The Bill Blackwood
Law Enforcement Management Institute of Texas

Properly Policing Mentally Ill Individuals

A Leadership White Paper
Submitted in Partial Fulfillment
Required for Graduation from the
Leadership Command College

By
Landon N. Rollins

Fort Worth Police Department
Fort Worth, Texas
February 2020

ABSTRACT

Interactions with law enforcement officers and individuals with mental health issues is growing and impacting the ability of agencies to effectively respond to this expanding need. Full-time Crisis Intervention Teams (CIT) should be implemented in police departments to address this concern. The magnitude of this growing crisis and its impact on agency resources and staffing makes this a current and relevant issue. Full-time dedicated units enable CIT-trained officers to handle specified calls for service regarding mental health concerns while freeing up other officers to focus on their respective assignments. Full-time CIT integrates stakeholders with social services and police enforcement efforts. Full-time units enable departments to handle departmental training through a streamlined approach with the department's CIT subject matter experts. Counter arguments are discussed regarding the effectiveness and ability for smaller departments to consider CIT-related programs. Recommendations for task responsibilities for full-time CIT units are discussed. These recommendations would benefit the case load management of mental health related calls for service such as conducting follow-ups and monitoring violent individuals and hazardous locations. Police departments that dedicate full-time units for CIT-trained officers will be better equipped to handle this growing issue.

TABLE OF CONTENTS

INTRODUCTION

Due to the increase in mental health illness in America and the impact to law enforcement, agencies should implement full time Crisis Intervention Teams (CIT) units. Police Departments around the United States are developing CIT in response to the growing need to address mental health concerns within their communities. While this issue is recognized as a current and expanding problem, the investment police departments should make is in a CIT model. According to Mental Health Texas, “1 in 5 Texans will experience a mental health concern at some point this year” (HHS Office of Mental Health Coordination, 2018, para 1). The National Alliance on Mental Illness, (NAMI) supports this number, and presents a statistic for the US as a whole that 43.8 million, or 18.5% of our population, experience mental illness per year (NAMI Numbers, 2019; NAMI Prevalence, 2019). Corresponding numbers from the National Institute on Mental Illness show that in 2016, one in six U.S. adults were deemed to have a type of mental illness, and one in 25 U.S. adults had conditions that were classified as a serious mental illness (Siewert, Mecozzi, & Hassan, 2018). These numbers may vary slightly per organization, but these statistic indicators represent the existing reality of mental illness in this country. The overall picture painted by these numbers demonstrates the impact mental health illness can have on the workloads of street officers chasing endless amounts of calls for service and the dispatchers and call takers fielding countless emergencies from their communities. It means that police departments, as a whole, are interacting with mentally ill and severely mentally ill people at an astonishing rate.

Based on 2016 statistics, 7% of all Police calls for service concern individuals with mental illness (Mulay, Vayshenker, West, & Kelly, 2016). Professionals in law enforcement face a growing problem regarding how to offer these people services in a safe and productive manner. The effort requires a multi-faceted approach. Safety concerns for police officers during their interactions with those suffering with mental illness is paramount. A secondary but vitally important consideration to be addressed is an emphasis on getting these citizens the help that they need while recognizing that some are in very desperate need for help and pose a very credible threat to themselves and the safety of others in society. By tackling this growing challenge, police departments can simultaneously address their attempts to limit use of force during encounters with people suffering from mental illness. This is a sensitive issue, as use of force interactions with this population, along all levels of the continuum from a simple take down to lethal force, regardless of necessity, can become problematic for police in today's watchdog-focused society. An approach is needed that will address the relevant and important concerns.

The implementation of CIT within police departments is a tactic that addresses these needs. The increase in mental health illness in America and the significant impact on law enforcement are extremes that have moved CIT to the forefront of discussion. Consideration of whether police departments with over jurisdictional populations of 100,000 should implement full-time units for CIT is underscored by a growing body of supportive literature. This population suggestion should not be viewed as a concrete criterion, but rather considered as an example of a department serving areas that are more urbanized with the likelihood that these departments would have

more resources to create a focused CIT specialized unit. By implementing full-time CIT, departments provide the community with proactive and highly trained crisis intervention officers that are supported by their administrations, partnered with mental health organizations, and enabled by other stake holders in the community. Employing CIT may be the key to addressing this growing issue.

