Emerging Needs for Crisis Intervention Teams

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Abstract

Law Enforcement and Corrections have a substantial level of contact with the mentally ill. These contacts have been increasing with the decline of in-patient treatment institutions. The level of use of force incidents and resultant injury to officers and the mentally ill in law enforcement/citizen contacts must be mitigated. A murder of a Police Officer in New Orleans highlights the situation. There are significant legal considerations. Law enforcement agencies need to train officers in ethical and constitutional interactions with the mentally ill, and develop appropriate policies and procedures. The Crisis Intervention Team model has proven to be successful in helping address the issue in both the field and in the corrections environment. An application of the model in a representative agency is discussed.

Emerging Needs for Crisis Intervention Teams

An issue that rose to prominence in law enforcement in the 1960s and continues to this day is law enforcement contact with, and subsequent incarceration of, subjects with serious mental illnesses. Some studies indicate that as many as one in ten field contacts are with individuals who are seriously mentally ill (Deane, Steadman, Borum, Veysey, & Morrissey, 1999). Other studies indicate that over 11% of use of force incidents for a sampling of agencies involved mentally ill suspects and of those, 12% resulted in injury to an officer and 28% in injury to the suspect. This compared to 7% and 18% respectively for non-mentally ill suspects (Morabito & Socia, 2015).

As law enforcement officers have largely become “first line mental health workers” and as the number of violent encounters with the mentally ill has increased, along with incarceration rates rather than hospitalization, a need for a unified and effective means to aid officers in dealing with the mentally ill has become pressing.

There are significant legal precedents to demonstrate the need for equipping officers and agencies to effectively deal with the mentally ill. An agency that neglects this could experience significant liability.

A tragic event in Memphis, Tennessee in 1987 involving the death of a mentally ill subject and the resultant public outcry, lead to the creation of the multidisciplinary Crisis Intervention Team or “CIT.”

Brief Historical Context

In the 1960s, a large effort to deinstitutionalize the nonviolent mentally ill took place. Large numbers of the mentally ill were released from in-patient mental hospitals and many of the hospitals were subsequently closed. The goal was to have these subjects receive community based treatment by diverting the resources formally used to house and treat them. These funds and programs never fully materialized in many parts of the country resulting in a large population that received no or inadequate treatment. Many were unable to adequately provide for themselves and many of their families were unable to provide the level of care they needed. This resulted in a poor quality of life, marginalization and even homelessness for a substantial number of these individuals (CIT History, n.d.).

Furthermore, this resulted in a large and rapid increase in the numbers of field contacts between ill-prepared law enforcement officers and the mentally ill, as offenders and victims, as well as dramatic increases in incarceration of the mentally ill due to a lack of appropriate mental health based solutions (CIT History, n.d.).

In September of 1987 Memphis police officers, responding to a call of a suicidal subject in a public housing project, encountered a man who was wielding a knife. Officers stated that he was cutting himself and charged towards them before he was fatally shot. He was 27 year old Joseph Robinson who had a long history of mental illness. The shooting was extremely controversial in Memphis. Many members of the community believed that other options could have been utilized that could have prevented the shooting (Jones, 2016).

This case and the subsequent outcry lead to the formation of a community task force that included wrap-around services such as law enforcement, mental health professionals and mental health advocates. Their goal was to find a model that would increase safety of police officers and

the mentally ill during contacts. Under the appropriate circumstances, that would divert those with mental illness from the criminal justice/incarceration path into the mental health system. The fruits of this effort have become known as the Memphis Crisis Intervention Team or "CIT." (Watson & Fulambaker, 2013). Today the "Memphis Model CIT" has been adopted by over 2,000 communities in more than 40 states (CIT History, n.d.).

