**The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to the column editor, Francine Cournos, M.D., at the New York State Psychiatric Institute, 1051 Riverside Drive, Unit 112, New York, New York 10032.**

## Improving Police Response to Mentally Ill People

More than a decade ago, the tragic shooting of a mentally ill person by a police officer in Memphis, Tennessee, led to the development of an innovative program for jail diversion and improvement of police response for mentally ill people in crisis: the Memphis crisis intervention team. The team evolved and currently operates through a partnership between the Memphis chapter of the Alliance for the Mentally Ill, the University of Memphis, and other local mental health providers. As part of the Memphis Police Department's community policing initiative, the program brings together law enforcement personnel and mental health professionals, consumers, and advocates for the common goals of improving understanding of, and safety and service to, mentally ill individuals and their families.

The crisis intervention team is staffed by police officers with special training in mental health issues. Besides their regular patrol duties, team officers provide a specialized response to "mental disturbance" crisis calls. For general patrol, the officers are assigned to a specific area; however, crisis intervention team officers have citywide jurisdiction to answer these specialized calls.

When police emergency dispatchers are notified of an incident that may involve a person with mental illness, they assign that call to a crisis intervention team officer. The team officer goes immediately to the scene, assesses the situation to determine the nature of the complaint and the degree of risk, intervenes as necessary to ensure the safety of anyone involved, and then determines and implements an appropriate disposition. The officer may resolve the situation at the scene through de-escalation, negotiation, or verbal crisis intervention. Alternatively, the officer may contact the case manager or treatment provider of the person in crisis, provide a referral to treatment services, or transport the person directly to the psychiatric emergency department of the University of Tennessee Medical Center in Memphis for further evaluation.

The crisis intervention team is currently composed of approximately 180 patrol officers out of a sworn police force of 1,800; the team provides 24-hour coverage in each of the city's seven precincts. Team officers respond to about 7,000 specialized calls a year.

Patrol officers volunteer for the program. If selected, they receive an initial 40 hours of specialized training from mental health providers, family advocates, and mental health consumer groups at no charge to the police department. The officers learn about mental illness, substance abuse, psychotropic medication, treatment modalities, patients' rights, civil commitment law, and techniques for intervening in a crisis. However, advocates of the crisis intervention team are quick to point out that it is more than a training program. Among law enforcement officers it promotes a philosophy of responsibility and accountability to consumers of mental health services, their relatives, and the community.

The partnership between the police department and the medical center's psychiatric emergency department is a key element in the program's effectiveness, and procedures were developed jointly. Team officers and emergency department staff work closely to facilitate a smooth transfer of custody of people in crisis and to ensure continuity of communication about patients. The emergency department immediately accepts all referrals by the police, eliminating any conflicts about patient selection and minimizing officers' waiting time.

The Memphis Alliance for the Mentally Ill sponsors an annual award and banquet to honor team officers. The program has gained national recognition from mental health advocacy organizations such as the National Alliance for the Mentally Ill and from the criminal justice community, including the National Institute of Justice. Programs based on the Memphis model have been adopted or are being developed by cities throughout the U.S.

Although the crisis intervention team has many proponents, only recently have empirical data on the program's effectiveness become available. A National Institute of Justice study conducted by Henry J. Steadman, Ph.D., and his colleagues examined the effectiveness of three models of police response to mental health crisis calls, including the Memphis program. The results indicated that all three programs diverted mentally ill people from jail; however, the Memphis program had the lowest arrest rate of people in crisis, and the officers were on the scene more often and much more quickly. The Memphis program more frequently transported, rather than referred, people to treatment than did the other programs, and the Memphis program made the greatest positive impression on officers.

The Memphis program appears to hold strong promise for communities planning to develop partnerships between the criminal justice and mental health systems in managing crisis calls in an effective, expedient, and sensitive manner.

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## Linking Discharged Patients With Peers in the Community

Few would disagree that peer support for people with severe and persistent mental illness strengthens the likelihood of their successful reintegration into the community, but little has been done to formally develop a consumer-centered approach within the discharge planning process at state hospitals. Eastern State Hospital in Medical Lake, Washington, has set up an innovative social network intervention that links patients who are being discharged from the hospital with peers in the community. Besides providing social support and friendship, a key role of peers is to help discharged patients consistently attend their weekly case management appointments at the local community mental health center.

The hospital's social work department began the intervention by selecting inpatients with an axis I diagnosis who met discharge criteria and expressed willingness to be matched with a peer. These patients were then referred by their social worker to a discharge readiness group to prepare them for reentry into the community. Participation in the group and in the peer support intervention, which was part of the group's focus, was voluntary.

A pool of potential peers was selected from three local resources: a psychosocial rehabilitation clubhouse, an Alliance for the Mentally Ill chapter, and a Depressive and Manic-Depressive Association chapter. During patients' participation in the discharge readiness group, a profile of each patient's preferences about a peer's age, interests, and similar factors was compiled. This information was provided to the patient's case manager at the community mental health center, who then selected the peer who best matched the patient's interests and commonalities. At the patient's discharge, case managers met with the patient and facilitated the initial meeting with the peer.

Thirty-five patients who were linked with peers in the community were followed up for one month after hospital discharge. Twenty-three of these patients consistently attended their weekly case management appointments, a 66 percent compliance rate. Aftercare service records indicated that discharged patients who did not participate in the peer support intervention attended only one-third of their postdischarge appointments. A 66 percent attendance rate for discharged patients is encouraging when compared with national study reports that only 30 percent of patients keep their first postdischarge appointment.

The majority of patients who received this intervention were enrolled in clubhouse services, which made outreach by peers easier, and most peer relationships were ultimately strengthened. The peer-linkage approach proved cost-effective and easy to implement. Initial observations were that it works best as a component of the discharge planning process and that its success depends on the level of case manager involvement, the rapport established between the patient and the peer, and the quality of their developing relationship. It was also found that for the peer linkage to be successful, it must be arranged within two days of the patient's discharge.

The linkage of patients with their peers in the community is a normalizing intervention that helps ease patients' transition from a highly structured ward milieu, which is often their only social support system. Replacing such supports by facilitating an active relationship with a peer is an opportunity to model "wellness" that cannot be duplicated by mental health professionals or therapeutic groups. Such an intervention also provides a social structure that is accepting and empowering. A more formal and comprehensive peer support program is currently being developed within the hospital.

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