THIRD JUDICIAL CIRCUIT
OF MICHIGAN

ROBERT J. COLOMBO, JR.
CHIEF JUDGE

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DETROIT, MICHIGAN 48226-3413

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LOCAL ADMINSTRATIVE ORDER 2015 - 18

STATE OF MICHIGAN
THIRD JUDICIAL CIRCUIT

SUBJECT: Establishment of a Juvenile Mental Health Court

This Administrative Order is issued in accordance with MCL 600.1090 *et seq*. The purpose of this Order is to establish a Juvenile Mental Health Court in the Family Division – Juvenile Section in the Third Judicial Circuit of Michigan (the Court). All policies and procedures comply with the statute as required by MCL 600.1091(2).

IT IS ORDERED:

1. The Court will enter into a Memorandum of Understanding (MOU) with the county prosecuting attorney, a representative of the community mental health services program, representatives of the community treatment providers, a representative of the juvenile defense bar, and other key parties pursuant to MCL 600.1091(2). In the development of the program's policies and procedures, consideration was given to the ten essential elements of a mental health court as described by the U.S. Department of Justice, Bureau of Justice Assistance (BJA). *See attachment A. A multidisciplinary group of stakeholders participated in the planning and program design of the mental health treatment court.

2. The Court has established eligibility criteria consistent with MCL 600.1093. Guidelines to identify and expeditiously resolve any participant competency concerns have been developed.

3. No participant shall be admitted until a preadmission screening and evaluation assessment are completed in accordance with MCL 600.1093(3).

4. All participants, and respective parents or legal guardians, shall sign a written agreement to participate in the Juvenile Mental Health Court in compliance with MCL 600.1094(1)(c).

5. Local evidence-based mental health and substance abuse treatment services and other ancillary services (e.g., medication compliance, housing and benefit issues, crisis intervention, peer and family support) have been identified and are available resources for program participants to utilize.

6. The court shall maintain case files in compliance with Trial Court General Schedule 16, the Michigan Case File Management Standards. The court has established procedures to ensure substantial compliance with Part 2 of Title 42 of the Code of Federal Regulations, and the Health Insurance Portability and Accountability Act (HIPAA) to safeguard the confidentiality of participants' medical records.

7. The Court has established, as part of the program requirements, procedures to assure compliance with MCL 600.1096 and MCL 600.1097.

8. Pursuant to MCL 600.1099, the Court shall provide the State Court Administrative Office (SCAO) with the minimum standard data established by SCAO for each individual applicant and participant of the Juvenile Mental Health Court Program.

9. The Court shall use the Drug Court Case Management Information System (DCCMIS) to maintain and submit the minimum standard data as determined by SCAO, while receiving grant funds from SCAO.

10. The Court acknowledges that case disposition information regarding Juvenile Mental Health Court participation is unavailable from the Department of State, driving records and criminal history records, and failure to use the DCCMIS will result in the absence of a complete record of Juvenile Mental Health Court participation in Michigan Courts.

11. Pursuant to MCL 600.1099a, the Court shall participate in training as required by SCAO.

12. Policies and procedures on the methods and frequency in which the responsible individuals will monitor participant compliance with the program requirements have been developed.

13. Funding sources and local treatment service resources have been identified as part of the plan for sustaining the mental health treatment court. The plan also includes the collection of data for SCAO to use in conducting a process and outcome evaluation that may be used to demonstrate the effectiveness of the program and thereby help secure future funding.

Dated: December 7, 2015

Robert J. Colombo Jr.

Hon. Robert J. Colombo, Jr., Chief Judge
Third Judicial Circuit of Michigan

Date Approved by SCAO: January 4, 2016

Memorandum of Understanding

WAYNE COUNTY JUVENILE MENTAL HEALTH TREATMENT COURT

This agreement ("MOU") is entered into on December 1, 2015, between Wayne County Third Circuit Court, the Detroit Wayne Mental Health Authority (DWMHA), the Wayne County Prosecutor's Office, and the Child Advocacy Program to document the roles and responsibilities of each agency in the planning and operation of the Juvenile Mental Health Court.

