

# **Mayor's Task Force on Law Enforcement and Mental Health**

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# **Report of the Mayor's Task Force on Law Enforcement and Mental Health**

## **Introduction**

According to the most recent statistics reported by the National Institute of Mental Health (2008), an estimated 57.7 million Americans (26.2%) ages 18 and older suffer from a diagnosable mental disorder. Although only a small percentage of those with mental illness come in contact with police in crisis situations, law enforcement must be prepared to respond effectively, efficiently, and compassionately to their needs, while protecting the safety of everyone involved and providing the highest quality service to all members of the community. To perform this complex task, police officers must have access to the best available training and resources, and they must function in partnership with each component of the mental health system.

On May 28, 2009, a Scranton woman was shot and killed by police when a routine mental health call turned violent. On June 19, 2009, in response to that incident, and cognizant of the increasing interaction between law enforcement and the mental health community, Scranton Mayor Christopher Doherty announced the organization of the Mayor's Task Force on Law Enforcement and Mental Health to examine the current relationship between law enforcement and the mental health system and make recommendations for improved police response to individuals with mental illness. Mental health and law enforcement professionals, family and consumer advocates, religious leaders, and community representatives were invited and enthusiastically agreed to participate in the process.

## **Mayor's Charge to the Task Force**

The Task Force was issued the following charge:

1. Examine the current relationship between law enforcement and the mental health community, including strengths, weaknesses, and gaps.
2. Create a culture of cooperation based on a seamless unified interagency team approach in dealing with individuals with mental illness.
3. Examine the current levels of law enforcement mental health training and education to ensure that police officers have the requisite skills, resources, and support to perform their jobs.
4. Assist in the development of a standardized written law enforcement mental health protocol for dealing with crisis situations involving persons with special needs.
5. Determine the need, if any, for possible legislative action.

Mayor Doherty requested a written report of the recommendations made by the Task Force for his review and implementation.

## **Scope and Limitations of the Work of the Task Force**

The immediate impetus for the formation of the Task Force was a shooting incident in which a woman with severe mental illness was killed during an encounter with Scranton police. The incident was fully investigated by the Pennsylvania State Police, the Lackawanna County District Attorney's Office, and the Scranton Police Department. It was not within the purview of the Task Force to reexamine that incident, nor should it be assumed that implementation of any recommendations herein would necessarily have prevented that shooting or could prevent future tragedies. The mission of the Task Force was to study the role of law enforcement in relation to the mental health community and to make recommendations that will ensure the police are equipped to provide the best possible service to the people of Scranton.

## **Task Force Activities**

Over the course of eight months, the Task Force engaged in various activities designed to gather information and fulfill its responsibilities as charged by Mayor Doherty.

### Review of Available Police Training and Response Models

The Task Force co-chairs initially conducted a review of the available literature on police training and program strategies, as well as data related to model effectiveness. The strategies reviewed are categorized as: (1) police-based specialized mental health models; and (2) police-based specialized police response models. The former includes mental health professionals as co-responder consultants to police officers during mental health calls. The latter, of which the Crisis Intervention Team (CIT) model is the best known, involves specially trained uniformed patrol officers as first responders to mental health crisis calls. A third strategy, the mobile crisis unit model, is not a law-enforcement based model, and therefore was not within the authority of the Task Force to consider.

### Participation in NAMI/Memphis CIT Conference Call

Three members of the task force participated in a conference call organized by the National Alliance on Mental Illness (NAMI), featuring Major Sam Cochran, formerly of the Memphis Police Department. In 1988, Major Cochran partnered with the Memphis Chapter of NAMI, local universities, and other community stakeholders to develop the Memphis Model Crisis Intervention Team (CIT)

program. Major Cochran discussed the background, organization and function of the Memphis CIT, and provided guidance for launching a CIT program.

### Task Force Meetings

The full Task Force met on seven occasions between July 14, 2009 and December 4, 2009.

During the first two meetings, Task Force members discussed the interaction between police and individuals with mental illness, from their own perspectives and from the perspectives of the agencies represented. Members gathered anecdotal information from populations served by their agencies, and they shared that information with the group. Members were also briefed on existing training and program models, and handouts and resources were distributed for their review.

Vito A. Forlenza, D.Ed., a professional facilitator recommended and funded by the Advocacy Alliance, led the next three meetings. Under his direction, the group identified and prioritized attributes of an ideal community model for handling mental health crises, and discussed the roles of police, mental health agencies, consumers, family members and the greater community in that model. Challenges and obstacles to the ideal model were discussed, and solutions for overcoming them were proposed. Through this process, ideas and perspectives emerged which are incorporated in the recommendations of the Task Force.

At the sixth meeting, the many ideas generated were encapsulated. The group agreed that the strategy most compatible with the ideals identified appeared to be the CIT model. Task Force members agreed to invite representatives of the Laurel Highlands CIT to present their program in detail to the Task Force and to respond to members' questions.

### Laurel Highlands CIT Presentation

On December 4, 2009, the Laurel Highlands Region Police Crisis Intervention Team presented information to the Task Force and responded to members' questions. The program, which is modeled after the Memphis CIT program, is currently in place in Cambria and Somerset Counties in Pennsylvania. The presentation was coordinated by Task Force Member Marie Onukiavage, Executive Director of NAMI's Scranton Chapter.

### Feedback and Wrap-Up of Task Force Activities

Following the presentation, feedback on the CIT model was requested and received from members of the Task Force. The responses were overwhelmingly favorable to CIT, and several members suggested supplements to the curriculum to

address some of Scranton's unique aspects. Those suggestions have been incorporated into the Task Force's recommendations.

### NAMI Family Support Group Meeting

On January 25, 2010, the co-chairs of the Task Force were invited by Task Force member Marie Onukiavage to attend a NAMI family support group meeting with mental health services consumers and family members to exchange information. The co-chairs explained the work of the Task Force, and NAMI members offered input on their experiences with police, some of their frustrations with the criminal justice and mental health systems, and their suggestions for improvement. This information, along with written feedback provided to the Task Force previously by members of NAMI, was considered and incorporated, where possible, into the report and recommendations of the Task Force.

### **Future of the Task Force**

Although the Task Force has now submitted its recommendations to the Mayor, it is envisioned the work of the group will continue. Several aspects of the Mayor's charge require ongoing study (for example, the need for legislative action, the potential expansion of the program beyond the Scranton city limits, and the formalization of written protocol). Further, to assess the effectiveness of the program as implemented and to identify areas for adjustment, data must be formally collected and analyzed.

Finally, the unique and changing needs of the community should be continuously monitored and addressed, and feedback from consumers, mental health and law enforcement professionals, advocacy groups and community members must be incorporated in both the recommended police training curriculum and the ongoing implementation of the program.

Because these continuing activities are viewed as vital to the success of the program, many of the Task Force members have agreed to continue their participation in the process as part of an Advisory Board.

**Recommendation 1**  
**The City of Scranton Should Adopt and Implement the Crisis Intervention Team (CIT) Strategy**

In his charge, the Mayor assigned the Task Force to: “Examine the current levels of law enforcement mental health training and education to ensure that police officers have the requisite skills, resources and support to perform their jobs.” The Mayor’s charge was two-fold: first, the Task Force was to review the current level of police training, and, second, to make recommendations for improving police response to calls involving individuals with mental illness.

The Task Force was informed that the current level of police training for the City of Scranton is in compliance with state mandated training requirements. Only a few Pennsylvania jurisdictions currently follow the growing nation-wide trend to offer training for specialized response teams to handle mental health crisis calls.<sup>1</sup> The Task Force recommends that the City join the growing number of regions that have implemented a specialized response program.

