>
</table>

7. Residential facilities are needed to keep people with serious mental illnesses away from their families.

<table>
<thead>
<tr>
<th></th>
<th>strongly agree</th>
<th>agree</th>
<th>not sure but probably agree</th>
<th>not sure but probably disagree</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
</thead>
</table>

8. More tax money should go to support residential facilities for people with serious mental illnesses.

<table>
<thead>
<tr>
<th></th>
<th>strongly agree</th>
<th>agree</th>
<th>not sure but probably agree</th>
<th>not sure but probably disagree</th>
<th>disagree</th>
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<th>p</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-efficacy-Suicidality</td>
<td>251 3.46 0.42</td>
<td>333 3.31 0.40</td>
<td>4.32</td>
<td>&lt;.001</td>
<td>.36</td>
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<tr>
<td>Stigma</td>
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<td></td>
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<td>Social distance-Psychosis</td>
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<td>De-escalation skills-Psychosis</td>
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<td>.41</td>
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<td>Referral decisions-Psychosis</td>
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<td>333 3.33 0.37</td>
<td>5.30</td>
<td>&lt;.001</td>
<td>.44</td>
</tr>
</tbody>
</table>
A Study of 1,098 Police Encounters
(R01 MH082813)
586 Officers Completed Aim 2 Surveys

251 CIT

397 Officers Enrolled in Aim 3 Follow-Up

335 Non-CIT

183 Officers Turned in Booklets with ≥1 Encounter

93 CIT

90 Non-CIT

n=1,098 Encounters
Range, 1-30
Median, 4
Please complete this Encounter Form (front & back) for every interaction with a person who you think has a serious mental illness, alcohol or drug problem, or developmental disability.

<table>
<thead>
<tr>
<th>Origin of call:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ dispatch-initiated</td>
</tr>
<tr>
<td>☐ request by another officer</td>
</tr>
<tr>
<td>☐ self-initiated</td>
</tr>
<tr>
<td>☐ just came across the person during routine patrol duties</td>
</tr>
<tr>
<td>☐ other: ______________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Subject is suspected to have (check all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ serious mental illness</td>
</tr>
<tr>
<td>☐ alcohol problem</td>
</tr>
<tr>
<td>☐ drug problem</td>
</tr>
<tr>
<td>☐ developmental disability</td>
</tr>
</tbody>
</table>

| Date: __/__/______ | Time: __________ |

<table>
<thead>
<tr>
<th>Location of incident:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ private home</td>
</tr>
<tr>
<td>☐ business</td>
</tr>
<tr>
<td>☐ street</td>
</tr>
<tr>
<td>☐ public park</td>
</tr>
<tr>
<td>☐ government facility</td>
</tr>
<tr>
<td>☐ other: ______________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address of incident:</th>
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<table>
<thead>
<tr>
<th>Time spent at the scene:</th>
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<tbody>
<tr>
<td>☐ less than 15 min.</td>
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<tr>
<td>☐ 15–30 min.</td>
</tr>
<tr>
<td>☐ 31–45 min.</td>
</tr>
<tr>
<td>☐ 46–60 min.</td>
</tr>
<tr>
<td>☐ &gt; 60 min.</td>
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</table>

<table>
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<tr>
<td>☐ 15–30 min.</td>
</tr>
<tr>
<td>☐ 31–45 min.</td>
</tr>
<tr>
<td>☐ 46–60 min.</td>
</tr>
<tr>
<td>☐ &gt; 60 min.</td>
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<table>
<thead>
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<tr>
<td>☐ 15–30 min.</td>
</tr>
<tr>
<td>☐ 31–45 min.</td>
</tr>
<tr>
<td>☐ 46–60 min.</td>
</tr>
<tr>
<td>☐ &gt; 60 min.</td>
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<table>
<thead>
<tr>
<th>Subject’s sex:</th>
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<tbody>
<tr>
<td>☐ male</td>
</tr>
<tr>
<td>☐ female</td>
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<table>
<thead>
<tr>
<th>Subject’s race/ethnicity:</th>
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</thead>
<tbody>
<tr>
<td>☐ Black or African American</td>
</tr>
<tr>
<td>☐ White or Caucasian</td>
</tr>
<tr>
<td>☐ Hispanic or Latino</td>
</tr>
<tr>
<td>☐ Other: ________________</td>
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<table>
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<th>Subject’s age:</th>
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<tr>
<td>☐ younger than 20</td>
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<td>☐ 20s</td>
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<td>☐ 40s</td>
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<td>☐ 50s</td>
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<tr>
<td>☐ 60s</td>
</tr>
<tr>
<td>☐ &gt;60</td>
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<table>
<thead>
<tr>
<th>Information gathered from subject, family, or others (check all that apply):</th>
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</thead>
<tbody>
<tr>
<td>☐ Currently has a mental or substance abuse diagnosis</td>
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<tr>
<td>☐ Currently prescribed psychiatric medications:</td>
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<tr>
<td>IF YES, ☐ currently taking these meds ☐ currently off these meds</td>
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</table>

