Cambridge Police Department

March 2019

Strategic Planning for Law Enforcement and Mental Health Services

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Executive Summary

Project Goals

Cambridge Police Department (CPD) was awarded a Justice and Mental Health Collaboration Program planning grant by the U.S. Department of Justice, Bureau of Justice Assistance (BJA). The purpose of this grant was to begin the process of evaluating the collaboration between CPD and its partner agencies to identify barriers and gaps in the coordination of care and services for individuals involved with the criminal justice system who are experiencing mental illness, particularly those who are also experiencing homelessness. The goal of this project was to collect data to inform the development of a strategic plan for CPD and its partners to further improve how law enforcement, local community agencies, and mental health service providers work together to respond to individuals with mental health needs in order to prevent persistent interactions with the criminal justice system.

Methodology

We conducted fourteen open-ended qualitative interviews with members of the Cambridge Police Department and partner agencies to learn about their policies and procedures for responding to individuals experiencing mental illness, particularly those experiencing homelessness, and to identify areas of opportunity to solidify their collaborative practices. Data analysis was conducted using a qualitative data software program through which we were able to identify themes regarding how police officers collaborate with mental health service providers and develop recommendations to further improve their collaboration. In addition to this data analysis, a community-wide Strategic Planning Committee met to identify barriers, existing policies and procedures, and coordination of services for this population.

Project Vision and Mission

PRIMARY OBJECTIVE

The goal of this project was to inform the development of a strategic plan for the Cambridge Police Department (CPD) and its partners to further improve how law enforcement, local community agencies, and mental health service providers work together to respond to individuals with mental health needs, particularly those experiencing homelessness, in order to prevent persistent interactions with the criminal justice system. In order to achieve this goal, we first documented existing policies, programs, procedures, and services in place that provide guidance on how police and mental health practitioners work together to respond to individuals with mental illness and minimize their contact or deeper involvement in the criminal justice system. This documentation was generated through 14 open-ended qualitative interviews with police officers and community partners. Data collected from these interviews were used to develop a strategic plan to further improve the impact of CPD's collaboration with mental health service partners on Cambridge residents' mental health and well-being. In addition, the team developed a Memorandum of Understanding to be signed by community partners and mental health service providers to solidify law enforcement-mental health collaboration.

VISION

A mental health system that is improved by community-based diversion practices designed to minimize criminal justice system involvement of vulnerable populations experiencing chronic mental illness, particularly those also experiencing homelessness, and to connect them with appropriate mental health services and supports.

MISSION

The mission of this collaborative, named the Multidisciplinary Team for Law Enforcement and Mental Health Collaboration (LEMHC), is to increase the effectiveness of CPD's policies and practices as they relate to vulnerable populations, particularly those with chronic mental illness who are homeless. The mission is achieved by solidifying and improving the partnerships between the Cambridge Police Department and its community partner agencies to provide the necessary resources for individuals living with mental illness who interact with the criminal justice system by:

- Supporting the engagement of adults at risk for involvement with the criminal justice system with existing community services and supports;
- Developing trusting cross-disciplinary partnerships in the service of improving law enforcement and mental health services while safeguarding confidentiality; and
- Evaluating these efforts

We present here a strategic plan for Cambridge, outlining a commitment to building a system that supports individuals suffering from mental illness and homelessness. Proposed goals and action strategies are designed to improve the collaboration between mental health organizations and law enforcement to divert vulnerable populations with mental illness from deeper involvement in the justice system and into the appropriate care.

Strategic Plan Development Process

PARTNERSHIPS

- Five major organizations work in close partnership with the Cambridge Police Department to assist individuals with criminal justice system involvement that are experiencing mental illness and homelessness: Cambridge Department of Human Services, Cambridge Health Alliance/Cambridge Department of Public Health, Vinfen, Mount Auburn, and Bay Cove.