**Current Levels of Training**

State-Mandated Police Training

Pennsylvania law mandates that all municipal police officers complete a course of training as established by the Municipal Police Officers Training and Education Commission (MPOTEC). The standard program is articulated in the Municipal Officers Education and Training Act, commonly referred to as Act 120 (1970). For an individual to become a certified police officer in Pennsylvania, the candidate must attend and successfully complete a 785.5 hour course of instruction. The training curriculum is standard state-wide, and it provides the skills necessary to qualify the cadet to practice his or her chosen profession (E.R. Baidas, personal communication, Jan. 22, 2010).

Of the 785.5 hours of police training completed by every Pennsylvania municipal police officer, approximately 28 hours address mental health-related issues. Specific topics and hours of training are as follows:

- Recognizing Special Needs 4 hours
- Custody of the Mentally Ill 4 hours

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<sup>1</sup> The Laurel Highlands Area (Summerset and Cumberland Counties), Pittsburgh, portions of Bucks County, and one precinct in Philadelphia have adopted CIT. York County has also begun training officers in CIT. (See p.A-9)

- Behavior Management /Crisis Intervention 4 hours
- Dispute Intervention/Conflict Management 4 hours
- Suicide, Barricaded Persons, Hostages 4 hours
- Perceptions of Human Behavior 8 hours

In addition, once initial training is completed, a police officer must successfully complete 40 hours of in-service training each year, covering current law enforcement topics as designated by the Commission. For example, during the 2003 MPOETC annual update training cycle, Pennsylvania municipal police officers were required to attend a block of instruction regarding individuals with special needs, and a booklet entitled *Recognizing Special Needs: A Police Officer's Field Guide to Selected Disabilities* (2001) was distributed to each participating officer.

Although mental health-related training is in fact a part of the required police training, a 2004 study determined that 47% of respondent Pennsylvania police offices did not feel they were qualified to manage persons with mental illness (Ruiz & Miller, 2004). It appears that officers throughout the state, all of whom receive the same level of training, lack confidence in their abilities to handle these duties and would welcome assistance in this area.

### Special Response Teams

Scranton maintains a SWAT-type team known as the Special Operations Group (SOG), comprised of tactical and negotiation units. Negotiation unit members receive initial training through law enforcement agencies such as the Pennsylvania State Police, FBI, Department of Corrections and other professional training sources. Negotiation skills necessarily involve in-depth training related to mental health issues, such as recognizing mental illness and crisis de-escalation techniques. These skills are “perishable” in nature and must be reinforced by regular team- based training and education.

Although the SOG team is available to the Scranton police, utilization of its services is generally reserved for high-risk incidents involving hostage/barricade situations. The cost of a SOG deployment can be considerable, given the number of team members, and the amount of special equipment and other resources involved. Because most routine mental health calls are non-confrontational and do not result in arrest or violence, trained SOG negotiators are not normally dispatched and such calls are generally handled by uniformed patrol officers.

A potential gap in services may emerge when a patrol officer responds to a mental health-related call, which requires a skill-set beyond the level of basic training and expertise of the responding patrol officer, but does not meet the criteria for full SOG activation.

This gap may be filled by the implementation of specialized mental health response teams. Such teams exist throughout the country; however, currently, they are the exception, rather than the norm. The Task Force has studied the feasibility of adopting this approach, and recommends that the City of Scranton adopt and implement a specialized response team strategy.

## **Response Models Considered by the Task Force**

According to a nationwide study conducted by the Police Executive Research Forum (PERF), “a tragic incident involving a person with mental illness often preceded the decision by law enforcement agencies to change their response to people with mental illness”(Reuland, 2004, p.24). Memphis, San Diego, Washington, D.C. and Bucks County, Pennsylvania are among the jurisdictions that have responded to such an incident by adopting a new model for handling mental health crisis calls.

Although each jurisdiction has customized its approach to fit specific community needs, the strategies generally fit into one of two categories<sup>2</sup>: Police-based Specialized Mental Health Response Models or Police-based Specialized Police Response Models. The Task Force studied models in both of these categories in detail.<sup>3</sup>

### Police-based Specialized Mental Health Response (Co-Responder Model)

In this approach, civilian mental health consultants serve on staff of the local police department to provide consultations to officers on-site or by telephone. Consultants might be social workers, psychologists or other mental health professionals.

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<sup>2</sup>A third model, in which responding officers summon community mental health mobile crisis teams to the scene of mental health calls, is used in some jurisdictions. Because this is not a law enforcement-based model, it was not within the scope of the Task Force’s authority to recommend. Although mobile crisis teams are often an effective supplement to the law enforcement response, the current trend in most jurisdictions is toward training first responders to handle mental health crisis calls.

<sup>3</sup>These categories were identified in 1999 by Deane, Steadman, Borum, Veysey, and Morrissey, in a 1996 survey of police departments in 174 cities with populations of 100,000 or more. At the time the survey was conducted, over 50% of cities had no specific strategies for dealing with mental health crises. Of the remaining departments, 30% relied upon mental-health-based mobile crisis teams alone, 12% used on-staff consultants, and only 3% used a form of CIT. Since that time, CIT has become the fastest growing model, and by 2008, CIT had been adopted in over 400 jurisdictions throughout the U.S. (Compton, Bahora, Watson & Oliva, 2008).

Also known as the “co-responder” model, one of the best known of these programs, the Psychiatric Emergency Response Team (PERT), is in use in San Diego County, California (Deane, Steadman, Borum, Veysey, & Morrissey, 1999). According to the San Diego County program description:

PERT Units pair a San Diego Police Department Officer who has undergone special training with a mental health clinician, comprised of a registered nurse, a licensed clinical social worker, or a psychologist. By design, the Team integrates law enforcement with mental health workers for the purpose of crises response and alternatives to jail for those with serious mental illness (Fix, n.d.).

The PERT program is a separate, incorporated entity, overseen by its own Board of Directors, which bills San Diego County when clinician services are used. A Coordinating Counsel, including representation by police, County Department of Mental Health personnel, and the PERT Executive Director supervises logistics and operations, and an Advisory Board, including mental health stakeholders and police coordinators, provides oversight and insures accountability.

PERT’s executive director provides training to police on various topics related to mental illness, and officers who participate in a 20-hour training program become “PERT-certified” co-responders. However, in this model, heavy reliance for crisis intervention is placed on civilian clinicians who work with police officers as first responders.

Reduction in arrests and incarceration, increased connection of individuals with mental illness to treatment, and higher consumer satisfaction were reported, once this model was instituted in San Diego (Ruiz, Long & Schnell, 2005).

One major drawback, however, was identified through an internal assessment of the PERT program. Because of funding constraints, clinician co-responders could not be available on a continuous, round-the-clock basis. According to the assessment, in some cases, due to budget constraints, clinicians were only available during regular daytime business hours, leaving the busy evening and night shifts without coverage (Ruiz et al., 2005).

Although this model shows promising results, as demonstrated in San Diego, prohibitively high costs may impede full implementation and serve as a serious obstacle to its effectiveness.

## Police-based Specialized Police Response: Crisis Intervention Team (CIT) Model

Rather than employing civilian mental health providers, jurisdictions that follow this model provide sworn police officers with specialized training in crisis intervention services. Those select officers serve as first responders to mental health crisis calls. Their duties include working cooperatively with local mental health agencies to link consumers to appropriate treatment. The Memphis CIT Model is the most frequently adopted version of this strategy.