<table>
<thead>
<tr>
<th>Observed or reported symptoms (check all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Feels sad or depressed</td>
</tr>
<tr>
<td>☐ Hears voices</td>
</tr>
<tr>
<td>☐ Thoughts of wanting to die</td>
</tr>
<tr>
<td>☐ Odd or unfounded beliefs</td>
</tr>
<tr>
<td>☐ Excessive energy</td>
</tr>
<tr>
<td>☐ Verbally abusive</td>
</tr>
<tr>
<td>☐ Damaging property</td>
</tr>
<tr>
<td>☐ Talking extremely rapidly</td>
</tr>
<tr>
<td>☐ Confused thinking</td>
</tr>
<tr>
<td>☐ Intoxicated</td>
</tr>
<tr>
<td>☐ Paranoid</td>
</tr>
<tr>
<td>☐ Problem with alcohol</td>
</tr>
<tr>
<td>☐ Problem with drugs</td>
</tr>
<tr>
<td>☐ Anxious/panicky</td>
</tr>
</tbody>
</table>
### Risks (check all that apply)

- [ ] Unable to care for self
- [ ] Suicide threat
- [ ] Suicide attempt
- [ ] Threat to harm others
- [ ] Threat to harm police
- [ ] Has a weapon

### Level of Resistance of Subject:

- [ ] Cooperative (Exhibited no resistance; was cooperative with or without direction)
- [ ] Passive Resister (Made non-movements in response to verbal and other directions, such as stiffening to dead weight)
- [ ] Active Resister (Made movements to avoid physical control, such as fleeing or pulling away)
- [ ] Assailant (Attacked you or another officer; actions were likely to cause death or serious physical injury with or without weapons)

### Equipment/Techniques Used (check all used):

1. My physical presence and authority as a law enforcement officer was enough
2. I called another officer for back-up
3. I verbally engaged the subject to de-escalate the situation
4. I negotiated with the subject to handle the situation
5. I put the subject in the car
6. [ ] __________ to handle the situation
   - [ ] asp baton
   - [ ] pepper or OC spray
   - [ ] electronic control device
   - [ ] firearm
   - [ ] hobble restraints
   - [ ] bean bags

7. [ ] __________ to handle the situation
   - [ ] asp baton
   - [ ] pepper or OC spray
   - [ ] electronic control device
   - [ ] firearm
   - [ ] hobble restraints
   - [ ] take down wrist lock
   - [ ] soft empty hands

8. [ ] __________ to handle the situation
   - [ ] arm bar takedown
   - [ ] hard empty hands

9. [ ] __________ to handle the situation
   - [ ] impact rounds
   - [ ] bean bags

### Disposition (check all that apply):

- [ ] Resolution at the scene with no further action
- [ ] Referral to services
- [ ] Transported to a treatment facility
- [ ] Arrested
- [ ] Charges:
The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest

Michael T. Compton, M.D., M.P.H.
Roger Bakeman, Ph.D.
Beth Broussard, M.P.H.
Dana Hankerson-Dyson, M.P.A., M.P.H.
Lethesha Husbands, B.A.
Shaily Krishan, M.P.H.

Tarianna Stewart-Hutto, M.S.
Barbara M. D’Orio, M.D., M.P.A.
Janet R. Oliva, Ph.D.
Nancy J. Thompson, Ph.D., M.P.H.
Amy C. Watson, Ph.D.

