Police-Mental Health Collaborations

A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs

Introduction

Law enforcement agencies across the country are being challenged by a growing number of calls for service involving people who have mental health needs. Increasingly, officers are called on to be the first—and often the only—responders to calls involving people experiencing a mental health crisis. These calls can be among the most complex and time-consuming for officers to resolve, redirecting them from addressing other public safety concerns and violent crime. They can also draw intense public scrutiny and can be potentially dangerous for officers and people who have mental health needs. When these calls come into 911/ dispatch, the appropriate community-based resources are often lacking to make referrals, and more understanding is needed to relay accurate information to officers. As such, there is increasing urgency to ensure that officers and 911 dispatchers have the training, tools, and support to safely connect people to needed mental health services.[1]

To respond to these challenges, police departments are increasingly seeking help from the behavioral health system.[2] This trend is promising, as historically, law enforcement and the behavioral health system have not always closely collaborated. Absent these collaborations, officers often lack awareness of, or do not know how to access, a community's array of available services and alternatives to arrest, such as crisis stabilization services, mental health hotlines, and other community-based resources. And even when officers are fully informed, service capacity is typically insufficient to meet the community's need. As a result, officers experience frustration and trauma as they encounter the same familiar faces over and over again, only to witness the health of these individuals deteriorate over time.

Police Departments Can't Do it Alone

Many communities continue to face pervasive gaps in mental health services, especially crisis services, placing a heavy burden on law enforcement agencies and, in particular, officers. Without access to appropriate alternatives, officers are often left with a set of poor choices: leave people in potentially harmful situations, bring them to hospital emergency departments, or arrest them.

Understanding a need for greater collaboration, many law enforcement and behavioral health agencies have begun taking important steps to improve responses to people who have mental health needs. These efforts have led to improvements in practices, such as providing mental health training to law enforcement workforces and including mental health, crisis intervention, and stabilization training as part of some states' law enforcement training standards. (Stabilization training refers to tactics used to defuse and minimize any harmful or potentially dangerous behavior an individual might exhibit during a call for service.) Some of these communities also designate officers to serve as part of specialized teams to respond to mental health-related calls for service. But while these steps are commendable and signify widespread

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CSG **Justice Center** THE COUNCIL OF STATE GOVERNMENTS

acknowledgment of the need to improve law enforcement's responses to people who have mental illnesses, they also underscore the need for more comprehensive, cross-system approaches.

Communities are learning that small-scale or standalone approaches—such as just providing mental health training or having a specialized team that is only available on certain shifts or in certain geographical areas—are not adequate to achieve community-wide and long-lasting impacts. They have also learned that even the most effective law enforcement responses cannot succeed without mental health services that provide immediate crisis stabilization, follow up, and longer-term support. Moreover, when there are limitations in data collection and information sharing, law enforcement leaders have a difficult time understanding whether the investments they have made in training or programs are working, because success is being defined by anecdotes, impressions, or even by the media's coverage of isolated, high-profile incidents instead of concrete measures and outcomes.

To address these challenges, some law enforcement agencies have invested in comprehensive, agency-wide approaches and partnerships with the behavioral health system. These cross-system approaches, also known as police-mental health collaborations (PMHCs), build on the success of mental health training and specialized teams by layering multiple types of response models—e.g., Crisis Intervention Teams (CIT),[3] co-responders, and mobile crisis intervention teams—and implementing one or more of these models as part of a comprehensive approach to meet their needs.[4] These agencies may also sometimes link their specialized teams to a designated 'mental health' officer in every precinct or neighborhood. PMHCs are distinguished by their leaders' commitment to integrating responses to people who have mental illness into the day-to-day functions of all officers. In PMHCs, law enforcement executives include the initiative in their agency mission instead of just assigning it to the exclusive domain of a specialized unit.

PMHCs feature strong, demonstrated commitment from law enforcement and political leaders; formal partnerships with community-based mental health providers and organizations representing people living with mental illnesses and their families; quality training on mental health and stabilization techniques that is provided to all officers and 911 dispatchers; and written procedures that are clear and adhered to by staff. And communities that create PMHCs are also committed to building an adequate array of community-based services such as short-term crisis stabilization programs, in-home intervention teams, and programs that can provide ongoing and intensive case management to people with complex mental health needs.

Police-Mental Health Collaboration Toolkit

For jurisdictions that are seeking to implement a new PMHC, the U.S. Department of Justice's Bureau of Justice Assistance provides additional background on PMHCs and the different PMHC response models (e.g., co-responder teams) in the *Police Mental Health Collaboration Toolkit*.

Visit pmhctoolkit.bja.gov for more information.

Using Data to Inform Success

Critical to the success of these cross-system PMHCs is the establishment of the baseline number of mental health calls for service that the police department is fielding (as a starting point) and other indicators of PMHC effectiveness, and the use of that data to review progress and troubleshoot any challenges. By using data, leaders have the ability to assess the impact of the approach over time and measure its success against the outcomes that matter most. The four key outcomes identified below, together provide a picture of whether or not a PMHC is successful, recognizing that data limitations and local context may necessitate variation in what data communities collect.

- **Increased connections to resources:** Officers in communities that have PMHCs should routinely refer people who have mental health needs to community services, and they should ensure a successful linkage to the behavioral health system. In these communities, 911 dispatchers also play a critical role in collecting mental health information and relaying it to officers prior to their response to a call for service. As a result, successful PMHCs see an increase in the number of people who have mental health needs connected to appropriate services and resources in the community. Greater success in this area is possible to the extent that adequate services are available in the community, 911/ dispatch capacity is increased, and officers are aware of how to refer people to behavioral health services.[5]

- **Reduced repeat encounters with law enforcement:[6]** A key measure of performance for a PMHC is the number of people who have repeat mental-health related encounters with law enforcement. Ideally, as PMHCs see an increase in their connections to resources and in officer referrals of people to appropriate services, they would likely also see a reduction in the number of repeat encounters because these individuals are provided the care needed to reduce or prevent future crises.[7] Thus, effective PMHCs ensure that the number of people who have mental health needs making or generating repeat calls for service is lower than the baseline number established at the start of the PMHC.

- **Minimized arrests:** With an increase in the availability of community resources and services, officers have a greater set of options/primary interventions other than arrest when responding to calls involving people who have mental health needs. Since one of the primary goals of a PMHC is to connect a person to mental health services (especially for low level and nonviolent offenses, like trespassing and vandalism, in which arrest is at the discretion of the officer and the person does not pose a threat to public safety),[8] having more options should ideally result in a lower rate of arrest among people in this population. Additionally, PMHCs are more successful when officers are provided with reliable information about a person's mental health needs prior to responding to a call. PMHCs should track the full range of disposition outcomes for mental health calls for service to analyze any trends or fluctuations that occur and increase their attention to the rate of these arrests.

