



**VETERAN
RESPONSE
TEAMS**

Law Enforcement Officers Respecting Service, Restoring Honor for Vets in Crisis



U.S. DEPARTMENT OF JUSTICE
NATIONAL INSTITUTE OF CORRECTIONS
320 FIRST STREET, NW
WASHINGTON, DC 20534

SHAINA VANEK
ACTING DIRECTOR

ROBERT M. BROWN, JR.
SENIOR DEPUTY DIRECTOR

HOLLY BUSBY
CHIEF, COMMUNITY SERVICES DIVISION

STEPHEN AMOS
CHIEF, JAILS DIVISION

GREGORY CRAWFORD
PROJECT MANAGER

NATIONAL INSTITUTE OF CORRECTIONS
WWW.NICIC.GOV

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Written by Hal Donahue and Kristen Brackett, Veteran Infrastructure Products (VIP), Bernard Edelman, Vietnam Veterans of America, and Greg Crawford, National Institute of Corrections. Edited by Donna Ledbetter, National Institute of Corrections, and Bernard Edelman, Vietnam Veterans of America.

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The National Institute of Corrections, in partnership with the Justice-Involved Veterans Network (JIVN), has developed this white paper to highlight innovative law enforcement approaches to veterans in crisis in the community.

A blue-tinted background image showing three soldiers in full combat gear, including helmets and tactical vests, moving through a grassy field. They are seen from behind, walking away from the viewer towards a line of trees in the distance.

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Contents

	ABSTRACT	viii
	FOREWORD	ix
CHAPTER 1	▶ SO, YOU'RE (THINKING OF) STARTING A VETERANS RESPONSE TEAM TO WORK WITH TROUBLED VETS	2
CHAPTER 2	▶ U.S. DEPARTMENT OF VETERANS AFFAIRS: VETERANS JUSTICE OUTREACH AND ENGAGEMENT WITH LAW ENFORCEMENT	4
CHAPTER 3	▶ VETERANS IN CRISIS ACROSS AMERICA	6
	IN THEIR OWN WORDS Frank Webb: An Enlightened Approach to Mental Illness, Crime, and Punishment.	12
	IN THEIR OWN WORDS Birth of a Friendship	16
	IN THEIR OWN WORDS Understanding through Training	17
CHAPTER 4	▶ AN INSPIRED IDEA IN APEX, NORTH CAROLINA	20
	IN THEIR OWN WORDS Chief Blair Myhand: Police Officers and Veterans Were Dying	26
CHAPTER 5	▶ FROM NO-WIN SITUATIONS TO WIN-WIN SOLUTIONS IN DAYTON, OHIO	30
	IN THEIR OWN WORDS Detective Patty Tackett: Overcoming Stigma with Knowledge	36
CHAPTER 6	▶ PREVENTING VIOLENT ENCOUNTERS IN NEW CASTLE COUNTY, DELAWARE	38
	IN THEIR OWN WORDS Officer Nicholas Hurst: Leadership Born in Fallujah	44
CHAPTER 7	▶ COLLABORATING TO COUNTER THE CAUSES OF CRIMINAL CONDUCT IN SALT LAKE CITY, UTAH	46
	IN THEIR OWN WORDS Detective Gregory Smith: I Speak Fluent PTSD	54
CHAPTER 8	▶ DIVERSION FIRST, JAIL SECOND IN FAIRFAX COUNTY, VIRGINIA	56
	IN THEIR OWN WORDS Captain Steve Elbert: Soothing the Scars of War	60
	CONCLUSION	62
	RESOURCES	65
	ACKNOWLEDGMENTS	72

Abstract

This white paper is based on a series of interviews, buttressed by personal observations, of key players in several jurisdictions where law enforcement officers, Veteran Justice Outreach specialists from the U.S. Department of Veterans Affairs (VA), and community-based agency representatives collaborate to implement approaches to de-escalate veterans in crisis in our communities. These programs are improving public safety. They are creating opportunities for veterans struggling to re-acclimate to civilian life. These traumatized men—and increasingly women—receive the help they need to address mental health issues, such as post-traumatic stress disorder or traumatic brain injury, related to their military experiences.

This is the third publication in the National Institute of Corrections justice-involved veterans compendium project. It shares the view of law enforcement programs at several locations across the country, from small towns to large cities, and highlights how each jurisdiction went about creating and implementing teams or programs to improve practices meant to serve veterans who are in crisis.

Veteran Response Teams are improving outcomes for these veterans and minimizing hostile and sometimes volatile situations for both law enforcement officers and the veterans. This paper shares the views of police officers, sheriff's deputies, corrections professionals, representatives from the VA and other community-based treatment providers, each of whom, in their own words, have stories to tell.

Foreword

Many veterans return home from deployments to a combat zone with Post-traumatic Stress Disorder or other mental health issues. They may feel isolated, lonely, or misunderstood. Separated from the military “family” with whom they served, they carry the burden of their service alone, and some struggle with how to cope with their feelings. Some self-medicate or act out to ease their pain, and some find themselves involved in the criminal justice system.

Once in the criminal justice system, a veteran may struggle further without access to proper programs and psychological care. That is why, for the past several years, the National Institute of Corrections (NIC) has been working with partners from all facets of the justice system to develop veteran-specific approaches and resources to improve procedures and processes for agencies, and support better outcomes for justice-involved veterans. These efforts have been based on an adaptation of the sequential intercept model, which pinpoints junctures along the criminal justice pipeline where a veteran may be diverted from incarceration in order to address the issues that got him or her in trouble with the law.

In 2015, NIC began working with nonprofit partners to develop publications and tools highlighting the advantages and the promise of Veterans Treatment Courts. Early in 2018, we highlighted efforts to establish specialized housing units, or pods, in local and regional jails for veterans incarcerated there. In this publication, we underscore the role that specially trained law enforcement officers play in de-escalating circumstances where troubled veterans pose a threat to themselves or others and, when practical, direct them to resources that address their needs at the time of arrest and link them with agencies that can help them address the roots of their distress.

Supporting and fostering safe communities is the goal. With law enforcement on the front line, NIC strives to provide resources to implement conflict resolution and tools

to de-escalate volatile situations. Just as important, we hope to create connections between corrections for law enforcement so that we can better work in tandem, creating a stronger network of criminal justice professionals with the common purpose of maintaining security in both our neighborhoods and in our correctional facilities.

Through stories of innovative practices of law enforcement agencies, we trust that *Veteran Response Teams: Law Enforcement Officers Respecting Service, Restoring Honor for Vets in Crisis* will help stimulate ideas that lead to actions that develop strategies in local jurisdictions to ameliorate the situations of justice-involved veterans. We owe these men and women who have served our country no less.

We at NIC value your willingness to collaborate, and to seek better ways of enforcing the law and increasing safety and security in our communities. We welcome your comments and your input.

Shana Vanek

Acting Director

National Institute of Corrections

**IN THIS PUBLICATION, WE UNDERScore THE ROLE
THAT SPECIALLY TRAINED LAW ENFORCEMENT
OFFICERS PLAY IN DE-ESCALATING CIRCUMSTANCES
WHERE TROUBLED VETERANS POSE A THREAT TO
THEMSELVES OR OTHERS.**



FOR THE PAST SEVERAL YEARS, THE NATIONAL INSTITUTE OF CORRECTIONS (NIC) HAS BEEN WORKING WITH PARTNERS FROM ALL FACETS OF THE JUSTICE SYSTEM TO DEVELOP VETERAN-SPECIFIC APPROACHES AND RESOURCES TO IMPROVE PROCEDURES AND PROCESSES FOR AGENCIES, AND SUPPORT BETTER OUTCOMES FOR JUSTICE-INVOLVED VETERANS.

So, You're (Thinking of) Starting a Veterans Response Team to Work with Troubled Vets

OR YOU'RE IN THE PROCESS of implementing a veteran response team (VRT) in your local jurisdiction to better respond to veterans in crisis in your community. You've got questions you've had to ponder or at least tentatively answer, and you've identified several issues and concerns.

CONSIDER THE FOLLOWING QUESTIONS TO HELP YOU DECIDE WHETHER STARTING A VRT IS RIGHT FOR YOUR JURISDICTION:

- ▶ What is the **FIRST THING** I/we ought to do?
- ▶ What are the **CORE COMPONENTS** needed for a VRT in my jurisdiction?
- ▶ Can we identify a **"CHAMPION"** who will work hard to create a VRT?
- ▶ Are we asking the **RIGHT QUESTIONS** about military service to those veterans who are in crisis?
- ▶ Are we tracking **RELEVANT DATA** on our veteran population?
- ▶ Do the **DATA SUPPORT** the need for such a unit? Does our county or region have the **DEMOGRAPHICS** to support such a programmatic effort for veterans? Do we have enough veterans passing through our justice system?
- ▶ What **TREATMENT OPTIONS** and/or services do we have—and need—to help these veterans?
- ▶ What **CRITERIA** should be established to determine whether a referral of a veteran in crisis is appropriate or if he/she needs to be taken into custody?
- ▶ What early intervention **PROGRAMMING OR SERVICES** could we offer to veterans to allow them to safely remain in the community?
- ▶ Is there a Veterans Justice Outreach **SPECIALIST** or other individual who can help set up our VRT and identify community resources?

- ▶ Does our **JURISDICTION** have a Veterans Treatment Court or a Veteran-Specific Housing Unit at the local jail? If not, do we need to plan for one?
- ▶ What is our **PLAN FOR IMPLEMENTATION**? What roadblocks or obstacles should we anticipate?
- ▶ Can we expect the local **LEGAL ESTABLISHMENT** to be supportive and community leaders accommodating?
- ▶ How do we achieve **BUY-IN** from the chief of police, sheriff, county executive, or mayor as well as other key stakeholders?
- ▶ Who are the **KEY PLAYERS**?
- ▶ How will the VRT and specialized training be **FUNDED**? Will there need to be an outlay of dollars or can we incorporate this training into existing training?
- ▶ How do we create a **SUSTAINABLE** program? What if our champion moves on or retires?
- ▶ How do we **GAUGE SUCCESS**?

You should discern answers to your questions and concerns in the sections that follow, which feature programs that are operating with significant success in saving law enforcement first responders as well as the agitated veterans they are called on to calm down.

A “CHAMPION” IS NEEDED; IT TAKES SOMEONE WHO IS WILLING TO PICK UP THE BALL AND RUN WITH IT AND MOVE IT FORWARD, BECAUSE I THINK THIS IS A HUGE IMPORTANT THING THAT WE’RE DOING.

—BLAIR MYHAND, CHIEF OF POLICE, CLAYTON, NORTH CAROLINA

Veterans Justice Outreach and Engagement with Law Enforcement

BY SEAN CLARK



SEAN CLARK

The Health Care for Reentry Veterans (HCRV) program provides outreach to veterans preparing to reenter their communities following incarceration in state or federal prison. Veterans Justice Outreach (VJO) directs its efforts toward the “front end” of the criminal justice system—courts, local jails, and law enforcement agencies. VJO is one of the U.S. Department of Veterans Affairs’ two healthcare outreach programs serving veterans who are involved with the criminal justice system. Every VA medical center has at least one VJO Specialist, a licensed independent mental health clinician who serves as a liaison between his/her VA facility and the criminal justice system in local communities.

Although the work that VJO Specialists do as members of Veterans Treatment Court teams is by far the best-known part of the program, VJO partnership with local law enforcement can ensure pathways into needed treatment for Veterans in crisis. VJO Specialists regularly deliver presentations to area law enforcement agencies, focusing on locally available VA treatment resources, and the practical steps involved in getting a Veteran from a street encounter into VA care. Some VJO Specialists even serve as faculty in formal law enforcement training programs, such as state police academies and Crisis Intervention Team trainings.

In addition to these local partnerships, the VA/VJO commitment to partnering with law enforcement has played out on a national scale. From 2012-15, the VJO program worked with VA’s Law Enforcement Training Center (LETC) and Office of Mental Health Services and Suicide Prevention to design, test, and deliver a two-day training to all VA Police officers across the country (there are approximately 3200 serving

**A VETERANS JUSTICE OUTREACH PARTNERSHIP WITH
LOCAL LAW ENFORCEMENT CAN ENSURE PATHWAYS INTO
NEEDED TREATMENT FOR VETERANS IN CRISIS.**

VA Police officers). This training focused on verbal crisis de-escalation, mental health issues, and locally available VA resources. Evaluation results showed that the training had a significant impact on improving officers' skill in identifying local treatment resources for Veterans in crisis. A condensed version of this training was filmed and incorporated into the Law Enforcement Training Center's Basic Officer course, which all newly hired VA Police officers complete. This training video is also publicly available: <https://sites.google.com/paloalto.edu/police-training>. In 2018, LETC also offered a half-day "train the trainer" session on these topics for community law enforcement and other first responders in 15 communities across the country.

Two needs that officers commonly relate to VJO Specialists are a way for an officer to determine an individual's Veteran status quickly and accurately, and a rapid turnaround when bringing a Veteran to a VA medical center for care. Both issues can be addressed through local law enforcement/VJO partnerships. Officers can use a VA web-based tool, SQUARES (Status Query Exchange and Response System) to determine, within a few minutes or less, whether an individual has a record of military service. Protocols for community law enforcement officers bringing Veterans to VA facilities for care can also be designed with the officers' needs in mind.

**VJO SPECIALISTS DELIVER PRESENTATIONS TO
LAW ENFORCEMENT AGENCIES, FOCUSING ON
AVAILABLE VA TREATMENT RESOURCES, AND THE
STEPS INVOLVED IN GETTING A VETERAN FROM A
STREET ENCOUNTER INTO VA CARE.**

Veterans in Crisis Across America

MEDICAL, MENTAL HEALTH, AND ECONOMIC ISSUES AFFECT TROUBLED VETERANS AND LEAD TO INCREASED RISKS FOR RESPONDING OFFICERS AND THE PUBLIC

The Department of Defense estimates that 2.5 million members of our armed forces have deployed to or in support of the Afghanistan and Iraq wars. More than 30 percent have deployed multiple times; nearly 40,000 have deployed more than five times. These wars, as well as the broader global war on terrorism have taken a toll on our service members—and their families. Current data from the departments of defense and veteran affairs (VA) and other entities have suggested what we have come to understand anecdotally: that many of our veterans are in crisis.

FOR FAR TOO MANY VETERANS, MENTAL HEALTH DISORDERS, INCLUDING PTSD, ANXIETY, AND DEPRESSION, INCREASE WITH EACH DEPLOYMENT. WHILE LESS THAN 1 PERCENT OF AMERICANS NOW SERVE IN THE MILITARY, FORMER SERVICE MEMBERS ACCOUNT FOR 20 PERCENT OF ALL SUICIDES IN THE UNITED STATES. ACCORDING TO THE VETERANS ADMINISTRATION, ONE VETERAN DIES BY HIS OWN HAND EVERY 80 MINUTES, AND SINCE 2001, MORE VETERANS HAVE DIED BY SUICIDE THAN IN THE COMBINED CASUALTY ROLLS IN THE WARS IN AFGHANISTAN AND IRAQ.

THESE NUMBERS SHOW HOW:

- ▶ In 2016, the number of veterans who received compensation for a disability was **4,356,443**.¹
- ▶ In any given year, **11-20%** of veterans who served in Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF) have post-traumatic stress disorder (PTSD).²
- ▶ Among deployed U.S. troops, PTSD diagnoses grew by **400%** from 2004 to 2012. As many as 500,000 veterans were diagnosed with PTSD.³
- ▶ Approximately **18 OUT OF EVERY 10,000** veterans in the United States experienced homelessness on a single night in 2018.⁴
- ▶ Between 2000 and 2018, the number of U.S. service members diagnosed with traumatic brain injury (TBI) was **383,947**.⁵
- ▶ In 2018, the unemployment rate for veterans was as high as **6.5 PERCENT** depending on geographic location, and it was an average of **5.2 PERCENT** nationally for veterans with service-connected disabilities. An average of **35.9 PERCENT** of veterans ages 18 to 24 were not working in 2018.⁶

¹ U.S. Department of Veterans Affairs, *VA Report: Disability Compensation and Patient Expenditures, FY 2000 to 2016* [U.S. Department of Veterans Affairs: Washington, DC, August 24, 2018]

² U.S. Department of Veterans Affairs, "How Common is PTSD in Veterans," accessed April 15, 2019, [U.S. Department of Veterans Affairs, VA National Center for PTSD] https://www.ptsd.va.gov/understand/common/common_veterans.asp

³ Mark Thompson, "Unlocking the secrets of PTSD," *Time* 2015;185:40-43.

