

**ENHANCING POLICE RESPONSE TO PEOPLE
WITH MENTAL ILLNESS IN THE DISTRICT OF COLUMBIA:
INCORPORATING THE CRISIS INTERVENTION TEAM (CIT)
COMMUNITY POLICING MODEL**



**REPORT AND RECOMMENDATIONS OF THE
POLICE COMPLAINTS BOARD**

TO

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THE COUNCIL OF THE DISTRICT OF COLUMBIA, AND
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I. INTRODUCTION AND OVERVIEW

The District of Columbia's Office of Police Complaints (OPC), and its governing body, the Police Complaints Board (PCB), were created by statute in 1999 to provide independent review of complaints filed by members of the public against Metropolitan Police Department (MPD) and D.C. Housing Authority Police Department (DCHAPD) officers.¹ PCB and OPC accomplish this function primarily by receiving, investigating, and resolving individual complaints. However, when, in the course of addressing individual complaints, PCB identifies systemic problems that, if remedied, may reduce the incidence of police misconduct, the Board is authorized to recommend corrective action to the Mayor, the Council of the District of Columbia, and the MPD Chief of Police.² It is pursuant to this statutory authority that PCB issues this report and its accompanying recommendations.³

Since OPC opened to the public in January 2001, it has regularly received complaints about MPD officer treatment of people suffering from mental illness. In some cases, individuals have been arrested and subjected to police use of force for engaging in behavior that is symptomatic, or otherwise the product, of mental illness or mental health problems.⁴ In other cases, officers allegedly have refused to assist or have treated disrespectfully members of the public suspected of being mentally ill.

PCB determined that OPC's ongoing receipt of such complaints warranted examination of MPD's policies, procedures, and training on handling persons who suffer from mental illness and merited investigation of alternatives that could improve MPD officer response to these situations. In order to gain a better understanding of the issues presented by these complaints and how best to address them, PCB consulted several officials from MPD and the D.C. Department of Mental Health (DMH), and an array of Washington-based mental health advocates and criminal justice experts, many of whom have worked cooperatively with MPD on related issues.

At the same time that PCB gathered information about how components of the criminal justice and mental health systems in the District have worked together to address the needs of people with mental illness, PCB examined police department best practices from around the country. PCB found innovative models in which police officers develop expertise in recognizing and responding appropriately to people with mental illness and partner closely with mental

health professionals in ways that reduce arrests of individuals suffering from mental illness, reduce injuries to police officers and citizens, and link people in need of mental health treatment with mental health services.

Of the different models examined, PCB believes that the Crisis Intervention Team (CIT) model, pioneered by the Memphis Police Department in 1988, would best serve the District of Columbia. In addition to studying how this model operates and has been implemented in other places, including nearby Montgomery County and Baltimore, two OPC staff members visited Memphis and met with representatives of the Memphis Police Department, the Memphis mental health system, and Memphis-based advocates for consumers of mental health services. The OPC staff members also participated in full-shift, CIT officer ride-alongs, in an effort to gain first-hand knowledge of how this model works in practice.

Based on the information gathered by PCB, the Board recommends that the District of Columbia implement CIT because:

- Of all the specialized police department responses to mental illness, CIT involves a fundamental change in police officer attitudes about, understanding of, and methods of responding to mental illness, a shift in thinking that PCB believes is needed in the District of Columbia and that would benefit the District and its police force in several ways;
- If fully implemented, CIT would make available, at all times in all parts of the city, police officers with the expertise to de-escalate a mental health crisis and quickly connect people in crisis to mental health professionals, who in turn would facilitate access to appropriate treatment;
- Successful implementation of CIT would reduce police misconduct that stems from inappropriate responses to people with mental illness, reduce arrests of persons suffering from mental illness, reduce police officer and citizen injuries associated with mental health crises, and reduce the filing of lawsuits against the city that stem from inappropriate handling of people with mental illness;
- Implementation of CIT would require the formation, and consequently foster the development, of a strong partnership among MPD, DMH, community-based

mental health service providers, consumers of mental health services, and advocates for people who suffer from mental illness, a collaboration that would benefit the entire District of Columbia community;

- The District of Columbia already has in place a number of the essential components necessary to implement a CIT program; and
- It would be better for the District to proactively adopt CIT now rather than reactively adopt it later in response to public outcry over an avoidable tragedy, such as the shooting of an unarmed, mentally ill person.

As this report was being prepared, PCB learned that other District of Columbia agencies recently have considered the need for a specialized police response to people with mental illness. On April 20, 2006, the Substance Abuse and Mental Health Workgroup of the District's Criminal Justice Coordinating Council (CJCC) issued a preliminary report concluding, among other things, that MPD implementation of a CIT program in Washington, D.C., would significantly aid efforts to divert individuals with co-occurring mental health and substance abuse disorders away from the criminal justice system, thereby increasing opportunities for treatment.⁵

A related development occurred in April 2006, when Stephen Baron, former head of Baltimore's public mental health authority, was appointed director of DMH. Mr. Baron had worked with mental health and law enforcement professionals to establish a CIT program in Baltimore and was able to provide insight on the merits of the program to members of the District's Jail Diversion Task Force and the CJCC as those groups considered the possible value of a CIT program to the District of Columbia. Mr. Baron assisted in arranging a formal presentation to MPD Chief Charles Ramsey and other members of MPD management by Major Sam Cochran, coordinator and co-founder of the Memphis Police Department's CIT program. As a result of that presentation, held June 29, 2006, MPD indicated receptiveness to improving how its officers respond to people with mental illness.

Subsequently, on August 30, 2006, the CJCC's Substance Abuse and Mental Health Workgroup held a roundtable discussion attended by representatives of the District Government's criminal justice, mental health, and substance abuse treatment agencies. Among

the issues discussed was whether the CIT community policing model should be implemented in Washington, D.C. The discussion resulted in establishment of a task force, to be led by representatives of MPD and DMH, that will examine various program models, including CIT, pursuant to which police and mental health professionals work together closely in addressing mental health crises. The task force will submit a report and recommendations by October 31, 2006, regarding which, if any, of the models should be adopted in the District of Columbia.

Based on PCB's review of the merits and the feasibility of adopting the CIT model, PCB urges the CJCC Substance Abuse and Mental Health Workgroup, and other District officials, to carefully consider PCB's report and its accompanying set of detailed recommendations, which offer a blueprint for prompt and successful implementation of CIT in the District of Columbia.

PCB's endorsement of the CIT model is not founded merely on the successful track record of CIT in other jurisdictions, as each community is different. Rather, PCB arrived at the conclusion that the District would be well served by the CIT model only after researching information about each of the primary models and considering the resources needed to implement them, and after exploring the capacity and willingness to implement CIT of those specific components of MPD and DMH most likely to be affected if that model were adopted. PCB found a level of interest and readiness that, when considered together with the many benefits that the District stands to realize, compels serious consideration of the CIT model.

PCB further urges District leaders not to delay implementing CIT based on a perceived need for further study. The District's need for a program such as CIT has been recommended and studied several times over the last decade, including in the late 1990s when the D.C. Jail Diversion Task Force recommended adoption of CIT while working with MPD to improve its officer training on handling people with mental illness, and again in 2004, when the Urban Institute, in a report commissioned by the CJCC.⁶ The Urban Institute's report concluded that as part of the District's strategy to assist individuals with co-occurring mental health and substance use disorders, MPD should institute changes that would permit its dispatchers and officers to better identify situations involving mental health issues and respond to such situations in a more therapeutic and collaborative manner in order to facilitate treatment where arrest and incarceration are inappropriate.⁷ All of these goals would be accomplished if CIT were adopted. Allowing further delay means that mentally ill people in the District will continue to face inappropriate treatment, arrest, and incarceration when they experience a mental health crisis to

which police are called. Delay also increases the risk that officers or citizens may be seriously injured or killed during a mental health crisis that is mishandled, resulting in the continued filing of lawsuits and the potential for monetary liability against the city.

II. THE NEED FOR SPECIALIZED POLICE RESPONSE TO PEOPLE WITH MENTAL ILLNESS IN THE DISTRICT OF COLUMBIA

A. Complaints Filed with OPC

OPC has received several police misconduct complaints that reveal deficiencies in the abilities of officers to recognize and respond appropriately to persons who suffer from mental illness. The complaints demonstrate two distinct concerns: (1) officers who escalate an encounter into an altercation that leads to use of force or arrest either because they do not recognize symptoms of mental illness or lack the skills to de-escalate the situation without confrontation and arrest; or (2) officers who recognize or suspect that a person is suffering from a mental illness but do not assist the individual. Consideration of the allegations in a few of the complaints that OPC has received helps illustrate the concerns.

