Implementing a Mental Health Assessment Response Team

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Abstract

Mental illness is a serious and extremely wide spread problem within the United States. In fact, the issue existed long before the United States became a country. For centuries, mental illness has plagued our citizens, and as time progressed into the society we know today, law enforcement officers (LEO) have been thrust into dealing with the issue. In the not so recent past, after changes in legislation, when it was no longer acceptable to lock emotionally disturbed people (EDP) away in mental health institutions, society looked to LEOs for the answer in dealing with the problem. Unfortunately, for all involved, the EDP, the EPD's family, the LEO, the correctional institutions, and the tax payers, most EDPs were incarcerated criminally through arrest. LEOs were doing what they had been taught or told to do and frankly, there was no other solution to the problem. This resulted in scores of mentally ill individuals who were incarcerated in prison when in reality, they should have received professional humane treatment by mental health professional instead. For this research, a survey was conducted using a mixed collection of nineteen separate law enforcement agencies; consisting of both municipal police departments and county sheriff's offices, within the state of Florida. The municipal police departments represented (36.8%) of recipients and the sheriff's offices represented (63.2%) of the recipients.

Introduction

The subject of mental health disorders within the United States has been thoroughly researched and well documented within the social services, scientific, psychological, and medical communities. How well has it been studied and dealt with in the law enforcement community? It has been estimated that one in five people in America, totaling approximately 44 million Americans, suffer from some form of a mental health disorder (National Alliance on Mental Illness, 2019). The research and results also revealed: 10 million Americans are afflicted by a co-existing mental health disorder and a drug or alcohol dependency, 26% of homeless people have a mental disorder, 90% who commit suicide have a mental disorder, and 24% of America's state prisoners have a mental disorder (National Alliance on Mental Illness, 2019). The aforementioned numbers are staggering, especially when you consider American is one of the most technologically and scientifically advanced countries in the world.

The results appear to indicate the problem with mental health disorders is not being handled properly, despite the available medical options. The question is, "Why are the numbers so high?" The statistics indicated nearly 60% of adult Americans with a mental health disorder did not seek mental health treatment (National Alliance on Mental Illness, 2019). The number was only about 10% lower for juveniles (National Alliance on Mental Illness, 2019).

Agency decision makers should be aware of the mental health problems which plague our communities and leave the Law Enforcement Officers (LEOs) holding the

proverbial bag. As with many other problems in our society, LEOs are forced into dealing with emotionally disturbed individuals, often without having the proper training and resources available. To put it into another perspective, in addition to handling everyday calls for service, such as violent crimes in progress, special events, traffic crashes, missing persons, domestic violence, and a whole litany of other duties, LEOs respond to a large number of calls for service which involve an emotionally disturbed person (EDP).

Law enforcement officers (LEOs) are left on the front lines when dealing with individuals suffering with some form of a mental disorder. The training offered today, in order to assist LEOs recognizing the signs of an EDP, and how to deal with an EDP is critical. Having the necessary training and ability to recognize an EDP is a key step in assessing whether that EDP presents a threat to the public and the LEO handling the call. Specialized training in dealing with EDPs teaches LEOs different tactics and strategies to help de-escalate the situation and resolve the matter with peacefully with a non-voluntary trip to a mental health assessment facility. One of the main problems LEOs face when dealing with an EDP is that most of the time it is on a continual basis. Meaning, the LEO responds to a call for service involving an EDP. The LEO takes the EDP into custody for a non-voluntary assessment at a mental health treatment facility and less than 72 hours the person is released back into the community.

Law enforcement is only part of the equation to the solution involving EDPs. The other part of the equation involves a strong partnership with mental health professionals (MHP). This can be achieved by combining LEOs and mental health professionals from the onset of the initial response to an EDP. By responding together as a team, the LEO and MHP can establish a relationship with the EDP, and follow through with the appropriate long-term mental health treatment. The overall goal is to obtain the necessary assistance for the EDP, while preventing the reoccurring calls for service, and avoiding the arrest of and possible incarceration of individuals diagnosed with some form of mental health problem.

Literature Review

History of Institutionalization in America

The study of history is important because it helps one to learn and understand mistakes, as well as the successes, of our predecessors. The concept of studying the history of mental health issues, the issue of institutionalization, and deinstitutionalization has been applied during the course of this research.

In early America, the mentally ill were generally cared for by family members, although, mental illness was grossly misunderstood due to the lack of formal study and education. In the past, mental illness was thought to be caused by a moral character flaw or the lack of religion in one's life; therefore, the mentally ill were often imprisoned.

According to the National Institutes of Health – U.S National Library of Medicine's web page,

> 1752 - The Quakers in Philadelphia were the first in America to make an organized effort to care for the mentally ill. The newly-opened Pennsylvania Hospital in Philadelphia provided rooms in the basement complete with shackles attached to the walls to house a small number of mentally ill patients. Within a year or two, the press for admissions required additional space, and a ward was opened beside the hospital (Ozarin, 2006).

During the early part of the 18th century, philosophers, theologians, and physicians all studied and thought mental health issues should fall under their own respective discipline. By the end of the 18th century the philosophers and theologians had abandoned the study of mental health issues, which eventually led to the birth of the psychiatric medical profession (Ozarin, 2006). By the end of the 18th century, mental health issues were believed to be related to "irritation of blood vessels in the brain" (Ozarin, 2006) and some forms of treatment consisted of "bleeding, purging, hot and cold baths, and mercury" (Ozarin, 2006) ingestion.

As the population significantly increased within the U.S. over the 19th century, a need for the care of the mentally ill inherently increased as well. It was during this time frame that the individual states began to assume responsibility for mentally ill individuals. Eventually, each state had established at least on hospital for the mentally ill. As an example of this process, the aforementioned Pennsylvania Hospital for the Insane, which was opened by the Quakers, transformed into the Pennsylvania Hospital for the Insane in 1856 and continued in operational capacity until 1998 (Ozarin, 2006). "By mid-20th century, the hospitals housed over 500,000 patients but began to diminish in size as new methods of treatment became available" (Ozarin, 2006).The trend continued to produce more hospitals and more patients who were suffering from mental illness. One of the biggest problems associated with the facilities was the various forms of treatment which was dependent upon each doctor's education, training, and the latest treatment phenomenon at the time. The poor treatment of patients and the unsanitary living conditions associated with mental health hospitals were not uncommon traits (Ozarin, 2006).

History of Deinstitutionalization in America

The state hospitals, or asylums as they were commonly called, originated from the good intention to help people who suffered from mental health related issues. These hospitals were built with large wings which sprouted off of the main facility. Generally, the hospitals were "large Victoria-era buildings surrounded by extensive grounds, often including farmland which was sometimes worked by patients for exercise and therapy" (Frances & Ruffalo, 2018). By the early part of the 1900s, the well-intended hospitals began a downward spiral, the facilities changed into vastly over populated human storage facilities. Due to the large size of the physical facilities and the overpopulation of patients, funding became difficult to maintain. The hospitals could not properly care for and treat patients properly and humanly. Mentally ill people were locked away; some for the rest of their life, without any due process. Patients who were subjected to these

hospital and treatment or lack thereof, resulted in the patient's condition worsening. (Frances & Ruffalo, 2018).

By the mid-1900s, the largest hospital, Pilgrim State Hospital, in New York, had a population of 13, 875 patients (Ruffalo, 2018). By the 1960s, over half a million American citizens were committed to psychiatric hospitals which were now being run like a prison. Experimental and dangerous treatments were being conducted on the patients. As funding for the hospitals continued to dwindle and the conditions continued to deteriorate, the problems associated with the treatment of the mentally ill became publicly noticeable. Books and reports on the issue were written making the public more aware. The advancement in prescription medicines and more importantly from the top official in the land, "Jack Kennedy, the newly elected president, had a strong personal commitment to help people with mentally illness based on his sisters' disastrous experience with lobotomy" (Frances & Ruffalo, 2018). Finally, in 1975, the Supreme Court weighed in on the matter of involuntary commitment to a mental health facility in the landmark case of *O'Conner vs. Donaldson* (422 U.S. 563). In a unanimous decision, the court ruled that committing a person involuntarily to a mental health facility was a violation of the individual's civil liberty and therefore, it was unconstitutional, unless the person was a danger to themselves or others (Xing, 2016). Additionally, in 1979, the court also raised the bar on the level of proof required to have a person committed. Prior to 1979, "preponderance of the evidence" was the required proof but after the *Addington v. Texas* (441 U.S. 418, 1979), the level of proof was raised to the higher "clear and convincing evidence" level (Xing, 2016).

All of the aforementioned issues started which would essentially become a large scale shutdown of mental health hospitals, effectively displacing over 600,000 patients into the community over a thirty year period of time (Frances & Ruffalo, 2018). "The early focus was on moving individuals out of state public mental hospitals and from 1955 to 1980, the resident population in those facilities fell from 559,000 to 154,000" (Koyanagi & Bazelon, 2007, p. 1).

> The history of deinstitutionalization began with high hopes and by 2000; our understanding of how to do it had solidified. But it was too late for many. Looking back, it is possible to see the mistakes, and a primary problem was that mental health policymakers overlooked the difficulty of finding resources to meet the needs of a marginalized group of people living in scattered sites in the community. Multiple funding streams were uncoordinated. Even when needs were eventually recognized it was difficult to braid together a comprehensive service package (Koyanagi & Bazelon, 2007, p. 2).

By releasing that many mentally ill people back into an ill prepared public, it was long before the problems of the mentally ill became the problem of everyday Americans. The resources that were imagined during the start of the deinstitutionalization process did not evolve over the course of the thirty-year time frame. Funding for programs continued to be cut and the insurance industry was also reducing mental health benefits. Citizens across American became less accepting of the public use of drugs and alcohol use within their communities. There were no viable solutions in place to

address the problem of the mentally ill and in turn, the problem fell right into the laps of local LEOs. It seemed the U.S had gone from one extreme to the other in terms of dealing with EDPs (Koyanagi & Bazelon, 2007).

Training LEOs to Respond to an EDP

Due to deinstitutionalization, the populations of jails, prisons, and homeless people on the street became increasingly noticeable (Frances & Ruffalo, 2018). Most LEOs during the course of the thirty-year period of deinstitutionalization had little to no training on how to deal with or how to handle EDPs. LEOs were created out of the need to prevent and suppress crime, and the only solution to dealing with an EDP at the time was often incarceration. The lack of training, related to dealing with EDPs, offered to LEOs was a disaster in the making. Due to the repeated calls for service involving the same EDPs and the consumption of time it took during a shift; LEOs became increasingly exasperated. “As a result of these frustrated attempts, officers frequently - although not usually - resort to arrest to dispose of the case, even for relatively minor offenses such as trespassing, disorderly conduct, or other non-serious misdemeanors” (Hails & Borum, 2003, p. 53). Studies conducted within the U.S. revealed that up to 15% of inmates within jails suffer from mental illness (Hails & Borum, 2003).

As a result of an increasing contact between LEOs and EDPs, the number of incidents involving use-of-force will logically increase, especially since LEOs lacked specialized training. Use-of-force incidents impact the EDP, the LEO, the LEO agency, and the community. High profile publicized use-of-force incidents, especially those involving the death of an EDP, may erode trust between the public and LEOs. Losing public trust may take years for a department to recover from, if ever. In addition to losing the trust, the department can expect law suits and possible intervention by the U.S. Department of Justice (Hails & Borum, 2003).

Due to the use-of-force issues associated with LEOs when dealing with EDPs, department heads began to realize the importance for the need to incorporate training aimed at dealing with EDPs. By the late 1990s, surveys indicated that approximately 90% of law enforcement agencies indicated they offered training to their officers on mental health related issues. Overall, a 90% benchmark is pretty significant but there was no standard or survey produced to measure exactly what the training entailed and the quality of the training. Surveys also indicated the amount of training averaged approximately six hours and at least one-third of the overall training was devoted to other topics such as substance abuse and disabilities, which clearly are different issues and topics opposed to EDPs (Hails & Borum, 2003).

Evolution of Training

Generally, LEOs had three options to use when dealing with an EDP. The first option is to handle the call informally, hoping to quickly resolve the issue while on scene. This may work sometimes depending on a multitude of factors, such as the disposition of the EDP, the severity of the crisis the EDP is experiencing at the time, the disposition of the LEO, and other surrounding factors. The second option was to make an arrest for a crime, which as we know isn’t the best solution but sometimes it

temporarily solves the issue at hand but does not solve the overall problem. The third option is to take the EDP into custody for an involuntary evaluation by a mental health professional (The University of Memphis, n.d.).