⁴ Meghan Henry, et al, *The 2018 Annual Homeless Assessment Report (AHAR) to Congress*, accessed April 15, 2019 [Washington, DC: U.S. Department of Housing and Urban Development, 2018] PDF e-book <https://www.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf>

⁵ Defense and Veterans Brain Injury Center (DVBIC) Report: DoD Worldwide TBI Numbers. 21 June 2018.

⁶ Department of Labor- Bureau of Labor Statistics (DOL BOLS) Report USDL-19-0451. 21 March 2019.

While the number of active duty troops across service branches has continued to decrease (from 1.370 million in 2013 to 1.294 million in 2017), the reserve forces (Reserve, Guard, and Ready Reserve) increased during that same period to 1.590 million. Because Section 12304b of the 2012 National Defense Authorization Act (U.S. Code › Title 10 › Subtitle E › Part II › Chapter 1209 › § 12304b) reduced benefits for activated reserve troops, including pre- and post-mobilization health care, National Guard and Reservists now face significant challenges and more disruptions to their lives, with fewer resources to access upon their return home. According to the DOD Suicide Event Report,⁷ reserve forces have higher suicide rates than active duty personnel or the general population. Additional study has found that National Guard and Army Reserve soldiers reported substantially higher rates of interpersonal conflict, PTSD, depression, and overall mental health risk.⁸

Regardless of military service type, those serving under OEF and OIF have experienced more deployments of active duty members, deployments of women, deployments of parents of



young children, and deployments of reserve forces than in previous U.S. conflicts.⁹ They have also been deployed for longer time periods with less time at home between deployments. Service members exposed to combat in OIF/OEF had higher rates of new-onset depression (men, 5.7 percent; women, 15.7 percent) than those who deployed but did not see combat (men, 2.3 percent; women, 5.1 percent).¹⁰ For far too many veterans, mental health disorders including PTSD, anxiety, and depression increase with each deployment, but studies indicate that 56–87 percent of service members experiencing psychological distress after deployment do not receive psychological help. Further, the Veterans Health Administration and the private sector are experiencing a shortage of mental health practitioners to meet current needs.

For far too many veterans, mental health disorders including PTSD, anxiety, and depression increase with each deployment. While less than 1 percent of Americans now serve in the

⁷ According to a 2015 Department of Defense Suicide Event Report (DoDSER) annual report, the standardized suicide rate was 20.2 per 100,000 for the Active component. For the Selected Reserves component, the rates were 24.7 per 100,000 for the Reserves and 27.1 per 100,000 for the National Guard. The rate for the general population was 17.3 per 100,000.

⁸ Milliken CS, Auchterlonie JL, Hoge CW. "Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war." *JAMA*. 2007;298(18):2141-2148.

⁹ Jennie W. Wenger, Caolionn O'Connell, Linda Cottrell, *Examination of Recent Deployment Experience Across the Services and Components* [RAND, 2018] RR-1928-A

¹⁰ Wells T.S., LeardMann C.A., Fortuna S.O., Smith B., Smith T.C., Ryan M.A., Boyko E.J., Blazer D. "A prospective study of depression following combat deployment in support of the wars in Iraq and Afghanistan," *American Journal of Public Health*. 2010;100(1):90–99.

**AN ENCOUNTER WITH A DISTRESSED VETERAN WHO IS
ARMED CAN BE PERILOUS FOR RESPONDING OFFICERS
AND DANGEROUS TO THE VETERAN HIMSELF.**

military, former service members account for 20 percent of all suicides in the United States. According to the VA, one veteran dies by his own hand every 80 minutes, and since 2001, more veterans have died by suicide than in the combined casualty rolls in the wars in Afghanistan and Iraq. Studies indicate that 50–90 percent of service members experiencing psychological distress after deployment do not receive psychological help, and the Veterans Health Administration, the VHA, is still experiencing a shortage of mental health practitioners to meet current needs.^{11,12}

For law enforcement, responding to even a seemingly minor incident can result in a potentially dangerous encounter with a stressed out or mentally ill citizen. The fragmented mental health system, which has placed great burdens upon local communities to find solutions, has also placed a considerable strain on law enforcement, and increases the risk of injury or death to the responding officers.¹³ Following the closing of state mental hospitals, persons with serious mental illness without adequate private care are three times more likely to be housed in a jail or prison than in a hospital.¹⁴ The mentally ill who once were treated at psychiatric hospitals now live on the streets, and often move through the criminal justice system following both non-violent and violent criminal acts. Approximately 20 percent of inmates in jails and 15 percent of inmates in state prisons have a serious mental illness.¹⁵ Additionally, it is estimated that each year 4,500 patients from state psychiatric hospitals who have been deemed incompetent to stand trial and 1,000 patients from state psychiatric hospitals who have committed major crimes deemed not guilty by reason of insanity are released into society.¹⁶

Studies have shown that in the general population, the risk of violence is doubled for those with mental health disorders *and* substance abuse.¹⁷ Additional struggles related to socio-economic status, especially poverty, also increase the likelihood of criminal activity, including violent crimes, as concluded by an unsurprising determination-of-risk assessment in the 2001

¹¹ Blais R.K., Renshaw K.D.. "Stigma and demographic correlates of help-seeking intentions in returning service members," *Journal of Trauma Stress*. 2013;26:77–85.

¹² Sandra Basu, "With New Hires, VA Has Net Increase of 8,303 Employees; Still Needs Mental Health Professionals" *The Psychiatric Shortage* [National Council for Behavioral Health, 2018] BH365, <http://www.usmedicine.com/agencies/departments-of-veterans-affairs/with-new-hires-va-has-net-increase-of-8303-employees-still-needs-mental-health-professionals>

¹³ Mental Health America Position Statement 59: Responding to Behavioral Health Crises. <http://www.mentalhealthamerica.net/issues/position-statement-59-responding-behavioral-health-crises>

¹⁴ *Serious Mental Illness Prevalence in Jails and Prisons*. [Treatment Advocacy Center, September 2016].

¹⁵ Torrey E.F., Zdanowicz M.T., Kennard A.D. et al. *The treatment of persons with mental illness in prisons and jails: A state survey*. Arlington, VA: Treatment Advocacy Center, April 8, 2014.

¹⁶ *Treat or Repeat: A State Survey of Serious Mental Illness, Major Crimes and Community Treatment*. Treatment Advocacy Center, September 2017.

¹⁷ Stuart, H. "Violence and Mental Illness: An Overview," *World Psychiatry*. 2003 June; 2(2): 121–124.

MacArthur Study of Mental Disorder and Violence. For veterans with untreated mental health disorders, with depression or PTSD or TBI, family stresses from repeated deployments, opioid addiction, unemployment, and/or homelessness present additional challenges to law enforcement. Veterans are combat-trained; many are combat-experienced. According to findings from the 2015 National Firearm Survey (Inj Epidemiol. 2017 Dec; 4:33), nearly half of all veterans own one or more firearms; more than half possess both handguns and long guns. An encounter with a distressed veteran who is armed can be perilous for responding officers and dangerous to the veteran himself.

The shortage of mental health emergency services across the United States has resulted in law enforcement officers often serving as first responders to veterans in crisis. As Ornstein and Leifman noted in the August 2017 issue of *The Atlantic*, “The potential consequences of these encounters—injured police officers; people dead... families grief-stricken and bereft; and wrongful-death lawsuits against cities, towns, or counties that result in large settlements paid by taxpayers—are bad for all.”

A crisis intervention team (CIT) program is an innovative, community-based approach to improve the outcomes of these encounters. Through collaborative partnerships and intensive training, these programs improve communication, identify mental health resources for those in crisis, and ensure the safety of responding officers. CIT programs can reduce arrests of people with mental health issues while also increasing the likelihood that these individuals will receive emergency services and support. Veteran-focused CIT programs specifically prepare law enforcement officers to have a greater understanding and awareness of veterans with mental health conditions.

Law enforcement CITs have demonstrated their effectiveness in reducing injury to law enforcement personnel and citizens and the criminalization of mental illness. A 2014 study of the CIT program in Louisville, Kentucky, found that annual savings from the CIT were \$3.5 million—more than \$1 million in deferred hospitalizations, almost \$2.3 million in reduced inpatient referrals from jail, and some \$10,000 in nullified booking and jail time. Another study found that officers with CIT training were less likely to use force to engage persons with mental health disorders.¹⁸ Additionally, CIT-trained officers believe that non-physical responses were more effective, and physical responses less effective, when responding to a person with mental illness.¹⁹

¹⁸ Amy C. Watson, Victor C. Ottati, Jeff Draine, Melissa Morabito, “CIT in Context: The Impact of Mental Health Resource Availability and District Saturation on Call Dispositions,” *International Journal of Law Psychiatry*. 2011 July-August; 34(4):287-294.

¹⁹ Michael T. Compton, Berivan N. Demir Neubert, Beth Broussard, Joanne A. McGriff, Rhiannon Morgan, Janet R. Oliva. Schizophr Bull, “Use of Force Preferences and Perceived Effectiveness of Actions Among Crisis Intervention Team (CIT) Police Officers and Non-CIT Officers in an Escalating Psychiatric Crisis Involving a Subject With Schizophrenia” 2011 Jul; 37(4): 737-745.



According to NAMI, the National Alliance on Mental Illness, implementing verbal de-escalation over physical response can lead to fewer injuries to both law enforcement and individuals with mental illness, saving law enforcement time and money and preserving the goodwill of the community. NAMI's policy statement stresses that "CIT gives officers more tools to do their job safely and effectively. It helps keep people with mental illness out of jail, and get them into treatment, where they are more likely to get on the road to recovery." Additionally, NAMI suggests that nationally:

- ▶ CIT improves officer safety. For example, after the introduction of CIT in Memphis, TN, officer injuries sustained during responses to "mental disturbance" calls **DROPPED SIGNIFICANTLY**.
- ▶ Compared to other jail diversion programs, officers say CIT is better at **MINIMIZING** the amount of time they spend on mental disturbance calls, **MORE EFFECTIVE** at meeting the needs of people with mental illness, and better at **MAINTAINING** police and community safety.
- ▶ CIT saves public money. Pre-booking early intervention programs, including CIT, reduce the number of re-arrests of people with mental illness by **MORE THAN HALF**.
- ▶ Individuals who encounter a CIT-trained officer receive more counseling, medication, and other forms of treatment than individuals who are not diverted—services that keep them out of expensive jail beds and hospitals. Community-based mental health treatment costs approximately **ONE-THIRD OF THE COST** to house an inmate with mental illness, which runs an average of \$31,000 per year.

VETERAN-FOCUSED CIT PROGRAMS PREPARE LAW ENFORCEMENT OFFICERS TO HAVE A GREATER UNDERSTANDING AND AWARENESS OF VETERANS WITH MENTAL HEALTH ISSUES.

AN ENLIGHTENED APPROACH TO MENTAL ILLNESS, CRIME, AND PUNISHMENT*

By Bernard Edelman

When Sheriff Ed Gonzalez took office in January 2017 in Harris County, Texas, one of his initial actions was to implement the first-ever Mental Health and Jail Diversion Bureau in the sheriff's office. To run it, he brought over Major Mike Lee, who had supervised the first-ever mental health unit in the Houston Police Department (HPD), which he'd developed into a division. Lee, in turn, asked Frank Webb, who had retired after 36 years with the HPD, to come over and work for him as project manager of the bureau. Although Webb, 64, is not a veteran, he knows of service and sacrifice: His older brother, a Marine, had been killed in Vietnam.

I'M NOT AWARE of another sheriff's office in the nation that has a whole bureau dedicated to mental health and jail diversion. Major Lee and I, we have a long history together of working on mental health issues related to law enforcement.

I think Sheriff Gonzalez, when he was with the Houston Police Department, was very aware of this issue. As a hostage negotiator, he had specialized training on the mentally ill, knew both Major Lee and myself, knew what we did and was very supportive. The HPD, in my opinion, is very progressive, especially in the area of law enforcement response to the mentally ill.

After he retired, Sheriff Gonzalez worked on mental health issues as a City Council member. He was really the driving force to open the first ever sobering center in Houston that diverts people with alcohol and substance abuse issues rather than jailing them for unlawful intoxication. This is a facility to divert them, even where there's no crime.

As sheriff, he's just very aware it's a huge issue in jails and in patrol. [In the time I've been here], we started an annual report; we're the only bureau in our agency that I'm aware of that has its own annual report. We started a website for our bureau, the only bureau in this agency that has its own website. We're working on a triage diversion desk in our new joint processing center [to help us to better] divert people with low-level crimes and mental health issues from being booked into jail and instead into mental health treatment.

We have a reentry program to try to help inmates to not recidivate. We have programs for inmates who have substance use issues. We have reentry programs for female inmates who were prostitutes. And we have a special reentry program for veterans; we have veterans' pods within our jail called the Stars and Stripes program.

* The views expressed here are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.



FRANK WEBB

Inmates who are veterans, if they have an inclination, they can opt to go into these pods with other veterans where they're surrounded by their peers. They're kept busy, basically, all day, Monday through Friday, 8:00 to 5:00. We bring in people from veterans' organizations to talk to them. We have a creative writing class that brings in someone from the university. Some of the veterans drew beautiful murals—of the American flag, of an eagle—on the walls.

We also have a mental health unit in our jail. We have 102 behavioral health professionals from our local mental health authority [who] work in our jail. Last year, we spent over \$20 million on mental health work there. We have nine psychiatrists [who] work full time in our jail. So we have a very robust program for helping inmates with mental health issues. That's on the jail side, and our jail is one of the largest in the nation, with a little over 10,000 inmates.

On the patrol side, we have a co-responder program, called CIRT, for Crisis Intervention Response Team, where we have a deputy riding with a master's-level licensed professional counselor from a local mental health authority. They ride as partners and they handle our most serious calls involving the mentally ill. We have nine units: nine deputies, nine clinicians. We also have a CIRT team in the jail [composed of] detention officers, two in a team, with 40 hours of training, who respond to the most serious mental health calls in the jail.

We have a Homeless Outreach Team, with one sergeant and two deputies. A lot of the people they come in contact with are veterans with mental health issues living on the street. And that's their full-time job, homeless outreach.

Another major implementation is a CIT (Crisis Intervention Team) program. When Sheriff Gonzalez took office, he mandated that all new contingent officers and patrol deputies in the academy receive a class on crisis intervention and mental illness. That's basically a Crisis Intervention Team class. It's a 40-hour class, with a two-hour block on PTSD (post-traumatic stress disorder). And the majority of that information is on veterans.

We talk about PTSD also from the standpoint of officers who can get PTSD, but the majority of the information relates to military veterans. We have an hour-long block on TBI (traumatic brain injury), and a lot of that is related to veterans. One of the instructors is a Harris County deputy. She's a veteran who is passionate about this issue, and she does a fantastic job.

We also work in concert with area organizations. A lot of this collaboration started when Major Lee and [I] were in the Houston Police Department. We have a long history working over the years with our local mental health authority, which is now called the Harris Center for Mental Health and IDD [Intellectual and Developmental Disabilities]. They're our main collaborator.

We've worked with Mental Health America, with the PTSD Foundation of America, with U.S. Vets, a local organization with a lot of housing and other programs. We continue to work with them at the sheriff's office. The Veterans Administration—we don't go to [them] on a day-to-day basis but use them as a reference that's high on a list of resources for veterans called a green sheet.



We have a number that anyone can call if they have a concern about their loved one in the jail. They can call and leave a message. But if there is an emergency, jail staff call 911. If the call-taker has information or believes that the call might involve somebody in a mental health crisis or with a mental health problem, then our dispatchers would try to dispatch one of our CIT-trained deputies. If it's a very serious call and a CIRT team is available, then they would try to dispatch the co-responder team.

You know, people with mental illness are no more prone to violence than the average population. However, the population that law enforcement deals with is usually the most volatile. They're the sickest of the sick, because that's who we get called to deal with, people who are out of control, in what could be a very dangerous situation, especially if it's not handled correctly.

And that's what CIT is all about. It's trying to understand about what's going on with people in mental health crisis. What is going on with someone who's psychotic, who's maybe hearing voices or seeing visions. They may be paranoid. These deputies and their clinicians, they respond to situations almost on a daily basis. And many of these situations are very volatile. They talk people down out of killing themselves. They talk people who have threatened to kill themselves into dropping a knife.

They use basic crisis intervention training techniques—being patient, talking in a calm tone of voice, letting them vent, not getting too close, not putting hands on unless they have

to, treating people respectfully, assuring them that you're there to help, not hurt and not displaying any behavior that might threaten them. You try to find out what their name is, use it in the conversation. Explain why you're there, explain ahead of time what you're going to do before you do it. Just don't startle or surprise. I mean, there's just a whole host of things that are involved in the training that all contribute, I believe, in trying to de-escalate these situations and keep everyone safe.