A. Program Description

The Third Circuit Court's Juvenile Mental Health Court is a diversion program based on a philosophy of therapeutic jurisprudence that seeks to address and reduce the involvement of juveniles with a serious mental health illness within the juvenile justice system in accordance with the 10 essential elements of a mental health court. A centralized juvenile mental health program utilizes available in-home service providers, community resources, and support systems to address the needs of program participants. This increases the efficiency of the juvenile court by focusing scarce residential, community, and prosecutorial resources and creates an environment that is conducive to addressing the underlying source of the delinquent conduct through the use of effective mental health treatment. The juvenile's behavior and progress in the community will be monitored by participating stakeholders to determine the effectiveness of the treatment plan and to increase public safety. This intervention will, in turn, reduce the need to refer participants to residential services and future contact with law enforcement.

B. Mission Statement and Program Goals

The mission of the Third Circuit Court's Juvenile Mental Health Court is to provide a problem-solving approach for persons who are charged with non-assaultive offenses, and are diagnosed with a serious mental illness. Qualifying individuals are given the opportunity to voluntarily participate in the program, which offers the opportunity to receive in-home and community services, diversion, and court approved service plans, as an alternative to residential programming and the juvenile prosecution process.

The goals of the Juvenile Mental Health Court are to reduce the involvement of juveniles with mental illnesses in the juvenile justice system; reduce recidivism and residential placement of juveniles with mental illnesses in the juvenile justice system; avoid a juvenile adjudication record; reduce the burden and cost associated with prosecuting these individuals

on law enforcement; to incorporate the principles of recovery within juvenile justice and mental health; and to increase public safety.

C. Provisions

To this end, each agency agrees to participate by coordinating and/or providing the following:

The Third Circuit Court Agrees to:

1. Designate a judge to preside over the Juvenile Mental Health Court program and docket.
2. Follow procedures to determine that respondents have sufficient understanding to participate in the program.
3. Establish entry points for participant eligibility for the Mental Health Court at any point in the adjudication process
4. Designate primary court personnel responsible for answering questions, serving as liaisons to agency personnel, and participating in treatment team meetings and status review hearings.
5. Develop and implement processes by which court personnel will identify prospective program participants to the community mental health service program for assessment.
6. Identify clinical eligibility criteria for the designated target population.
7. Designate case manager roles, responsibilities and caseloads.
8. List the procedures court personnel use to relay information regarding prospective participants to the treatment agency to enable them to conduct the psychiatric assessment to determine clinical eligibility.
9. Use preferred methods, forms, and timetables for exchanging information between court staff and agency personnel regarding court-related progress and compliance of program participants, including filing of new juvenile criminal charges or technical probation violations, and reporting of drug and alcohol tests.
10. Compile and submit any mandated financial and program progress reports to the appropriate agencies.
11. Comply with all Mental Health Court Policies and Procedures developed in accordance with the 10 essential elements of a mental health court and that have been agreed upon by all parties.
12. Work with the community mental health service program to identify and invite consumer representatives on the planning committees to represent the interests of participants and their families.
13. Work with an evaluator to collect program data and participate in evaluation activities, including access to data under the Third Circuit Court's jurisdiction.

The Juvenile Mental Health Court Treatment Court Judge(s) agrees to:

1. Chair Juvenile Mental Health Court Committee meetings, preside over status review hearings, coordinate team meetings, and participate in the development of policies and procedures.
2. Use incentives, sanctions and disciplines as deemed necessary for participant success.
3. Comply with all Juvenile Mental Health Court Policies and Procedures that have been previously agreed upon and established by all parties.
4. Participate in training on how to screen for eligible participants.

The Detroit Wayne Mental Health Authority

1. Participate on the Juvenile Mental Health Court Committee.
2. Comply with all Mental Health Court Policies and Procedures that have been previously agreed upon by all parties.
3. Identify primary Authority personnel or designees responsible for answering questions, and serving as liaison to court personnel.
4. Provide a description of services including admissions and discharge criteria available to Juvenile Mental Health Court program participants and notify the court in writing of changes in program services offered.
5. Develop preferred methods, forms, and timetables for exchanging information between Authority and the Juvenile Mental Health Court docket personnel regarding progress and compliance of program participants, including appointment attendance, medication compliance, drug and alcohol test results, individualized treatment plan status, progress, changes, discharge plans, and recommendations for continuing care or additional service needs.
6. Provide training to team members on how to screen individuals exhibiting symptoms of mental illness.
7. Provide information to the Juvenile Mental Health Court team on relevant mental health confidentiality and recipient rights laws.
8. Work with an evaluator to collect program data and participate in evaluation activities, including access to data under the Authority's jurisdiction.

