

**A DESCRIPTIVE EVALUATION OF THE SEATTLE POLICE DEPARTMENT'S
CRISIS INTERVENTION TEAM/MENTAL HEALTH
PARTNERSHIP PILOT PROJECT**

Final Report

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EXECUTIVE SUMMARY

In October 2010 the Seattle Police Department (SPD) launched a 24-month Crisis Intervention Team (CIT)/Mental Health Professional (MHP) pilot program with funding from a 2009 Federal Justice Assistance Grant to establish a Crisis Intervention Response Team (CIRT) comprised of members of the CIT and licensed mental health professionals (MHPs) trained in crisis assessment, intervention, and resource referral. The Seattle Police Department's CIT was implemented in 1998 to improve police response in dealing with mentally ill individuals. CIT is operated by a sergeant and two officers assigned full-time to crisis intervention who spend their time following up on cases, working with mentally ill individuals to help them stay connected with social service agencies, and serving as a liaison between family members and the Seattle Mental Health Court. Now a nationally recognized program, the SPD CIT has provided 40-hour crisis intervention training for nearly 365 of the department's 1,296 officers, 256 of whom are assigned to patrol (J. Fountain, Personal Communication, July 31, 2012).

The purpose of the addition of the MHP and the development of the CIRT is to provide assistance to field officers when they encounter a person who may be experiencing a crisis resulting from mental illness or chemical dependency. The goal of the pilot program is to improve police response in situations involving mentally ill and chemically dependent individuals through specialized mental health provider response in the field. This response includes assessment and referral of individuals to community based resources which may better meet their housing, mental health, substance abuse and other needs, and avoiding the use of jail or hospital emergency rooms when appropriate. The MHPs take direction from the

CIT sergeant and work in collaboration with a sworn officer/partner to exercise their professional discretion in day-to-day contacts with street-level mental health and chemical dependency problems.

The goal of the CIRT pilot evaluation is to describe the value added by the MHP in police encounters with persons with mental illness (PwMI), as well as the effectiveness of the CIRT program with regard to the role and function of the MHP. To date, very few jurisdictions have implemented similar programs partnering law enforcement with mental health providers. The current state of knowledge about crisis intervention teams in law enforcement and partnerships with mental health professionals is primarily anecdotal in nature. This evaluation is incident-based and descriptive in nature. Results provide valuable information to assist the SPD in determining the benefits of the CIRT program and in making resource decisions about law enforcement/mental health partnerships.

Research Design

A descriptive process evaluation of the SPD's CIRT pilot program was conducted to determine the degree to which the pilot program is successfully addressing its intended goals. The overall objective of the CIRT Pilot Project is to provide a more efficient and effective response to incidents involving mentally ill individuals, with the hope that doing so will:

- Reduce the number of mentally ill and chemically dependent dispositions to jail and hospital emergency rooms.
- Reduce the number of people who recycle through jail, returning repeatedly as a result of mental illness or chemical dependency.

- Divert mentally ill and chemically dependent youth and adults from initial or further justice system involvement.

The specific goals of the CIRT Pilot Project are to:

- Get individuals involved in crisis connected more quickly with appropriate services that can help them achieve stability, including housing and social services for those who are homeless, and treatment for those suffering from mental illness and/or drug abuse.
- Provide a linkage to crisis and commitment services for those individuals who may require involuntary hospitalization and achieve other system cost savings through diversion from jail and costly hospital services and/or admissions.

The CIRT Pilot is a 24-month pilot involving the addition of a 1.25 FTE MHP in the CIT unit. The full-time and part-time MHPs on this project are not able to respond to every call involving mentally ill individuals, and the decision to involve the MHP depends on a number of factors including the way in which the incident is initially reported to 911, the descriptive terms used by the 911 dispatcher to describe the individuals involved in the scene, and the decision of the precinct officers to call the CIRT to the scene. Given these design features, it was determined that evaluation measuring global outcome variables (such as citywide case dispositions or jail admissions) in an experimental or quasi-experimental framework was not feasible.

This evaluation sought to measure, on an incident-specific basis, the degree to which the MHP plays a role in improving police-citizen relations in incidents where the MHP is involved, as well as perceived changes in the nature of these incidents as reported by responding officers. This entailed understanding and describing what the MHP does and the ways in which the inclusion of the MHP changes the nature of Seattle Police response to

incidents involving mentally ill individuals. Specifically, it was hypothesized that the assistance of the trained MHP would affect the nature of incidents involving mentally ill individuals in three ways: (1) Reduce the amount of time to case resolution; (2) Reduce the number of repeat contacts involving the same individuals; and (3) Change the nature of the incident disposition reflecting predominantly referrals to non law enforcement resources and informal social controls.

Method

Cases coming into the CIT Office from January 2011 – December 2011 were included in the evaluation. Incident and supplemental reports were provided to researchers by the Seattle Police Crisis Intervention Team Unit in PDF format, and subsequently entered into the Statistical Package for the Social Sciences (SPSS) for processing and analysis. Cases included all SPD incident reports triaged to the CIRT and supplemental reports by CIRT staff written by MHP and CIT Officers. Data were collected for 290 cases from incident reports and supplemental reports on incident location, incident characteristics, officer descriptions of incidents, CIT follow-up, MHP follow-up, and case disposition. Background interviews were conducted with CIRT Staff and others involved in the development and implementation of the pilot. The purpose of these interviews was to ensure that research staff had comprehensive knowledge of the CIRT program's processes and procedures, as well as to provide important context to empirical observations.

To provide an overall picture of the CIRT Pilot and its effectiveness in relation to hypothesized outcomes, key variables were examined to describe the types of cases triaged to

CIT, the nature of the cases, case disposition, and the role of the CIT officer and MHP in the case resolution. Key variables included:

- Nature of Incident
- Repeat Calls/Contacts
- Incident Location
- Case Disposition
- Linkages to Services
- Case Clearance Time

Descriptive analyses were conducted on key variables to provide an overall picture of the CIRT program, the types of cases triaged to CIRT, the CIT and MHP response on each case, and the final case disposition. Case clearance was calculated based on the time and date the incident was reported to the time and date the case was administratively cleared. In addition to descriptive data, cases involving low and high contact with police were identified and qualitative data from incident and supplemental reports were analyzed in order to provide a profile of low and high contact cases handled by CIRT.

Summary of Findings

Results show that from January 2011 through December 2011, 3,029 cases were referred to the CIT Unit. Of the 3029 cases referred to the CIT in 2011, 669 (22%) were followed up by CIT staff. Of these 669 cases, 290 were assigned to the MHP and 379 to the CIT Officers. Of the 379 CIT Officer cases, those involving violent crimes with clear probable cause were triaged to the CIT Officer designated to handle the serious criminal cases and cases involving less serious incidents were handled by CIT Officer designated to handle less serious cases. Incidents involving nuisance cases with no probable cause that a crime had been committed were referred to the MHP. The majority of incidents referred to CIRT involved

isolated incidents where there was no repeat contact with police (n=126, or 43.4% of cases). However, there was a substantial number of incidents that involved 2-6 repeat contacts (n=97, or 33.4% of cases) and a small number of incidents (n=15, or 5.2% of cases) that involved high volume contacts (HVCs) with 15 or more contacts to police.

The process used by the CIRT to designate cases involved a triage process whereby cases were placed into seven categories based on the nature of the incident and whether or not it involved criminal behavior with clear probable cause or other types of behavior reflecting mental health or substance use issues involving a person with mental illness (PwMI). Results indicate that the majority of cases triaged to CIRT (n= 124, or 42.8% of cases) were cases classified as “mental” with no criminal behavior involved.

Spatial analyses demonstrated that the MHP engaged in true City-wide activity, with responses to mental health incidents distributed across the entire Seattle metropolitan area. There was some clustering of MHP response activity noted in the Northeast part of the city as well as the downtown core, reflecting a small number of specific addresses that accounted for a high proportion of MHP response activity with approximately 6% of the unique addresses generating 27% of the MHP responses. Statistical tests for clustering confirmed significant clustering in the northeast and downtown locations, as well as in an area of West Seattle. The West Seattle and Downtown clustering are likely a reflection of mental health service agencies in those locations, while the Northeast clustering is apparently driven by a number of residents in that area who required extensive MHP follow-up contacts. Density estimations showed that

the concentration of MHP responses was highest in the downtown core, where the density approached 36 contacts per square mile.

About a third of cases (34.1%) were referred to non-law enforcement agencies (for example, inpatient or outpatient chemical dependency treatment, mental health case management). Twelve percent were recommended for administrative clearance, and seven percent had some other type of disposition. Of particular interest, although infrequent, were cases that were handled through some type of individual-local-community resolution. These types of resolutions are indicative of informal social control networks that may not have otherwise been activated through traditional police response. It is also important to note that very few cases (about one percent in each category) resulted in arrest or transport to hospital facilities.

Results show variability in the number of contacts, time to clearance, and time spent on each case. The number of contacts with subjects ranged from one to as many as 20, days to clearance ranged from 0 to 219 days; and time spent on case ranged from 10 minutes to more than four hours. Cases were typically cleared in about 19 days, and the time spent per case was approximately 50 minutes. Results suggest that there is also high variability in terms of the origins of the mental health issues that result in high and low contact incidents. CIRT response in incidents involving individuals who repeatedly contact law enforcement are characterized by lack of support services already in place with the individual(s) involved. Resolution of low contact cases is characterized by contact with agencies with which the individual was previously involved. In other words, results suggest that the individuals who come to the attention of the

police once, rather than multiple times tend to have already established community or other connections with whom CIRT officers could coordinate with to resolve the case. This pre-existing social network and/or resource connection was less likely in the high volume cases.

Conclusion

The results of this descriptive evaluation of the CIRT pilot program suggest that the CIRT is relieving an otherwise substantial, unnecessary, and inappropriate burden on law enforcement officers by triaging cases that would otherwise be taking up time of law enforcement personnel to the MHP. Although comparable empirical benchmarks prior to the pilot program are not available, the descriptive information concerning repeat contacts, dispositions, time spent on cases, and the spatial distribution of incidents demonstrate that a substantial workload was appropriately shifted from patrol officers to the MHP. The finding that 6% of unique addresses accounted for 27% of MHP responses suggests that, based on these locations alone, the MHP is alleviating what would otherwise be a significant resource strain on patrol officers, and that even greater efficiency gains could be achieved with a more regionalized approach. The MHP averaged 3 contacts with subjects (with no repeat contact in 43% of cases), cleared cases in approximately 19 days, and spent about 50 minutes per case. About a third of cases (34.1%) were referred to non-law enforcement agencies to address in- or out-patient chemical dependency treatment or mental health case management. Anecdotally, when reviewing these empirical findings with program staff it was observed that these represented substantial improvements in the amount of time to case resolution, repeat contacts, and referrals to non law enforcement resources. Based on these results, it appears

that on a descriptive basis the anticipated benefits of adding a trained MHP to the CIRT are being realized and that the program has the potential for continued improvement in the quality of police response to persons experiencing mental health crises in Seattle.

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FINAL REPORT

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CHAPTER 1

Introduction

In October 2010 the Seattle Police Department (SPD) launched a 24-month Crisis Intervention Team (CIT)/Mental Health Professional (MHP) pilot program to establish a Crisis Intervention Response Team (CIRT) comprised of members of the CIT and licensed mental health professionals (MHPs) trained in crisis assessment, intervention, and resource referral for persons with mental illness (PwMI). The CIRT pilot program and the addition of the full-time MHP was a long awaited enhancement of the already successful SPD CIT that brought the MHP staff-member to the team to work with mental health-trained law enforcement officers. This Report presents evaluation results from a 12-month period of the 24-month CIRT pilot program (January 2011-December 2011) to determine the value added by the MHP and to describe the CIRT pilot and the contributions of this enhancement to CIT in law enforcement interactions with PwMI.

The Seattle Police Department's CIT was implemented in 1998 to improve police response in dealing with mentally ill individuals. Now a nationally recognized program, the SPD CIT has provided 40-hour crisis intervention training for 365 of the department's 1,296 officers. CIT is operated by a sergeant and two officers assigned full-time to crisis intervention who follow up on cases, working with mentally ill individuals to help them stay connected with social

service agencies, and serving as a liaison between family members and the Seattle Mental Health Court.

The purpose of the CIRT, and the inclusion of the full-time mental health professional to the CIT, is to assist field officers when they encounter a person who may be experiencing a crisis resulting from mental illness or chemical dependency. The goal of the pilot program is to improve police response in situations involving mentally ill and chemically dependent individuals through specialized mental health provider response in the field. The MHPs take direction from the CIT sergeant and work in collaboration with a sworn officer/partner to exercise their professional discretion in day-to-day contacts with street-level mental health and chemical dependency problems. The MHP role includes assessment and referral of individuals to community based resources with the idea that a mental health professional will be able to better meet the housing, mental health, substance abuse and other needs of the PwMI which will ultimately help to avoid the use of jail or hospital emergency rooms when appropriate.

