

## This issue: **Best Practice Police Response to Mental Illness**

**September 2015**

Studies show that the vast majority of individuals with mental illness are no more likely to be violent than the general population unless other risk factors exist, such as alcohol use or untreated active psychosis. People with mental illness are more likely to be *victims* of violent crime than the general population. Untreated mental illness can, however, lead to disruptive behavior, leading to years of cycling through prisons and jails, shelters, and emergency rooms. This costs communities, burdens law enforcement and corrections, and is tragic for individuals with mental illness and families.

A grassroots organization, NAMI Maryland's stakeholders include individuals living with mental illness, their friends, families, community service providers, criminal justice and health staff.

NAMI Maryland and its local affiliates have worked for years to improve community-based services, increase diversion from the criminal justice system to the mental health system where appropriate, and improve the criminal justice system's response to mental illness. We work regularly with mental health agencies, law enforcement, corrections, courts and other leaders at the local, state and national level to improve society's response to mental illness. Increased attention to these issues gives us hope that more individuals with mental illness will join those who currently live *productively in the community* and that there will be a *reduction in costs to public systems*, such as criminal justice.

The criminalization of people with mental illness is a significant problem in Maryland and across the country. With the decrease in inpatient psychiatric beds and insufficiently funded and accessible community mental health services, individuals with serious mental illness frequently go without the treatment and services they need. When someone experiences a psychiatric crisis or acts out as a result of symptoms of their illness, often law enforcement are the first-line responders. Too often the result is arrest – not because the individual

committed a violent crime, but because officers have few alternatives to resolve the situation. Sometimes the officer or the individual is injured. Even if there is no arrest or injury, the individual who needs behavioral health services may not be linked to those services.

Jails and prisons are increasingly used to house individuals with mental illness. Once incarcerated, they may not receive the services that they need and are vulnerable to abuse. Most leave the system worse off and with fewer options for getting needed treatment and services, employment and housing.

We believe overuse of criminal justice resources and adverse outcomes between law enforcement and individuals with mental illness can be reduced humanely and effectively. This can be done through improved collaboration between systems, improved behavioral health service system design, and training. A CIT program is a best practice solution. (CIT stands for Crisis Intervention Team. The term is a bit confusing. The model is not really about teams, but is a collaborative problem solving model which includes training of a percentage of regular patrol officers to be "CIT officers.") *See p. 8.*

A CIT program is a model community initiative built on law enforcement agencies partnering with mental health providers and advocacy organizations like NAMI. Individuals with mental illness and families are involved at all levels of decision-making and planning. CIT programs typically provide 40 hours of training for law enforcement on how to better respond to people experiencing a mental health crisis. Equally important, CIT programs provide a forum to coordinate solutions which increase diversion from the criminal justice system to mental and behavioral health services. *See p. 6.*

In many communities, CIT serves as a springboard

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for broader collaboration between systems. Many CIT programs include partners from the juvenile justice system, schools, courts, corrections, hospitals, homeless services, children's mental health services, the Veterans Administration and others. Many CIT programs are offering trainings to correctional officers, dispatchers, EMTs, firefighters, school resource officers, hospital safety officers, and those who work with veterans.

CIT programs are intended to address cycles of crisis and improve police interactions with individuals with mental illness. CIT programs should not be mistaken

for mobile crisis response teams, which are teams made up of behavioral health professionals. Most mobile crisis teams do not have a law enforcement component, though they should work closely with police.

### References

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Teplin, L., McClelland, G., Abram, K., & Weiner, D. (2005). Crime victimization in adults with severe mental illness: Comparison with the National Crime Victimization Survey. *Archives of General Psychiatry*, 62(8), 911-921. doi: 10.1001/archpsyc.62.8.911.

## What You Need to Know About Calling the Police

*The following material was compiled from a variety of sources for the project Beyond Punishment: Helping Individuals with Mental Illness Navigate Maryland's Criminal Justice System (Ed. K. Farinholt, 2009.)*

Sometimes, despite taking every preventive step, individuals with mental illness may interact with the criminal justice system. It helps to understand the processes, points of intervention, and possible outcomes when police become involved.