  Through the strategic planning process, the stakeholders of the mental health collaboration solidified existing partnerships to create stronger and effective planning as well as system and community-based collaboration. Representatives from these partner organizations were interviewed by researchers from the Health Equity Research Lab, a research center in the Department of Psychiatry at the Cambridge Health Alliance/Harvard Medical School, to gather data to better understand current policies and procedures as well as future recommendations. After data collection, members of these partner organizations who serve on the strategic planning committee were presented with findings from the interviews and helped to translate them into recommendations. To formalize this collaborative, a Memorandum of Understanding was also completed among these partner organizations. As part of the MOU, partners have agreed to sign onto the following tasks:

  - Agree to coordinate priorities, actions, and resources for the benefit of providing multi-systemic approach to prevention and treatment of individuals with mental illness who are at risk of involvement with the criminal justice system.
  - Work with the strategic planning committee representatives to provide necessary information to achieve agreed upon goals, objectives, and actions that are aligned with each organization's mission.
  - Provide assistance to writing grant applications, professional services, providing consultation, education and facilitation and in endeavors critical to the purposes of the MOU under separate formal arrangements. Prior to requesting assistance under this Section, the strategic planning committee will detail the type and nature of assistance requested and each Partner Agency will have the opportunity to agree to provide the requested assistance.
  - Recognize that other organizations may be involved, but are not listed as partners to assist with the endeavors aforementioned.

Strategic Plan Development Process

BACKGROUND ON THE CITY OF CAMBRIDGE

The City of Cambridge is a densely populated urban area, with 110,402 residents (4th most populous city in Massachusetts) spanning 64 square miles. Cambridge is home to world-renowned Harvard University and MIT, a significant biotech industry, and a growing influx of information technology companies. It is estimated that Cambridge's daytime population exceeds 180,000. Cambridge residents are a diverse population: 27% of the city's residents are foreign-born and 32% speak a language other than English at home. About 45% of public school students receive free or reduced lunch. Cambridge has long served as a port of entry for immigrants from around the world and remains a sanctuary city today.

The homeless population in Cambridge consists of about 500 individuals. However, of less than 0.5% of the city's population, homeless arrests accounted for 15.8% of the citywide arrest totals in 2015. Most arrestees are chronic offenders in high pedestrian traffic areas such as Central Square, Harvard Square, Porter Square, and Inman Square, as well as around the shelters. Most crimes include simple assault (homeless fighting each other), shoplifting, larcenies from businesses and automobiles, disorderly conduct, drinking in public, indecent exposure ("flashing" or public urination), and trespassing.

Community Policing and Current Procedures During Encounters with Individuals Experiencing Mental illness and Homelessness

Over the last 10 years, CPD has transformed its community policing philosophy to focus more on prevention, intervention, and diversion. Recognizing that at least 70% of people in the criminal justice system are mentally ill, city agencies have been working to connect people with the mental health services they need prior to arrest or incarceration. Prior to 2007, officers documented only involuntary hospitalizations (as opposed to calls for service and voluntary admissions) and relationships with service providers were limited. Officers also had no formal training on mental health, mental illness, or adolescent development. Today, the CPD has a Family and Social Justice Section (FSJS) with 21 dedicated sworn and civilian staff. The unit within the FSJS that works with vulnerable adults is the Social Justice Unit (SJU), which is comprised of a supervisor, two homeless outreach officers, two mental health outreach officers, a senior/elderly outreach officer, and two business liaisons. In 2015, the SJU began convening Quarterly Stakeholders Meeting, with over 40 agencies participating (including local hospital, shelters, community mental health agencies, domestic violence shelters, and veterans' services). The purpose of the meetings is to promote information sharing across agencies, address fractures across system and disciplines, and ultimately improve outcomes for individuals.

Strategic Plan Development Process

BACKGROUND ON THE CITY OF CAMBRIDGE

- There are two officers assigned to homeless outreach in the SJU, and each has over 100 active cases. In addition to homeless outreach, the SJU has dedicated officers available for mental-health related calls. In 2016, 315 referrals were made to the mental health outreach officers. The senior/elderly outreach officer had 67 referrals, an array of topics including elder abuse, Alzheimer's, and hoarding.

- While there has been a rapid evolution in how CPD has promoted public safety for individuals with mental illness and homelessness, there has not been full documentation of the newly formed responsibilities and internal and partner agency communication processes. To address this need, this current document outlines policies and responsibilities, inventories of existing resources, and identifies gaps in services and can be used to formalize a risk assessment tool and case management system, and to develop a training plan.

DEFINING THE TARGET POPULATION

- The target population for the JMHCP grant includes adults (age 18 and older) in Cambridge whose mental health needs are not currently being met by existing services: homeless individuals; individuals living with mental illness (as defined by the Diagnostic and Statistical Manual of Mental disorders, 5th Edition) and substance abuse disorders; and individuals at risk for criminal justice involvement.