POSITION

CIT officers are selected with the intention of having special training, attention, and a skill-set, centered on the unique needs of those suffering with mental illness. Having officers dedicated to call-specific needs, focusses the officers with the experience and training to directly handle these calls. Officers with the training to appropriately incorporate empathy, patience, and effective options in addition to jail come as a package with those specially trained for CIT (Hanafi, Bahora, Demir, & Compton, 2008). With this approach in play, CIT officers can filter radio traffic and call loads, paying specific attention toward interactions that indicate red flags for mental health concerns. These officers can also proactively focus on the follow-up needs of community members who repeatedly interact with the police and mental health professionals. Additionally, CIT officers intensely monitor mental health individuals that are legitimate and known threats to government entities, public officials, politicians, schools, churches, etc. Veterans in crisis are also monitored and receive follow-ups from CIT officers. Specially trained skill-sets, particularly aimed at mental health related issues with veterans have been shown to lead to increasing an officer's effective management of violent behavior and non-criminal mental illness (Mok, Weaver, Rosenthal, Pettis, & Wickham, 2018).

These primary functions of the CIT officers lighten the burden on patrol officers and others in different specialized or investigative units to handle other services. CIT can further assist those various units when they encounter those with mental illness in the capacity of their own focused work. The members of CIT essentially become the experts in their field that become a valuable resource department-wide (Hanafi, Bahora, Demir, & Compton, 2008).

Stakeholders from other aspects of the community, including county and social services, can also benefit from an incorporated effort with a dedicated CIT unit. Full-time CIT officers can work with members of other agencies in a coordinated effort to provide the best and most appropriate services to the citizens in need. Brennan et al. (2016) note the significant impact that addressing those in mental health crisis can have when it is undertaken in a collaborative manner between police and mental health professionals. Through their research, Pakes, Shalev-Greene, and Marsh (2014) discuss how the unmet needs of those in crisis, whether it be due to trauma, loss, illness, or other dynamic reluctance to get services, can be better helped when different angles of need are considered by those who specialize in mental health. A clear example of how this works can be seen in the model used by the Fort Worth Police Department's CIT. CIT officers in this unit work side by side with members of the Tarrant County MHMR Law-Liaison. In doing so, sworn CIT officers ride in partnership with embedded MHMR liaisons, bringing additional skills and resources to each call for service concerning citizens with mental illness.

Full-time CITs can address an important component of required training needs of police departments. Texas specifically now mandates that all recruits receive training in dealing with mentally ill persons. Officers in the field who are not yet certified as Intermediate Peace Officers under the guidelines of the Texas Commission on Law Enforcement (TCOLE), must attend a 40-hour training on CIT in order to meet that requirement. Officers wishing to further enhance their skill set in mental health can attend the TCOLE Mental health peace officer (MHPO) course, which dives much deeper into mental health related issues and law enforcement. The purpose of the Mental Health Peace Officer course is to further inform and educate officers in the area of mental health and issues pertaining to serving as a mental health (CIT) officer (Texas Commission on Law Enforcement Officer Standards and Education [TCLOSE], 2008; TCOLE, 2016). Training in this course includes advanced crisis intervention training, communicating with people in crisis, mental disorders, indicators of mental illness, understanding mental illness, handling a person in acute phase of mental illness, the law and liability issues, documentation, safety and assessment, intervention in high and low risk situations (TCLOSE, 2008; TCOLE, 2016).

The President's Task Force on 21st Century Policing, published in May 2015, set out for Police departments to acknowledge that their roles and responsibilities are continually and constantly growing. And with this fact, officers are encountering a wider array of challenges, with one of the most pressing is the growing mental health crisis. It can be commonly acknowledged that in the last ten years or so, law enforcement has adapted higher training in tactics, patrol procedures, operations, narcotic investigations and the like. These skill sets are critically important for officers in the field. That point is

not in question. The need, however, is to implement effective training for our officers to deal with the mentally ill and it should be an additional critical element on that list.

Not only does the task force recommend CIT units for police departments, it recommends incorporating CIT training for both recruit and line officers in service trainings. Pillar five from the task force on 21st century policing references training and education for agencies (COPS Office, 2015; President's Task Force on 21st Century Policing, 2015). Essentially, the recommendation within this pillar is for those with practical experience to teach officers patience, tolerance, interpersonal skills, and effective communication, while passing on knowledge regarding the most common mental illnesses they will encounter daily in their duties (President's Task Force on 21st Century Policing, 2015). Having CIT officers in a department can serve as subject matter experts in the field that can advise and train other officers in their area of expertise.