In 1988, Major Sam Cochran of the Memphis Police Department and Randolph DuPont with the University of Memphis met the challenge by designing and promoting the core elements of CIT. Due to the consistent reduction of available psychiatric services throughout the United States, the need for such a program was well received. The Memphis model suggests that at least 40% of a police department should be trained in CIT and that CIT officers volunteer for the position of CIT Officer. CIT Officers should request to be CIT trained and not just assigned to the position without their full approval and interest (Dupont, Cochran, & Pillsbury, 2007). Dupont and associates described three required core elements for a successful CIT program. These must be ongoing (e.g., partnerships, community ownership, policies and procedures), operational (e.g., CIT, curriculum: CIT Training, Mental Health Receiving Facility), and, sustaining (e.g., evaluation and research, In-Service Training, recognition and honors, outreach). These researchers further indicate that CIT international promotes the program in five categories to include police training, community collaboration, vibrant and accessible crisis system, behavioral health staff training, collaboration and education for families, consumers (i.e., mentally ill), and advocates.

Case Study 1 (Field Operations)

On January 28, 2008 at approximately 0930 hours New Orleans Police Officer Nicola Cotton was dispatched to the 2000 block of Earhart Boulevard regarding a black male suspect who matched the description of a rape suspect.

The black male suspect, Bernel Johnson, was sitting on the curb by a strip mall with luggage by his person. This Bernel Johnson was not the rape suspect as that man's name was spelled Bernell Johnson, with two "l's". According to Eaton (2008,) Bernel Johnson suffered from untreated psychosis and on January 8, 2008 he was forcibly committed to the state mental health care system. For reasons unknown, Johnson was released from custody. Johnson was diagnosed with paranoid schizophrenia at the age of 19 and spent 26 years of his adulthood in a cycle of jails, mental hospitals and homelessness. Johnson's family had long struggled to get him mental health assistance and was told he wasn't eligible unless he hurt someone. Johnson had diagnoses of paranoid schizophrenia, delusions, and suicidal tendencies and had multiple drug overdoses. Family reported that Johnson would take his prescribed medications while incarcerated or in a mental health facility, but upon his release would stop taking his medications and suffer relapses.

According to McCarthy (2008), video surveillance footage from a nearby convenience store shows Officer Cotton and Johnson struggling for roughly 7 minutes. Johnson eventually wrestled Officer Cotton's duty weapon away from her possession and shot her multiple times. After Officer Cotton fell to the ground, Johnson stood over her and emptied her department issued Glock 40 into her body. Responding New Orleans officers were met with Bernel Johnson holding her weapon by the handle. He gave the weapon to officers with no resistance. Officer Cotton died shortly later at University Hospital.

Officer Cotton had a working relationship with James Arey who is a Psychologist and the Commander of the NOPD Crisis Negotiation Team. According to Eaton (2018) James Arey was quoted saying, “The State of Louisiana had ample time to figure out this guy, and because they weren’t doing their job, this officer, my friend, is dead.”

According to Filosa (2010) on September 2, 2010, Bernel Johnson was ruled “irrestorably incompetent“ and ordered into custody of the state Department of Health and Hospitals under a civil commitment and will live at the forensic hospital in Jackson, Louisiana indefinitely.

According to Eaton (2008), this incident occurred at a time when local residents were rebuilding their lives after the destruction of Hurricane Katrina. Katrina caused many residents to seek mental health treatment due to being alone and having lost most, if not all, of their personal possessions. Many also state that New Orleans has attracted transients with mental health issues. Prior to Katrina, New Orleans had roughly 555 public and private inpatient psychiatric beds and in 2008 the city had roughly 268. Many facilities closed after Katrina and never reopened and the already thin resources for mental health became even more scarce. During this period the Orleans Parish Prison was serving as the holding area for mental patients which also caused huge issues with jail overcrowding and forcing the jail to release inmates.

This case study shows just one example of how a young Police Officer was killed during an encounter with a mentally ill individual who was not receiving adequate treatment. According to Kulbarsh (2010) approximately 1,500 homicides yearly in the US are committed by individuals with psychiatric disorders. 13% of in the line of duty deaths are at the hands of the mentally ill. Approximately 4.5 million Americans have a severe mental illness. According to the

Treatment Advocacy Center's website, people with untreated mental illness are 16 times more likely to be killed by law enforcement.