In 1987, the Memphis Police Department received a call for service involving an emotionally disturbed man. The man was armed with a knife when the LEOs made contact with him and subsequently ordered him to put the knife down. The man became increasingly agitated and aggressively moved towards the LEOs, still armed with the knife. The Caucasian officers fired their weapons, striking the African- American man, and ultimately killing him. Prior to the incident, the relationship between the African-American community and the Memphis Police Department was poor at best, due to racial tension and this particular shooting created a public uproar. Citizens began protesting against racism and police brutality.

> The Mayor of Memphis turned to local advocates from the National Alliance On Mental Illness (NAMI) and enlisted police, community mental health professionals, university leaders, hospital administrators, and church officials to seek a new approach to working with persons with mental illness in crisis. What emerged from this initial task force was the Memphis Police Department Crisis Intervention Team (CIT) that would become known in later years as the Memphis Model. The originators of CIT combined several insights that revolutionized how individuals with mental illness in crisis would be approached by police officers and effectively routed to appropriate mental health care facilities rather than jail. The CIT pioneers envisioned a team of uniform patrol officers selected for specialized training in basic crisis intervention. The officers would be spread throughout the city on all shifts. These officers would perform the usual duties of uniform patrol officers but would be available for immediate dispatch to mental health crisis scenes. Arriving without delay, CIT officers would be able to de-escalating the crisis, decreasing the likelihood of violence and injury to patients, family members, neighbors and police officers. With assistance from other police officers, the CIT officer would assess the individual in crisis and make the decision whether or not to transport a patient for further evaluation. The receiving facility would offer a single point of entry with referrals to resources such as community mental health services, social services and Veteran's services (The University of Memphis, n.d.).

The CIT model, developed in Memphis, was a giant step in the right direction for LEOs when dealing with EDPs. The model developed a standard which provided direction and understanding for the LEO in terms of recognizing the signs and symptoms of an EDP. Studies have revealed that CIT trained officers are less likely to use force on an EDP as opposed to officers who are not CIT trained (Bonkiewicz, Green, Moyer, & Wright, 2014). Relationships between the CIT trained officers and public, especially an EDP revealed significant improvement. The study determined the improved relationship is largely in part to the training the LEO receives, which boosts the officer’s confidence when dealing with an EDP.

CIT vs. Mental Health Assessment Response Team

Orange County Sheriff's Office (OCSO) General Order (G.O.) 6.2.1 – Mental Health Encounters / Baker Act, defines a CIT as "Crisis Intervention Team (CIT) – a team of specially trained deputies who are designated to handle situations involving the mentally ill in crisis." "The Baker Act is a Florida law that enables families and loved ones to provide emergency mental health services and temporary detention for people who are impaired because of their mental illness, and who are unable to determine their needs for treatment" (University of Florida Health, 2019). OCSO G.O.6.4.0 – Crisis Intervention Team (CIT) defines "crisis" as,

> – a crisis could consist of a call for service involving a person having paranoid delusions or hallucinations, displaying erratic behavior (disorientation, disorganized speech or confusion), causing a disturbance (mania, belligerent, angry or hostile), and talking to themselves or other activity that causes alarm or concern to the average person. The calls for service can also include Baker Acts, suicidal persons, and "wanderers" with dementia or Alzheimer patients and disorderly or intoxicated persons. It could involve an armed person threatening or actually engaging in violence or harm to another or self-neglect such as refusing to take prescribed medicines. It may also include nuisance type calls for service (loitering, panhandling or trespassing) (Orange County Sheriff's Office, 2018).

Breaking down the definition of a "crisis", one may quickly realize that the definition is broad and some of the examples provided may not necessarily warrant a Baker Act or an arrest.

The word "crisis" may have a broad definition within the OCSO policy but U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA) recommended a language change in some of the agency's literature. The recommended change was to stop using the word "crisis" as a cover all word when referring to an EDP and use the word "situation" instead. This little recommendation may seem insignificant but if one refers back the OCSO definition of "crisis", not every example provided within the definition contained within the policy, rises to the true meaning of "crisis." "Such a shift would emphasize the occurrence of these events as a regular part of life to which the health care system usually should be equipped to respond, rather than high-profile events always requiring a law enforcement response" (Steadman & Morrissette, 2016).

Having LEOs trained as a member of a CIT is a great concept and has proven useful in many instances, especially recognizing the signs of an EDP and how to deal with the subject. However, the CIT is designed to handle an immediate situation and is not designed to provide assistance over a long period of time.

> Although CIT has proven effective in resolving acute mental health crises, both law enforcement agencies and mental health organizations have devoted less attention to contact with consumers after the crisis. In other

> words, when the police officer and mental health crisis team member go home, the consumer often attempts to obtain services without any assistance. For a consumer with untreated depression, anxiety, or schizophrenia, obtaining mental health services without help can be supremely challenging. Regardless of whether officers informally handle a crisis, arrest the consumer, or place the consumer in EPC, post-crisis assistance might help consumers obtain services, and in turn, reduce future mental health crises and contact with the police (Bonkiewicz, Green, Moyer, & Wright, 2014, p. 765).

Now is the time for law enforcement agencies to look at continuing to progress when it comes to dealing with EDPs. Creating and implementing a mobile mental health assessment response team is a viable option which should be considered to assist the citizens and ensure the safety the person suffering from mental illness, the family members, and the LEOs who respond to the calls for service. The following research will focus on the implementation of a mobile mental health assessment response team. The mobile mental health assessment team would be composed of civilian employees of the law enforcement agency and are licensed mental health specialists who would respond to calls involving EDPs but only after they are called upon by the LEOs on the scene.

Methods

This research was conducted to ascertain more information on the services offered by police departments and sheriff's offices, regarding calls for service, which involve an emotionally disturbed person. The research attempted to identify which law enforcement agencies use a specialized co-response, in which a mental health professional responds and provides direct assistance to the LEO when answering a call for service involving an EPD. The purposes of the co-responder model is to enhance public safety for all parties involved, have the EDP assessed by a qualified medical professional, implement the correct medical care plan, avoid incarceration of the EDP, and allow the LEO to rapidly return to service.

The data was collected from the responses of a survey which had been distributed to nineteen law enforcement agencies within the state of Florida. The survey was distributed to each agency's subject matter expert, via Survey Monkey; an online commercial software product used to develop, manage, and analyze data from surveys.

The survey and the procedures associated with it had been approved by the Florida Department of Law Enforcement (FDLE) – Senior Leadership Program prior to distribution. Participants reviewed a consent form and agreeably responded in order to continue the survey.

The survey questions were designed to elicit information from the participants', in reference to their agency's structure and methods when responding to an EDP call.

An identified weakness was the limited amount of data due to the small number of sample agencies comparable in size to the Orange County Sheriff's Office.

Results

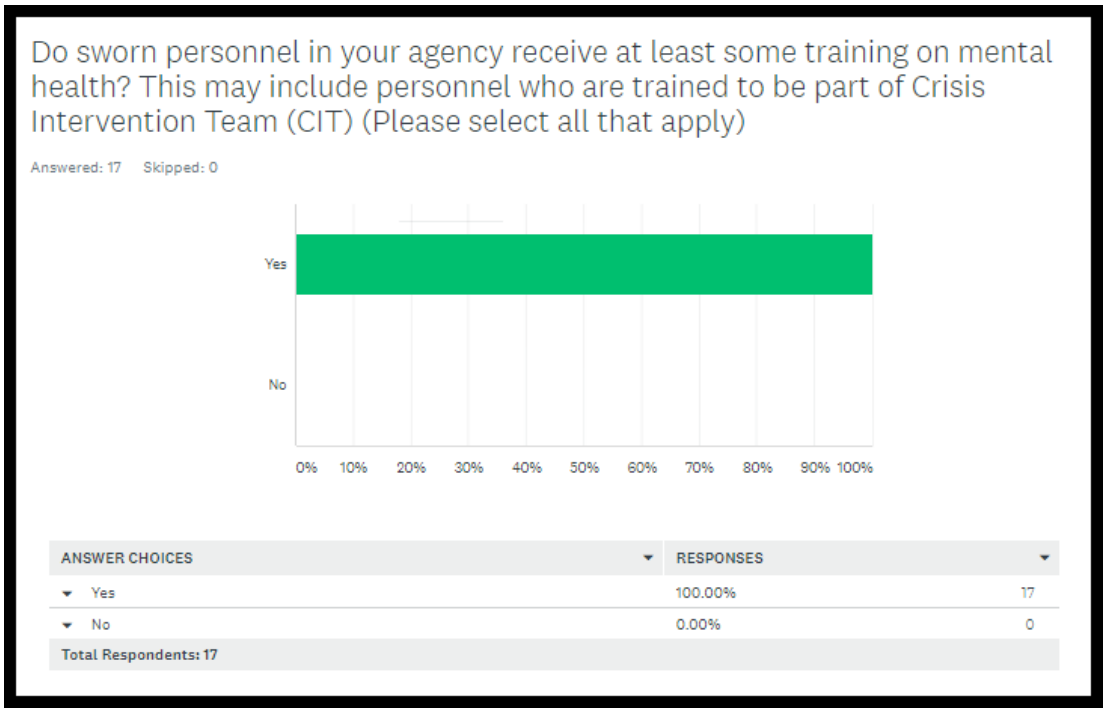
On June 13, 2019, a survey consisting of 19 questions was launched. The survey was sent to 19 recipients via Survey Monkey, in the form of an electronic mail (e-mail), which contained a hyperlink. The survey recipients consisted of a mixed group of 19 individuals, employed at 19 separate law enforcement agencies, and consisted of both municipal police departments and county sheriff's offices, within the state of Florida. The municipal police departments represented (36.8%) of recipients. The sheriff's offices represented (63.2%) of the recipients. Federal and state law enforcement agencies were not included in the survey due to the unique difference in their respective law enforcement missions compared to that of sheriff's offices and municipal police departments.

On June 21, 2019 a second e-mail invitation was sent out via Survey Monkey, reminding the recipients to complete the survey. Also, on July 8, 2019, a third e-mail was sent out to the recipients, reminding the participants to complete the survey because it was going to close out.

In total, 18 (94.7%) recipients, opened the survey; however, only seventeen recipients (89.5%) completed 100% of the survey. One recipient (5.3%) "clicked" through the survey but never completed any responses (0%) and one (5.3%) recipient never opened the survey. The survey took an average of eight minutes to complete.

Question 1:

The first question of the survey asked the participants, "Do sworn personnel in your agency receive at least some training on mental health? This may include personnel who are trained to be part of Crisis Intervention Team (CIT)." The only answer response options for this question were "yes" and "no."



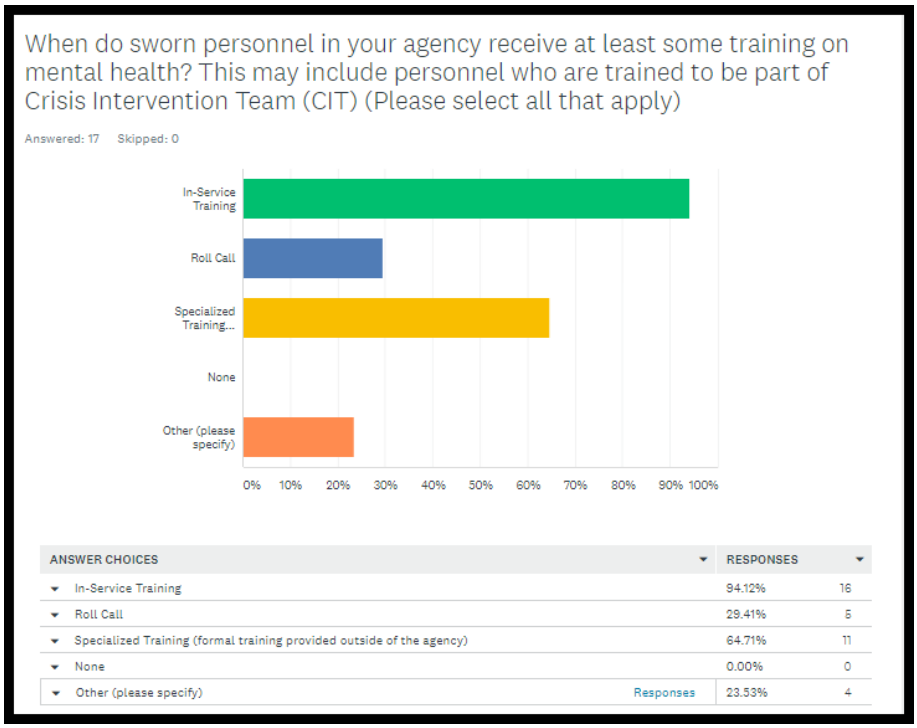
Question 2:

The second question of the survey asked the participants, "When do sworn personnel in your agency receive at least some training on mental health? This may include personnel who are trained to be part of Crisis Intervention Team (CIT) (Please select all that apply)." Question 2 had multiple choice answers and allowed for the participants consisted of the following optional answers:

1. In-Service Training
2. Roll Call Training
3. Specialized Training (formal training provided outside of the agency)
4. None
5. Other (explain answer)

Q2 results:

1. In-Service Training – 16 responses = (94.12%)
2. Roll Call Training – 5 responses = (29.41%)
3. Specialized Training (formal training provided outside of the agency) – 11 responses = (64.71%)
4. None – zero responses = 0%
5. Other (explain answer) – 4 responses = (23.53%). Of those who answered this question, the following explanations were provided:
    a. New recruits go thru a four-hour block during orientation.
    b. We have an 8hr mental health course that was required to be completed by all members of the agency, which took a few years to get everyone through. This was in addition to the mental health block received during annual IST.
    c. All of the above.
    d. Ongoing Police One online courses.