In 1987, Memphis police shot and killed a man with mental illness while he was threatening a responding officer with a knife. In response to public concerns, the mayor of Memphis formed a taskforce of community stakeholders, led by Major Sam Cochran of the Memphis Police Department, and including local citizens, NAMI representatives, mental health practitioners, police officers, and experts from local universities. The group set out to design a model that would both improve police response to mental health crisis incidents and enhance the safety of everyone involved. The resulting program became known as the Memphis Model, and has been adopted in over 400 jurisdictions nationwide (Compton et al., 2008). To date, CIT has been adopted in four Pennsylvania jurisdictions (see p.A-9). According to the Memphis Police Department:

Traditional police methods, misinformation, and a lack of sensitivity cause fear and frustration for consumers and their families. Too often, officers' respond to crisis calls where they felt at a disadvantage or were placed in a no-win situation. . . . Due to [specialized crisis intervention] training, CIT officers can, with confidence, offer a more humane and calm approach (Lowe, 2010, ¶9).

Crisis intervention team members are screened and selected from uniform patrol officer volunteers. They participate in an intensive 40-hour training curriculum that includes standard modules (such as de-escalation techniques) and modules customized to the specific needs of the community. "Train the Trainer" programs allow for a small number of individuals, including officers, to participate in training and return to train others, keeping the cost of the program to a minimum. Local mental health care providers, family and peer advocates, and mental health consumer groups also conduct training modules.

Once trained, CIT officers are scheduled to provide continuous coverage. When a mental health crisis call is received, it is routed to a CIT officer on duty to respond. CIT officers also perform their regular duty assignments.

The Memphis Police Department reports realizing the following benefits since the CIT program was implemented:

- decrease in arrests and use of force during mental health crisis calls
- increase in identification and care of underserved consumers
- decrease in patient violence and use of restraints in the ER
- decline in officer injuries during crisis events
- fewer “victimless crime” arrests
- cost savings

Qualitative benefits, such as recognition and appreciation of officers by the community and increased officer confidence in handling mental health crisis calls, are also reported (Lowe, 2010, ¶10-11).

In 1997, after considering a number of crisis intervention models, the Albuquerque, New Mexico police department adopted the Memphis Model of CIT. Albuquerque is a city of approximately 450,000 residents with a police force of some 850 police officers, 403 of whom are uniformed patrol officers. The program was adopted in conjunction with Albuquerque’s existing community oriented policing program. By training approximately one-fourth of their patrol officers in CIT, the department was able to set up continuous coverage with trained CIT officers assigned to each shift.

Data collected by the Albuquerque Police Department showed that, in the three years after CIT was adopted, SWAT call-outs for crisis interventions were reduced 58%, mental health crisis calls resulted in fewer arrests and more frequent transportation of patients to mental health treatment facilities, and injuries to citizens involved in crisis calls decreased. In addition, positive attitude changes and increased cooperation between the police and mental health treatment providers were reported (Bower & Pettit, 2001).

The study found CIT to be both effective and cost-efficient – ultimately saving the city money while improving the quality of life for many. As Albuquerque Police Chief Gerry Galvin observed: “The intervention by CIT-trained officers in crisis situations is directly responsible for a decrease in police shootings and has saved the lives of both citizens and police officers” (Bower & Pettit, 2001, p.7).

A 2005 study conducted in Louisville, Kentucky found, once that city’s CIT program was implemented, injuries and use of force by police on mental health calls were reduced. The program also saved money and helped untreated individuals to obtain care (Straus et al., 2005).

Reuland (2004) collected data on response models adopted by 28 police departments across the United States, examining department size, population served, and outcomes reported by each city. Adoption of CIT was the overwhelming trend, regardless of department size, and positive outcomes were uniformly reported.

A 2008 review of empirical literature on CIT programs examined 12 studies that evaluated the effectiveness of the program on a variety of measures. The data showed CIT was effective in connecting individuals with mental illness to appropriate treatment services, improving officer attitudes and confidence in handling mental health calls, reducing arrest rates and decreasing associated criminal justice costs. Other improvements, including earlier connection with treatment and improved treatment outcomes for mental health service consumers referred by police, were also indicated (Compton et al., 2008).

The CIT model has generated widespread enthusiasm and support. NAMI, which was instrumental in designing the Memphis program, reports that CIT is now recognized both nationally and internationally. Large cities, such as St. Louis, Missouri, and Orlando, Florida, as well as smaller jurisdictions, like Clackamas County, Oregon, and Lake-Summer County, Florida, have adopted the program. CIT programs have been established internationally in Australia, Canada and Israel. (NAMI CIT Resource Center, 2010)

### **Rationale for the Task Force Recommendation of CIT**

The Task Force recommends that the City of Scranton adopt the CIT model over other potential models for several reasons:

1. Departments that have adopted the model have reported positive results, including reduction in police use of force and increased safety during mental health crisis calls, fewer arrests and increased connection with treatment for mentally ill individuals, improved cooperation between law enforcement and mental health care providers, and improved police/community relationships.
2. Of the strategies examined, the CIT model has generated the most data supporting its effectiveness on several different measures.
3. The CIT model appears to be efficient, cost-effective, and flexible enough to respond to the unique needs of the community.
4. Although the Police Department of the City of Scranton is large enough to support its own CIT program, the Task Force envisions the potential for expansion of the Scranton CIT program to a broader region, for the sake of efficiency, cost-effectiveness, continuity and expansion of services to those residing in surrounding areas with smaller police departments. The design of the CIT model lends itself to a regional structure, as illustrated by the Laurel Highlands CIT program, which serves two counties in Southwestern Pennsylvania.

5. The co-responder model, also considered, appeared logistically difficult and prohibitively costly for a city the size of Scranton. The benefit of working cooperatively with mental health treatment providers is incorporated into CIT, but the staffing, shift coverage, and compensation issues of the co-responder model are avoided, because CIT first responders are on-duty police officers.

## **Implementation of CIT**

### CIT Officers

The Police Department of the City of Scranton, consisting of approximately 150 police officers, is large enough to train and staff a fully functioning CIT with 24-hour coverage. Ultimately, the goal would be to train 20-25% of the uniformed patrol division, as well as a limited number of detective division members, as certified CIT officers. Once the program is running, CIT members are designated to respond to mental health crisis calls during their regularly scheduled shifts. When not involved with mental health calls, CIT officers perform their usual duties.

### Dispatchers

A successful CIT program must begin at the point of dispatch, and all CIT program guides recommend dispatcher training. It is recommended that all dispatchers handling City of Scranton calls for service receive CIT-related training, a procedure supported by Lackawanna County's Director of Emergency Services (T. Dubas, personal communication, February 12, 2010).

### Training and Curriculum

The Laurel Highlands Region was one of the first areas in Pennsylvania to adopt the CIT model. Representatives from the Laurel Highlands CIT program spoke to the Task Force, describing the details of the program and outlining the necessary steps in implementing CIT. The presenters were trained in Memphis, and now present training to organizations interested in implementing CIT in Pennsylvania.

A week-long, 40-hour training will be offered by the Laurel Highlands Region CIT in April, 2010 in Johnstown, Pennsylvania. Eight seats have been offered to Scranton police officers and Task Force members, to participate in a "Train the Trainers" program. Upon the completion of the training and certification, those individuals will be qualified to serve as CIT trainers for additional police officers.

This training strategy is cost-effective, because after the initial group completes the program, all training can be conducted locally.