### WHEN FAMILIES AND FRIENDS CALL 911

The public may also call because they observe behavior they interpret as problematic. Families and friends of an individual with mental illness may call the police for many reasons. They may call for help finding an individual who has wandered off without their medications. They may anticipate a crisis, based on experience, well in advance of the legal criteria for an emergency petition. They may call for help because the psychiatric crisis meets the criteria for an emergency petition or there is a public safety issue for the individual or others. They may call because they have tried everything they know, they are not aware of other community or crisis services, and they think this is the only way to get treatment. Individuals with mental illness and their families are sometimes *told* to call 911 or the police when treatment providers are unavailable.

Families and friends who call police often become angry and frustrated. They do not understand that the officer has protocols to follow and may not believe the

situation is criminal or meets criteria for an emergency evaluation. They may not know of available intermediate interventions that do not require police involvement. In many cases, calls for police can be reduced if family and friends receive support and education on how to recognize psychiatric symptoms, to effectively communicate with someone with disordered thinking or emotions, and how to access community resources to prevent and even de-escalate crises. *NAMI offers such programs.*

### WHAT POLICE CAN AND CANNOT DO

Police investigate when someone in the community makes a complaint or the officer sees aberrant behavior. Officers are trained to collect information from people to understand a situation. Police are not mental health professionals. ***They are public safety officers taught to control a scene.***

If an individual is not directly threatening another person or himself, it helps to give them time to calm down. But officers are usually trained to intervene quickly, resolve the safety issues, and to be available for the next call. In some jurisdictions, the pressure to resolve a call quickly is immense.

To ensure safety, officers are trained to take command of situations, typically using body language and voice to compel people to cooperate with stated instructions. However, when dealing with an individual with a mental illness, especially someone in a

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delusional or crisis state, such an approach may escalate the situation and make a crisis worse.

Depending on the severity of symptoms, an individual may find it difficult to follow directions, to respond quickly and accurately, or even to respond to their name. If officers on the scene have no special training in mental disorders, and there are no obvious signs of disturbed thinking, it can be easy for them to overlook the possibility that an individual has a mental illness. They may therefore interpret the individual's inappropriate behavior as lack of cooperation or even defiance. *J. Massaro, Working with People with Mental Illness Involved in the Criminal Justice System: What Mental Health Service Providers need to Know (2d ed.), Delmar, NY: Technical Assistance and Policy Analysis Center for Jail Diversion, p19.*

When officers believe an individual is deliberately disobeying their instructions, they are trained to increase their compliance tactics. In situations involving someone whose mental illness is preventing him from following officers' instructions, the stage may be set for a confrontation. The individual may become irrationally fearful and may strike out in what they believe is self-defense. People with mental illness often have poor impulse control and have trouble controlling their anger or frustration. If the individual is also under the influence of alcohol or drugs, he will have less impulse control and be more likely to exhibit higher levels of aggression. *Massaro, 19.*

Depending on symptom severity, it may also be difficult for the individual to understand his rights during the process of police investigation, questioning, or arrest. They may have difficulty explaining his behaviors or presenting his side of a given situation.

### SPECIALIZED TRAINING AND TEAMS

Officers who receive special training and their department's support can add mental illness crisis de-escalation tools to their other strategies. When offic-

ers are trained to recognize signs of mental illness and communicate effectively with people who may have a cognitive or emotional disturbance, they can often de-escalate crises entirely. If they know available mental health and crisis response resources, they can often divert people to available community resources which can prevent repeat calls for police.

These programs require specialized training about mental illness for police officers, and typically have a 24-hour crisis drop-off center with a no-refusal policy for individuals brought in by the police. Other models of pre-booking diversion involve collaboration between police and specially trained mental health service providers, who "co-respond" to calls involving a potential mental health crisis.

