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LAW ENFORCEMENT RESPONSE TO MENTAL HEALTH CRISIS INCIDENTS: A SURVEY OF ILLINOIS POLICE AND SHERIFF'S DEPARTMENTS

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Abstract: Law enforcement agencies in Illinois and across the country are seeking ways to increase the safety and efficacy of interactions between officers and individuals experiencing a mental health crisis. Researchers conducted a statewide survey to learn more about how police and sheriff's departments respond to mental health crisis incidents. This article describes responding departments' policies and procedures to handle mental health crises in their jurisdictions and community resources available to help them address individuals' mental health needs. Researchers found that mental health crises are a main concern of law enforcement in their communities, with a majority of respondents employing a specialized response to handle such incidents. Recommendations for policy and future research are discussed.

Introduction

Police and sheriff's departments often are called upon to assist individuals experiencing a mental health crisis. An estimated 7 to 10 percent of police-citizen interactions involve a citizen with a mental health disorder.[1] Further, researchers estimate officers are 1.4 to 4.5 times more likely to use force during these interactions, increasing the risk of harm for both the officer and the individual in crisis.[2] Since many of these incidents are not crime-related and do not necessitate formal legal action, law enforcement agencies have implemented specific protocols and procedures, or specialized responses, to properly address them. These responses aim to divert individuals from criminal justice involvement and into mental health services and treatment, as needed.

ICJIA researchers sought to gain a better understanding of how police and sheriff's departments in Illinois respond to mental health crisis incidents. Researchers conducted a statewide online survey to learn more about departments' policies and procedures, successes and challenges, and mental health services in their jurisdictions.

Literature Review

Contact with police officers or sheriff's deputies can be a crucial point at which to divert an individual experiencing a mental health crisis from formal involvement with the criminal justice system. Officers and deputies have significant discretion to determine the disposition of a mental health crisis incident, including which individuals are eligible for diversion to treatment and which require arrest.[3]

The goal of specialized responses is to make interactions between law enforcement personnel and individuals experiencing a mental health crisis safer and more efficient for all parties. Safety for all parties can be increased by reducing the number of incidents that require use of force. Efficiency can be improved by implementing a standardized protocol for crisis situations and, when possible, helping individuals avoid unnecessary involvement with the criminal justice system.[4] If a crisis incident is the result of a lack of access to treatment, connecting an individual to the appropriate mental health services may reduce repeat calls for service.

Two of the most common specialized responses are the crisis intervention team (CIT) model and the co-responder model. While some departments employ other models or variations, empirical research is largely limited to CIT and, to a lesser extent, the co-responder model.

Crisis Intervention Teams

The CIT model is a widely used specialized response, with as many as 3,300 programs in operation in the United States and abroad.[5] The model's two main components include training and collaboration with mental health service providers.

- **Specialized Training** – Officers and deputies receive training to recognize signs of mental health disorders, de-escalate crises, and utilize the mental health services in their specific community. Training typically is provided through a 40-hour course. Many departments make participation voluntary, while others require certain ranks or all

personnel to complete the training. Researchers estimate that training 15 to 25 percent of patrol officers should be enough to provide trained personnel to respond to all crisis incidents.[6] Emergency communications personnel, including call-takers and dispatchers, also should receive training to identify and dispatch CIT-trained personnel to calls that require a specialized response.

- **Community Mental Health Partnerships** – Collaborative relationships with community mental health service providers allow the CIT model to have an impact beyond officer training.[7] The functions of these partnerships are driven by the resources available in the community. Some common collaborative elements include a drop-off location with a no-refusal policy available to officers at all times and a streamlined intake process to increase efficiency for officers when dropping off an individual in crisis.[8]

Research on CIT. CIT can be considered evidence-based if the scope is limited to improving officers' knowledge and attitudes toward individuals with mental health disorders.[9] Empirical research consistently demonstrates officers who have completed CIT training display more positive attitudes toward individuals with mental health disorders, demonstrate greater knowledge regarding mental health disorders, and report feeling more confidence in their ability to handle mental health crisis situations.[10]

Research findings are mixed on whether CIT training impacts the arrest rate for individuals with mental health disorders. A systematic review did not find a significant difference in the likelihood of arrest between CIT officers and non-CIT officers.[11] However, in one study, CIT-trained officers were significantly more likely to transport individuals in crisis to a mental health or social service provider than officers who have not been trained.[12]