- **Reduced use of force in encounters with people who have mental health needs:** A critical measure of performance for a PMHC is the frequency of use of force during encounters with people who have mental health needs. Jurisdictions must determine what constitutes use of force in the context of the PMHC (e.g., use of handcuffs during transport, hands-on maneuvers) so consistent analysis is possible in the future. With training and a comprehensive PMHC in place, police officers are better able to manage encounters with people experiencing a mental health crisis, and force is then proportionate to the situation the officer encounters. It is important to track and analyze this outcome for both mental health calls and non-mental health calls for service.

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While law enforcement agencies must partner with the behavioral health system and other community supports to make a PMHC successful, officers and 911 dispatchers are often the first ones interacting with people who have mental health needs, especially during crisis situations. Therefore, the success of a PMHC is largely determined by the level of engagement and commitment of law enforcement executives and the buy-in from their workforce. Thus, this framework's primary audience is law enforcement executives. It aims to inform and inspire such executives by providing examples of how PMHCs are improving key outcomes in police departments across the country. The framework also provides a list of six questions that law enforcement and political leaders may ask to assess their current responses to people who have mental illnesses and identify steps to improves those responses.

The Six Questions Law Enforcement Leaders Need to Ask to Develop and Sustain a Police-Mental Health Collaboration

Whether they are seeking to either implement a new PMHC or to improve an existing one, law enforcement leaders should consider the following six questions to help determine whether their current responses are comprehensive, identify areas in need of improvement, ensure that they are conducting ongoing quality reviews, and ultimately, whether their PMHCs are resulting in the aforementioned four key outcomes. Albeit not a step-by-step guide, by answering these six questions, law enforcement executives can work with their behavioral health counterparts to assess their community resources and better understand what necessary additions and changes are needed. The questions, then, are also designed to assist these leaders in executing changes to produce measurable progress in reducing the number of people who have mental illnesses in their communities who come into contact with law enforcement.

1. **Is our leadership committed?**

2. **Do we have clear policies and procedures to respond to people who have mental health needs?**

3. **Do we provide staff with quality mental health and stabilization training?**

4. **Does the community have a full array of mental health services and supports for people who have mental health needs?**

5. **Do we collect and analyze data to measure the PMHC against the four key outcomes?**

6. **Do we have a formal and ongoing process for reviewing and improving performance?**

Many agencies can likely provide excellent examples of what successfully addressing one or more of these questions looks like, but only a small number of jurisdictions to date have sufficient answers to all of the questions above. If law enforcement executives thoughtfully consider each question, and regularly revisit them, they will be able to determine whether and to what extent their efforts are having a community-wide impact and are built for long-lasting success.

1 Is Our Leadership Committed?

Are law enforcement and behavioral health executives fully invested in implementing and sustaining a PMHC? Have leaders publicly indicated that effectively responding to people who have mental health needs is essential to the law enforcement agency's mission? Are there champions within the agency that are empowered to develop, implement, and improve the collaboration? Are staff recognized and rewarded for engaging in day-to-day behavior that supports the goals of the PMHC?

Why it matters

PMHCs have real-world implications. They can help communities address challenges like the toll that repeated arrests and police encounters take on people who have mental health needs. They can also help ensure officer well-being and allow officers to focus on public safety and addressing violent crime. These collaborations often rely on the strength and vision of law enforcement executives (and their behavioral health counterparts) to convey the importance of the PMHC and to lead by example. Law enforcement leaders who demonstrate their commitment to the PMHC through concrete action (such as developing new policies and procedures and rewarding staff who consistently act in support of the goals of the PMHC) find that their officers are more likely to share in the vision. When these leaders become more invested in the collaboration, communicate its importance to all staff, provide incentives for involvement, and incorporate the goals of the PMHC throughout the agency, a trickle-down effect often occurs and more support and buy-in from staff follows. With this buy-in and support, the goals of the PMHC are part of the fabric of everyday policing.

What it looks like

✓ **Law enforcement leadership support:** The top law enforcement executive sets the tone in the agency for the collaboration and is most critical to its success. The executive is the highest-level leader to serve as the "champion," has the power to reach out to jurisdictional leadership for support (e.g., commissioners, mayors, and legislative bodies), and provides direction to administrators and managers to secure agency-wide commitment. These leaders reach across systems to develop relationships with executives in the behavioral health system to get buy-in for the collaboration, promote the initiatives to the public and internally in their agencies, and coordinate efforts with advocacy organizations.

✓ **Partnership with community champions:** In addition to developing strong partnerships with behavioral health, law enforcement also engages local community organizations and advocacy groups that represent consumers of mental health services and people with lived experience and their family members. Community champions engender support and buy-in from local agencies, bringing partners together that might not otherwise have a strong record of collaboration. With firsthand knowledge of how to navigate the behavioral health system, these groups are also able to assist in the PMHC planning process by contributing feedback on developing policies and procedures and building the core components of the PMHC. Advocacy groups are able to mobilize their constituencies to convince legislators and other key stakeholders to help fund PMHC response models and initiatives. They are also instrumental in marketing the initiatives to the community, which helps strengthen law enforcement's community ties.

✓ **Interagency workgroup:** A formal interagency workgroup (including law enforcement, behavioral health, and government and community-based organizations) plays a vital role in bringing the partner agencies together to regularly plan, implement, and assess the success of the PMHC. An effective workgroup is reflective of the community's demographic composition (e.g., racially and economically) and includes members from not just law enforcement and behavioral health, but also local advisory groups, criminal justice coordinating councils, public safety answering points (e.g., 911 dispatchers), hospitals, courts, and corrections, as well as people who have mental illnesses, family members, and other advocates who have a stake in the success of the collaboration. Memorandums of understanding (MOUs)

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are created to outline the responsibilities of the partners in the interagency workgroup, such as how often meetings will occur, which staff member(s) will attend, members' responsibilities to subcommittees, funding, and other agency commitments. Workgroup members ensure that their participating agencies are promoting the PMHC and its milestones for success within their agencies, and help to assess progress toward agreed upon goals, recommending changes to address challenges when necessary.

✓ **Designated chairperson and project coordinator to oversee the PMHC:** The law enforcement executive establishes the interagency workgroup, which appoints a chairperson from the law enforcement agency or behavioral health system. The chairperson oversees the implementation of the PMHC community wide and ensures all efforts and response models adopted fit together to achieve the PMHC's goals. A coordinator is also designated who is given authority (as clearly represented in the agencies' organizational charts) and has demonstrated a commitment to the PMHC. The coordinator is selected to oversee the day-to-day operations of the PMHC and report back to the chairperson of the interagency workgroup on the overall implementation and success of the initiative. The coordinator will regularly evaluate the collaboration (e.g., review data on performance and adherence to policies and procedures) to ensure operations are in line with the PMHC's mission, as well as coordinate outreach and engagement with other partners. The coordinator also organizes subcommittees, facilitates planning meetings, builds agendas, and makes recommendations to the interagency workgroup.