The Wayne County Prosecuting Attorney agrees to:

1. Participate in the Juvenile Mental Health Court Committee and staffing of cases.
2. Designate someone to attend treatment team meetings and all scheduled court proceedings, at the discretion of the prosecuting attorney for each case. In the event that the prosecuting attorney elects not to attend treatment team meetings, scheduled court proceedings or status review hearings for a case, file materials regarding such case shall be made available to the prosecuting attorney.
3. Interact with defense counsel to address pleas.

4. Comply with all Juvenile Mental Health Court Policies and Procedures that have been agreed previously upon by all parties.

The Child Advocacy Program agrees to:

1. Participate on the Juvenile Mental Health Court Committee.
2. Attend all treatment team meetings, scheduled court hearings and status review hearings.
3. Comply with all Juvenile Mental Health Court Policies and Procedures that have been previously agreed upon by all parties.
4. Interact with the Prosecuting Attorney to address pleas and the application of sanctions and incentives.
5. Assure that participant procedural and due process rights are protected.
6. Participate in training on how to screen for eligible participants.

The Program Coordinator agrees to:

1. Coordinate the work and activities of all parties serving as members of the Juvenile Mental Health Court team.
2. Serve as primary contact person for the Mental Health Court.
3. Oversee the screening of all potential participants based upon established eligibility criteria by the case manager.
4. Collaborate with the participant and Juvenile Mental Health Court team members when developing the treatment plan.
5. Comply with all Juvenile Mental Health Court Policies and Procedures that have been previously agreed upon by all parties.
6. Coordinate activities with assigned case managers without duplication of services.
7. Serve as the primary team member that coordinates services for treatment and education, and monitors participant compliance and progress with the treatment plan.
8. Participate in training on how to screen for eligible participants.

D. Methods for Exchanging and Maintaining Confidential Information

All participant medical and treatment records shall be maintained in accordance with HIPAA: 42 CFR Part 2; Michigan Mental Health Code; Michigan Public Health Code and all other applicable federal, state and local laws. Information shared among the partners shall be maintained according to the statutes, rules and regulations as they apply to that particular partner. Juvenile Mental Health Court participants and/or their parents or legal guardians shall consent to the sharing of information necessary to evaluate, adjudicate, and meet the goals of the program. Individuals and their parents or legal guardians may limit and/or revoke their consent in writing, with the understanding that

the limitation or revocation may terminate their eligibility to participate in the Juvenile Mental Health Court program.

E. Other Data Reporting Requirements

For purposes of internal evaluation, there may be several sources of data to be examined and integrated to track outcomes for individuals involved in the Juvenile Mental Health Court. Possible data sources include, but are not limited to: The Third Circuit Court Juvenile Information System, and the Community Mental Health database that would report treatment encounters and type of treatment received (e.g. hospitalization, medication review, outpatient therapy, etc.). Participation in the evaluation and agreement from the relevant stakeholders to share data has been incorporated in the MOU.

To obtain the needed information from the various databases, personal identifiers will be used to locate the necessary data. However, once the data is obtained and linked with other sources of data, the personal identifiers will be stripped from the data which will be assigned a "subject code" that cannot be linked to the individual. All subsequent analysis will be completed in aggregate. The process of using identifiers to obtain the original data, de-identifying the data, and then assigning a subject code that cannot be linked to the individual satisfies HIPAA and other confidentiality regulations.

All of the procedures for evaluation and data collection will be reviewed by the University of Michigan, and the Detroit Wayne Mental Health Authority.

F. Procedures and Conflict Resolution

The participating stakeholders acknowledge that they have a common interest in preventing any misunderstandings or differences that may arise between them from becoming claims against one another. With the intent of avoiding this, the parties agree that they shall make good faith efforts to identify such issues in advance and discuss the potential causes of disputes. The parties further agree that should an actual dispute arise among them that they shall make good faith efforts to resolve such disputes by voluntarily negotiating their own written resolution of the matter directly among the parties. The parties agree that should the matter remain unresolved for more than thirty days, the parties shall seek a mutually agreed upon neutral mediator to work out a voluntary resolution of the matter.