Analyses by the Washington State Institute for Public Policy suggested the CIT model has a benefit-to-cost ratio of a loss of $2.94 for every $1 spent.[13] However, other studies have reported department-level benefits resulting from the implementation of CIT, such as fewer utilizations of SWAT teams and fewer use of force incidents.[14]

Co-Responder Programs

The co-responder model is a specialized response in which mental health professionals provide direct assistance to officers handling crisis incidents. The joint response allows officers to address the initial safety concerns, both parties to collaboratively de-escalate the situation, and the mental health professional to facilitate access to appropriate treatment options.[15] This coordination improves efficiency; mental health professionals can navigate processes related to service providers and officers can more quickly return to law enforcement duties.[16] The Los Angeles Police Department exemplifies this model with its Systemwide Mental Assessment Response Team (SMART). The co-responder model also can be adapted to allow mental health professionals to provide consultation via phone or radio, rather than traveling to the scene of the incident.[17]

Research on co-responder programs. Research suggests co-responder programs improve access to mental health services for individuals in crisis.[18] Multiple program evaluations

demonstrated positive perceptions of the model from consumers, their families, and service providers.[19] However, some officers did not view co-responder programs as efficient with regard to officer time or effective in reducing arrests and improving public safety.[20] Other potential challenges include limited availability, with some programs operating only during certain hours, and protecting the confidentiality of health and legal information when cooperating with individuals outside of law enforcement to deliver crisis response services.[21]

Current Study

Methodology

ICJIA researchers created an online survey that was distributed by email through the Illinois Association of Chiefs of Police and the Illinois Sheriff's Association to their respective members in May and June 2018. A reminder email was sent in July and the survey closed in August.[22] The final dataset was extracted in August and responses were analyzed using Microsoft Excel and SPSS statistical software. The survey and its associated procedures were approved by the Illinois Criminal Justice Information Authority's Institutional Review Board prior to distribution. The survey was created and administered through Qualtrics, an online survey management program.

Departments were asked to designate the most knowledgeable person in this topic area to complete the survey. Respondents reviewed a consent form and affirmatively responded with their consent to continue the survey. Respondents could skip any question and continue the survey. A total of 49 questions were developed; however, filter questions and skip patterns were implemented, so no respondent would answer every question.

Sample Description

Seventy respondents answered some survey questions and 59 respondents (84 percent) completed the survey.[23] In one case, two individuals from the same agency completed the survey; researchers reconciled the two responses where possible, keeping answers that agreed and treating the rest as missing data.[24] *Table 1* provides information about the sample.

Table 1
Mental Health Crisis Response Survey Sample[25]

		n	Percent
Department Type (n=44)	Municipal Police Departments	25	56.8%
	Sheriff's Offices	16	36.4%
	Other	3	6.8%
Region (n=44)	South	4	9.1%
	Central	17	38.6%
	North	6	13.6%
	Collar	11	25.0%
	Cook	6	13.6%
Rurality (n=56)	Mostly Urban	27	48.2%
	Mostly Rural	24	42.9%
	Completely Rural	5	8.9%
Counties Represented		28	27.5%

Note: Department type "other" includes campus police and park police/rangers.
Note: Jurisdiction rurality was reported by respondents.