✓ **Funding and resource allocation:** Local leadership (including elected officials) designate funds for the collaboration (e.g., funding specialized training and education, authorizing funds to pay for overtime, and allocating funds for PMHC resources, such as vehicles and office space). The financial investment can vary (e.g., funding a part-time case manager position four hours a week), but designating funds and resources to support the PMHC demonstrates to staff that the collaboration is an agency and community priority worthy of financial investment. Longer-term funding efforts are driven by performance data and other needs assessments.

✓ **Ongoing internal and external recognition of the initiative:** Law enforcement leaders help to affect a cultural shift by modifying officers' performance evaluations to include the goals of the collaboration, publicly recognizing staff who employ skills to defuse situations, developing commendations or other awards for exemplary staff, and recognizing police and supervisors who volunteer for PMHC positions. These leaders also make it clear that the initiative is part of the overall mission of the department to combat any bias or stigma that staff might hold about collaborating with behavioral health not being true police work.

IN PRACTICE | Effective Leadership in Action, Portland, ME

The Portland Police Department (PPD) implemented their PMHC out of a proactive effort by their leadership, a core collaborative workgroup, and a fully invested department to improve their responses to people who have mental illnesses. The commitment from leadership drove a shift in culture in the department that began in the 1990s, with officers slowly, then enthusiastically, embracing new models and interventions such as CIT training and a mental health liaison program, as well as a year-long internship program for Master's level students to assist in responding to calls for service with officers.

In place now is a robust program that includes a full-time behavioral health coordinator, mental health liaison, and substance use liaison. Additionally, 100 percent of the officers on the force are mandated to complete CIT training,[9] dispatchers receive training on how best to respond to people who have mental health needs, and PPD has implemented a mental health liaison internship program.

Since the start of these efforts, the police chief and other leaders have been able to secure continued funding from the city's operating budget to ensure the behavioral health coordinator was expanded to a full-time position. The chief was also able to secure additional funding from a local nonprofit provider to continue the mental health liaison position, as well as secure a commitment from the department to direct funding from the drug forfeiture program to support a full-time substance use liaison.

The behavioral health coordinator role is integral to the day-to-day operations of Portland's PMHC, managing the mental health liaison and co-responder program and facilitating officer training. The coordinator also oversees a robust working group, the Cumberland County Crisis Providers Meeting, which includes people from the emergency departments, inpatient facilities, substance addiction and mental health partners, shelters, and other community organizations. This group, which has convened for more than 10 years, provides an opportunity for community leaders to come together to discuss the PMHC, strengthen their collaboration, and discuss changes the agencies might be seeing in their staffing or services. A universal release of information developed for all the providers in attendance allows them to discuss clients they have in common. The workgroup members use these meetings to discuss issues that may arise with these individuals, which allows the behavioral health coordinator and mental health liaison opportunities to form relationships with the provider organizations in attendance and better connect their clients to services in the community.

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2   **Do We Have Clear Policies and Procedures to Respond to People Who Have Mental Health Needs?**

Does the law enforcement agency have documented policies and procedures for how to respond to people who are experiencing a mental health crisis? Do these policies and procedures account for the jurisdiction's PMHC response models and for each instance in which law enforcement interacts with people who have mental health needs (e.g., dispatch, at the scene, and follow-up)? Do staff have a clear understanding of these policies and procedures and their roles in executing them?

Why it matters

Written policies and procedures that are communicated clearly to staff are critical to the overall success of a PMHC and empower officers to take actions that can enhance their safety and the safety of others. When policies are in place for each type of instance where officers interact with people who have mental health needs, officers are equipped with the knowledge to consistently respond to common events. Combined with skill enhancement and training, clear policies also reduce overall risk for the department. The PMHC will only realize success, and policies and procedures will only be effective, when these policies and procedures are disseminated, followed, and enforced by leaders in both the law enforcement and behavioral health agencies.

What it looks like

✓   **Comprehensive process review:** Prior to the creation of any new policies or procedures, the law enforcement agency conducts a comprehensive process review of current policies and procedures for encounters with people who have mental health needs. This process review allows the agency to see how people who have mental health needs flow through the criminal justice system and the ways in which police officers regularly interact with them. With proper planning and analysis, the agency can address the full range of issues that officers encounter and reduce opportunities for ambiguous responses during an encounter or call for service. A useful end product of this review is a process flow chart that provides staff with a visual depiction of how people who have mental health needs flow through the criminal justice system. It can also show all potential dispatch and disposition outcomes to help ensure that the policies and procedures account for all possible scenarios and outcomes.

✓   **Selected PMHC response models:** Based on assessed community needs, law enforcement and behavioral health system partners select a primary intervention or a combination of approaches that their jurisdiction will adopt. The goals of these response models are then integrated into the agencies' missions and community-wide initiatives. The interagency workgroup starts the process of building new policies and procedures for each response model chosen. People who have mental illnesses, their family members, and advocacy organizations who represent them are involved in the conversations that determine which PMHC response model(s) are selected.

✓   **Comprehensive, clearly written policies and procedures:** The law enforcement agency has written policies and procedures in place that have been provided to staff, have a clear purpose, and illustrate to supervisors what steps they should take to implement them. These policies and procedures outline roles and responsibilities of all agency staff members, define frequently used terms, give specific response guidelines for scenarios that officers and staff frequently encounter, and are mindful of officer safety and the potential volatility of encounters. When writing their policies and procedures, law enforcement consults with their behavioral health system counterparts and advocacy organizations to ensure they are appropriate from the behavioral health perspective and from that of people who have mental illnesses. Law enforcement also acts as a resource for the behavioral health system as it creates policies and procedures to ensure they align with officers' needs, culture, and the community's perspective.

✓   **Information-sharing agreements:** These agreements establish what information can be shared among the partners

during an encounter (such as physician information, diagnoses, or recent hospitalizations) and give law enforcement and mental health staff the ability to identify a shared population of people who have mental health needs. The interagency workgroup aids in the development of these agreements and facilitates conversations among relevant partners, better equipping officers, dispatchers, and others to stabilize an encounter with a person who has mental health needs. This information also enables law enforcement staff to connect people to needed services and supports, reduce potential injuries to officers and people who have mental health needs, and arrive at the best disposition. In addition to agreements involving medical and protected health information, the interagency workgroup also develops a data-sharing agreement(s).

✓ **Staff awareness of policies and procedures:** Written policies and procedures are posted and circulated to all staff of the partnering agencies, and supervisors are held accountable for ensuring that their staff understand each new policy or procedure and have received training on how to employ them. These policies and procedures are transparent and posted online for the public to view. Staff are notified when changes to the policies or procedures take place.