CREATING THE STRATEGIC PLAN COMMITTEE

- The Strategic Planning Committee, created in 2018, consists of six members from both the Cambridge Police Department and its partner agencies who also participated in the qualitative interviews. The first meeting was convened on November 6, 2018 at the CPD and all members were in attendance. Members of the committee were presented with the findings from the qualitative interviews to gather their feedback on how to translate findings into recommendations for the strategic plan; to identify gaps in services; and to develop the Memorandum of Understanding.

Strategic Plan Development Process

DATA COLLECTION AND ANALYSIS

In the spring of 2018, researchers from the Health Equity Research Lab conducted 14 in-person open-ended interviews with members from the Cambridge Police Department and its partner agencies.

Qualitative interviews were centered on the following questions:

- What is the current plan at CPD when engaging with individuals with mental illness for patrol and SJU officers?
- What more could be done (e.g., training, systems integration, tracking) to improve safety, referrals to treatment, and other outcomes during these interactions?
- What follow-up policies have been/could be useful for stabilizing an individual in the community and reducing CPD calls?

The qualitative data collected from the interviews were transcribed and analyzed using a qualitative research software program, Dedoose. The analyzed data was presented to members of the Strategic Planning Committee to inform their recommendations for the strategic plan.

STRATEGIC PLAN

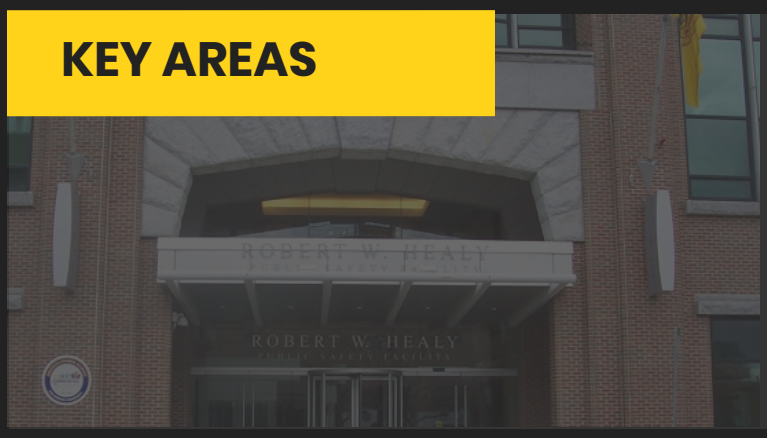
Guiding Principles

This strategic plan is the culmination of the work of the Strategic Planning Committee, Cambridge Police Department, and the Health Equity Research Lab. This work was completed between September 2017 and December 2018. This plan was developed in a collaborative effort with partners and in accordance with the following principles and planning guidelines:

- Develop a plan that is community-based and collaborative
- Use both rigorous quantitative and qualitative measures to pursue data-driven outcomes to inform decisions
- Develop an effective system guided by evidence-based best practices

The strategic plan includes recommendations for (1) case management, (2) information sharing, (3) training, and (4) communication. As noted earlier, the recommendations were informed by the qualitative data collected through interviews. Below, we report a brief description of policies and procedures, followed by challenges stemming from the qualitative interviews and recommendations issued by the Strategic Planning Committee for each of the four areas:

KEY AREAS



- CASE MANAGEMENT
- INFORMATION SHARING
- TRAINING
- COMMUNICATION

Case Management

Policies and Procedures

- Calls are generated from voluntary or involuntary hospitalization that would require section 12 for psychiatric reasons. Patrol officers are often first on the scene.

- Officers try to engage the person and ask if they want to go to the hospital. Officers conduct a mental health report with an assigned file number which is classified right away. That report goes to one of the two investigators who generates the incident case and conducts a supplement. There is a separate case for people involving elderly. Mental outreach officers (lieutenant or sergeant of the unit) would open the case, look at the name, and run an in-house search of the person's name to see previous interactions. If there were previous interactions, the person would then follow up on the case via phone or in person or sometimes through a social worker. If the person doesn't answer, it is documented in the case. The information given to law enforcement by family members is also documented into the case file. Once the investigator has completed their involvement, the case goes to the sergeant for review before closing the case.

    - A case management system was developed which allows for tracks and follow ups to assess how cases have evolved over time and actions taken for those cases.

    - Reports are often documented with an incident report. There are different types of incident reports (e.g., miscellaneous report, psycho assistance report, etc.).