In one complaint, a man went into a CVS store late at night to make a purchase and got into an argument with a store clerk over the price of an item. An off-duty MPD officer, who was working as a security guard at the store, intervened and ordered the man to leave. The man insisted on being allowed to purchase the item and shouted profanity at the officer. The officer then attempted to physically eject the man from the store. The man pulled away from the officer and flailed his arms, almost striking the officer. The man was then placed under arrest for disorderly conduct and unlawful entry. When transport officers arrived, the man continued to resist arrest by cursing and banging his head repeatedly against the metal door of the transport wagon. The man later filed a complaint alleging that the officers had used unnecessary or excessive force against him. In investigating the man's complaint, OPC learned that he suffered from paranoid schizophrenia, had not taken his medication on the date of the incident, and had consumed alcohol. OPC also learned that the man had been arrested multiple times before for exhibiting behavior that may have been symptomatic of his mental illness.

In another case, MPD officers were dispatched to a location in response to a call that reported an unconscious person. When the officers arrived, they saw the complainant, a homeless man, sleeping under a plastic covering. The officers feared the man may have been

suffering from hypothermia because it was cold. The officers awakened the man and ordered him to remove his plastic and leave the area. The man became upset that he had been disturbed, and began cursing and yelling at the officers. The officers then forcibly arrested the man for disorderly conduct. The man filed a complaint alleging that he been subjected to harassment. Information obtained from the complainant indicated that he suffered from an unspecified mental illness and alcohol abuse.

In a third case, a homeless man alleged that an MPD officer discriminated against him based on his race and his status as a homeless person by refusing to take seriously his report that he had just been the victim of an assault. The man alleged that he had been beaten with a belt by another homeless person. The man reported his allegations to an MPD officer who had been dispatched to the scene, and he pointed out his alleged assailant. However, the officer declined to take notes or otherwise document the complainant's report of crime, allowed the alleged assailant to leave the area, and asked the complainant if he was mentally ill or on medication for mental illness. When the complainant began crying, the officer allegedly laughed at him, called him a racially-derogatory term, and left without assisting him. In the course of investigating the complaint, OPC learned that the subject officer confirmed that the man was homeless but believed he was mentally ill because of the appearance of white foam around his mouth, which the officer assumed was a side effect of medication for mental illness. It was later determined, through the work of an officer assigned to MPD's Gay and Lesbian Liaison Unit (GLLU), that the man had in fact been assaulted, and the alleged assailant was thereafter convicted of the assault in District of Columbia Superior Court.⁸ An OPC complaint examiner subsequently determined that the first officer had unlawfully discriminated against the man by failing to assist him.⁹

Finally, in a fourth matter, a woman filed a complaint with OPC in which she alleged that she had gone to MPD's Third District police station to report that she had been subjected to domestic abuse. The complainant alleged that an officer at the station spoke to her disrespectfully, pushed her out of the station, and warned her that if she came back she would be arrested. In the course of investigating the complaint, OPC learned that the woman suffered from a mental illness that caused her to exhibit bizarre behavior and to complain repeatedly to police and other agencies about imaginary problems and forces, a factor that may have led police to refuse to assist her.¹⁰

B. Incidents in Which People with Mental Illness Have Been Killed by Police

Complaints received by OPC are not the only indication of the need to improve the way MPD officers handle situations involving people with mental illness. Far more serious are instances in which individuals experiencing a mental health crisis have been killed by police. The most recent was the fatal shooting of Terrance Andre Nowlin on April 29, 2005, in Southeast Washington by two MPD officers. It is alleged that Mr. Nowlin had a history of mental illness and was attacking a female family member when police arrived.¹¹ It is further alleged that the officers first attempted to subdue Mr. Nowlin using police batons and subsequently shot him after he had ceased attacking his relative and had begun walking toward the officers.¹² Mr. Nowlin was unarmed, however, and his family has now filed a civil action against the District of Columbia in federal court.¹³ The suit alleges, among other things, that officers should have provided a verbal warning to Mr. Nowlin and should have used less-than-lethal tactics to subdue him, given that he was unarmed and no longer attacking the relative.¹⁴ The suit seeks \$50,000,000 in damages.¹⁵

Such incidents regularly occur in the metropolitan Washington area and show that the problem is not limited to the District of Columbia. On May 14, 2006, for example, Anne Arundel County, Maryland, police fatally shot 18-year-old Justin Fisher, who allegedly was suicidal and carrying scissors as he approached police.¹⁶ It is alleged that Justin's mother had called police earlier that day to report that Justin, who suffered from a mental illness, had been threatening to hurt himself and his girlfriend and may not have been taking medication prescribed for his mental illness.¹⁷ When police stopped Justin's car near his girlfriend's home, he allegedly got out of his car with a pair of scissors pressed to his throat.¹⁸ Following a 35-minute standoff, Justin allegedly ran toward police holding the scissors in front of him.¹⁹ Four officers fired at Justin, striking him five times in the upper body.²⁰ This incident was the fourth in a year in which Anne Arundel County police used deadly force against a citizen, and it is alleged that three of the four persons killed were experiencing a mental health crisis at the time of their deaths.²¹ Justin Fisher's death led to renewed pleas from the community for Anne Arundel police to modify how they handle people with mental illness.²²

C. Increased Incidence of Encounters Between Police and People with Mental Illness in the District of Columbia

The complaints highlighted above illustrate that in Washington, as is the case elsewhere, police frequently encounter people who suffer from mental illness. It has been reported that law enforcement professionals “interact with more persons with mental illness than any other occupational group outside the mental health field.”²³ This is attributable in part to the shift over the last several decades away from institutionalized care of persons with mental illness and the failure to have replaced institutional care with sufficient community-based treatment and affordable housing.²⁴ The District of Columbia’s experience with this national phenomenon is well documented in the history of *Dixon v. Weinberger*, 405 F. Supp. (D.D.C. 1975), the class-action lawsuit that was instituted for the purpose of securing the right of mentally ill persons in the District of Columbia to treatment in the least restrictive setting and that led to a major, permanent decrease in the population of St. Elizabeth’s Hospital, the District’s public psychiatric hospital. The District’s struggle to comply with the terms of the *Dixon* consent decree has continued up to the present time. Having recently emerged from court receivership, DMH has made great strides toward creating a mental health system that focuses on community-based systems of care. However, the transition is far from complete, and gaps that remain to be filled are a factor in the prevalence of untreated or inadequately treated mental illness in the District of Columbia.²⁵

It is estimated that between 6% and 9% of the adult, unincarcerated, non-institutionalized population of the District of Columbia suffers from serious mental illness.²⁶ However, it has been reported that as many as one third (33%) of people detained at the District of Columbia Detention Center (D.C. Jail) suffer from serious mental illness.²⁷ These statistics demonstrate that in the District of Columbia, persons with serious mental illness are disproportionately represented in the jail population. These numbers also indicate extensive contact between police officers and mentally ill persons in the District, as persons with mental illness who are detained at the D.C. Jail arrive through arrest, usually by MPD officers.

Other indicia of the increased opportunity for police officers in the District of Columbia to have encounters with people suffering from mental health problems are found in statistics on homelessness. More than 16,000 people, or 3.2% of the population of the District, are homeless over the course of a year.²⁸ This is reported to be the highest rate of homelessness in the

country.²⁹ It is estimated that 25% of people who are homeless meet criteria for serious mental illness.³⁰ Of those who are homeless and seriously mentally ill, 50% have co-occurring mental illness and substance use disorders.³¹ Moreover, homeless individuals with serious mental illness are twice as likely as other homeless people to be arrested and jailed, mostly for misdemeanors.³²

Police in Washington regularly come into contact with people experiencing mental health problems not only because more people with mental illness are in the community as a result of deinstitutionalization and homelessness, but also because in the District, as in most other communities, the city relies on the police to be all-purpose first-responders. “Police are first-line, around the clock, emergency responders, mediators, referral agents, counselors, youth mentors, crime prevention actors, and much more.”³³ In an effort to assess how police departments have coped with their “first responder” role in the mental health context, researchers conducted a survey of police departments in 174 U.S. cities with populations greater than 100,000. The survey found that 7% of all police contacts, including complaints and investigations, involve persons believed to be mentally ill.³⁴ MPD estimates that it responds to approximately 500,000 calls for service annually.³⁵ Applying the survey results to MPD’s statistics indicates that MPD officers have at least 35,000 encounters annually with persons suffering from mental illness.

Because MPD officers have many contacts with persons who are experiencing mental health problems, and because such encounters pose unique challenges, it is essential that they be handled properly. The way police respond to persons with mental illness has a tremendous impact not only on how particular encounters are resolved but on the future such persons can expect to have.³⁶ One difficulty, however, is that officers frequently do not realize that a person with whom they are dealing may be experiencing a mental health problem.³⁷ A person engaged in disorderly conduct in a public place is a typical example of a person who may be experiencing a mental health crisis without it being apparent.³⁸ When officers try to handle such a situation as usual (by giving directions, issuing commands, or making an arrest) and do not get the cooperation or compliance expected – as active, untreated mental illness can make it difficult, if not impossible, to comply – officers often escalate the tension by using force or other measures that exacerbate the crisis.³⁹ Experts have observed that reliance on traditional police tactics when responding to people with mental illness not only is ineffective but often turns tragic.⁴⁰

Police officers' failure to recognize signs of mental illness and insistence on using traditional police tactics in situations where they are ineffective is not the only concern. In instances where police know or suspect that a person is mentally ill, they often respond based on commonly-held misconceptions.⁴¹ Contrary to popular belief, however, "most people with mental illness are not criminals, and of those who are, most are not violent."⁴² Indeed, "encounters with police are more likely to be dangerous for people with mental illness than for police.... It is estimated that people with severe mental illness are four times more likely to be killed by police."⁴³

The fact that MPD officers often encounter people with mental illness and either do not recognize signs of mental illness or recognize mental illness but nevertheless respond inappropriately, underscores the need for a specialized response that emphasizes training in mental illness recognition and crisis management techniques.