Police departments have partnered with mental health providers and advocacy organizations like NAMI to develop training to provide officers with additional skills to manage delicate, potentially volatile, crisis situations. NAMI members advocate for best practice training and provide workshops. NAMI Maryland trains individuals and family members to deliver workshops.

### CALLING 911

Call 911 if you are concerned for your or another's immediate safety. Otherwise, first call the individual's mental health provider or a local crisis hotline.

When you call 911, an operator takes your information. They forward what they consider the **key** information to a police dispatcher, or directly to officers (or in some jurisdictions, in non-emergencies, to a mental health crisis team.) The person calling 911 should explain that the individual needs a psychiatric assessment and that you need assistance. ***Ask if an officer trained to deal with a mental illness crisis is available.***

Providing useful information to the 911 dispatcher, and ***then again to officers who arrive***, can ensure the safety of all involved. Recognize that calling 911

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is merely the first step in getting help—all of your information may not have been received by officers



who come to the scene. ***Even when an officer has all available information, they may want the complainant on scene to provide it again.*** If you have time, take a brief moment to organize your thoughts and jot down the key points in writing. This will help you be specific and brief.

Give this information to 911 ***and again to the officers who arrive*** to help them engage the individual and to better understand how to protect themselves and others on the scene:

- your relationship to the individual
- the individual's current problematic behavior
- any mental health diagnosis or diagnoses
- additional relevant medical diagnoses
- whether the individual is in treatment
- prescription medication the individual is taking
- any history of alcohol or drug abuse
- any history of self-harm
- any history of violence toward others and any specific people or types
- Be sure to state if there is *no* history of violent acts.
- anything that may trigger or escalate the situation
- anything that could help de-escalate the situation
- weapons access or weapons use history (knives, broken glass, etc.)
- age, height, and weight
- physical fitness, weight training or martial arts experience
- hospital preference (sometimes possible)

### WHEN POLICE COME TO THE SCENE

Expect two or more officers to respond. This is standard procedure to maintain safety for everyone. If possible, have someone known to the individual stay with him or her, while someone else meets directly with the police officers. Remember, the officers may not know exactly ***who*** is in crisis when they arrive, so, for their safety, the officers must assume *an-*

*yone* may be that individual. Ideally, when discussing the situation, do so away from the symptomatic individual (e.g., before officers enter the home, etc.) Describe the crisis, repeating the information given to 911 and let the officers know of any changes since the call for help. Explain how the individual might react to multiple officers. When you speak with the officer(s) convey the message that the individual has a mental illness that may make communicating or interacting difficult. Explain specifically, if you can, what happened to precipitate your call, and what happens when the individual is in crisis. For instance, if an individual hears voices and cannot easily follow verbal instructions, they may appear to disregard the officer's orders. If this is the case, explain to the officer that delusional individuals may perceive the police officers as aliens or some other threat and may be unreasonably afraid and unable to comply with commands. Remember, the police officers are not mental health professionals and have to follow certain department directives and policies: They are first required to assess and then to protect the safety of everyone involved.

Once you state the facts clearly, stand back and allow the police to follow their procedures. Police officers have many responsibilities when responding to a 911 call. They must stabilize the situation, ensure everyone's safety, resolve the situation, and return to radio calls as quickly as possible. Their priorities include not only the care of the individual, but also you, themselves, and the community. Interference with their management of the scene usually hinders the officers' ability to control the situation and can even lead to arrest of the person causing interference.

The officer may be able to take persons to a hospital or crisis unit for evaluation instead of arrest. You can also offer to accompany the person or to meet the ambulance or police transport at the hospital or crisis unit.

### OPTIONS AVAILABLE TO OFFICERS

Officers typically have 3 choices when deciding how to resolve situations involving persons with mental illness.

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### OFFICER DISCRETION: Pre-booking Diversion or Encounters Without Arrest

**The first option:** if the individual's behavior does not meet the criteria for an emergency petition, and the criminal violation, if any, is minor, officers may have the discretion to resolve the situation informally. For example, if the officers have diffused the crisis to the point where the individual agrees to get treatment voluntarily, they may leave the scene without taking formal action. In some cases, the officers may provide referrals to mental health crisis or other community resources. But if the individual's behavior is too erratic or disturbing, the police may take the individual into custody to transport them to a hospital (or even to jail) to maintain safety.