✓ **Regular review of policies and procedures:** Law enforcement and behavioral health system leaders assess whether established policies and procedures are being followed. In conjunction with the project coordinator, the interagency workgroup conducts regular reviews of the policies and corresponding procedures and ensures that they are being communicated to all supervisors (and their direct reports). Mechanisms are also in place to make sure that these policies and procedures are meeting the needs of the community, and that the community has an opportunity to offer feedback. Periodically, the interagency workgroup revisits all policies and procedures, analyzes them against any internal or community feedback, and makes recommendations for needed changes.

Types of PMHC Response Models

PMHC response models are the cornerstone for comprehensive, cross-system responses to people who have mental health needs. The leadership team must select the model(s) most appropriate to address the community's needs. These models are not mutually exclusive, and, depending on their contexts and needs, jurisdictions often adopt and layer multiple response models with comprehensive training and data-driven management to build a comprehensive initiative. For additional information, support, and resources on these models, visit the Bureau of Justice Assistance's PMHC Toolkit, pmhctoolkit.bja.gov. Below are four of the most common PMHC response models.

Crisis Intervention Teams (CIT): These widespread, specialized teams are composed of officers who receive specialized training to respond to mental health calls. CIT officers are dispatched to mental health calls or assist officers who are not CIT trained.[10]

Co-responder Team: Specially trained officers and a mental health crisis worker respond together to address mental health calls. Most commonly, they ride in the same vehicle for an entire shift, but in some agencies, the crisis worker meets officers at the scene, and they handle the call together once the crisis worker arrives.

Mobile Crisis Team: A team of mental health professionals, skilled at helping stabilize people during law enforcement encounters as well as general crisis, available to law enforcement and the community. These teams are available to respond to calls for service with the goal of diverting people from unnecessary jail bookings and/or emergency room visits.

Case Management Team: A team of behavioral health professionals (with or without officers) and peers that provide outreach, follow up, and ongoing case management to select priority people, such as repeat callers of emergency services. Officers do not treat or diagnose the individuals but work with mental health professionals to develop solutions to reduce repeat interactions. Case management is often used as a proactive response in addition to other selected PMHC response models.

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IN PRACTICE | Building a New Program with Clearly Defined Policies and Procedures: 911 Crisis Call Diversion Program, Houston, TX

The Houston Police Department (HPD) Mental Health Division (MHD), in partnership with The Harris Center for Mental Health and Intellectual and Developmental Disabilities (the Harris Center), operates a multi-faceted, successful PMHC to respond to people in mental health crisis. Houston's PMHC response models and initiatives include: a CIT training program for all cadets,[11] co-responder and homeless outreach teams, and a chronic consumer stabilization unit. While already using a comprehensive approach, HPD's coordination with the Harris Center helps them to regularly assess their models and initiatives and make changes as needed.

In 2015, the MHD identified a new and innovative opportunity to help people in mental health crisis while relieving financial strain on both the criminal justice and behavioral health systems. This early intervention program, called the 911 Crisis Call Diversion (CCD) program, places mental health phone counselors inside Houston's Emergency Communications Center to work directly with 911 call takers and dispatchers to identify and divert callers with non-emergency mental health concerns away from police or fire/EMS.

To develop this new program, the Houston PMHC first created a response logic tree (or process map) to define when 911 operators could determine that a call was eligible for mental health counselors to intervene and establish how they should respond while accounting for a variety of possible scenarios. HPD and the Harris Center then developed operational guidelines and protocols and rolled them out during a six-month pilot period to ensure they were appropriate for the new program.

During this pilot period, they were able to establish with a great amount of certainty what a majority of their calls would look like, what phone counselors should expect when on a call, and what to do in specific scenarios. Based on these experiences, they also learned that while they were expecting the CCD program to save money and time for the police and fire departments, they could also use it to make more appropriate referrals in the community.

After one full year of implementation, with clearly developed policies and procedures in place, the CCD program has seen significant change in how calls are handled. In one quarter of operation, they were able to divert both the fire/EMS and police from the scene for more than half of calls received. In a short period of time, the unit has shown how important it is to the overall functioning of the department and how resources have been saved as a result.

3 Do We Provide Staff with Quality Mental Health and Stabilization Training?

Is basic mental health awareness and stabilization training provided to all law enforcement employees at all staffing levels—recruit, in-service, and specialized? Is this training offered in coordination with mental health partners? Are the voices of people who are living with mental illnesses and their families incorporated into the training?

Why it matters

Learning how to defuse situations is foundational to the goals of all PMHCs and helps officers better recognize and address the behaviors they encounter in many mental health calls for service.[12] When officers receive high-quality mental health and stabilization training, they are better prepared to use techniques to stabilize and defuse encounters when responding to people who have mental health needs. While training alone does not ensure an improved response to people who have mental health needs, it is essential to equip officers, supervisors, 911 dispatchers, and mental health staff with the knowledge and support they need to take actions that are grounded in current research and practices. Such training promotes the safety of officers and all involved.

What it looks like

✓ **Knowledge and skills training for all staff:** Mental health and stabilization training occurs for all agency staff at the beginning of their tenure with the agency and then continually throughout their service to make sure their skills reflect any changes in systems, policies, or evidence-based practices. The knowledge and skills-based training that a jurisdiction includes in its training curriculum varies depending on the needs of the particular jurisdiction, staffing structure, and culture,[13] but at a minimum the law enforcement workforce receives training on basic mental health awareness, recognizing the signs and symptoms of mental illness, and how to manage a person in crisis. Table 1 below provides a list of common basic PMHC training topics.

TABLE 1. BASIC PMHC TRAINING TOPICS[14]

Overview of Mental Illness and Wellness
Compassion Fatigue/Vicarious Trauma and Officer Selfcare
Cultural Sensitivity
Disorders in Children—Autism and Developmental Disorders and Disruptive, Impulse-Control, and Conduct Disorders
Gender Sensitive Responses
Identifying Signs, Symptoms, and Behaviors of Mental Illness
Stigma
Substance-Related, Co-Occurring Mental Health and Addictive Disorders
Suicide Intervention and Non-Suicidal Self Injury

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Trauma-Informed Responses—Basic
On Scene Assessment and Response Protocols
Active Listening, Nonverbal Communication
Crisis De-Escalation, Stabilization Techniques, and Mediation Skills
Officer Safety
Use of Force
Disposition and Resource Options
Community Resources and After Hours Referrals and Resources
Homelessness and Housing Alternatives
Involuntary Commitment Process
Military Personnel/Veterans Resources and Specific Needs
Transportation of People Who Have Mental Health Disorders, Intellectual and Developmental Disorders (I/DD), and Physical Disabilities
Understanding of PMHC Policies and Procedures

✔ **Training aligned with staff roles and experiences:** Training is consistent with staff roles, level of engagement, and interest in selected PMHC response models, as well as skill set and expertise. Topics and skills vary depending on the type of training delivered; for example, a CIT training takes a deeper dive into subject matter than training included as part of an academy for new recruits. Skills topics needed for officers may also be different than training needed for 911 dispatchers. Leadership develops tailored training curriculum to equip staff for their jobs, particularly for specialized units or positions in the department. Table 2 lists advanced topics that are typically included in trainings for specialized teams or officers that play a particular role in a PMHC response model.