Additionally, MPD adoption of a specialized response to handling persons with mental illness appears to be required by the Americans with Disabilities Act (ADA).⁴⁴ Title II of the ADA prohibits any state or local government agency from discriminating against persons with disabilities in any program, service, or activity that the agency provides.⁴⁵ As a municipal law enforcement agency, MPD is obligated by the ADA to ensure that its officers extend to persons with disabilities the same protections and services it extends to the non-disabled. To achieve this equality, the ADA requires law enforcement agencies to modify policies, practices and procedures as necessary to reasonably accommodate people with disabilities. Mental illness is a disability covered by the ADA.⁴⁶ Because an individual in a mental health crisis often lacks the capacity to respond to police in the way a non-disabled person can, officers may need to modify their standard procedures in order to ensure that such people are handled appropriately. MPD's not having an adequate program in which officers receive specialized training and skill necessary to provide an appropriate, modified response to persons with mental illness could lead to legal liability against the city.⁴⁷

D. Current MPD Policy and Training on Handling Mentally Ill People

MPD's policies and procedures regarding handling people with mental illness are primarily contained in MPD General Order 308.4. A major revision of this order took place in

September 2000 with significant input from District mental health and criminal justice advocates, including members of the D.C. Jail Diversion Task Force.

General Order 308.4 primarily outlines criteria and procedures to be followed in transporting, either voluntarily or involuntarily, suspected mentally ill people to DMH for emergency psychiatric evaluation and observation. Significantly, the order also contains the following official policy statement: “The policy of the Metropolitan Police Department is to treat and process suspected mentally ill persons in a manner which reflects sensitivity to the needs and rights of the persons involved, and to work cooperatively with all public and private institutions to provide citizens of the District of Columbia with a viable and effective mental services program. Understanding that mental illness is a disease and not a crime, it is preferable to assist a person into treatment rather than jail, especially for quality of life crimes.”

The policy statement contained in General Order 308.4 acknowledges that people with mental illness are a special population meriting sensitivity in handling and that it is preferable to refrain from arresting them for minor offenses. The issue is that this policy does not appear to have been communicated or emphasized often enough to the patrol force. Accordingly, people with mental illness are routinely arrested for minor offenses based on behavior that is a manifestation of mental illness.

MPD’s current in-service officer training on handling suspected mentally ill persons was instituted at the same time that General Order 308.4 was revised. As with General Order 308.4, the training was developed with input from mental health and criminal justice advocates who saw the need for MPD officers to better understand mental illness and its effects and to acquire techniques for de-escalating a mental health crisis.

The course consists of a four-hour presentation by mental health professionals and is required to be taken by all officers and sergeants. The course provides a basic understanding of mental illness and describes symptoms of particular mental illnesses that are common among people with whom police interact. A psychodrama/role-play is used to teach de-escalation techniques. The course also discusses the emergency psychiatric evaluation process in the District of Columbia and reviews with officers the rules and circumstances under which police may voluntarily or involuntarily transport and refer members of the public for emergency psychiatric evaluation.

MPD's training course on mental illness is valuable in that it is taught by mental health professionals and relays basic information about what mental illness is, how it impacts a person who is suffering from it, and the ideal way that officers should approach and interact with people in crisis. It is also commendable that the course is required to be taken at some point by all officers and sergeants. One concern is that the course is not offered every year. A larger concern is that the course is too brief. The Police Executive Research Forum, for example, recommends that police officer training on responding to people with mental illness should entail at least 16 hours of instruction.⁴⁸ It is easy to understand why a minimum of 16 hours is recommended for such a course. MPD's four-hour course is too short to permit the trainers to go into depth about many significant matters. Moreover, there is not enough time for each officer in attendance to practice the de-escalation skills taught. There also is insufficient time to educate officers about the network of community-based mental health service providers and ways officers might use this as an alternative to arrest. It is also problematic that officers are not required to incorporate information from the course into their policing strategies.

The training, with the exception of certain procedures mandated by General Order 308.4 and the Ervin Act,⁴⁹ the District's civil commitment law, thus amounts to useful but voluntary suggestions that officers may incorporate as they see fit. While there are definitely officers who internalize and draw on the training, it is evident from the OPC complaints, as well as from D.C. Jail mental illness statistics, that many officers do not recognize mental illness, do not seek to de-escalate situations in which mentally ill persons experience behavioral crises, and routinely arrest and charge such persons with minor offenses. It is clear, therefore, that to effectuate the policy statement contained in General Order 308.4, there needs to be a significant change in the way MPD officers respond to people who suffer from mental illness.

III. POLICE DEPARTMENT BEST PRACTICES FOR RESPONDING TO PEOPLE WITH MENTAL ILLNESS

Over the last 15 to 20 years, law enforcement agencies across the country have recognized the need to improve how their officers interact with people suffering from mental illness.⁵⁰ This has led to the development of innovative partnerships between law enforcement and the mental health community and to the development of alternative policing strategies designed to better serve people with mental illness.⁵¹ The main objectives of these efforts have

been: (1) reduction of arrest and incarceration of mentally ill persons for exhibiting symptoms of untreated mental illness; and (2) enhanced safety of police officers, people with mental illness, and other members of the public.⁵²

The three main program models that have emerged are: (1) the “police-based specialized police response,” in which police officers who receive intensive training in recognizing and understanding mental illness as well as in negotiating in a non-confrontational manner provide crisis intervention services and link people in crisis with mental health professionals who determine and arrange appropriate mental health treatment; (2) the “police-based specialized mental health response,” in which mental health professionals, who are employed directly by the police department, either travel with police officers to the scene of a mental health crisis or provide consultation to officers by telephone; and (3) the “mental health-based specialized mental health response,” in which mental health department-operated mobile crisis units, consisting of vehicles staffed by mental health professionals, assist police by traveling to the scene of a mental health crisis.⁵³

The first model – police-based specialized police response – is popularly known as the crisis intervention team (CIT) or “Memphis model” and was created by the Memphis, Tennessee, Police Department in 1988. Hybrid programs also exist, in which one or more of the three primary models are combined.⁵⁴ For example, Montgomery County, Maryland, combines the CIT model with the mental health-based specialized mental health response.⁵⁵ The county’s CIT officers act as first responders and, when necessary, those officers are joined by mental health department-operated mobile crisis units. Similarly, Los Angeles, California, combines “CIT-like” specially trained police officers with mental health professionals who are employed directly by the Los Angeles Police Department.⁵⁶

There are advantages and disadvantages associated with each model. The second and third models, which rely on mental health professionals to provide mental health expertise at the scene of a mental health crisis, are attractive because it is generally agreed that, where possible, it is preferable to have the expertise of a professional in responding to people with mental illness. The disadvantage, however, is that few police departments have the resources to hire a sufficient number of mental health professionals to respond to all or even most incidents requiring mental health intervention.⁵⁷ Similarly, mental health departments generally cannot afford to provide a sufficient number of mobile crisis units to serve as first or even second responders on most

incidents requiring mental health intervention.⁵⁸ Moreover, even the limited number of mobile crisis units that typically are available have been associated with slow response times and lack of availability after midnight and on weekends, often leaving police officers who do not have specialized mental health training to handle most mental health crises.⁵⁹

The CIT model, which relies on specially trained police officers to defuse a crisis and then quickly put mentally ill people into contact with mental health professionals, is the one approach that has been found to be capable of providing immediate, specialized response to virtually all calls for service identified as requiring mental health intervention.⁶⁰ Because the CIT model has proven to be efficient, practical, and successful at reducing arrests of mentally ill persons while improving officer and citizen safety, it has been implemented either alone, or in conjunction with one of the other models, in several major cities, including Memphis (population 650,100); Baltimore (population 635,815);⁶¹ Albuquerque (population 494,236); Houston (population 2,016,582); Denver (population 557,917); San Jose (population 894,943); Seattle (population 563,374); Las Vegas (population 545,147); and Portland (population 556,370).⁶² CIT has also been successfully adopted in several smaller cities, including Akron, Ohio (212,000); Hartford, Connecticut (population 121,578); St. Louis, Missouri (348,189); Minneapolis (population 382,618), and Miami (population 362,470).⁶³

The United States is not the only country where CIT programs have been adopted. The Independent Police Complaints Commission (IPCC), a police oversight agency with authority for investigating police misconduct complaints in England and Wales, is working with police departments in Great Britain to foster the adoption of CIT training and programs, and some have already been implemented.⁶⁴ The IPCC began advocating reform of police training and procedures for handling people with mental illness after finding that mental illness was a factor in many of the most serious cases of police misconduct and that 50% of persons who died in police custody suffered from mental health problems.⁶⁵

IV. THE CRISIS INTERVENTION TEAM (CIT) MODEL

The CIT model, which has been recognized as a best practice by the U.S. Department of Justice⁶⁶ and the U.S. Department of Health and Human Services⁶⁷ consists of a select group of police officers who, although continuing to serve as regular patrol officers in a district or precinct, are certified to provide highly specialized mental health crisis intervention.