In 2008, an exploratory study of the SPD CIT (Neidhart, 2008) was conducted to examine the extent to which incidents were handled by CIT-trained and non-CIT-trained officers, incident characteristics, and case disposition. The study examined all incidents including 2624 incident reports from November 1, 2006 through October 31st, 2007. Results showed that incidents involving mental health issues during that time frame were handled by non-CIT officers more frequently than CIT-trained officers in a 3 to 2 ratio. The study also found that the majority of CIT resource time was spent responding to incidents involving attempted suicides, attempted suicides, suicide ideation, threats, and disturbances with most incidents resulting in

hospitalization, that both CIT-trained and non-CIT-trained SPD officers made arrests in incidents involving PwMI infrequently (5.8% of all incidents involving PwMI),¹ that CIT trained officers tended to direct PwMIs to treatment (hospitalization) rather than jail, and that certain precincts (North and West) have higher CIT officer response rate.

Neidhart's (2008) study was the first attempt to empirically study the SPD CIT training and the ways in which the training was being implemented in Seattle. The current study extends this earlier work with specific focus on the impact of the CIT Unit and the CIT Sergeant, CIT officers and MHP that comprise the new Crisis Intervention Response Team. The goal of the CIRT pilot evaluation is to describe the value added by the MHP in police encounters with persons with mental illness (PwMI), as well as the effectiveness of the CIRT program with regard to the role and function of the MHP. One of the findings in the Neidhart (2008) study was that officers recurrently encounter some of the same individuals. Thus, a goal of the CIRT and the addition of the MHP to the CIT is to utilize the mental health professional in cases that do not require traditional law enforcement resources such as these sorts of recurrent contacts. The current study seeks to evaluate the CIRT and the value added by the MHP in incidents involving PwMI.

To date, while there are many CIT Units across the country, very few jurisdictions have implemented similar programs partnering law enforcement with mental health providers where the MHPs hold full-time positions and are assigned cases. The current state of knowledge

¹ This arrest rate is lower than rates reported in studies of traditional law enforcement officer interactions with mentally ill individuals (Teplin, 2000) and consistent with recommendations in the research community (Laberge & Morin, 1996; Lamb et al., 2004, Lurigio, 2000; Perez et al., 2003; Thompson et al, 2003).

about crisis intervention teams in law enforcement and partnerships with mental health professionals is primarily anecdotal in nature. Evaluations of CIT programs to date have not included control groups with rigorous experimental methods because CIT and other such criminal justice interventions are implemented in real-world settings and as such have been very difficult to study. While this evaluation is incident-based and descriptive in nature as have been many of the other studies of CIT and CIRT programs in other jurisdictions, the results provide valuable information to assist the SPD in determining the benefits of the CIRT program and in making resource decisions about law enforcement/mental health partnerships and (in conjunction with the Neidhart (2008) study) provide additional data specific to the CIT Unit, the CIRT Pilot, and the value added by the full-time MHP.

Background and Literature Review

A variety of innovative models have arisen as communities search for more effective ways to respond to police calls involving people with severe mental health and/or chronic substance abuse issues (Compton et al, 2008; Reuland, Draper & Norton, 2010; Deane, Steadman, Borum, Veysey, & Morrissey, 1999). Some have focused primarily on the law enforcement side with formal mental-health training for police officers such as the use of Crisis Intervention Team (CIT) programs. Others have relied on those in the mental health community to be available to respond and assist in these police calls in the form of Mobile Mental Health Crisis Teams. Another model that has evolved is the pairing of a law enforcement officer with a mental health professional (MHP) to respond to these crisis situations and/or provide preventative intervention and follow-up, utilizing the professional skills from both sides to best resolve the

incident. Sometimes a combination of these models is utilized within one community such as those communities having CIT trained police officers as well as a dedicated team of an officer paired with a mental health worker to respond to certain high-crisis situations. All have at their core a common goal of obtaining the needed treatment for these individuals, reducing the frequency of their arrests and incarcerations, and ultimately reducing the frequency of their contacts with law enforcement over the long term. ²

Many jurisdictions self-describe their programs as pairing law enforcement officers with mental health workers (Criminal Justice/Mental Health Consensus Project, 2011). However, how these collaborative teams are utilized and function may vary, with different communities using these pairings in different capacities. Some of these law enforcement/mental health teams (LE/MH) are deployed to active incident scenes involving individuals identified as having mental health issues such as is the case with the programs in Los Angeles County, California and Vancouver B.C.'s "Car-87" (Adelman, 2003; Lamb, Shaner, Elliot et al., 1995). Here the MHP will attempt to resolve the situation on the scene, and if resolution is not possible or unsuccessful, the officer has the authority to transport and admit the individual for hospitalization. Vancouver's "Car-87" model is widely seen as a success and has been replicated in many communities throughout Canada (Adelman, 2003).

Other communities take a different approach with their teams focusing more on follow-up and preventive intervention. Many of the individuals with mental illness in a community who are involved in police calls are essentially "frequent-fliers," people who are well-known to

² See Compton et. al.(2008) for a comprehensive review of CIT Programs.

both the law enforcement and the mental health communities and whose persistent, though mostly misdemeanor reoffending consumes a disproportionate amount of police response time over the long term (Reuland, Schwarzfeld & Draper, 2009). Some groups such as Akron, OH's CIT Outreach team and Pasadena, CA's Homeless Outreach Psychiatric Evaluation (H.O.P.E.) team have found that focusing their efforts on these "high-utilizers" before another incident occurs, by periodically checking in on them and their case-workers, doing "knock and talks" and making sure they are getting the services they need, can result in a reduction in law enforcement incident calls regarding these individuals (Criminal Justice/Mental Health Consensus Project, 2011; Reuland, Draper & Norton, 2010). Abbotsford, BC, a community where 1 in 10 police calls involve individuals with mental health issues, considered their LE/MH program a success after one year and was considering program expansion. Case examples from the Abbotsford LE/MH program show that intervention and follow up on a PwMI who had in the past generated an average of 100 calls to police, had not only substantially reduced the calls to the police about this individual but had also enabled the individual to better recognize when his behavior was sliding and empowered him to reach out and seek help (Hopes, 2011). In Pawtucket, Rhode Island, the Pawtucket Police Department teamed with Gateway Healthcare Inc., the largest non-profit behavioral healthcare organization in Rhode Island to more effectively respond to incidents involving mentally ill individuals after criticism and negative press about the Pawtucket Police Department's handling of some incidents involving emotionally disturbed individuals. The Pawtucket CIT program now stands as a successful model for other police departments. The Pawtucket model pairs a clinician from Gateway with

a Pawtucket officer to respond to incidents involving emotionally disturbed or suicidal individuals with the idea that this team approach pairing law enforcement and mental health professional is better suited to respond to incidents that can be made more difficult with a traditional law enforcement response. The Pawtucket CIT has been viewed as a success based on less traditional outcome variables such as establishment of trust and information sharing between law enforcement and mental health professionals and recognition that some incidents may be more effectively handled in the long run with a more nuanced response that may initially take longer at time of incident, but will result in outcomes such as greater trust between the PwMI and law enforcement, reduction of anxiety for the PwMI and more appropriate referral to resources, and de-escalation of a potentially volatile event through active listening, understanding, and communication that reduces future law enforcement contacts (Kirwin, 2011).

In terms of success, many of the communities utilizing these LE/MH teams are currently collecting information related to incident outcomes and recidivism details that may ultimately provide the hard data needed to assess how effective these programs truly are on a larger scale. To date though, there are relatively few analytical studies on these findings with most evidence of success at this point being primarily anecdotal. However, Lamb, Shaner, Elliot et al. (1995) in their study of the Los Angeles teams, found these teams to be effective in resolving crisis situations in the community and successful in diverting individuals with mental illness from incarceration. Evaluations of Houston's Crisis Intervention Response Team (CIRT) pilot program, which serves as an extension of the CIT program and pairs a CIT trained officer with a

MHP who do both response and follow-up work, were reported to be 100% favorable and the program was adopted permanently in 2009 and has since expanded the number of responding teams available (Houston, n.d.).

One acknowledged limitation of this type of program when these teams are used to respond to active crisis incidents has been this issue of availability, with teams only having the capability to respond to one situation at a time and only within certain hours, a drawback similar to what was found regarding the use of mobile mental-health based crisis-response teams such as the one in Knoxville, TN (Adelman, 2003; Steadman, Deane, Borum & Morrissey, 2000). However, a statistical review of the Vancouver Island, B.C., Integrated Mobile Crisis Response Team (IMCRT), which pairs a plain-clothes officer with a MHP, found they were actually able to handle more than double the amount of high crisis calls in a similar time period as compared to situations utilizing standard patrol-officers, due to the integrated nature of services and no need to wait for coordination of services (Baess, 2005). Findings such as this may serve to offset some of the concerns over limited response capabilities.

From a long-term perspective, successful outcomes will be substantially and directly impacted by the availability of resources and social services for these individuals within any given community (Wilson-Bates, 2008). In their two-year study, Vancouver, B.C.'s police department found that despite active intervention and referral many of their chronic offenders were back in circulation (Thompson, 2010). Even if intervention and/or diversion occurs, without concurrent and adequate support housing programs, short and long-term institutional mental-health bed availability and sufficient mental health and substance abuse treatment

programs, these same individuals are likely to resume and continue in their cycle and depletion of police resource time.

CHAPTER 2

Research Design

A descriptive process evaluation of the SPD's CIRT pilot program was conducted to determine the degree to which the pilot program is successfully addressing its intended goals.

The overall objective of the CIRT Pilot Project is to provide a more efficient and effective response to incidents involving mentally ill individuals, with the hope that doing so will:

- Reduce the number of mentally ill and chemically dependent dispositions to jail and hospital emergency rooms.
- Reduce the number of people who recycle through jail, returning repeatedly as a result of mental illness or chemical dependency.
- Divert mentally ill and chemically dependent youth and adults from initial or further justice system involvement.

The specific goals of the CIRT Pilot Project are to:

- Get individuals involved in crisis connected more quickly with appropriate services that can help them achieve stability, including housing and social services for those who are homeless, and treatment for those suffering from mental illness and/or drug abuse.
- Provide a linkage to crisis and commitment services for those individuals who may require involuntary hospitalization and achieve other system cost savings through diversion from jail and costly hospital services and/or admissions.

The CIRT Pilot is a 24-month pilot involving the addition of a 1.25 FTE MHP in the CIT unit to assist designated CIT (dCIT) Officers assigned to the CIT Unit with the incidents that come to their Unit involving PwMI. The CIT Unit and the full-time and part-time MHPs assigned to the new CIRT Pilot are not able to respond to every call involving mentally ill individuals. Calls are filtered through a triage process and the decision to involve the MHP depends on a number

of factors including the way in which the incident is initially reported to 911, the descriptive terms used by the 911 dispatcher to describe the individuals involved in the scene, and the decision of the precinct officers to call the CIRT to the scene. Given these design features, it was determined that an impact evaluation measuring global outcome variables (such as citywide case dispositions or jail admissions) within an experimental or quasi-experimental framework was not feasible.

This evaluation sought to measure, on an incident-specific basis, the degree to which the MHP plays a role in improving police-citizen relations in incidents where the MHP is involved, as well as perceived changes in the nature of these incidents as reported by responding officers. This involved understanding and describing what the MHP does and the ways in which the inclusion of the MHP changes the nature of Seattle Police response to incidents involving mentally ill individuals. Specifically, it was hypothesized that the assistance of the trained MHP would affect the nature of incidents involving mentally ill individuals in the following ways: (1) reduce the amount of time to case resolution; (2) reduce the number of repeat contacts involving the same individuals; and (3) change the nature of the incident disposition reflecting predominantly referrals to non law enforcement resources and informal social controls.

Method

Cases coming into the CIT Office from January 2011 – December 2011 were included in the evaluation. Incident and supplemental reports were provided to researchers by the Seattle Police Crisis Intervention Team Unit in PDF format, and subsequently entered into the Statistical

Package for the Social Sciences (SPSS) for processing and analysis. Cases included all SPD incident reports triaged to the CIRT and supplemental reports by CIRT staff written by MHP and CIT Officers. Data were collected for 290 cases from incident reports and supplemental reports on incident location, incident characteristics, officer descriptions of incidents, CIT follow-up, MHP follow-up, and case disposition. Background interviews were conducted with CIRT Staff and others involved in the development and implementation of the pilot. The purpose of these interviews was to ensure that research staff had comprehensive knowledge of the CIRT program's processes and procedures, as well as to provide important context to empirical observations.

To provide an overall picture of the CIRT Pilot and its effectiveness in relation to the hypothesized outcomes, key variables were examined to describe the types of cases triaged to CIT, the nature of the cases, case disposition, and the role of the CIT officer and MHP in the case resolution. Key variables included:

- Nature of Incident
- Repeat Calls/Contacts
- Incident Location
- Case Disposition
- Linkages to Services
- Case Clearance Time

Data were collected from incident and CIRT Supplemental Reports relevant to these variables including incident characteristics, number of times an individual was involved in an incident, location of incident, location of person reporting incident, related incidents, victim

characteristics where identified, time to clearance, time spent on incident, intervention, CIRT and MHP response, and case disposition.