Case Study 2 (Corrections)

Here is a description of an issue at the Lafourche Parish Detention Center in Thibodaux, La. Mr. James Soco, a military veteran with a history of bipolar disorder, had his fair share of run-ins with the local law enforcement dating back to 1999. Mr. Soco had 62 separate incidents resulting in 7 different extended jail stays-his last arrest led to 177 days on administrative segregation due to his inability to function in general population and to ensure his safety and well-being. Because he suffered from mental illness, his behavioral outbursts banned him from many public places over the years, and his return to those areas caused his incarceration and ties to the criminal justice system. Understanding his continuous conflicts with law enforcement and the criminal justice system stems from his mental health illness, LPSO reached out to the Veteran's Affairs (VA) for help because there were no other formalized options or established systems in our parish. Under the assistance of the VA office and a local judge, once he was released from custody, Mr. Soco was placed into assisted living. To this date, Mr. Soco has not had any further encounters with law enforcement.

In addition, at The Lafourche Parish Detention Center in 2017, 421 inmates presented mental health illness- 35% were females and 65% were males. Of those mental illness classifications, 26% were placed on suicide watch while 13% were repetitive mental illness offenders.

Due to cases like Mr. Soco and the continuous growth of incarcerated persons with mental health illness, the Lafourche Parish Sheriff's Office is in the planning stages of developing and introducing the CIT program in Lafourche Parish.

Legal Considerations

Law enforcement's interactions with the mentally ill present many legal challenges as well. These legal challenges vary widely depending on the location of the interaction and the circumstances surrounding the interaction. In a corrections setting, one set of legal considerations are applicable while interactions on the street require another set of legal considerations. For law enforcement agencies to avoid civil liability for civil rights violations, agencies need to train their officers in crisis intervention and the needs of the mentally ill to ethically and constitutionally interact with them in both settings.

When an arrestee is booked into a correctional facility with a history of mental illness, the law enforcement agency has a duty to protect the health and safety of that inmate (Farmer v. Brennan, 511 U.S. 825, June 6, 1994). Officers must determine if this person is currently being prescribed medication for a mental illness, when it was last taken, what medications need to be prescribed, and how soon they need to be administered. If this medication is not administered as prescribed, the agency must know if the withdrawal symptoms can be serious. Officers must also ascertain if the subject is suicidal or wants to hurt himself or herself upon intake to the facility. For officers to understand the importance of gathering this information, agencies should explain the "why" to their officers (Sinek, 2011).

Without knowing the answers to these questions, a law enforcement agency can lose millions of dollars in a single lawsuit for civil rights violations. For example, if a mentally ill inmate dies from drug withdrawal symptoms, the agency may be liable (Jacobs v. Trochesset, 2016 U.S. Dist. LEXIS 152111 (U.S.D.C. S.D. Tx., Galveston Division, November 2, 2016) [where a drunk driver died from a withdrawal form Benzodiazepines (Xanax) he had been taking for severe panic disorder and anxiety.] There, the court found that abrupt disruption of Xanax may have led to seizures, and many other dangerous side effects. These known and foreseeable symptoms may have been avoided by tapering the patient off the medication, under physician supervision.

Agencies have incurred liability where an inmate came into the jail with a valid prescription for Klonopin and its policy required that he be taken off the Benzodiazepine. The policy did not provide either an independent medical examination prior to making that decision or a replacement to treat the inmate's Tourette's syndrome (Treadwell v. McHenry County, Illinois, 13 C 50077, 193 F. Supp. 3d 900, 2016 U.S. Dist. LEXIS 111087, 2016 WL 4394514, at *5 (N.D. Ill. June 20, 2016). Likewise, an on-going failure to provide mental health treatment to an inmate with severe depression, hallucinations, acute anxiety, and feelings of hopelessness and helplessness that required medical attention can be a constitutional violation of the inmate's rights because of the serious danger posed by these conditions (Depaola v. Clarke, 2018 U.S. App. LEXIS 5962 (4th Cir., March 9, 2018).

In addition, if an inmate expresses his desire to harm himself to officers at a facility and later commits suicide, the agency may be liable for failure to protect the health and safety of that inmate. The agency may be deemed liable for failure to properly isolate that inmate and

keep that inmate under observation in a safe cell until a psychiatrist could evaluate him or her and decide on medication. (Jacobs v. West Feliciana Sheriff's Dep't, 228 F.3d 388 (5th Cir. September 13, 2000).