    - Cases can be open indefinitely. There is no standard operating procedure for whether a case is open or closed. Cases are usually closed based on the time elapsed between the first and latest incident documented. There is no template or algorithm to provide guidance on case closure.

Case Management

Challenges

- Patrol officers are usually first on the scene. They usually issue the first report and then SJU officers add a supplement report describing their involvement. For the most part, patrol officers don't have prior information related to SJU contacts with the person committing the offense.
  - There is little communication between patrol officers and SJU unit. Patrol officers do not have access to SJU reports.
  - Communication between patrol officers and SJU unit happens through informal channels
- There are various types of reports (e.g., miscellaneous, psych-assistance) as opposed to a single, master report.
- Cases tend to remain open indefinitely: "We have no, sort of no standard operating procedures for this because it's sort of a new field and no one has decided what an appropriate time to close the case is."
- The fragmented nature of data in mental healthcare and criminal justice data systems makes it difficult to gain a deep understanding of vulnerable populations by officers other than SJU's and collecting information to inform actions and develop interventions.
- Engagement of multiple providers and officers all managing one case creates a challenge for communicating with one another because there is not a central portal for all providers and officers to document information.
- Lack of integration of information from social workers and case management sources
  - Data is fragmented
  - Multiple providers serving one person encounter challenges communicating with one another.
  - Providers use incompatible programs (QED and Excel) to document cases.
  - In QED, an individual can have multiple notes and different cases but no master case. QED makes it very difficult to track and to figure out how many cases one single person has. It also makes it difficult to track notes attached to the case by multiple providers. Additionally, the confidential nature of criminal investigations prevents detectives from adding notes to the cases.

Case Management

Priority Recommendation

Priority Recommendation	
GOAL 1	Improve **internal** case management system
OBJECTIVE 1	Formalize communication between patrol officers, social worker and investigators.
Strategy 1	Convene biweekly or monthly meetings with patrol officers and SJU unit to discuss reports and cases generated from incidents.
Strategy 2	Standardize case management system to QED to track all notes and incident reports for each individual.
Strategy 3	Create a QED master case in order to be able to track notes and incidents for each individual.
Strategy 4	Generate guidelines of how long to keep cases open and when to close them. Consider a non-binary identification of the case status.
Strategy 5	Expedite linking of cases through flagging individuals within data system (e.g., flag individuals when they join recovery programs).
Strategy 6	Integrate social worker database with QED while observing confidentiality rules.

Priority Recommendation	
GOAL 2	Improve **external** case management system
OBJECTIVE 1	Develop more cohesive data sharing and data matching efforts to facilitate planning and evaluation.
Strategy 1	Link newly acquired service data from the Cambridge Police Department with Cambridge Health Alliance's electronic health records to conduct an evaluation on the law enforcement and mental health collaboration, capitalizing on a unique cross-systems dataset that includes healthcare and criminal justice outcomes.
Strategy 2	Develop data-sharing agreement with partner agencies (e.g., domestic violence shelters) to monitor, analyze, and evaluate the impact of the target populations as interventions are being implemented over time.
Strategy 3	Facilitate user access to existing databases that contain relevant information on individuals and progress in each case.

Information Sharing

Policies and Procedures

- Law enforcement requests individuals to fill out the release of information. Many individuals with significant mental illness and chronic illness individuals are difficult to locate, let alone have them sign and understand confidentiality.
- Partner agencies are covered by HIPAA.

Challenges

- Adhering to HIPAA while providing pertinent information for case and follow up except in situations in which safety trumps confidentiality
- There are no clear guidelines about what to share and what not to share.
- Difficulties around information sharing impact decisions related to chronic mentally ill individuals, such as:
  - Medication, treatment, location, symptomatology contributing to arrestable offenses.
  - Makes case management more difficult for SJU officers.
  - "So typically, you know, we call the hospital [and] they won't tell us anything anyway…"
- Getting people to sign information sharing waiver by individuals or family members could be challenging. If waiver is not in place, it's difficult for partner agencies to share certain information (e.g.,….) to law enforcement regarding status of individuals.
- Social workers working for the police department are in a unique position because the police department is not a medical or mental health setting. This unique arrangement calls for specific information sharing guidelines.
  - "So, just when communicating with folks that are in the private sector, there's a lot of apprehension sometimes on their part to give information that they feel like they're violating someone's confidentiality. And it's – to this point, it's still unclear what, you know, what type of information is protected, what information is not. And so, when I'm trying to connect someone to services, it's difficult – it's difficult to get things done. If I'm talking to someone and I'm giving them information and they're nodding and they're saying, 'Okay, information,' you know"