Objective: The crisis intervention team (CIT) model is a widely implemented police-based program to improve officers’ responses to individuals with behavioral disorders. The authors examined levels of force used by officers with or without CIT training and disposition decisions in a large sample of encounters with individuals whom they suspected of having a serious mental illness, a drug or an alcohol problem, or a developmental disability. Methods: A total of 180 officers (91 with CIT training and 89 without) in six departments reported on 1,063 encounters, including level of force and disposition (resolution at the scene, referral or transport to services, or arrest). Results: CIT training status was generally not predictive of level of force, although CIT-trained persons with serious mental illnesses are overrepresented in jails and prisons (1), and some of their charges likely stem from officers’ misinterpretation of disorder-related behaviors (2). The criminalization of serious mental illnesses may be partly a manifestation of insufficient training on the front lines (3,4). During patrol duties, law enforcement officers, who often take on a mental health
Police officers' volunteering for (rather than being assigned to) Crisis Intervention Team (CIT) training: Evidence for a beneficial self-selection effect

Michael T. Compton M.D., M.P.H.¹ | Roger Bakeman Ph.D.² | Beth Broussard M.P.H.³ | Barbara D'Orio M.D.⁴ | Amy C. Watson Ph.D.⁵

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² Georgia State University, Department of Psychology, Atlanta, GA, USA
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⁴ Emory University School of Medicine, Department of Psychiatry and Behavioral Sciences, Atlanta, GA, USA
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Officers' volunteering for Crisis Intervention Team (CIT) training—rather than being assigned—is assumed to be an important, beneficial self-selection bias. This bias remains poorly characterized, though CIT officers are more likely to be female and to have had exposure to the mental health field. We determined whether or not self-selection is beneficial with regard to knowledge, attitudes, and skills, as well as level of force used (i.e., no or low force versus any form of physical force) and disposition of subjects, in actual encounters.

We compared CIT-trained officers who had volunteered with those who had been assigned using data from two prior, linked studies that compared CIT-trained and non-CIT officers on knowledge, attitudes, and skills (251 CIT-trained officers; 68% had volunteered), as well as behaviors (517 actual encounters provided by 91 CIT-trained officers; 70% had volunteered).

Of 28 scores on knowledge, attitudes, and skills compared, six were statistically significantly different (p < .01) and another eight were
<table>
<thead>
<tr>
<th>Variable</th>
<th>Possible score range</th>
<th>Volunteered for training</th>
<th>Assigned to training</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>N of respondents</td>
<td>Score M &amp; SD</td>
<td>N of respondents</td>
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<tr>
<td>Knowledge about mental illnesses</td>
<td>0–100</td>
<td>171 60 16</td>
<td>80 58 14</td>
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<tr>
<td>Attitudes toward mental illnesses and their treatments</td>
<td>1–6</td>
<td>169 4.29 .43</td>
<td>80 4.14 .48</td>
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<tr>
<td>Opinions About Mental Illnesses Scale</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Personal responsibility (P)</td>
<td>1–9</td>
<td>171 2.56 1.34</td>
<td>78 2.51 1.24</td>
</tr>
<tr>
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<td>1–9</td>
<td>171 4.62 1.75</td>
<td>80 5.44 1.82</td>
</tr>
<tr>
<td>Pity (P)</td>
<td>1–9</td>
<td>171 6.39 1.75</td>
<td>78 6.24 1.68</td>
</tr>
<tr>
<td>Pity (S)</td>
<td>1–9</td>
<td>170 5.95 1.68</td>
<td>80 5.83 1.85</td>
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<tr>
<td>Anger (P)</td>
<td>1–9</td>
<td>171 3.13 1.72</td>
<td>78 3.64 1.71</td>
</tr>
<tr>
<td>Anger (S)</td>
<td>1–9</td>
<td>171 2.92 1.58</td>
<td>80 3.58 1.75</td>
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<tr>
<td>Fear (P)</td>
<td>1–9</td>
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<td>78 5.00 1.74</td>
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<td>80 4.43 1.71</td>
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<tr>
<td>Help (P)</td>
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<td>171 3.66 1.46</td>
<td>79 3.09 1.15</td>
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<tr>
<td>Help (S)</td>
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<td>80 4.63 1.72</td>
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<td>79 5.03 1.76</td>
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<td>Coercion-segregation (S)</td>
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<td>171 3.02 1.58</td>
<td>80 3.15 1.52</td>
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<tr>
<td>Revised Causal Dimensions</td>
<td>Scale</td>
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<tr>
<td></td>
<td>External control (P)</td>
<td>1–9</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>External control (S)</td>
<td>1–9</td>
<td>171</td>
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<tr>
<td></td>
<td>Personal control (P)</td>
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<td>171</td>
</tr>
<tr>
<td></td>
<td>Personal control (S)</td>
<td>1–9</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>Self-efficacy (P)</td>
<td>1–4</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>Self-efficacy (S)</td>
<td>1–4</td>
<td>171</td>
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<td></td>
<td>Social distance (P)</td>
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<td>171</td>
</tr>
<tr>
<td></td>
<td>Social distance (S)</td>
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<td>166</td>
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<td>Stigmatizing attitudes (P)</td>
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<tr>
<td></td>
<td>Stigmatizing attitudes (S)</td>
<td>0–9</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>Deescalation skills (P)</td>
<td>1–4</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>Deescalation skills (S)</td>
<td>1–4</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>Referral decisions (P)</td>
<td>1–4</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>Referral decisions (S)</td>
<td>1–4</td>
<td>171</td>
</tr>
</tbody>
</table>
Figure 2. Bars represent the percentage of encounters resulting in each disposition by level of force used, separately for officers who had volunteered for or been assigned to crisis intervention team (CIT) training. Numbers are odds ratios, computed by MPlus, comparing volunteered versus assigned percentages ($p$-values in parentheses); odds ratios > 1 usually indicate a higher percentage for volunteered than assigned.