Main Findings

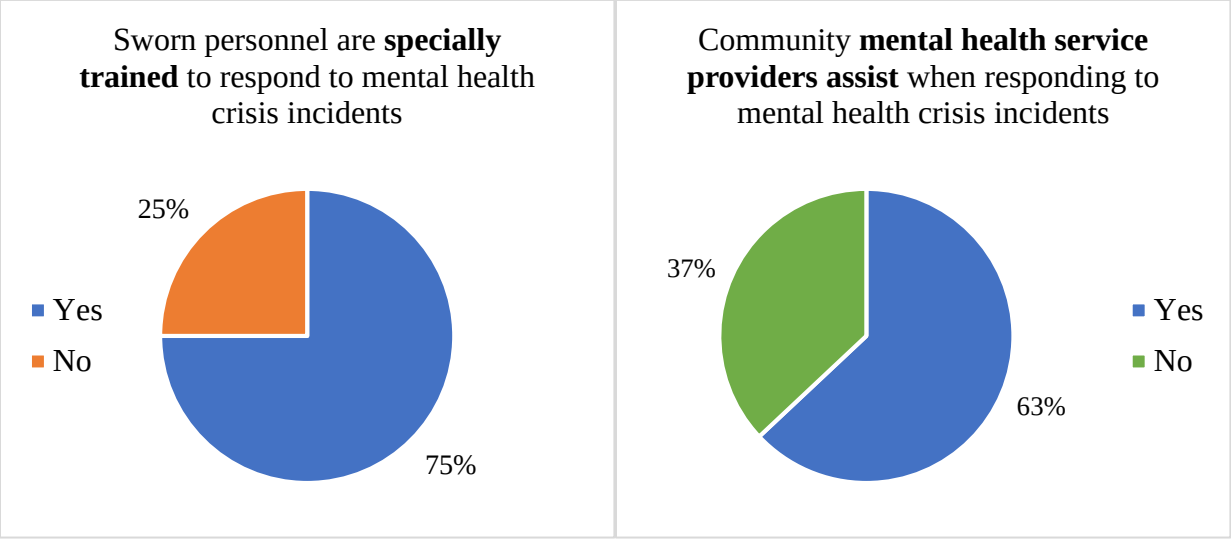
Community issues. An introductory question was asked to gauge the relative importance of mental health crisis responses compared to other issues departments face in the community. Sixty-eight percent of survey participants ranked responding to mental health crises as one of their top three priorities. Also cited as important was illicit drug use (50 percent) and domestic violence (43 percent).

Mental health training. In prior surveys, officers reported mental health crisis calls to be a difficult issue, due in part to a lack of adequate training on recognizing and appropriately responding to mental health disorders.[26] The present survey asked respondents to indicate in what settings sworn personnel receive training regarding mental health. All respondents selected at least one of the provided training settings. The most common responses were: training academy (n=51), in-service training (n=49), and specialized training (n=46). Respondents reported the highest average number of hours for specialized training (27 hours), followed by hours during training academy (10.2 hours) and hours of in-service training (9.9 hours).

A total of 75 percent of respondents reported at least some sworn personnel in their department were specially trained to respond to mental health crises. Sixty-three percent reported receiving

assistance from community mental health service providers when responding to mental health crises (*Figure 1*). This demonstrates a greater emphasis on training than on community provider partnerships. Collaboration with the mental health service providers is essential to reduce the burden on law enforcement and facilitate efficient access to treatment.[27]

Figure 1
Law Enforcement Response to Mental Health Crisis Incidents (n=63)



Source: ICJIA survey, 2018

Use of Crisis Intervention Teams. The CIT model has been widely adopted by police and sheriff's departments in the United States and around the world.[28] Forty-eight percent of respondents indicated their departments have a crisis intervention team (n=30), the most common type of specialized response reported by respondents. On average, 45 percent of sworn personnel were CIT-trained in each department sampled. Many CIT programs are voluntary; however, some departments are moving to train all sworn personnel to ensure sufficient coverage and enhance officer knowledge and public safety.[29] Forty-seven percent of respondents reported all sworn personnel in their department received CIT training (n=14), while another 47 percent reported only those who volunteer received CIT training (n=14). Forty percent of respondents reported not having enough CIT-trained personnel (n=12) due to lack of availability for CIT training (n=8) and lack of personnel to spare to attend training (n=5).[30]

Use of Co-Responder Programs. The co-responder model has been gaining popularity but existing research is limited.[31] Only 11 respondents (17 percent) indicated their department employs a co-responder model when responding to mental health crisis incidents. When asked to characterize the type of collaboration between their agency and community mental health service providers, the most common response was that mental health professionals are available to remotely assist, by phone, officers/deputies who are in the field (n=6). Respondents most commonly reported partnering with mental health professionals from another government agency (n=6) or from a private mental health provider (n=5); three respondents indicated their department employs a mental health professional.[32] Thirty-six percent responded

officers/deputies were required to complete training related to their co-responder program. When asked how often mental health professionals were available to assist with mental health crisis incidents as part of the co-responder program, 73 percent reported they are available "often" or "almost always" (n=8). No respondents indicated "rarely" or "almost never" for mental health professionals' availability.

Implementation and challenges of specialized responses. Specialized responses can be adapted to the individual needs and resources of a jurisdiction.[33] Respondents most commonly cited an increase in mental health crisis calls as the reason their department implemented a specialized response (n=37); 36 percent indicated national attention on the issue influenced their decision to implement their program.