**The second option:** if the behavior meets the criteria for emergency psychiatric evaluation, police have the authority to transport the individual to a designated mental health facility, usually an emergency department or general hospital.

### ARREST

**The third option:** if the individual's behavior is a significant violation of the law, police officers are required to arrest the individual, as they would anyone else who violates the law.

To make a lawful arrest, police officers must have *probable cause* that there is a reasonable basis for believing that a person has committed a crime. This *probable cause* can result from observing a crime or through information provided by a reliable witness. A person may be arrested for apparent criminal behavior, as a result of investigation or because of an outstanding warrant relating to an offense, violation of a judge's order, failure to appear in court, or to pay a fine.

In some jurisdictions, officers may decide to issue a citation rather than arrest the individual, in which case the individual is released. The citation describes the charge and lists the court hearing date and place. Police are more likely to issue a citation if the individual has adequate identification, has a place to stay,

and is not a flight risk. If the person does not show up at the hearing, an arrest warrant will be issued.

Any information obtained by police, even if obtained before a formal arrest, can be used against the person. If the individual is arrested and taken into custody, and the police want to question the individual about the crime, Miranda rights must be given to inform the individual of their constitutional rights.

The Miranda warning states that: the individual has the right to remain silent, anything said can and will be used against the individual in court, the individual has a right to consult with an attorney during interrogation, and if the individual is indigent, an attorney will be appointed to represent him.

After an arrest, the police can search the individual and any illegal items found (e.g., illegal drugs, drug paraphernalia, weapons or possible weapons) can be taken as evidence for additional charges.

### What To Do (and Not Do) When Family and Friends Believe Police Action Is Inappropriate

Officers are trained to gain control over an arrestee and to control the setting and any people nearby who might interfere. There are times when observers at a crisis scene may feel that the law enforcement officers have used inappropriate or excessive methods. The best thing observers can do, despite their concerns, is to stand back and to advise the individual calmly to cooperate with the officers, rather than further escalating the individual's behavior. Observers who appear to the police to be escalating a situation take the chance of being arrested themselves. After a situation is under control, most officers will listen to your description of an individual's special needs.

If you still have concerns about the officers' handling of the situation, write down what happened as soon as possible. You may discuss these actions:

- By requesting to speak with a supervisor or have one respond to your location
- By contacting the internal investigation unit of the department. Many have complaint forms that can be submitted online.
- By discussing your concerns with defense council

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For agencies to investigate your concerns they only need basic information such as address, date, and time, they can easily obtain other need information from police department systems.

*The preceding material was compiled from a variety of sources for the project Beyond Punishment: Help-*

ing Individuals with Mental Illness Navigate Maryland's Criminal Justice System (2009).

*The original editor, Kate Farinholt, plans to update and expand the materials with the help of many of the original contributors and others, subject to funding and capacity.*

*To find out more, contact [info@namimd.org](mailto:info@namimd.org).*

## What are the Essential Elements for Effective Police Response ("CIT") ?

*The following guide, slightly edited for this newsletter, was adopted in 2014 by the Maryland Criminal Justice Mental Health Partnership on which NAMI Maryland serves, and is based almost entirely on the U.S. Department of Justice report: Improving Police Response to People with Mental Illness: the Essential Elements of a Specialized Law Enforcement-Based Program, Schwarzfeld, Reuland, Plotkin, Council of State of Governments and Police Executive Research Forum..*

Every community will confront behavioral emergencies in which a person poses or appears to pose a danger to themselves or others. The extent to which these incidents are managed and resolved in the most humane and effective manner depends on service system design as well as preparation and training. CIT programs are best practice local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises. They are built on strong partnerships between law enforcement, mental health provider agencies, and individuals and families affected by mental illness. CIT's focus is to help communities develop more responsive access to mental health services, increase collaboration between police and crisis mental health clinicians, and provide structured training for police agencies that increases understanding of behavioral health issues and provides skills that are effective in intervening in the field. (For this document, "CIT" is used generically to describe the process, and no specific model is being endorsed.)