The Laurel Highlands CIT curriculum addresses topics related to suicide and crisis prevention, intervention and de-escalation strategies, understanding psychotropic medications, legal and civil rights, cultural diversity, juvenile issues, and veteran's issues, all instructed by certified trainers or local mental health professionals. The program also includes site visits to local emergency rooms, mental health treatment facilities, community programs, and consumer centers (Margucci, 2009). A sample of the Laurel Highlands Training Curriculum can be found on page A-10.

The curriculum is flexible – although it contains core requirements, each jurisdiction may include training modules that address specific needs of the local community. In the course of its work, the Task Force identified some components necessary to meet the needs of the City of Scranton, including:

- Training in cultural competency: members of the task force recognized that mental illness is viewed and handled differently within different cultural and ethnic communities. Understanding these differences is particularly important in the increasingly diverse City of Scranton.
- Training for specific populations: the demographics of the City of Scranton must also be considered in developing the training curriculum for CIT. Instruction in working with specific populations such as the elderly, veterans, and individuals with developmental disorders and intellectual disabilities should be included.
- Instruction in local emergency mental health procedures, and site visits, tours and informational sessions at the CMC inpatient unit, the Scranton Counseling Center partial hospitalization and other treatment programs should be included in the curriculum.

A cadre of qualified instructors is essential to a successful CIT training program. The Task Force is comprised of a diverse, multi-disciplinary group of dedicated community stakeholders who have developed excellent relationships and rapport over the lifespan of the Task Force. Many members have expressed a willingness to either teach or offer representatives from their agencies to instruct on topics within their expertise.

#### Training for All Officers

Any police officer in the City of Scranton, in the course of regular duties, may be called upon to respond to a mental health crisis. As discussed, state-wide

research indicates that almost half of all patrol officers do not feel confident in handling such calls. In addition to the specialized training recommended for CIT officers, the Task Force recommends additional training for all officers to recognize the symptoms of mental illness and respond effectively. Additionally, officers should understand the procedure for requesting a CIT officer on a particular call, and each should have access to mental health treatment referral information.

### **Anticipated Costs of Instituting a CIT Program**

In today's current economic climate, police department budgets offer little room for additional expenditures. A CIT program, however, can be implemented even with limited funds and personnel.

The Memphis CIT Program offers training at the University of Memphis CIT Center, but the cost of the program, travel and accommodations, can be prohibitive. Members of the Laurel Highlands Team attended training in Memphis at a cost of \$2,500 per person. Because the Laurel Highlands Team attended the "Train-the-Trainer" program, they are now able to offer training at a minimal cost. As discussed, Laurel Highlands has offered the City of Scranton eight seats in the April, 2010 training class, for the cost of materials, travel, lodging and meals. Those eight individuals, once trained, will then be qualified to conduct training of additional officers locally.

Costs to maintain the program, once training is completed, are also minimal. Interested officers volunteer to be part of CIT, and from that pool of volunteers, those that fit the program best are selected. Although selection to CIT is prestigious, CIT officers are not offered additional compensation for their participation. This not only keeps program costs to a minimum, but ensures that only officers that are sincerely interested in the program will become part of the team. Incentives may be offered (travel to conferences, awards, and banquets, for example), if funding allows.

Grants may also be available to help cover CIT costs. For example, the City of Scranton has in the past received police department funding through the United States Department Justice, Office of Community Oriented Policing Services (COPS) Program, and, because CIT is a community policing-based model, funding through this program may be available. Numerous other funding sources exist, and NAMI is an excellent resource for assistance in locating and applying for grants to support CIT programs.

Departments that have adopted CIT report a decrease in civilian injuries and related litigation, fewer officer injuries and related costs, a decrease in arrests and accompanying court and corrections costs, and a reduction in the need to deploy

costly SWAT teams. Statistics on the effectiveness of the Laurel Highlands CIT were distributed to the Task Force during the presentation, and these statistics are reprinted on page A-11. The benefits and long-term savings demonstrated by departments that have adopted the program make clear that, although the program is accompanied by some costs, a 21<sup>st</sup>-century police department cannot afford *not* to have a specialized CIT program.

**Recommendation 2:  
A Specialized Protocol for Handling Mental Health Crisis  
Calls Should be Developed in Conformity with the Model  
Adopted**

The specific protocol, including policies and procedures to be followed by police officers, will be established in conjunction with the development of the program ultimately adopted. Much of that protocol will depend on interagency collaboration, as discussed in detail in the next section. The Task Force recommends that specific features be included in the adopted protocol.

First, a wide range of inpatient and outpatient referral sources must be available to law enforcement. The Task Force recommends that all CIT officers carry cards with names and telephone numbers of mental health treatment providers, peer advocates, family advocates, and NAMI, for their own reference and to distribute to consumers and family members whenever appropriate. It is also recommended that all Scranton Police Officers have access to these referral materials. Simply being given this information by an officer may be instrumental in introducing a person in need of treatment to necessary care. Cards should also be provided at various other points in the system, for example, in the Emergency Room, the Drop-In Center, and NAMI offices, among other locations.

The Task Force is also concerned that protocol be developed that protects and maintains consumer confidentiality. The CIT program works effectively within the confines of Pennsylvania's confidentiality requirements. Protocol involving the keeping of records related to mental health calls by police and dispatchers is addressed within the program itself.

In some situations, mental health service consumers may execute advance directives, which include instructions related to treatment preferences, or wellness recovery plans, which detail information specific to the individual to be used in the event of a crisis. Standard procedures for securing this information and the appropriate release forms must be put into place. In addition, procedures for making that information available to police and treatment providers in crisis situations should be developed in conjunction with the CIT protocols.

The City of Scranton is fortunate to have an excellent network of mental health consumer advocacy services, and among those services is the peer advocacy component of the Advocacy Alliance. Through this service, consumers connect with peers who have had similar experiences to help guide them through the treatment process. The Task Force recommends that the protocol ultimately adopted include a role for peer advocates during and after a crisis situation, to help consumers understand their rights and treatment options.

**Recommendation 3:**  
**The Culture of Cooperation Between Law Enforcement and Mental Health Care Providers, Initiated by the Task Force, Should Continue to be Fostered**

When the goals of law enforcement and community mental health services are not in harmony, gaps in treatment for individuals with mental illness may result. Models under which law enforcement and mental health agencies traditionally operate can lead each to operate in isolation, intersecting only out of necessity, which, in turn, may fail to provide optimal services to people with mental illness. The CIT model recommended by the Task Force is designed not only to improve officer response to mental health calls, but also to fill treatment gaps so individuals with mental illness can be better served. Thus, the law enforcement component is only part of the CIT program; its success depends on positive relationships and continuous cooperation between police and mental health care providers.

The creation of the Mayor's Task Force on Law Enforcement and Mental Illness, in itself, has done much to build bridges within the mental health system and between law enforcement and the mental health community. The Task Force is composed of some of the main stakeholders on this issue – treatment agency representatives, police, mental health care consumers, family members, and advocacy groups. By sharing information, identifying issues, brainstorming solutions, and committing to continue working together, the first steps in building a culture of cooperation have been taken.

Collaboration among many of the major stakeholders led to the identification of community needs, barriers to meeting those needs, and solutions for overcoming obstacles. The Task Force members agreed that the comprehensive, interagency-based CIT model best addresses the issues identified.

### **Collaboration in Development and Delivery of CIT Officer Training**

The CIT program, by definition, includes participation and cooperation by all stakeholders in order to succeed. Local mental health care providers assist in developing the curriculum to meet the unique needs of their consumers and provide instruction to police officers in their areas of expertise. CIT training involves site visits, where police can visit mental health programs, interact with consumers, and learn to better understand the people they serve.