COUNTER ARGUMENTS

Some may question the effectiveness of implementing full-time CIT versus continuing to use patrol and other resources to handle mental health-related calls. Sometimes it is difficult to explicitly state the effectiveness of having dedicated CIT officers within a department as the results of the daily work and function of the unit sometimes cannot be quantified. For example, a school shooting that is prevented after veiled or explicit threats were made by an individual is difficult to quantify, particularly when the violent act prevented the carnage that often accompanies these types of episodes. Lord, Bjerregaard, Blevins, and Whisman (2011) make the argument that the

assessment of these services by CIT officers are more qualitative and would be assessed by the consideration of other dispositional outcomes.

Comparing statistics of a newly implemented full-time CIT unit versus individually dispersed CIT-trained officers throughout a department can demonstrate the effectiveness of having a dedicated unit. One full year of statistics garnered from the newly dedicated unit of CIT officers at the Fort Worth Police Department demonstrates the effectiveness that even a small reserved unit can have on a department. With approximately 1700 sworn officers department-wide, only six officers, one detective, and one supervisor made up the newly formed unit from December 7, 2017 to December 7, 2018 (TriTech Software Systems, n.d.). During that period, this small focused team of CIT officers submitted 682 police reports, completed 498 Mental Apps (also referred to as Involuntary Mental Health Warrants), and conducted 4,039 follow-ups for mental health individuals (TriTech Software Systems, n.d). The CIT unit also handled 2,066 additional follow-ups that were originally directed toward patrol units in which the reporting officer noted a need for mental health follow-up in the call disposition (TriTech Software Systems, n.d). To further demonstrate the need for CIT, the total calls routed to police communications for dispatch that were specific to mental health, were 3,685 (TriTech Software Systems, n.d). The total calls answered by CIT that were taken over from the original patrol-based dispatch were 1,937 (TriTech Software Systems, n.d). The cumulative calls for service and follow-ups totaled 9,790 (TriTech Software Systems, n.d). With only six field officers staffing the FWPD CIT the impact this dedicated unit had is evident in these numbers. Considering that each

officer worked at a different pace and with varying degrees of work ethic and output, the influence this full-time CIT had is clear.

A valid argument when implementing any specialized unit involves the reasonableness and necessity of cultivating resources for that unit. These considerations would include questioning where to find the manpower, training, and resources to staff the full-time team. Most research concerning CIT has in fact been conducted with medium to large sized departments, leaving smaller agencies to question whether their size and the proportionally lower amount of resources could see effective benefits from implementing CIT (Lord, et al., 2011).

Regardless of the size of a department or whether an abundance of resources are available, CIT can be an effective tool for any department. Lord, et al. (2011) highlighted servicing these types of calls with CIT and the differences in persistence and effective resolutions over time between large and small agencies. The statistics previously presented demonstrate how even a small reserve of officers from one of America's largest cities can have a big impact. Small departments or county agencies that do not have the staffing or manpower to staff a full-time CIT unit can still impact mental health individuals in a positive way by employing MHPO training for officers in the field. This answers the question as to manpower, where CIT can be incorporated in the daily capacity of individual officers.

Interagency training exists for departments that cannot host or provide specialized CIT training for their own officers. Utilizing officers who volunteer to become CIT trained has be shown through research evidence to produce officers who demonstrate great attitudes, behavior, and outcomes (Compton, Bakeman, Broussard,

D'Orio, & Watson, 2017). These agencies could send officers to regional academies for MHPO and CIT courses. Group discounts can even be considered for course fees if a number of officers are sent to the training together. Those running smaller agencies can also reach out to organizations and stakeholders, such as NAMI, to facilitate training opportunities. NAMI has even held fundraisers and assisted with state and federally funded grant applications focused on bringing mental health training to law enforcement agencies.

It is recommended that members of CIT units wear soft uniforms. The patrol uniform can generate fear, apprehensiveness, and/or agitation in the mind of someone suffering from mental illness. This type of suggested soft uniform does not need to be expensive, as cost-effective options include polo shirts, t-shirts, and tactical pants. Equipping a small dedicated unit that is not tactical in nature will not typically require excessive finances to fund their daily existence.