Information Sharing

Priority Recommendation

Priority Recommendation	
GOAL 1	Improve understanding for information-sharing between partner agencies and law enforcement.
OBJECTIVE 2	Address the limitations and confines of HIPAA.
Strategy 1	Address the multidisciplinary nature of the team involved including the role of social workers.
Strategy 2	Consult with the appropriate legal authorities to develop information-sharing agreement and guidelines regarding roles and confidentiality. This can be outlined in the Memorandum of Understanding. • Standardize information-sharing and HIPAA policies both internally (with social worker and other law enforcement officers) and among partner agencies. Collaborating partners must have a clear understanding of what information can and cannot be shared • Agreed-upon protocols for information sharing should be documented within the information-sharing agreement. • Develop information sharing guidelines between police officers and hospitals.
Strategy 3	Initiate didactic training courses and discussions with all stakeholders to lay out the parameters of information sharing

Training

Policies and Procedures

- Crisis Intervention Training (CIT) is a co-training where medical and police personnel share their experiences with a group of police officers who have no experience or no training in dealing with vulnerable individuals. It's a one-week long multi-agency offered to multiple police departments.
- Officers receive training on de-escalation, trauma-informed law enforcement, and mental health first aid. Other trainings topics include gender responsivity, cultural competence, and implicit bias.
- Most cross-trainings are informal in nature because they take place during meetings in which they share policies or procedures
- Trainings are delivered by law enforcement personnel, mental health personnel, advocates, and court personnel.

Challenges

- There is a limited amount of formalized training directly focused on vulnerable populations.
- Officers have experienced a great deal of training through "learning by doing."
- Training mostly targets law enforcement personnel and not partner agencies.
- Case management training is scarce.

Training

Priority Recommendation

Priority Recommendation	
GOAL 1	Train law enforcement officers to be able to identify and address early symptoms of mental distress or psychotic episodes.
OBJECTIVE 2	Improve the interaction of law enforcement with vulnerable populations with mental health illnesses and link them to the right resources.
Strategy 1	Create multidisciplinary cross-trainings delivered or co-led by mental health service partners.
Strategy 2	Develop more training regarding symptom recognition and crisis intervention.
Strategy 3	Offer trainings for partner agencies on what law enforcement officers do in order to strengthen collaborations.
Strategy 4	Bring together criminal justice and behavioral health practitioners to learn about new program opportunities and existing programs within the behavioral health and criminal justice systems.

Communication

Policies and Procedures

- Police officers and partner agencies meet on a case-by-case basis to assess case status and disposition.
- Communication is guided by HIPAA and release of information waiver.

Challenges

- Communication between law enforcement and partner agencies are impacted by information-sharing challenges.
- Communication pattern is shaped by relationships with partners and trust level.
- High turnover rates of providers at hospitals/clinics impact communication and continuity with chronic patients.
- Balancing tension between confidentiality and compromising confidentiality for the sake of safety presents challenges.
- Law enforcement officers usually don't know if an individual under arrest is DMH-involved until later, after a section 12 has been issued.
- Multiple providers and officers may be working on one case but without much communication amongst themselves.
- Communication flow is often unidirectional: from law enforcement to partner agencies
- Law enforcement personnel is often viewed as adversarial
    - "...and they still perceive us as a law enforcement entity, so you can imagine if their job is to provide shelter for someone who is a member of a vulnerable population and lots of vulnerable people don't have a positive view of the police department, right, so when they see the police they think arrest, prosecution; they don't think here comes the police, they're going to help me get into drug rehab. Well some folks, there are some shelter operators, some medical providers that will not -- they will not talk to us. It's not that they don't want to participate but they always fall back on confidentiality and HIPAA. Sometimes some of the partners are a little more apprehensive and some of them just seem to be just there to be part of the discussion, but they don't really participate."