If the responder is a veteran, then, I think, they can hopefully relate, [because] veterans in crisis do pose maybe a few more challenges because of their training, their training with firearms, their training with defense tactics, maybe martial arts. So the responders definitely have to be aware of that and [be] careful. But again, the whole goal is to verbally de-escalate situations, not get physical, engage them in conversation, and do all the things that they're trained to do.

Because we do have resources for veterans, we want to find out if someone is a veteran. One, we want to help veterans, and two, we want to try to direct them to resources for veterans—housing, Veterans Affairs, medical, U.S. Vets.

We've also piloted a telepsychiatry program. We're not aware of any other law enforcement agency in the nation that has done this. Telepsychiatry and telehealth have been used for years, but as far as we know, not with law enforcement first responders. So, back in December 2017, we piloted a three-week program. Three patrol deputies were given an iPad. While they [were] out on patrol, if they came across a person in a mental health crisis, and they needed the assistance of a psychiatrist, they could access a psychiatrist over the iPad in about 20 minutes.



FRANK WEBB

And it's amazing that you can actually bring psychiatry into the field via technology. Some of the goals of the program are, one, to help the deputies better triage and make the appropriate decision of what needs to be done with the individual, and two, to see if we can cut down on the number of times we bring those individuals to the hospital emergency departments. Because what's happening around the country, law enforcement is increasingly responding to individuals in serious mental health crisis, and a significant number of those are veterans.

And if they're to the point where they're a danger to themselves or others, most law enforcement agencies, at least the ones that I've talked to around the country, they're bringing these individuals to hospital emergency departments to be evaluated. And it's inundating the emergency departments. I've had medical directors tell me that, in their opinion, a lot of these people don't need to be there, but if they're brought in, they have to evaluate them.

In Charleston, South Carolina, every time they bring someone to a hospital emergency room, it's \$2,000. So there's a big push to try to make better decisions. And if you can have assistance with mental health professionals on the scene [who] can help you make that evaluation, you may not have to bring all these people to a hospital emergency room. Helping the deputies just make the better decision[s] on triaging and where to take the individual is huge.

In phase two [of the telepsychiatry pilot], the same three deputies have an iPad, but rather than access a psychiatrist, they're testing out accessing our master's-level clinicians. That's working out very well, and if this phase is successful, we're going to move on to phase three and provide an iPad to 25 patrol deputies.

These programs are designed to, one, keep everyone safe. We want to keep the deputies safe. We want to keep the individuals they're interacting with safe. We want to try to make the best, the appropriate decision of what needs to be done with the individual. We want to try to divert them from jail whenever possible.

In my opinion, there's a huge interest in the community for helping, especially the veterans and people with mental illness. So our programs are very well-received. We get visitors from across the area, across the state, and even outside the state, who come down and look at what we're doing, not just for the veterans, but for mental health in general. We don't expect everyone to be able to replicate everything we do. We're a very large agency. We have a lot of resources. We have a big budget. We're always open to other ideas, we're always looking at ways to do things better [because] we are spending so much time, attention, and money on mental illness in the jail and on patrol. This is what we do, and this is the way we do it.

Information on the efforts by the Harris County Sheriff's Office to deal with mental health issues can be found at www.harriscountycit.org. Click on Recidivism and a little arrow to bring up Chaplaincy, Inmate Education, and Re-entry. Go to Re-entry for information on the Stars and Stripes program. Another tab, Law Enforcement, is highlighted. Click on the little arrow beside it to bring up CIT Training, Crisis Intervention Response Team, and Homeless Outreach Team.



Birth of a Friendship*

WHEN I WAS WITH the Houston PD [police department]—it's probably been three or four years ago—the sergeant over at our Homeless Outreach Team, his name is Steven Wick, just really, really had a passion for helping the homeless.

What the Homeless Outreach Team people do, they come across homeless people all day, every day. They interact. They offer to help. And if the homeless want help, then they will do everything they can, if that means getting them to a hospital, to a sobering center, to the VA (Veterans Administration), whatever. But unfortunately, a lot of the homeless don't want help. They're just not ready at that time.

This sergeant came across a veteran, an alcoholic, living on the streets of Houston. And for about a year and a half, he'd meet him every few days. He'd ask, "How's it going today? How're you doing?" The sergeant just developed a relationship, a rapport, with him. And he'd offer, "Hey, you want any help today?" The usual reply was, "No, I'm okay, Sarge," even though he had been beaten up several times, just living on the streets. Finally, Sergeant Wick came across him one day, and when he said, "Hey, do you want some help? Are you ready?" the veteran said, "You know what? I'm ready."

So they took him to the VA, where he got dried out. He got help. He got into housing, got a job. He was, I think, an X-ray technician before he went into the military. So he had a trade, a skill, and he got back on his feet. He got a relationship with his family back. And he went from living on the streets to running marathons, and he'd run two or three marathons a year.

So, this sergeant and this veteran, they have maintained a relationship to this day. And the veteran, when he got his coin—I think when you're in AA after about a year of being sober they give you a coin—he gave that coin to this sergeant.

It's really an amazing story of the difference you can make, how this sergeant completely turned this veteran's life around. There are many veterans that our Homeless Outreach Team comes in contact with. They don't help them all, and not all the veterans and not all the homeless want help, unfortunately. But for those who do, we can really make a huge impact.

They try to provide help and social services to these individuals. They hardly ever write tickets because, as Sergeant Wick says, it's ridiculous to write a homeless person a ticket. They can't pay it, and it actually costs the city money every time you write a ticket.

Before we had a Homeless Outreach Team, one of the officers [who] started the unit with Sergeant Wick used to carry water and food in his patrol car when he was on patrol. And he'd hand this out on his own. In law enforcement, we have become the de facto social workers of the 21st century. We respond to more people in serious mental health crises on a daily basis than any mental health professional. We literally save people's lives. It's amazing, yeah.



ANONYMOUS
HOMELESS VETERAN
IN HOUSTON AREA

* The views expressed here are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Understanding through Training

FOUR OR FIVE years ago, we started to provide mandatory training on PTSD (post-traumatic stress disorder) to every classified employee of the Houston Police Department, about 5,200, from the chief on down. We did that because our union had a concern about veterans who had come back from the military, from combat, to our department with PTSD and other mental health issues. And the real impetus for this training was a veteran.

He was very young. He only had a few years on the department. He'd been in the Marines, went to Iraq, was deployed twice, came back, and his family saw that he had some issues. He denied it. He later told me he did finally realize that he probably had PTSD, but he was like, "Frank, I was a Marine. I didn't need help. I could take care of this on my own."

So he applies to the Houston Police Department (HPD). He does not bring up anything about any kind of mental health problems. Their psychologist who did the interview evidently did not detect anything.

So he goes through the academy with no problems and graduates. And he's an officer on patrol and he's a very good officer. So what happened with him, he did have problems with PTSD. And the way he dealt with his PTSD is he would stay very busy. He would work overtime, and he was a very hard worker. His supervisors loved him.

However, he's still not getting any help. So on his days off, now he's not busy. He would drink, and he had a problem with alcohol.

And one night he and another officer, they had gone out drinking. All night. Coming home very late at night, or very early in the morning, they got into an accident. They fled the scene. He did not stop to make a report.

Someone got his license plate number and complained. And he got in trouble. He got suspended. And the department told him, "You know, you evidently have a problem with alcohol. And you need to get that addressed. And if you address your problem, get it under control, serve your suspension, you'll go on with your career, and nothing more will be said. But you do need to go to AA."

**...EVERYONE FROM THE CHIEF ON DOWN FELT TERRIBLE
BECAUSE EXCEPT FOR THE OFF-DUTY, HE WAS NOT A PROBLEM
CHILD. HARD WORKER, YOUNG OFFICER, VETERAN, HONORABLY
DISCHARGED, EVERYONE FELT BADLY ABOUT IT. HE KIND OF
FELL THROUGH THE CRACKS.**

That was what was called a “last chance agreement.” It’s like, “We’re going to make this agreement, but if you do not get help and if you have another problem, then you won’t be able to work here anymore.”

He went to one AA meeting and stopped going. The department at that time did not keep track to make sure he kept going. I guess they just assumed that he was. So, it happened again. He got in another accident. It was late at night. He had been drinking. He climbed the fence of a very affluent house. He started doing pushups and jumping jacks in their fountain, woke the people up. They called the police. And he got fired.

When they called him in and talked to him, now he brings up PTSD. First time ever. Well, the department said, “You know what? We’d love to help you. You’re a veteran. You’re a good officer. But we gave you this chance. You did not take it. We’re sorry, but you’re fired.”

I was told everyone from the chief on down felt terrible because except for the off-duty, he was not a problem child. Hard worker, young officer, veteran, honorably discharged, everyone felt badly about it. He kind of fell through the cracks.

And our union felt so strongly about that incident and other officers that they had concerns about. So we got permission from the chief to develop a training on PTSD for the whole department. And what we did was, we had information on PTSD, and we put this video together. We had a female officer who served in Iraq who had PTSD. She and other HPD officers [spoke about their PTSD]. And we had another officer who had PTSD because his partner and best friend was shot and killed in front of him.

So to do mandatory training at the HPD, it took a year to train 5,200 people. They had 50, 60, 70 in a class two or three times a week. And I can’t tell you how many officers that I had come up to me and thank me for the training.

OUR UNION FELT SO STRONGLY ABOUT THAT INCIDENT AND OTHER OFFICERS THAT THEY HAD CONCERNS ABOUT. SO WE GOT PERMISSION FROM THE CHIEF TO DEVELOP A TRAINING ON PTSD FOR THE WHOLE DEPARTMENT.

A BIG PART OF THE TRAINING THAT WE DID WAS TELLING THE OFFICERS THAT IF YOU HAVE PTSD OR ANY OTHER MENTAL HEALTH PROBLEM, GET HELP. YOUR CHANCES OF LOSING YOUR JOB, LOSING YOUR CAREER, LOSING YOUR FAMILY ARE GREATER IF YOU DON'T SEEK HELP THAN IF YOU DO.

I had one officer come up who said, "My father . . . Now I know." He said, "My father was a Vietnam veteran. He lived in a trailer by himself out in the woods. My family never understood what was going on with him. Now I know he had PTSD. I just never knew the symptoms before." And he goes, "I'm divorced. I think if I had this training before my divorce, I think I would still be married. And after taking this training, myself and another officer at my station, we went to the VA, and we're getting help for our PTSD. Without this training, I don't think I would have recognized it, and I wouldn't have gotten help."

I actually used that officer [in the video]. I got his permission. I didn't use his name, but I used his experience. And I said, "This happened in our department. You don't want this to happen to you." The officer who lost his job, he came and sat through the first training. He was working in construction, but he said, "I completely support what you're doing." He said, "I wish that I had this training. It may have helped me."

There's no telling how many officers on the Houston Police Department sought out help because of that training. It's so important that law enforcement agencies do that because, similar to the military, there's a stigma against coming out saying you have any kind of mental health problem. There's a stigma against going to psych services. They think it's going to be a career killer. It doesn't go with the image. And a big part of the training that we did was telling the officers that if you have PTSD or any other mental health problem, get help. Your chances of losing your job, losing your career, losing your family are greater if you don't seek help than if you do.

There are similarities between law enforcement and the military. I'm not saying that we see things on the scale that the military does. But we do see dead bodies, abused kids, stuff like that. That puts law enforcement at a high risk for developing PTSD.

— Bernard Edelman

An Inspired Idea in Apex, North Carolina

Nationally, the number of veterans with repeated deployments is growing, as is awareness of the issues that present challenges to their readjustment in the civilian world. Because of mental health issues made worse by factors such as unemployment and drug abuse, some veterans become justice-involved. Increasingly, several hundred communities have created Veterans Treatment Courts that provide support and services to divert veterans charged with mostly non-violent felonies from incarceration. Yet situations in which peace officers engage with troubled veterans prior to any court appearance are potentially dangerous both for officers and veterans because escalation can occur very quickly.

Apex is located in North Carolina's economic development triangle with a population of approximately 50,000. One in ten residents has an income below the federal poverty threshold. Apex is part of Wake County, which has more veterans — 58,000 — than any other county in the state. Between 2008 and 2016, veterans there comprised almost 10 percent of all homeless veterans in the state. Like other smaller communities across America, Apex is dealing with the opioid and heroin crisis, and the county estimates that up to 70 percent of those in the Wake County jail have a mental illness or substance abuse disorder. Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans who have survived serious injuries have undergone long and painful recoveries. Just as the general population was prescribed the new, “safe” synthetic opioids for pain management, veterans have also been affected by opioid addiction, which increases the likelihood that they will interact at some point with law enforcement. As Dr. Art Zee described in his study “The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy” (American Journal of Public Health. 2009 February; 99(2): 221–227), doctors were deliberately misled about the addictive nature of this drug when prescribed as a treatment for chronic pain management. Furthermore, GAO found

**IN A MOMENT OF CRISIS, A FAMILIAR FACE CAN
CONTRIBUTE TO A CALMED AND PEACEFUL RESOLUTION
IN VOLATILE AND POTENTIALLY VIOLENT SITUATIONS.**

that “Purdue conducted an extensive campaign to market and promote OxyContin using an expanded sales force to encourage physicians, including primary care specialists, to prescribe OxyContin not only for cancer pain but also as an initial opioid treatment for moderate-to-severe non-cancer pain. The Drug Enforcement Administration (DEA) has expressed concern that Purdue’s aggressive marketing of OxyContin focused on promoting the drug to treat a wide range of conditions to physicians who may not have been adequately trained in pain management. FDA has taken two actions against Purdue for OxyContin advertising violations. Further, Purdue did not submit an OxyContin promotional video for FDA review upon its initial use in 1998, as required by FDA regulations.”¹

The empathetic response of the Apex Police Department (PD) is changing how police respond to incidents involving veterans in cities across the country. In an incident in 2015, two young officers, Jonathan Guider and Harry Pennington, both Marine veterans, answered a domestic disturbance call involving an Air Force veteran diagnosed with PTSD and TBI. What began as



CHIEF MYHAND AND VETERAN CIT TRAINING CLASS

a tense situation was de-escalated quickly when the officers told him that they, too, had served. As the local newspaper reported, “Guider and Pennington coaxed Blalock out of hiding by offering to talk, instead of shouting orders. They bonded over stories about deployments to the

Middle East, and they learned Blalock’s loss of his beloved pit bull was just one of the factors that set off his anger. Guider offered to buy him a new one.” The officers were able to establish rapport with Blalock, and instead of taking him to jail and charging him, resolved the situation peacefully and connected him to much-needed resources.

When the officers reported to then-Captain Blair Myhand, the Chief of Police, Myhand recognized a training opportunity. He researched reports, newspaper articles, and other media accounts of encounters between law enforcement and veterans across the United States. He was struck by how many of these incidents resulted in injury or death of the officer or the veteran. So, based on the actions of his officers in responding to Blalock, he began to develop a new program.

Launched in 2015, the Apex PD’s Veterans Crisis Response Program seeks to protect the lives of police officers while helping veterans avoid escalation of problems that lead to incarceration.



CHIEF
BLAIR MYHAND

THE EMPATHETIC RESPONSE OF THE APEX POLICE DEPARTMENT IS CHANGING HOW POLICE RESPOND TO INCIDENTS INVOLVING VETERANS ACROSS THE COUNTRY.

¹ U.S. Government Accountability Office. “Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem” (19-DEC-03, GAO-04-110).

SITUATIONS IN WHICH PEACE OFFICERS ENGAGE WITH TROUBLED VETERANS PRIOR TO ANY COURT APPEARANCE ARE POTENTIALLY DANGEROUS FOR BOTH OFFICERS AND VETERANS BECAUSE ESCALATION CAN OCCUR VERY QUICKLY.

In September 2015, the first class of 22 officers from Wake County law enforcement agencies completed the curriculum. The program is a component of the Crisis Intervention Training (CIT) and was originally reserved for police officers with military backgrounds. However, due to interest and the realization that others may benefit from this specialized training, subsequent training programs have been inclusive of police officers without prior military backgrounds and others from outside agencies.

The program consists of two days of training, including a half-day of situational training and role-playing scenarios based on actual crisis-response incidents. It also features presentations by area mental health experts on issues such as PTSD (post-traumatic stress disorder), TBI (traumatic brain injury), and suicide. The objectives are to educate officers on the mental health aspects of service-related conditions, to inform the officers on a variety of treatment and resource options, and to expose them to realistic role-playing with coaching and feedback. Officers are also informed about mental health and veteran-specific resources available in their communities.