CIT officers serve as front line responders and links to the mental health system. CIT officers respond both to calls involving people experiencing mental health problems and to regular, non-mental health-related calls within their patrol areas. There are a sufficient number of CIT officers in each patrol district during each shift to permit these officers to alternate between regular patrol duties and responding to mental health crises. This method of CIT staffing allows immediate, specialized response to mental health problems throughout the city at all times.⁶⁸ Because CIT officers return to their regular, non-CIT duties upon completion of a CIT call, the police department is able to maintain adequate staffing in all districts for the full range of other law enforcement priorities.

When a CIT officer arrives at the scene of a mental health disturbance, the officer will attempt to de-escalate the situation through compassionate communication and avoidance of aggressive action. The CIT officer will, to the greatest extent possible without compromising officer or bystander safety, avoid use of force and avoid causing injury to the mentally ill person. In addition to seeking to prevent or reduce injury, the CIT officer will seek to determine what kind of assistance the individual needs. If emergency psychiatric evaluation appears necessary, the CIT officer will transport the person to the mental health triage center, where a mental health professional will make the decision regarding the appropriate course of action. If emergency evaluation is not necessary but mental health intervention is needed, the CIT officer may refer the individual or that person's family to appropriate community-based mental health services or may call a mobile crisis unit, staffed by a mental health professional who can intervene. A CIT officer might assist the person to contact a mental health case worker or a homeless outreach worker or shelter. A CIT officer might also help simply by listening supportively. CIT officers do not act as mental health professionals or social workers; however, they are trained to understand and assist mentally ill people in crisis.

As illustrated above, CIT officers use non-traditional policing strategies when handling a mental health crisis. The traditional model of policing emphasizes the assertion of authority and maintenance of verbal and physical control. In contrast, CIT officers – who develop in-depth knowledge of various mental illnesses and their symptoms, empathy for people in the throes of a mental health crisis, mastery of the use of de-escalation skills in the specific context of mental health crises, and extensive knowledge of available community mental health services – are encouraged to connect with and calm a person in crisis while determining whether and how to

link the individual to mental health services. The stark difference between the CIT method and traditional policing is reflected in this description from a training article in *Police Magazine*: “The essential difference between suspect encounter training that officers traditionally receive and how to approach the mentally ill is the need to be non-confrontational. Such a requirement ... is diametrically opposed to the way officers are routinely expected to control conflict. The same command techniques that are employed to take a criminal suspect into custody can only serve to escalate a contact with the mentally ill into violence.”⁶⁹

CIT officers are taught to achieve compliance by avoiding the use of force. However, in instances where CIT officers are confronted by a mentally ill person with a weapon (which usually is not a gun) or who poses an imminent threat to the safety of others, they are trained, equipped, and encouraged to use less-than-lethal weapons whenever possible, but remain authorized to employ deadly force if necessary. CIT officers deliberately avoid confrontations that result in arrest of mentally ill people for minor offenses. However, where a serious criminal offense has been committed, CIT officers will arrest the person. Even in that instance, however, CIT officers refrain from further agitating the individual.

Not every officer is well-suited to perform the unique duties of a CIT officer that require interacting with mentally ill persons in crisis with calmness and compassion. Accordingly, applicants are carefully screened for experience, maturity, personality traits, communication skills, and disciplinary records that indicate fitness. CIT officer candidates complete a 40-hour certification training course initially and, thereafter, receive up to 16 hours of CIT in-service training annually. Non-CIT officers receive 8 to 16 hours of mental health training to ensure that they have basic knowledge of mental illness and how a mental health crisis should be handled. The non-CIT officer training is important because although CIT officers serve in the lead role on mental health disturbance calls, they are never alone. Non-CIT officers also respond to CIT calls in order to assist and support CIT officers.

CIT officer training is coordinated by the police department but includes trainers from the local mental health community and other community partners, such as the local chapter of the National Alliance for the Mentally Ill (NAMI). Cooperation between the police department, the mental health community, and consumers of mental health services and their advocates continues throughout the life of the program and is a key feature of this model. CIT has been described as community policing at its best.⁷⁰

A crucial component of the CIT model is dispatch operations. To ensure that calls involving mental health issues are properly identified and that CIT officers are dispatched to those calls, dispatchers and 911 call takers receive specialized training on how to perform their duties in support of the CIT program. Dispatch operations also play a critical role in the creation of data that are collected and analyzed to evaluate the CIT program. Police departments with CIT programs tend to employ a broader array of codes to help identify types of mental disturbance calls and to note the various dispositions that can occur. Computer Assisted Dispatch (CAD) technology is also used by CIT programs to anticipate and prepare for mental health disturbances in certain areas.⁷¹

A number of important benefits have been found to result from adoption of the CIT model. First and foremost is better treatment of people with mental illness by police. A related, although distinct, benefit is linking more persons in need of mental health services to treatment.⁷² CIT also reduces arrests of people with mental illness and thereby reduces the inappropriate use of jails to house persons with symptoms of mental illness, reduces use of force, and reduces police officer and citizen injury.⁷³ Moreover, the reduction in use of force by CIT officers has resulted in a decrease in lawsuits and liability for damages stemming from use of excessive force and other inappropriate action in handling people with mental illness.⁷⁴

Among the welcome, although unanticipated, benefits is a reduction in the number of people who are involuntarily committed or who are subject to temporary involuntary evaluation.⁷⁵ It is believed that this outcome results from the calming effect of de-escalation techniques, frequent CIT officer use of community-based mental health resources, and reliance on community-based mental health services, where appropriate, by psychiatric triage centers.⁷⁶

In addition to reducing officer injuries, CIT has benefited police departments in other ways. One major, although difficult to measure, benefit is improved relations between police and the community. CIT officers report that when citizens repeatedly witness them responding in a caring, non-threatening manner to people with mental illness, there is a concomitant rise in citizen cooperation with and respect for the police.⁷⁷ Family members of mentally ill persons especially report acquiring renewed faith and trust in law enforcement after witnessing CIT officers treat their family members with understanding and dignity.⁷⁸ CIT officers report that they frequently employ their CIT communication and negotiation skills in non-CIT contexts and as a result are able to handle more situations non-confrontationally than they could before they

became CIT officers.⁷⁹ Use of CIT officers has also decreased the need to utilize specialized “SWAT” teams for low-level mental health crises.⁸⁰ It should be noted that CIT does not usurp or supplant the role of SWAT teams, as their functions, training, and expertise are different. Nevertheless it has been found that CIT officers have helped reduce the need to deploy SWAT officers in situations not involving barricades, hostages, or deadly weapons.⁸¹ Finally, the professional development that CIT officers undergo produces a cadre of leaders who make good candidates for supervisory positions within the police department over time.⁸²

CIT has also been praised as a low-cost initiative. CIT officers receive almost no pay differential above non-CIT patrol officers. The community approval of their function, informal non-monetary recognition and nurturing from within the police department, and pride in holding the CIT designation have proved to be more than sufficient to attract and retain CIT officers in other jurisdictions.⁸³ In addition, the organizations with whom a police department partners in creating a CIT program often provide various components of the training free of charge.

A graphic illustration of the positive difference a CIT program can make is found in *Crazy: A Father's Search Through America's Mental Health Madness*, a recently published book by award-winning journalist, author, and former Washington Post reporter, Pete Early. This portrait of the plight of people whose mental illnesses cause them to become entangled with the criminal justice system describes how a young man in Miami-Dade County who suffered from schizoaffective disorder, and who was in the midst of a severe mental health crisis, was shot and killed by non-CIT-trained Miami-Dade County police officers after he picked up a shard of broken glass from a window he had broken. The book notes that at virtually the same time the young man in Miami-Dade County was killed, CIT-trained officers in the Miami (City) Police Department disarmed a mentally ill man in crisis who was swinging a butcher knife without injury to the man, the police, or other citizens.⁸⁴ This tragic irony is but one of many discovered by Mr. Early during his journalistic exploration of the criminalization of mental illness. Among the solutions Mr. Early felt compelled to champion in the concluding chapter of his book is this: “Every police department in America should implement Crisis Intervention Team training.”⁸⁵

V. IMPLEMENTING CIT IN THE DISTRICT OF COLUMBIA

PCB has no doubt that the District of Columbia would benefit tremendously from a CIT program. Fortunately, there would be little difficulty implementing CIT in the District because it already has in place the essential elements necessary for this program to work. The first is a police department organized for community policing.⁸⁶ With seven districts and 46 police service areas (PSAs), CIT officers could be assigned and scheduled to meet the individual needs of each district and PSA.⁸⁷ Moreover, because community policing is MPD's overarching operational philosophy, the department already has significant experience operating initiatives that involve extensive collaboration with citizens and non law-enforcement groups and agencies.⁸⁸

MPD also has available within its ranks officers who could readily become good CIT officers. In the course of gathering information for this report, PCB learned of a number of officers who possess the interest, sensibilities, and "knack" for interacting positively with mentally ill people and who already informally act as CIT officers when they have the opportunity. Having a CIT program would provide the support and training that these officers need to continue their efforts while expanding their ranks. Most cities that have adopted the CIT model achieve full CIT coverage when approximately 25% of the patrol force is CIT certified, a process that typically takes from three to five years to achieve. In the District, that would translate into approximately 450-500 CIT-certified officers within five years of implementing CIT.