<table>
<thead>
<tr>
<th>Resolution</th>
<th>Volunteered</th>
<th>Assigned</th>
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</thead>
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<tr>
<td>No or low force</td>
<td>0.93 (.84)</td>
<td>55</td>
</tr>
<tr>
<td>Physical force</td>
<td>0.91 (.93)</td>
<td>54</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral</th>
<th>Volunteered</th>
<th>Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>No or low force</td>
<td>0.92 (.84)</td>
<td>37</td>
</tr>
<tr>
<td>Physical force</td>
<td>3.13 (.23)</td>
<td>51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Arrest</th>
<th>Volunteered</th>
<th>Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>No or low force</td>
<td>2.02 (.38)</td>
<td>8</td>
</tr>
<tr>
<td>Physical force</td>
<td>0.35 (.13)</td>
<td>35</td>
</tr>
</tbody>
</table>
CIT and Mental Health Service Accessibility in Police Encounters: Impact on Outcomes for Persons with Serious Mental Illnesses

Credit where credit is due

- Co-investigators & Consultants
  - Michael Compton, MD, MPH, Columbia University
  - Jeff Draine, PhD, Temple University
  - Jen Wood, PhD, Temple University
  - Joel Caplan, PhD, Rutgers University
  - Don Hedeker, PhD, University of Chicago
  - Linda Owens, PhD, University of Illinois at Chicago
  - Melissa Morabito, PhD, UMASS-Lowell
  - Melissa Reuland, Johns Hopkins
  - NAMI Chicago

- *work supported by NIMH R01 MH096744

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- This data was provided by and belongs to the Chicago Police Department. Any further use of this data must be approved by the Chicago Police Department. Points of view or opinions contained within this document are those of the author and do not necessarily represent the official position or policies of the Chicago Police Department.
Chicago Police Districts, Designated ER drop offs & MH Service Providers

Jane Addams College of Social Work

UIC
Methods

- **District visits**
  - Call data collection from officers
  - Ride-along observations
  - Qualitative interviews

- **Mapping**
  - Services
  - Call locations
  - Community characteristics

- **Call Subject Follow-up**
  - Experience of encounter
  - 3, 6, 9 & 12 month follow-up
  - Qualitative interviews.
Mental Health Related calls
Data collected July 2013-Sept 2016

- 300 officers participated
  - 81 (27%) were CIT trained

- 428 Mental Health related calls
  - 134 (31.3%) with CIT response
  - 279 (65.2%) Dispatch initiated
    - (109, 25.5% Dispatched as MD)
  - 150 (35%) subjects officer had dealt with before
Call Characteristics and Outcomes

134 (31.3%) with CIT response
109, 25.5% Dispatched as MD
Some descriptive findings related call outcomes

- More than half of the encounters did not require taking an individual into police custody for arrest or transport to the hospital.

- Informal resolutions included providing rides to transit or home, releasing the subject to a family member and creative solutions to problem solve encounters.