TABLE 2. ADVANCED PMHC TRAINING TOPICS[15]

Assessment, Commitment, and Legal Considerations
Data Collection and Demonstrating Program Success
Guardianship, Power of Attorney, and Issues of Aging
Information Sharing across Law Enforcement and Mental Health
I/DD and Neurodevelopmental/Neurocognitive Disorders—Adults
Mood, Psychotic, and Personality Disorders
Motivational Interviewing
Post Incident Debrief and Departmental Support
Procedural Justice, Fairness, and Bias

Psychopharmacology and Medications
Responding to Media and Community Inquiries/Outrage
Specialty Courts and Other Diversion Options
Stakeholder Engagement
Trauma-Informed Responses—Advanced

✓ **Training instruction and delivery:** Regardless of the curricula chosen, content is taught by law enforcement and mental health provider instructors, subject experts, and others with first-hand knowledge, like people who have mental illnesses and their family members, as appropriate. Trainings taught by people with lived experience and their family members give officers the opportunity to informally interact with people who have mental health needs and their families in a non-crisis setting. The delivery of training comes in both experiential and hands-on opportunities if possible, but also in lecture-style presentations, simulations and/or virtual training, scenario-based role playing, group problem-solving exercises, site visits to mental health facilities, and ride-alongs so that coursework is varied and accessible to people who have different learning styles. Refresher training is provided periodically.

✓ **Evaluation of training:** Trainings are regularly evaluated to assess their overall quality and impact. A review process ensures that the curriculum is meeting its intended purpose of preparing law enforcement staff to more effectively respond to mental health calls and defuse these encounters. Pre- and post-testing of the training participants ensure that participants have developed new or enhanced existing skills and knowledge as a result of the training. Evaluations are reviewed, and modifications to the training curriculum are made based upon the findings. There is also a process for the interagency workgroup to periodically review the curriculum and assess the need for changes based on community needs or crime trends. Using results from these training evaluations, supervisors assess how well staff understand the training content and use it in their day-to-day activities.

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IN PRACTICE | Using Coordinating Councils to Promote Training Across the State: State of Missouri

In partnership with their mental health providers, law enforcement leaders in Missouri developed a successful multi-pronged approach to training officers using a statewide CIT curriculum that every local jurisdiction could adapt. The training includes a core 32-hour base curriculum covering 19 mandatory topics, but each jurisdiction can customize their remaining 8 hours of training (selecting from more than 23 electives). Elective topics cover areas such as homelessness, trauma, officer suicide, and "suicide-by-cop" prevention.

As with many states, Missouri officials determined that while some of their larger cities like St. Louis had the resources and funding to implement the training, other smaller suburban and rural locales did not. To address this challenge, officials allowed some of the smaller jurisdictions to send an officer to larger jurisdictions offering the training once a week for five weeks to complete CIT training.[16]

Most importantly, Missouri officials leveraged a network of coordinating councils to customize the curriculum and training approach based on local needs. Each council covers a geographic area comprised of local law enforcement agencies and community and state-based organizations. The councils meet at least quarterly to develop local training schedules, adapt the state's CIT curriculum to meet their local needs, determine which electives from the state curriculum they will adopt, and develop relationships with providers and individuals to deliver core components of the curriculum. The state also hosts a CIT conference bringing together members from all of the coordinating councils each year. During these events, members vote on what topics to include or modify in the state's CIT curriculum and receive additional professional development.

The state also provides ongoing mentoring and specialized training through a network of 31 mental health professionals called community mental health liaisons who are available to every law enforcement department in Missouri. Similar to a traditional co-responder team, these liaisons respond to calls and provide training on complex cases to jurisdictions and individual officers that may otherwise not have access to more advanced training.

4   Does the Community have a Full Array of Mental Health Services and Supports for People Who Have Mental Health Needs?

Does an array of mental health and community services exist for people who are experiencing a mental health crisis? Are the services regularly utilized by the PMHC partners? How often are these services available when law enforcement encounters a person in need of them? Have the PMHC partners worked together to leverage additional funding to address gaps in service capacity?

Why it matters

Law enforcement officers can more effectively respond to people who have mental health needs and connect them with appropriate community supports when a full range of mental health and community services is available. Officer awareness of these services further expands the disposition options available to them, reducing the need to arrest as the only option for these encounters. These connections can provide opportunities for long-term treatment. And when long-term treatment options are available, officers are better able to connect people who have more complex needs to these supports in an effort to reduce future encounters and arrests. While intended to be a seamless continuum of services, in practice, law enforcement only controls a subset of these services, namely the PMHC response models (e.g. CIT or co-responder teams). In collaboration with the behavioral health system, law enforcement can help to ensure that the full array of service options (e.g. mobile crisis, crisis stabilization facilities, etc.) is available and that officers are aware of how and when to use them. When law enforcement helps identify missing services and their behavioral health counterparts prioritize existing resources in support of the PMHC, the behavioral health system also benefits. Together, these systems can make a strong, data-driven argument to elected officials for more funding to increase service capacity.

What it looks like

✓   Inventory of existing services: Law enforcement leaders partner with their behavioral health counterparts and other community organizations to inventory services in the community. Services appropriate for this inventory include those that address crises (e.g., diversion or crisis facilities, single-point of access facilities, shelters, and detox/rehabs) and longer-term services to reduce repeat encounters (e.g., Assisted Outpatient Treatment, Assertive Community Treatment, outpatient treatment, and housing programs and services). This inventory helps partners identify if there are major gaps in the array of service options for this population, how they can access these services, and eligibility restrictions, such as insurance limitations, diagnostic criteria, or other thresholds. One of the more common techniques used to develop this inventory, or system map, is Sequential Intercept Mapping.[17] In addition to helping promote collaboration and partnership between the criminal justice and mental health partners involved, the mapping helps identify diversion opportunities and resources for people who have mental health needs. For instance, the inventory could reveal that there are crisis services but that the community lacks long-term interventions. Once the interagency workgroup reviews the inventory, it is better positioned to identify services to fill those gaps and determine if additional PMHC response models or services are needed in the community.

✓   Assessment of program and service capacity: The interagency workgroup determines whether the existing services and programs are operating at the scale required to meet the needs of the community. This assessment is strengthened when it is informed by data collected on the utilization rates for all existing services and patterns of instances in which a given service is requested but not available. A designated individual or subcommittee is identified to oversee the data collection process and works in tandem with the interagency workgroup to assess the PMHC's resource capacity and compare it to the volume of what is actually needed on an ongoing basis. This assessment examines which resources may be underutilized due to lack of awareness, over-subscribed because there are more people eligible than spaces available, and which services may not align with what the community needs.