Analyses

Descriptive Analysis

Descriptive analyses were conducted on key variables to provide an overall picture of the CIRT Pilot and its effectiveness in relation to the hypothesized outcomes, the types of cases triaged to CIRT, the nature of incidents, the number of repeat contacts, the nature of incident for lower and higher volume contacts, the CIT and MHP response on each case, and the final case disposition. Case clearance was calculated based on the time and date the incident was reported to the time and date the case was administratively cleared.

Narrative data from incident reports was recorded for all cases and analyzed to determine the nature of the incidents to give a more detailed picture of the types of incidents handled by the CIRT and MHP and the distinguishing characteristics of low and high volume contacts. In addition to descriptive data, 20 cases including 10 low and 10 high contact with police were identified and qualitative data from incident and supplemental reports were analyzed in order to provide a profile of low and high contact cases handled by CIRT.

Spatial Analysis

Following the manual coding of all incident report data, the address fields were cleaned and prepared for geocoding. The cleaning process required some realignment of address fields, creation of additional address fields, and adjustments to SPD naming conventions, abbreviations, and street intersections. An address locator was generated using the SPD streets

layer files, and all incidents were successfully geocoded through either automated or manual processes. We used existing SPD city layers for other features, such as building footprints, highways, and the locations of various waterways. The coordinate system is the State Plane for Washington North (FIPS 4601). All geoprocessing and spatial analyses were performed using ESRI ArcGIS version 10.

The analytic plan called for beginning with simple point maps of MHP incidents in order to visually assess the spatial distribution and calculate basic, global tests for clustering. We also wanted to learn something about the distribution of high volume locations by identifying the number of unique incident addresses and the number of incidents at those locations. We next moved to aggregations at the census-tract level to help visually confirm any observed clustering of point data and to assess the degree of localized clustering. We then conducted local statistical tests for clustering, which provide an empirical basis of confidence for local clustering (i.e., “hot-spots”) but also provide greater confidence in the validity of our final spatial technique, hot-spot mapping of MHP incidents using kernel density estimation.

CHAPTER 3

Results

DESCRIPTIVE OVERVIEW

CIT, CIRT, MHP Definition of terms and Roles

Crisis Intervention Team (CIT): The SPD Crisis Intervention Team (CIT) was formed in 1998, 10 years after the first CIT was implemented in Memphis, Tennessee in 1988.³ Modeled after the Memphis CIT program, SPD's CIT is a collaborative effort between the Seattle Police Department, Seattle-King County Department of Public Health, King County Department of Community and Human Services Mental Health Division, Washington Alliance for the Mentally Ill (WAMI), and Mothers for Police Accountability (Seattle Police Department, 2002). The CIT provides a 40-hour training course and one-day refresher courses for CIT-trained officers to attend on a voluntary basis. The 40-hour CIT course includes subjects such as *Mental Disorders, Geriatric Mental Disorders, Understanding Mental Illness, The Law and Mental Illness, Communication With Mentally Ill Individuals, and Intervention in High Risk Situations (Suicides), and other topics*. Subjects are taught by local professionals who are experts in the specific subject matter (Seattle Police Department, 2000). The CIT is staffed with a Sergeant, two dedicated Crisis Intervention (dCIT) Team Officers.

³ Like the Memphis CIT which was formed in response to public outcry in the aftermath of the shooting of a young African American male with a history of mental illness (Vickers, 2000), the SPD CIT was motivated at least partially in response to two incidents involving law enforcement's interactions with PwMIs – a 1996 stand-off between an elderly mentally ill man who had shot a utility worker that ended with the man being killed by police gunfire and a 1997 case involving a man with a samurai sword who disrupted city traffic for 11 hours before the police were able to bring the incident to a peaceful resolution using non-lethal tactics. The SPD CIT program was launched the following year in response to recognition that officers could benefit from specialized training in dealing with PcMI (Neidhart, 2008).

Crisis Intervention Response Team (CIRT): The Crisis Intervention Response Team (CIRT) was formed in 2010 with the award of a federal grant as an enhanced version of the CIT with the inclusion of a full-time mental health professional (MHP). The grant was awarded to contract a mental health professional to work directly with a dedicated Crisis Intervention Team officer (dCIT).⁴ The Downtown Emergency Services Center (DESC) was selected to fulfill the contract for a 1.25 FTE for the 24 month project period. The full and part-time MHPs were selected based on experience in crisis intervention, outreach, and chemical addiction and dual diagnosis. The dCIT officers were selected from all patrol officers based on their reputation for problem-solving, strong work ethic, teaching skills, and ability to work with diverse populations. The CIRT is comprised of one sergeant, two dCIT officers, 1 FT MHP, and 1 PT MHP. Together the CIRT Staff developed a triage process for cases and a continuum of intervention ranging from a phone call and records check to arrest and booking, and including outreach, assessment, referral to services, engagement with family and case managers, mental health court intake without booking, and other options (Sergeant Joe Fountain, Personal communication, October, 2011). The CIRT is also tasked with presenting information and training to local community groups and agencies known to house and provide services to PwMI. The CIRT represents a unique partnership between law enforcement and mental health agencies with the mutual benefit of reciprocal training between law enforcement officers and mental health professionals with the effect of creating a culture of true collaboration between law

⁴ Dedicated Crisis Intervention Team Officers (dCIT) who staff the SPD CIT Unit are differentiated from other SPD officers who have completed the 40 hour CIT training and are considered CIT Officers.

enforcement and mental health agencies to provide services to PwMI that take into consideration the complexity of the behavioral events associated with mental illness.

Specific function of the MHP

The specific function of the MHP in CIRT has evolved during the course of the pilot program as the program has been developed by the CIRT. The role of the MHP is to handle cases involving mentally ill individuals where no probable cause for a crime exists as well as high volume “nuisance” cases. Additionally, the role of the MHP is to work with the dCIT Officers to triage cases to designated CIRT members for effective, appropriate, and meaningful case disposition. Over the course of the CIRT Pilot, the MHP has been increasingly involved in fieldwork including “knock and talks” where CIRT officer and the MHP check in on PwMI for inquiry and follow-up as well as call-out to incidents involving PwMI.

Triage process

From January 2011 through December 2011, a total of 3,029 cases were referred to the CIT Unit. Cases were classified into four categories based on the nature of the call: (1) Imminent public danger; (2) Escalating mental condition involving repeat contacts; (3) Specific requests by officers; and (4) Repeat contacts/Nuisance callers. Figure 1 shows the triage process and the types of calls referred to CIT. As part of the triage process, a determination is made to place the incidents with appropriate CIT staff. The addition of the MHP in the CIT Unit allows for incidents involving mentally ill individuals who engage in repeat nuisance contacts to be diverted to a mental health professional rather than a law enforcement officer. In 2011, 669 (22%) of the total 3,029 cases referred to the CIT were followed up by CIT staff. Of these 669

cases, 290 were assigned to the MHP and 379 to the CIT Officers. Of the 379 CIT Officer cases, those involving violent crimes with clear probable cause were triaged to the CIT Officer designated to handle the serious criminal cases (Officer Enright) and cases involving less serious incidents were handled by CIT Officer Nelson. Incidents involving nuisance cases with no probable cause that a crime had been committed were referred to the MHP (Dawson or his part-time alternate MHP) (See Figure 1/CIRT Triage Process).

---- Insert Figure 3-1/ CIRT Triage Process Here ----

Community Relations

The CIRT dCIT Officer and MHP conducted presentations with local social service and housing agencies to explain the CIRT Pilot and the services available through SPD CIRT to assist local agencies in incidents involving PwMI. In addition, the CIRT has been featured in news reports that describe the CIT and CIRT process and the role of the MHP.⁵ The CIRT was also awarded the 2011 Employee Recognition Award by the Seattle Police Foundation. News features on the CIRT, community presentations on the role and function of the unit and the collaboration between law enforcement and mental health. This public exposure has served the function of educating the public about the possibilities for this sort of law enforcement-mental health agency partnership and the potential for deepening the service and order maintenance

⁵ See Krishnan, (2010), Lightfoot (2012), a September 15, 2010 Q13 News story on CIT: http://www.q13fox.com/news/kcpq-091510-psychiatrists_in_blue,0,5588084.story and June 13, 2011 Komo News story on CIRT: <http://www.youtube.com/watch?v=R-MmPVSGcnM>.

components of the police role in ways that diminish reliance on crime control for PwMI who do not present a threat to public safety.

Nature of Incidents Referred to CIRT

Cases triaged to CIT were placed into seven categories based on the nature of the incident: (1) Mental – cases that involved an encounter with a person with mental illness (PwMI); (2) Assault/Threat/Harrasment involving cases with probable cause; (3) Suicide; (4) Suspicious Circumstance; (5) Disturbance; (6) Robbery/Burglary/Theft/Property; and (7) Other. Results indicate that the majority of cases triaged to CIRT were cases classified as “mental” with no criminal behavior involved (n= 124, or 42.8% of cases) followed by assault/threat/harassment (n=41, or 14.1% of cases), and suicide (n=34, or 12.1% of cases). The smallest category of incidents were those involving robbery or burglary/theft/property crime (n=10, or 3.4% of cases). Table 3-1 shows the frequency and percent of incidents by type.

---- Insert Table 3-1/Nature of Incidents Here ----

The incidents were triaged to CIT as a result of some reference to mental disorder by individuals reporting the incident or officers who had previous contact with the individuals involved. Of the 290 cases for which a diagnosis was indicated in the incident report, the majority were identified as “general mental illness” (n=196, 67.6%), followed medication/drugs/alcohol (n=27, 9.3%) Table 3-2 shows the frequency and percent of the diagnostic references to the PwMI involved in the incidents.

---- Insert Table 3-2/Diagnostic References to PwMI in Incidents Triaged to CIT ----

KEY OUTCOME VARIABLES

Spatial Distribution of Incidents

The distribution of MHP incidents is presented as a point map in Figure 3-2. At first glance, it is clear that the incidents are spread across the entire Seattle metropolitan area. Visual clustering is apparent in the northeast part of the city, as well as in the downtown core. The Nearest Neighbor Index, a global statistical test for clustering, was significant indicating that the MHP incidents are not distributed in a spatially random pattern; rather, there is statistically significant clustering of incidents within the study area. The visual distribution indicates the MHP is being used city-wide, and we may presume the MHP does so with a particular level of efficiency. However, given evidence of significant global clustering of incidents, there may be a case for greater efficiency with a more regionalized approach, provided additional MHP resources can be acquired.

---- Insert Figure 3-2/ Point Map of MHP Incidents Here ----

Some locations (addresses) generated a higher volume of activity than others. These high volume locations are depicted in Figure 3-3 as large circles with the number of incidents at the location appearing within the circle. For example, there are two locations on the map in Figure 3-3 where 10 incidents occurred during the study period; one location where 9 incidents occurred; two locations where 8 incidents occurred; and so on. The 12 locations identified on the map (or 6% of all unique addresses) generated 83 incidents (or 27% of all incidents). The finding that 6% of addresses accounted for 27% of incidents suggests that the MHP is, with

these locations alone, alleviating what would otherwise be a significant resource strain on patrol officers.

---- Insert Figure 3-3/ High Volume Locations Here ----

MHP incidents were aggregated to census tracts in the choropleth (area) map presented in Figure 3-4. The census tracts are shaded according to the frequency of MHP incidents. Two census tracts (one in the downtown core and one in the northeast) are in the highest category, with 20 and 18 incidents, respectively, over the study period. Nearby census tracts also have higher frequencies of MHP incidents. This tends to confirm the apparent clustering in the point map, and suggests local clustering in these areas.

---- Insert Figure 3-4/ MHP Incidents Aggregated to Census Tracts Here ----

In order to test for local clustering, the Getis-Ord G_i^* statistic (a Local Indicator of Spatial Autocorrelation, or LISA statistic) was calculated and mapped in Figure 3-5. Statistically significant clustering of the aggregated data is indicated by standardized G_i values exceeding 1.96 ($p < .05$). The three areas of the city identified earlier (the downtown core, an area in the northeast, and an area in West Seattle) showed significant clustering of high count census tracts.

---- Insert Figure 3-5/ Map of Getis-Ord G_i^* Statistics Here ----

We then used Kernel Density Estimation (KDE), a smoothing technique typically used in representing crime data, to visualize hot spots of MHP incidents. It is particularly important to

note the visual overlap of the qualitative, smoothed hot-spots with the LISA statistics indicating statistically significant clustering of incidents; where there is statistically significant local clustering, we have greater confidence in the validity of the smoothed data. The KDE appears in Figure 3-6. The density of incidents is greatest in the downtown core, where it approaches 36 incidents per square mile.

---- Insert Figure 3-6/ Kernal Density Estimation Here ----

Repeat Contacts

Contacts with police ranged from 1-20 ($n=186$, $M=4.5$, $Sd = 4.72$). The majority of incidents referred to CIRT involved isolated incidents where there was no repeat contact with police ($n=126$, or 43.4% of cases). However, there was a substantial number of incidents that involved 2-6 repeat contacts ($n=97$, or 33.4% of cases), approximately 18% ($n=52$) involving 7-15 repeat contacts, and a small number of incidents ($n=15$, or 5.2% of cases) that involved high volume contacts (HVCs) with 15 or more contacts to police. Thus, the majority of incidents ($n=164$, 56.6%) involved multiple contacts with police (See Table 3-3).