According to Chief Myhand, veteran-focused CIT, like Veterans Treatment Courts, not only save taxpayer dollars, they help protect the lives of both officers and veterans. In addition to incarceration being expensive, the collateral consequences of justice-system involvement can be severe. With a criminal conviction it is tougher to get a job, more difficult to find housing, more difficult to access financial assistance for education and training opportunities, and it often strains family relationships. The cost of housing individuals in prison long-term is far more expensive and less effective than treatment and rehabilitation, especially for those with mental health diagnoses.²

The training Chief Myhand developed targets and attempts to intervene with veterans who appear to be on the road to justice system involvement with the potential for long-term incarceration, or even suicide. Agitated veterans are offered hope, for themselves and for their families, through specialized de-escalation measures that are more likely to result in peaceful and safe outcomes.

In constructing his program, Chief Myhand began by seeking allies. He reached out to the National Alliance on Mental Illness in North Carolina to present his concept. This led him to Roosevelt Richard of Alliance Behavioral Healthcare, who was instrumental in helping him transform his concept into reality.

² Chief Myhand's assertion is confirmed by NAMI. Housing an inmate with mental illness in jail costs \$31,000 annually, while community mental health services cost about \$10,000.



Chief Myhand, who is himself a veteran, focused on community resources in addition to what the local VA (Veterans Administration) could provide, inasmuch as many veterans are often skeptical of the VA's ability to help them. Lack of timely access to VA resources and specialists is often a contributing factor to their crisis situation. Myhand recognized

that non-VA services such as therapeutic riding, acupuncture, and certain veteran-focused events should be a component of the program. Initially, Myhand and Richard thought the Veteran CIT program would be limited to combat veterans because of their own combat experiences. They soon recognized that the struggles of non-combat veterans warranted inclusion in the program as well.

With assistance from NAMI (National Alliance on Mental Illness), they identified subject matter experts on PTSD, TBI, military sexual trauma, and other mental health conditions relating to military service. NAMI also helped identify instructors for the training curriculum.

Wake Technical Community College waived fees in providing the training facilities for the police. Course presenters volunteered their expertise. At the conclusion of the training, officers are provided with crisis contact cards to connect veterans and their families with both crisis intervention and comprehensive case management services.

By the end of 2017, five Vet CIT courses had been completed, and more than 125 officers had been trained. Since the implementation of this program, no fatalities have occurred during interactions between first responders and veterans.³ When asked how he assesses the success of the Vet CIT program, Richard said, "I measure this in two ways: validation from the people [who] have actually taken the class and the usefulness that they found in it, as well as the fact that we haven't had one of these incidents in our community that [turned out] badly [for officers or veterans]. According to Chief Myhand, there have been 25 encounters with veterans since implementing the Vet CIT program in 2015 with no fatalities or injuries.

Chief Myhand said the Wake County CIT was inspired by the original CIT program, the Memphis model, and that he wanted the Vet CIT model tied to the Memphis CIT model to add some credibility to their efforts. Myhand believes their program is portable as well. Richard and Myhand have provided training to law enforcement leaders from other states who have taken the training back to their jurisdictions and implemented similar programs. There are core facets of the training that can be adapted by any jurisdiction; however, each community will have different resources available and different challenges to overcome. The first step is to identify local stakeholders interested in helping veterans and then to build partnerships that can sustain programmatic efforts.

³ We have been unable to get data about numbers related to incidents with veterans prior to implementation of the CIT program.

**IN ADDITION TO INCARCERATION BEING EXPENSIVE,
THE COLLATERAL CONSEQUENCES OF JUSTICE-SYSTEM
INVOLVEMENT CAN BE SEVERE.**

Retired Army officer Nicole Bordeaux, who is now an investigator in the Wake County Sheriff's Office, offers advice to departments considering implementing programs that focus on military veterans. She advises them "to get involved in the community with their veterans" and host community events that allow vets and officers who also served in the military to meet and interact with one another. In a moment of crisis, a familiar face can contribute to a calmed and peaceful resolution in volatile and potentially violent situations.




ED FAIRFAX

Additional support for the Vet CIT program comes from the Healing Transitions VA Grant led by Ed Fairfax. Ed is a veteran of the Army, and after his service he struggled with alcoholism and homelessness, eventually ending up at Healing Transitions homeless shelter. Ed's positive experience led him to seek employment with the shelter so that he could support other veterans in crisis. The facility currently provides 11 beds for veterans who are homeless. He also works with Roosevelt Richard, giving presentations on substance abuse to students in the Vet CIT training program. Ed's goal in his work with homeless veterans is to "is to get them to see that there is hope, and there are positive outcomes to the work that law enforcement is doing." He also works through his presentations to change negative views of addicts among law enforcement officers. To that end, he says, "If what I said might have changed one person's negative view of the people [who] are addicts or alcoholics and maybe gave them a little bit more compassion or empathy, then I succeeded today."

The nearby Raleigh Police Department (Wake County), for example, also implemented a CIT program. Walter McDonald is a Marine Corps veteran who has worked for the department for 22 years, and says it is a priority of Raleigh PD that every officer complete CIT training. As part of his community policing focus, Officer McDonald identifies veterans struggling with homelessness, mental health disorders and other issues. His goal is to assist his department in creating a veteran-specific CIT program because, "We have five or six chaplains [who] are on call; we can have either five or six CIT veteran qualified officers on call" to support those in crisis.

Vet Crisis Intervention Training is designed to be both scalable and adaptable to local conditions. The program's strength is its ability to unite various community assets to focus on a specific target population.



THE TRAINING CHIEF MYHAND DEVELOPED TARGETS AND ATTEMPTS TO INTERVENE WITH VETERANS WHO APPEAR TO BE ON THE ROAD TO JUSTICE SYSTEM INVOLVEMENT WITH THE POTENTIAL FOR LONG-TERM INCARCERATION, OR EVEN SUICIDE. AGITATED VETERANS ARE OFFERED HOPE, FOR THEMSELVES AND FOR THEIR FAMILIES, THROUGH SPECIALIZED DE-ESCALATION MEASURES THAT ARE MORE LIKELY TO RESULT IN PEACEFUL AND SAFE OUTCOMES.

LAW ENFORCEMENT OFFICERS
AND VETERANS WERE DYING*

I JOINED THE ARMY with all intentions of making a career out of the military. I was stationed in Fort Myer, Virginia, right outside D.C. I met a couple of guys who were officers with the Metropolitan Police Department there in D.C., and the job sounded so exciting. I thought, “Well, I think I want to go do that for a living.”

I ended up leaving active duty with the intention of going back later. I got into law enforcement work and I was pretty good at it. And I enjoyed it. They always say, if you do what you enjoy, you’ll never work a day in your life, and so the rest is history. After serving as a police captain on the Apex Police Department, I’m now Chief of Police in Clayton, North Carolina.



CHIEF BLAIR MYHAND
(RIGHT) WITH VET CIT
CLASS PARTICIPANT

I had a couple young officers [who] worked for me, they were both former Marines. They responded to a call of a veteran in crisis. He was an Air Force veteran who we learned was diagnosed with PTSD (post-traumatic stress disorder) and TBI (traumatic brain injury). He had got in a fight with his father and kind of trashed the house. So Dad calls the police and we respond. And so, these two officers got the idea to talk to this individual, one veteran to another. They were able to establish a rapport with him, divert him from going to jail... and instead connected him with resources.

When they told me about the incident, I figured, well, if it worked here it would work in other places. So, I just did some real basic Internet research.

And what I found were all these reports, newspaper reports, media reports, of encounters between law enforcement and veterans in crisis all over the United States. And the biggest thing that stuck out to me was that most of these incidents, these encounters, resulted in some sort of injury or death, either to the police officer or the veteran. And realizing that there’s a problem, I really worked at capitalizing on the success that these officers had and developed the curriculum to train police officers who are military veterans and also CIT-trained, how to respond to a veteran in crisis in a manner that, hopefully, prevents injury or death to anybody.

More than three years ago, we started talking about veterans in crisis training, I’ve never had anybody say, “No, I don’t think this is a good idea and you shouldn’t do it.” Every person I’ve talked to, and I’ve talked to many different groups while we were conceptualizing this idea and working to the point when we actually developed a curriculum because I wanted to make sure I wasn’t stepping on any land mines, if you will. Everybody was super supportive. My boss at the time gave me the time that I needed to devote to creating what we have today.

* The views expressed here are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

We created a 16-hour curriculum to train officers who are veterans on how to respond to a fellow veteran in crisis. Being a law enforcement executive, I know sometimes it's hard to send people away for training. So we really tried to trim the fat, if you will, and condense the training down as tightly as possible while still being able to capture everything that we wanted to. So I figured any more than two days might prevent some agencies from sending somebody.

Students are reintroduced to things that are veteran-specific in terms of how veterans respond: how they commit suicide, why they commit suicide, why they drink or take drugs, what combat trauma looks like, and what it's like when the guys that get injured and get sent back to the rear have guilt that they're not with their unit.

The program that we created, the structure that we created, was done with the idea that this needed to be something that can be plugged and played in any department around the country. I didn't want it to be so unique to Wake County, North Carolina, that you couldn't do it in Oklahoma or Ohio or wherever.

And so, I think folks already understand the value of it, and the veterans already get it. This light bulb never went off before these two guys came to me. I was famously quoted for saying, "Duh, why haven't we done this for years?" But it's one of those things where you're like, "Man, I don't know why we haven't had this approach for forever." And it just makes so much sense.

It took a couple of young officers to just have a bright idea and we're fortunate that I happened to be their patrol captain. Maybe somebody else would have told them, "No, sit down and be quiet," but everything worked out. No one's ever not given me 100 percent support to do this. A champion is needed. Whether that's here or in Charlotte or in Indiana, it takes someone who is willing to pick up the ball and run with it wherever they're at and move it forward. Because I think this is a hugely important thing that we're doing.

And it's very fulfilling for me to feel like I have really accomplished something in my career. I think that this is something that will really have a lasting effect on society. I don't have any awards hanging on the wall, but I know I was part of creating something that saves people's lives. I know firsthand that we've

saved people's lives already. And I've had other officers call me and tell me about an encounter they had and they swear up and down they saved somebody's life, too.

In that regard, it's already a win. I would just love for this thing to catch on like wildfire. From all

the encounters that I know about from students who've graduated this class, today we haven't had one injury or death in any one of those encounters, and they've all been able to divert the veterans.

[Absent this training], officers and veterans will continue to be killed [unnecessarily].

THE PROGRAM THAT WE CREATED WAS DONE WITH THE IDEA THAT THIS NEEDED TO BE SOMETHING THAT CAN BE PLUGGED AND PLAYED IN ANY DEPARTMENT AROUND THE COUNTRY.

LETTING THEIR GUARD DOWN THROUGH EQUINE THERAPY



AMY DUFFY

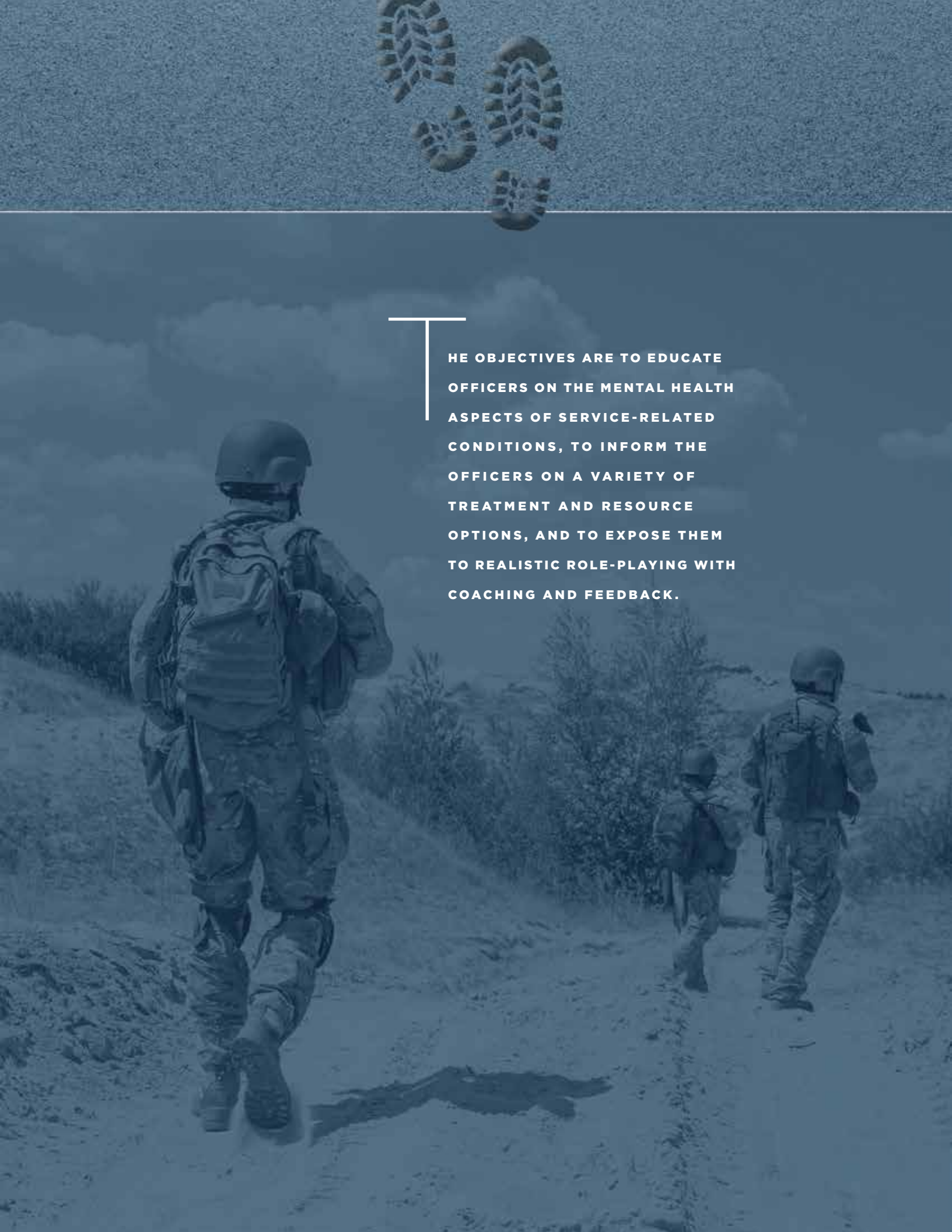
AMY DUFFY is a licensed outpatient psychotherapist and leader of Harbor Reins, a non-profit organization that provides equine therapy services to veterans. She met Chief Myhand several years ago and told him about her program to support those with PTSD and other trauma or mental illness. Since that meeting, Amy has become involved in the Vet CIT training program as a presenter. Her organization also accepts referrals from the Vet CIT to work with those in need of services, regardless of their ability to pay. Additionally, Harbor Reins is an authorized provider of VA-funded equine therapy services to qualified veterans.

When asked if veterans with PTSD or other mental health diagnoses are resistant to working with the horses, Amy responded, “After the first session with the horse, they tend to let their guard down. They just haven’t realized that they’ve started to let their guard down. It’s so outside the box that it’s not really viewed as treatment by them, so that makes it easier. We’re outside. It’s fresh air. I interfere on a very limited basis, so I call myself ‘pasture decoration.’ It’s them and the horse, and I’m just there to say a few words over the course of a 75- to 90-minute session, just to help them process some things that I’m seeing between them and their horse. It’s about the experience between the veteran and the horse, and not necessarily what I think about anything going on. They get to work everything out on their own, with a little bit of guidance from me—suggestive guidance.”

The treatment model Amy follows is called Natural Lifemanship, which is the originator of Trauma-Focused Equine-Assisted Psychotherapy (TF-EAP™). Natural Lifemanship incorporates many of the principles, theories, and practices of other EAP organizations, such as The Equine Assisted Growth and Learning Association (EAGALA), the Professional Association of Therapeutic Horsemanship International (PATH Intl.) and the Equine Guided Education Association (EGEA). However, NL importantly emphasizes the principles guiding the horse-human relationship over any specific practices or techniques. On average, Amy is able to serve 20 veterans each year through this program.



Amanda English Photography



THE OBJECTIVES ARE TO EDUCATE OFFICERS ON THE MENTAL HEALTH ASPECTS OF SERVICE-RELATED CONDITIONS, TO INFORM THE OFFICERS ON A VARIETY OF TREATMENT AND RESOURCE OPTIONS, AND TO EXPOSE THEM TO REALISTIC ROLE-PLAYING WITH COACHING AND FEEDBACK.

From No-Win Situations to Win-Win Solutions in Dayton, Ohio

Montgomery County, Ohio, has a population of approximately 532,000. Some 37,000 are military veterans, almost 60 percent of whom are under the age of 65. Its major city is Dayton, with a population of 140,000. Dayton in particular, but also the rest of the county, has been plagued by economic problems, high crime rates, and an opioid crisis so bad that the city reached number one in the nation for drug overdoses in 2016 and 2017. According to the Dayton Veterans Affairs Medical Center (VAMC), up to 40 percent of those on opioid prescriptions develop an addiction, and veterans are twice as likely to suffer an accidental overdose. Among the 761 people in Montgomery County counted as homeless in a 2016 survey, one in ten were veterans, accounting for five percent of all homeless vets in the state.