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✓ **Prioritized behavioral health resources and increased funding:** Law enforcement and behavioral health agencies partner to prioritize available services for people who have mental health needs. The interagency workgroup supports these efforts by examining the data and pointing to areas in need of additional service capacity. Law enforcement leaders aid their behavioral health partners in seeking support and buy-in from elected officials by combining their data and showing a specific, quantified need for additional services. Advocacy groups also help to rally support (and members) around these initiatives to bring additional legislative buy-in and potential funding.

IN PRACTICE | The Evolving PMHC: A Data-Informed Approach to Assessing Services and Improving Responses in Tucson, AZ

Since 2000, the Tucson Police Department (TPD) has been working to effectively respond to people in mental health crisis. While they initially began their efforts by employing only acute crisis mobile teams (CMT), TPD's use of data led them to identify limitations in using just one response model and a need for a more comprehensive PMHC to better respond to this population. For instance, while officers appreciated having access to trained clinicians to help them divert people to behavioral health services, they also expressed concern about how long it took the clinicians to respond—sometimes up to an hour after the officer arrived on scene. Also, TPD determined that the local hospital was unable to keep up with the demand for stabilization services for people in crisis.

Equipped with the number of mental health calls they received per month, the estimated time it took to respond to these calls, the number of mental health and law enforcement staff deployed in the CMTs, and other relevant data, TPD's Mental Health Investigative Support Team (MHST)—a specially trained unit of the TPD that serves as a mental health resource for other officers—community members, and health care providers identified the need for adding a co-responder team to their resources to address the needs of the community.

To create the co-responder team, they suggested the following: (1) change the staffing of the CMT to one clinician instead of two, and deploy the second clinician to the new co-responder team with an officer, thereby cutting down wait times officers were experiencing (as this would be a direct police resource); and (2) change the new team's primary focus to answering 911 calls, while the CMT would focus on proactive community outreach and engagement.

MHST presented the plan to TPD and the Pima County Regional Behavioral Health Authority leadership and emphasized the cost savings both partners would realize if a co-responder model was implemented in addition to the CMTs. The plan would also benefit the local hospitals by decreasing crisis placements and promoting stabilization for people in crisis or who have mental health needs.

With these changes approved and implemented, TPD has been able to develop a more comprehensive partnership between law enforcement and the behavioral health system. Instead of standalone programs working in silos, system partners now work in collaboration and have utilized their resources to reduce wait times, more efficiently staff both the CMTs and co-responder teams, and link more people to services. The CMTs and the co-responder teams have been able to take full advantage of the city's 24-hour crisis center, which opened in 2011 as an initial attempt to help stabilize people in crisis. Law enforcement has also seen a reduction in wait times due to the implementation of the co-responder team; and the co-responder team has helped MHST tailor their case management approach to focus on involuntary commitments, linking these individuals to services before they are in crisis, and significantly decreasing the number of involuntary commitment orders.

5   Do We Collect and Analyze Data to Measure the PMHC Against the Four Key Outcomes?

Do we collect data to measure our success against the key outcomes of a PMHC, such as the four outlined in the introduction of this framework? Is the data regularly reviewed? Do we assess performance against established goals? Is there a dedicated person responsible for leading the data collection efforts? Are staff assigned to review the data and generate reports?

Why it matters

Data collection and analysis gives leaders in the law enforcement and behavioral health systems the ability to gauge the effectiveness of their responses to people who have mental health needs. It also arms them with concrete data to present to local officials and the public at large to garner buy-in and support for the PMHC. Establishing baselines or benchmarks early on is important to ensure PMHC progress can be tracked over time. For example, if the jurisdiction determines how many people who have mental health needs come into contact with law enforcement officers prior to the start of the PMHC, they can see progress on this outcome the following year. Additionally, leaders can use data to determine whether current efforts and procedures need modification or improvement, and if there are any gaps in community-based mental health services. Law enforcement leaders may also use data to identify high-need populations that may require a more targeted approach. Data also helps law enforcement leaders place individual instances or cases in context—as exemplary situations, typical examples, or extreme outliers—so that response models can address the typical encounters, rather than respond to rare cases. Critical to this work is the sharing of data across systems; PMHC partners can see which clients they have in common and measure service utilization and dispositions.

What it looks like

✓   Tracking of specific metrics: Jurisdictions establish clear guidelines about what information should be collected and tracked. During planning, all partners working on the PMHC day-to-day (e.g., call takers and dispatchers, officers on the scene) agree on the definition of a "mental health call for service" to establish the level of need in the community. The tracking system also supports changing or re-coding a call based on information learned on the scene. Communities also establish the key indicators of success for the PMHC that measure progress on the four key outcomes. Table 3 provides examples of the types of data agencies can consider measuring to track the PMHC's success against the four key outcomes.

TABLE 3. EXAMPLES OF PMHC DATA TO COLLECT TO MEASURE SUCCESS

Level of Need
Number of calls for service involving people who have mental health needs
Minimized Arrests
Number of arrests involving people who have mental health needs
Number of people who have mental health needs who have >1 arrest in last 12 months
Disposition/Resolution of Call (e.g., arrest, resolved at scene, transported for voluntary evaluation, detained for involuntary evaluation, referral to mental health treatment)
Reduced Repeat Encounters
Number of repeat calls to the same location

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Reduced Use of Force
Number of encounters with people who have mental health needs where force was used
Type of force used by officers during encounters with people who have mental health needs
Injuries to officers during encounters with people who have mental health needs

Administrative and Process Outcomes
Number of officers receiving mental health and stabilization training
Number of officers trained in selected PMHC response models
Percentage of shifts covered by trained officers
Percentage of dispatchers trained on PMHC response models
Number of mental health–related calls receiving a response by a trained officer

✔ **Establish baseline data:** The PMHC establishes baseline data on the number of mental health calls for service and on the key outcomes. This baseline data is used as a comparison point at regular intervals to assess the PMHC's progress.

✔ **Process for ongoing data collection and tracking:** The interagency workgroup takes steps to develop data collection policies and procedures. In addition, the workgroup appoints a subcommittee or staff person to be responsible for collecting and analyzing the available data and producing reports for review by the workgroup.

✔ **Process for identifying individuals with frequent arrests and repeat encounters:** The interagency work group defines what constitutes "frequent" or "repeat." Arrest record data and mental health calls for service are disaggregated and examined at the individual level to identify people that both the law enforcement agency and the behavioral health partners frequently see. Since a small number of individuals often account for a large portion of arrests and encounters, the workgroup regularly identifies these individuals and crafts targeted responses for how law enforcement and other PMHC partners should handle their cases. The workgroup explores proactive case management and follow up as a strategy to prevent repeat encounters.

✔ **Data-sharing agreements:** In addition to coordinating data collection, the interagency workgroup develops mechanisms for how the partner agencies share data. These written formal agreements go beyond what information is shared on the scene between officers and mental health professionals to facilitate PMHC performance assessment. For example, these data-sharing agreements answer questions such as what data points will be shared, who is collecting this information, how it will be accessed (e.g., through a simple file exchange between agencies, in a password protected drive, etc.) and the frequency for sharing datasets. Jurisdictions follow federal, state, and local statutes on information that may be shared among agencies.