----- Insert Table 3-3/ Repeat Contacts Here -----

Incidents involving lower and higher volume contact with police differed with respect to incident nature, $\chi^2(6, N=186) = 14.64, p = .02$. Higher volume contacts were more likely to involve assault, threats, and harassment, or suicide, while lower volume contacts were more likely to involve incidents coded as “mental” involving a police report or call for service involving a PwMI that was not deemed an imminent threat or characterized by probable cause

for an offense. Table 3-4 shows the incident nature by low (0-7 contacts) versus higher (7 or more contacts) with police.

----- Insert Table 3-4/ Contacts with Police by Incident Nature Here -----

Case Disposition

Table 3-5 shows the distribution of case dispositions. About a third of cases (34.1%) were referred to non-law enforcement agencies (e.g., inpatient or outpatient chemical dependency treatment, mental health case management). Twelve percent were recommended for administrative clearance, and seven percent had some other type of disposition. Of particular interest, although infrequent, were cases that were handled through some type of individual-local-community resolution (e.g., asking the PwMI's neighbor or landlord to keep an eye on them and call police if there is a problem). These types of resolutions are indicative of informal social control networks that may not have otherwise been activated through traditional police response. It is also important to note that very few cases (about one percent in each category) resulted in arrest or transport to hospital facilities.

----- Insert Table 3-5/Case Disposition Here -----

Time Spent on Intervention

Table 3-6 shows the results of time analyses based on 186 cases with usable data. There is a fair amount of variability in the number of contacts, time to clearance, and time spent on each case: the number of contacts with subjects ranged from just one to as many as 20; days to clearance ranged from zero to 219 days; and time spent on case ranged from 10 minutes to

more than four hours. Due to skew in these variables, the median is a better indicator of the “typical” case than the mean: on average, the MHP had about 3 contacts with subjects; cases were typically cleared in about 19 days, and the time spent per case was approximately 50 minutes.

----- Insert Table 3-6/Time Spent on Intervention Here -----

High and Low Volume Contacts

Given the quantitative results demonstrating a small number of high volume cases (cases that placed burdens on CIT staff prior to the addition of the MHP), a qualitative examination of these cases was undertaken in order to understand the true nature of both high volume and low volume contacts. Four examples are provided below, including two high volume contacts and two low volume contacts. The top 10 high volume cases and 10 lowest volume cases were selected to provide incident details to provide snapshot of the nature of the cases involving high volume contacts (PwMI who either called police multiple times or were reported to police as a result of a disturbance, community concern, or other witness report) and low volume contacts (PwMI who came to the attention of police only once). Table 3-7 compares the high and low volume contacts.

----- Insert Table 3-7/High and Low Volume Contacts Here -----

The case analyses show that the HVCs, in particular those involving over 15 contacts during the study period , require a high amount of resources in both the initial response and follow-up every time the PwMI is routed to the CIT Unit. To determine the degree to which

contact with law enforcement in the HVC group decreased during the study period, the number of contacts per month over the one year study period from January 2011 through December 2011. Figure 3-8 and Table 3-8 show the number of contacts for each month across the one year study period for the HVCs.

Examination of the case study subsample of HVCs and LVCs shows the nature of the case disposition. In most of the cases the CIT Officer and MHP worked to link the PwMI with resources or to resolve the incident at the informal community level. While approximately 80% of all incidents handled by the CIRT and MHP resulted in a case disposition involving referral to a non-law enforcement agency, administrative clearance, or individual-local-community resolution, within the HVC case category, 100% involved referral to non-law enforcement agency and administrative clearance with no arrests or transport to hospital with these high volume contacts. Table 3-8 shows the breakdown of case disposition across the lower to higher volume contacts.

----- Insert Table 3-8 Number of Contacts by Case Disposition Here -----

CHAPTER 4

Conclusion and Policy Implications

This evaluation of the Seattle Police Department Crisis Intervention Response Team Pilot Program sought to measure, on a descriptive incident-specific basis, the degree to which the MHP plays a role in improving police-citizen relations in incidents where the MHP is involved, as well as perceived changes in the nature of these incidents as reported by responding officers. This entailed understanding and describing what the MHP does and the ways in which the inclusion of the MHP changes the nature of Seattle Police response to incidents involving mentally ill individuals. Specifically, it was hypothesized that the assistance of the trained MHP would affect the nature of incidents involving mentally ill individuals in three ways: (1) Reduce the amount of time to case resolution; (2) Reduce the number of repeat contacts involving the same individuals; and (3) Change the nature of the incident disposition reflecting predominantly referrals to non law enforcement resources and informal social controls.

QUESTIONS ANSWERED

How has the inclusion of the MHP changed the nature of Seattle Police response to incidents involving mentally ill individuals?

The MHP program has clearly changed the nature of police response to PwMI. The most common case disposition in this study (occurring in about one third of all cases) was a referral to a non-law enforcement agency and over 80% of cases (and 100% of the HVCs) were handled by either referral to a non-law enforcement agency, individual-local-community resolution, or administrative clearance. One example of such a referral would be directing the PwMI to

available chemical dependency treatment programs. In contrast, very few cases (about one percent) resulted in an arrest or a transport to hospital facilities for evaluation, the latter being a “default” type of response for patrol officers responding to PwMI without the benefit of MHP involvement. The outcomes of cases handled by the MHP represent a clear shift from prior practice.

To what degree does the MHP play a role in improving police-citizen relations in incidents where the MHP is involved?

One area of potential improvement in police-citizen relations is in those cases where the MHP facilitated some kind of individual-local-community resolution to the problem. Informal social control networks can often be more effective in addressing neighborhood issues and problems than formal police responses. The former tend to have longer lasting effects than the latter. It is very unlikely that a traditional police response to PwMI would lead to these kinds of collaborative, community-building types of activities. This is not to say that traditional patrol officers are unable or unwilling to facilitate local responses, but that they probably lack the necessary time and other resources to support local efforts. The MHPs fill this gap.

To what degree does the inclusion of the MHP save police resources?

In addition to improving police-citizen relations and the quality of interactions between the police and PwMI, the MHP program represents a substantial improvement in the use of police resources. This descriptive evaluation of the MHP program has demonstrated that the MHP takes on a substantial burden which existed for traditional patrol resources which were being directed toward essentially non-law enforcement matters and with resulting inefficient and ultimately less effective responses (for example, unnecessary and resource-consuming

transports to Harborview). The high volume, repeat contacts in the “mental” category in particular represent an unnecessary and inappropriate burden on patrol officers that is alleviated by the MHP and leads to a more appropriate response.

However, the results suggest that in the case of the high volume contacts, there was not a clear decrease in contacts during the study period as hypothesized.

POLICY IMPLICATIONS

We are hesitant to make any policy recommendations based on this descriptive evaluation of a relatively new program. Although this study provides clear evidence that the MHP is alleviating a sizeable burden that would otherwise be carried by regular patrol officers, and the MHP arguably represents a more refined and comprehensive response to persons experiencing mental health crises, no conclusions can be drawn from this evaluation regarding the effectiveness of the MHP program in contrast to previous or alternative responses. That being said, the results of this descriptive study suggest that there is true “value-added” by the MHP program and that continued use of the MHPs is merited. The study also points to possible program enhancements, such as an expansion of the number of MHP FTEs combined with a regionalized approach to resource allocation, which may lead to further efficiencies. The original vision of the addition of the MHP was the addition of 4 MHPs who would be paired with 4 CIT officers/detectives in teams of two who would work in shifts to cover the entire 24-hour period of the day, modeled after the Los Angeles Police Department (L. Eddy, Personal Communication, July 30, 2012). The addition of 1 MHP made possible by the federal funding brought these enhanced services to interactions involving police and mentally ill individuals for

incidents triaged to the MHP. Additional MHPs would allow for more comprehensive 24-hour coverage across the city to provide services to mentally ill individuals in need.

Concluding Comments

The results of this descriptive evaluation of the CIRT pilot program suggest that the CIRT is relieving an otherwise substantial, unnecessary, and inappropriate burden on law enforcement officers. Although comparable empirical benchmarks prior to the pilot program are not available, the descriptive information concerning repeat contacts, dispositions, time spent on cases, the nature of incidents, and the spatial distribution of incidents demonstrate that a substantial workload was appropriately shifted from patrol officers to the MHP. The finding that 6% of unique addresses accounted for 27% of MHP responses suggests that the MHP is – based on these locations alone – alleviating what would otherwise be a significant resource strain on patrol officers, and that even greater efficiency gains could be achieved with a more regionalized approach.

The MHP averaged 3 contacts with subjects (with no repeat contact in 43% of cases), cleared cases in about 19 days, and spent about 50 minutes per case. About a third of cases (34.1%) were referred to non-law enforcement agencies to address in- or out-patient chemical dependency treatment or mental health case management. Anecdotally, when reviewing these empirical findings with program staff it was observed that these represented substantial improvements in the amount of time to case resolution, repeat contacts, and referrals to non law enforcement resources.

Methodological considerations are worth noting in assessing the contribution of the descriptive findings presented here. In their comprehensive review of research on CIT programs from 1988 – 2006 Compton et al., (2008) found that the CIT model can be an effective component in connecting PwMI who come to the attention of the police with appropriate psychiatric services. However, the authors note that interventions like CIT which are implemented in truly real-world settings are difficult to study. Many of the evaluations of CIT programs have been descriptive in nature, highly localized, utilizing small samples with no control groups, and researchers have yet to tease out program components in diverse jurisdictions that are most beneficial. Furthermore, CIT research to date has primarily examined intermediate officer-level outcomes that have been extrapolated to more distal patient-level outcomes. For example, researchers suggest that findings showing that CIT training and CIT officer interactions with mental health professionals has the immediate effect of changing officer attitudes toward PwMI, and that this change in attitude may have an impact on patients in terms of more appropriate referral to services, earlier referral to treatment and so on. Any research on the effects of CIT interventions have to be understood within the context of these previous CIT evaluation studies.

The value-added by the MHP in the SPD CIRT pilot as shown in the findings presented here can also be extrapolated to patient-level outcomes. However, further research is needed to determine the impact of the different components of the MHP role. For example, Morton (2010) found that practitioners across health and social care backgrounds overwhelmingly identified “emotional support” or just “being there” as the most significant thing they had done

to help the person in crisis regardless of what the crisis was or what category of disorder they were deemed to have, and that “emotion” was not a named or measured component of the intervention. This suggests that the function the MHP can potentially serve by handling appropriate and high volume contacts is to offer this emotional component that officers may not have the time or resources to provide. According to Morton (2010, p. 472), “For an individual experiencing a crisis in their emotional life, that experience...is felt as an immediate experience where emotions are difficult to contain. Whatever category individuals are put into is largely irrelevant; what is relevant is what happens next whether in services or outside of them.” The role of the MHP in crisis incidents involving PwMI has the effect of changing “what happens next” in crisis incidents by infusing a professional trained in providing emotional support at the times of crisis where individuals who are not able to contain their emotions come to the attention of the police because their behaviors that may appear irrational or unreasonable. The effect of this intervention on patient-level outcomes deserves further exploration and future research following individuals with whom the MHP has worked would provide further information to assess the value added of the MHP in the SPD CIRT.

Overall, it appears that on a descriptive basis the anticipated benefits of adding a trained MHP to the CIRT are being realized and that the program has the potential for continued improvement in the quality of police response to persons experiencing mental health crises in Seattle. The addition of MHPs assigned to individual precincts would enhance coverage, allow for more field responsiveness, and increase overall visibility of CIRT staff (J. Dawson & D. Nelson, Personal Communication, July 30, 2012). More comprehensive coverage

across the city by the MHP in individual precincts would allow for future research that could potentially incorporate a more sophisticated methodology. Further research utilizing a comparison or control group comparing incidents involving the MHP to matched incidents where no MHP is available would be a valuable next step in obtaining additional data to measure officer-level, patient-level, and system-level outcomes. Additionally, further qualitative research examining the individual differences in the trajectories of high volume contacts and role of the MHP in providing emotional support to PwMI, in deescalating crisis incidents, in providing enhanced services and reducing the amount of time police spend dealing with PwMI, in changing the culture of the CIT unit would be an important addition to the findings here.