A multidisciplinary group of partners is essential to provide a variety of perspectives that guide the development of a department's specialized response.[34] Mental health service providers were the stakeholders most often involved in planning, implementation, and maintaining ongoing partnerships throughout the creation of a specialized response. Stakeholders less commonly involved were individuals with mental health disorders and their families/loved ones.

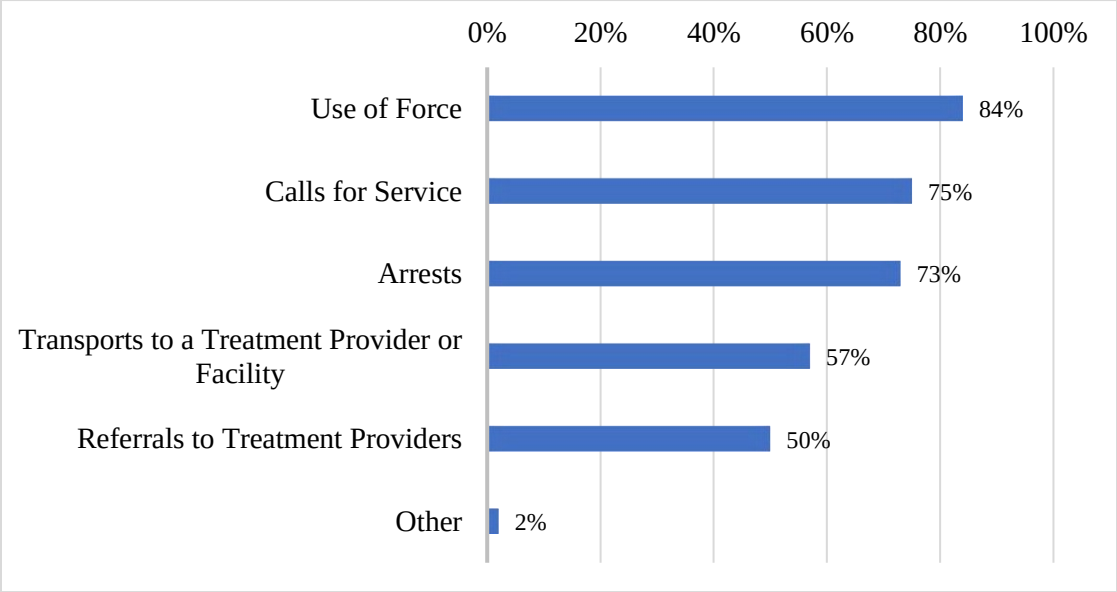
Transportation of individuals experiencing a mental health crisis was identified as a challenge for law enforcement. Respondents most often reported emergency medical services (EMS) as the entity responsible for transport (n=35), followed by law enforcement (n=25). The exchange of information between law enforcement and mental health professionals is important to provide an appropriate and efficient response to individuals with mental health disorders; however, this must be balanced with an individual's right to privacy and confidentiality.[35] Fifty-seven percent of respondents indicated that information-sharing with mental health service providers was a concern (n=25); however, most characterized the problem as "minor" or "moderate."

Measurement of outcomes related to program goals is critical to the evaluation of program success.[36] Respondents most commonly reported collecting data on use of force, calls for service, and arrests specifically related to mental health crisis incidents. Fewer departments collected information on referrals to or transportation to a treatment provider or facility (*Figure 2)*.

Training for groups other than officers/deputies, such as emergency communications personnel and emergency medical services, regarding specialized response protocols is a key component of an effective response.[37] Ninety-two percent of respondents reported that EMS personnel are trained to identify and respond to an individual experiencing a mental health crisis (n=22). Eighty-one percent said the emergency communications personnel (e.g. dispatchers, call-takers) they work with have received training on these topics.