Implementing CIT in communities results in better dispositions for those in crisis; reduced use of lethal force; increased safety for law enforcement, clinicians, consumers, and families; and decreased exposure to legal liability. The trainings also improve interactions with individuals with non-mental health issues, such as intellectual or developmental disabilities, physical disabilities, and substance abuse.

### CIT - Ten Essential Elements

1. Collaborative Planning and Implementation
2. Program Design
3. Specialized Training
4. Call-Taker and Dispatcher Protocols
5. Stabilization, Observation, and Disposition
6. Transportation and Custodial Transfer
7. Information Exchange and Confidentiality
8. Treatment, Supports, and Services
9. Organizational Support
10. Program Evaluation and Sustainability

Advocates, community providers and agencies can work together to make sure that the following 10 "essential elements" are achieved.

### 1. Collaborative Planning and Implementation

A specialized response by law enforcement to people with mental illness should reflect a partnership at the highest level, led by the primary local law enforcement agency. It should include the local mental health authority, behavioral health and crisis providers, local hospital emergency departments representatives, as well as mental health (and intellectual and developmental disability) advocates representing individuals and families. This Collaborative Planning and Implementation Committee (CPIC) will provide program planning, guide implementation, problem solve ongoing issues, and provide leadership for sustaining the program, including funding, community support, and promotion of the program internally *and* externally.

The CPIC determines specific outcomes measures and develops and implements evaluation methods. It re-

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## Essential Elements

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views law enforcement policies and standard operating procedures, mental health emergency policies and procedures, and other relevant system policies and procedures to determine where changes can improve police and mental health response to individuals with mental illness and to outcomes. The CPIC will implement the collection of State-required measures and add additional measures specific to its jurisdiction.

### 2. Program Design

The CPIC will design a specialized law enforcement-based program to address the root causes of the problems that are impeding improved responses to people with mental illness. It will combine current resources, including in-kind services, and creatively search for additional funding sources. The CPIC will be a standing committee and continue to review and problem-solve issues on an ongoing basis.

Specifically, CPIC reviews critical incidents involving injury and/or death from a systems perspective. It reviews operational issues such as the time officers spend waiting for medical clearance in emergency rooms, the frequency which officers repeatedly come in contact with the same individuals without an effective resolution, officer safety/injury and/or community safety. Committee members should consider officers' ability to reorient from the traditional method of gaining control using an authoritative approach, to a non-adversarial, crisis-intervention style.

The CPIC shall design a program providing for systemic linkages to behavioral health services (e.g., officer tracking of behavioral health calls requiring behavioral health follow-up in the community, or direct linkages with a mobile mental health crisis system.

The CPIC should consider the designation of a Law Enforcement Coordinator, a Mental Health Coordinator *and* an Advocacy Coordinator.

### 3. Specialized Training

Specific training for law enforcement is an important component of CIT, but it should be thought of as a broader systems approach to improving the intersection between criminal justice and individuals with mental illness. Skills-based training is provided to im-

prove officers' responses to individuals with mental illness and other disabilities which affect individuals' behaviors.

All law enforcement personnel who respond to incidents involving individuals with mental illness or should receive training which effectively prepares them to resolve these encounters and improve outcomes. *Those who are designated as CIT receive more comprehensive and ongoing training.* It is the goal to have sufficient percentage of CIT-trained officers who can respond in all districts and on all shifts. Dispatchers, call takers, and other individuals in a support or supervisory role will receive training tailored to their needs. Recruit and in-service trainings will routinely include basic information about behavioral disorders.