G. Hold Harmless Provision

The participating agencies agree to hold each other and their directors, agents and employees harmless from any and all claims, actions or proceedings arising solely out of

the acts or omissions of the agency, officers, agents and/or employees in the performance of this MOU.

The participating agencies agree that each is acting in an independent capacity and not as directors, officers, employees or agents of the other agencies.

This section must not be construed as a waiver of any governmental immunity available to a Party or its directors, officers, agents, faculty members, employees, or students.

H. Term of Agreement

This MOU is effective on January 1, 2016 and shall continue for a term of 1 ("one") year, ending on December 31, 2016.

I. Fiscal Terms

This MOU does not involve any exchange of funds. Any exchange of funds for services rendered as part of the Juvenile Mental Health Court will be described in a separate contract.

J. Terms and Conditions

All terms and conditions of this MOU are subject to the continuation of the Juvenile Mental Health Court funding.

K. Termination of Memorandum of Understanding

Upon mutual consent of all parties, this MOU is subject to further negotiation and revision as required to support the needs of the Juvenile Mental Health Court Program. Any changes shall be in writing and signed by all parties herein or their duly appointed representatives authorized to act on their behalf. This MOU may be terminated by any party for any reason by giving a 30 calendar day written notice.

L. Review of the Memorandum of Understanding

This MOU will be reviewed on a yearly basis by the Wayne County Third Circuit Court Juvenile Mental Health Court Committee and revised as necessary upon mutual agreement of all parties.

[EXECUTION PAGE(S) FOLLOWS]

SIGNATURES OF AUTHORIZED REPRESENTATIVES

Zenell B. Brown

Name and Title **Zenell B. Brown, Executive Court Administrator**
Wayne County Third Circuit Court
Date 12/16/15

COO

Name and Title
Detroit Wayne Mental Health Authority
Date 16 DEC 2015

Kym L Worthy WAYNE COUNTY PROSECUTOR

Name and Title
Wayne County Prosecutor's Office
Date 12/10/15

Mayra Attia Executive Director

Name and Title
Child Advocacy Program
Date 12/15/15

Ten Essential Elements

1 Collaborative Planning and Implementation

Organizations and individuals representing a wide range of disciplines and perspectives and with a strong interest in improving law enforcement encounters with people with mental illnesses work together in one or more groups to determine the response program's characteristics and guide implementation efforts.

Specialized responses to people with mental illnesses are an outgrowth of community policing and as such should reflect a partnership between a law enforcement agency and other stakeholder groups and individuals. Partners for the lead law enforcement agency should include mental health service providers, people with mental illnesses and their family members and loved ones, and mental health advocates. Based on the nature of the problem, additional partners could include other area law enforcement professionals; health and substance abuse treatment providers; housing officials and other service providers; hospital and emergency room administrators; crime victims; other criminal justice personnel such as prosecutors and jail administrators; elected officials; state, local, and private funders; and community representatives. Any stakeholder may initiate the planning for the specialized response, but to take root, the lead law enforcement agency must fully embrace the effort.

At the outset of the planning process, leaders from each of the stakeholder agencies who have operational decision-making authority and community representatives should come together as a multidisciplinary *planning committee.* This executive-level committee should examine the nature of the problem and help determine the program's objectives and design (see Element 2, Program Design), taking into consideration how the committee will relate to other criminal justice–mental health boards that may be in place or are in the process of being established. The planning committee also should provide a forum for developing grant applications and working with local and state officials. Although focused primarily on planning decisions, members should remain engaged during the implementation phase to provide ongoing leadership and support problem solving and design modifications throughout the life of the program.

Agency leaders on the planning committee also should designate appropriate staff to make up a *program coordination group* responsible for overseeing day-to-day activities. (In some jurisdictions, the two bodies may be the same—particularly those with small agencies, in rural areas, or with limited resources.) This coordination group should oversee officer training, measure the program's progress toward achieving stated goals, and resolve ongoing challenges to program effectiveness. The group also should serve to keep agency leaders and other policymakers informed of program costs, developments, and progress. Both groups' members should reflect the community's demographic composition.