Figure 2

Data Collected by Departments on Mental Health Crisis Incidents (n=44)



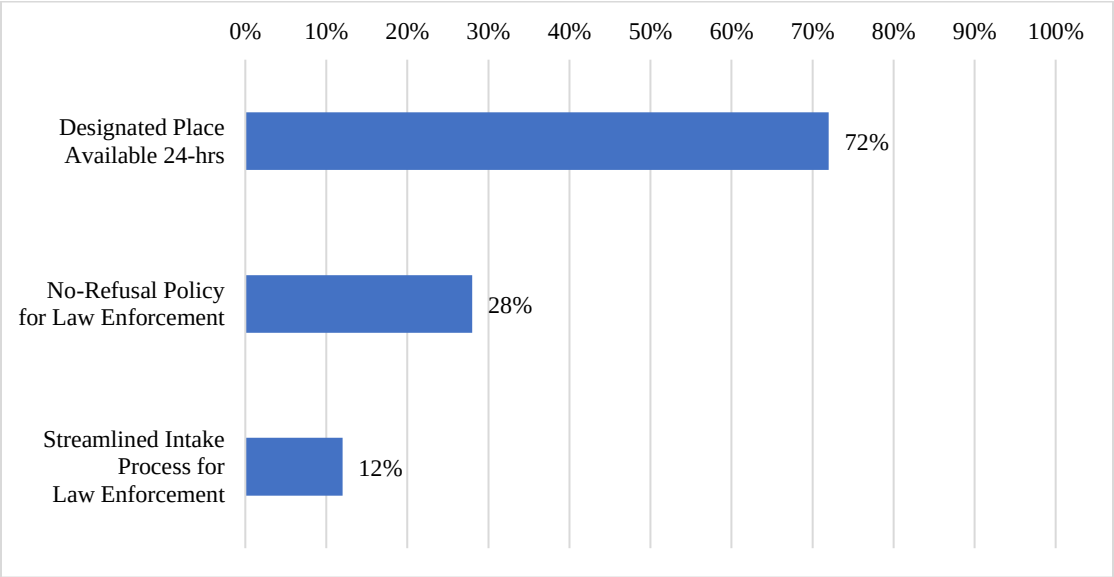
Source: ICJIA Survey, 2018

Departments without a specialized response. Researchers sought to gather information on departments that do not employ a specialized response and on any implementation barriers they may be experiencing. Twenty-nine percent of those surveyed reported following no specialized protocol or procedure when responding to individuals experiencing a mental health crisis (n=18). The most common reason cited for not having a specialized response was a lack of resources for program implementation (n=10). However, 73 percent of those reporting no specific protocol agreed that they would be interested in employing a specialized response if their existing limitations were resolved (e.g., resources were made available or more officers were able to attend training) (n=11); none responded that they would *not* be interested in a specialized response.[38]

Existing community mental health resources. The existence, capacity, and location of mental health service providers in a jurisdiction will impact how a department's specialized response operates.[39] Access to community mental health services varied within the sample. Seventy-two percent of respondents reported having 24-hour access to a service provider for individuals in crisis (n=42). Twenty-eight percent of respondents said they had access to a facility with a no-refusal policy for law enforcement (n=16) and 12 percent of respondents reported access to a facility with a streamlined intake process to increase efficiency for law enforcement during a drop-off (n=7) (*Figure 3).* Research on specialized response models has illustrated the importance of a centralized facility that possesses all three of the above traits; however, only two respondents reported access to all three resources.[40] Of respondents with none of the aforementioned resources, 36 percent reported a total absence of mental health services in their communities (n=5). Forty-five percent of responding departments reported conducting

community outreach on when and how to contact law enforcement if an individual is experiencing a mental health crisis (n=27).

Figure 3
Community Mental Health Resources Available to Law Enforcement (n=58)



Source: ICJIA Survey, 2018

Conclusion

Survey findings indicate police and sheriff's departments in Illinois have an interest in effectively handling mental health crisis incidents in their jurisdictions. However, departments often encounter challenges, such as limited budgetary resources and barriers to collaboration with community mental health service providers. While there is much variation in need and current operations among departments, researchers offer the following recommendations to develop the capacity of specialized responses and acknowledge common limitations.

Expand Specialized Responses to Mental Health Crisis Calls. Nearly 70 percent of the Illinois police and sheriff's departments that responded to this survey cited mental health crisis response as one of the most important issues for their department, and many ranked it as the top issue. Nationally, as many as 10 percent of police contacts involve a citizen with a mental health disorder.[41] In this statewide sample, departments with a specialized response cited an increase in mental health crisis calls as a basis for implementation.

