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A descriptive evaluation of the Seattle Police Department's crisis response team officer/mental health professional partnership pilot program☆,☆☆,★

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ABSTRACT

The Seattle Police Department (SPD) recently enhanced their response to individuals in behavioral crisis through a pilot Crisis Response Team (CRT) consisting of dedicated Crisis Intervention Team (CIT) officers (OFC) paired with a Mental Health Professional (MHP). This study presents results of an incident-based descriptive evaluation of the SPD's CRT pilot program, implemented from 2010 to 2012. The purpose of the evaluation was to determine the value-added by the MHP in cases involving individuals in behavioral crisis as well as the effectiveness of the CRT program with regard to resolution time, repeat contacts, and referral to services. Data were collected from SPD general offense and supplemental reports for a 12-month segment of the program. Key variables included incident location, case clearance, repeat contacts, linkages to services, and case disposition. Results of analyses of general offense and supplemental reports are presented and implications for future development of the OFC/MHP partnership are discussed.

1. Introduction

The Seattle Police Department's (SPD) Crisis Response Unit (CRU)[1] was implemented in 1998 to implement the Crisis Intervention Team (CIT) model to improve the police response to individuals in behavioral crisis. The Seattle Police Department's Crisis Intervention Policy[2] defines individuals in behavioral crisis as people exhibiting signs of mental illness, as well as people suffering from substance abuse and personal crises. The CRU is comprised of CIT trained officers responsible for follow-up involving individuals in behavioral crisis. The CRU officers are part of a larger cadre of CIT-trained officers within the Seattle Police force who

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[1] During the study period, the CRU was referred to as the "Crisis Intervention Team" (CIT) Unit. The SPD CIT Unit was renamed the "Crisis Response Unit" (CRU) and the OFC/MHP Team is referred to as the "Crisis Response Team" (CRT) in the new SPD CIT Policy developed in 2015. To avoid confusion and for continuity in future research, the terms used in the current SPD CIT policy will be used in this paper.

[2] The Seattle Police established a Crisis Intervention Committee in 2013 to make improvements to the implementation of the CIT model in Seattle Police Department. A new CIT Policy was developed and is expected to be approved and effective in 2015. For an earlier draft of the policy, see: http://static1.squarespace.com/static/5425b9f0e4b0d66352331e0e/t/542ae365e4b0957885ec68f5/1412096869192/Crisis_Intervention_Policy_Final_Draft_12-16-13.pdf.

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have advanced training in dealing with individuals in behavioral crisis. At the time of this study, 365 (28%) of the department's 1296 officers were CIT-trained officers.[3] The CRU is operated by a sergeant and two officers assigned full-time to crisis intervention who follow up on cases, working with individuals in behavioral crisis to help them stay connected with social service agencies, and serving as a liaison between family members and the Seattle Mental Health Court.

In 2010 the SPD launched a 24-month Crisis Response Team (CRT) pilot program comprised of members of the CRU and a licensed mental health professionals (MHP) trained in crisis assessment, intervention, and resource referral for individuals in behavioral crisis. The CRT pilot program was a long awaited enhancement to the SPD implementation of CIT model that brought the MHP staff-member to the CRU to partner with CIT-trained law enforcement officers. The purpose of the CRT pilot was to assist field officers when they encounter an individual experiencing behavioral crisis. The goal of the pilot program was to improve police response in situations involving mentally ill and chemically dependent individuals through specialized mental health provider response in the field. The MHP takes direction from the CRU sergeant and works in collaboration with a sworn officer/partner (OFC) to exercise their professional discretion in day-to-day contacts with street-level mental health and chemical dependency problems. The MHP role includes assessment and referral of individuals to community based resources with the idea that a mental health professional will be able to better meet the housing, mental health, substance abuse and other needs of individuals in behavioral crisis. Ultimately, the objective of the addition of the MHP to the CRU is to help avoid the use of jail or hospital emergency rooms when appropriate.