MPD's Office of Police Communications is also currently equipped to be able easily to support a CIT program. Indeed, PCB discovered in preparing this report that the technology and organization of MPD's communications division are nearly identical to that of the Memphis Police Department, where CIT has flourished. MPD communications officials have already acknowledged that changes in dispatch protocols and training that would need to occur in order to support a CIT program could easily be done. These officials likened a CIT transition to changes that were made in support of MPD's domestic violence initiative.

Although as shown in the section on best practices, CIT has been adopted in cities large and small, it is worth noting that the District has demographic characteristics that favor successful implementation of CIT. At 550,521, the District's population, though smaller, is similar to that of Memphis (650,100).⁸⁹ The racial makeup of the District's population (56%

black, 36% white, 8% Hispanic, 3% Asian) is also similar to Memphis (61% black, 34% white, 3% Hispanic, 2% Asian).⁹⁰ Moreover, because the District's police force is larger (3,800)⁹¹ than that of Memphis (2,000)⁹² and because the District's land area (61 square miles) is significantly smaller than that of Memphis (279 square miles), it should be easier to deploy CIT officers in the District than it is in Memphis.

Several key components of the District of Columbia's mental health system also would make implementation of CIT easy. The first is a 24-hour emergency psychiatric triage center, DMH's Comprehensive Psychiatric Emergency Program (CPEP) unit, to which officers can bring persons in crisis and that strives to allow officers to return to patrol duty as quickly as possible.⁹³ One current weakness is CPEP's lack of emergency medical services. This makes it difficult for police officers who bring in people needing both mental health and medical screening to return quickly to the field, because transport has to be arranged to a hospital emergency room. Because individuals with co-occurring mental health and substance use disorders frequently need both types of screening and represent a large proportion of police referrals, this is a matter that will need to be addressed. However, this situation can and should be rectified in the immediate future, and adoption of CIT might provide the impetus for that to happen.

In addition to a centralized psychiatric triage, DMH both operates directly and licenses several community-based mental health centers called core service agencies, which can be utilized by CIT officers to assist persons who may not require emergency transport to CPEP. In addition to DMH's core service agencies, a number of non-DMH affiliated community-based mental health service providers operate vibrant programs in the District of Columbia. They too can be utilized by CIT officers in assisting persons who may not require emergency psychiatric evaluation. In order to realize the full benefit of the District's growing network of community-based mental health service providers, it will be important to include DMH-affiliated and non-DMH-affiliated service providers in the development of the District's CIT program.

Still another DMH resource that would facilitate a well-functioning CIT program is its homeless outreach program and the mobile crisis unit it operates. A mobile crisis unit consists of a van or other vehicle that transports mental health professionals to the scene of a mental health crisis. The mental health professionals are able to determine whether the person in crisis needs emergency psychiatric intervention or can be stabilized through on-scene counseling and referral

to community-based treatment options. This service is currently used most often to respond to homeless people in crisis but had been used more widely in the past. Before its recent transfer to DMH's Homeless Services unit, the mobile crisis unit had been chronically under-funded and under-staffed. Because a well-funded mobile crisis program would be a tremendous resource for a CIT program, it will be important for the District to ensure that DMH's mobile crisis program has adequate funding and staff.

The District's active and engaged network of advocates for people with mental illness, including several criminal justice agencies that have worked passionately to establish programs to divert mentally ill persons out of the criminal justice system, represent another ready-made, essential component of a successful CIT program. The majority of the relevant organizations are members of the CJCC's Substance Abuse and Mental Health Workgroup, a body which is currently considering, as part of a larger study, whether a specialized police response to persons with mental illness should be implemented in the District of Columbia. This CJCC workgroup is the kind of collaborative body that communities which adopt CIT typically form as they begin the process of implementing CIT. Because in the District such a workgroup already exists, this is yet another advantage the District would have if a decision were made now to implement CIT in the District of Columbia.

In addition to organizational infrastructure that would make CIT easy to adopt, the District also has the expertise of DMH's director, Stephen Baron, whose experience helping to implement CIT in Baltimore is an asset.

In light of the need for change in the way MPD officers respond to persons with mental illness, the District's clear capacity to easily institute CIT, and the many benefits that would flow from instituting CIT, PCB recommends that the District of Columbia move forward with implementing a CIT program.

VI. RECOMMENDATIONS

- 1. Designate a Subgroup of the Criminal Justice Coordinating Council's Substance Abuse and Mental Health Workgroup to Serve as the District's CIT Task Force***

The CIT program model recommends at the outset formation of a collaborative body consisting of representatives of the police department, mental health department, providers of

community-based mental health services, consumers of mental health services, and advocates for people with mental illness, among others. This group, called a CIT Task Force, becomes educated about the specifics of the CIT model, partners with the police department in establishing CIT in a manner that maximizes its benefit to the community, and assists in implementing CIT for the life of the program.

Because the CJCC's Substance Abuse and Mental Health Workgroup is composed of the same stakeholder group that typically forms a CIT task force, and given that this workgroup is currently considering the merits of adopting CIT, PCB recommends that a District of Columbia CIT Task Force be appointed out of the existing CJCC Substance Abuse and Mental Health Workgroup. The following CJCC workgroup participants should be invited to participate on the CIT Task Force: representatives of the Mayor's office, MPD, DMH, various community-based mental health service providers, the D.C. Department of Health's Addiction Prevention and Recovery Administration (APRA), and the Emergency Medical Services Bureau (EMS) of the D.C. Fire and Emergency Medical Services Department. Other CJCC workgroup members who should be represented on the CIT Task Force include representatives of the D.C. Jail Diversion Task Force, the D.C. Pretrial Services Agency, the Court Services and Offender Supervision Agency (CSOSA), and the D.C. Public Defender Service Mental Health Division.

It is essential that consumers of mental health services and consumer advocates such as the D.C. Chapter of the National Alliance for the Mentally Ill (NAMI) be included on the CIT task force. If these stakeholders are not currently represented on CJCC's Substance Abuse and Mental Health Workgroup, they should be sought out and invited to participate. Representatives of other relevant organizations, such as University Legal Services (the District's protection and advocacy program), the Community Partnership for the Prevention of Homelessness, and Washington Legal Clinic for the Homeless should also be invited to participate.

2. MPD Should Select a CIT Coordinator Now So This Person Can Participate in the Development of the Program

MPD should, with great care, select from among its force an officer of the rank of lieutenant or higher to serve as its CIT coordinator. MPD's CIT coordinator will be responsible for organizing and overseeing the operation of the CIT program within MPD. This person will be responsible for interacting with all of the organizational elements within MPD that will provide crucial support to the CIT program and will serve as the chief liaison between MPD and

the various community organizations with whom MPD will partner in implementing the CIT program. The CIT coordinator must be a strong and capable leader who nevertheless is sensitive to the issue of mental illness and receptive to the non-traditional policing strategies that are the hallmark of CIT. The mentality of MPD's CIT coordinator will profoundly impact the program. If a person of the caliber described is identified now, that person will be able to participate on the CIT Task Force and help build the District of Columbia's CIT program from the ground up.⁹⁴

3. Apply for CIT Grant Funds

MPD, DMH, and the CIT Task Force should begin identifying and applying for grant funds to underwrite CIT start-up and development costs. A number of government and private foundations provide grants for criminal justice-mental health collaborations that aim to reduce the criminalization of mental illness. CIT is considered a pre-booking jail diversion program because it reduces arrests of persons with mental illness. Sources of funds for CIT programs include: (1) the U.S. Department of Justice (DOJ), Bureau of Justice Assistance (BJA), Justice and Mental Health Collaboration Program;⁹⁵ (2) the Substance Abuse and Mental Health Services Administration (SAMSHA), Center for Mental Health Services (CMHS), Targeted Capacity Expansion (TCE) Jail Diversion Program;⁹⁶ and (3) the DOJ, BJA, Office of Community Oriented Policing Services (COPS).⁹⁷

4. A Subcommittee of the CIT Task Force Should Participate in a Two-Day Planning Workshop in Memphis

A small subset of the District's CIT Task Force should travel to Memphis as soon as practicable and participate in a two-day CIT orientation and planning workshop sponsored by the Memphis Police Department. This planning workshop is specifically designed to assist communities that are in the initial stages of creating a CIT program. In addition to founding CIT and successfully operating a CIT program for the past 18 years, the Memphis Police Department has established a program that guides and assists other jurisdictions in adopting the program, particularly in altering and adjusting the program to meet the unique needs and characteristics of specific communities. PCB believes, based on the observations of OPC staff who made an on-site visit to learn about the Memphis Police Department's CIT program, that attending this initial planning workshop will greatly enhance the chances of successfully implementing CIT in the District of Columbia.