Following decades of decline in its industrial sector, Dayton as well as other portions of Montgomery County now suffer from low levels of full-time employment opportunities and low earnings, as well as declining home values. The unemployment rate, according to the federal Bureau of Labor Statics, was 4.7 percent in March 2018, higher than the 3.8 percent national average, and higher than nearly all other cities in the state. And the unemployment rate for younger veterans has remained at least double the state average across all communities, according to the Ohio Department of Job and Family Services (ODJFS).

Although the Akron Police Department (PD) was the first in the state to start a Crisis Intervention Team program; Dayton quickly followed, based off the Memphis CIT

**UP TO 40 PERCENT OF THOSE ON OPIOID PRESCRIPTIONS
DEVELOP AN ADDICTION, AND THE VETERAN POPULATION IS
TWICE AS LIKELY TO SUFFER AN ACCIDENTAL OVERDOSE.**

model, launching its effort in 2002 to address an increase in illegal narcotic and alcohol abuse, the deinstitutionalization of mentally ill citizens, and an increase in homelessness, all of which contributed to more citizen involvement with law

enforcement. According to the Dayton Police Department, “Traditional police methods, misinformation, and a lack of knowledge caused fear and frustration for residents and families.” Too often, officers responded to crisis calls where they felt disadvantaged or placed in a dangerous, no-win situation. As a proactive program, CIT focuses on preventing tragic situations from escalating out of control and finding win-win solutions for all concerned.

The Dayton PD’s Crisis Intervention Team recognizes a population that warrants special care, treatment, and services. The mission of their CIT is to use understanding and skills gained

TRADITIONAL POLICE METHODS, MISINFORMATION, AND A LACK OF KNOWLEDGE CAUSED FEAR AND FRUSTRATION FOR RESIDENTS AND FAMILIES.

through training to identify and provide a safe, effective, and compassionate response in situations involving troubled veterans. Ohio Attorney General Mike DeWine

emphasizes that the CIT programs in Dayton and Montgomery County “protect officers, protect the public, and increase the safety of our communities.” CIT also allows those with mental illness to get help sooner rather than later, before a situation evolves into a crisis. And the CIT program saves law enforcement time and money because it reduces the number of re-arrests and officer dispatches to mental health situations.

Dayton’s CIT is led by Detective Patricia Tackett. She was inspired to start the program after reading an article about Chief Blair Myhand’s program in North Carolina. Montgomery County also has a CIT program in place, part of the larger community partnership with the Dayton VAMC, the Montgomery County Office of Alcohol, Drug Addiction and Mental Health Services (ADAMHS), the National Alliance on Mental Illness of Ohio (NAMI Ohio), the Office of Criminal Justice Services (OCJS), and the Ohio Attorney General’s Office. These entities share information and resources, thereby reducing costs and increasing efficiencies for the program.



VA MEDICAL CENTER, DAYTON, OH

CIT training for Dayton and Montgomery County is a 40-hour program conducted by local CIT-trained officers, mental health professionals, family advocates, and community-based providers offering practical techniques for de-escalating tense situations. The program for law enforcement has now been standardized across the state and embraces the following:

DIDACTICS AND LECTURES	PRACTICAL TRAINING
<p>Clinical Issues Related to Mental Illnesses, Medications, and Side Effects</p> <p>Alcohol and Drug Assessment</p> <p>Co-Occurring Disorders, Personality Disorders</p> <p>Developmental Disabilities</p> <p>Family/Consumer Perspective</p> <p>Suicide Prevention and Practicum Aspects</p> <p>Rights/Civil Commitment</p> <p>Mental Health Diversity</p> <p>Equipment Orientation</p> <p>Policies and Procedures</p> <p>Post-Traumatic Stress Disorder (PTSD)</p> <p>Legal Aspects of Officer Liability</p> <p>Community Resources</p>	<p>On-Site Visits and Exposure: Practical Skill Training/Scenario-Based</p> <ul style="list-style-type: none"> ■ Crisis De-Escalation Training, Part I Basic Strategies ■ Crisis De-Escalation Training, Part II Basic Verbal Skills ■ Crisis De-Escalation Training Part III Stages/Cycle of Crisis Escalation ■ Crisis De-Escalation Training, Part IV Advanced Verbal Skills ■ Crisis De-Escalation Training, Part V Advanced Strategies: Complex Scenarios

Additional in-service training is provided annually for officers who have completed the program. The Dayton Police Department provides two additional days of advanced training in collaboration with the Dayton VAMC. There is also an opportunity during training for officers to meet veterans in the community and create relationships. Most recently, a mobile crisis response team was established to work with the veterans court when responding to those in crisis. Additionally, the Dayton VAMC meets with these veterans to determine eligibility for benefits and provides support for homeless vets.

A monthly roundtable of key stakeholders evaluates program effectiveness and needs on a continual basis. At these meetings, a list is created of community members with multiple contacts with emergency responders, e.g., those who are utilizing the most police, hospital, and corrections resources. The roundtable works to identify the best resources and agencies

within the community for each individual on the list to address their mental health, medical, or economic needs. Field Interrogation Cards, or FICs — information sheets that police fill out after stopping and questioning a citizen — are used on patrol or when responding to incidents to record veteran status, and the roundtable group submits these to the appropriate VA representative for follow-up.

The Dayton PD's approach when encountering veterans in crisis is to help them identify and utilize resources instead of taking them into custody. One option is to take the veteran directly to the VA facility for immediate assistance. While not all veterans have an honorable discharge, a less-than-honorable discharge still provides access to some VA services.

Officer Shaina V. Newell recently joined the new Dayton PD Mobile Crisis Response Team specifically to respond to mental health emergencies, as well as provide assistance to the

homeless. What makes Dayton's mobile team unique is that a full-time social worker is part of the unit. When assisting veterans, Officer Newell is able to collaborate with medical and mental health providers at the Dayton VAMC, as well as other community agencies that provide shelter, transitional housing, food, and related services. The team's work does not end when the veteran is taken to the VAMC; team members conduct follow-up visits and are provided with ongoing updates from community partners. At first, Officer Newell was concerned that being in uniform might be a barrier to interacting with the veterans

in mental health crisis, but she says "It really hasn't been much of a problem. I think it's just about the way you approach the person. And, if you talk to somebody and tell them a little bit about yourself it helps [lower their guard]."



OFFICER SHAINA NEWELL

TOO OFTEN, OFFICERS RESPONDED TO CRISIS CALLS WHERE THEY FELT DISADVANTAGED OR PLACED IN A DANGEROUS, NO-WIN SITUATION.



OUTREACH
COORDINATOR
MELISSA HALL

Melissa Hall, the VA's Veteran Justice Outreach coordinator, is part of the roundtable group focused on helping justice-involved veterans, as well as providing connections to other VA resources, to address drug abuse, mental health issues, and medical support. Melissa's work is very rewarding as "there's nothing better than watching veterans complete the program and get their felony charges dismissed. That's an opportunity that they might not have had otherwise. So that's just fantastic."

Dr. Victor Knapp, Chief of Mental Health Services at the Dayton VA Medical Center, noted that "collaborative efforts like the roundtable are focusing on those patients who have

particularly intense needs or have a need that we haven't yet been able to meet." The Ohio justice system creates an opportunity for substance abuse treatment similar to what Ohio does for mental illness. The legislation is relatively new and the petition to the court for involuntary treatment must be brought by a family member; a medical professional has no standing. Dr. Knapp confirms to the court that a veteran is eligible for full coverage of treatment costs so that the process can begin as soon as a family member files the petition.

Judge Dennis Adkins of the Montgomery County Court, a Veterans Treatment Court "champion," understands how a veterans court could serve both law enforcement agencies and citizens. He began in 2013 with an advisory group to assist him in establishing the court; one year later he presided over his first veterans court session. Judge Adkins reached out to the community via public speaking, radio, and TV to emphasize the importance of this program and to get support from law enforcement and the general public. The program has been effective. Several veterans who were once potential threats to the safety of law enforcement and the community are now productive citizens and taxpayers.

Newer local programs also complement the CIT program. In September 2016, community partners across the county formed the Community Overdose Action Team (COAT). COAT operates under the National Incident Management System framework, providing a consistent template for partners to work in tandem to respond to emergencies. COAT's primary goal is to reduce the number of fatal overdoses in the county. It reportedly has had a significant effect in lowering the number of fatalities from drug overdoses in Montgomery County. According to the Montgomery County Coroner's Office, 15 overdose deaths were recorded in March 2018, the lowest number since March 2015, when 12 overdose deaths were reported. In between

were high numbers, including May 2017 when overdose deaths peaked at 81, adding to 2017's record 566 people who died from drug overdoses.



JUDGE DENNIS ADKINS

Additionally, in 2015 Ohio developed and implemented a statewide CIT Strategic Plan under the direction of the Criminal Justice Coordinating Center of Excellence (CJCCE) in cooperation with the Ohio Department of Mental Health and Addiction Services, NAMI of Ohio, the Office of Criminal Justice Services, and the Ohio Attorney General's Office. The goal of this plan, to provide a roadmap to continue development of Crisis Intervention Teams, identifies strategies beyond training to build key elements that will strengthen CITs and their foundation for successful interventions. The ultimate goal is to have a fully developed CIT program in every county, with every law enforcement agency participating. As of March 2016, 60 percent of Ohio law enforcement agencies have developed teams to address special populations, including veterans, with mental health or drug addiction issues.

"The Effect of Crisis Intervention Team Training on Police Disposition of Mental Disturbance Calls," a study conducted by Kent State University and the Ohio Office of Criminal Justice Services, found that CIT programs in the state are effective and are making a difference. The study offers the following statistics:

- ▶ **ONE-THIRD** of CIT-trained officers were more likely than officers not trained in crisis intervention to transport mentally or emotionally disturbed individuals to psychiatric or other emergency services (e.g., VA Hospital, local hospital, or crisis stabilization centers).
- ▶ CIT-trained officers (**16%**) were more likely than non-CIT-trained officers (12%) after program implementation to transport a person in crisis to other treatment facilities.
- ▶ CIT-trained officers (**44%**) were less likely than non-trained officers to determine a call did not need transport.

The city of Dayton and county of Montgomery have been recognized not only for their early development and implementation of a CIT program, but also complementary programs to deal with drug addiction and overdoses, unemployment, and homelessness.

SEVERAL VETERANS WHO WERE ONCE POTENTIAL THREATS TO THE SAFETY OF LAW ENFORCEMENT AND THE COMMUNITY ARE NOW PRODUCTIVE CITIZENS AND TAXPAYERS.

OVERCOMING STIGMA
WITH KNOWLEDGE*

I ALWAYS WANTED to do law enforcement. I actually took a law class when I was in high school but had no desire to be an attorney or anything like that.

We've recently [combined] our existing crisis intervention training (CIT) with new training concerning veterans to give our officers and mental health workers the needed education [specific to veterans issues and concerns]. Mental Health Court personnel also complete CIT training. Most recently we started the Mobile Crisis Response Team to deal specifically with veterans and work with the mental health and veterans courts.



DETECTIVE
PATTY TACKETT

We've been dealing with veterans and had veterans court for quite some time. Since the CIT inception in 2002, we've conducted refresher courses and advanced training for our CIT graduates. I had read an article about Blair Myhand in North Carolina, who was creating a refresher course for CIT graduates that was specific to veterans. Long story short, I contacted him, received information from him, and then we collaborated on the training. Chief Myhand came to a CIT conference and conducted a breakout session. I attended the conference and he invited me to attend his class in Apex, North Carolina.

After a lot of research, and coming back and working with the VA (Veterans Administration), my training committee, and my staff, we made the decision to open our training to any CIT graduate, which includes court personnel [and representatives] of our hospitals, our colleges, and universities. We developed a two-day program for this advanced training and worked with the VA to make that happen.

We have two-day training to educate staff, and one of the most important things covered is what our referrals and resources are. [These are] things that we never used before. I think that's one of the biggest keys: to know what resources and referrals are available to these people who we come into contact with 24/7. I think that the VA has had a stigma [attached to it for many veterans, and] I think it's important that we actually continue to address some of those stigmas. Part of our program [focuses on] how we get people's opinions away from that stigma.

Another thing that's important that we ask our officers to do is to find out if the person is a veteran. I don't think all of our officers feel real comfortable in asking that question. At what point of our

* The views expressed here are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

contact with [mentally ill individuals] are the officers going to ask that? And how [will they] ask those questions? But what I have found is that veterans [are assumed] to have a stereotypical look to them, age to them, gender to them, even race to them. So we brought people into the classes that actually were non-stereotypical. One of them was a black female in her 60s. This would not probably be a person that any of our officers would have even asked that question [about veteran status] to.

**VETERANS [ARE ASSUMED] TO HAVE
A STEREOTYPICAL LOOK TO THEM,
AGE TO THEM, GENDER TO THEM, EVEN
RACE TO THEM.**

The other thing we did that I thought was very successful was that on the first day of the training [the trainees] stay in for lunch and watch a film on suicide prevention.

The second day after role-playing, they go to the cafeteria and eat lunch with a veteran. The class participants weren't really excited about it beforehand, but when they

came back and debriefed in regards to the conversations, I think they [gained] an extreme amount [from the experience]. It brought tears to many people's eyes as they told their stories.

I think that when you've got a veterans court, it complements what you're doing. Working with the jail complements what you're doing. The mental health court complements it, and they have a probation officer who is geared towards our veterans. So, with any type of special court there needs to be somebody who is the go-to person, whether it be probation or whoever, who has the specialized training [and expertise] as to the resources available to our veterans. And the most important thing is to make sure those people who come to the table are not only good go-to people, but also are willing to find the resources in the community.

**I THINK THAT THE VA HAS HAD A STIGMA [ATTACHED TO IT
FOR MANY VETERANS, AND] I THINK IT'S IMPORTANT THAT WE
ACTUALLY CONTINUE TO ADDRESS SOME OF THOSE STIGMAS.
PART OF OUR PROGRAM [FOCUSES ON] HOW WE GET PEOPLE'S
OPINIONS AWAY FROM THAT STIGMA.**

Preventing Violent Encounters in New Castle County, Delaware

Throughout Delaware, several initiatives have been introduced and implemented to address the needs of veterans and their families.

The Delaware Joining Forces (DJF) network includes state agencies and external service providers who proactively work together to provide solutions for a range of issues including mental health, homelessness, job training, legal assistance, and education. New Castle County also provides Mobile Crisis Intervention Services (MCIS), hotline support, outreach, and walk-in crisis services (which is staffed 24 hours a day, 7 days a week). Additionally, the county's police department partnered with Connections Community Support Programs, one of Delaware's largest nonprofits, to provide licensed professional counselors alongside law enforcement officers to provide mental health services support.

Ten years ago, a retired officer, Joshua Thomas, helped coordinate Crisis Intervention Training (CIT) for police to de-escalate crisis situations and offer options beyond the criminal justice system to disturbed individuals. "Unfortunately, police officers in our country end up becoming the default boots-on-the-ground mental health professionals because we have very limited resources," Thomas said. The public expects that police will have the knowledge and skills to address those in a mental health crisis, avoiding a violent encounter, and crafting a peaceful resolution. Yet police are not mental health service providers, and in Delaware they lacked the training or resources until Joshua Thomas created the CIT program. The National Alliance on Mental Illness (NAMI) of Delaware, now led by Thomas, is active in supporting the county's CIT program and its Veterans Response Team program.

THE PUBLIC EXPECTS THAT POLICE WILL HAVE THE KNOWLEDGE AND SKILLS TO ADDRESS THOSE IN A MENTAL HEALTH CRISIS, AVOIDING A VIOLENT ENCOUNTER AND CRAFTING A PEACEFUL RESOLUTION.



VA MEDICAL CENTER, NEW CASTLE, DE

New Castle County, which embraces the city of Wilmington, has a population of 557,000. There are some 33,000 veterans in the county, more than half of whom are under the age of 65. The county has struggled with several issues over the past few years. In 2014, Wilmington ranked third on the Federal Bureau of Investigation's list of the most violent cities of comparable size, and fifth in violent crime when compared to all cities with populations greater than 50,000. In 2015, the Office of National Drug Control Policy designated New Castle County part of the Philadelphia/Camden High-Intensity Drug Trafficking Area. The Drug Enforcement Administration's

2016 Intelligence Report analyzed the state of drug use in Delaware and identified New Castle County as a priority because of the volume of heroin and prescription opioids available, along with seizures, treatment admissions, and overdose deaths.