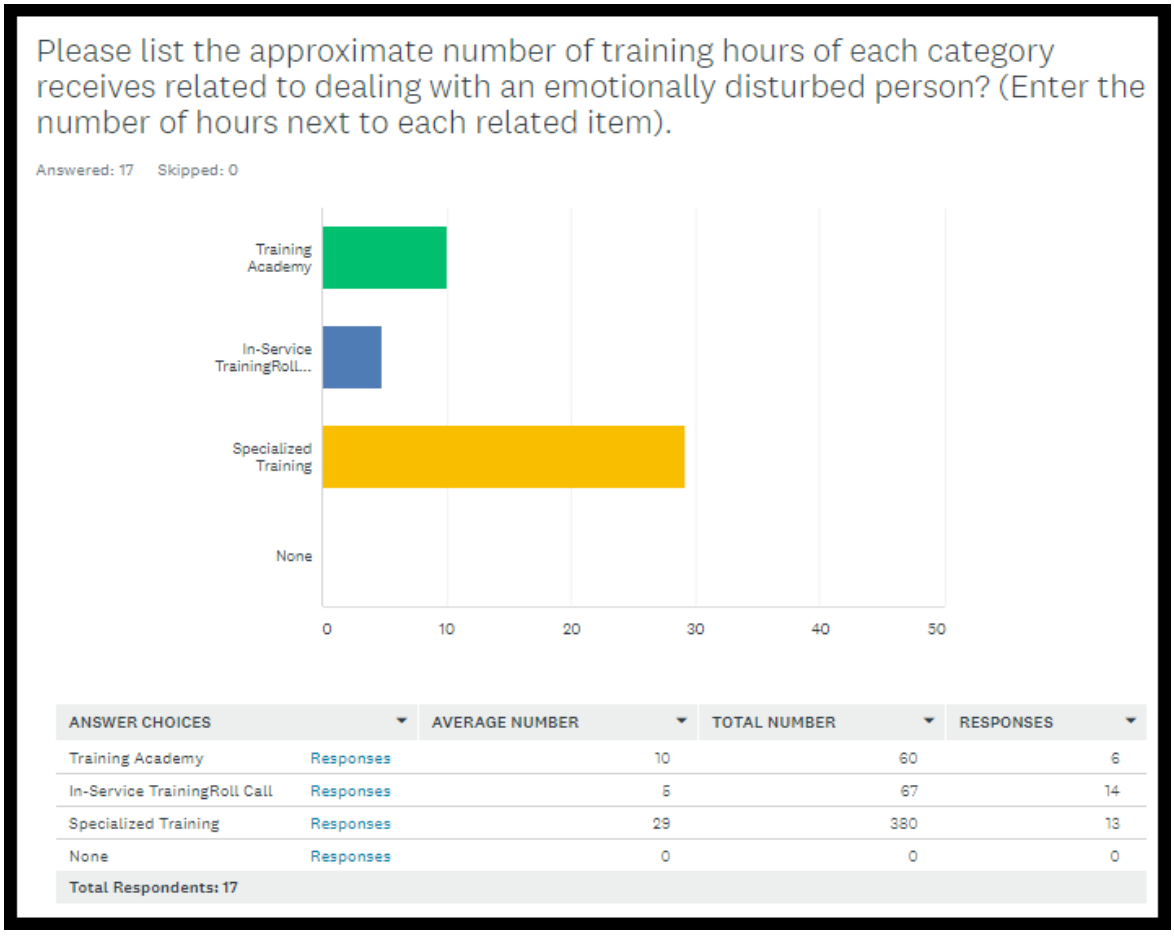
Question 3:

The third question asked participants, “Please list the approximate number of training hours of each category receives related to dealing with an emotionally disturbed person? (Enter the number of hours next to each related item).” The answer options for were:

1. Training Academy
2. In-Service Training/Roll Call
3. Specialized Training
4. None

Q3 Results:

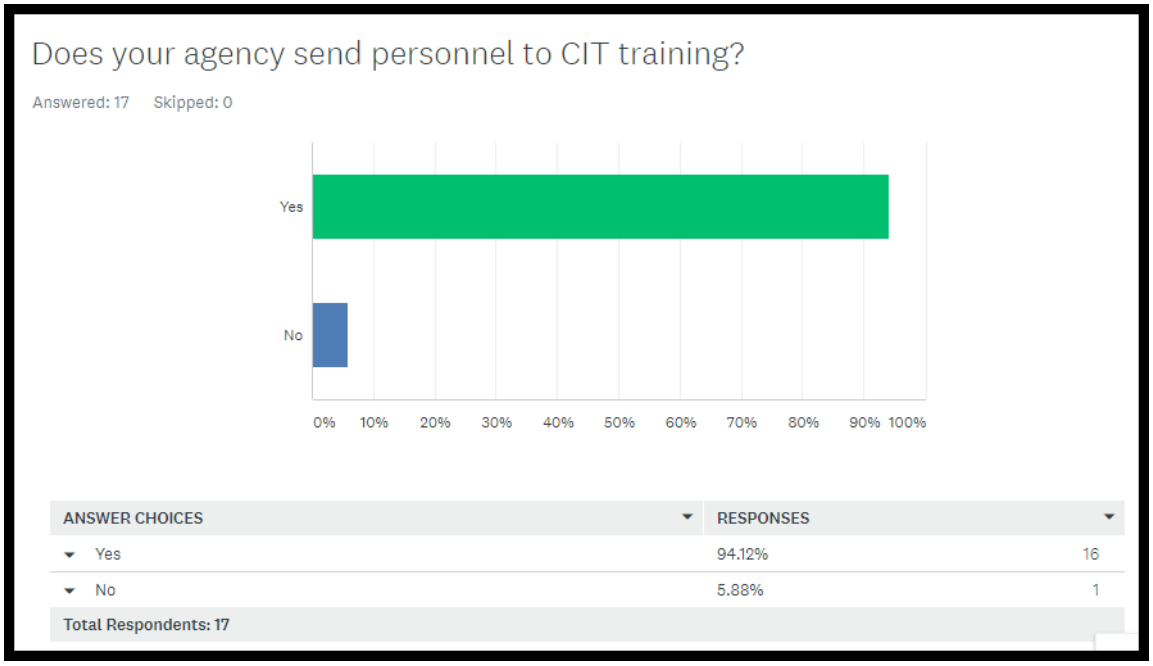
1. Training Academy – six respondents (35.3%) answered 10 hours
2. In-Service Training/Roll Call – 14 respondents (82.4 %) answered five hours
3. Specialized Training – 13 respondents (76.5%) answered 29 hours
4. None – no respondents answered this option (0%)



ANSWER CHOICES		AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
Training Academy	Responses	10	60	6
In-Service TrainingRoll Call	Responses	5	67	14
Specialized Training	Responses	29	380	13
None	Responses	0	0	0
Total Respondents: 17				

Question 4:

Question four asked, “Does your agency send personnel to CIT training?” The options to this question were “yes” and “no.” Sixteen of the 17 respondents (94.12%) answered in the affirmative. Only one respondent answered (5.88%) answered “no.”



Question 5:

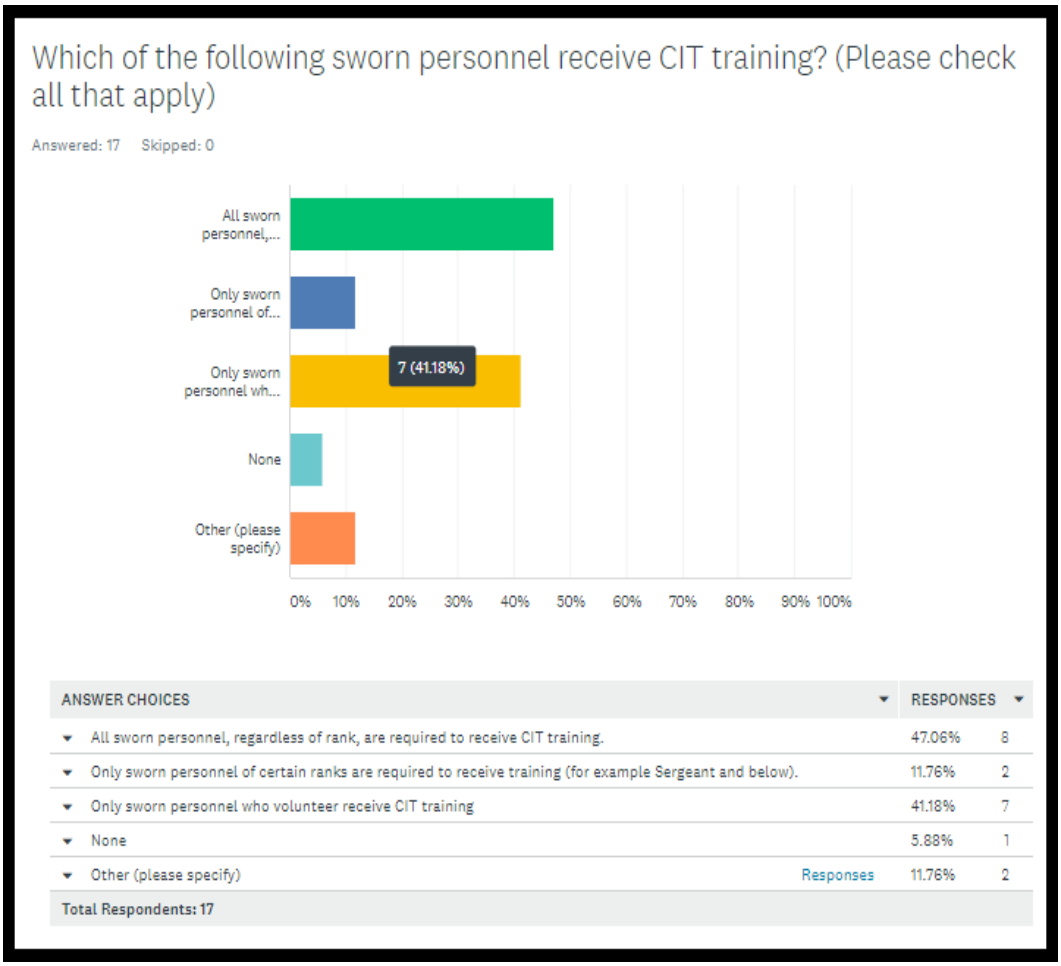
The fifth question was a five-answer multiple choice question that asked, “Which of the following sworn personnel receive CIT training? (Please check all that apply).” The five answer choices for the respondents were:

1. All sworn personnel, regardless of rank, are required to receive CIT training.
2. Only sworn personnel of certain ranks are required to receive training (for example Sergeant and below).
3. Only sworn personnel who volunteer receive CIT training.
4. None
5. Other (please specify)

Q5 Results:

1. All sworn personnel, regardless of rank, are required to receive CIT training – Eight respondents = (47.06%).
2. Only sworn personnel of certain ranks are required to receive training (for example Sergeant and below) – Two respondents = (11.76%).
3. Only sworn personnel who volunteer receive CIT training – Seven respondents = (47.18%).
4. None – One respondent = (5.88%).