✔ **Data management system:** The law enforcement agency has a mechanism to track its data, such as a dedicated database or fields created in a computer aided dispatch system. The information system has the capability of tracking PMHC's success rates against the four key outcomes and other key indicators identified by the interagency workgroup. This data collection method or database can be queried, allowing for reports to be generated by dedicated staff members. It also allows for the matching of data among agencies and systems to identify shared clients and to examine their service usage and outcomes.

IN PRACTICE | Weaving Data Collection Practices into Daily Program Operations, Los Angeles Police Department, CA

For the Los Angeles Police Department (LAPD) and its Mental Evaluation Unit (MEU), data collection is the foundation supporting the full range of PMHC response models and initiatives they have implemented. Started in 1993, LAPD's Systemwide Mental Assessment Response Teams (SMART) was one of the first police-mental health co-responder programs to link people in crisis to appropriate mental health services and contribute to the core data collection practices that the department has implemented.

The success of this program rests in how officers are trained to collect and capture data when they respond to a call for service and how that data is then used to inform the rest of the department and MEU. All 110 MEU officers and 50 mental health clinicians receive 40 hours of training to ensure that calls involving people who have mental health needs are properly categorized, dispatched, and managed. The MEU Operations Guide is distributed to all 160 personnel assigned, providing them with a core understanding of the mission and operation. The MEU's Triage Desk collects data on all law enforcement contacts with people in mental health crisis, providing guidance and call management. These contacts, including the circumstances of the call and disposition, are documented in a Mental Evaluation Incident Report (MEIR). The MEIR is a structured behavioral health screening tool, data collection instrument, and report that captures information such as a person's behavior, thought processing, family and personal relationships, religious affiliations, and medication usage. SMART team officers not only respond to field calls but staff the triage desk during assigned times throughout the year (e.g. for a month) to ensure that officers are familiar with what happens during the call taker process.

The department collects data that is used to inform the changes necessary to improve the daily operations of their PMHC. The data collected by the triage desk, for example, is available to staff and leadership at all levels to determine if changes need to be made to the mental health training curriculum that the department provides, an increase in staff during certain shifts is needed, or if different content should be collected in the triage desk assessments. Data is available "real time" to any officer in the MEU to help manage a call or analyze crime trends, and weekly reports are generated to provide the assistant chief with data analysis on the number of calls the unit is handling, types of calls, location, and how they are resolved, among other things. Additionally, dedicated data analysts present data to the chief during monthly COMPSTAT meetings to inform how the MEU is operating overall, based on set performance metrics and if there are any trends that would inform staffing or other resource allocations. Every three months, data is also presented to the Mental Health Crisis Response Program Advisory Board to inform them of how the partnership is operating, with information regarding whether a specific hospital or crisis center has seen an increase or decrease in referrals, if there are more calls from a particular community, or an increase in certain behaviors such as overdoses.

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6   Do We Have a Formal and Ongoing Process for Reviewing and Improving Performance?

Has the interagency workgroup appointed a person or subcommittee to report to leaders on the progress of the PMHC? How are leaders staying informed of overall progress toward the stated outcome goals? Is there a process in place to adapt policies and procedures when performance reviews show a need for improvement? Is there a plan to ensure the sustainability of the PMHC?

Why it matters

Regular, data-driven assessment of the PMHC is critical to ensure the collaboration achieves its goals. When law enforcement leaders and their behavioral health partners use data to review the PMHC's performance, it gives them the ability to determine if expansions to the collaboration's capacity are needed, with the decision based on data rather than anecdotal information. A thorough review of the data gives executives and other leaders the ability to address issues they might not have otherwise discovered. Sharing information about the PMHC's progress and impact is essential for buy-in, sustainability, and growth. The PMHC data analyses should be used to update leaders and to inform budget decisions and recommendations for PMHC refinements. This review process must be transparent to the interagency workgroup, staff in both agencies, and the results should be shared with the public. When these processes are in place, the agency can show short-term success (e.g., the implementation of new policies or evidence-based practices) and/or long-term achievements (e.g., minimizing arrests of people with mental health needs) to secure internal and external support. This continuous monitoring of PMHC performance metrics provides leaders with the justification necessary to make the case for expanding services and securing additional funding, which aid sustainability efforts.

What it looks like

✔ Routine data-driven performance assessments: The collaboration is periodically assessed based on its progress in achieving the four key outcomes described in the introduction and any other agreed upon outcomes. The achievement of short-term, more immediate accomplishments such as the implementation of new procedures, policies, or practices is included in regular reports to the interagency workgroup. Community advocacy organizations representing people with lived experience, along with their family members and peers, are provided information from these regular assessments and reports and given an opportunity to provide feedback.

✔ Results-based refinements to policies and procedures: Data on the agreed-upon measures is analyzed regularly to evaluate the PMHC's progress and inform the refinement of programs, policies, and/or procedures. This data analysis also helps inform the workgroup's contemplation of any needed course corrections.

✔ Shared accountability among PMHC partners: Law enforcement leaders and their behavioral health partners share the responsibility to continually review performance data to identify PMHC service capacity issues, such as low utilization rates for a given service or if a service is consistently unavailable. Partners work together to address these issues. Procedures are in place—which are outlined in interagency MOUs and/or information-sharing agreements—that designate key staff to lead the performance review.

✔ Communication with external partners and leaders: Information is shared with county legislators, funders, and

community-based organizations to gain buy-in and support of the collaboration. Sharing successes or challenges with stakeholders leads to the PMHC receiving buy-in from the community and the additional support necessary for its growth. The PMHC establishes regular mechanisms to receive feedback from the community on how to tackle challenges and make improvements. Law enforcement leaders are responsive to the feedback of their officers, community leaders, the media, public officials and other policymakers, and ensure that initiatives are reflective of the public's interests and concerns.

✓ **Additional PMHC capacity and long-term sustainability:** Performance reviews reveal if PMHC response models or community services must be scaled to satisfy the need in the community and to ensure that sustainable funding is in place for various PMHC response models. During the planning phase, a long-term sustainability plan is developed to ensure the interagency workgroup plans for obstacles that the PMHC might encounter in the future.

IN PRACTICE | Improving PMHC Performance Using Data Analysis, Madison, WI

The Madison Police Department (MPD) has advanced their data analysis practices to understand PMHC performance and to enhance their responses to people who have mental health needs. In 2016, with the University of Wisconsin, MPD conducted a program evaluation of their mental health unit using data collected between 2013 and 2016. The main findings confirmed what they had suspected: mental health-related incidents doubled over this timeframe (as a proportion of all calls for service), calls for people with co-occurring substance addictions also quickly grew, and most importantly, a small number of people accounted for a disproportionate amount of mental health calls for service (i.e., 3 percent of unique individuals accounted for 17 percent of their total mental health reports).