Planning and implementing the training program that supports a CIT program is a collaborative effort between the law enforcement agency and stakeholders represented on the CPIC Program Subcommittee. The CPIC reviews and evaluates trainings and modifies the curriculum based on findings and need. The training program improves understanding and skills relating to signs and symptoms of mental illness and substance use disorders and their impact on individuals, families and communities, verbal de-escalation, disposition resources, and legal issues, with an emphasis on hands-on skills learning regarding stabilization, de-escalation, and problem-solving techniques.

### 4. Call-Taker and Dispatcher Protocols

Call takers and dispatchers receive training and use procedures to identify critical information to direct calls to appropriate responders, inform law enforcement response, and record information for analysis by the CPIC and as a reference for future calls for service.

### 5. Stabilization, Observation, and Disposition

Specialized law enforcement responders de-escalate, stabilize and problem solve incidents in which mental illness may be a factor, using safety-focused tactics. Officers are not expected to diagnose, but to be able to observe and recognize behaviors that might benefit from their specialized training. Drawing on their understanding and knowledge of relevant laws and available resources, and any tools and procedures to link

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individuals to other systems, officers then determine the appropriate disposition. If this is done in concert with mental health professionals such as a Mobile Crisis Team (MCT), the disposition is determined jointly. If this is done only with consultation from the mental health system, the officer determines the disposition.

This disposition may include, where appropriate, linking these individuals with mental health or other services and supports that reduce the chances of further interactions with the criminal justice system.

### **6. Transportation and Custodial Transfer**

Law enforcement responders transport and transfer custody of the individual with a mental illness in a safe and sensitive manner that supports the individual's efficient access to mental health services and the officers' timely return to duty. Policies regarding transport should be reviewed to strike a balance between ensuring safety for the officer and de-escalating the behavioral dyscontrol of the individual in distress. Systems planning should be done to determine which facilities are best equipped to manage the individual and provide the appropriate level of care based upon the presenting crisis. The range of these facilities will be different in each jurisdiction, but have in common the ability to administer a mental health evaluation and formulate the proper disposition. Collaboration from some part of the mental health system should be available to all officers engaged in this type of response.

### **7. Information Exchange and Confidentiality**

Law enforcement and mental health personnel need to have well-designed procedures governing release and exchange of information to facilitate necessary and appropriate communication while protecting the confidentiality of community members. This is an important consideration for the CPIC, and needs to be done at the system level to assure required legal standards are maintained, but functional information pertaining directly to crisis services the individual requires and safety considerations for officers, mental health personnel, family, and the individual may be exchanged appropriately. All issues regarding sharing information should be explored through legal consultation and poli-

cies. All mechanisms for increasing communication clarity should be explored such as MOU's between organizations or use of individuals' advance directives requiring services should be explored.

### **8. Treatment, Supports, and Services**

Specialized law enforcement based response programs connect individuals with mental illness to comprehensive and effective community-based treatment, supports, and services. This means that although the service system will be different in every jurisdiction, systemic coordination must focus on the intersection between the criminal justice and mental health systems. Access to the psychiatric crisis system component involves coordination of hospital-based ED's and inpatient resources, existing community crisis behavioral health services, and addictions inpatient and outpatient treatment programs. The available array of services must be sufficiently comprehensive and accessible that individuals who come to the attention of law enforcement may be safely and appropriately linked with these services, thereby allowing officers to return to service.

### **9. Organizational Support**

The law enforcement agency's policies, practices, and culture support CIT and the personnel who further its goals. It is critical that the law enforcement leaders make clear on several levels that CIT is a priority. Internally, this includes making necessary resources available, putting forward messages to staff about its value, and making systemic changes that create incentives for officers to choose to participate in CIT training. Externally, this involves participation in professional organizations such as the Police Executive Research Forum (PERF) or International Association of Chiefs of Police (IACP) that educate their membership and advocate for use of best practices. It also involves working within the larger system to secure additional resources across department and organizational boundaries and to conceptualize this as only one part of a larger systemic change in dealing with the intersection between behavioral health and criminal justice.