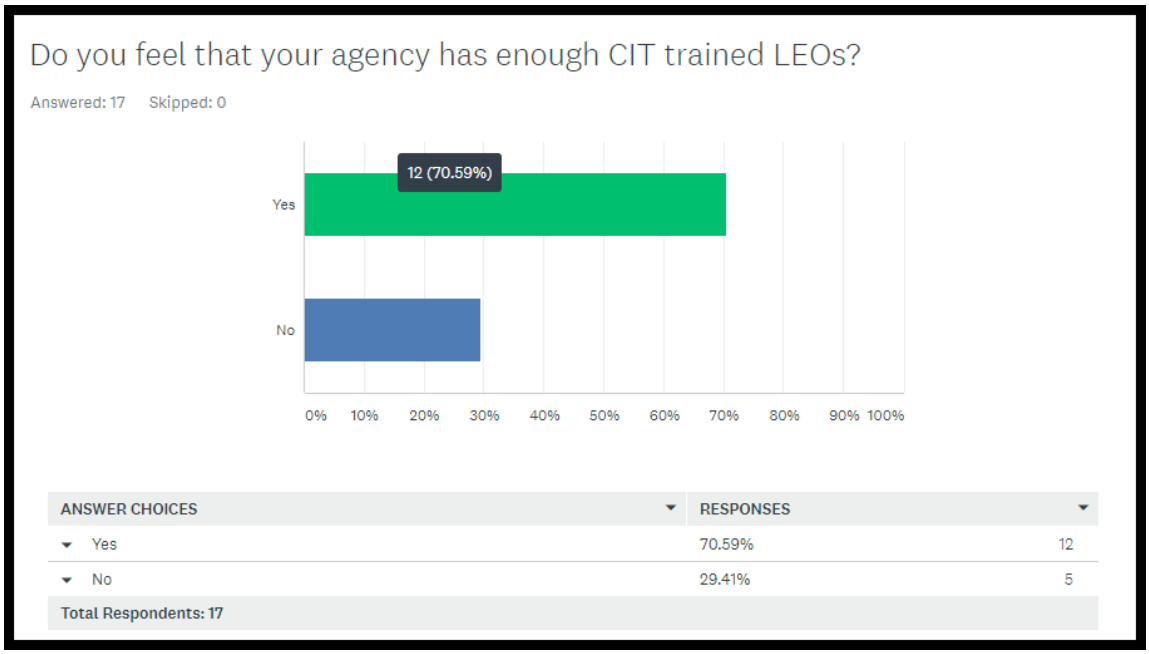
6. Other (please specify) – Two respondents = (11.76%). Of the two who answered this question, the following explanations were provided:
   a. All personnel will eventually receive the 40 hour CIT Training.
   b. All certified LEO and CO personnel are required. We also send some civilian members depending on their duties



ANSWER CHOICES		RESPONSES	
All sworn personnel, regardless of rank, are required to receive CIT training.		47.06%	8
Only sworn personnel of certain ranks are required to receive training (for example Sergeant and below).		11.76%	2
Only sworn personnel who volunteer receive CIT training		41.18%	7
None		5.88%	1
Other (please specify)	Responses	11.76%	2
Total Respondents: 17			

Question 6:

Question six asked the respondents, “Do you feel that your agency has enough CIT trained LEOs?” The choices for the answers were a “yes” and “no” option only. Twelve respondents (70.59%) answered “yes.” Five respondents (29.41%) answered “no.”



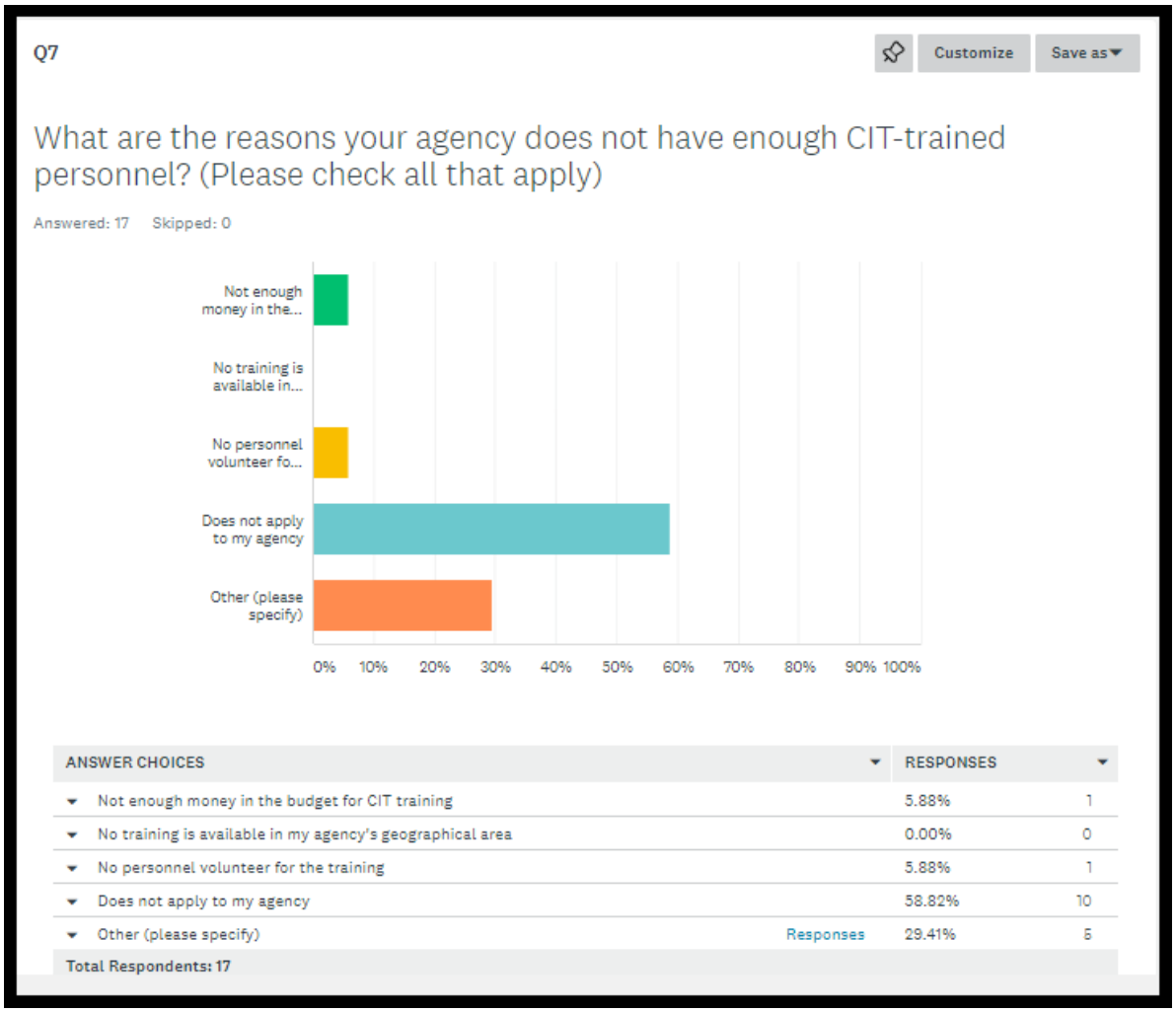
Question 7:

Question 7 asked, "What are the reasons your agency does not have enough CIT-trained personnel? (Please check all that apply)." This was a five-answer multiple choice question with the following answer choices:

1. Not enough money in the budget for CIT training.
2. No training is available in my agency's geographical area.
3. No personnel volunteer for the training.
4. Does not apply to my agency.
5. Other (please specify).

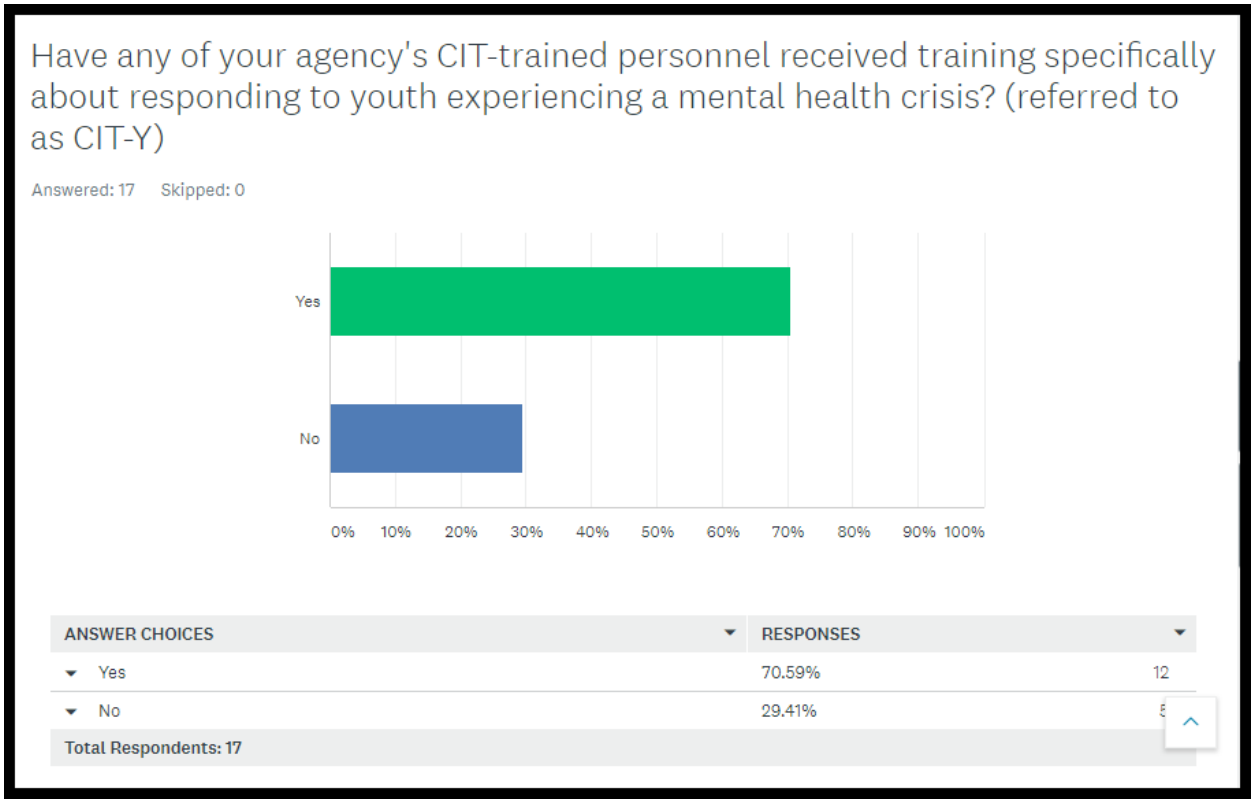
Q7 Results: (Note: The following results were rounded up to the nearest whole number)

1. Not enough money in the budget for CIT training – one respondent = (6.00%)
2. No training is available in my agency's geographical area – none = (0.00%)
3. No personnel volunteer for the training – one respondent = (6.00%)
4. Does not apply to my agency – Ten respondents = (59.00%)
5. Other (please specify) = Five respondents = (29.00%)
    a. N/A
    b. Small to midsize agency and it's tough to get enough trained personnel
    c. We have enough
    d. Staffing Issues



Question 8:

Question eight was a “yes” or “no” answer options only and asked the participants, “Have any of your agency's CIT-trained personnel received training specifically about responding to youth experiencing a mental health crisis? (Referred to as CIT-Y).” Twelve (70.59%) of the 17 respondents answered “yes” and five respondents (29.41%) answered “no.”



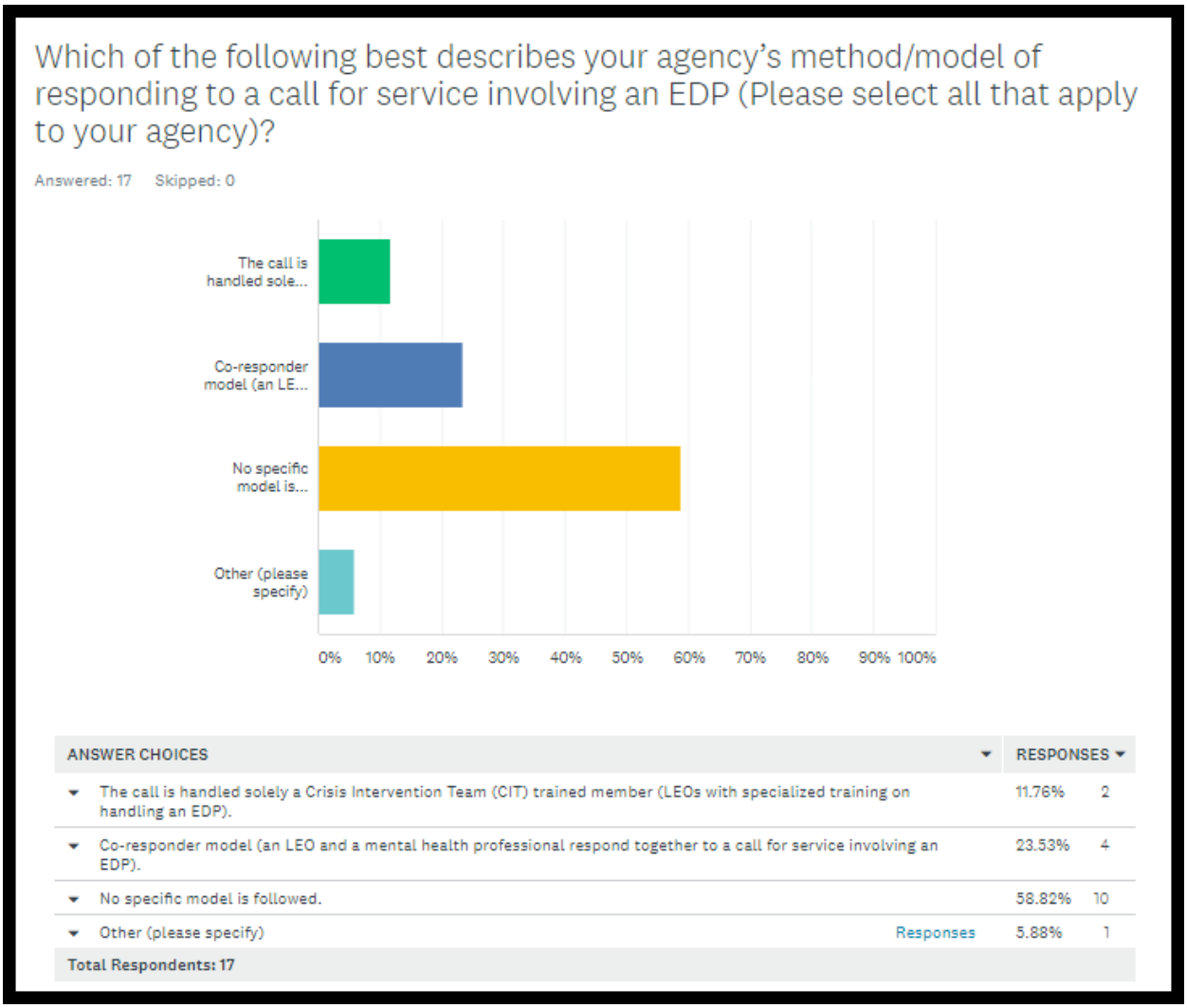
Question 9:

Question nine was a four-answer multiple choice question and asked the respondents, "Which of the following best describes your agency's method/model of responding to a call for service involving an EDP (Please select all that apply to your agency)?" The multiple choice answers were:

1. The call is handled solely a Crisis Intervention Team (CIT) trained member (LEOs with specialized training on handling an EDP).
2. Co-responder model (an LEO and a mental health professional respond together to a call for service involving an EDP).
3. No specific model is followed.
4. Other (please specify)

Q9 Results: (Note: The following results were rounded up to the nearest whole number)

1. The call is handled solely a Crisis Intervention Team (CIT) trained member (LEOs with specialized training on handling an EDP) – Two respondents = (12.00%)
2. Co-responder model (an LEO and a mental health professional respond together to a call for service involving an EDP) – Four respondents = (23.00%)
3. No specific model is followed – Ten respondents = (59.00%).
4. Other (please specify) – One respondent = (6.00%).



Question 10:

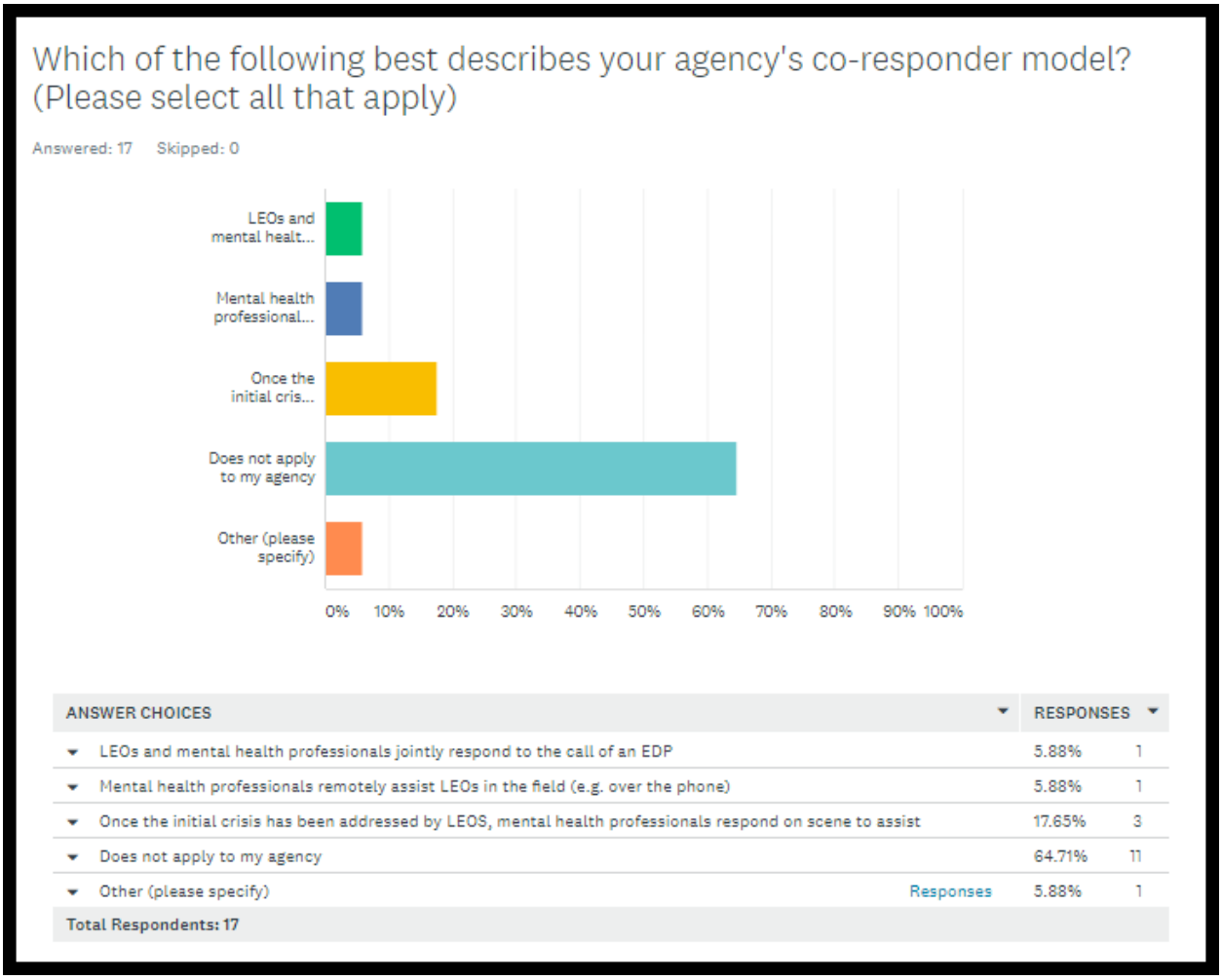
Question ten was a five-answer multiple choice asked the respondents, "Which of the following best describes your agency's co-responder model? (Please select all that apply)." The following were the multiple choice answers which the respondents were instructed to check all answers that applied.

1. LEOs and mental health professionals jointly respond to the call of an EDP.
2. Mental health professionals remotely assist LEOs in the field (e.g. over the phone).
3. Once the initial crisis has been addressed by LEOS, mental health professionals respond on scene to assist.
4. Does not apply to my agency.
5. Other (please specify).

Q10 Results:

1. LEOs and mental health professionals jointly respond to the call of an EDP – One respondent = (5.88%).
2. Mental health professionals remotely assist LEOs in the field (e.g. over the phone) – One respondent = (5.88%).

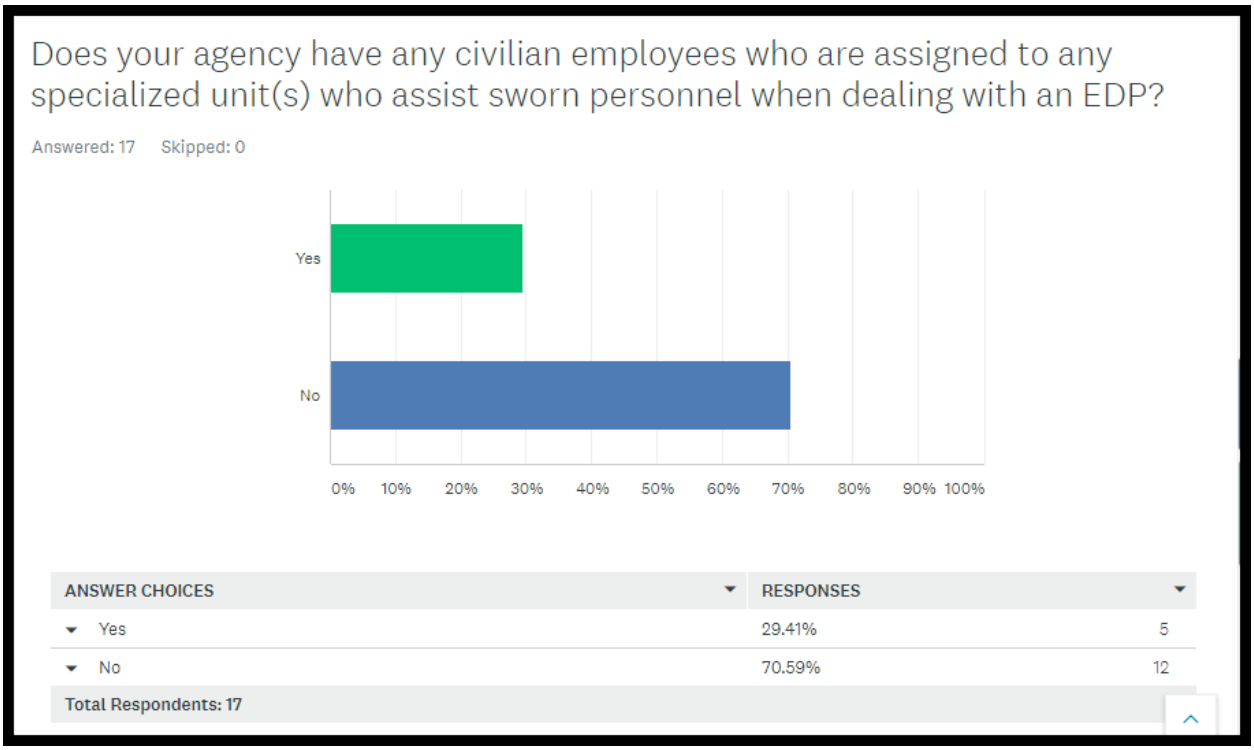
3. Once the initial crisis has been addressed by LEOS, mental health professionals respond on scene to assist – Three respondents = (17.65%).
4. Does not apply to my agency – 11 respondents = (64.71%).
5. Other (please specify) – One respondent (5.88%).
    a. Our policy states; Supervisors shall ensure that whenever possible, a CIT member is dispatched to calls involving a confirmed or suspected developmentally disabled, or mentally ill person in crisis. A crisis could consist of, but is not limited to: a person having delusions, refusing to take prescribed psychotropic medications, erratic behavior, suicidal thoughts or ideation, causing a disturbance, talking to themselves, or other activity that causes alarm or concern to the average person.



ANSWER CHOICES		RESPONSES	
LEOs and mental health professionals jointly respond to the call of an EDP		5.88%	1
Mental health professionals remotely assist LEOs in the field (e.g. over the phone)		5.88%	1
Once the initial crisis has been addressed by LEOS, mental health professionals respond on scene to assist		17.65%	3
Does not apply to my agency		64.71%	11
Other (please specify)	Responses	5.88%	1
Total Respondents: 17			

Question 11:

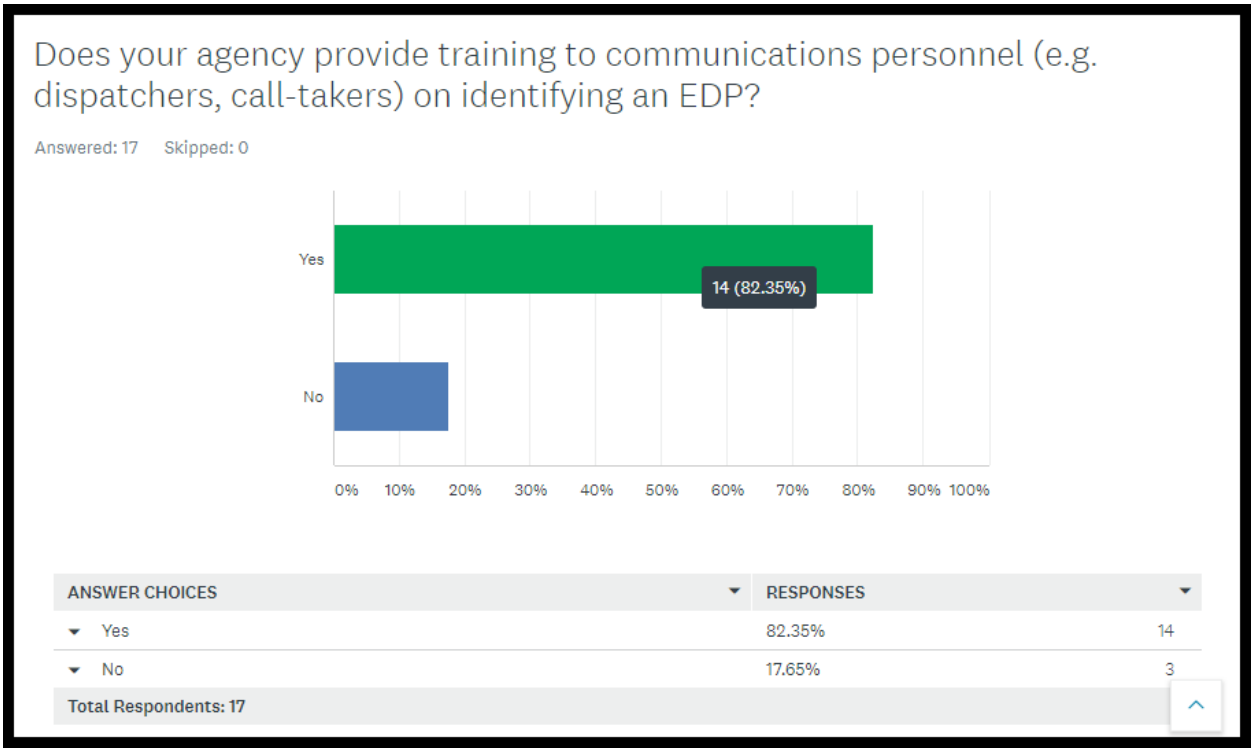
Question 11 was a “yes” or “no” option question and asked the particpants, “Does your agency have any civilian employees who are assigned to any specialized unit(s) who assist sworn personnel when dealing with an EDP?” Five respondents (29.41%) answered “yes.” Twelve respondents (70.59%) answered “no.”