5. *Following Receipt of the Subcommittee's Report, the CIT Task Force Should Outline Key Elements of the District's CIT Program*

The subcommittee that participates in the two-day CIT workshop in Memphis should report on its finding to the larger CIT Task Force. Using insights gained from the subcommittee's report, the District's CIT Task Force should decide collectively to what extent the CIT program should track or deviate from the Memphis model, and specific CIT program components should be discussed and decided upon.

6. *Task Force Members Responsible for CIT Officer Training Should Participate in 40-Hour Training Program in Memphis*

The development of CIT officer training is a crucial step in the creation of a CIT program. The decision about what information to include and how to present it will have a major impact on the program. Because the Memphis CIT has created a training program that has been effective in bringing about a cultural shift in the mentality of its officers, and because that aspect of CIT is unique, PCB recommends that the MPD CIT coordinator and other CIT Task Force members who will assist in providing training to District police officers, attend a 40-hour CIT training program in Memphis so they can see first-hand the nature of the training and its impact and can then incorporate aspects of that training into the District's CIT program. The Memphis CIT program is designed to accommodate this training visit.

7. *Prepare Dispatch Operations for Changes Necessitated by CIT*

In recognition of the critical role of dispatch operations to the CIT program, MPD should begin the process of updating its dispatch protocols to accommodate CIT, such as by (1) adding codes that will identify various types of mental health disturbances to which CIT officers will be called, (2) developing the ability to track locations from which repeat mental health disturbance calls come, and (3) expanding disposition codes to reflect the range of specialized responses that may be employed by CIT officers, such as (a) voluntary or involuntary transport to CPEP, (b) on-scene counseling, (c) referral to core service agency or other community-based mental health service provider, or (d) request for DMH mobile crisis unit. Moreover, training for dispatchers should be developed at the same time that CIT officer certification training is being developed. Dispatchers will need to be trained to request additional information in order to identify calls that may involve a potential mental health problem, thereby warranting dispatch of a CIT officer.

Modifications of dispatch operations should be developed while the CIT program is under development so that the need for these changes does not later delay the start of the program.

8. *Coordinate with the Emergency Medical Services Bureau (EMS) of the D.C. Fire and Emergency Services Department*

Mental health crises frequently involve physical injury requiring medical attention. Accordingly, CIT officers and emergency medical technicians often co-respond to incidents. Moreover, in jurisdictions where CIT has been implemented, a large number of calls for CIT assistance come from EMS workers who notice the need for mental health intervention. In order to ensure smooth collaboration between the District's CIT and EMS, representatives of EMS should be invited to participate on the CIT Task Force. As the CIT program is developed, EMS will likely need to update its protocols and training to reflect the existence of the CIT program.

9. *MPD Should Prepare to Collect and Analyze CIT Service Call Data*

Because it will be necessary to collect and analyze data on the nature, frequency, source, and disposition of requests for CIT intervention from the time the program becomes operational, MPD should plan and establish the capacity to perform this function while the CIT program is being developed. Some jurisdictions that have implemented CIT have partnered with a local university to perform this function. MPD may be able to perform this function in-house through the Research and Resource Development Division of its Office of Organizational Development. The collection and analysis of CIT call data will allow MPD and the CIT Task Force to assess the impact of the program over time and will indicate whether and when changes need to be made to improve the program. Also, these data will be required for purposes of obtaining grants for the CIT program.

10. *DMH Should Prepare to Collect and Analyze Data on Outcome of CIT Officer Referrals*

Although the DMH CPEP unit already monitors the number of citizen referrals from MPD officers and the average time that officers are required to remain at CPEP to complete forms and assist with referral, DMH will likely need to collect additional data, such as the short-term and long-term outcome of CIT officer referrals, including whether citizens brought in by CIT officers were hospitalized for observation and evaluation or were referred to community-

based services. It also would be beneficial to know the frequency with which CIT referrals result in inpatient or outpatient commitment following the initial evaluation. DMH also will need to establish a way to collect and analyze data on referrals made by CIT officers directly to community-based mental health service providers. Because CIT officer use of community-based alternatives to CPEP in appropriate cases will be a new strategy, it is necessary to plan ways to capture data on this activity while the CIT program is in development. As with other data discussed above, acquiring this information will assist with evaluation of the CIT program, particularly its impact on access to mental health treatment.

11. Ensure that CIT Officers Develop Knowledge of and a Close Working Relationship With Community-Based Mental Health Service Providers

The most effective CIT programs are those in which CIT officers have options other than transport to a psychiatric triage facility for assisting persons in need of mental health services. It is therefore essential that the District's CIT program be designed in such a way as to emphasize CIT officer knowledge of and reliance on community-based mental health resources. CIT officers should be provided opportunities through training and field work to become intimately familiar with community-based mental health service providers, including those that constitute DMH core service agencies as well as the many non-DMH affiliated providers. This will eliminate the issue of officers not assisting people who would benefit from mental health services but who do not require transport to and evaluation by the DMH CPEP unit. This would also allay the concerns of mental health advocates that adoption of CIT will lead to a rise in involuntary hospitalization for emergency psychiatric evaluation.

12. DMH Should Strengthen and Expand its Mobile Crisis Unit

A fully-funded and staffed mobile crisis unit would allow mental health professionals to assist CIT officers at the scene of a mental health crisis. The mental health professionals could determine whether individuals in crisis need emergency psychiatric intervention or can be stabilized through access to community-based treatment options. A strong mobile crisis unit has the potential to reduce the need for CIT officers to transport people to a psychiatric triage facility and would facilitate greater use of community-based mental health services. Prior to its recent relocation to the DMH Homeless Services unit, DMH's mobile crisis program had been

chronically under-funded. It is recommended that the Mayor and the Council ensure that DMH be provided the resources necessary to permit DMH to strengthen its mobile crisis unit.

13. DMH's Comprehensive Psychiatric Emergency Program (CPEP) Should Be Relocated to a Facility that Includes Emergency Medical Treatment and Alcohol and Drug Detoxification Services

CIT programs work best in jurisdictions where there is one central drop-off point to which officers can transport individuals who are not able to be stabilized through de-escalation and referral to community-based resources. The ideal triage facility is one where emergency psychiatric evaluation, emergency medical treatment, and substance abuse detoxification services are available in one place. The reason is that a fairly large proportion of those people whom officers currently transport to CPEP are homeless and have co-occurring substance abuse and mental health disorders, and many cannot be evaluated by CPEP mental health staff until after medical screening has been completed. In some instances, detoxification is the immediate need, but once that process has been completed, psychiatric evaluation is necessary. Although CPEP and APRA's detox facilities are currently located near one another in buildings on the grounds of the D.C. General Hospital, the conversion of D.C. General from a full-service hospital to an urgent care facility left CPEP without emergency medical treatment on the same grounds. Thus, when a police officer brings an individual to CPEP who exhibits mental health problems and that person also presents medical needs, CPEP currently has to request that the officer transport the individual to a hospital where emergency medical treatment is available, or CPEP has to engage ambulance transport to a medical facility, a process that is costly to CPEP. A District of Columbia-operated triage center that provides emergency psychiatric evaluation, emergency medical screening, and detoxification is needed even in the absence of a CIT program. PCB therefore urges those District officials with authority over this complex matter to work toward locating DMH's CPEP unit in a facility that can provide all of the services that people brought in for emergency mental health care are likely to need.

14. DMH Should Ensure that CPEP Policies Emphasize Use of Community-Based Resources and Outpatient Observation, Evaluation, and Treatment to the Greatest Extent Possible

During PCB's research into this matter, some advocates for people with mental illness expressed a concern that creation of a CIT program would increase involuntary hospitalization

for psychiatric evaluation and increase involuntary commitment for mental health treatment.⁹⁸ The concern was that the act of bringing people to CPEP more often than not results in some form of involuntary mental health treatment, even for persons who may not be a danger to the community. CPEP, however, has the ability to refer to community-based services individuals who do not require temporary hospitalization. Moreover, under recently-enacted amendments to the District's civil commitment law (the Ervin Act), CPEP staff are authorized and encouraged to utilize the least restrictive form of treatment, including outpatient facilities, for initial observation and evaluation as well as for commitment.⁹⁹ Police officers also have expressed concern that they are required to complete paperwork (the "FD-12" form) that triggers involuntary hospitalization even in cases where a less restrictive intervention might be helpful. PCB strongly recommends that DMH review CPEP's policies and procedures for handling individuals brought in by police officers to ensure that officers are not deterred from bringing in persons who need mental health intervention but may be appropriate for outpatient services. It may be useful to develop an alternative to the FD-12 form for cases where officers seek CPEP's assistance in identifying appropriate community-based treatment. DMH should also ensure that CPEP is using the full spectrum of treatment alternatives, consistent with the Ervin Act's emphasis on treatment in the least restrictive environment.