The evaluation also showed that when the Mental Health Unit provided follow-up services, the vast majority (over 80 percent) of people served generated no additional incident reports, which cut down on repeat encounters. With evidence that follow-up services produced successful outcomes, MPD was positioned to enhance their follow-up capacity, creating five full-time mental health officer (MHO) positions to help mitigate the increasing demands on patrol officers and to prevent repeated calls for service related to the same person. The MHOs were added to support the existing Mental Health Liaison program already in place. In their work, the MHOs provide follow-up support for people; coordinate with mental health providers, case managers, advocates, and families; and share information with patrol officers to develop response plans.

Based on these demonstrated successes and with this data in hand, the department expanded their in-house crisis worker program to include three part-time crisis workers covering the equivalent of two full-time positions to further support the program.

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Acknowledgments

Endnotes

1.   Jennifer D. Wood, Amy C. Watson, and Anjali J. Fulambarker, "The 'Gray Zone' of Police Work During Mental Health Encounters: Findings from an Observational Study in Chicago," *Police Quarterly* 20, no. 1 (2017): 81-105, http://doi.org/10.1177/1098611116658875.

2.   The "behavioral health" system refers to both mental health and substance addiction services (and providers). For the purposes of this framework, the focus is solely on people who have mental health needs and the portion of the behavioral health system that serves this population. That said, given the high rate of co-occurring substance addictions among this population, the framework also makes reference to connections to substance addiction treatment for people who have co-occurring conditions.

3.   CIT International (CITI), the organization that leads the proliferation of the Crisis Intervention Team model, similarly calls for law enforcement responses to people with mental health needs to be implemented not as a training alone or small-scale programs, but as a comprehensive, community-wide approach. See, Dr. Randolph Dupont, Major Sam Cochran, and Sarah Pillsbury, *Crisis Intervention Team Core Elements*, (Memphis, TN: The University of Memphis, 2007), http://www.citinternational.org/resources/Pictures/CoreElements.pdf.

4.   See, the "Police Mental Health Collaboration Toolkit," U.S. Department of Justice, Bureau of Justice Assistance, https://pmhctoolkit.bja.gov.

5.   Michael T. Compton et al., "A comprehensive review of extant research on Crisis Intervention Team (CIT) programs," *The Journal of the American Academy of Psychiatry and the Law* 36, no. 1 (2008): 47-55, http://jaapl.org/content/36/1/47.

6.   Before leaders in a PMHC can determine if fewer repeat encounters are occurring, they first must define what constitutes a repeat encounter in their community. For example, it could be defined as a person having a second mental health call in a six-month period or it could be defined as multiple calls for service to the same location. Once properly defined, this target population can be prioritized for tailored interventions and treatment, and more accurate benchmarks can be established to gauge the success of the PMHC. For general discussions on the importance of benchmarking, see, Gregory H. Watson, Benchmarking Workbook: Adapting the Best Practices for Performance Improvement (Portland, Oregon: Productivity Press, 1992); and Theodore H. Poister, Measuring Performance in Public and Nonprofit Organizations (San Francisco, CA: Jossey-Bass, 2003).

7.   Jennifer L. S. Teller et al., "Crisis intervention team training for police officers responding to mental disturbance calls," *Psychiatric Services* 57, no. 2 (2006): 232-237, https://doi.org/10.1176/appi.ps.57.2.232.

8.   Research pertaining to the reduction of arrests after implementation of a PMHC is still in its infancy and in need of more review and evaluation. Studies have shown a greater likelihood of diversion from the criminal justice system after a PMHC has been implemented, as well as fewer arrests in some communities. See, Henry J. Steadman and Michelle Naples, "Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders," *Behavioral Sciences and the Law* 23, no. 2 (2005): 163-170, https://doi.org/10.1002/bsl.640; and Henry J. Steadman et al., "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies," *Psychiatric Services* 51, no. 5 (2000): 645-649, https://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.51.5.645.

9.   Portland has adapted elements of the CIT model to meet their local needs. As such, it may not represent fidelity to the CIT model.

10.   While many law enforcement agencies are familiar with "CIT" as a specialized team or training program, the Crisis Intervention Team model is a comprehensive, community-wide response in which a specialized team works within a larger agency context and partnership, consistent with the approach outlined in this framework. See, Dr. Randolph Dupont, Major Sam Cochran, and Sarah Pillsbury, *Crisis Intervention Team Core Elements* (Memphis, TN: The University of Memphis, 2007), http://www.citinternational.org/resources/Pictures/CoreElements.pdf.

11.   Houston has adapted elements of the CIT model to meet their local needs. As such, it may not represent fidelity to the CIT model.

12.   Michael T. Compton et al., "Use of force preferences and perceived effectiveness of actions among Crisis Intervention Team (CIT) police officers and non-CIT officers in an escalating psychiatric crisis involving a subject with schizophrenia," *Schizophrenia Bulletin* 37, no. 4 (2011): 737-45, https://doi.org/10.1093/schbul/sbp146.

13.   For more information on state training standards and requirements, see Martha Plotkin and Talia Peckerman, *The Variability in Law Enforcement State Standards: A 42-State Survey on Mental Health and Crisis De-escalation Training* (New York: The CSG Justice Center, 2017), https://csgjusticecenter.org/law-enforcement/publications/the-variability-in-law-enforcement-state-standards/.

14.   These topics were compiled from nationally available CIT curricula, as well as feedback-generated conversations held with employees of the 10 national Law Enforcement-Mental Health learning sites. Each of these sites has adopted or customized their own curricula and suggested the most common topics that they use.

15.   These topics were compiled from nationally available CIT curricula, as well as feedback generated conversations held with employees of the 10 national Law Enforcement-Mental Health learning sites. Each of these sites has adopted or customized their own curricula and suggested the most common topics that they use.

16.   Missouri has built on the CIT model and adapted elements to meet their local needs. As such, it may not represent fidelity to the CIT model.

17.   Sequential Intercept Mapping uses the Sequential Intercept Model to access the available resources, determine gaps in services, and plan for community change within a jurisdiction. "These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance use, law enforcement, pre-trial services, courts, jails, community corrections, housing, health, social services, people with lived experiences, family members, and many others." See, The Sequential Intercept Model, https://www.prainc.com/sim/; Dan Abreu et al., "Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0," *Behavioral Sciences and the Law* 35, no. 5-6 (2017): 380–395, https://doi.org/10.1002/bsl.2300; Mark R. Munetz and Patricia Griffin, "Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness," *Psychiatric Services*, no. 57 (2006): 544-549, DOI: 10.1176/ps.2006.57.4.544; and SAMHSA GAINS Center for Behavioral Health and Justice Transformation, Developing a Comprehensive Plan for Mental Health & Criminal Justice Collaboration: The Sequential Intercept Model.

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