## **Continuing Collaboration in Implementation of the CIT Program**

Collaboration does not end with training. Frequent interaction between law enforcement and mental health treatment providers is an integral part of the CIT program, both when police are handling a crisis situation and in times of relative calm. The effectiveness of CIT officers, in part, depends on the community's perception of them. Interaction between officers and consumers at drop-in centers, treatment programs and in other contexts increases comfort levels and further educates each group in what to expect from the other. CIT programs also work very closely with local NAMI chapters to disseminate information to consumers, family members, and advocates, raise funds through grants, and develop CIT officer recognition programs.

In fact, only with ongoing cooperation between law enforcement and local agencies can a CIT program succeed in the multi-faceted goal of improving interactions between law enforcement and people with mental illness.

## **Integration of Interagency Cooperation in CIT Protocol**

The specifics of the protocol to be followed by police officers will be developed parallel to the development of the CIT program. However, the Task Force recommends certain features, related to interagency collaboration, be included in the protocol ultimately adopted.

First, as discussed in the previous section, law enforcement officers must be aware of the wide range of inpatient and outpatient services available, and the Task Force recommends that all CIT officers carry cards with names and telephone numbers of mental health treatment providers, peer advocates, family advocates, and NAMI, for their own reference and to distribute to consumers and family members whenever appropriate. Cooperation among all agencies will be vital in compiling and keeping these resources up to date, as well as in ensuring their distribution at various points in the system.

When an individual is experiencing a mental health crisis, immediate access to care should be available. An important element of many CIT programs – a single point of entry where officers transport patients for emergency mental health services – is in place in the City of Scranton, and part of the officer training curriculum should include detailed instruction in how to access those services.

In addition, a system is currently in place to minimize police turn-around times, so officers are not dissuaded from seeking treatment by long wait times. That system should be continuously monitored and evaluated to ensure that it functions as efficiently as possible.

Another element necessary to support a successful CIT program is that individuals transported for evaluation are immediately linked with mental health services. Inpatient treatment will not be feasible in every situation. In that case, an immediate referral to an available program or treatment provider, or access to a peer advocate may be the connection needed to introduce the individual to the necessary care.

To accomplish these goals, the establishment and maintenance of close working relationships between CIT officers and mental health treatment providers are essential.

### **Appointment of CIT Law Enforcement and Mental Health Coordinators**

The Task Force recommends the designation of a CIT Law Enforcement Coordinator. This should be a trained CIT police officer who, in addition to his or her regular duties, will direct and organize training programs, work with mental health agencies to develop procedures that will ensure the goals of the programs are carried out, and identify gaps and necessary improvements as the program is implemented. The officer will also act as a point of contact for the community, and will work to maintain relationships between law enforcement and other agencies.

In other communities that have instituted CIT, a CIT Mental Health Coordinator is often appointed to carry out similar functions for treatment providers. This strategy may help to avoid fragmentation and isolation and can lead to a more unified mental health system. The CIT Mental Health Coordinator would also work closely with the CIT Law Enforcement Coordinator to ensure the necessary cooperation among agencies.

**Recommendation 4:  
Informal Educational Programs, Information-Sharing  
Sessions, and Community Involvement Should be an  
Integral Component of the CIT Program**

In developing recommendations for improved interactions between police and mental health care consumers, the Task Force identified training as the highest priority. Although the CIT curriculum is customized to provide comprehensive formal police training, the Task Force also recognizes that, to reach its full potential, ongoing community support, education and involvement are important components of CIT.

Consumers and family members should be aware of the program and become familiar with the officers involved and resources available. To ensure that crisis situations are handled effectively, treatment providers must understand law enforcement procedures, and officers must recognize the functions and limitations of treatment agencies. Stigma accompanying mental illness, existing throughout the community, is counterproductive to the goals of CIT and should also be addressed through education.

The City of Scranton is comprised of organizations that offer a myriad of services, including mental health treatment programs, support groups, and consumer and family advocates. A wealth of highly regarded educational institutions and hospitals are also located in and around the region. The City is composed of close-knit neighborhoods with active religious, civic, ethnic and social organizations. Local media, including newspapers, television and radio, reach a wide audience. These assets should be employed to further the goals of the CIT program. The leaders of many of these organizations participated in the Task Force and have readily agreed to contribute resources to enhance understanding, strengthen relationships, and provide information to the community.

### **Involvement of Local Advocacy and Support Organizations**

#### Peer Advocacy

The Task Force has made a number of recommendations, most importantly implementation of the CIT program, to address the responsibilities of the police in interactions with mental health care consumers. Consumers must also bear some responsibility to ensure that interactions with police are minimal and resolutions are positive.

The Advocacy Alliance, particularly through its peer advocate program, offers education to consumers on matters such as rights and treatment options. Effective tools encouraged by peer advocates are advance directives and wellness recovery action plans, which allow consumers to designate their preferred treatment providers, effective treatment methods, medications, and other important information that may be helpful in case of a crisis.

The Task Force recommends that police work closely with the Advocacy Alliance to develop effective procedures for providing CIT officers access to these instructions, while appropriately protecting consumer confidentiality, for the benefit of mental health consumers during interactions with police.

### Drop-In Center

Laurel Highlands CIT officers participate in a monthly informal program known as “Coffee with the Cops,” giving police and consumers the opportunity to spend time together in a relaxed and positive atmosphere. This reportedly has allowed for increased education and information sharing, and has decreased stigma and negative perceptions. The benefits of this program also carry over into crisis situations. Recognizing the responding officer as a friend and helper, rather than an impersonal authority figure, can help calm an individual experiencing a crisis. Frequently, consumers or family members will request particular CIT officers, with whom the consumer has made a connection, to respond to crisis calls. (Margucci, 2009)

The Task Force recommends a similar program of meetings among consumers and members of the Scranton Police Department, especially CIT officers, on an ongoing basis, to increase familiarity, allow members of both groups to get to know each other in a relaxed setting, and help develop positive relationships. The Scranton Drop-In Center was discussed as a potential venue for this program. The Drop-In Center offers regular social events, including weekly breakfasts, summer picnics and evening informational meetings that may also be appropriate settings for informal interaction. Task Force members have arranged to attend a Drop-In Center meeting to discuss this recommendation and seek feedback and suggestions from consumers.

### NAMI Scranton Chapter

Scranton is fortunate to have a very active chapter of NAMI, and its director has played a pivotal role in the development of the Task Force recommendations. The director of Scranton’s NAMI chapter has indicated a willingness to facilitate educational and information-sharing sessions among officers and family members of

mental health care consumers. Informal data on consumers' and family members' past experiences with police has been gathered by NAMI, and has been considered in the formulation of these recommendations. Task Force members have also attended a NAMI family support group meeting to explain the CIT program and gather further feedback and suggestions from consumers and family members. The CIT program met with overwhelming support at that meeting, and members expressed their hope that the program, once instituted, would be expanded beyond Scranton's city limits. The NAMI group has invited interested officers to attend future meetings to continue the information-sharing and relationship-building that has already been initiated.

The Task Force recommends that CIT officers connect with consumers and family members through NAMI on an ongoing basis, to increase familiarity between the groups, share information and concerns, and adapt the local CIT program to incorporate suggestions and feedback into the program.

### **Community Oriented Policing Activities**

The Scranton Police Department currently embraces the philosophy of community oriented policing: officers should be perceived and perceive themselves as members of the communities they serve. Principles of this policing strategy, already in place in the City, should be integrated into the CIT program. Police officers should be encouraged to attend NAMI community events, neighborhood meetings, block parties and cultural events. CIT officers should work closely with civic, neighborhood, and religious leaders to share information, receive suggestions, and develop relationships based on mutual cooperation.