CIT was the most common type of specialized response; however, many agencies reported needing more CIT-trained officers. While research suggests training 15 to 25 percent of patrol officers should be sufficient to meet the needs of the community, the required number for each jurisdiction will vary based on size, mental health resource locations, and frequency of crisis incident calls for service.[42] Further research is needed to ascertain the influence of those factors and provide more individualized recommendations to departments.

Departments that reported an unmet need for a specialized response most commonly cited a lack of resources as a barrier. While opportunities may exist to increase available departmental resources, partnerships at the local level have the potential to mitigate barriers to operating a specialized response and enhance a department's capacity for effective responses.

Emphasize Community Mental Health Partnerships. Emphasizing local mental health service provider partnerships can increase capacity to handle mental health crisis incidents while reducing the burden on law enforcement. While 75 percent of respondents indicated their officers received training on responding to mental health crisis incidents, just 63 percent reported receiving assistance from community mental health providers when responding to crisis incidents. This exemplifies that partnerships are not currently employed to the same extent as officer training.

Proponents of CIT emphasize the model is "more than just training."[43] A department focus on training is understandable, as processes and decision-making are largely within the control of the agency. The focus on training was demonstrated by the 14 departments in this sample that required CIT-training for all sworn personnel. However, this level of training is not feasible or necessary for all jurisdictions. Cost-benefit analyses have demonstrated law enforcement agencies are often solely responsible for the cost of officer training, while much of the potential savings will be accrued by agencies in other fields (e.g. healthcare).[44] Ideally, coordinating with stakeholders involved in all stages of mental health crisis incidents will allow for consideration of how the benefits and burdens can be more equitably distributed.

The efficacy of the response is limited if the response protocol does not extend beyond an interaction with an officer. Crisis incidents can be an opportunity to facilitate linkage to a mental health service provider. Law enforcement collaboration with service providers in the community is key to developing procedures that encourage service linkage and improve efficiency for all parties. Service providers that streamline the intake process can simplify the officers' role when they drop off an individual experiencing a mental health crisis. This can be accomplished at little to no cost and removes a potential barrier to law enforcement diverting an individual to services.

Enhance Program Sustainability. Community ownership is an important part of successful specialized responses. This shared commitment provides an ongoing dedication to the response that is able to withstand potential turnover in individual stakeholders.[45] Many respondents reported consulting with mental health service providers and law enforcement agencies in other jurisdictions on how to implement and employ a specialized response. However, individuals with mental health disorders, or "consumers," and their families were less often involved in these processes. Consumers and their loved ones can provide valuable input when developing a specialized response. Consumers should have an opportunity to provide ongoing feedback even in jurisdictions with a response protocol already in place. By cultivating buy-in among a broad and diverse group of stakeholders, support for the specialized response can be developed and sustained at the community level.

The variability in specialized responses reported in this study indicates how responses can be customized to meet the needs of each jurisdiction. When adapting or altering a specialized response model, it is important to track outcome measures to determine whether the changes produced the intended impact. Respondents reported collecting information on calls for service, arrests, and use of force; however, fewer indicated they have data on referrals to mental health treatment or transports to treatment providers. Information in this area is critical to understanding whether the partnership between law enforcement and service providers is being fully leveraged and the response is increasing access to mental health treatment for individuals in crisis. Integrating more data collection into the specialized response process will provide for more rigorous research on whether departments are achieving their intended goals. Employing high quality data in ongoing program evaluation will allow for improvements in the response's efficiency and effectiveness, making the model more sustainable.

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[22] Note: Researchers made targeted follow-up efforts with departments that had the most arrests for UCR index offenses in 2015 (the most recent year for which data were available), because it

was assumed these departments would have the most opportunities to receive mental health crisis calls.

[23] Note: This response rate is slightly below the typical response rate for online surveys, which is generally about 10 to 15 percent. A low response rate can limit the generalizability of survey findings, so the results here should not be assumed to be indicative of all police and sheriff's departments.

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Note: Of the 11 who did not complete the entire survey, four answered more than 50 percent of all questions and seven completed at least one question, but less than 50 percent of all questions.

[24] Note: Due to the method of distribution and functionality of the survey, there was no feasible way to entirely prevent this issue. Researchers chose this course of action to avoid discarding all data from two responses and also avoid the bias of selecting only one of the responses to represent the jurisdiction.

[25] Note: Respondents could complete the survey anonymously, if desired. Fourteen respondents (24 percent) chose not to provide their department name. Department type, region, and county were only available for respondents who provided their department name.

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