The unemployment rate for veterans in Delaware is 3 percent (Delaware Business Now, 27 March 2019), and an estimated 4,000 veterans are receiving SNAP benefits (formerly food stamps) according to the Center on Budget and Policy Priorities (8 November 2018). Additionally, an average of 52% of veterans 18 years and over in Delaware were no longer in the workforce in 2018 (DOL-BOLS Economic News Release). On any given night, an estimated 100 veterans are homeless.¹ Although state and local efforts have significantly reduced the number of homeless veterans, finding permanent housing remains a challenge, especially in New Castle County.

New Castle launched its CIT program a decade ago to address the many challenges faced by law enforcement when responding to individuals affected by mental illness and/or substance abuse. The addition of a CIT unit to address the special needs of veterans came more recently, when New Castle County Police Officer Nicholas Hurst recognized the need for training to respond effectively to veterans in crisis. As a Marine who served in Iraq prior to joining the New Castle County Police Department (PD), Hurst understands the prevalence of post-traumatic stress disorder (PTSD) and the high numbers of suicides by veterans of the current wars. The Veterans Response Team program, launched in September 2017, was the second in the nation. It teaches veteran first responders to effectively and peacefully resolve incidents using their own military experiences to connect with veterans to defuse volatile situations, and help connect troubled veterans with appropriate resources.

¹ Delaware State Working Group. "Achieving an End to Veteran Homelessness in Delaware," 4/1/2017.

Prior to launching the program, four New Castle County police officers attended Veterans Response Training in Apex, North Carolina, learning the skills necessary to address veterans in crisis and help them not only to safety but to resources available to them in the community. The officers came back to Delaware and shared that knowledge with local agencies, including the Wilmington Police Department, the U.S. Department of Veterans Affairs Police Service in Elsmere, and Delaware State Police. The newly CIT-trained veteran officers have gained the skills required to assist veterans in crisis, efficiently and effectively de-escalate the situation, ensure the safety of officers, and divert veterans from the criminal justice system. The program has been successful in preventing suicides and other potentially violent actions against first responders. Although CIT training initially had been available only to those who have served in the military, other entities in the state were able to participate in training beginning in 2018.

To introduce the VRT program, the New Castle County Police Department chose to publicize the unit in an attempt to reach as many veterans as possible. They turned to the media to promote their program and build community support for their efforts. They publicized their willingness to go out into the community and support any veteran with his or her needs, offering assistance and access to resources. Wellness checks at the request of a family member is one way the VRT assists both an individual in crisis and the public, proactively preventing more serious incidents, including suicide, from occurring.

“There are so many people coming back from [the] military who’ve been having a hard time adjusting,” Police Chief Colonel Vaughn Bond has observed. “In order to have a successful outcome, you should have someone there who speaks that language and can relate.” Because the New Castle police are frequently encountering individuals struggling with mental health issues, Chief Bond told the News Journal, “Having our officers with the most up-to-date training, like de-escalation techniques, lessen the chances of having to use any type of force.”



CAPTAIN JOHN TREADWELL

Captain John Treadwell, who served in the Army Reserves for eight years, feels that officer safety is an important focus of this initiative because, he told the News Journal, “a barricaded veteran [who feels trapped or ‘cornered’] has a much different knowledge of weaponry and skill sets that the average person doesn’t often possess.” He stresses how the Operation Enduring Freedom/Operation Iraqi Freedom/Global War on Terror (OEF/OIF/GWOT) deployments have affected the veteran population: “More soldiers are coming home. More soldiers are having issues. Usually, when

CRISIS INTERVENTION TEAM & VETERANS RESPONSE TEAM GOALS

1. Calm the individual in crisis.
2. Assess the situation.
3. Use active listening skills to identify needs.
4. Facilitate a solution

—NEW CASTLE POLICE DEPARTMENT

they have an issue with law enforcement it results in one or two outcomes: the death of a law enforcement officer or the death of a veteran.”

Captain Treadwell advises other police departments to be open-minded about implementing a Veterans Response Team (VRT) in their organization. Treadwell stressed that the first critical

requirement is for senior leadership to listen to those whose boots are on the ground and take a chance. “Be willing to admit that law enforcement can do better by our veterans. We can do better by anybody [who’s] in an emotional or chemically driven crisis.” He recommends sending current CIT-trained officers, preferably veterans themselves, to receive “train the trainer” education that will benefit the entire department. Another critical step is to identify local resources, such as the National Alliance on Mental Illness (NAMI), for additional support.



OFFICER KORY THOMPSON

Officer First Class Kory Thompson joined the New Castle County Police Department in 2014 after earning a degree in psychology. He currently serves in both the CIT and VRT units. He says that solutions to helping those in crisis may include taking the individual to the hospital to address injuries, or taking veterans to the VA Medical Center where they can receive care from a psychiatrist or other mental health practitioner. Thompson uses his specialized training for responding to all calls to achieve better outcomes.

Detective Brian Shahan, who has served with the New Castle County PD for 18 years, leads the Crisis Negotiation Team (CNT). Shahan, who completed the first course in the state’s Crisis Intervention Training years ago, has developed a passion to assist people with mental health issues. He joined Officer Nick Hurst last year in Apex, North Carolina, for VRT program training, which he saw as an opportunity to strengthen his CNT skills while also helping veterans in crisis. Further, he recognized the importance of reducing the

**LAW ENFORCEMENT CAN DO BETTER BY OUR VETERANS.
WE CAN DO BETTER BY ANYBODY WHO’S IN AN EMOTIONAL
OR CHEMICALLY DRIVEN CRISIS.**

CAPTAIN JOHN TREADWELL, NEW CASTLE COUNTY, DELAWARE, POLICE DEPARTMENT



NEW CASTLE PD VETERANS RESPONSE TEAM MEMBERS OFFICER NICHOLAS HURST, OFFICER DEANNE WARNER, AND DETECTIVE BRIAN SHAHAN (LEFT TO RIGHT)

risk to law enforcement and the community in confrontations with troubled veterans. Shahan has seen steady improvement in the level of cooperation between law enforcement and community agencies, including the Veterans Administration, to identify and provide proper support for veterans. As for the VRT team, Shahan sagely says, “It’s long overdue that we start doing something for the people [who] have always taken care of us—veterans.”

Detective Shahan suggests that if another law enforcement agency wants to start a similar program, they should first contact their local or regional VA hospital. The VA and their police department have become invaluable partners, he says. He also suggests working with a local chapter of NAMI. “You don’t have to re-invent the wheel, but you do have to make it state-specific,” he reasons. “Obviously, each

state has different laws. We’re fortunate in Delaware we have the Veteran Treatment Courts. [Many] other states, unfortunately, don’t have that.”

An Air National Guard member since 2003, Officer Deanne Warner is an eight-year veteran on the Wilmington Police Department, which has its own Veterans Response Team, as well as a military liaison who can reach out to military family readiness centers. Prior to the creation of her city’s VRT program, it was difficult for law enforcement to begin a conversation because the veteran in crisis didn’t want to hear it from a cop. VRT training makes the difference. “I absolutely recommend it,” she says. “If we get out there and treat people the way that they need to be treated, we can definitely make a difference.” After all,” she notes, “10 percent of the people...we lock up now are veterans. And that’s a pretty big percentage.”

Paul Woodland is a 12-year Navy veteran currently serving as Deputy Chief of Police for the Wilmington Veterans Affairs Medical Center (VAMC). Chief Woodland sees his position as marrying the two great interests in his life—law enforcement and serving veterans. The Wilmington VA practices veteran-centered policing, which is civilian community policing modified for veterans to facilitate better outcomes. The department encourages veterans to enter treatment as an alternative to the criminal justice system. As an avid supporter of VRT programs, Woodland recommends that any law enforcement agency looking to launch a VRT program first contact the local VA Police Department for collaboration and sharing of

resources and strategies. Woodland emphasizes that “there are a lot of resources and benefits that the veterans are missing out on, and outreach is so important.” He believes the Veterans Response Team helps with this outreach and communication.

As a clinical social worker serving as a Veterans Justice Outreach (VJO) specialist for Delaware, Cecilia Gonzalez began her career when there were no Veterans Treatment Courts and identifying justice-involved veterans was a challenge. VJOs serve veterans at earlier stages in the criminal justice process, using a three-pronged approach for outreach to law enforcement, courts, and jails. VJOs conduct outreach in local jails and provide VA-focused training sessions and other informational presentations. To assist VJOs and other professionals, the VA established the Veterans Reentry Search Service (VRSS) system (<https://vrss.va.gov/>), a web-based tool that enables prison and jail personnel to quickly identify inmates with records of military service. VRSS alerts VA staff when veteran inmates are identified, making it a valuable tool for conducting outreach to veterans who need assistance planning for a successful reentry.

In Gonzalez’s view, “VRT is unique because the officers are [also] veterans, with empathy that has already developed and experience they relate to when they encounter veterans in some kind of crisis. They have background knowledge and insight as to what the underlying issues are, which helps to de-escalate crisis situations. So it has improved the relationship that we have with law enforcement and the services that we can broker through the law enforcement agencies. It’s not only good for the veteran; it’s also good for the law enforcement officers, because they want to go home at night safely.”

Emergency responders and police are aware that they, too, may suffer from post-traumatic stress disorder (PTSD). The recognition of PTSD in their own ranks forms a bond between law enforcement, especially officers who have served in the military, and veterans they encounter in responding to a mental or domestic disturbance call. Addressing this issue, one who is intimate with the ravages of PTSD observed that suicide was the highest among veterans, followed by police. But it’s highest among those who are both military veterans and law enforcement officers.

THE VETERANS RESPONSE TEAM PROGRAM TEACHES VETERAN FIRST RESPONDERS TO EFFECTIVELY AND PEACEFULLY RESOLVE INCIDENTS USING THEIR OWN MILITARY EXPERIENCES TO CONNECT WITH VETERANS AND DEFUSE VOLATILE SITUATIONS.

LEADERSHIP BORN IN FALLUJAH*

I CHOSE LAW ENFORCEMENT as a career because one of my mentors, who is also one of the reasons I joined the Marine Corps, is actually a lieutenant on the New Castle County Police Department. And after some strong convincing and several years, I finally decided to hang up my fire helmet and try the police department.

I was an infantryman with two deployments to Fallujah, Iraq, as a machine-gunner. There was an incident involving a kid in my unit. It was his first deployment to Fallujah and my second. And he was in crisis one night. There was a call that came in as a kidnapping. After some investigative steps, we determined that it was far from the truth, and that the veteran was actually just in crisis, extremely intoxicated and having flashbacks and stuff like that.



OFFICER
NICHOLAS HURST

Well, that night, I got him to calm down. I went back out later and calmed him down again. He asked me to smoke a cigarette, and my partner and I were talking to his wife. My partner was not a veteran. Fifteen minutes went by and he didn't come back in. Well, knowing how military veterans smoke cigarettes, how quickly it goes, it was definitely odd that he didn't come back in that 15 minutes. So I went out looking for him and found him passed out under his camper, underneath the wheel. Which leads into the next morning.

We were able to convince him to go to the VA [Veterans Administration] and get treatment. And when he walked into the VA, his blood alcohol content was 0.42. He had been drinking for a very long time. The nurse commented that she'd been working there for 30 years and she hadn't seen anybody with a blood alcohol content that high. I got off duty that morning and I went home, changed, [and then] went back just to make sure that he got where he needed to be. We got him up to the Coatesville VA and got him situated, and now he actually comes in to help with the VRT [Veterans Response Team] course.

So [my] idea for the VRT came about by me sitting in a parking lot in New Castle County thinking of how I could serve veterans better, and how to help veterans, and not let them be tossed away like a piece of trash. And the best way I could think of doing that was as a law enforcement officer and try to help them get [what] they need for whatever problems that they're suffering from. And, hopefully, help them.

OUR BIGGEST CHALLENGE IS THE DATA COLLECTION BECAUSE WE HAVEN'T ACCURATELY CAPTURED DATA IN THE PAST [REGARDING] INVOLVEMENT BETWEEN VETERANS AND LAW ENFORCEMENT.

* The views expressed here are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

SITTING IN A PARKING LOT IN NEW CASTLE COUNTY, I WAS THINKING OF HOW I COULD SERVE VETERANS BETTER, AND HOW TO HELP VETERANS, AND NOT LET THEM BE TOSSED AWAY LIKE A PIECE OF TRASH.

Those who weren't veterans probably gave me the most struggles. When I [presented] my proposal, there were individuals who were not military veterans, and they basically didn't see a need for it. Just telling people why it's important, that's the biggest thing I've fought against, trying to prove the need for it.

Our VRT partners with the Army and they've been a big help. We've partnered with the VA, Delaware State Police, Wilmington Police, and we just keep building the partnerships, [and include] any other veterans resources that we can get a hold of.

We have a Veterans Court in Delaware and we make connections there and continue working with them. Our biggest challenge is the data collection because we haven't accurately captured data in the past [regarding] involvement between veterans and law enforcement. So we're basically starting from scratch, building data as far as our contacts with veterans.

If another department wanted to start a similar program, I would go two routes. One is to make sure that you have buy-in from your higher-ups. And it definitely helps having military veterans in the chain of command. The other is going to one of the agencies that has done it before. So either go to Chief Myhand in North Carolina or come to us, or we can [go to the agency looking to start a VRT program].


One of the things that I had struggles with was setting up [our program] because Myhand's program was based on North Carolina. I had to go and almost recreate the system [specific to] Delaware. And I think one of the regrets I had was not bringing Chief Myhand up [to Delaware]. I loved the course and we would have still done it that way, but I think I would have taken the next step and brought him up here instead of trying to navigate everything myself.

We just added a political piece... and we're getting more and more buy-in from different political figures in the state. It's impressive to see how many resources they have that we didn't know about. I mean, I'm a military veteran and I'm registered with the VA, but nobody ever told me, 'Hey, Senator Coons has these resources.' They have a lot of control and abilities that will be extremely helpful to veterans.

I'm not done yet. And I'm still figuring out new and exclusive ways to make this work. My goal is to help as many veterans as I possibly can. And whatever way I have to do that, I'll do it. And if anybody has or wants to start a program, contact me, and I'll definitely help out in any way I can so they don't have as many struggles as I did.

IF ANOTHER DEPARTMENT WANTS TO START A VETERAN RESPONSE TEAM, MAKE SURE THAT YOU HAVE BUY-IN FROM YOUR HIGHER-UPS. AND IT DEFINITELY HELPS HAVING MILITARY VETERANS IN THE CHAIN OF COMMAND.

Collaborating to Counter the Causes of Criminal Conduct in Salt Lake City, Utah



Salt Lake City's crisis intervention Team (CIT) program, as well as CIT development statewide, began in 2000 when state and local law enforcement agencies recognized the need for de-escalation training and crisis intervention teams. So, they created a committee to evaluate how law enforcement throughout the country dealt with mental health issues. Their CIT program became an important resource in the development of the U.S. Bureau of Justice Assistance study, *Statewide Law Enforcement/Mental Health Efforts: Strategies to Support and Sustain Local Initiatives* under the Council of State Governments Justice Center. The Utah model, as it's been called, has been studied by law enforcement agencies in several other states, and has been cited by numerous agencies and organizations for its success. The Salt Lake City Police Department serves as the administrative agency for the state's CIT program, and it serves as one of six national learning sites for specialized police response.

Utah, which used the Memphis CIT Program as its model, launched its CIT program in 2001. The 40-hour training sessions are provided on a regional basis across the state and include law enforcement agencies and mental health services partners. Topics covered include mental illness issues such as non-psychiatric behaviors, age-related disorders, substance abuse, co-occurring disorders, civil commitment laws, and liability issues. The program also includes scenario-based training with real-life situations involving mentally ill citizens.

Utah also has a statewide CIT training program for those who work in corrections. The training covers the same topics, but situational training gears toward work in a prison or jail. According to the Utah Department of Corrections (<https://www.corrections.utah.gov/...policies>), CIT skills have prevented staff and inmates from being injured during disturbances from volatile situations, especially within the Maximum-Security Gang Unit of Utah State Prison.

Officers who complete the CIT program are certified by Utah's Division of Substance Abuse and Mental Health. They are then assigned to a patrol division of a police

department and respond to regular calls for service in addition to mental health-related calls. Utah has also established Mobile Crisis Outreach Teams (MCOTs) that consist of a mental health-designated



VET COURT MENTORS

examiner and a certified peer specialist. These teams have the training and expertise to take over mental health incidents from CIT officers once it is deemed safe to do so. Additionally, Utah offers CIT training specific to working with youth.