### **Informal Agency-Based Training**

Although part of the CIT training curriculum incorporates site visits at local mental health treatment programs, interactions with consumers and treatment providers involved in these programs should be an integral part of CIT, even beyond initial training. In particular, the Task Force suggests officers participate in informal information-sharing sessions through Scranton Counseling Center's partial hospitalization program and Community Medical Center Emergency Mental Health Services, among other programs.

The Scranton Police Department has already begun setting the groundwork for programs of this type. In December, 2009, Scranton Police Training Officer Sgt. Patrick Gerrity met with physicians, staff and patients at the Clarks Summit State Hospital to discuss workshops for officers on topics such as de-escalation techniques and verbal responses to individuals in crisis.

## **Partnerships with Local Media**

The Task Force recognizes the significant impact of local media, and the vital role print and broadcast outlets can play in helping to reduce stigma and misinformation in community perceptions of mental illness.

Throughout the country, media have played an important part in furthering the goals of CIT programs. The Laurel Highlands website features a local television news piece describing the CIT program and highlighting its successes. This piece was aired in the Laurel Highlands region, and is used as a teaching tool to illustrate the essential role of positive partnerships with local news organizations (Laurel Highlands Region Crisis Intervention Team, 2010).

The Task Force encourages the forging of positive relationships among police, mental health treatment agencies and local media, to raise awareness about the CIT program, highlight success stories, and help reduce stigma and misinformation about mental illness.

**Recommendation 5:  
An Advisory Board of Stakeholders should be Organized to  
Oversee the Crisis Intervention Team Program**

Although the Task Force has studied the issue from many perspectives and has made recommendations based not only on other programs but on the unique needs of the City of Scranton, adjustments may be required once the recommendations are implemented. Further, formal data should be collected to ensure the system is working as intended and goals are being met. The unique and ever-changing needs of the community must be continuously monitored and the program adjusted in response to those needs, and once the initial phase of CIT is implemented, additional components may be considered to support and supplement the program.

An Advisory Board, charged with overseeing the program, is recommended to fulfill these functions, as well as to sustain the culture of cooperation initiated by the Task Force. It is suggested that current Task Force members continue to serve as part of the Advisory Board. In addition, membership on the Board should be extended to other agencies that have been identified through the work of the Task Force as playing an essential role in the issue. Representation by drug and alcohol treatment agencies, veterans' organizations, and agencies serving the elderly, among others, should be considered.

### **Future Directions**

#### Regional Expansion of CIT

The Task Force, in fulfillment of the Mayor's charge, examined police response and delivery of services to mental health care consumers within the City of Scranton. In studying the issue, Task Force members recognized that, although the Scranton Police Department is sufficiently large to maintain a CIT program, mutual benefits, such as consistency of procedures and continuity of services, may exist in expanding the program to include a broader region.

The Advisory Board should work in cooperation with officials and stakeholders from the broader region, particularly the Lackawanna County Criminal Justice Advisory Board (CJAB). Liaisons should also be established to keep neighboring law enforcement agencies informed of the Scranton Police Department's progress in implementing the CIT program.

### Association with Specialized Courts

Lackawanna County is a leader in both the state and the nation in its development of a specialized mental health court, designed to divert individuals toward treatment and away from the criminal justice system, when charges arise primarily as a result of mental illness. This procedure serves purposes consistent with the goals of CIT: providing a more compassionate response to people with mental illness; connecting people with treatment rather than punishment; and reducing the far-reaching costs and consequences of criminalizing mental illness.

Examination of the potential link between the CIT program recommended for the City of Scranton and the Lackawanna County Mental Health Court was beyond the scope of the Mayor's charge to the Task Force. The Task Force suggests that this issue be examined in detail by an Advisory Board.

### Mobile Crisis Units

Research literature on CIT often cites the value of mental health-based mobile crisis units in serving as secondary responders when called by CIT officers to the scene of an incident (Deane, 1999). Because even CIT-trained officers cannot be expected to have the expertise of mental health treatment providers, the use of these teams has been found to provide effective support for CIT programs.

Mobile crisis units are traditionally a service provided by community mental health systems, and therefore, the charge of the Task Force did not include examination of the feasibility of these services. Further consideration of this option may be task appropriate for a multi-disciplinary Advisory Board.

### Investigation of Funding Sources

Although the CIT program recommended by the Task Force is extremely cost-efficient, some expenses are associated with officer training and program implementation, and grants may be available to offset any burden on taxpayers. In addition, funding for supporting mental health services might need to be secured before those components can be added to the program. The CIT program might qualify for grant funding under the U.S. Department of Justice Community Oriented Policing Services (COPS) program, the Pennsylvania Commission on Crime and Delinquency, the Office of Mental Health and Substance Abuse Services, and a number of other funding sources. Investigating potential sources of funding is a function appropriately served by an Advisory Board.

### Legislative Activities

The Mayor, in his original charge, asked the Task Force to determine the need, if any, for possible legislative action.

The CIT program, recommended by the Task Force, is based on other programs currently operating in Pennsylvania. It appears, therefore, that the goals of CIT can be accomplished within the confines of current state law, and therefore, legislative action is not deemed necessary by the Task Force at this time. As previously discussed, however, not until the recommendations of the Task Force are implemented will it become clear whether legislative action is necessary, and the Advisory Board should monitor the program for any such issues.

Other states have enacted laws requiring state-wide adoption of CIT or some form of the program. For example, based on the success of several county programs, Georgia has implemented CIT state-wide, and the administration of this program has become a model for other states (Olivia & Compton, 2008). State-wide implementation has been shown to increase continuity of services, and state funding has been used to offset costs. The Advisory Board should study the advisability of pursuing such legislation in the future. In the meantime, a copy of the Task Force report will be provided to local state representatives for information and any action deemed appropriate.

### Data Collection and Program Review

Finally, one of the most important functions of the Advisory Board will be to oversee data collection and analysis on the many aspects of CIT, including outcomes of calls, costs, and officer, consumer and community responses. This data will be necessary to assess effectiveness and steer the Board toward continuously improving and enhancing the CIT program.

## **Conclusion**

The Report and Recommendations of the Mayor's Task Force on Law Enforcement and Mental Illness is the result of a collaborative effort among stakeholders representing diverse perspectives. As in any endeavor of this type, the issues engendered considerable discussion, and every effort was made to incorporate each member's views to the greatest extent possible.

This Report outlines the first steps toward a compassionate, efficient, and effective police response to mental health crisis situations. Implementation will provide law enforcement the opportunity to learn, refine, and move toward the goal of providing the best possible service to the City of Scranton.

## **Summary of Recommendations of the Mayor's Task Force on Law Enforcement and Mental Illness**

### **1. The City of Scranton should adopt and implement the Crisis Intervention Team (CIT) strategy.**

This model has been shown to increase safety of all participants (police officers, individuals experiencing a mental health crisis, family members and bystanders), to reduce arrests for behavior primarily arising from mental illness, to divert more individuals toward mental health treatment, to provide a more respectful, dignified and compassionate method of treating individuals with mental illness, and to reduce costs associated with the criminal justice system.