In a patrol setting, use of force legal issues arise involving the mentally ill. Compton and associates (2011) found that CIT-trained officers are less likely to endorse the use of force as an effective method of gaining compliance from persons with mental illness. They found that when officers were given a hypothetical vignette to analyze concerning a person with mental illness, and asked to select appropriate action steps, CIT trained officers selected actions characterized by a lower use of physical force than non-CIT trained officers, and CIT trained officers perceived nonphysical actions as more effective than non-CIT trained officers. Other research (see Morabito, Kerr et al., 2012) used similar methodology and found that CIT-trained officers were slightly more likely to endorse the use of force. Kohrt and associates (2015) reported that, in West Africa, officer's knowledge of mental health increased and relationships were fostered between officers and mental health clinicians after the implementation of CIT.

Federal courts have questioned the constitutional use of force by police against the mentally ill. For example, in the case of Estate of Armstrong v. Village of Pinehurst, 810 F.3d 892 (4th Cir. January 11, 2016), police responded to a mental patient escaping from a hospital. The patient grabbed a sign post near a roadway and would not let go despite police demands. Police tased him.

In evaluating the claim of excessive force, the courts reasoned that Armstrong's mental health was one of the facts and circumstances that a reasonable officer on the scene should have ascertained. Further, the court provided that the problems posed by, and thus the tactics to be employed against, an unarmed, emotionally distraught individual who is creating a disturbance or

resisting arrest are ordinarily different from those involved in law enforcement efforts to subdue an armed and dangerous criminal who has recently committed a serious offense. The court examined numerous cases from around the country addressing use of force against the mentally ill. The court stated that the use of force that may be justified by the government's interest in seizing a mentally ill person differs both in degree and in kind from the use of force that would be justified against a person who has committed a crime or who poses a threat to the community.

The court reasoned that increasing the use of force may, in some circumstances, exacerbate the situation. Accordingly, the use of officers and others trained in the art of counseling is ordinarily advisable, where feasible, and may provide the best means of ending a crisis. The court emphasized that even when this ideal course is not feasible, officers who encounter an unarmed and minimally threatening individual who is exhibiting conspicuous signs that he is mentally unstable must de-escalate the situation and adjust the application of force downward.

The Armstrong court also held that where a seizure's sole justification is preventing harm to the subject of the seizure, the government has little interest in using force to effect that seizure. Rather, using force likely to harm the subject is manifestly contrary to the government's interest in initiating that seizure. When a mentally disturbed individual not wanted for any crime is being taken into custody to prevent injury to himself, directly causing that individual grievous injury does not serve the officers' objective in any respect. The court also provided that the level of force an individual's resistance will support is dependent on the factual circumstances underlying that resistance. And, here, the factual circumstances demonstrate little risk -- Armstrong was stationary, non-violent, and surrounded by people willing to help return him to

the hospital. In light of all these circumstances, the court held that the level of force officers chose to use (tasing) was not objectively reasonable (Estate of Armstrong v. Village of Pinehurst, 810 F.3d 892 (4th Cir. January 11, 2016).

Based on the above analysis, law enforcement agencies need to have leaders that are agents for change and step up to lead and train officers in ethical and constitutional interactions with the mentally ill, and develop appropriate policies and procedures. One means of accomplishing this is to train officers in crisis intervention and the needs of the mentally ill. By this means, law enforcement agencies can assure ethical and constitutional treatment of the mentally ill and avoid civil liability.

Diversion Initiatives

Diversion programs are initiatives in which persons with serious mental illness who are involved with the criminal justice system are redirected from traditional criminal justice pathways to the mental health and substance abuse treatment systems. The use of diversion initiatives is to reduce recidivism and to reduce incarceration among adults with serious mental illness with justice involvement. Evidence has found that diversion initiatives have garnered much interest as a strategy for reducing the presence of persons with mental illness in the criminal justice system. Mental health diversion programs provide treatment-based alternatives to criminal sanctions for persons with serious mental illness who have come into conflict with the law.