To overcome challenges inherent in multidisciplinary collaboration, including staff turnover and changes in leadership, partnership and program policies should be institutionalized to the extent possible. Interagency memoranda of understanding (MOUs) can be developed to address key issues such as how each organization will commit resources and what information can be shared through identified mechanisms.

Specialized Training

All law enforcement personnel who respond to incidents in which an individual's mental illness appears to be a factor receive training to prepare for these encounters; those in specialized assignments receive more comprehensive training. Dispatchers, call takers, and other individuals in a support role receive training tailored to their needs.

Training must be provided to improve officers' responses to people with mental illnesses. Agencies may differ in the amount of training they offer: some will provide comprehensive training to all officers, some will provide this training only to a subset, and some will provide basic training to everyone in combination with more comprehensive training to a subset. At a minimum, a group of officers sufficient to cover all time shifts and geographic districts should receive extensive skills and knowledge training that builds on the more cursory information routinely given on this topic at recruit and in-service trainings.[12] The chief law enforcement executive should ensure that training is also provided to supervisory and support personnel, such as midlevel managers, field training officers, call takers, and dispatchers, who advance the specialized program's operations.

Planning and implementing a training initiative that supports the specialized program should be a collaborative effort between the law enforcement agency and stakeholders represented on the program coordination group. The coordination group should help guide training decisions, which include selecting content and techniques, ensuring the instruction is culturally competent, identifying and preparing trainers, and evaluating effectiveness. The group's multidisciplinary/multisystem composition helps make certain that the training initiative reflects an appropriate range of perspectives; members can identify mental health practitioners, consumers, and family members to provide some of the training instruction. Likewise, the group helps ensure quality by establishing a process for consistently reviewing and evaluating training and then modifying the curriculum based on the findings. The group can be particularly helpful in identifying resources to defray law enforcement agency costs.

Specialized training should, at a minimum, provide officers with an improved understanding of the following: mental illnesses and their impact on individuals, families, and communities; signs and symptoms of mental illnesses; stabilization and de-escalation techniques; disposition options; community resources; and legal issues. Trainers should provide sufficient opportunities for hands-on experiential learning, such as role play and group problem-solving exercises.

Training should address issues specific to the community in which it is being given. Mental health personnel and other stakeholders should be invited to participate in the specialized training to help improve cross-system understanding of agencies' roles and responsibilities, as well as to convey any requirements for accessing community-based services. Planners should brief any trainers outside law enforcement about effective techniques, language, and sensitivities to the law enforcement culture that will improve their connection with this audience. When possible, additional cross-training should be provided to improve the mental health professionals' understanding of law enforcement issues, such as ride-alongs and other opportunities to see policies translated into action.

12. For more information on various types of training opportunities for law enforcement personnel, see Council of State Governments, *Criminal Justice/Mental Health Consensus Project Report* (New York, N.Y.: Council of State Governments, 2002), www.consensusproject.org.

Stabilization, Observation, and Disposition

Specialized law enforcement responders de-escalate and observe the nature of incidents in which mental illness may be a factor using tactics focused on safety. Drawing on their understanding and knowledge of relevant laws and available resources, officers then determine the appropriate disposition.

Specialized law enforcement–based response programs are designed to resolve officers' encounters with people with mental illnesses safely and, when appropriate, link these individuals to mental health supports and services that reduce the chances for future interactions with the criminal justice system. The success of these programs is contingent on officers' using tactics that safely de-escalate situations involving someone who is behaving erratically or is in crisis. The high prevalence of trauma histories in this population requires the use of trauma-informed responses. In addition to de-escalating the incident, responding officers should assess whether a crime has been committed and observe the person's behavior within the given circumstances to determine if mental illness may be a factor. Officers should draw upon expertise acquired in specialized training and from their experiences to identify signs and symptoms of mental illness. Officers must ascertain whether the person appears to present a danger to him- or herself or others. To assist in this determination, officers may gather information from knowledgeable individuals at the scene, including mental health co-responders.