ANSWER CHOICES	RESPONSES	
Yes	29.41%	5
No	70.59%	12
Total Respondents: 17		

Question 12:

Question 12 is a “yes” or “no” question that asked the participants, “Does your agency provide training to communications personnel (e.g. dispatchers, call-takers) on identifying an EDP?” Fourteen (82.35%) of the 17 respondents answered “yes” to the question and three (17.65%) responded “no.”



Question 13:

Question 13 was a four-answer multiple choice question that asked the respondents, "When do your civilian employees receive at least some training on issues related to mental health? (Please select all that apply)." The answer choices for the respondents were:

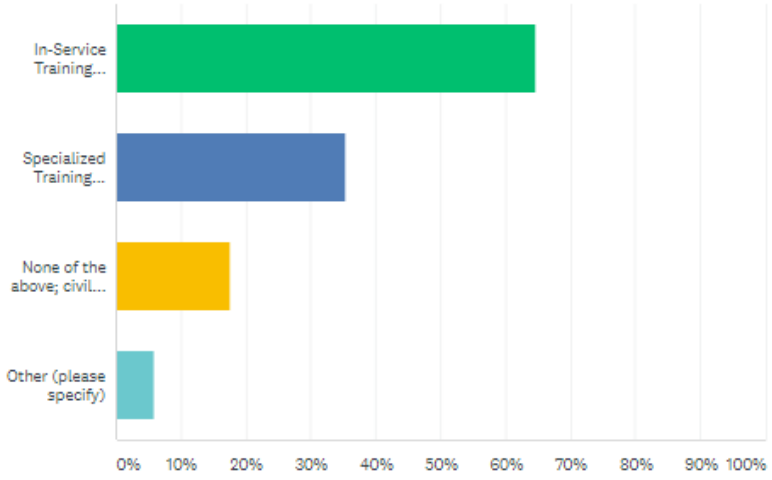
1. In-Service Training (formal training provided within the agency).
2. Specialized Training (formal training provided outside of the agency).
3. None of the above; civilian personnel do not receive this type of training.
4. Other (please specify).

Q13 Results:

1. In-Service Training (formal training provided within the agency) – 11 respondents = (64.71%)
2. Specialized Training (formal training provided outside of the agency) – 6 respondents = (35.29%).
3. None of the above; civilian personnel do not receive this type of training – 3 respondents = (17.65%).
4. Other (please specify) – 1 respondent = (5.88%).
    a. When hired

When do your civilian employees receive at least some training on issues related to mental health? (Please select all that apply)

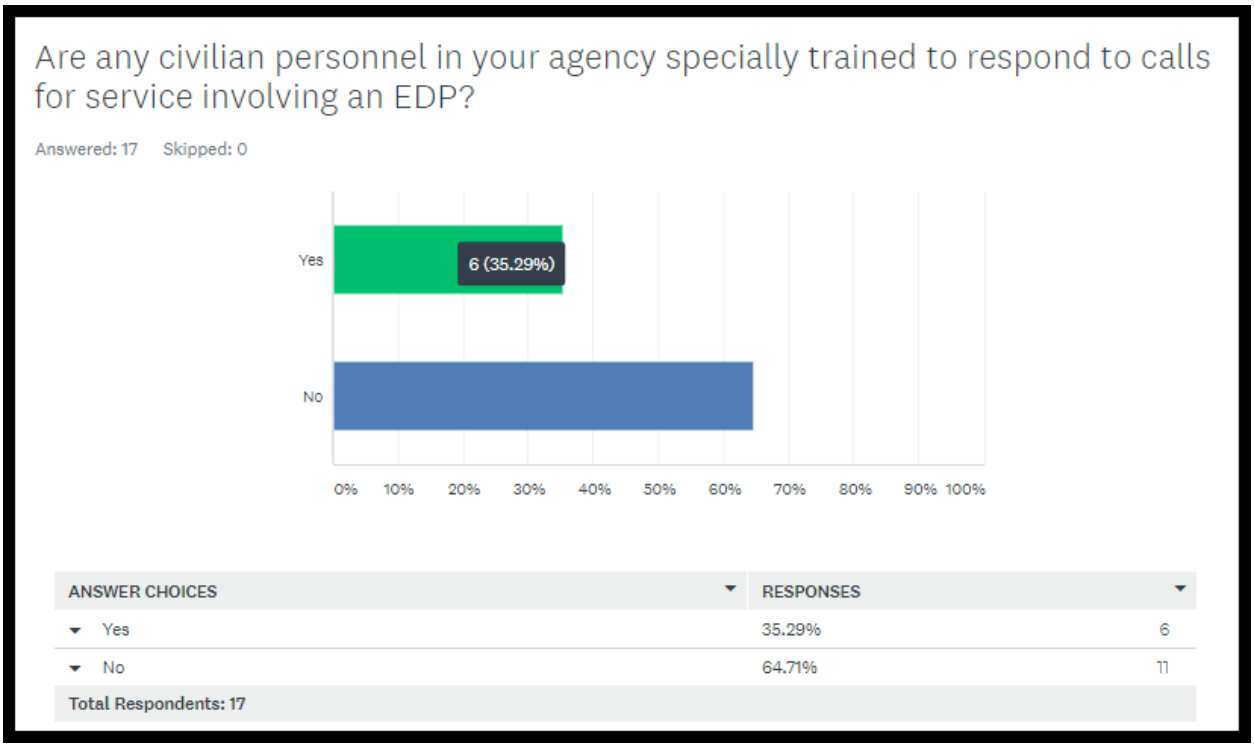
Answered: 17 Skipped: 0



ANSWER CHOICES		RESPONSES	
In-Service Training (formal training provided within the agency)		64.71%	11
Specialized Training (formal training provided outside of the agency)		35.29%	6
None of the above; civilian personnel do not receive this type of training		17.65%	3
Other (please specify)	Responses	5.88%	1
Total Respondents: 17			

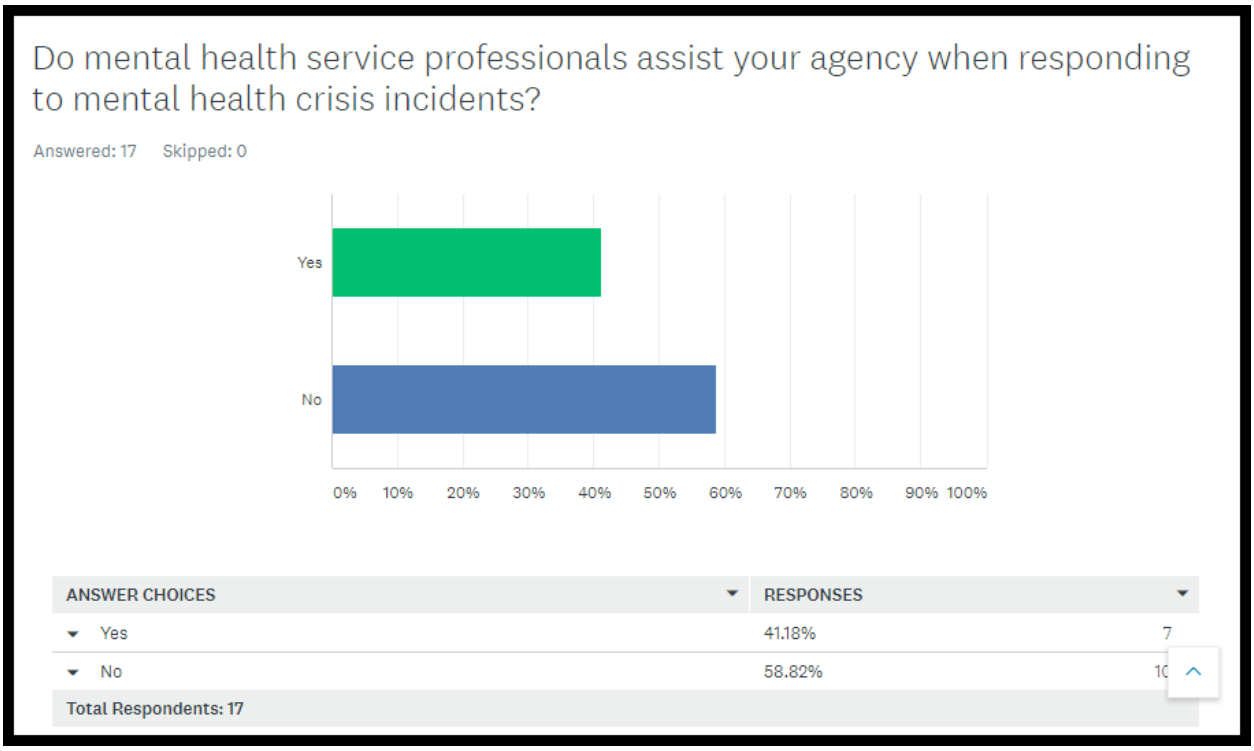
Question 14:

Question 14 was a “yes” and “no” answer option that asked the participants, “Are any civilian personnel in your agency specially trained to respond to calls for service involving an EDP?” Six participants (35.29%) responded “yes” to the question and 11 participants (64.71%) responded “no.”



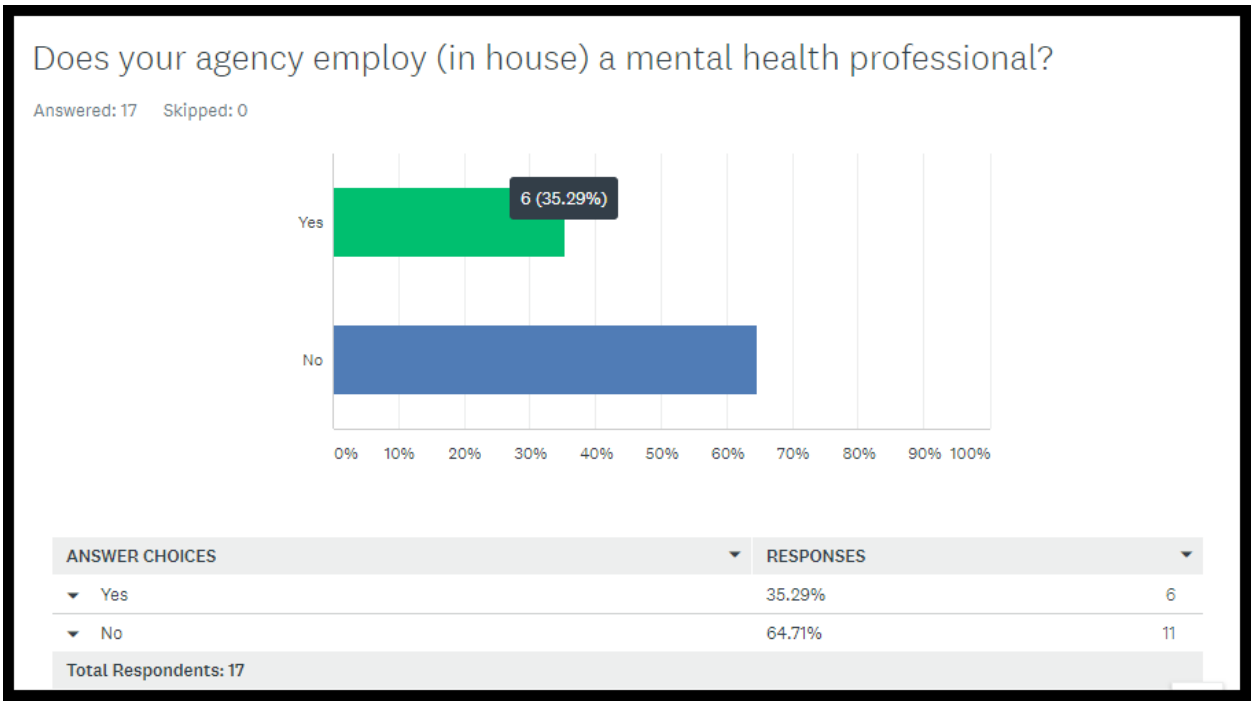
Question 15:

Question 15 was a “yes” and “no” question, which asked the participants, “Do mental health service professionals assist your agency when responding to mental health crisis incidents?” Seven participants (41.18%) responded “yes” and 10 participants (58.82%) responded “no.”