There is a wide range of diversion models in operation across jurisdictions in the United States. Although they vary in their structure and procedures and operate from different juncture points with the criminal justice process, all have at their core the idea that persons with severe

mental illness should be handled through the mental health system rather than the criminal justice system. These initiatives operate on the premise that individuals with mental illness who come into conflict with the criminal justice system do so because of their illness and therefore require treatment rather than criminal sanctions. It is believed that linking the mentally ill accused and offenders to community-based treatment services will have the effects of reducing police contact and the likelihood of criminal recidivism. Concomitantly, shifting the focus of intervention to community-based mental health treatment services may also provide potential benefits for crowded jails that lack facilities to treat this population adequately, as well as for overburdened courts.

Jail diversion initiatives have arisen as a result of concern that people with serious mental illness are grossly overrepresented in the criminal justice and correctional systems. Estimates of the prevalence of serious mental illness among jail inmates and prisoners within the United States vary between 6 and 18 %, depending on the methodology, setting, and precise definition of serious mental illness. Prevalence rates are estimated to be two to five times higher than in the general population. In addition to prevalence rates, data on length of incarceration within the U.S. indicate that individuals with serious mental illness serve a disproportionate amount of time in jail and prison compared with individuals without mental illness. Evidence from the work of Compton and associates (2008) and Heilbrun (2012) suggests that CIT increases the connection of persons with mental illness to psychiatric services or diverts them to services instead of jail. Studies within the United States have found that between 28 and 52 % of persons with severe mental illness have been arrested at least once.

Community Collaboration

Crisis Intervention Team (CIT) Model is a solution focused community response to helping people with mental illness. CIT programs bring stakeholders together from the law enforcement, behavioral health and advocacy sectors, along with people with live experience with mental illness, to develop solutions for safely re-directing people in crisis away from the judicial system and into the health care system whenever appropriate.

Community oriented policing is vitally important to successful CIT programs in building relationships and breaking down silos between organizations and stakeholders. Community ownership should occur in all phases of CIT programs…initial planning, curriculum development, policies and procedures, and ongoing problem solving. This broad-based, grassroots community collaboration is what makes CIT programs sustainable over time.

An outcome of productive community collaboration is the transformation of crisis response systems that are vibrant, responsive and easily accessible. Communities should work to provide a 24/7 crisis response, a "no wrong door" philosophy, and a quick turnaround time to get first responders back on the streets.

As members of the CIT, law enforcement and other first responders are trained through a 40 hour training curriculum designed to be taught by local specialists from law enforcement, behavioral health and the mental health advocates. Upon completion of this training, officers and first responders are better equipped to understand common signs and symptoms of mental illnesses and co-occurring disorders; recognize when those signs and symptoms represent a crisis situation; safely de-escalate individuals experiencing behavioral health crises; and utilize community resources and diversion strategies to provide assistance. Law enforcement and first

responders who volunteer to be identified as part of CIT are skilled and passionate about responding to these calls.

It is imperative that behavior mental health professionals develop an understanding of the role of law enforcement and first responders, and why they are trained to respond in ways that they do. This understanding helps to provide insight and gain appreciation for what can otherwise be a cultural divide. It is highly recommended that mental health care providers conduct ride-alongs with law enforcement officers. It is equally important for law enforcement officers to shadow mental health providers. In addition, it is important that law enforcement officers provide training to front-line behavioral health workers on law enforcement culture. The ultimate goal is to have a deeper understanding and appreciation of one another's roles which leads to improved collaboration, and an effective CIT.

People with lived experience provide valuable insight. Consumers and family members are key resources in advocating for the success of CIT programs and improved crisis services. Their involvement helps to form understanding of how law enforcement is trained, building reasonable expectations of what to anticipate when law enforcement is called to an incident.

Alabama CIT

The problems we have been discussing regarding the incarceration of mental health consumers, as well as the lack of available services, is affecting law enforcement all across the country. The liability concerns we have addressed became a great concern to Sheriff Derrick Cunningham in Montgomery County, Alabama.