RECOMMENDATION

The primary purpose of CIT is to reduce the hazards associated with interactions between law enforcement personnel and people suffering from mental illness. The secondary role is to proactively, and with the no time limitation, engage mental health individuals who pose a significant threat to their communities and to society as a whole. CIT should also maintain a large focus to reduce return and repeated calls for service related to mental health individuals. This aspect of the CIT program has the ultimate goal aimed at freeing-up patrol officers, communications, or any other unit or division directly impacted, so that they can better provide service to the community. The following are recommendations for implementing full-time CIT, accompanied by

additional action steps that could be considered based on department-specific jurisdictional needs.

An implemented component of a full-time CIT unit should be a focus on conducting in-home follow up visits with MHMR liaisons (if available, agency specific) on people suffering from mental illness who have been contacted by Law Enforcement Agencies/Police Departments. The documented contact could result from an offense report, suicide attempt/mental detention, incident report or a CAD disposition marked MHMR Follow-Up Request, or again, agency specific dispositions. Referrals may also come from other internal units or divisions, outside agencies, or directly from community organizations (i.e. NAMI).

A full-time CIT unit should prioritize the development and maintenance of positive relationships with low-risk MHMR individuals to educate them on alternative sources of assistance other than repeatedly calling 911. This effort would aim at reducing incoming calls to the police department that tie up valuable Communications and Patrol resources.

Roles of officers working in a dedicated CIT unit should respond, when available, to assist patrol officers on calls involving persons suffering from mental illness. CIT detectives could accept referrals from investigative units on cases that involve people showing signs of mental illness or who are documented MHMR individuals. CIT detectives should not be assigned to investigate these cases unless directed by the CIT supervisor. This avoids “mission creep” for the CIT unit and keeps other investigative units from draining/misusing CIT detectives. Additionally, detectives and officers assigned to a dedicated CIT unit could assist intelligence units in the investigation of

mental illness sufferers who have made credible threats to public safety. The specialized understanding and training of the members of a CIT unit could provide invaluable insight and support to colleagues fielding intelligence that indicates possible escalations and threats of violence.

Violent threats by possibly unstable individuals should be a priority for full-time CIT units. Upon request, CIT officers could respond to barricaded persons or other high-risk incidents involving people who are suspected of suffering from mental illness. CIT officers should work as a front-line assistant in the effort to peacefully resolve these types of incidents, if possible. The CIT unit should be on the lookout (aka BOLO's) for high risk MHMR individuals who pose a credible threat to law enforcement and/or the community as a whole. CIT officers should be on a rotational 24/7 emergency call-back status. After CIT duty hours, supervisors could contact the on-call CIT officer through police communications for the barricaded subjects, active suicidal subject standoff (e.g. jumper, observed weapon), any response of a hostage negotiation team, or to answer questions regarding issues dealing with mental health consumers.

In alignment with monitoring threats, dedicated CIT units should maintain and disseminate focused communication to colleagues. Due to their focused work, dedicated CIT officers could provide updates on hazardous location updates on known high-risk locations associated with MHMR individuals. CIT units could generate Crime Analysis Bulletins associated with high risk MHMR individuals. These bulletins would create agency-specific and for appropriate outside agencies to increase officer safety and awareness.

A dedicated full-time CIT unit could enable more streamlined coordination between the CIT and MHMR liaisons, homeless liaisons, neighborhood police officers, intelligence units, and any other units involved with known MHMR individuals. These types of relationship would be agency specific. Additionally, the CIT unit could serve as a liaison with service providers and hospitals within the community to develop mental health policies that help resolve mental health public safety issues.

For smaller agencies that may not have the manpower to fully man a CIT, officers could be selected and be trained in the Mental Health Peace Officer course, to be certified mental health peace officers. These officers could then assist patrol, the department as a whole, and their jurisdiction for situations involving those with mental health issues. The scope and size of this would be department size specific. For some agencies, it could be as little as having one officer trained; for others, no more than two to four officers. For larger agencies, one officer per division, sector, or district, would likely create a step toward better assisting departments with handling mental health related issues.

The research and statistics presented in this project demonstrate both the critical need to address the ever-present interactions experienced between law enforcers and community members suffering with mental illness. The implementation of full-time police units specializing in CIT will give agencies an advantage in dealing with training and safety related to these interactions. Officers with CIT training will likely increase the ability for inter-departmental units to work in coordination or direct specially-trained officers to engage the needs of these citizens. A full-time CIT unit presents an opportunity to streamline resources while simultaneously increasing the effectiveness of

the police response for mental health-related calls for service. Employing CIT as a full-time resource within departments offers an approach to a growing social issue while increasing the safety and effectiveness of police services.