- Because in the course of regular duties, any police officer may be called to respond to a mental health crisis, all officers should be trained to recognize symptoms of mental illness and respond effectively.
- A segment of officers (ideally 20%) should receive specialized training in handling mental health crisis calls. These officers, during their regular shifts, should be designated to respond to such calls whenever possible.
- Dispatchers who handle calls for the City of Scranton should receive training to recognize mental health issues, ask essential questions, and appropriately direct calls.
- Training should be ongoing – officers should receive training updates on a regular basis in conformity with the established CIT curriculum and in response to community needs as they arise.
- Training should be tailored to the needs of the community, and should include
  - i. cultural competency.
  - ii. instruction in working with specific populations such as the elderly, veterans, and individuals with developmental disorders and intellectual disabilities.
  - iii. emergency mental health services procedures.
  - iv. site visits and informational sessions at local partial hospitalization and inpatient programs.

### **2. A specialized protocol for responding to mental health crisis calls should be developed in conformity with the model adopted.**

The Task Force recommends that the City of Scranton develop and implement a protocol consistent with the CIT program, with adjustments tailored to the needs of the community.

- Referral materials should be developed to be distributed by CIT officers, mental health treatment providers, and consumer and family advocacy groups.
- A standard procedure should be adopted for securing information and making information available to police and treatment providers during a mental health crisis, while protecting and maintaining confidentiality.

- A role for peer advocates should be built into the procedure adopted, to ensure individuals involved in crisis situations understand their rights and treatment options.

**3. The culture of cooperation between law enforcement and mental health care providers, initiated by the Task Force, should continue to be fostered.**

Law enforcement is only one component of CIT. The program's success depends on positive relationships and continuous cooperation between police and mental health service providers.

- Law enforcement and mental health service providers should collaborate in curriculum development and delivery of CIT officer training.
- Law enforcement and mental health service providers should continue to work together in establishing specific protocol and in the long-term implementation of the program.
- Specific areas in which interagency cooperation will be vital include:
  - i. developing referral materials to be distributed by CIT officers, mental health treatment providers, and consumer and family advocacy groups.
  - ii. training officers in the use of a single point of contact for police officers to transport consumers requiring urgent care.
  - iii. monitoring the emergency system to ensure minimal turn-around time for officers to return to their regular duties.
  - iv. maintaining a system of immediate referral to treatment and access to peer advocate services for individuals transported by law enforcement who are not admitted for inpatient treatment.
- Appointment of a CIT Law Enforcement Coordinator is recommended, and designation of a CIT Mental Health Coordinator is encouraged, for the purposes of program oversight and inter-agency communication.

**4. Informal educational programs, information-sharing sessions, and community involvement should be an integral component of the CIT program.**

Similarly, community members must also be involved and informed for the CIT program to reach its full potential. The Task Force recommends:

- Instituting information-sharing sessions among police officers, mental health services consumers and family members on issues such as police protocol, mental health and recovery issues, advance directives and wellness recovery plans, treatment and advocacy services, and other topics as they arise.
- Initiating regular meetings among consumers and members of the Scranton Police Department at the Drop-In Center on an ongoing basis to increase

familiarity, to allow members of both communities to get to know each other in non-emergency settings, and to help change negative perceptions.

- Encouraging CIT officer attendance at NAMI meetings and events, Drop-In Center events, and mental health community activities to gather information and interact with consumers and family members.
- Encouraging CIT officer attendance at neighborhood meetings and events to interact with community members and enhance cultural competency.
- Gathering feedback from mental health services consumers, family members, and other members of the mental health community to gauge effectiveness and identify additional needs.
- Working with local media to educate the public, help reduce stigma and misinformation associated with mental illness, publicize success stories, and develop positive perceptions of the CIT program.

**5. An Advisory Board, comprised of major stakeholders, should be appointed to oversee, analyze, recommend modifications and study future directions of the CIT program in the City of Scranton.**

Institution of the Task Force recommendations is viewed as only the first step in an ongoing process. Once recommendations are implemented, the program must be continually assessed for effectiveness and monitored for any needed changes. Additional initiatives, outside the scope of the current charge of the Task Force, should also be considered. Some areas for future action include:

- Working closely with regional officials and stakeholders, particularly the Lackawanna County Criminal Justice Advisory Board (CJAB) to explore the possibility of expanding the program to a larger region.
- Linking CIT with the Lackawanna County specialty courts, such as Mental Health Court, as a post-arrest diversion option.
- Examining the feasibility of instituting Mobile Crisis Units for individuals needing urgent care, to support law enforcement as first responders and to work closely with CIT where appropriate.
- Seeking grants and other funding opportunities to support training costs and program development.
- Overseeing the collection and assessment of data to monitor the effectiveness of the program as implemented, and recommending modifications as necessary.

## Agency Descriptions

The Mayor's Task Force on Law Enforcement and Mental Health was comprised of a diverse group of individuals who contributed their expertise to this important project. Each of the area agencies, described below, was represented on the Task Force:

**The Advocacy Alliance** serves persons who have a mental illness and persons who have mental retardation in Northeastern and South Central Pennsylvania, the Poconos and the Lehigh Valley.

The mission of the Advocacy Alliance is to promote mental well-being, support recovery for adults who have a mental illness, resiliency in children and adolescents who have emotional disorders, and everyday lives for persons who have mental retardation and other developmental disabilities and provide to them advocacy and culturally competent services.

**Community Medical Center Healthcare System** is a leading provider of quality healthcare services in Northeastern Pennsylvania. A not-for-profit corporation located in Scranton, CMC offers a complete continuum of educational, diagnostic, therapeutic and rehabilitative services and programs. CMC has a 24-bed inpatient behavioral health unit that provides recovery-oriented care for adults with mental illness.

**Keystone Community Resources, Inc.** is an organization of caring professionals who provide innovative and quality services to assist individuals with special needs in reaching their highest potential in a safe, nurturing environment.

Keystone consists of over 50 community homes, 26 supported living sites, and 12 family living homes located in the greater Scranton area. Keystone also offers specialized programs in areas such as Prader-Willi Syndrome, Autism, Elder Care and a Children's program.

The mission of Keystone Community Resources, Inc., is to provide people with developmental disabilities diverse opportunities to lead fulfilling lives.

**Lackawanna County Department of Human Services** facilitates and supports the development, coordination, and delivery of human services to County residents. The department utilizes categorical program agencies, including the Area Agency on Aging, Children and Youth Services, Drug and Alcohol Program and the Mental Health/Mental Retardation Program to address the human service needs, most particularly, of the county's most vulnerable populations.

**Lackawanna County District Attorney's Office** The District Attorney is the Chief Law Enforcement Officer of Lackawanna County and has been provided the

statutory authority to prosecute violations of the Pennsylvania Crimes Code that occur within the County.

**Lackawanna County District Attorney's Office – Trauma Services Unit** provides 24 hour comprehensive assistance to victims of violent crime, through direct services with victims, consultation with the law enforcement community regarding specific cases and needs, assistance to law enforcement with death notification as well as continued supportive therapy for victims and co-victims.

**The Lackawanna-Susquehanna (L-S) Mental Health/Mental Retardation (MH/MR) Program** serves more than 13,000 individuals through various providers of mental health and mental retardation services in Lackawanna and Susquehanna counties in Northeastern Pennsylvania.

The program's primary goal is to facilitate the inclusion and full participation of all persons with mental disabilities in their local communities, by proactively addressing the planning, development, procurement, management, and evaluation of services, thereby enhancing consumer satisfaction and positive personal outcomes. The MH/MR program assumes a leadership role in collaboration with consumers, families, advocates, providers and local government to ensure full participation of persons in their communities.

The mission of the Lackawanna/Susquehanna Counties Mental Health/Mental Retardation Program is to connect consumer satisfaction, outcome evaluation and accountability with the planning, procurement, and efficient management of effective services and supports.