Over the last several years, Alabama has closed 90% of the state mental health facilities. These closures occurred after legislation was enacted that required law enforcement officers to

take several specific steps when they came into contact with person(s) they had reason to believe were suffering from mental illness. In the event that they believed the individual was likely to be of immediate danger to themselves or others, the law enforcement officer was to make contact with a Community Mental Health Officer (CMHO). In theory, the CMHO was someone who had received specialized training in the field of mental health. The training was similar to the CIT training that we recognize today. The law required that the CMHO join the law enforcement officer at the scene to determine if care was needed by a designated mental health facility. If the CMHO determined that the person appeared to be mentally ill and posed a danger to themselves and others, the officer would be directed to take the person into custody and, together with the CMHO, deliver the person directly to the designated mental health facility. In many cases there is no private insurance which requires the states or agency to be responsible.

Once additional evaluations were conducted at the mental health facility, the personnel on staff would determine if admission was necessary. If so, they would be admitted, otherwise it was the responsibility of the law enforcement officer to release the individual. In cases where admission was granted, it was the responsibility of the CMHO to file a petition for commitment with the probate court on the person by parties in interest. If no family member or other responsible party came forward to timely file the petition, the CMHO would file the petition in his or her official capacity no later than the second business day following the date of admission.

The legislation required the CMHO to then conduct follow up appearances at designated intervals before the County Judge of Probate in order to testify and assist the Judge with the proper determination of care (AL Crim Code 22-52-91). The lack of qualified and trained CMHO personnel as well as the aforementioned closures of the majority of mental health facilities, made this legislation very impractical and in many cases impossible to adhere to.

Montgomery County is the third largest county in the state of Alabama. On an annual basis, approximately 4,604 offenders flow through the Montgomery County Detention facility. The Montgomery County Sheriff's Office records estimate that at any given time, 12% of the detainees are clients with some type of mental health need or substance abuse disorder, and a large portion are dually diagnosed (R.G. Walker, personal communication, June 4, 2018) .

Due to the lack of adequately trained CIT personnel statewide, as well as the lack of facilities and state funding, Sheriff Cunningham took the lead in the state and began working with numerous partners to come up with a solution for this problem. In 2014, the Healthy Minds Network created a demonstration project, Post Incarceration Mental Health Case Management, to identify individuals in State Prison being released on Community Corrections supervision, as well as Montgomery County Jail detainees being released, either under supervision or directly to the community, who have continuing (post-incarceration) mental health needs (R.G. Walker, personal communication, June 4, 2018)

Among the collaborating partners were; Envision 2020, The Montgomery Area Mental Health Authority, Montgomery County Community Corrections Department, Montgomery County Sheriff's Office, Office of the Probate Judge of Montgomery County. The case manager worked directly with the clients to meet their needs for: housing, food, job placement (according to each client's ability to work), Mental Health Authority appointments, psychotropic medications, etc. (R.G. Walker, personal communication, June 4, 2018) .

This demonstration project revealed several priority areas of focus. Among them were: 1.) The need for housing for people with behavioral health needs; 2.) The need for a Crisis Center (an alternative to arrest and incarceration on the front end of the system), a place where first responders can take people who are mentally ill or dually diagnosed. A center of this nature

has been a primary need in Montgomery for several years. Local justice and mental health partners have engaged in these discussions for years but lack of available resources have precluded these discussions from coming to fruition and progressing beyond the discussion stage, that is, until the comprehensive community collaboration facilitated by Envision 2020 and the Healthy Minds Network. The studies by this group along with the follow up revealed that the aforementioned closings throughout Alabama and the lack of adequate re-integration services has created an increased incarceration of mental health consumers. (R.G. Walker, personal communication, June 4, 2018).

The need for an expanding role in the community to assimilate some of these individuals and to provide them with timely mental health intervention and care (especially in emergent situations) calls for multiple agency CIT training and the development of a referral process that avoids most incarceration ER visits. Montgomery is currently in the planning stages of identifying intervention points. Partners have discussed and offered several innovative approaches to better address justice and mental health issues at various stages of the justice system. It is not their intent to reinvent the wheel and they plan to utilize the sequential intercept model to discuss and finalize intervention points. They are planning to continue aligning with the national "Stepping Up" initiative and working on issues related to reducing the number of mentally ill who go to jail. (R.G. Walker, personal communication, June 4, 2018).