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Figure 3-1

CIRT Triage Process

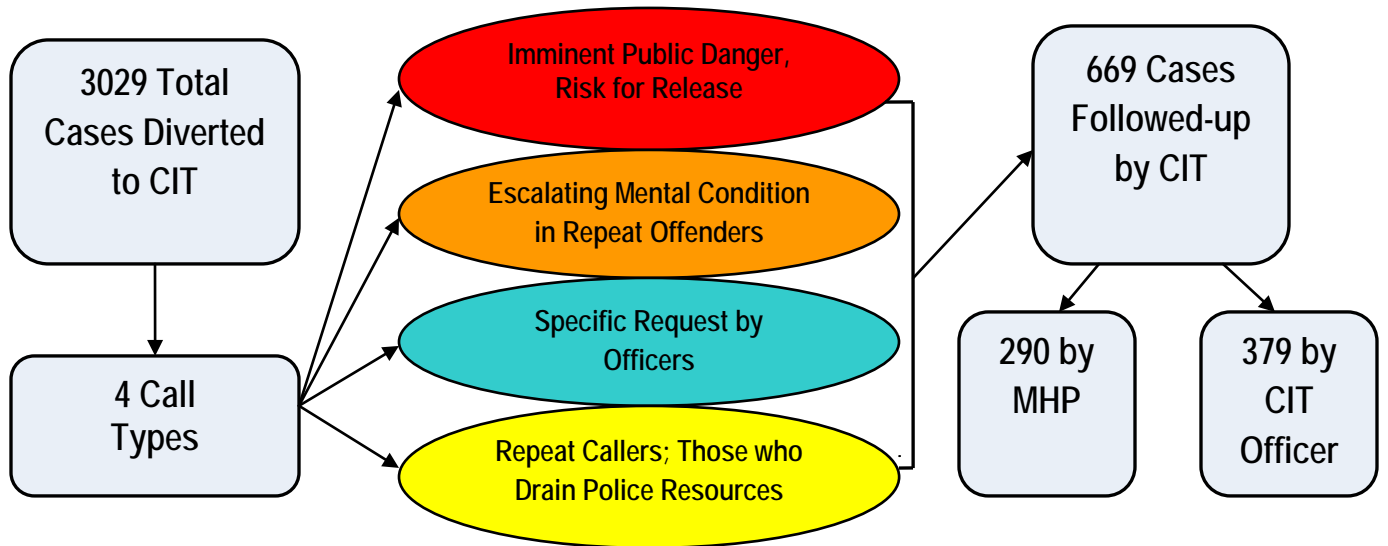


Table 3-1

Nature of Incidents

Incident (N=290)	Frequency	Percent
Mental	124	42.8
Assault/Threat/Harrassment/Robbery*	42	14.4
Suicide	35	12.1
Suspicious Circumstance	31	10.7
Disturbance*	27	9.3
Other	22	7.6
Burglary/Theft/Property	9	3.1
TOTAL	290	100

*Of these offenses, 17 (6.6%) were identified as "Family Violence" – 7 were assaults and 10 were disturbances, and 1 was a robbery incident involving an PwMI who reported being robbed at gunpoint .

Table 3-2

Diagnostic References to PwMI in Incidents Triaged to CIT

Incident (N=290)	Frequency	Percent
General Mental Illness	196	67.6
Redacted	28	9.7
Meds/Drugs/Alcohol	27	9.3
Bipolar/Manic Depression	18	6.2
Schizophrenia	8	2.8
Depression	5	1.7
Manic Depression	3	1
Paranoia	3	1
PTSD	3	1
Dementia	2	.7
TOTAL	290	100