While there are many law enforcement units based on the CIT model across the country, few jurisdictions have implemented programs partnering law enforcement with mental health providers where the MHP holds a full-time position and is assigned cases. The current state of knowledge about implementation of the CIT model in law enforcement and partnerships with mental health professionals is primarily anecdotal. Evaluations of CIT programs to date have not included control groups with rigorous experimental methods because CIT and other such criminal justice interventions are implemented in real-world settings and as such have been very difficult to study (Neidhart, 2013).

This study presents evaluation results from a 12-month implementation period of the CRT pilot program (January 2011–December 2011) describing the pilot and contributions of this enhancement to implementation of the CIT model in law enforcement interactions with individuals in behavioral crisis. While this evaluation is incident-based and descriptive in nature, the results provide valuable information to assist agencies in determining the benefits of a CRT program, and in making resource decisions about law enforcement/mental health partnerships.

In the next section, we provide a brief review of literature focused on the implementation of the CIT model in law enforcement. We then provide a detailed background on the implementation of the CIT model in Seattle, the development of the CRU, and the transition to the CRT pilot program. Following this, we describe our methods and results, and then discuss the findings and their implications for future programs.

2. Literature review

A variety of innovative models have arisen as communities search for more effective ways to respond to police calls involving people with severe mental health and/or chronic substance abuse issues (Compton, Bahora, Watson, & Oliva, 2008; Deane, Steadman, Borum, Veysey, & Morrissey, 1999; Reuland, Draper, & Norton, 2010). Some have focused primarily on the law enforcement side with formal mental-health training for police officers such as the use of CIT programs. Others have relied on those in the mental health community to be available to respond and assist in these police calls in the form of Mobile Mental Health Crisis Teams. Another model that has evolved is the pairing of a law enforcement officer with a MHP to respond to these crisis situations and/or provide preventative intervention and follow-up, utilizing the professional skills from both sides to best resolve the incident. Sometimes a combination of these models is used within one community, such as those communities having CIT trained police officers as well as a dedicated team of an officer paired with a mental health worker to respond to certain high-crisis situations. All have at their core a common goal of obtaining the needed treatment for these individuals, reducing the frequency of their arrests and incarcerations, and ultimately reducing the frequency of their contacts with law enforcement over the long term.[4]

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

Other communities take a different approach with their teams focusing more on follow-up and preventive intervention. Many of the individuals in behavioral crisis who come into contact with police are "frequent-fliers" — people who are well-known to both the law enforcement and the mental health communities. These individuals exhibit persistent, though mostly misdemeanor offense behaviors that consume a disproportionate amount of police response time over the long term (Reuland, Schwarzfeld, & Draper, 2009). These individuals have been referred to in the literature as "mental health frequent presenters" (MHFP) who are mentally ill or disordered, have multiple needs, and are frequent presenters in emergency services (Andrews & Baldry, 2013). There is increasing and widespread evidence nationally and internationally attesting to the overrepresentation of individuals with complex needs and cognitive disability and disadvantage in the criminal justice system (Baldry & Douse, 2013). Some groups such as Akron, OH's CIT Outreach team and Pasadena, CA's Homeless Outreach Psychiatric Evaluation (H.O.P.E.) team have found that focusing their efforts on these "high-utilizers" before another incident occurs, by periodically checking in on them and their case-workers, doing "knock and talks" and making sure they are getting the services they need, can result in a reduction in law enforcement incident calls regarding these individuals (Criminal Justice/Mental Health Consensus Project, 2011; Reuland et al., 2010).

Abbotsford, BC, a community where 1 in 10 police calls involve individuals with mental health issues, considered their LE/MH program a success after one year and was considering program expansion. Case examples from the Abbotsford LE/MH program show that intervention and follow-up on an individual in behavioral crisis who had in the past generated an average of 100 calls to police, not only had substantially reduced the calls to the police about this individual but also had

[3] Currently 411 of 1130 officers (36%) have completed the 40-hour CIT training. This is expected to increase as the Seattle Police have increased the number of CIT-trained officers as an outcome of the new Crisis Intervention Policy developed.

[4] See Compton et al. (2008) for a comprehensive review of CIT Programs.