### **10. Program Evaluation and Sustainability**

The CPIC ensures that performance measures are in-

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corporated into ongoing program implementation. Quantitative and qualitative data are collected and analyzed to help demonstrate the impact of, and inform program modifications. Data collected may include: number of injuries and deaths to officers and civilians, officer response time, voluntary vs. involuntary engagement, number of repeat calls for service, officers' disposition decisions, time required and method used

for custodial transfer, officers' feedback, etc.

The CPIC works to ensure the program's long-term sustainability. Support for the program is continuously cultivated in the community and the law enforcement agency through partners in the CPIC and others. The CPIC and its partners should provide recognition and honors as well as provide input to law enforcement agencies regarding creation of incentives and organizational support for participation in the program.

**How Can YOU Support Best Practice Police Response to Mental Illness in Your Community?**

**KNOW THE RECOMMENDED ESSENTIAL ELEMENTS OF BEST PRACTICE POLICE RESPONSE TO MENTAL ILLNESS!** Review the materials in this newsletter.

**LEARN MORE!** NAMI Maryland can provide education and resources about best practice police response to mental illness. Questions? Ask us!

**GET INVOLVED!** NAMI Maryland members participate in local planning committees and in trainings of CIT officers.. NAMI Maryland trains individuals with mental illness and family members about CIT best practice and trains them to deliver effective workshops for police trainings.

**STAY INFORMED!** NAMI Maryland helps individuals and organizations who want to know more about advocating and supporting these programs. **Join** NAMI Maryland's email list to receive timely updates about criminal justice issues, information about local and national news, webinars and teleconference opportunities and events across Maryland, and information about policy issues and action alerts.

For information, contact [info@namimd.org](mailto:info@namimd.org) or call 410-884-8691

**A View From the Field**

I remember being a young police officer and the frustrations I felt when responding to calls for folks in crisis. Back then, the options were few. We could make arrests if the situation merited it. Even in that case, we knew that the arrest, though legal, wasn't always the best resolution. We could do emergency petitions, but the criteria were high and more difficult to meet. We could try to influence or cajole people to get services, but those services often weren't convenient or accessible in the middle of the night. Oftentimes, the best we could do was to show concern, offer support, ask people to promise not to harm themselves and hope they called us back if their situation worsened. We had few options to provide for family and friends. I remember many times leaving a call, having done what I could, but knowing that I didn't do much to resolve anything.

Thirty years later, law enforcement's response to these situations is so much better. Though not perfect, we do a better job of understanding mental illness and work more collaboratively with mental health professionals and other service providers to provide both short term responses and longer term resolutions. We train our officers, dispatchers and other employees in much better ways. We partner with others to ensure that people in crisis, and the people that care about them, know about available resources. We do a better job of identifying people to whom we respond an inordinate amount of times and help them get the help they need.

One of the biggest improvements in police response to mental health issues has been the implementation of Crisis Intervention training. This enhanced training for

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## A View From the Field

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officers and others combines classroom training and experiential experiences that really help the officer understand the complex issues involved and gives them very practical skills on approaching, talking to and deescalating people in crisis. When we began implementing this program in Howard County, we faced some resistance. Since then, even veteran officers label the training as some of the best they ever received.

From my experience, several elements must be included to implement and improve CIT:

- Understand that the CIT approach is more of a program than it is “training”. There is no “end date.”
- Real tangible support from the leadership of the law enforcement agency. The Chief/Sheriff *must* cheerlead for the program: this needs to be “top-down”.
- Real collaborative relationships between law enforcement executives and mental health leaders in government and the community. A real partnership!
- A “marketing plan” within the agency to let officers and other know the value of the training, not just for the public, but for themselves.
- Internal “advocates”. Often veteran officers with credibility have more influence than the CEO.
- Training must be multi-disciplinary, recognizing the mental health needs of the consumer, but also acknowledging the challenges these situations create for law enforcement and the community.
- The training must be **local**: it’s value increases significantly when officers know what resources exist in **their** communities and know how to access them.