Officers must make disposition decisions based on their observations, information they gather at the scene, and their knowledge of community services and legal mandates. To assist officers in their decision making, the planning committee should develop clear guidelines that are consistent with the program's goals and governing authorities. For example, such programs might promote alternatives to incarceration for eligible individuals. If a person has come to the attention of law enforcement because of behaviors that appear to result from a mental illness and no serious crime has been committed, guidelines and protocols consistent with existing law should enable officers to divert the individual to mental health supports and services. When a serious crime has been committed, the person should be arrested.

To make these decisions, officers must be familiar with available community resources—particularly any 24-hour center that can receive individuals in mental health crises. Officers also must understand their state's criteria for involuntary emergency evaluation to make appropriate decisions regarding whether to detain and transport the person to a facility where he or she can undergo an emergency mental health evaluation. Officers must take into consideration both the individual's treatment needs and civil liberties and should pursue voluntary compliance with treatment whenever possible.

In the rare case when an incident involves barricaded individuals or de-escalation fails, responding officers will require additional support. Some agencies may equip officers who most frequently encounter people with mental illnesses with less-lethal weapons, so as to minimize injuries that could occur if there is a threat to safety and some use of force becomes necessary. Agencies should provide officers with additional training on the safe and appropriate deployment of these weapons and should establish protocols to guide officers in their decisions to use them. The planning committee also should develop protocols to make certain there is effective coordination during such incidents among specialized law enforcement responders, SWAT teams, and mental health professionals. Although agencies often are under pressure to resolve these situations quickly, it may be best, when there is no imminent threat of danger, to allow time for mental health personnel with expertise in crisis negotiation and law enforcement operations to communicate with the individual.

Information Exchange and Confidentiality

Law enforcement and mental health personnel have a well-designed procedure governing the release and exchange of information to facilitate necessary and appropriate communication while protecting the confidentiality of community members.

Law enforcement and mental health professionals should exchange information about people with mental illnesses who frequently come in contact with the justice system for many reasons: foremost among them, information sharing is essential to achieve desired outcomes by helping responders be more sensitive to individual needs, reduce injury, and enhance their ability to determine next steps. To facilitate an appropriate disposition decision, law enforcement officers should collaborate with mental health professionals to better understand the individual's mental health needs. Similarly, mental health providers working at receiving facilities can conduct a more effective mental health evaluation if law enforcement officers share their observations regarding the person's behavior at the scene. In addition to improving the outcomes of specific incidents, sharing information across systems will help program planners as they develop the program and its outcome measures.

The program's planning committee should carefully consider the type of information needed and existing barriers to its exchange and then develop procedures (and in some cases MOUs) to ensure that essential information is shared in an appropriate manner. These protocols should be reviewed during cross-training sessions, which will provide law enforcement and mental health professionals an opportunity to develop relationships with their counterparts and learn why they need certain information. Agency leaders also can explore the possibility of linking information systems to share certain information either on an ongoing or a one-time basis.[15]

Information should be shared in a way that protects individuals' confidentiality rights as mental health consumers and constitutional rights as potential defendants. The planning committee should determine which personnel have the authority to request and provide information about an individual's mental health and criminal history. In general, mental health records should be maintained by mental health professionals. Information exchanges should be limited strictly to what is needed to inform an appropriate incident response or disposition, and officers should focus on documenting observable behaviors only. All communications must, of course, comply with state and federal laws requiring the confidentiality of mental health records, such as the Health Insurance Portability and Accountability Act.[16] Cross-training should ensure that program staff understand relevant state and federal regulations about issues such as how medical information is released, secured, and retained.

Individuals with mental illnesses who have been in contact with a mental health agency should be offered an opportunity to provide consent in advance for mental health providers to share specified information with law enforcement authorities if an incident occurs (sometimes called an advance directive).[17] Individuals should be asked if an advance directive exists, and if so what the instructions are and who should be contacted to verify this information.

Officers can play an important role in exchanging information with family members and crime victims by providing explanations about criminal proceedings or diversion programs. They may inform the person with a mental illness and his or her family members about mental health treatment linkages and how to access other services or support groups, such as those related to substance use disorders. Law enforcement officers also can assist victims of crimes committed by people with mental illnesses by providing information about protective orders, victim support groups, and other services.