Communication

Priority Recommendation

Priority Recommendation	
GOAL 1	Integrate the delivery of services within law enforcement and effectively coordinate with mental health partner agencies.
OBJECTIVE 2	Enhance communication between partners and law enforcement officers regarding mental healthcare services provided to SJU-involved individuals.
Strategy 1	Develop a report that outlines all the services that are currently being provided to an individual with a list of point of contacts.
Strategy 2	Expand and convene regular strategic planning committee meetings to discuss individual cases and overall collaboration. Continued collaboration and communication through monthly meetings is critical during the planning and implementation phase to keep the partners focused on shared goals and targets.
Strategy 3	Utilize technology to increase collaboration. Employ online collaboration and communication tools that streamline service delivery and allow efficient communication across partner agencies and departments

Appendix

PROGRAMS

Local or state-level diversion or reentry initiatives/programs that help people who have mental illnesses avoid future contact with police are listed below. These programs may include those that focus on supportive housing, mental health courts, supportive employment, and access to affordable behavioral health care or case management for people who have repeat contact with police.

The following programs help people who have mental illnesses avoid future contact with the police:

- VinFen
- Bay Cove Human Services
- On The Rise
- Cambridge Continuum of Care
- Y2Y Harvard Square
- National Alliance on Mental Illness – Cambridge/Midddlesex
- Riverside Community Care
- Cambridge/Somerville Emergency Services
- Middlesex County Homeless Court
- Healthcare for the Homeless
- Cambridge Veterans Services
- Cambridge-Somerville Elder Services
- Hoarding Coalition
- Youth on Fire

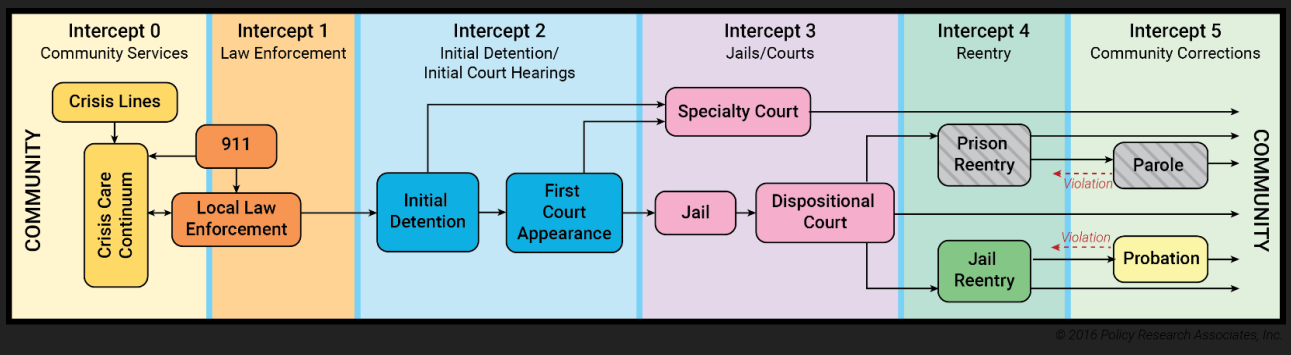
Appendix

Sequential Intercept Model

The Sequential Intercept Model below illustrates how people who have behavioral health needs may come into contact with and move through the criminal justice system. As such, it offers context for what other agencies may be involved in criminal justice-behavioral health partnerships.

In addition to the entities listed in the Sequential Intercept Model above, other people and agencies to consider consulting as part of your work:

- Direct service workers and supervisors/managers/administrators;
- Other (non-law-enforcement) first responders (e.g., emergency medical technicians [EMTs] and firefighters);
- People who have mental illnesses, families, and advocates;
- Community membership organizations (e.g., churches);
- Court staff, including prosecutors, defenders, and judges;
- Schools;
- Housing organizations and shelters; and
- Representatives from agencies and providers that focus on other aspects of behavioral health, including:
- Substance use disorders;
- Intellectual and developmental disabilities; and
- neurocognitive disorders (e.g., Parkinson's, Huntington's, Alzheimer's).



Appendix

Recommended Risk and Needs Assessment Tool

When working with adult populations with mental illness, we suggest the Level of Service/Case Management Inventory (LS/CMI). The tool is similar to the YLS in that it assesses risk and need factors while also being a case management tool. Below is a link of the most recent version of the measures.

https://www.assessments.com/assessments_documentation/LSCMI_Tech_Brochure.pdf

Strategic Plan 2019

Health Equity Research Lab/
Cambridge Health Alliance

bcook@cha.harvard.edu
www.healthequityresearch.org

Health Equity Research Lab @cmmhr