VII. USEFUL RESOURCES

- *NAMI National Crisis Intervention Team Technical Assistance Resource Center*, www.nami.org/Template.cfm?Section=CIT2 Provides consumers, family members, and criminal justice and mental health care professionals with current information about Crisis Intervention Teams (CIT), prisoner reentry, decriminalization, professional functions, and funding opportunities.
- *The Criminal Justice/Mental Health Consensus Project*, www.consensusproject.org A repository of information about all aspects of jail diversion, reentry, and enhanced treatment for offenders with mental illness.
- *The Criminal Justice/Mental Health Information Network*, www.cjmh-infonet.org New database to help improve understanding of criminal justice/mental health collaborations.
- *U.S. Department of Justice, Bureau of Justice Assistance*, www.ojp.usdoj.gov/BJA/ Administers federal mental health courts program, provides resources and information for jail diversion, and has publications, reports, and information about federal funding sources.
- *The National Gains Center*, www.gainscenter.samhsa.gov/html/default.asp Focused on expanding access to community-based services for adults diagnosed with co-occurring mental illness and substance use disorders at all points of contact with the justice system.
- *Substance Abuse and Mental Health Services Administration (SAMHSA)*, www.samsha.gov Administers federal jail diversion grant program, and is a resource for information, publications, and other helpful information about criminal justice and mental health.
- *Police Executive Research Forum (PERF)*, www.policeforum.org Information about criminal justice and mental health, community policing, and other relevant police related information, including *The Police Response to People with Mental Illnesses Trainer Guide and Policy Manual*.
- *The Ohio Criminal Justice Coordinating Center of Excellence (CJ/CCoE)*, www.neoucom.edu/CJCCOE/ Established in May 2001 to promote jail diversion alternatives for people with mental illness throughout Ohio.
- *Connecticut Crisis Intervention Teams*, www.ctcit.org Offers training information, posts, and articles with information concerning the implementation and sustainability of CIT.

Endnotes

¹ D.C. Official Code § 5-1101, *et seq.*

² The relevant statutory provision states that PCB “shall, where appropriate, make recommendations to [the Mayor, the Council, and the Chief of Police] concerning those elements of management of the MPD affecting the incidence of police misconduct, such as the recruitment, training, evaluation, discipline, and supervision of police officers.” D.C. Official Code § 5-1104(d).

³ PCB would like to acknowledge the assistance of OPC’s staff in preparing this report. OPC’s executive director, Philip K. Eure, and deputy director, Thomas E. Sharp, managed the project. Other OPC staff who performed research, conducted interviews, or assisted in drafting the report include special assistant Angela Kiper, lead investigator Mona Andrews, senior investigator Anthony Lawrence, investigators David Curcio, Andrea del Pinal, Alpha Griffin, paralegal specialist Takima Davis, and law clerks Loren Turner, a student at American University’s Washington College of Law, and Carol Jun, a student at Northeastern University School of Law.

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⁴ The District of Columbia Hospitalization of the Mentally Ill Act, D.C. Official Code § 21-501 *et seq.*, popularly known as the Ervin Act, defines mental illness as “a psychosis or other disease which substantially impairs the mental health of a person.” *See* D.C. Official Code § 21-501(5). The Act distinguishes between mental illness and mental health problems, which may not meet criteria for mental illness, but specifies that the Act applies to both.

⁵ Similarly, less than a year ago, on September 28, 2005, the Court Services and Offender Supervision Agency for the District of Columbia (CSOSA), an agency with which MPD has developed an innovative community partnership, held a mental health conference devoted to meeting the needs of persons with mental illness who have been released to the community following incarceration on criminal charges. Among the strategies discussed by the mental health and criminal justice professionals who attended that conference was how an MPD CIT program would help mentally ill ex-offenders avoid re-arrest and re-incarceration, thereby enhancing their opportunities to receive community-based mental health treatment. *See Premiere Mental Health Conference Attracts Over 200 Registrants*, The CSOSA Newsletter, Winter 2006, at 11.

⁶ *See* Gretchen Moore, Megan Shaffer, Janine Zweig, *Addressing Co-occurring Mental Health and Substance Abuse Disorders in the Criminal Justice System: Guiding Principles and District of Columbia Practices*, Urban Institute, Justice Policy Center (September 2004).

7 *Id.*

8 MPD's GLLU is a specialized unit that was created for the purpose of improving MPD response to the GLBT community. The GLLU officer's attentive response to the homeless complainant's case illustrates the significant difference that specialized training and sensitivity can make in police-citizen encounters. The success of the GLLU thus counsels in favor of adopting programs such as CIT.

9 OPC Case No. 02-0361, 2006 DC POLICE LEXIS 2, also available at <http://policecomplaints.dc.gov>.

10 These complaints reflect that OPC has significant contact with persons with mental illness as they seek to file police misconduct complaints. As a result of this review of MPD procedures, OPC has instituted additional staff training for the purpose of increasing understanding of mental illness and is currently reviewing ways to improve its procedures so that persons with mental illness have better access to the police misconduct complaint process.

11 *See* Petula Dvorak and Del Quentin Wilber, *S.E. Neighbors Shocked by Man's Rage*, Washington Post, April 30, 2005, at B4.

12 *Id.*

13 *See Shooting Victim's Family Sues City*, National Legal News, February 9, 2006, available at <http://www.lawyershop.com/news/2006/02/09/shooting-victims-family-sues-city/>.

14 *See Nowlin v. District of Columbia*, 1:06-cv-00134-RMC, United States District Court for the District of Columbia.

15 *Id.*

16 *See* Annie Linskey, *Shootings of Disturbed Suspects Spur Debate Over Police Tactics; Lethal Force May Be Justified, But Some Say It Can Be Avoided*, Baltimore Sun, May 23, 2006, at 1B.

17 *Id.*

18 *Id.*

19 *Id.*

20 *Id.*

21 *Id.*

22 *Id.*

23 Heidi Vermette, Debra Pinals & Paul Appelbaum, *Mental Health Training for Law Enforcement Professionals*, Journal of the American Academy of Psychiatry and the Law, at 42 (2005), available at www.jaapl.org.

24 *See Criminal Justice/Mental Health Consensus Project*, Council of State Governments, at 7 (June 2002) available at www.consensusproject.org.

25 *See Status of Reforms to the District's Mental Health System*, United States General Accounting Office Report to the Chairman, Committee on Government Reform, House of Representatives (March 2004), available at www.gao.gov/cgi-bin/getrpt?GAO-04-378.

26 *See The Numbers Count, Mental Disorders in America*, National Institute of Mental Health, (February 17, 2006), available at www.nimh.nih.gov/publicat/numbers.cfm; *see also* 2004 State Estimates of Serious Psychological Distress Among Adults, 2004 National Survey of Drug Use and Health, Substance Abuse and Mental Health Administration, Office of Applied Studies, available at www.oas.samsha.gov/2K4State/DCMH.htm.

27 *See* Facts on Homelessness, Washington Legal Clinic for the Homeless (January 1, 2006), available at www.legalclinic.org/homelessness.

28 *Id.*

29 *Id.*

30 *See* Homelessness - Provision of Mental Health and Substance Abuse Services, Frequently Asked Questions, Substance Abuse and Mental Health Administration, Center for Mental Health Services, available at www.mentalhealth.samsha.gov/publications/allpubs/homelessness/.

31 *Id.*

32 *Id.*

33 *See Criminal Justice/Mental Health Consensus Project*, at 34.

34 Martha Deane, Henry Steadman, Randy Borum, Bonita Veysey & Joseph Morrissey, *Emerging Partnerships Between Mental Health and Law Enforcement*, 50 *Psychiatric Services* No.1 at 100 (1999).

35 Data collected by MPD's Office of Research and Resource Development indicates that it receives 600,000 calls for service annually and self-initiates approximately 75,000 police-citizen contacts. Accounting for the fact that officers are not dispatched to all calls received and that many of the 75,000 self-initiated contacts ultimately are included in calls for service as officers call for backup assistance, MPD estimates that its officers handle approximately 500,000 contacts annually. MPD indicated, however, that each contact could involve more than one person so a single contact may not represent only one person.

36 *Id.*

37 *See* Gary Cordner, *People with Mental Illness*, Community Oriented Policing Services (COPS) Problem Oriented Guides for Police, Problem-Specific Guides Series No. 40, at 4 (2006), available at www.cops.usdoj.gov or www.popcenter.org.

38 *Id.*

39 *Id.*

40 *Id.* at 1.

41 *Id.* at 4.

42 *Id.*

43 *Id.* at 5.

44 *See* Americans with Disabilities Act of 1990 as amended, 42 U.S.C. § 12101 *et seq.*

45 42 U.S.C. § 12132.

46 28 C.F.R. § 35.130(b)(7).