- In just over half of the encounters (221, 51.6%), someone on scene requested a specific resolution, most often this was a family member, and most often the request was for a transport to the ED.

- In the 402 calls in which no arrest was made, officers indicated they could have arrested the individual in 129 (32%).
CIT and Call Outcomes

Outcomes collapsed to three categories, Arrest, Linkage to Services, and Informal Resolution

Multilevel logistic regression for each outcome with the following predictors:

- Call location type, Mental Health Call (Y/N), CIT Response, Officer Race, Officer Gender, District level economic disadvantage.
CIT and Call Outcomes

- **Arrest**
  - Only Dispatched as Mental Health Call significant-if MH Call, odds of arrest lower. (OR 0.08)
  - ICC indicates 19% of variance attributed to District

- **Linkage***
  - CIT Response (OR 1.66), MH Call (OR 2.83) increased odds of linkage
  - Location type Street (OR 0.38) or Business (OR 0.41) decreased odds relative to Home
  - Not much variance due to district

- **Informal**
  - Calls originating from the Street (OR 2.89) or business (OR 1.86) more likely than those originating from a home more likely to have informal resolution
  - Calls designated as MH calls less likely (OR .476) to be resolved informally
  - Not much variance due to district
The Crisis Intervention Team Model: Evidence Summary

- CIT improves officer knowledge, attitudes, and confidence in responding safely and effectively to mental health crisis calls
- CIT increases linkages to services for persons with mental illnesses
- CIT reduces use of force with more resistant subjects
- Effects are strongest when CIT follows a volunteer/specialist model
- Findings related to diversion from arrest vary

Recommendations for CIT Research

- Development of a fidelity measure
- RCT testing the impact of CIT training skills on safety, call outcomes, subsequent police/emergency service contacts, and MH & CJ outcomes
- Research examining volunteer / specialist model vs. mandated CIT training for all
- Effectiveness for serving specific populations
- Cost effectiveness
Mobile Crisis Teams

Teams of clinicians that can be accessed/deployed without any law enforcement involvement

May respond at the request of law enforcement

May request law enforcement assistance when safety issues are identified

In several communities, CIT/PMHC programs have advocated and developed Mobile Crisis Teams as part of the crisis response system
Evidence: Mobile Crisis Teams

- First descriptions in the literature in the 1970s
- Research by Dyches et al. (2002) found that:
  - MCT intervention increased likelihood of use of community mental health services in 90-day follow-up by 17%, compared to hospital-based emergency services
  - Those receiving ED-based services were 1.5 times more likely to be hospitalized in 30-day follow-up period
- Common finding related to MCT programs is lack of 24/7 availability
- Can also be used as follow-up for those receiving hospital-based crisis care
Research Recommendations

- Stakeholder acceptability
  Experimental (RCT or quasi-experimental) research testing the impact on immediate outcomes and subsequent police/emergency service contacts, hospitalizations, MH & CJ outcomes
- Effectiveness for specific populations
- Cost effectiveness
Co-Responder Teams (aka Street Triage, PACER)

- Predominant model in Canada and the U.K.; growing popularity in Australia and the U.S.
- Pairing of clinicians and officers to provide response
- Significant variation
  - Ride together, arrive together, or telephone support
  - Hot calls vs. secondary response or follow-up
  - Often not 24/7
  - We are now seeing co-response teams that include EMTs, Peers
- Goals
  - Reduce arrests & increase safety
  - Reduce ED transports & hospitalization
  - Increase linkage to community care
Co-Responder Teams: Evidence

First mention in the literature is a descriptive study in 1995, LA’s Systemwide Mental Health Assessment Response Team.

Lamb et al., 1995 described outcomes:

Teams were able to respond to individuals that were acutely ill and potentially violent, potentially reducing entry into the criminal justice system.