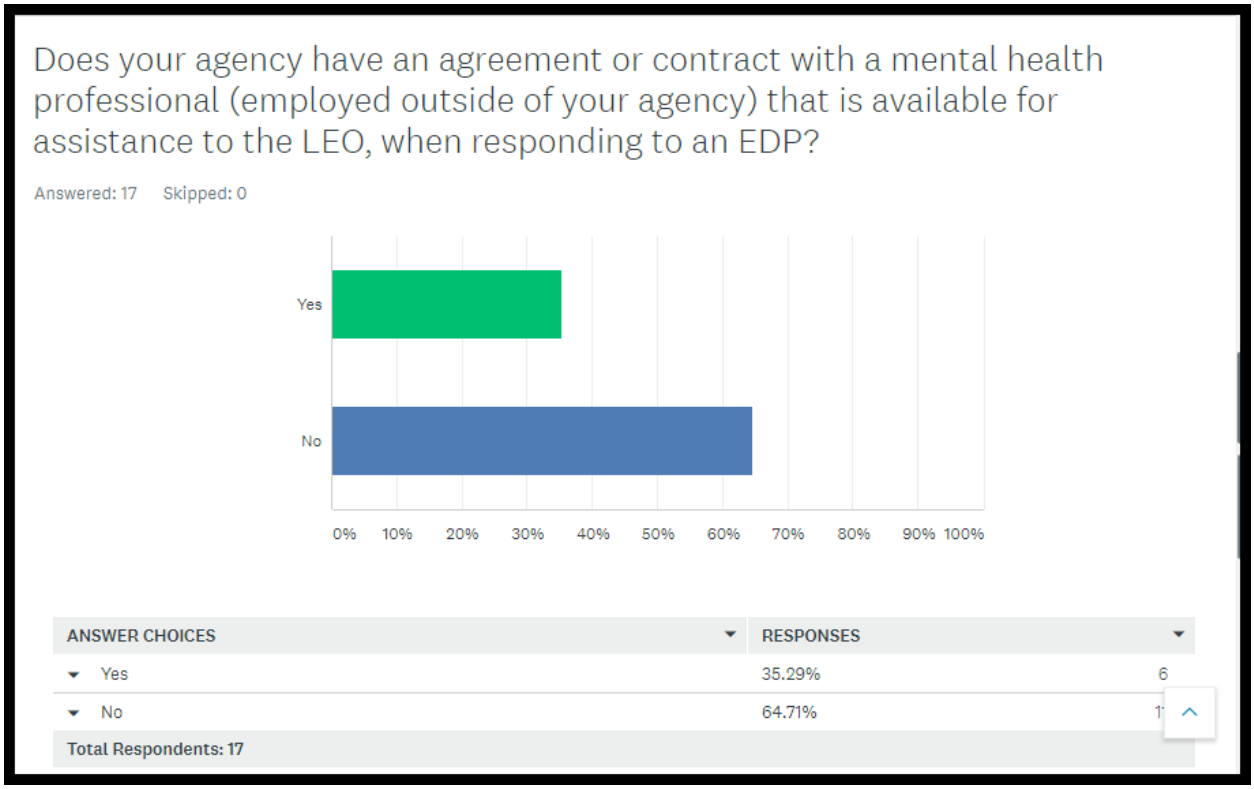
Question 16:

Question 16 was a “yes” and “no” question which asked the participants, “Does your agency employ (in house) a mental health professional?” Six participants (35.29%) responded “yes” and eleven participants (64.71%) responded “no.”



Question 17:

Question 17 was a "yes" and "no" question which asked the participants, "Does your agency have an agreement or contract with a mental health professional (employed outside of your agency) that is available for assistance to the LEO, when responding to an EDP?" Six participants (35.29%) responded "yes" and eleven participants (64.71%) responded "no."



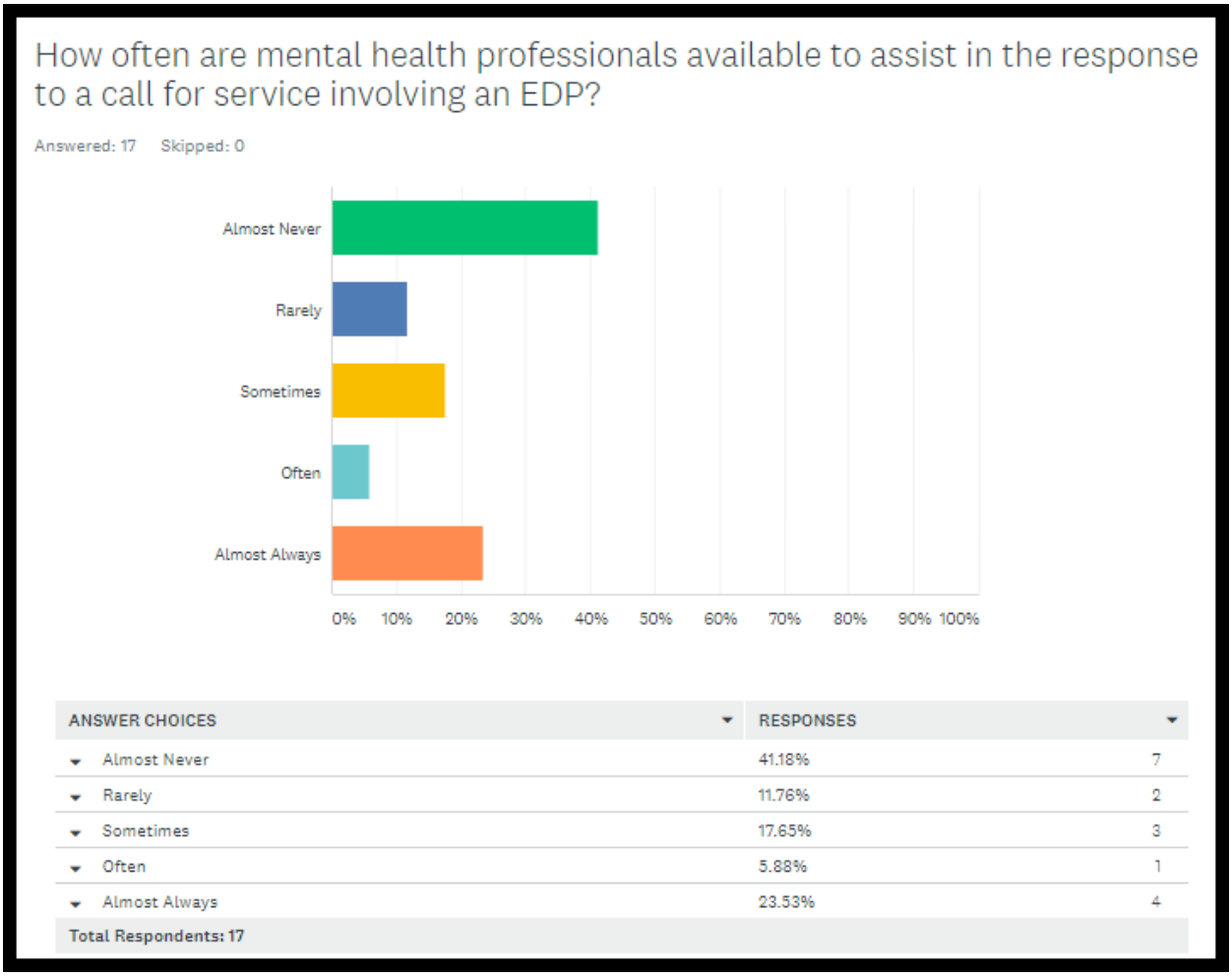
Question 18:

Question 18 was a five-answer multiple choice question which asked the participants, "How often are mental health professionals available to assist in the response to a call for service involving an EDP?" The answer choices for participants were:

1. Almost Never
2. Rarely
3. Sometimes
4. Often
5. Almost Always

Q18 Results:

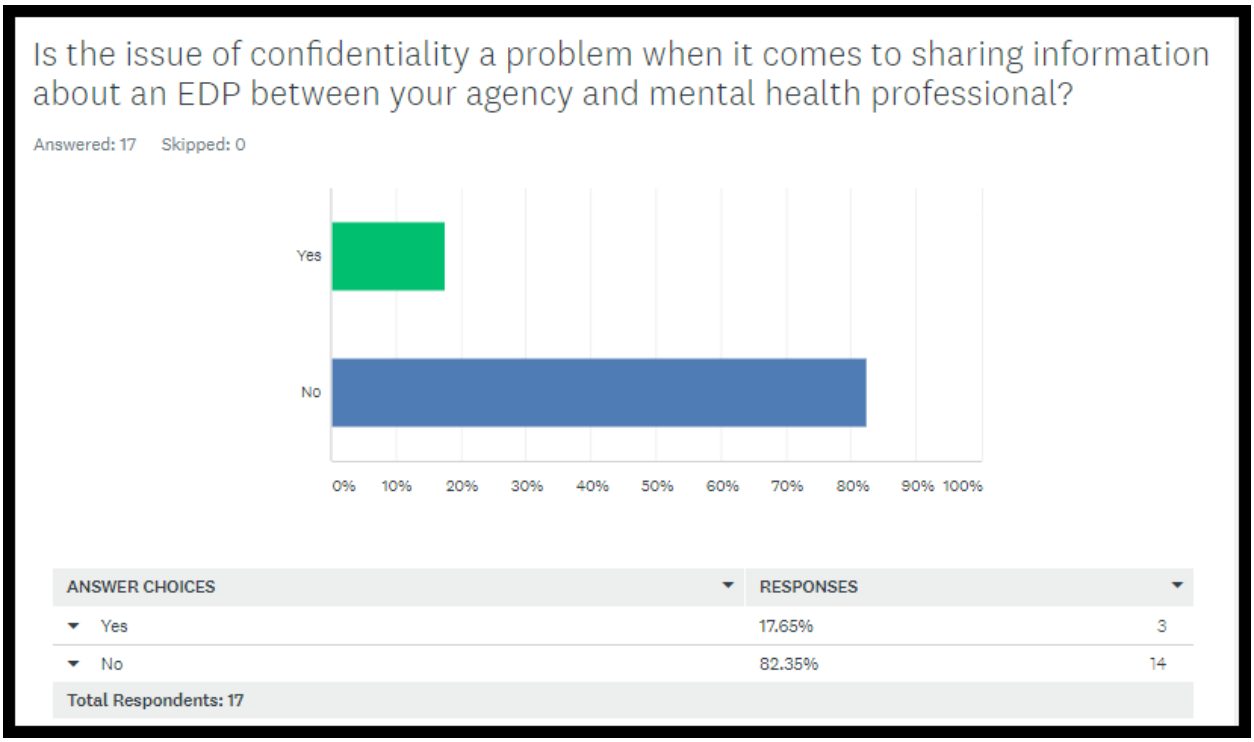
1. Almost Never – seven responded = (41.18%)
2. Rarely – two participants responded = (11.76%)
3. Sometimes – three participants responded = (17.65%)
4. Often – one participant responded = (5.88%)
5. Almost Always – four participants responded (23.53%)



ANSWER CHOICES	RESPONSES	
Almost Never	41.18%	7
Rarely	11.76%	2
Sometimes	17.65%	3
Often	5.88%	1
Almost Always	23.53%	4
Total Respondents: 17		

Question 19:

Question 19 asked the participants, "Is the issue of confidentiality a problem when it comes to sharing information about an EDP between your agency and mental health professional?" The answer options were either "yes" or "no." Of the 17 respondents (89.5%), the following results were obtained: Three participants (17.65%) answered the question with "yes." Fourteen (82.35%) of the participants answered "no."