This project demonstrated that law enforcement agencies should implement full time CIT units to handle the increase and impact of mental health illness in their communities. Full time units dedicated for CIT enable CIT officers to lighten the burden for other officers to handle the specific work from their own assignments. Stakeholders, particularly those involved with local support services can benefit from an increased partnership with a focused group of dedicated CIT officers. A full-time unit will also enable a department to better address training needs while following the federal and state recommendations for implementing these types of units. Arguments countering support for a full-time unit include questioning a full-time unit's effectiveness and the ability for smaller departments to fund and staff a specific unit for CIT. The overall effectiveness of implementing full-time CIT appears to be demonstrated in the research.

REFERENCES

Brennan, A., Warren, N., Peterson, V., Hollander, Y., Boscarato, K., & Lee, S. (2016). Collaboration in crisis: Career perspectives on police and mental health professional's responses to mental health crises. *International Journal of Mental Health Nursing, 25*(5). doi:10.1111/inm.12233

Compton, M. T., Bakeman, R., Broussard, B., D'Orio, B., & Watson, A. C. (2017). Police officers' volunteering for (rather than being assigned to) crisis intervention team (CIT) training: Evidence for a beneficial self-selection effect. *Behavior Science and Law, 35*, 470-479. doi:10.1002/bsl.2301

COPS Office. (2015). *President's task force on 21st century policing implementation guide: Moving from recommendations to action* (USDOJ Grant No. 2015-CK-WX-0001). Washington, DC: Office of Community Oriented Policing Services.

Hanafi, S., Bahora, M., Demir, B. N., & Compton, M. T. (2008). Incorporating crisis intervention team (CIT) knowledge and skills into the daily work of police officers: A focus study group. *Community Mental Health Journal, 44*, 427-432. doi:10.1007/s10597-008-9145-8

HHS Office of Mental Health Coordination. (2018). *Mental health in Texas*. Texas Health and Human Services. Retrieved from: http://mentalhealthtx.org

Lord, V. B., Bjerregaard, B., Blevins, K. R., & Whisman, H. (2011). Factors influencing the responses of crisis intervention team-certified law enforcement officers. *Police Quarterly, 14*(4) 388-406. doi:10.1177/1098611111423743

Mok, C., Weaver, C., Rosenthal, J., Pettis, T., & Wickham, R. (2018). Augmenting Veterans Affairs police mental health response: Piloting diversion to health care as risk reduction. *Journal of Threat Assessment and Management, 5*(4), 227-237. doi:10.1037/tam0000112

Mulay, A. L., Vayshenker, B., West, M. L., & Kelly, E. (2016). Crisis intervention training and implicit stigma toward mental illness: Reducing bias among criminal justice personnel. International Journal of Forensic Mental Health. 15(4), 369-381. doi:10.1080/14999013.2016.1208308

National Alliance on Mental Health. (2019). *Mental health by the numbers*. NAMI. Retrieved From: http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

National Alliance on Mental Health. (2019). *Prevalence of mental illness*. NAMI. Retrieved From: http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

Pakes, F., Shalev-Greene, K., & Marsh, C. (2014). Crisis, trauma and loss: An exploratory study into those who 'come to notice' to police and health services and subsequently abscond. *International Journal of Police Science and Management, 16*(4). 297-307. doi:10.1350/ijps.2014.16.4.348

President's Task Force on 21st Century Policing. (2015). *Final report of the President's task force on 21st century policing* (USDOJ Publication No. e011522679). Washington, DC: Office of Community Oriented Policing Services.

Siewert, T., Mecozzi, M., & Hassan, B. (2018, August). Embracing CIT and the one mind campaign to make a difference. *The Police Chief: The Professional Voice of Law Enforcement*. 85(8). 22-25.

Texas Commission on Law Enforcement. (2016). Mental health officer curriculum [Course 4001]. Retrieved from https://www.tcole.texas.gov/training-instructor-resources

Texas Commission on Law Enforcement Officer Standards and Education. (2008). *Mental health officer course #4001* [PowerPoint slides]. Retrieved from https://www.tcole.texas.gov/training-instructor-resources

TriTech Software Systems (n.d.). Fort Worth Police Department records management system [database system]. Retrieved January 25, 2019, from https://rmswebiis01,ci,fort-worth,tx.us/InformRMS/