2010-on there has been an increase in articles/research on co-responder teams, much of it descriptive.
Co-Responder Teams: Evidence

Two systematic reviews and quasi-experimental and descriptive research suggest versions of the model:

- Are acceptable to stakeholders
- Improve collaboration between police/mental health
- In some communities, may reduce officer time on scene
- May reduce ED transports but increase admission rate for those transported
- May reduce repeat calls for service
Co-Responder Teams: Evidence

Considerations

- Concern about the lack of community mental health services consistently noted as an issue for co-responder programs
- Concern about including police officers in events that might be better handled with mental health only response emerged in a couple of studies
- Benefits appear to similar those of mobile crisis teams
Co-Responder Teams: Recommendations for research

- Development of a fidelity measure (or classification typology)
- Examine impact on safety and immediate call outcomes, subsequent police/emergency service contacts, and MH & CJ outcomes
- Examine the effectiveness for specific populations
- Cost effectiveness
- System impacts
EMS/Ambulance-Based Response

- 31% of individuals arriving at the ED for mental health reasons were transported by ambulance (compared to 14% for all ED visits)
- Push in some communities to shift transports from police to ambulance
- Development of alternative receiving facilities
- Community paramedic programs
- EMS/MH clinician co-response
- Stockholm, Sweden PAM (psychiatric emergency response team) - two psychiatric nurses and a paramedic
- MHFA-EMS/First Responders
EMS/Ambulance-Based Response: Evidence

- There is virtually no research on this model
Research Recommendations

- Descriptive research on program models and populations served
- Stakeholder acceptability
- Effectiveness for safety, MH and CJ outcomes, and system outcomes
- Cost effectiveness
Linkage / Case Management / High Utilizer Teams

Clinician/officer teams provide outreach and follow-up care for individuals who have frequent contact with police and other emergency services, or are considered high risk.
Program Descriptions

Los Angeles Police Department
Case Assessment and Management Program (CAMP)

- Det/Clinician teams provide engagement, linkage, monitoring, recover firearms

Portland Police Bureau BHRT

- Referrals from officers via BERS form
- Review of mental health contacts
- High Risk/Escalating/High Utilizer
- Clinician/Officer Teams provide outreach and linkage, short-term
Evidence on Linkage / Case Management / High Utilizer Teams

Houston’s Chronic Consumer Stabilization Initiative

- Identified 30 individuals with SMI who were the highest utilizers of police services
- 2 clinicians funded by the City (rather than officer/clinician team)
- Reportedly reduced police contacts by 70% in the first six months
Recommendations for Research

1. Descriptive models of programs
2. Stakeholder acceptability
3. Experimental research testing impact of this model on subsequent police/emergency service contacts and MH/CJ outcomes.
4. Effectiveness of model for specific populations
5. Cost effectiveness of this service model
6. “Frequent utilizer” criteria
Voluntary entry into alert system

- Smart911
- Janesville PD crisis information sheet

Communication Cards

- Communication tips, contact person

Both raise issues of voluntariness and safety
The Linkage System

This police–mental health linkage system differs from other pre-booking jail diversion models (e.g., CIT) in that officers need not step outside of their usual professional role to assess someone’s mental health status. Instead, officers running a routine inquiry are invited to access information that might assist them.
A police officer has an encounter with a subject (who happens to be an enrolled study participant). When using the Mobile Data Terminal (in-car laptop), the officer inquires about the subject’s current status:

- **Wanted:** No
- **Probation:** Yes
- **Missing:** No
- **Protected:** No
- **Other:** The subject has special mental health considerations. Call 1-800-Gateway for support.

The officer enters the subject’s name, date of birth, and other identifiers to run a routine inquiry. Officer sees that the subject has mental health considerations and calls 1-800-Gateway. The Linkage Specialist provides relevant information and advice.

This potentially averts discretionary arrest.
Police - Mental Health Linkage System

Types of Inquiries
- Wanted / Missing Person
- Drivers License
- Criminal History
- Sex Offender
- Protection Order

LE-MH Response Returned in Addition to Other CJIS Responses

* Participants have given the required consent

Criminal Justice Information System (CJIS) Network*, Managed by GBI

*Georgia's CJIS Network
  - Provides direct access to over 32 computerized databases
  - Has more than 17,000 users operating over 10,000 devices
  - Handles more than 30 million messages per month in support of Georgia’s criminal justice agencies.
A signed Consent Form must be obtained from all participants before the participant's information is entered into the Linkage System and/or before criminal history information can be accessed.

The signed consent form must be kept on file for the duration of the project and beyond as research is conducted regarding this project.

If a participant withdraws from the project, the record must be removed from the Linkage System immediately. The signed consent form remains on file.