Discussion

The results of the survey indicate that the law enforcement agencies in Florida recognize that training their sworn personnel on how to deal with an EDP is a benefit to all of stakeholders (the EDP, the family of the EDP, the LEOs, corrections, and tax payers) involved in the process. One-hundred percent of the 17 agencies surveyed answered “yes” when asked, if their agency provides at least some training on how to deal with an EDP. It is incumbent for LE agencies to train their LEOs to recognize the signs and symptoms of mental illness. In short, it will save lives, reduce incarceration costs significantly, and more importantly, it will prevent unnecessary and unwarranted incarceration.

Keeping on the topic and importance of training, the survey also indicated that LEOs (94.12%) received formal in-service training on mental health issues and dealing with an EDP. Rounding up, (65%) received specialized training. Not surprisingly, every agency surveyed conducted some form of training on dealing with an EDP. The hours dedicated to training ranged from five – 29 hours. Specialized training took up a majority of the hours spent on training.

As the research revealed during this project, the CIT model was the vast choice of most LE agencies nationwide. The survey indicated (94%) of the agencies who participated sent their LEOs to CIT training. Only one agency (5.88%) did not send their LEOs to CIT training. Out of the 17 agencies who responded to the survey, (47.06%) required all their sworn personnel, regardless of rank, to receive CIT training. Two more agencies (11.76%) reported that all of their personnel will eventually receive the 40 hour CIT Training. Another two agencies (11.76%) reported that only personnel of certain

ranks (sergeant and below) receive CIT training. Seven agencies (41.18%) sent their LEOs to CIT training only if the LEO volunteered to attend and one agency did not send any of their LEOs to CIT training.

Twelve agencies (70.59%) felt that their agency had enough LEOs who were trained in the CIT model, while five agencies (29.41%) did not believe their agency had enough CIT trained personnel. Only one agency (5.88%) indicated that their agency did not have enough money in the budget to attend CIT training. One agency (5.88%) reported that no LEOs volunteered for CIT training. Five (29.41%) of the agencies chose the "Other (please specify)" answer. Two out of the five indicated staffing was an issue and interfered or restricted training. One of the five indicated that their agency was in the process of training all personnel and another agency indicated it had enough personnel.

The heart of the survey, revolved around the type of response an agency used when responding to a call involving an EDP. Ten agencies (58.82%) do not follow any specific response model when responding to a call involving an EDP. This simply means that when a call for service comes into dispatch, the call is given to the first available patrol unit who can respond. To be abundantly clear on this question, this does not mean that the personnel responding to call are not trained, it just refers to how the LEOs respond. Two (12.00%) of the agencies handle calls involving an EDP with CIT trained LEOs. One agency (6.00%) respond using an ordinary patrol response and then determines if a CIT trained LEO is needed for additional assistance with the EDP. Four (24.00%) of the agencies use a co-responder model (an LEO and a mental health professional respond together to a call for service involving an EDP). Out of the four agencies who reported that they utilize a co-responder model, one (6.00%) agency uses a true co-responder method, in which the LEO and a mental health professional respond to the EDP call together. Other agencies also use a form of a co-responder model: One agency (6.00%) receives assistance remotely from mental health professionals while in the field (e.g. over the phone). Three (18.00%) agencies will send a mental health professional out to the scene, once the initial crisis call is handled. Five agencies (29.00%) have civilian personnel assigned to a specialized unit to assist sworn personnel in handling the follow-up involving an EDP.

Recommendations

Overall, the survey revealed LE agencies realize the importance of dedicating time and resources to some form of training, in order to deal with people suffering from mental illness. LE agencies often look around the nation and sometimes the world for the best practices when dealing with specific issues. It has taken decades to reach the unimaginable numbers of people roaming society without the benefit of mental health treatment. The pendulum has swung from locking people away in mental institutions to now allowing them to go virtually untreated, often with no quality of life for themselves or their family. Law enforcement historically shapes and shifts with the demands of society and will most likely continue to do so in the future; however, nobody can say with certainty what the future will look like. Super-forecasters will make their best effort at hypothesizing but the wheels of government turn slowly and unpredictably; therefore, it

is recommended that LE agencies should seek the best available training for its personnel on how to respond and deal with EDPs. It is further recommended that LEOs seek the guidance of the legal profession and of course the mental health profession when creating the training. The legal and mental health professions should also receive reciprocal training from a LE perspective, to better understand what LEOs deal with over the course of career.

Mental health issues should not fall directly on to law enforcement's lap but that ship sailed decades ago and therefore, LE is stuck with it. The recommendation obtained from this research and survey that seems most plausible at the moment is to pair LEOs with civilians who are specifically trained in the area of mental health. CIT is a great tool at recognizing and dealing with the immediate need during LEO interventions but CIT does not appear to be the long-term solution to the problem.

City and county governments should look at employing certified mental health professionals to assist LEOs for citizens who reside within their respective jurisdictions. This means funding must be allocated to attract and retain certified mental health professionals. Having professionals on staff to handle EDPs and make professional assessments will cut down on the amount of time patrol officers spend responding to repeat calls for service involving EDPs.

Furthermore, it is recommended that agencies, large and small, look at creating a specialty unit composed of both LEOs and mental health professionals. The unit or section should be designed to handle EDPs on an on-going basis and make professional assessments and diagnoses. This unit's duties would include assisting families in obtaining ex parte orders and would allow the LEOs to serve the orders.

It is recommended that LE agencies continue to share information and best practices within the LE community. The failure of mental health related training and programs should also be shared and studied to avoid the similar mistakes.

Lieutenant Michael Segreaves has been with the Orange County Sheriff's Office since 1999. He currently serves as the lieutenant in the Criminal Intelligence Section. He has served in the Uniform Patrol Division, the Criminal Investigation Division (Auto Theft, Organized Crime, Sex Crimes, & Homicide), the Professional Standards Section, and the Criminal Intelligence Section. Mike is retired from the United States Army Military Police Corps. He has a Master's of Science degree in Cyber-Security from Webster University.

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Appendix A

Survey Information

Welcome to my survey. Your feedback is important. Thank you for participating.

Introduction & Consent.
You are being asked to voluntarily complete the survey as a representative of your agency. This survey will ask questions about how your agency responds to calls for service involving an emotionally disturbed person (EDP).

What is the purpose of this research?
This survey is also part of a student research project for the Florida Department of Law Enforcement (FDLE) – Senior Leadership Program (SLP). The intent of the survey is for the researcher to learn more information about the possibility of the Orange County Sheriff's Office implementing a MHRT. Researcher's note: A MHRT is not to be confused with a Crisis Response Team (CRT). A MHRT is a supplemental program and does not replace a CRT.

How will the information be used?
The researcher is documenting the types of programs LEA use when responding to calls for service involving an EDP. No information collected will be shared in a manner that could be used to identify you or negatively impact your agency.

What about privacy and confidentiality?
Your individual participation in the research will not be known to individuals other than the researcher and no personal data that identifies you will be reported. This is simply a project designed to gather information and learn study practices used by respected law enforcement agencies.

Whom should I contact if I have questions?
Please feel free to contact Orange County Sheriff's Office - Lieutenant Michael Segreaves, at (407) 448 – 6095 or michael.segreaves@ocfl.net if you have any questions about this research project.

Consent
I have read the above information and by continuing, I agree that I am providing my consent to complete the survey.

Start Survey

***1. Do sworn personnel in your agency receive at least some training on mental health? This may include personnel who are trained to be part of Crisis Intervention Team (CIT) (Please select all that apply)**

- ☐ Yes
- ☐ No

***2. When do sworn personnel in your agency receive at least some training on mental health? This may include personnel who are trained to be part of Crisis Intervention Team (CIT) (Please select all that apply)**

- ☐ In-Service Training
- ☐ Roll Call
- ☐ Specialized Training (formal training provided outside of the agency)
- ☐ None
- ☐ Other (please specify)

***3. Please list the approximate number of training hours of each category receives related to dealing with an emotionally disturbed person? (Enter the number of hours next to each related item).**

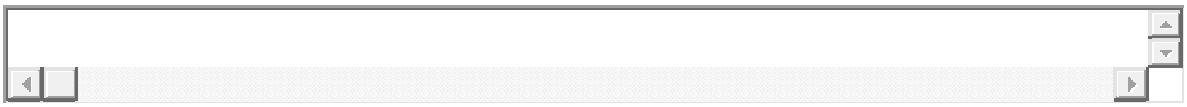
- Training Academy
- In-Service Training / Roll Call
- Specialized Training
- None

***4. Does your agency send personnel to CIT training?**

- ☐ Yes
- ☐ No

***5. Which of the following sworn personnel receive CIT training? (Please check all that apply)**

- ☐ All sworn personnel, regardless of rank, are required to receive CIT training.
- ☐ Only sworn personnel of certain ranks are required to receive training (for example Sergeant and below).
- ☐ Only sworn personnel who volunteer receive CIT training
- ☐ None
- ☐ Other (please specify)

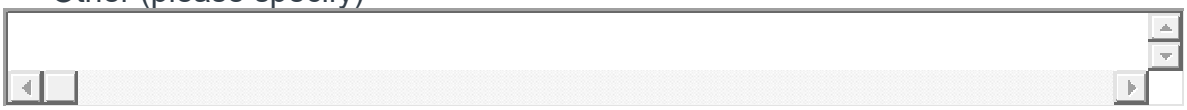


***6. Do you feel that your agency has enough CIT trained LEOs?**

- ☐ Yes
- ☐ No

***7. What are the reasons your agency does not have enough CIT-trained personnel? (Please check all that apply)**

- ☐ Not enough money in the budget for CIT training
- ☐ No training is available in my agency's geographical area
- ☐ No personnel volunteer for the training
- ☐ Does not apply to my agency
- ☐ Other (please specify)

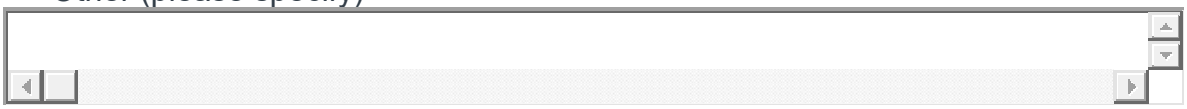


***8. Have any of your agency's CIT-trained personnel received training specifically about responding to youth experiencing a mental health crisis? (Referred to as CIT-Y)**

- ☐ Yes
- ☐ No

***9. Which of the following best describes your agency's method/model of responding to a call for service involving an EDP (Please select all that apply to your agency)?**

- ☐ The call is handled solely a Crisis Intervention Team (CIT) trained member (LEOs with specialized training on handling an EDP).
- ☐ Co-responder model (an LEO and a mental health professional respond together to a call for service involving an EDP).
- ☐ No specific model is followed.
- ☐ Other (please specify)



***10. Which of the following best describes your agency's co-responder model? (Please select all that apply)**

- ☐ LEOs and mental health professionals jointly respond to the call of an EDP
- ☐ Mental health professionals remotely assist LEOs in the field (e.g. over the phone)
- ☐ Once the initial crisis has been addressed by LEOS, mental health professionals respond on scene to assist
- ☐ Does not apply to my agency
- ☐ Other (please specify)

***11. Does your agency have any civilian employees who are assigned to any specialized unit(s) who assist sworn personnel when dealing with an EDP?**

- ☐ Yes
- ☐ No

***12. Does your agency provide training to communications personnel (e.g. dispatchers, call-takers) on identifying an EDP?**

- ☐ Yes
- ☐ No

***13. When do your civilian employees receive at least some training on issues related to mental health? (Please select all that apply)**

- ☐ In-Service Training (formal training provided within the agency)
- ☐ Specialized Training (formal training provided outside of the agency)
- ☐ None of the above; civilian personnel do not receive this type of training
- ☐ Other (please specify)

***14. Are any civilian personnel in your agency specially trained to respond to calls for service involving an EDP?**

- ☐ Yes
- ☐ No

***15. Do mental health service professionals assist your agency when responding to mental health crisis incidents?**

- [ ] Yes
- [ ] No

***16. Does your agency employ (in house) a mental health professional?**

- [ ] Yes
- [ ] No

***17. Does your agency have an agreement or contract with a mental health professional (employed outside of your agency) that is available for assistance to the LEO, when responding to an EDP?**

- [ ] Yes
- [ ] No

***18. How often are mental health professionals available to assist in the response to a call for service involving an EDP?**

- [ ] Almost Never
- [ ] Rarely
- [ ] Sometimes
- [ ] Often
- [ ] Almost Always

*

19. Is the issue of confidentiality a problem when it comes to sharing information about an EDP between your agency and mental health professional?

- [ ] Yes
- [ ] No

DONE