Figure 3-2

Point Map of MHP Incidents

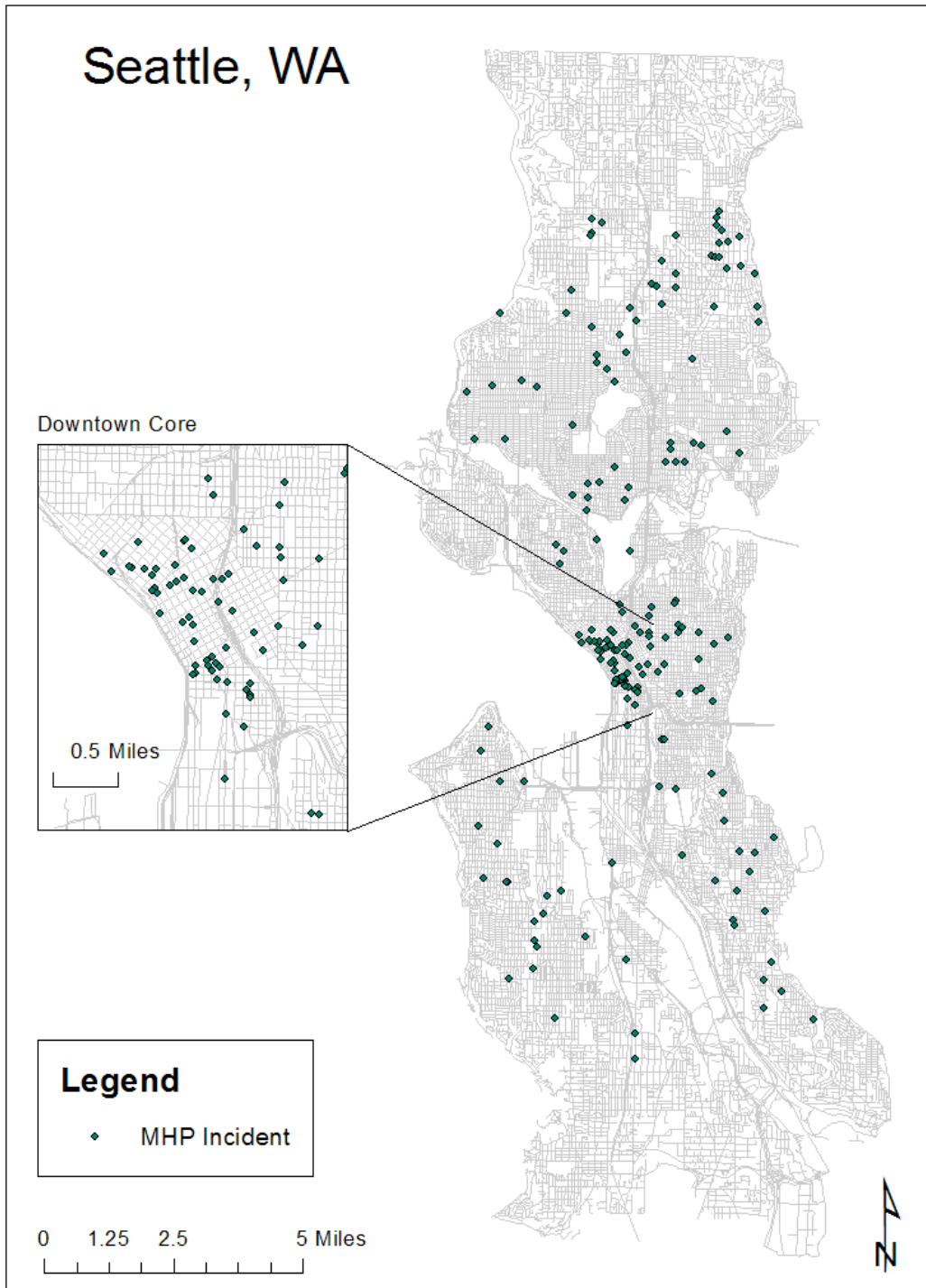


Figure 3-3

High Volume Locations

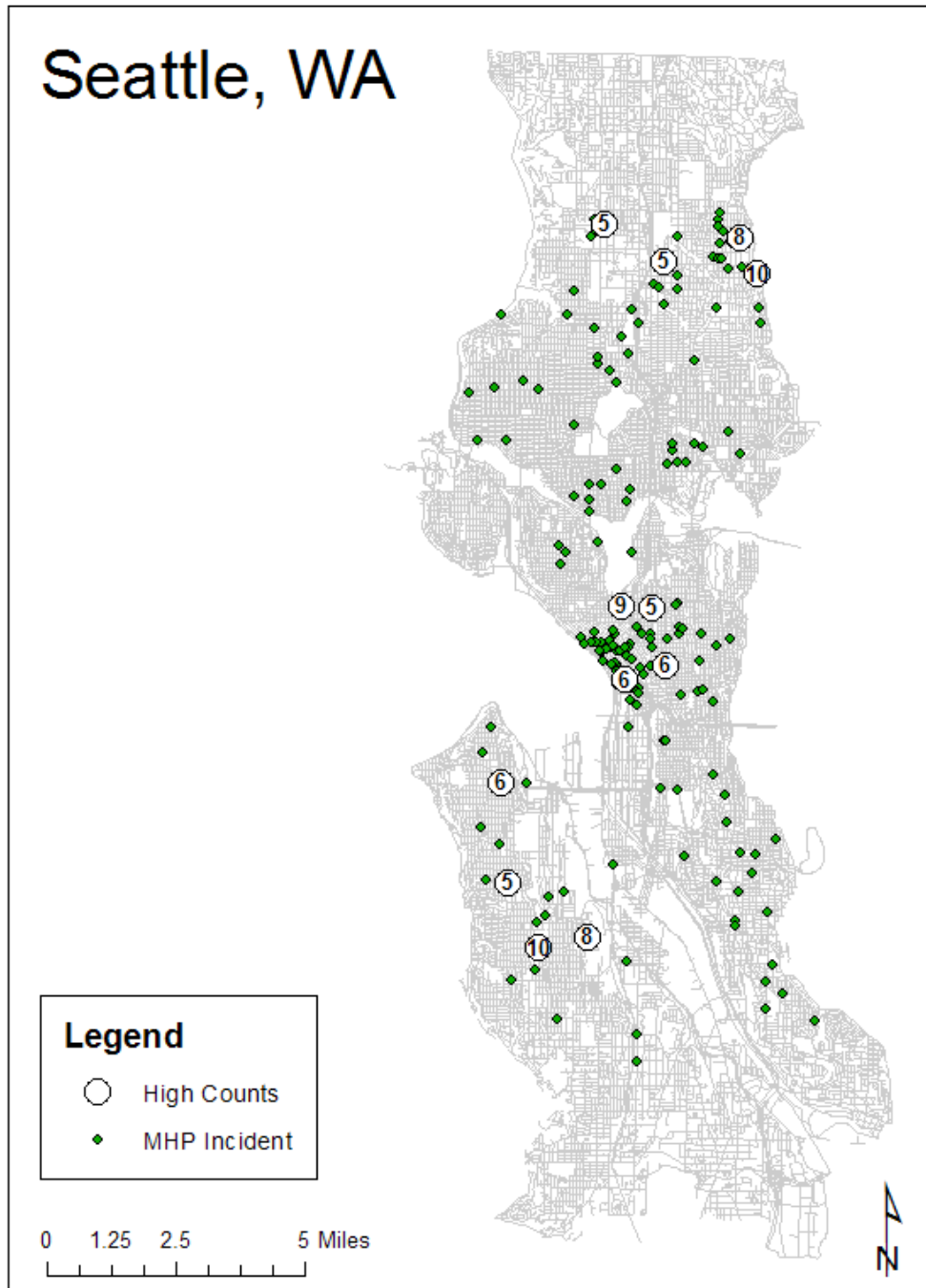


Figure 3-4

MHP Incidents Aggregated to Census Tracts

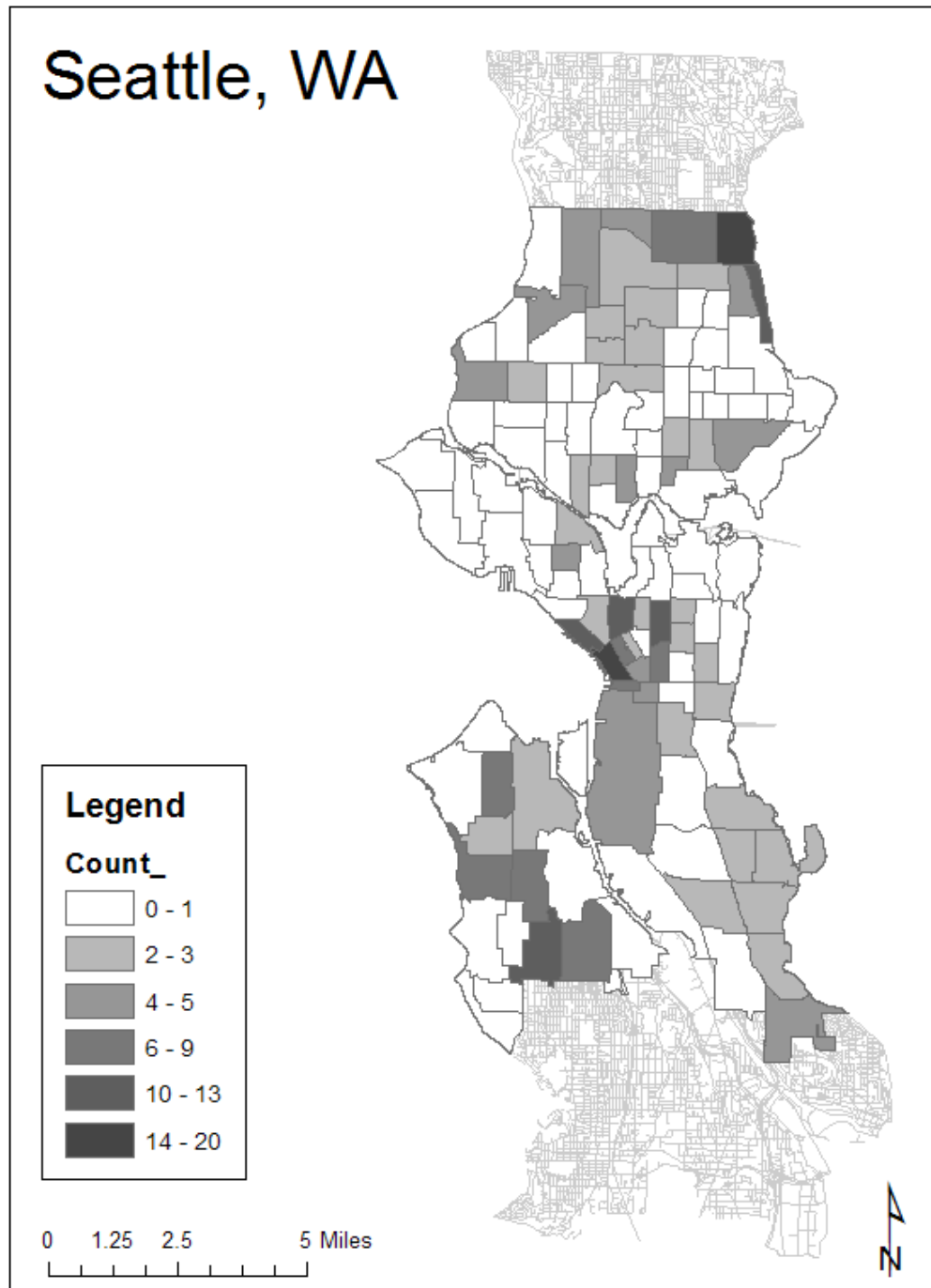


Figure 3-5

Map of Getis-Ord Gi* Statistics

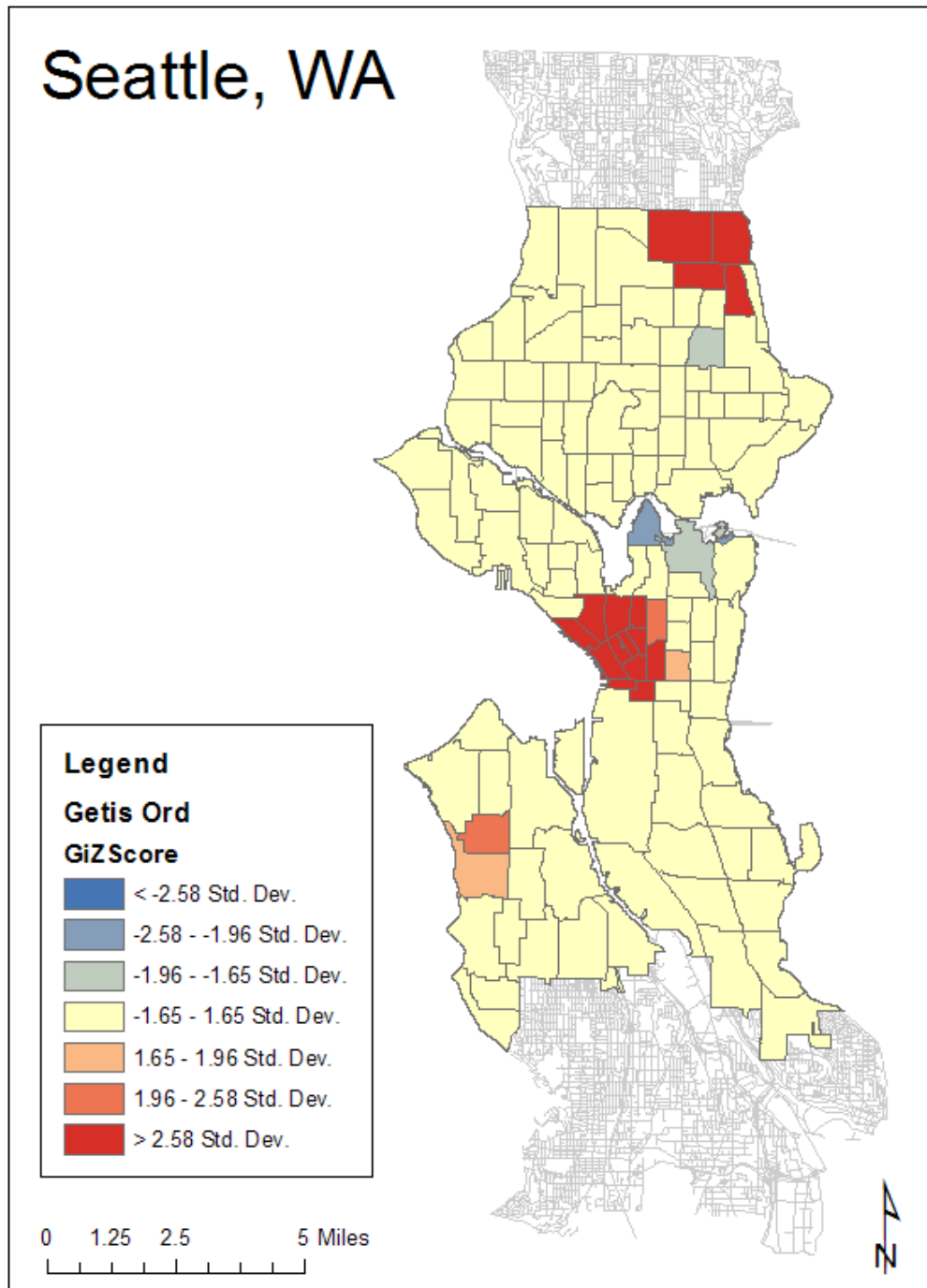


Figure 3-6

Kernel Density Estimation

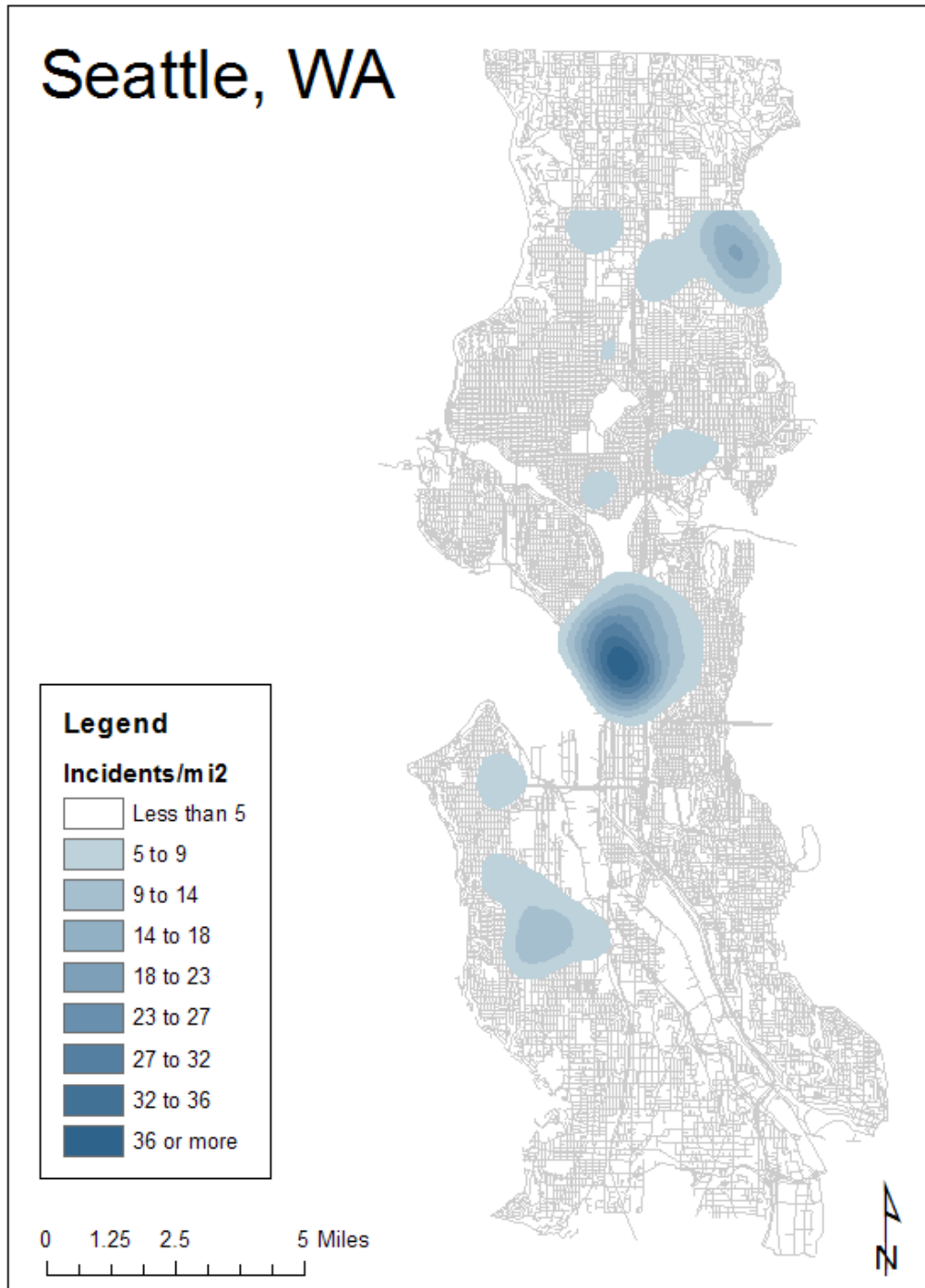


Table 3-3

Case Disposition

Incident (N=290)	Frequency	Percent	Valid Percent
Referral to Non-Law Enforcement Agency	99	34.1	58.6
Recommend Administrative Clearance	35	12.1	20.7
Other*	21	7.2	12.4
Suggestion for Individual-Local-Community Resolution	4	1.4	2.4
Assistance Declined	4	1.4	2.4
Transport to Hospital or Outpatient	3	1.0	1.8
Arrest	3	1.0	1.8
TOTAL	169	58.3	100

*The majority of these incidents were situations in which the CIRT Officer and MHP followed up but could not make contact with the PwMI. Other cases involved dropped charges or complaints, involuntary detention of the PwMI, and completed suicide.

Table 3-4

Repeat Contacts

Incident (N=290)	Frequency	Percent
0-1	126	43.4
2-6	97	33.4
7-11	34	11.7
12-15	18	6.2
>15	15	5.2
TOTAL	290	100

Table 3-5

Repeat Contacts by Nature of Incident

Incident Nature	0-6 Contacts with Police <i>(n=158/84.9% of Total)</i>	>7 Contacts with Police <i>(n=28/15.1% of Total)</i>	Total Number of Coded Incidents <i>(n=186/64% of Total)</i>
SUICIDE	13.9% (n=22)	7.1% (n=2)	24
MENTAL	39.9% (n=63)	21.4% (n=6)	69
ASSAULT/THREAT/HARRASSMENT	15.8% (n=25)	35.7% (n=10)	35
SUSPICIOUS CIRCUMSTANCES	8.9% (n=14)	7.1% (n=2)	16
DISTURBANCE	9.5% (n=15)	3.6% (n=1)	16
BURGLARY/THEFT/PROPERTY	5.1% (n=8)	3.6% (n=1)	9
OTHER	7% (n=11)	21.4% (n=6)	17
TOTAL # Contacts with Police	158 100%	28 100%	186 100%

Table 3-6

Time Spent on Intervention

	N	MEAN	MEDIAN	SD	MIN-MAX	RANGE
Number of contacts with subject	186	5	3	4.72	1-20	19
Time to clearance (days)	186	36	19	44.02	0-219	219
Time spent per case (minutes)*	186	67	50	59.03	10-250	240

*Each email/phone call = 10min. Each face-to-face encounter = 60min.

Table 3-7

High and Low Volume Contacts

TYPE OF CONTACT	HVC #1	HVC #2	LVC #1	LVC #2
# Incidents	28	42	1	1
Incident Code	"Mental"	"Harassment"	"Mental"	"Assault"
Incident Overview	<ul style="list-style-type: none"> • Occurred at residence/home • Woman with 3-year history of calls to 911 to report various threats to her safety. • Approximately 20-30 calls per year. • 28 related incidents/calls during study period. 	<ul style="list-style-type: none"> • Occurred at residence/home • 3-year history of 911 calls to residence. Officers to house 14 times in two month period. • 42 related incidents/calls during study period. 	<ul style="list-style-type: none"> • Occurred at a liquor store • 911 call in regards to a man banging his head against a store window • This was the only incident recorded during study period. 	<ul style="list-style-type: none"> • Occurred at residence/home • 911 was dispatched to a supportive housing location for a reported threat • No related incidents during study period.
Incident Details	<ul style="list-style-type: none"> • HVC called about vehicles circling her house at night. Later, she went on to report an unknown male watching her through her house windows and attempting to break in. 	<ul style="list-style-type: none"> • Officers responded to 6 hang-up calls to 911. 	<ul style="list-style-type: none"> • Officers were dispatched to a local liquor store to respond to a call of a LVC male banging his head against the store window. 	<ul style="list-style-type: none"> • Officers arrived at a supportive housing location for reports of a resident threatening a staff member.
Incident Nature and Why Flagged for CIT and Triaged to CIRT	<ul style="list-style-type: none"> • Officer asked HVC how she saw these prowlers, questioned her about the incident, asked what types of medications she was using. • HVC known to police for 3 years. Over 29 calls in first 2 months of year and 20 calls just before new year. 	<ul style="list-style-type: none"> • Officer arrived at residence. Male and female HVC informed by officers during previous incident that the next occurrence would result in an arrest for harassment. Man said he made the calls and was arrested and taken to the precinct. 	<ul style="list-style-type: none"> • The male subject smelled strongly of liquor and seemed to be under the influence of some other intoxicant. • The LVC subject was handcuffed for his own safety, and was transported to a nearby hospital for a mental health evaluation. 	<ul style="list-style-type: none"> • The staff member told officers that the female LVC subject threatened her when she came to pick up her medications that night. • Because the LVC subject was on anti-psychotic medications she was transported to a local hospital for a mental health evaluation.