Another innovative program of the Salt Lake City Police Department (PD) is their Homeless Outreach Service Team. HOST was created in 2012 to conduct street outreach on a regular basis, maintain public awareness efforts, develop and enhance relationships with homeless

service providers, and provide individual case management using Salt Lake City Police Department (SLCPD) social workers. The HOST program is administered under the Community Operations division that includes

THE GREATEST STRUGGLE FOR THE POLICE HAS BEEN THE LACK OF SUPPORT SERVICES FOR THOSE AFFLICTED WITH MENTAL HEALTH ISSUES.

the Crisis Intervention Team and the Social Work Program, all of which coordinate efforts to address community needs. HOST also coordinates with the VA in Salt Lake City to assist those in need of shelter and permanent housing.

The greatest struggle for the police has been the lack of support services for those afflicted with mental health issues. This is especially true for the Rio Grande District of the city that has the largest population of homeless residents. Police estimate that 15 percent of calls deal with someone who has a mental illness and who may be suicidal and threatening to harm themselves. “The police department has become the de facto social workers for our community on the very front lines,” Salt Lake City Police Social Work Manager Lana Dalton said on KUTV.

Both city and county have a large population with many challenges to address and a police force that, until 2018, was understaffed.¹ Salt Lake City, which is located in Salt Lake County, has a population of approximately 1.1 million.² Of the estimated 43,000 veterans who reside in the county, 57 percent are under age 65.³ The city, which was known for the high numbers of serious and violent crimes, which peaked in 2015, is experiencing a gradual decrease in those

¹ Whitney Evans, “Salt Lake City Council to Approve Budget with \$6 Million for More Police,” KUER, June 11, 2018. <https://www.kuer.org/post/salt-lake-city-council-approve-budget-6-million-more-police#stream/0>

² census.gov

³ National Center for Veterans Analysis and Statistics, Veteran Population Database and Projection Model.

COUNTY COURTHOUSE,
SALT LAKE CITY, UT



JUDGE ROYAL HANSON

felonies. Less serious incidents, however, such as disorderly conduct, drug abuse, driving under the influence, vandalism, trespassing, and other nonviolent offenses, have been on the rise. The murder rate, especially domestic violence homicides, has remained constant, if above the national average.⁴ According to the Salt Lake City VA Health Care System, nearly ten percent of those in Utah jails and prisons are veterans.

To assist justice-involved veterans, the first federal veterans treatment court program was established in Salt Lake City in 2010. With support from the VA's Veterans Justice Outreach (VJO) coordinators, the U.S. Attorney's Office, the federal public defender, and the U.S. Probation Office, the court connects these veterans with services in a collaborative model designed to address the root causes of criminal conduct.

In early 2015, Salt Lake City County created a veterans court program in its Third District Court that identifies high-risk, high-need offenders who struggle in the traditional court system and provides tailored solutions including a trained mentor to guide veterans through the process and build lasting relationships. Priority is placed on substance abuse and mental health treatment under the supervision of a judge rather than sentencing offenders to jail. Mentors are typically appointed by the VA with the goals of ensuring that every veteran receives the support needed to navigate not only the veteran court system, but also the VA system and community resources.

The Third District Veterans Court is a cooperative effort between the VA, local government, and community organizations. It allows eligible veterans to move from the traditional courtroom environment into the veterans treatment court where they agree to actively engage in treatment and counseling, make regular court appearances, and are carefully supervised. Veterans treatment court is a post-plea, felony-level court. Participants charged with a felony must enter a plea of guilty; this plea, however, is held in abeyance until successful completion of the program. Upon graduation from veterans treatment court, the guilty plea is withdrawn and the criminal charges are then dismissed. Through a partnership with state Adult Probation and Parole, probationers have also been allowed to enter into Veterans Court as a condition of probation, but will not have their charges dismissed upon completion of the program.

Judge Royal Hansen, who serves as the Veterans Court judge, is proud of the successful partnerships established with the federal veterans treatment court and the Salt Lake County Justice Court. While not a veteran himself, Judge Hansen stressed his positive experience

⁴ *Salt Lake City Tribune*. 2 January 2018.

with justice-involved veterans. “I have great respect and admiration for veterans.

I appreciate the contribution that they’ve made to our community and that they’re

willing to lay their lives on the line for all of us,” he said. “I’d previously presided over a drug court and I thought that was a terrific experience, but it pales in comparison to the opportunity to work with veterans. These are talented men and women that are capable of doing great things. And we’re the ones that lose out if we don’t allow them to contribute to our community and society.”

Judge Hansen acknowledges that the involvement of the VA, particularly the VA’s mentoring program, makes the veterans treatment court as effective as it is unique. With his team, Judge Hansen matches high-risk, high-need veterans with qualified experts capable of addressing their problems. With federal agency support, access to treatment by therapists well-versed in veterans’ issues is available without the need to wait months for access to treatment. The goals are not only for these veterans to resolve issues such as drug addiction and depression that led them into the system in the first place, but also to help them obtain housing, secure and maintain employment, repair family relationships, and become contributing members of the community. The court has the luxury to follow and assess each veteran’s progress, which does not otherwise exist in the criminal courts.



**NIC PROJECT MANAGER GREG CRAWFORD WITH
SALT LAKE CITY VETERANS COURT MENTORS**



**VJO SPECIALISTS
JESSICA MANN
AND AMY EARLE
(LEFT TO RIGHT)**

Jessica Mann and Amy Earle are VJOs in Salt Lake City County and have strong relationships with local law enforcement, who bring veterans in crisis to the Veterans Affairs Medical Center (VAMC) emergency room for evaluation and assessment. Earle emphasizes that local veterans, officers and the VA work on building stronger and more supportive relationships. All team members, she believes, realize that having a symbiotic relationship benefits everyone involved.

For veterans without VA eligibility for mental health services, the VJOs provide referrals to other entities such as Valley Behavioral Health, which serves Salt Lake County. Earle educates veterans, community providers, police, jail and court staff about the critical need to determine veteran status. “First and foremost, not everyone knows if they are eligible for VA services; getting the word out to all of our community providers, law enforcement, jail staff, court staff to get them asking the question, ‘Have you served in the U.S. military,’ is really important.”

**WE'RE THE ONES WHO LOSE OUT IF WE DON'T ALLOW
VETERANS TO CONTRIBUTE TO OUR COMMUNITY AND SOCIETY.**

ROYAL HANSEN, JUDGE, VETERANS TREATMENT COURT

Jessica Mann, her colleague, is thankful for increased involvement by police. She acknowledges that there exists mistrust of mental health treatment providers in general and the VA in particular by many veterans. Police officers assigned to CIT can contact her day or night, on weekends or holidays, to get help for a veteran in crisis, and they follow up to ensure that the veteran has been cared for.

“Success for each person, for each veteran, is different,” Mann says. “We as the treatment providers try and help our court team understand that. That it’s going to look different to everybody. We really pride ourselves on individualized treatment plans, meaning that... client[s] help plan their own recovery. We’ve been able to work on our technique and our strategy with each veteran to help them realize this is more about their recovery plan and less about what the court wants them to do.”



RAY SPRAY

Ray Spray, a Disabled Veterans Outreach Program specialist, provides assistance to Utah’s veterans courts. He finds employment opportunities and works to help veterans overcome their past, which can be a barrier to employment. When asked if he felt anything was lacking in the veterans treatment court program, his response was instant and simple: “More.” More judges or more veterans courts because, he says, “It’s not just putting them in some type of rehab, and then they graduate, and off they go. It’s walking them through all these phases to where they’re successful, and they have aftercare with their mentors. They get reconnected to a community of veterans, which is that camaraderie that they lose when they leave the military.

“Seeing a man’s life change for the better, and for him to be reunited with his family and his kids, and be able to function as a father, as a spouse, as a bread winner in the house, that’s what drives me,” he says.

Marine veteran Keith Brown and Army veteran Nagi Woodhouse, both of whom served in Vietnam, know first-hand the difficulties in returning and adapting to civilian life. They serve as mentors in the veterans treatment court program, and they’re impressed by the level of cooperation between the prosecutor, defense, and judge who are all working for the same thing—to redeem justice-involved veterans. As Brown emphasizes, “There’s no combat between the prosecutor and the defense. It’s mutual cooperation in the best interest of the veteran. We can bring to the court’s attention information that we know would be helpful to the veteran, as



NAGI WOODHOUSE

long as we're not trying to take the place of the mental health people, or the defense attorney, or someone like that."

Woodhouse sees his role as mentor as more than just supporting the veteran; mentors, he notes, also serve as resources for the spouse and children. The veteran treatment court program is proof, he says, that the system cares about what happens to veterans when they return home and struggle to readjust. Having a mentor with shared experiences and backgrounds is key to helping vets succeed as they transition through the program.

Woodhouse stresses the need for more veteran mentors to help other veterans in distress. "We have a huge need for our younger veterans. They need people to lift them up. They don't want a handout; they want a hand up, and we can provide that. We are a great force for good in this country. We've sworn an oath," he says, and that oath "does not go away. I think veterans carry this with them all their life."

Greg Young, the General Manager of Latter-Day Saints (LDS) Transitional Services, is another key member of the veterans court program in Utah. His office provides a variety of services for men and women who are homeless, transient, or exiting correctional facilities. Homeless veterans are a priority in his program, and although not a veteran himself, he comes from a family of veterans.

Young's office works closely with the mentoring program in Judge Hansen's court, as well as providing support to law enforcement in the Rio Grande District where the majority of the city's homeless gather. When working with the veterans courts, his office receives lists of items needed by these veterans, and this direct, continuous collaboration allows his organization to respond quickly. Young emphasizes that some veterans freshly released from the corrections system don't have the basics, from food and a place to sleep to a copy of their birth certificate and government-issued identification. "And we provide an avenue for them to get [what they need]."

GREG YOUNG



LATTER-DAY SAINTS FOOD PANTRY

PRIORITY IS PLACED ON SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT UNDER THE SUPERVISION OF A JUDGE RATHER THAN SENTENCING OFFENDERS TO JAIL.



CHURCH GROUNDS
OF THE CHURCH OF
JESUS CHRIST OF
LATTER-DAY SAINTS

Young's outreach efforts also embrace prisons and jails. Through grant programs, LDS transitional services provides funds to non-profit organizations to support community efforts to address the multitude of needs of the homeless. His office, he says, looks to preserve life, relieve suffering, and foster self-reliance for all whom he serves.

Kathryn Roessler founded VetOps6 two years ago to assist those returning from war to find the resources they need as they transition back to civilian life. Gavin Gloyne is the organization's Executive Program Director. An Army veteran of Operation Iraqi Freedom, he never believed that he would have difficulty readjusting to civilian life. But he did.

Following his medical discharge from the military, Gloyne had difficulty finding steady employment. Although he was receiving help with housing and employment from Roessler, he struggled with addiction following long-term use of painkillers prescribed by the VA. When his medications ran out, Gloyne faced a three-month wait for an appointment with a primary care provider. Out of the medications he needed, he says, "I started buying them on the street. And then I found that heroin was cheaper and works better. And so, I did that for 10 years."

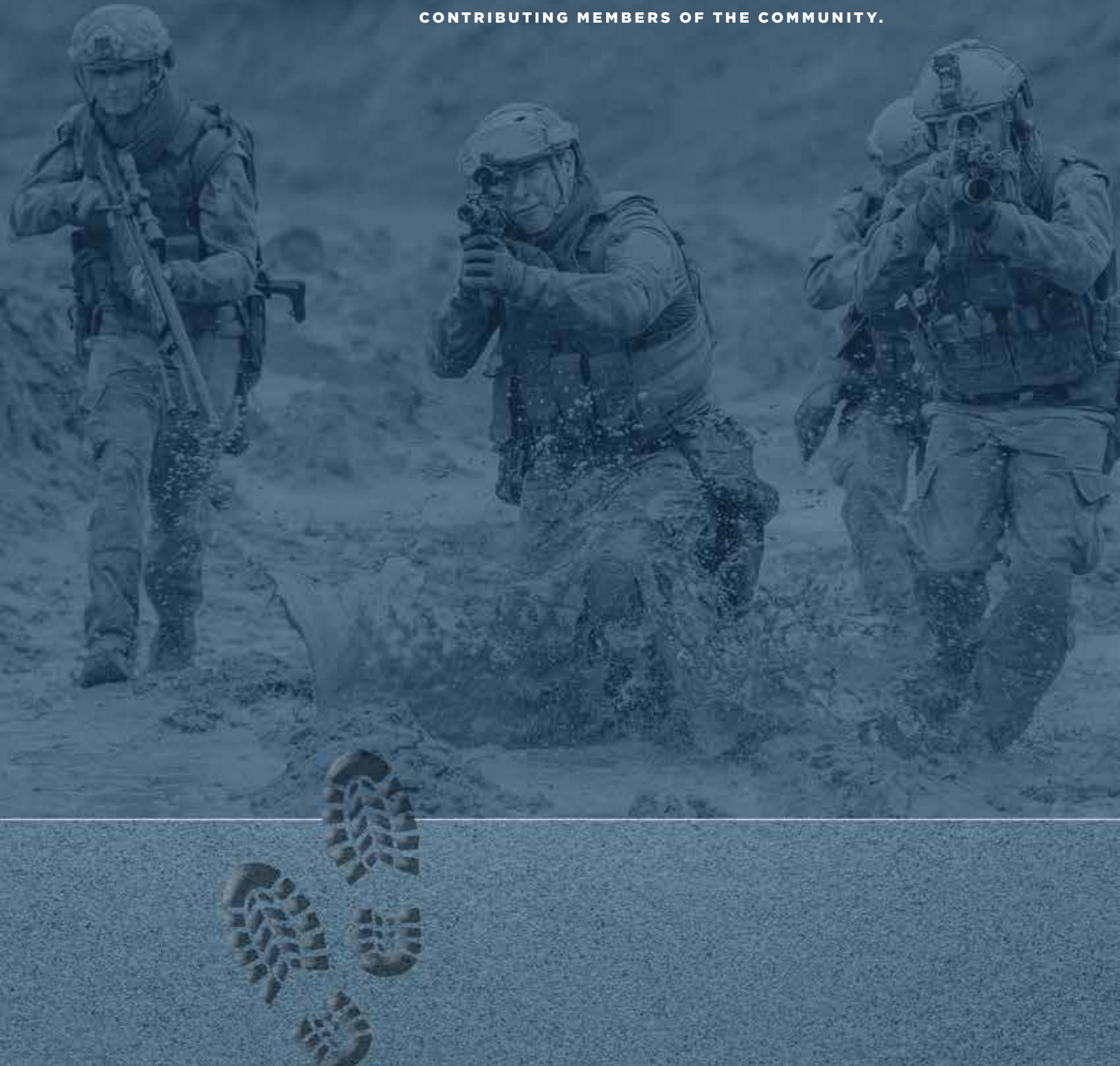
As his addiction spiraled out of control, Gloyne stole a car from a dealership to be able to get to his job. During a stop by police, they discovered his license was suspended and his pocket was full of drugs. Fearing he would be put in jail, Gloyne disappeared before a court appearance to avoid imprisonment. When the police found him, the assigned public defender transferred his case to veterans treatment court. Although he was distrustful and uncooperative at first, he came to realize that everyone in the court wanted to help him. He was assigned to 23 days in the inpatient psychiatric unit for detox, followed by a stay at the First Step House for continuing treatment. And everything changed for Gavin Gloyne for the better.

Kathryn Roessler took note of the many ways Gloyne assisted other veterans in the program, and she gradually assigned him new responsibilities. Eventually he worked his way up to a key position in the organization and now supports other veterans who struggle with the same issues he was able to overcome. Now, Gloyne says, he is paying taxes from steady employment for the first time in a decade.

**WE'VE SWORN AN OATH, AND THAT OATH DOES NOT
GO AWAY. I THINK VETERANS CARRY THIS WITH THEM
ALL THEIR LIFE.**

NAGI WOODHOUSE, MENTOR, VETERANS TREATMENT COURT

THE GOALS ARE NOT ONLY FOR THESE VETERANS TO RESOLVE ISSUES SUCH AS DRUG ADDICTION AND DEPRESSION THAT LED THEM INTO THE SYSTEM IN THE FIRST PLACE, BUT ALSO TO HELP THEM OBTAIN HOUSING, SECURE AND MAINTAIN EMPLOYMENT, REPAIR FAMILY RELATIONSHIPS, AND BECOME CONTRIBUTING MEMBERS OF THE COMMUNITY.



I SPEAK FLUENT PTSD*

I AM A DETECTIVE with the United Police Department in Great Salt Lake, and I'm assigned to the 3rd District Court, the veterans treatment court. My grandfather was a police officer, my father was a soldier, and my son was a soldier. So, I come from a long history of service. That was the way I was raised. I have family members, uncles, cousins, who were involved in the military, but I chose to serve here. You know, some of the guys, they talk about, "We didn't know who the enemy was because they weren't wearing uniforms." Well, the people who have tried to kill me weren't wearing uniforms either.