A copy of the signed consent form will be provided to GBI-GCIC as requested.
## Entry Screen

### GBI MONITORING SYSTEM (GMS) PROJECTS

**User ID:** 
**Password:** 
**Participant's Number:** 
**Action:** 

- **Clear Page**

**Response Message:**

<table>
<thead>
<tr>
<th>Participant's Data</th>
<th>Navigator's Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GMS Enrollment Date</strong></td>
<td><strong>GMS Team:</strong> Gateway Behavioral Health Services</td>
</tr>
<tr>
<td>Year/Month/Day:</td>
<td>1st- Last Name:</td>
</tr>
<tr>
<td></td>
<td>First Name:</td>
</tr>
<tr>
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<td></td>
<td>State:</td>
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<tr>
<td></td>
<td>Zip:</td>
</tr>
</tbody>
</table>
*** ATTENTION ***
The below individual is a possible participant in a mental health linkage system project; participants are enrolled in a treatment program. If contact is made with the participant, please call 912-XXX-XXXX.

Participant Info Name: MOUSE, MICKEY M Sex: M Race: B DOB: 19820206
Participant Info Hair: BLK Eye: BRO HGT: 600 WGT: 185 SOC: 252525256
SID: 1234567X
Participant Assigned Team: GATEWAY BEHAVIORAL HEALTH SERVICES

*** Actual Inquiry: 00002/28/18 11:58
MFCT10000QWA.GAGB100A3.NAM/MOUSE, MICKEY M.DOB/19820206.SEX/M.RAC/B.SOC/252525256
NIMH R34 Grant

- 3-year grant

- Focuses on one specific ingredient of ODR: the linkage between local police and a “linkage specialist” (rather than an ODR CNS)

- 200 patients enrolled in the linkage for one year

- GCIC arrest data pre-linkage and after the linkage (rap sheets)

- A number of focus groups
A potential new form of jail diversion and reconnection to mental health services: I. Stakeholders' views on acceptability

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Abstract
The most effective point of intervention to prevent unnecessary arrest/incarceration of persons with serious mental illnesses is the initial encounter with police. We piloted a new police-mental health linkage system. When officers run an enrolled participant's name/identifiers, they receive an electronic message that the person has mental health considerations and that they should call for information. The linkage specialist receives the call and assists telephonically. In this qualitative study to examine acceptability of the linkage system, we conducted nine focus groups with diverse stakeholders (e.g., enrolled patients, officers). Focus groups revealed that patients enrolled with the hope that the linkage system would prevent negative interactions with police and minimize risk of arrest. Officers reported preferring not to arrest mental health
Focus Groups on “Acceptability”

Patients noted that the linkage system might be especially useful when confused, angry, or intoxicated, as they would be less able to explain their mental illness.

Savannah Police Department Officers:
- appreciated the idea of a “fourth option” that involved receiving immediate, real-time advice from mental health
- stated they would call the linkage specialist so they would not have to struggle over whether a mental illness was present during the encounter, and because they want to avoid arresting people who are “seeing a doctor, taking their medications, and trying to address their mental health issues”
A potential new form of jail diversion and reconnection to mental health services: II. Demonstration of feasibility


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Abstract
Given fragmentation between mental health and criminal justice systems, we tested the feasibility of implementing a potential new form of pre-booking jail diversion. Our “linkage system” consists of three steps: (i) individuals with serious mental illnesses and an arrest history give special consent to be enrolled in a statewide database; (ii) if an officer has an encounter with an enrolled patient and runs a routine background check, he or she receives an electronic message to call; and (iii) the “linkage specialist” provides brief telephonic assistance to the officer. Of 206 eligible individuals, 199 (96.6%) opted in, the database received 679 hits, and the linkage specialist received 31 calls (and in at least three cases an arrest was probably averted). The mean number of arrests was 0.59 ± 0.92 in the year before enrollment (38.7% arrested) and 0.48 ± 0.83 during
During the study, 3 participants withdrew consent to be in the linkage system and were removed from database.

During the course of the study period, the Linkage Specialist received 31 calls.

Among those, in at least 3 cases, an arrest was likely averted (in many instances, an arrest was not being considered).

Re-connection to care was even more common.
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<th>≥1 arrests</th>
<th>mean # arrests</th>
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<td>Year Before Enrollment</td>
<td>77 (38.7%)</td>
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…coming soon…

RCT
outpatients in public-sector clinics
n=1,600, Linkage System v. TAU
enrollment, then collect administrative data

Aim A: Study effectiveness of the police–MH linkage system in reducing arrests. Patients randomized to the linkage system will be less likely to be arrested, and have fewer arrests, in the 24-month study period than those not in the system, based on rap sheet data.