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15. The Bureau of Justice Assistance has supported groundbreaking advances that facilitate the electronic exchange of information between agencies. To learn more about efforts involving the development of national policies, practices, and technology capabilities that support effective and efficient information sharing, see www.it.ojp.gov.
16. For more information, see John Petrila, "Dispelling the Myths about Information Sharing between the Mental Health and Criminal Justice Systems," National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness (February 2007).
17. For more information on psychiatric advance directives, see the National Resource Center on Psychiatric Advance Directives (NRC-PAD), at www.nrc-pad.org. NRC-PAD provides an overview, forms to complete psychiatric advance directives, links to state statutes, educational Web casts and discussion forums, and other resources.

Organizational Support

The law enforcement agency's policies, practices, and culture support the specialized response program and the personnel who further its goals.

Law enforcement leaders who recognize the value of a specialized response program to reduce repeat calls for service and produce better outcomes for people with mental illnesses must create an organizational structure to support it. Leadership cannot be limited to endorsing the program and authorizing staff training. Establishing that the response program is a high priority for the agency is essential and is best demonstrated through visible and practical changes in how the agency partners with the community and realigns internal processes.

Specifically, leaders should embrace new partners and foster a supportive culture through frequent messages about the value of this type of "real" policing work. Communications with officers at every level of the agency should stress the benefits of the response program. Officers should be encouraged to volunteer for the program's assignments when possible, rather than receive mandatory reassignment. Enlisting the support of supervisors and field training officers is critical to transforming how the program will be viewed by others in the agency. A program "champion" in a position of authority within the agency and with a demonstrated commitment to the specialized program should be identified to serve as the agency's representative on the coordination group and the program's representative within the agency.

Leaders should modify officers' performance evaluations to take into account the initiative's unique objectives. As a program designed to improve the safety of all those involved in an incident and to reduce the number of people inappropriately taken into custody, success should not be measured by the number of arrests. As with other successful law enforcement problem-solving efforts, personnel performance should be evaluated and rewarded based on officers' success collaborating with and making referrals to community partners, addressing the underlying causes of calls for service, and taking measures that reduce the need for force.[19] The law enforcement agency and planning committee should acknowledge these professionals' hard work through commendation ceremonies and other forms of recognition.

Agency leaders may need to adjust officers' schedules, obtain grants, or devote funds to specialized program training, create new positions dedicated to coordinating program activities and recruiting and screening responding officers, and revise deployment strategies to maximize the availability of trained law enforcement responders across shifts and geographic areas. Agencies may find it beneficial to develop a standard operating procedure to enumerate specific processes and roles and responsibilities within the program. In some jurisdictions, these issues will require close cooperation with labor unions.

19. For more information on innovative personnel performance measures for community policing initiatives, see Mary Ann Wycoff and Timothy N. Oettmeier, *Evaluating Patrol Officer Performance under Community Policing: The Houston Experience*, U.S. Department of Justice (Washington, D.C.: National Institute of Justice, 1993).

Conclusion

Many law enforcement agencies around the nation struggle to respond effectively to people with mental illnesses. Officers encounter these individuals when citizens call them to "do something" about the man exhibiting unusual behavior in front of their business, the woman sleeping on a park bench, or someone who is clearly in need of mental health services—whether or not a crime has been committed. Law enforcement professionals in many jurisdictions have lacked community-based support, guidance, and a clear framework for crafting a program to improve their response to people with mental illnesses.

But innovative solutions are at hand. Increasingly, law enforcement agencies of all sizes are implementing creative approaches despite scarce resources. The range of approaches in communities across the country reflects the realization that strategies must be tailored to each jurisdiction's unique needs. These agencies are engaged in problem solving with a range of partners from diverse disciplines and have access to a growing pool of programs and knowledge about promising practices. This publication outlines the essential elements of successful specialized law enforcement–based efforts that reflect this expanded knowledge base and experience to better guide practitioners initiating or enhancing their own programs.

The tone of the elements may suggest that these changes are easy to make. They are not. There are many challenges to these efforts, including politics, turf battles, competition for limited funding, lack of legal foundations for officers' actions, and scarce law enforcement and community mental health resources. Leaders in jurisdictions that have implemented a specialized response acknowledge that it takes commitment to overcome these obstacles, but agree that the costs—in dollars and human lives—are too high to sanction continuing with only more traditional law enforcement responses to people with mental illnesses. Their efforts have resulted in increased public safety and improved public health.

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