	<ul style="list-style-type: none"> Known to police that over one year ago she was diagnosed and is on medications. 	<ul style="list-style-type: none"> Officers to residence numerous times over the last 3 years regarding 911 hang up calls --14 times in two months at year start. 		
CRT Response/ Case Disposition	<ul style="list-style-type: none"> CIT assigned for follow-up in an attempt to engage HVC with services in an effort to decrease her frequent calls to 911. CIRT (CIT + MHP) met with HVC at her residence, listened to her concerns and observations. CIRT was able to have HVC acknowledge that others are not seeing what she is doing, but she declined to meet with them further. 	<ul style="list-style-type: none"> MHP assigned to follow up by CIT Sergeant due to continued 911 hang-up calls. Female HVC stated that her insurance will no longer pay for therapy. MHP located several replacement centers, emailed them to female HVC and requested email progress updates. Recommended case be cleared administratively as female HVC was offered resources and reported a plan to locate services to help her through her mental health symptoms. 	<ul style="list-style-type: none"> CIT assigned for follow-up to assist with investigation and attempt to engage LVC with services in an effort to assist him with his mental health issues. MHP located the LVC subjects NAVOS case manager and coordinated a plan to increase his supports in the community. There was an appointment scheduled with case manager and subject to discuss increasing his support that he receives. Case was referred to a non-law enforcement agency. 	<ul style="list-style-type: none"> CIT assigned for follow-up with LVC due to CIT's familiarity with the subject. CIRT (CIT + MHP) was in email contact with LVC subject's case manager and offered assistance in helping to decrease LVC's behaviors that might result in further police contacts. LVC's treatment team meets with her twice daily and she also has the support of her housing staff. Due to her intensive services there is no further role CIT can play in her treatment, and the case was cleared.

Table 3-7

High and Low Volume Contacts

TYPE OF CONTACT	HVC #3	HVC #4	LCV #3	LVC #4
# Incidents	19	11	1	1
Incident Code	"Other"	"Suicide"	"Suicide"	"Disturbance"
Incident	<ul style="list-style-type: none"> Occurred at residence/home 	<ul style="list-style-type: none"> Occurred at residence/home 	<ul style="list-style-type: none"> Occurred at a residence/home 	<ul style="list-style-type: none"> Occurred at residence/home 911 was dispatched for a

Overview	<ul style="list-style-type: none"> • Subject has history of calling 911 and running away from home because he does not feel safe around his parents. • 19 related incidents during the study period. 	<ul style="list-style-type: none"> • HVC is a chronic 911 caller, who often threatens to commit suicide. HVC is well known by SFD, has made 5+ suicide attempts/threats since 2009. 	<ul style="list-style-type: none"> • 911 called for reports of an attempted suicide, called in by the subject's in-home attendant. • No related incidents during study period. 	<ul style="list-style-type: none"> disturbance call • Police had responded to the same location the day before
Incident Details	<ul style="list-style-type: none"> • Police responded to an assistance call. 	<ul style="list-style-type: none"> • Police responded to threats of suicide by medication overdose. 	<ul style="list-style-type: none"> • Officers responded to a 911 call reporting an attempted suicide by the LVC subject. The call was made by the LVC's in-home attendant. 	<ul style="list-style-type: none"> • Officers responded to a disturbance call of a woman trespassing on local business property.
Incident Nature and Why Flagged for CIT and Triaged to CIRT	<ul style="list-style-type: none"> • Subject told officers that he was being neglected by his parents and did not feel safe staying under the same roof as them. • Officers continuously spoke to the parents who assured them that they were in no way neglecting their son. 	<ul style="list-style-type: none"> • HVC called 911 saying he wanted to kill himself, and he had medications do to it. • When police arrived the HVC was being treated for 2 lacerations on his left wrist. • HVC suffers from major mental health issues, and is believed to be in need of detox from alcohol/narcotics. 	<ul style="list-style-type: none"> • SFD treated the female subject, who had 3-4 cuts on her wrists from what she stated was a piece of glass. • LVC's in-home attendant said that the subject was allowed to leave her house, and came back later that day with a piece a glass she picked up outside. 	<ul style="list-style-type: none"> • LVC had previously been removed from the property for making a sleeping area in an alley behind a restaurant, and was found trespassing on the property again • Police spoke with LVC while workers cleaned up all the garbage the LVC had accrued. LVC kept trying to collect her "valuables", all of which the officer confirmed as trash from the nearby dumpster.
CRT Response/ Case Disposition	<ul style="list-style-type: none"> • MHP assigned to follow up by CIT Sergeant due to continued 911 contacts and the subject's refusal to receive any mental health services. • MHP spoke to HVC who repeatedly refused any mental health service, and only wanted to be placed in a foster home to get away from his parents. • Recommended 	<ul style="list-style-type: none"> • CIT was assigned for follow up due to the HVC's increased contacts with SPD due to suicidal ideation after consuming large quantities of alcohol and mixing with pills • MHP unable to reach the HVC, HVC's sister said he uses alcohol to numb his pain issues, and refuses to take his prescribed meds. 	<ul style="list-style-type: none"> • CIT assigned for follow-up with LVC to check on her safety and well being. • CIT found the contact information for the LVC's case manager, who stated that they had no had contact with the LVC for almost 18 months. . • CIT worked to re-establish contact between LVC and her case manager, after which there was nothing more CIT 	<ul style="list-style-type: none"> • CIT assigned for follow-up with LVC. • MHP checked ECLS and found no case manager information for LVC. Emailed DESC and HOST to check if they were familiar with the LVC. Another email was sent to HOST outreach to obtain information for an outreach plan for the LVC. • CIT continued outreach attempts to engage LVC in the community. Requested collaboration with SPD, and continued to alert them of LVC's whereabouts so that they may attempt further outreach assistance.

	case be referred to another agency as the subject was refusing any help from the MHP or any other mental health services.	• CIT recommended the case be referred to another/non-law enforcement agency to help with HVC's substance abuse treatment.	could follow-up on.	
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Table 3-7

High and Low Volume Contacts

TYPE OF CONTACT	HVC #5	HVC #6	LCV #5	LVC #6
# Incidents	14	15	1	2
Incident Code	"Robbery"	"Disturbance"	"Suspicious Circumstance"	"Other"
Incident Overview	<ul style="list-style-type: none"> • Occurred on a street/highway/road/alley/sidewalk • Officer was flagged down on street for a theft investigation. • Reports show HVC has reported being the victim of several robberies in the recent past. 	<ul style="list-style-type: none"> • Occurred at a bar/nightclub • 911 responded to reports of aggressive panhandling and trespassing. • Police had been informed of the HVC's panhandling and trespassing from other local businesses in the recent past. 	<ul style="list-style-type: none"> • Occurred at a residence/home • 911 call in regards to providing assistance with the LVC • This was the only incident recorded during study period. 	<ul style="list-style-type: none"> • Occurred on a street/highway/road/alley/sidewalk • LVC stooped a police officer on the street claiming to have been robbed. • There was 1 other related incident during the study period.
Incident Details	<ul style="list-style-type: none"> • Officer was flagged down outside of an exotic nightclub for reports of a robbery. 	<ul style="list-style-type: none"> • 911 responded to reports of aggressive panhandling and trespassing. 	<ul style="list-style-type: none"> • Subject called 911 after receiving a call from the LVC requesting help, but when the subject arrived at the house the LVC would not let her and her husband in the house. The subject feared for the LVC's safety. 	<ul style="list-style-type: none"> • Officers were approached while sitting in their car by the LVC who wanted to voice his concerns about a theft.
Incident Nature and Why Flagged for CIT and Triaged to CIRT	<ul style="list-style-type: none"> • Police spoke with the HVC who claimed his knife was taken by a prostitute. Officers went by the suspected residence of the prostitute, but the front desk clerk was not aware of anyone of that nature living there. • A routine background check revealed that the HVC had reported being the victim of several other robberies in the recent future, all of which took place in vague locations, and no suspect 	<ul style="list-style-type: none"> • police had received numerous calls complaining about aggressive panhandling and trespassing by the HVC. • When police arrived the HVC had moved on from the local business, but was found nearby and taken into custody for the criminal trespass. • HVC had stated to 	<ul style="list-style-type: none"> • Officers arrived at the house, but the LVC would not let them in and began screaming at them. Officers were eventually let inside and LVC admitted the need for assistance.. • Officers stated that it was clear that LVC had some mental health issues and was not capable of caring for her 95- 	<ul style="list-style-type: none"> • Officers listened as the LVC explained his concerns. The LVC mentioned he was currently carrying a knife, the officer called for back-up, then asked to see the knife, informing the LVC it was illegal to carry. • Police requested that CIT follow up with the LVC for mental, and safety concerns.

	was found.	the police that he was bi-polar.	year-old mother.	
CRT Response/ Case Disposition	<ul style="list-style-type: none"> • CIT was assigned for follow up due to the HVC's constant, unfounded claims of being robbed by an unknown, female assailant. • CIT found no ECLS case manager for the HVC. They made an attempt to reach out to the HVC at his residence, but received no answer. Second attempt to contact HVC was successful, HVC expressed the desire to be reconnected with services. • MHP contacted GRAT and made a referral for HVC. GRAT reported that he would be screened within the next 3 days and would be placed in contact with a MHP for evaluation. 	<ul style="list-style-type: none"> • CIT was assigned for follow up in an effort to offer assistance to the HVC's current mental health treatment team. From prior experience, CIT knew that the HVC was working with the DESC program of assertive community treatment team. • MHP spoke to PACT's program coordinator, who was given details of the incident. She expressed gratitude for bringing it to her attention and would remain in contact with CIT regarding further assistance. 	<ul style="list-style-type: none"> • CIT assigned for follow-up with LVC • MHP spoke to NAVOS Outpatient, who was unaware of the LVC's status, as they had not heard from the LVC since October of 2010. The 95-year-old mother had been living in a skilled nursing facility before moving in with her LVC daughter. • The case was referred to another/non-law enforcement agency in order to provide the necessary services for the LVC and her mother. 	<ul style="list-style-type: none"> • CIT was assigned for follow up on the case due to public safety concerns as a result of the LVC's level of paranoia and his carrying a knife. • CIT attempted to locate records and information on the LVC from DMHP's, but no records could be found. CIT met with the LVC's mother to gather more information on his mental condition. • LVC was arrested and booked for safety precautions, and was given both the officer's, and CIT's contact information. His progress through the mental health court was being monitored closely by CIT.