Aim B: Study effectiveness of the linkage system in reducing MH services discontinuities. Patients randomized to the linkage system will be less likely to have discontinuities in MH services, as evidenced by fewer absences from care of >3 months (and a greater count of months in which the patient accessed services over the 24-month follow-up period), based on EMR data.

Aim C: Determine effects of five potential moderators on arrest probability and MH service discontinuities (urban v. rural site, male v. female subject, psychotic v. mood disorder, high v. low likelihood of arrest based on lifetime arrests adjusted for age, and Caucasian v. African American).

Target Engagement: We will be able to show that outcomes (arrests, outpatient MH service discontinuities) can be traced back to two targets: (1) the linkage system database being “hit” by officers running inquiries, and (2) those officers calling the Linkage Specialists. As such, target engagement is concrete and readily verifiable.
Recommendations for Research

- Descriptive research on variations of the model
- Stakeholder acceptability, uptake/enrollment and usage
- Impact on safety, immediate call resolution, subsequent police/emergency service contacts, hospitalizations, and MH and CJ outcomes
- Effectiveness of models for subpopulations (e.g., individuals with SMI, I/DD, co-occurring disorders)
- Cost effectiveness
Some communities are mandating some level of mental health training for all sworn personnel. Some states (e.g., Illinois) have recently passed 8-hour training requirements:

- Mental Health First Aid for Public Safety
- Integrating Communications, Assessment, and Tactics (ICAT) training (PERF)
- Agency-developed trainings of 8-16 hours
- Some agencies are using 40-hour CIT training in this way; this may not be the optimal approach and is expensive
- So far, no research to provide guidance
Research on Stand-Alone Mental Health / De-Escalation Training

Scan of mental health trainings for police in Canada found common elements:

- signs and symptoms of major mental disorders, other disorders affecting cognition and emotions, and substance use disorders
- assessment of suicidal intent
- de-escalation and behavioral management techniques
- relevant mental health policies
- available mental health services

Variation in length and inclusion of mental health professionals and persons with lived experience
## Research on Stand-Alone Mental Health / De-Escalation Training

### Descriptive studies of brief mental health trainings suggest
- Stakeholder acceptability
- Improvements in knowledge and attitudes

### Krameddine et al., 2013 examined one day scenario based training
- Improvements in supervisor ratings of de-escalation skills at six-month follow-up
- Reduction in uses of force in mental health calls across the agency in six-month follow-up period (continuation of a trend that began before the training)

### A cluster randomized trial of a 1-day mental health training in England (Scantlebury, 2017) found:
- No differences in applications of the mental health act
- Improvements in how officers recorded mental health encounters
Stand-Alone Trainings: I/DD Specific

Law Enforcement: Your Piece to the Autism Puzzle: 13-minute video

- RCT with survey completion pre-training and immediately post found improvements in knowledge and confidence (Teagardin et al. 2012)
Research Recommendations

- Descriptive research on training models
- Impact of the training models on skill acquisition, and durability of training-related improvements
- Impact of training models on performance in the field and MH and CJ outcomes
- Research that examines the critical components, optimal delivery formats, training length, frequency of refresher training, etc.
I/DD-Specific Models and Strategies

Pathways to Justice

Unpublished pilot evaluation of Pathways at 6 sites suggested:

- Participants were satisfied with training
- Disability Response Teams continued to meet
Recommendations for Research

- Descriptive research examining service models
- Formal research on Pathways to Justice and Disability Response Teams
- Stakeholder acceptability
- Experimental research testing the impact of service models on safety and call outcomes, subsequent police/emergency service contacts, and MH & CJ outcomes
- Cost effectiveness
- Research on the extent to which the non-I/DD-specific models are serving persons with I/DD and the extent to which the models are effectively serving this population
- Research examining the cost effectiveness of such service models
Summary/Discussion

- Growing bodies of promising research on several models of LE/MH response
- Strongest evidence to date is for CIT
- There is a need for fidelity measures and measures of common cross model components
- There is a need for research to examining if LE/MH models adequately address the needs of persons with IDD (or if modifications or new models are needed)
Thank you!

Questions?

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