**National Alliance on Mental Illness (NAMI) Pennsylvania, Scranton Area Chapter** is a local affiliate of NAMI, a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, autism and pervasive developmental disorders, attention deficit/hyperactivity disorder, and other severe and persistent mental illnesses that affect the brain.

NAMI is dedicated to the eradication of mental illnesses and to the improvement of the quality of life of all whose lives are affected by these diseases

**Scranton Counseling Center** is a private, nonprofit comprehensive behavioral healthcare program providing a complete range of evaluative and treatment services, both directly and through affiliation with other qualified providers/programs.

The Center's mission is to promote emotional well-being and recovery through a comprehensive range of quality counseling, treatment, and support services designed to maximize each person's potential while respecting individual dignity

and privacy. The Scranton Counseling Center maintains an active partnership with the community in the design and delivery of service and supports the concepts of prevention, early intervention, and individual/family focused planning.

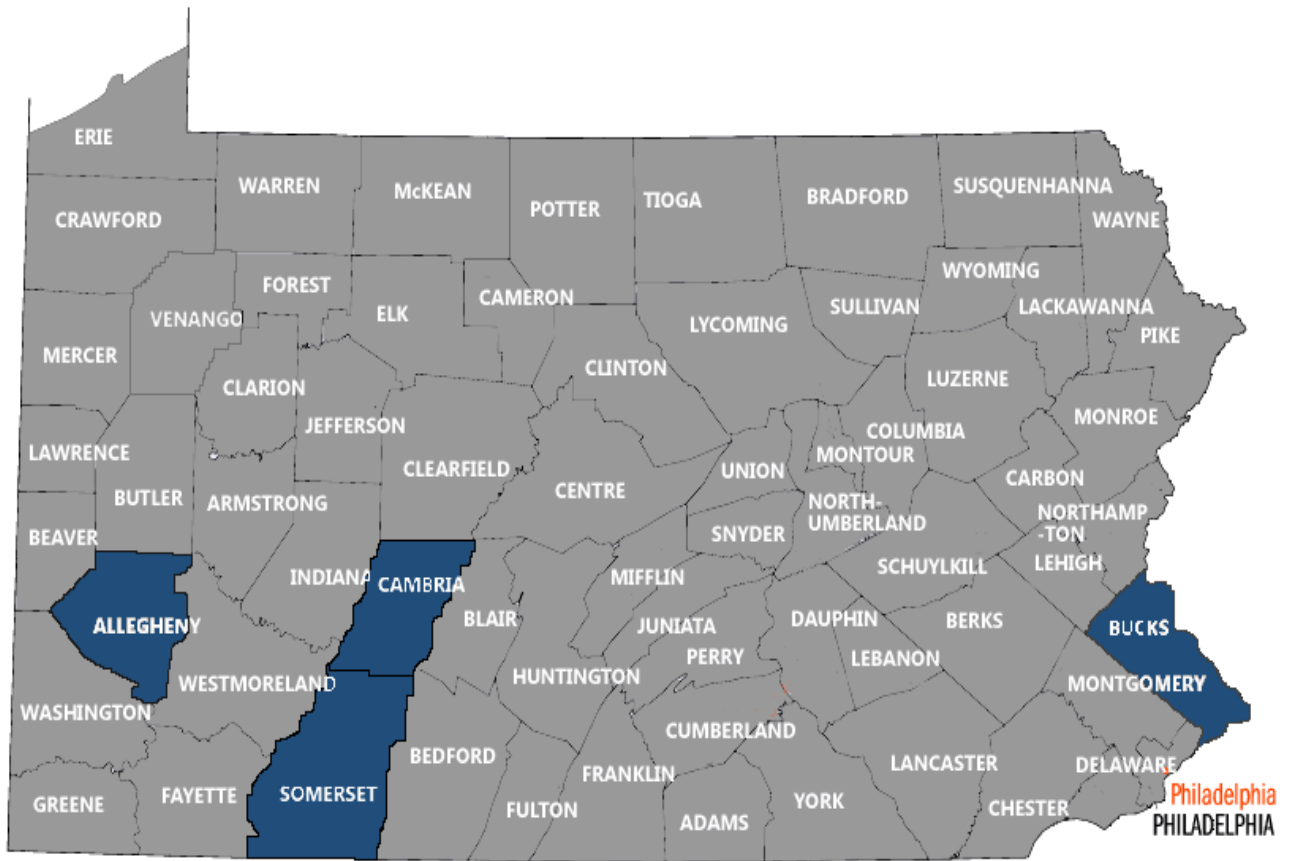
**Scranton Police Department** is organized to protect and preserve life and property, to understand and serve the needs of the Scranton neighborhoods, and to improve the quality of life by maintaining order, recognizing and resolving community problems, and apprehending criminals.

The Scranton Police Department strives to excel through innovative leadership, accountability, and a commitment to providing the highest level of service and protection to the City of Scranton.

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**Pennsylvania Jurisdictions that have adopted the CIT Model in dark gray (reprinted from University of Memphis CIT Center, 2010)**

## Laurel Highlands Region Crisis Intervention Team Training Schedule

<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
Opening remarks and CIT overview	Equipment & Policy	Suicide Prevention Suicide by Cop Video	Family Perspectives	Legal Aspects
(0800-0900)	(0800-0830)	(0800-0930)	(0800-0930)	(0800-0900)
Introduction to Clinical Issues Relating to Mental Illness	“In Our Own Voice”	Rights and Civil Commitment	Stages of Escalating Crisis	Community Resources
(0900-1100)	(0830-0930)	(0930-1030)	(0930-1030)	(0900-1030)
Psychotropic Medications and Side Effects	Veterans Panel PTSD	Basic Strategies of De-Escalation	Substance Abuse and Co-Occurring Disorders	Complex Crisis Intervention Strategies
(1100-1215)	(0930-1100)	(1030-1215)	(1030-1200)	(1030-1200)
Lunch On own	Lunch w/vets Provided by CIT	Lunch Virtual Hallucination Simulator “Hearing Voices” headset	Lunch On own	Graduation Luncheon
(1215-1315)	(1100-1200)	(1215-1315)	(1200-1300)	(1200-1300)
Developmental Disabilities	Site Visits	Systems Issues Panel Discussion	Advanced Verbal Techniques	Complex Crisis Intervention Strategies
(1315-1415)		(1315-1345)		(1300-1430)
Juveniles		Cultural Diversity		Graduation
(1415-1530)		(1345-1445)		
Borderline and Other Personality Disorders	(1200-1700)	Verbal Techniques	(1300-1700)	(1500-1630)
(1530-1700)		(1445-1700)		

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## Laurel Highlands CIT Statistics March 2009 – October 2009

<b>TOTAL CALLS</b>	<b>280</b>
<b>Arrests</b>	<b>3</b>
<b>Hospital for MH Evaluations</b>	<b>199</b>
<b>Police Departments</b>	<b>19</b>
<b>CIT Officers</b>	<b>53</b>
<b>Incident at Consumer's Residence</b>	<b>206</b>
<b>Under the influence</b>	<b>79</b>
<b>Consumer injury prior to police contact</b>	<b>32</b>
<b>Consumer injury during call</b>	<b>2</b>
<b>Officer injury (during suicide attempt)</b>	<b>1</b>
<b>Force-Taser</b>	<b>3</b>
<b>Force-all other</b>	<b>10</b>
<b>Consumer age</b>	
Under 18	51
19-25	45
26-40	66
41-60	90
Over 60	27
<b>Suicide attempt</b>	<b>54</b>
<b>Suicide threat</b>	<b>77</b>
<b>Threat to others</b>	<b>16</b>

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 (highlights in original)