The first step that Sheriff Cunningham has completed in this process was the application and receipt of a grant to begin multi agency CIT training statewide. In early 2016 his office started a training program for statewide first responders. They partnered with the National Alliance on Mental Illness (NAMI) of Alabama and sent one of their Deputy's to become a CIT trainer. Working through federal grant incentives they provide approximately four 24 hour

training sessions per year. Since this program has begun they have sent an additional 7 members to the CIT trainer's course which was an intensive 7 day course in Minnesota. Together this group of trainers has provided training to approximately 235 first responders in the state of Alabama. The three-day curriculum is comprised of both classroom instruction and practical exercises/scenarios supervised by mental health professionals, other subject matter experts and certified CIT instructors. The class features practical de-escalation role play exercises of lived experiences of consumers and family members.

Along with furthering training throughout the State of Alabama, Sheriff Cunningham instituted a strict screening regiment within the Montgomery County Jail. Currently a mental health survey is conducted on every individual that is booked into their facility. If there is any indication that there are mental health issues, arrangements are immediately made for the staff nurse and mental health counselor to meet with them. This is followed by a visit from a mental health Doctor who will prescribe medications as needed.

This training and screening regiment is one of the first in the state of Alabama, and the training is accessible to first responders statewide. While there is still a great deal of work to be done, the Sheriff's Office in Montgomery is well along the way to completing the first of their long-term goals as it pertains to CIT implementation. These goals include the following;

- Increase the number of first responders who are Crisis Intervention Team (CIT) trained
- Reduce police and first responder contact by diverting frequent users to other services
- Coordinate services to clients to reduce repeated interactions with law enforcement
- Engage clients into mental health, alcohol/drug treatment rehabilitation, and other needed services, and
- Provide effective alternatives to incarceration

They are currently tracking the personnel trained and following up the course work with surveys to determine the efficacy of the training. Early numbers are showing that first responders are feeling much more comfortable in dealing with mental health consumers. The MCSO plans to continue to collect annual statistics of field contacts and incarcerations of the mentally ill, the goal over the next 5 years is to hopefully see a drop in numbers of those incarcerated, as well as an increase in local services to assist the mental health consumer.

Conclusion

With the prevalence of mental illness in the US, interactions between law enforcement, both in the field and in the correction environment, are not going to decline. Leaders need to ensure personnel are trained in methods of moral, ethical, and empathetical treatment of consumers. Ensuring proper treatment of the mentally ill will help leaders build credibility within the communities they serve. To reduce injury to officers and to the mentally ill and to insure the mentally ill are effectively treated, de-escalation techniques and diversion must take place.

Available research on the effectiveness of CIT suggests that the program can be successful in improving police officers' attitudes, knowledge, and confidence regarding people with mental illness and interactions with them. CIT also appears to be effective in connecting people with mental illness to mental health services. No studies have examined whether CIT reduces officer or consumer injuries (although informal evidence suggests that CIT is associated with reduced officer injuries). Several studies have tested the relationship between CIT and arrest of mentally ill persons and found that CIT was not associated with changes in arrest. We suggest that ongoing research efforts on CIT, especially high-quality scientific research, will help

researchers and law enforcement agencies understand the potential benefits of CIT and which components of the program are associated with the most positive results.

Having a successful CIT program will create positive community relationships; improve crisis response systems; have trained response to behavior health crisis calls; reduce unnecessary use of force and arrest; reduce officer and citizens injuries; increase officer confidence in their skills for dealing with individuals with mental health illness; (A survey of officers suggests that they do not feel adequately trained to respond to mental health crises, (Watson & Fulambarker, 2012, p. 1); reduce officers and organizations liability; and allow a more efficient use of criminal justice resources, including increasing jail diversions.

Leadership in the criminal justice system must be committed to developing, funding and maintaining a collaborative approach to dealing with the mentally ill. Change agents within an agency, along with officers with versatility will be required for successful implementation. An appropriate professional culture will be required for success over time.

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