- The training is **part of larger** “program.” This is not intended to replace Mobile Crisis Teams or other initiatives, but as a way to enhance all of the efforts.
- Recognizing that this is “evolutionary”. The training will need to be modified to meet the changing needs, research and resources available and may need to go beyond just police officers (dispatchers, clerks, correctional officers, fire/ems).

Nationwide, police response to those with mental illness is being examined. Recently, the “President’s Task Force of 21st Century Policing” was released and a portion of that report focused on that issues. Here at the Training Commission, we hosted Laurie Robinson, one of the co-chairs of the sub-committee, to debrief that report to a group of Maryland’s chiefs of police and sheriff. In December, we will be hosting a similar session with Mr. Chuck Wexler, the Executive Director of the Police Executive Research Forum. He will be discussing the recent release of their report on “Reengineering Training on Police Use of Force”. Developed after a meeting of national and international law enforcement executives, this report focuses on the need to teach de-escalation techniques to our officers.

Maryland law enforcement has come a long way in improving our response to those in crisis. We continue to look for the best approaches for these challenging situations and always concern about the safety of all.

William J. McMahon, Director  
*Leadership Development Institute, Maryland Police and Correctional Training Commissions*  
*Retired Chief, Howard County (Md) Police Department*

## A Personal Interaction with Law Enforcement By Sarah Crimmins

It was a fall day. I don’t remember what month and I had just returned from yet another visit to the hospital. I had gotten a new doctor. That afternoon I had called to tell him I was experiencing suicidal thoughts. This was nothing new, and I had told many a doctor this, without causing alarm.

This time it was different. I was stubborn and told the doctor I wasn’t going to the ER, that I would be fine. I was never one to cause alarm, and I didn’t like being

told to go to the hospital, I would go when and if I pleased. Apparently, he didn’t like being told no.

My first experience with law enforcement occurred that evening. Four police cars showed up in front of my small suburban home. I was mortified. All I wanted them to do was leave.

The officer who came in to talk to me was one of the most calm, pleasant police officers I’ve ever talked

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## A Personal Interaction with Law Enforcement *By Sarah Crimmins*

*(Continued from page 10)*

with. He sat down on my porch with me, chatted, looked at my cuts, and then told me that either I needed to come with them, or he was going to have to take me in.

Not being one to make a scene and already worried about what my parents were thinking, I agreed to go with him. But his demeanor made the choice an easy one. He was matter of fact, easy going, and not at all put out by having to come see me. I wasn't an inconvenience. He let me ride in the front of the police car and chatted with me on the way to the hospital. I felt at ease. The only difficult moment was when he dropped me off in the empty room at the hospital. He had built a rapport with me. I felt comfortable with him. I felt frightened when he left.

My second experience with law enforcement was that same fall. I was in a mixed manic state, experiencing mania and depression at the same time. I went from feelings of euphoria, to crying spells, wanting to walk in the middle of the road, and being suicidal. My friend called the police. The officer who came, stood over me in the living room. He kept asking me what I wanted to do. I was in no state to make any decision, and instead of attempting to build a rapport with me, he constantly questioned me and appeared frustrated.

Finally he stood to leave, and my friend called him to take me to the hospital, and, obviously annoyed, he put me in the back of his police car crying with my blanket. It was a humiliating experience, and I felt alone and like he didn't care. He dropped me at the hospital, still questioning me.

From my experience with law enforcement, I would say it is important for the police officer to build a rapport with the individual as much as possible, and for the officer to express care and concern for the person as they are in a very vulnerable state. The more a rapport is built, the more the person feels they can trust the officer and a better solution to the problem is more likely.

*The author has been trained to talk about her personal experience through the NAMI In Our Own Voice program. NAMI Maryland provides an additional "refresher" module to prepare for police trainings. Sarah presents at police trainings in her community.*

*Note: NAMI Maryland also trains family members to present "Working with Families in Crisis" for first responders and other audiences.*

*For more information about these workshops or trainings, contact NAMI Maryland at [info@namimd.org](mailto:info@namimd.org) or 410-884-8691*

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