47 *See Schorr v. Borough of Lemoyne*, 243 F.Supp. 2d 232 (MD. Pa. 2003) (holding that a police commission and police chief could be held liable under the ADA for not properly training officers to modify practices and procedures in dealing with persons with mental illness).

48 *See The Police Response to People with Mental Illness*, Trainers Guide and Model Policy, at x, Police Executive Research Forum (1997).

49 D.C. Official Code § 21-501 *et seq.*

50 *See* Melissa Reuland, *A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness*, at 3 (January 2004).

51 *Id.*

52 *Police Encounters with Persons with Mental Illness in the Capital District*, at 5, New York Civil Liberties Union (February 2006), available at www.cqcapd.state.ny.us/criminal%20justice/Police%20EncountersReportTitlePageDAI%20revised.pdf.

53 See Reuland, at 3; *see also* *Criminal Justice/Mental Health Consensus Project*, at 40-41.

54 See Reuland at 10.

55 See *The Montgomery County CIT Model: Interacting with People with Mental Illness*, The FBI Law Enforcement Bulletin, July 2004, at 20, <http://www.fbi.gov/publications/leb/2004/july2004/july04leb.htm>.

56 See Reuland at 7.

57 See Henry Steadman, Martha Deane & Joseph Morrissey, *Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies*, *Psychiatric Services* Vol. 51, at 646 (May 2001).

58 *Id.*

59 *Id.*; *see also* Reuland, at 17.

60 See Steadman et al., *Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies*, at 646.

61 The Baltimore CIT program, known as BEST (Behavioral Emergency Services Team) began in 2003, the same year three Baltimore City police officers shot and killed a woman with a knife who was experiencing a mental health crisis. See Ann LoLordo, *It's All for the Best*, *Baltimore Sun*, December 4, 2004, at 14A. Currently the Baltimore Police Department has approximately 150 CIT officers out of a force of 2,900 officers.

62 Population statistics cited are from the U.S. Census Bureau's 2000 census and can be found at the U.S. Census Bureau's State and County Quick Facts, <http://quickfacts.census.gov/qfd/index.html>.

63 *Id.*

64 For example, the Northumbria Police Department in Northeast England has adopted CIT. See, *Police Training on Mental Health*, Independent Police Complaints Commission at http://www.ipcc.gov.uk/index/resources/themes/mental_health/police_training.htm.

65 See Independent Police Commission, *Policing and Mental Health*, available at http://www.ipcc.gov.uk/index/resources/themes/mental_health.htm.

66 See Betsy Vickers, *Memphis, Tennessee, Police Department's Crisis Intervention Team*, *Practitioner Perspectives*, U.S. Dep't. of Justice, Bureau of Justice Assistance (July 2000).

67 See *Jail Diversion Programs Enhance Care*, SAMSHA News Vol. 8, No. 2, Substance Abuse and Mental Health Services Administration (Spring 2000).

68 Most cities that have adopted the CIT model achieve full CIT coverage when approximately 25% of the patrol force is CIT certified.

69 See Van Blaricom, *Handling the Mentally Ill: There Are No Shortcuts for Officers*, *Police Magazine*, March 2000, at 33.

70 Interview with Major Sam Cochran, Coordinator, Memphis Police Department CIT Program, May 2, 2006.

71 For a comprehensive description of various dispatch protocols utilized by CIT programs, *see* Reuland, at 13.

72 See Henry Steadman, Martha Deane & Joseph Morrissey, *Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies*, *Psychiatric Services* Vol. 51, at 646 (May 2001).

73 See Vickers, at 10; *see also* Steadman, Deane, et al., *Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies*, at 648.

74 See, e.g., Deborah L Bower, W. Gene Pettit, *The Albuquerque Police Department's Crisis Intervention Team: A Report Card*, *FBI Law Enforcement Bulletin*, February 2001, 4 and 6 (noting reduction in civil liability that has accompanied implementation of CIT in Albuquerque); *see also* *Mental Illness and the Criminal Justice System: A Recipe for Disaster/A Prescription for Improvement, Final Report of the Miami-Dade County Grand Jury*,

January 11, 2005, 27 (noting that among the benefits experienced by several Miami-area police departments that have adopted CIT are fewer lawsuits filed against these law enforcement agencies); Rodney Hill, et al., *The Montgomery County CIT Model, Interacting with People with Mental Illness* at 25-27 (noting that police departments can reduce civil liability by proactively adopting CIT).

⁷⁵ See Vickers, at 10.

⁷⁶ Interview with Dr. Randolph Dupont, Ph.D., Chair Dep't of Criminology and Criminal Justice, University of Memphis, May 2, 2006.; see also *Police Learn Better Response to People With Mental Illness*, *Psychiatric News*, Vol. 41, No. 5, at 8 (March 3, 2006).

⁷⁷ Interview with Memphis Police Department CIT officers Kobena Cash and Elliason Flagg, May 2, 2006.

⁷⁸ Interview with Bradley Cobb, Executive Director, Memphis Chapter, National Alliance for the Mentally Ill, May 2, 2006.

⁷⁹ Interview with Memphis Police Department CIT officers Kobena Cash and Elliason Flagg, May 2, 2006.

⁸⁰ See Vickers, at 10.

⁸¹ *Id.*

⁸² Interview of Major Sam Cochran, May 2, 2006.

⁸³ *Id.*

⁸⁴ See Pete Early, *Crazy: A Father's Search Through America's Mental Health Madness* 119-20 (G.P. Putnam's Sons 2006).

⁸⁵ *Id.* at 353.

⁸⁶ Community policing promotes organizational strategies that address crime and related social disorders through identifying causes and preventive solutions. Community policing represents a shift from traditional policing in that it stresses decentralized command and innovative problem solving through partnerships with community groups, government agencies, and non-government organizations. See Matthew Hickman, Brian Reave, *Local Police Departments 2000*, at 14, U.S. Dept. of Justice, Bureau of Justice Statistics (January 2003), <http://www.ojp.usdoj.gov/bjs/publ/pdf/lpdoo.pdf>

⁸⁷ A detailed description of the organization and goals of MPD's police districts and PSAs is available on the department's website: <http://mpdc.dc.gov>.

⁸⁸ See *Policing for Prevention: Community Policing in D.C.*, Presentation to the District of Columbia Council, July 13, 2005, (describing MPD's adoption of community policing as its prime operational model), available at http://mpdc.dc.gov/mpdc/frames.asp?doc=/mpdc/lib/mpdc/publications/PFP_Council_0705.pdf.

⁸⁹ See U.S. Census Bureau's State and County Quick Facts, <http://quickfacts.census.gov/qfd/index.html>.

⁹⁰ *Id.*

⁹¹ See District of Columbia Metropolitan Police Department at <http://mpdc.dc.gov>.

⁹² See "Memphis Police Department at a Glance" at <http://www.memphispolice.org/MPD%20at%20a%20Glance.htm>.

⁹³ In an effort to improve its response to police officer referrals, CPEP monitors the amount of time MPD officers spend facilitating intake of persons they bring in. In FY 2005, the average time officers were required to remain at CPEP was 19 minutes, a time-frame that is within the range recommended by the CIT program model. This did not include the time that some officers spent transporting persons to hospitals for emergency medical treatment.

⁹⁴ A strong CIT coordinator is needed not only to assist with the development of the program, but to ensure that the program lives up to its potential. The CIT coordinator will need to insist that a sufficient number of CIT officers be trained over time to ensure that CIT officers can be deployed as often as needed. He or she will also

need to ensure that CIT officers consistently apply their specialized training. This advice is based on a Police Assessment Resource Center (PARC) review of Portland, Oregon's CIT program while it was still young. PARC found that CIT officers were not deployed at times when they should have been and that CIT officers did not always employ their de-escalation techniques and other specialized training. Although the reasons for these lapses were not identified, the report urged that if a police department is going to have a CIT program, it must ensure consistent adherence to the policies and purposes of the program or it will not be effective. *See The Portland Police Bureau: Officer Involved Shootings and In-Custody Deaths, Police Assessment Resource Center, August 2003, 204-207, available at <http://parc.info/pubs/pdf/ppbreport.pdf>.*

⁹⁵ The Mental Health Collaboration Program administered by BJA is the vehicle for distributing grant funds authorized by the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (P.L. 108-414). The program provides funds to help develop an array of community-based alternatives to criminal justice involvement, including CIT programs. Information on this program is available at www.ojp.usdoj.gov/BJA/grant/mentalhealth.html.

⁹⁶ Information about SAMSHA FY2007 jail diversion program grants is available at <http://www.samsha.gov/Grants/2007/fy2007opps.aspx>.

⁹⁷ The Akron, Ohio Police Department utilized COPS grant funds in starting its CIT program. *See www.copsreportsfromthefield.org/reports/OH-HIRING-Akron.pdf.*

⁹⁸ As noted on p.17 of this report, in Memphis, adoption of CIT has resulted in a *decrease* in involuntary mental health evaluation and treatment, despite frequent use of a centralized psychiatric triage center.

⁹⁹ *See* D.C. Official Code §§ 21-522(c) and 21-545(2).