Table 3-7

High and Low Volume Contacts

TYPE OF CONTACT	HVC #7	HVC #8	LCV #7	LVC #8
# Incidents	10	8	1	1
Incident Code	"Suspicious Circumstances"	"Disturbance"	"Mental"	"Mental"
Incident Overview	<ul style="list-style-type: none"> • Occurred in a residence/home • Police responded to a 911 hang up call. • Reports showed that officers had been to the HVC's residence numerous times in the last few weeks. 	<ul style="list-style-type: none"> • Occurred in a residence/home • Officers were dispatched for a welfare check. • Police have had contact with the HVC numerous times over the past 	<ul style="list-style-type: none"> • Occurred at a residence/home • Officers responded to a disturbance call. • This was the only incident recorded during study period. 	<ul style="list-style-type: none"> • Occurred in a residence/home • Police responded to a call for help from the LVC. • This was the only incident during the study period.

		few weeks for a variety of 911 calls.		
Incident Details	<ul style="list-style-type: none"> The HVC's neighbor stated that the HVC said that she had a male friend over earlier that day, and that he had hit her. 	<ul style="list-style-type: none"> Officers responded to a 911 call for a welfare check on the HVC. 	<ul style="list-style-type: none"> Police responded to a disturbance call, reporting that the LVC was screaming and throwing items out of his apartment window. 	<ul style="list-style-type: none"> The LVC called 911 for assistance, stating that she drank some Lysol cleaner hoping that it would stop her from overheating.
Incident Nature and Why Flagged for CIT and Triaged to CRT	<ul style="list-style-type: none"> Police knocked at the front door, but got no response. Officers spoke to the neighbor, who stated that the HVC told her that she had a male friend over earlier, and that he had hit her. Officers kicked the door down as a precaution and located the HVC, who was alright, and grateful for the police concern. HVC has a history of mental illness, and stated to the officers that she had a mental illness. 	<ul style="list-style-type: none"> The apartment manager stated that the HVC claimed that people were kicking him out of his room, and that he wanted to hurt himself. HVC's roommate had also expressed a fear of HVC. Officers were concerned with the HVC's physical and mental well being, and arranged for him to be taken to the hospital for an involuntary evaluation. 	<ul style="list-style-type: none"> Officers contacted the LVC, who stated that he was on medication, and conducted a check of his apartment, which did not contain any pill bottles. The LVC was transported to a nearby hospital for a mental evaluation out of concern that he was unable to care for himself and might be a danger to others. 	<ul style="list-style-type: none"> Officers responded along with SFD, and the LVC was taken to a nearby hospital to be treated. Reports show that the LVC has a reoccurring history of mental health problems, and has been admitted to hospitals for mental evaluations before.
CRT Response/ Case Disposition	<ul style="list-style-type: none"> CIT was assigned for follow up due to the HVC's numerous contacts with SPD. CIT attempted to reach out to the HVC at her residence, but received no response. After the second attempt contact was made and the issue at hand was discussed. HVC expressed gratitude for the follow up. The HVC indicated that she did not need any further assistance. The case was referred to another/non-law enforcement agency, as she is connecting with both mental health and primary 	<ul style="list-style-type: none"> CIT was assigned for follow up due to HVC numerous contacts with SPD, and concerns of his deteriorating mental health. CIT made contact with the HVC, who stated that he was detoxing from drugs and alcohol, which made him hallucinate, but that he was in AA and NA meetings. CIT's contact information was left for the HVC, and the 	<ul style="list-style-type: none"> CIT assigned for follow-up due to prior history and knowledge of LVC. An ECLS check resulted in case manager information for the LVC. Contact with DESC's PACT team yielded information that the LVC had been detained to NAVOS inpatient hospital. PACT created a plan to encourage daily medication, and are in frequent contact 	<ul style="list-style-type: none"> CIT was assigned for follow up on the case to check on the mental and physical well being of the LVC. CIT checked ECLS and found the LVC's case manager. A voicemail was left to set up a meeting to discuss the current availability of community supports for the LVC. The LVC's case manager was given the LVC's contact information, and indicated that he would keep giving CIT updates about the LVC's treatment, which may facilitate decreased SPD contact. CIT offered their

care services.	case was recommended to be cleared administratively due to the HVC's connections with substance use groups and his acknowledgment of the reason behind his mental health related symptoms.	with the LVC. • Due to the LVC's wrap-around community support already working to create a plan for his eventual return to the community, the case was requested to be cleared administratively.	continued support if the case manager thought it might be helpful in the future.
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Table 3-7

High and Low Volume Contacts

TYPE OF CONTACT	HVC #9	HVC #10	LCV #9	LVC #10
# Incidents	10	12	1	1
Incident Code	"Suicide"	"Mental"	"Mental"	"Mental"
Incident Overview	<ul style="list-style-type: none"> • Occurred in a residence/home • Police responded to reports of a suicidal female. • Officers recognized the HVC from several previous suicide threats. 	<ul style="list-style-type: none"> • Occurred in a residence/home • Officers were dispatched to reports of 911 hang up calls. • The HVC had been known to live out of her car, and officers knew the HVC as well as her car's make and model. 	<ul style="list-style-type: none"> • Occurred on a street/highway/road/alley/sidewalk • Officers responded to a disturbance involving assault. • This was the only incident recorded during study period. 	<ul style="list-style-type: none"> • Occurred in a residence/home • Police responded to a call from the LVC claiming that people were trying to kill her. • This was the only incident during the study period, but this was the 4th similar call to 911 in 4 days.
Incident Details	<ul style="list-style-type: none"> • Officers responded to reports of a suicidal female threatening to harm herself with a knife. 	<ul style="list-style-type: none"> • Officers responded to a 911 call in which the dispatcher could only hear breathing/moaning on the other end and then would hang up. This occurred several times. 	<ul style="list-style-type: none"> • The 911 caller, a mental health professional, reported that the LVC was a mental patient, and had hit her twice. 	<ul style="list-style-type: none"> • The LVC called 911 for assistance, stating that people were trying to kill her.
Incident Nature and	<ul style="list-style-type: none"> • The HVC stated that she was hearing voices and was going to kill herself to get 	<ul style="list-style-type: none"> • Dispatch was able to pinpoint the location of the calls, where 	<ul style="list-style-type: none"> • Officers contacted the LVC, and placed him into custody for 	<ul style="list-style-type: none"> • Officers contacted the LVC's daughter, who informed them that MHPs had been at

<p>Why Flagged for CIT and Triaged to CIRT</p>	<p>rid of them.</p> <ul style="list-style-type: none"> The HVC was taken to a nearby hospital for an involuntary mental evaluation. 	<p>officers found the HVC lying on a mattress, trying to fake a seizure. SFD arrived and also came to the conclusion that the HVC was faking seizures. The HVC was going to be taken to the hospital, but then woke up and refused to go anywhere.</p> <ul style="list-style-type: none"> The HVC was living in her mother's old apartment to "clean" it before she returned the keys, which were due a week earlier. It was believed that she faked seizures in order to receive medical resources, but woke up before transportation out of fear she might lose her living space. 	<p>everybody's safety. It was determined that the LVC was unable to care for himself and has taken substantial steps at refusing his medication for schizophrenia.</p> <ul style="list-style-type: none"> Reports had shown that the LVC had a history of attempted assaults against officers. 	<p>the apartment the day before. The LVC claimed the managers poisoned her, but had no proof.</p> <ul style="list-style-type: none"> Officers cleared the scene after determining that the LVC was not in danger to herself or others, but forwarded the report to CIT for follow up.
<p>CRT Response/ Case Disposition</p>	<ul style="list-style-type: none"> CIT was assigned for follow up on the case due to the HVC's numerous contacts with SPD recently in regards to suicide threats . MHP contacted the HVC's ECLS case manager and informed them of the details of the case, and let DESC know about HVC's information and whereabouts. After passing on the HVC's most recent information the case was recommended to another/non-law enforcement agency in order to allow them to provide the necessary treatment services. 	<ul style="list-style-type: none"> CIT was assigned for follow up due to HVC numerous contacts with SPD, and SFD. MHP attempted to set up a plan to meet with the HVC and discuss how to reduce SPD and SFD contacts, but the HVC constantly reschedule the meeting appointments and the MHP was never able to meet her. The HVC stopped answering her phone or responding 	<ul style="list-style-type: none"> CIT was assigned for follow up on the case due to their familiarity with the LVC, and in an attempt to facilitate contact between the LVC and his current case manager. A copy of the police report was submitted to the LVC's case manager and CIT offered support in assisting with the LVC. DESC PACT program felt that it was not necessary to file 	<ul style="list-style-type: none"> CIT was assigned for follow up on the case to assess the possibility of referring the case to GRAT. CIT met with the LVC who claimed the Catholic Church had something to do with her becoming ill. The LVC showed signs of short term memory loss, which CIT informed the LVC's daughter of. CIT determined that the LVC was not suitable for a GRAT referral and requested the case be cleared administratively.

		<p>to messages as well.</p> <ul style="list-style-type: none">• CIT recommended the case be cleared administratively due to their inability to make contact with the HVC.		<p>charges against the LVC, and requested that hospitalization be the course of action rather than jail.</p>	
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Figure 3-7

HVC Monthly Contacts

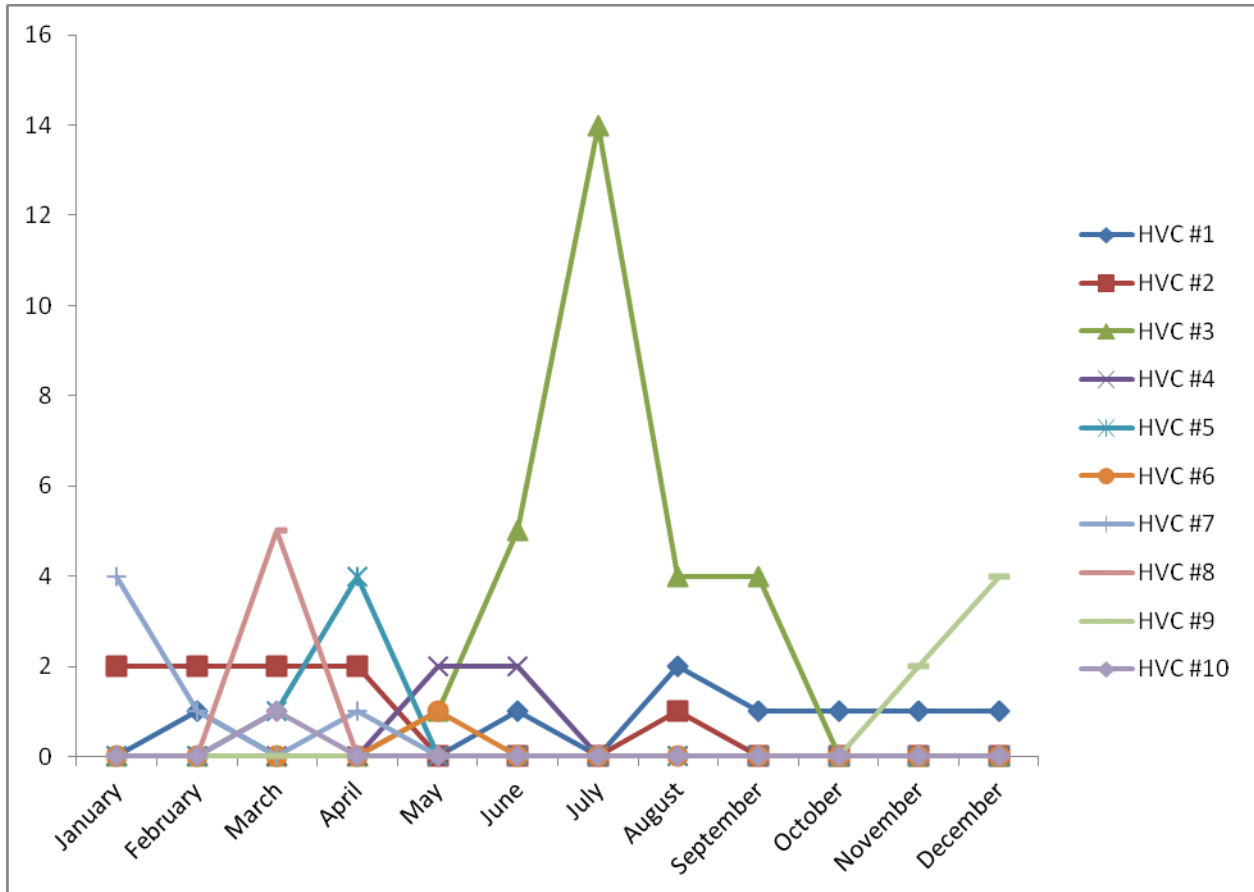


Table 3.8

HVC Monthly Contacts Table

Name	January	February	March	April	May	June	July	August	September	October	November	December	Total
HVC #1	0	1	0	0	0	1	0	2	1	1	1	1	8
HVC #2	2	2	2	2	0	0	0	1	0	0	0	0	9
HVC #3	0	0	0	0	1	5	14	4	4	0	0	0	28
HVC #4	0	0	0	0	2	2	0	0	0	0	0	0	4
HVC #5	0	0	1	4	0	0	0	0	0	0	0	0	5
HVC #6	0	0	0	0	1	0	0	0	0	0	0	0	1
HVC #7	4	1	0	1	0	0	0	0	0	0	0	0	6
HVC #8	0	0	5	0	0	0	0	0	0	0	0	0	5
HVC #9	0	0	0	0	0	0	0	0	0	0	2	4	6
HVC #10	0	0	1	0	0	0	0	0	0	0	0	0	1
Total	6	4	9	7	4	8	14	7	5	1	3	5	73

Table 3-9

Number of Contacts by Case Disposition

Case Disposition	Number of Contacts (n=169)					
	0-1	2-6	7-11	12-15	>15	Total
Referral to non-law enforcement agency	55% (n=22)	57.4% (n=58)	60% (n=6)	0% (n=0)	81% (n=13)	59% (n=99)
Suggestions for individual-local-community outreach	0% (n=0)	4% (n=4)	0% (n=0)	0% (n=0)	0% (n=0)	3% (n=4)
Administrative clearance	17.5% (n=7)	19.8% (n=20)	8.6% (n=3)	100% (n=2)	0% (n=0)	20% (n=35)
Assistance declined	0% (n=0)	3% (n=3)	10% (n=1)	0% (n=0)	0% (n=0)	3% (n=4)
Transported to hospital/outpatient	5% (n=2)	1% (n=1)	0% (n=0)	0% (n=0)	0% (n=0)	2% (n=3)
Arrested	3% (n=1)	2% (n=2)	0% (n=0)	0% (n=0)	0% (n=0)	2% (n=3)
Other	20% (n=8)	13% (n=13)	0% (n=0)	0% (n=0)	0% (n=0)	11% (n=21)
Total	100% (n=40)	100% (n=101)	100% (n=10)	100% (n=2)	100% (n=16)	100% (n=169)