DETECTIVE
GREGORY SMITH

I have worked a multitude of detective assignments, financial crimes, domestic violence, burglary, larcenies. I spent years on the SWAT team. I've been assigned to vice – public-order crimes like gambling, narcotics, prostitution, and illegal sales of alcohol a couple of times. I've also worked a lot of patrol assignments where I learned about human nature. I interacted with homeless veterans on the streets downtown. I learned that I could trust them and they trusted me because I respected what they had done, the personal sacrifice that they had made. I showed them that respect. I showed them that dignity. And always, I was able to have a really good rapport.

I've been a hostage negotiator for over 20 years and have negotiated with people, including vets, to help them not to end their lives. One of the concerns I have is that 18 to 20 vets across our nation end their lives each day. And so I choose to extend my hand not as a threat, but as a friend, to try to help them find a better way than what they're choosing at that moment.

I've seen some things that help me to relate to the folks in vet court. I spent four years taking pictures of crime scenes. I've taken pictures of hundreds of dead people [to document] bullet or stab wounds. I quit counting at 200. I've seen people who were laying there [and wondered], *Why are you dead?*; then others who are laying there, wondering, *How are you still alive?*

I LEARNED THAT I COULD TRUST HOMELESS VETS AND THEY TRUSTED ME BECAUSE I RESPECTED WHAT THEY HAD DONE, THE PERSONAL SACRIFICE THAT THEY HAD MADE. I SHOWED THEM THAT DIGNITY.

I personally [always wanted] to help, even as I was going through some of the most traumatic events in my life, not just in my professional life, but in my personal life. I have a divorce in my background probably because of a lot of reasons and reasons I don't even understand. I sought out a Navy psychologist. He was a Navy corpsman

during Vietnam who was assigned to a Marine battalion. He saved a lot of lives. I spoke to him every week for two years, and so, I speak fluent PTSD. I refer to veteran court guys as "my guys."

* The views expressed here are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

THE ONLY HONEST WAY THROUGH PTSD IS TALKING THROUGH IT, BUT YOU HAVE TO FIND SOMEONE YOU CAN TALK TO, THAT YOU CAN UNBURDEN YOURSELF WITH.

When I talk to my guys, I tell them that the only way through PTSD is not in a bottle, it's not in a needle, it's not in a straw up your nose, and it is not in a pill. The only honest way through it is talking through it, but you have to find someone you can talk to, that you can unburden yourself with. So every one of my guys, I tell them the truth: that the only way through this is finding somebody who specializes in PTSD and talk to them.

The way I see it in Veterans Treatment Court, I'm kind of like the camp counselor, because a lot of what they've seen and a lot of what they've experienced are similar to things that I have seen and experienced. What I try to do is give them hope every single day, with every single phone call. I don't put my knee in their neck, I don't force them, I don't make excuses for them, but I do help them make decisions that can turn out the best for them. And most of my guys, are pretty reasonable. Some of them are fighting some pretty nasty demons, and when you add addiction on top of PTSD, it complicates the underlying problem of PTSD. I try to give them hope that there is a better tomorrow if you just don't quit. I invite them, "If you're going to use, first call me."


IN VETERANS TREATMENT COURT, I'M KIND OF LIKE THE CAMP COUNSELOR, BECAUSE A LOT OF WHAT THEY'VE SEEN AND EXPERIENCED ARE SIMILAR TO THINGS THAT I'VE SEEN AND EXPERIENCED.

I work for a department that has given me amazing latitude. My clock starts whenever it starts, and some days are 19-hour shifts. Most days are not, but they always get more than their fair share of time out of me. And they do call me. Guys

will call me one, two, three, four o'clock in the morning when they're struggling. We'll talk, and if that's not good enough, then I'll go and meet them. We'll sit and eat. It's hard to be mad at somebody or not trust somebody who's willing to get up in the middle of the night and come and sit with you and eat breakfast. And then, I either take them back home, or to a hospital, or a detox center.

My advice to another jurisdiction planning to do work like this is: First off, don't be afraid to be involved. Don't be afraid to extend yourself, even make yourself vulnerable. Don't be afraid to expose yourself. Don't be afraid to show them that you honestly care, because if you don't, they can tell. If you're faking, they'll know it. There are a lot of people with the best of intentions who are pretty timid about stepping up. And I'll ask guys straight up, Are you thinking of hurting yourself? Do you see a way out of your situation? How do you think this is going to turn out? And most people, most warriors, will tell you pretty bluntly where they are, what they're thinking, what they see the future as.

Diversion First, Jail Second in Fairfax County, Virginia



Fairfax County, Virginia, has focused on developing compassionate responses to help individuals in mental health crises and to divert those whose actions might otherwise warrant them be arrested into treatment programs instead. The county police respond annually to more than 5,000 calls for service related to individuals with a mental illness in need of assistance. According to Sheriff Stacey Kincaid, nearly half of all Fairfax County Jail inmates at any given time have mental health and/or co-occurring substance abuse disorders. Encounters between police and those with untreated mental illness can escalate quickly, sometimes with tragic consequences. According to the 2015 Fairfax County Mental Health and CIT Subcommittee Final Report, nearly half of all fatal shootings by police in Fairfax County involve persons with mental illnesses.

According to the Mental Health and CIT Subcommittee of the county's Ad Hoc Police Practices Review Commission, "persons with mental illnesses remain incarcerated four to eight times longer than those without mental illnesses for the exact same charge and at a cost of up to seven times higher, making their incarceration a financial burden for taxpayers as well as a social, health, and justice issue." Research by the State of Virginia Compensation Board found that Fairfax County Jail provided 1,640 treatment hours to inmates with mental health disorders in FY2016, provided psychiatric medications to 268 inmates, and spent a total of \$1.87 million during this same period for all mental health support combined.¹ The average annual cost of incarcerating an individual with mental health disorders in the Fairfax County jail is approximately \$64,000. In comparison, providing a year of mental health treatment costs just \$7,500.² Crisis training for law enforcement, crisis assessment sites, and mobile crisis units were determined to be "best practices" in developing a diversion program. Fairfax also recognized that a CIT

¹ *Mental Illness in Jails Report. State of Virginia Compensation Board. November 2016.*

² *Confirmed in WTOP News, Fairfax County, 28 April 2018.*

program tied to other support programs, such as diversion to treatment or its Veterans Treatment Docket, presented opportunities to realize significant savings.

On January 1, 2016, the county launched Diversion First, which offers alternatives to incarceration for people with a mental illness or developmental disability who come into contact with the criminal justice system for low-level offenses. The goal is to intercede whenever possible to provide assessment, treatment, and support, to include addressing substance abuse and addiction. The Crisis Intervention Team plays a key role towards achieving this goal. Diversion First brings together 180 stakeholders who collaborate, including law enforcement, mental health providers, advocates, public defenders and prosecutors, judges and magistrates, and leaders of both the county and state. In its first two years of operation, almost 800 people were diverted from potential arrest, thereby avoiding incarceration. Currently, more than 400 police officers assigned to the Fairfax County Patrol Bureau have attended CIT courses, which involves 40 hours of instruction, simulation, and practical exercises. Additionally, current and future police recruit classes attending the Fairfax County Criminal Justice Academy also receive Crisis Intervention Training (CIT) designed to enhance the capabilities and awareness critical for new officers.

In cooperation with the county's CIT Program, the Mobile Crisis Unit (MCU) is an emergency mental health program of the Fairfax-Falls Church Community Services Board that provides on-scene evaluation, treatment, and crisis intervention. The MCU specializes in providing these services to individuals who are experiencing a mental health emergency. In many of these situations there is concern that, as a result of a psychiatric condition, a person may pose a danger to himself or others or may not be caring about himself. The MCU is authorized to recommend and facilitate involuntary hospitalization and treatment when necessary. There are currently two units, operating in shifts, for 24/7 coverage. The MCU also supports the

ENCOUNTERS BETWEEN POLICE AND THOSE WITH UNTREATED MENTAL ILLNESS CAN ESCALATE QUICKLY, SOMETIMES WITH TRAGIC CONSEQUENCES...NEARLY HALF OF ALL FATAL SHOOTINGS BY POLICE IN FAIRFAX COUNTY INVOLVE PERSONS WITH MENTAL ILLNESSES.

county's Special Weapons and Tactics (SWAT) team and police negotiators responding to hostage/barricade incidents.


The Fairfax County Veterans Treatment Docket of the General District Court, launched in 2015, is a court-supervised, comprehensive treatment program that is supported by the county's sheriffs department. All participants have been determined to have substance use issues and/or have been diagnosed as having mental health conditions. Participants are supervised through regular court appearances before the Veterans Treatment Docket judge and treatment that includes drug testing, individual counseling, and group counseling provided by the Department of Veterans Affairs and Fairfax County facilities. Like the Third District Court in Salt Lake City, participants are assigned a veteran peer mentor in addition to receiving services such as employment assistance. The program is individualized and is determined in part by each participant's progress. Typically the program runs 18-24 months in three phases: Orientation/Stabilization, Treatment, and Transition/Graduation.

The Veterans Treatment Docket was started by Circuit Court Judge Penney Azcarate, who was a General District Court judge from 2008–2015. A Marine Corps veteran, she had seen veterans coming back from deployments overseas and finding themselves in her courtroom



JUDGE PENNEY AZCARATE

time and again. She established the docket to address young combat veterans' unique issues such as post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). Azcarate stressed the importance of Veterans Justice Outreach (VJO) specialists from the Veterans Administration (VA) as integral to this system and veteran mentors as key to the success of the Veterans Treatment Docket. "The veterans we're dealing with have high needs. They're homeless, some sleeping in their car. They need jobs. And now, some of them have felony convictions, so it's hard to get jobs. The mentors really help them through their day-to-day, calling them every day in between court sessions." And this, she says, is really important in turning worthy lives around.



CRISIS TRAINING FOR LAW ENFORCEMENT,
CRISIS ASSESSMENT SITES, AND MOBILE
CRISIS UNITS WERE DETERMINED TO BE “BEST
PRACTICES” IN DEVELOPING A DIVERSION
PROGRAM. IT WAS ALSO RECOGNIZED THAT
A CIT PROGRAM TIED TO OTHER SUPPORT
PROGRAMS, SUCH AS DIVERSION TO TREAT-
MENT OR ITS VETERANS TREATMENT DOCKET,
PRESENTED OPPORTUNITIES TO REALIZE
SIGNIFICANT SAVINGS.

SOOTHING THE SCARS OF WAR*

WHEN I GOT OUT of the Marine Corps, I wasn't looking for law enforcement, but since I was a Marine security guard, I was semi-recruited for Fairfax County Sheriff's Office. I applied and was readily accepted. I served my country; I was very comfortable with service and happy to serve my country again.

I was not part of any war. I was in during the first Persian Gulf War, but I was at the embassy in Costa Rica. Sometimes I regret that, but a lot of times I'm very, very thankful for that. There's two ways to look at it. Obviously I raised my hand to serve and when I went to volunteer for embassy

duty, the colonel said, "Now, son, if war breaks out, you're not going to be able to say, 'Hey, I'm really a machine-gunner. I wanna go fight.' You're signing up to do this." And I honestly said to him, "Sir, what are the odds of a war breaking out?" I didn't expect it to happen.

It was early '90s when I started my career. But later, I began reflecting on veterans and asking them why they [had gotten into trouble]. Most of the time it was substance abuse. I don't carry the burden of things they saw. These are individuals who, in my opinion, if they hadn't been exposed to war, or to trauma while in the military, they probably would not be in the state that they are in. [In the Marines,] they trained us to overcome our objective and then to walk away. But sometimes when you walk away you have memories and scars. They don't train us on how to take care of those scars. And we are reluctant to say, "I need help."



CAPTAIN
STEVE ELBERT

Fairfax County started looking at doing more to help veterans when the Veterans Treatment Docket was being formed. The team started talking in late 2014, early 2015. It got up and running in 2016. Sheriff Kincaid asked me if I would serve on the veteran team. She knew I was a veteran and what my answer would be. I told her I would be honored to serve on it.

Judge Azcarate is a former Marine and she spearheaded the treatment docket here in Fairfax. She was the champion who wanted it to happen and she reached out to different stakeholders, the sheriff included. And she went to look at best practices, went to look at other veterans treatment courts around the country. She wanted to start a program that was going to last.

[IN THE MARINES] THEY TRAINED US TO OVERCOME OUR OBJECTIVE AND THEN TO WALK AWAY. BUT SOMETIMES WHEN YOU WALK AWAY, YOU HAVE MEMORIES AND SCARS. THEY DON'T TRAIN US ON HOW TO TAKE CARE OF THOSE SCARS...AND WE ARE RELUCTANT TO SAY, "I NEED HELP."

* The views expressed here are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

THEY ARE ASKED IF THEY'VE EVER SERVED IN THE MILITARY, BUT A LOT OF THEM WON'T SELF-REPORT AND SOMETIMES THEY JUST REFUSE TO ANSWER. PRIDE IS THE REASON FOR THEIR RESISTANCE.

Law enforcement had a dual role when the docket first started. The police department was involved as well and the sheriff's office. Our role is identification and referrals and making sure that as many veterans as possible that come into contact with us are screened.

There is a question that's asked by the booking officer and by the magistrates because, quite often, [those who've been arrested are] brought to the jail, and the magistrate's office is inside the jail. But they're issued a summons and are released at the window; they aren't committed to the jail. So they are asked if they've ever served in the military, but a lot of them won't self-report and sometimes they just refuse to answer. Pride is the reason for their resistance. If they are actually booked in, then we are able to determine if they're veterans through the VA (Veterans Administration).

The biggest obstacle was down in Richmond, trying to get authorization for a specialty court. And as it turns out in Virginia, it was a specialty docket only, not a specialty court. That was overcome, I guess, as a team effort through legislators and stakeholders and taking notice of the issues our veterans are dealing with on a daily basis, and the reason they are becoming justice-involved.

Communities are safer as a result of a veteran going through vet court because they've dealt with their underlying issues. The likelihood of them having a meltdown is diminished greatly. They come out not just a better person, but they come out with that pride because they are on a day-to-day, or at least, on a weekly basis associating with other veterans in a positive way. So then they have that esprit de corps and they have that sense of belonging, and they show that pride in their walk.

If a sheriff's department is considering a program, I would say there's always time to help the people who need the help the most. They sacrificed or put their life on the line for our freedom. We can sacrifice a little bit of time and a little bit of effort to restore them back to the way they used to be.

My long-term vision for the program is to grow it. And we're now in the process of growing it to a Juvenile and Domestic Relation Court, because that's where it's going to manifest the first time, when they're young. When they're self-medicating at home, it's going to be the spouse, it's going to be the child, that they lash out at. So as long as it's something minor, that's usually that first cry for help.

The biggest thing I'd like to share is the beauty of my role in this program. I get to see the veterans from the day they walk into that courtroom, until the day they graduate. And there have been a few when I have said, "They're not going to make it, there's just no way." And the emotional feeling I get when they graduate is incredible.



Conclusion

BY GREGORY CRAWFORD

According to the U.S. Department of Veterans Affairs (VA), some 4.4 million men and women have voluntarily served our country in uniform since the terrorist attacks on September 11, 2001. Nearly 2.7 million of these troops have been deployed overseas in support of the Global War on Terror, many having endured multiple deployments. Approximately 20 percent of those who have served in Afghanistan and Iraq have sought treatment and disability compensation for post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and/or other mental health conditions related to their service.

Returning home for our service members becomes more and more challenging with each deployment. Just as our veterans sometimes struggle to acclimate back into our communities, law enforcement officers, many of whom are veterans themselves, are increasingly encountering veterans who either did not get the help they needed during their transition to civilian life or have struggled in the weeks, and months, and even years since separating from the military. Our law enforcement officers and corrections officers, particularly those who have not seen service in the military, are ill-equipped to engage a veteran effectively in crisis and de-escalate a volatile situation, one which can all too easily turn violent and result in tragedy for both veterans and law enforcement officers lacking the training and intuition to deal with such a situation.

The more training, education, and experience our law enforcement officers receive around the underlying mental health issues for military veterans—issues that can be traced to their experiences in a combat zone—the better chance they have to defuse situations and prevent violence from veterans who, fueled by alcohol or drugs, are acting out. A referral for help when warranted is often a better option than an arrest and incarceration and the collateral consequences that come with involvement in the criminal justice system. As Chief Blair Myhand has noted, affected veterans are offered hope—for themselves and for their families—through specialized de-escalation measures that are more likely to result in peaceful outcomes that preserve public safety.

Similar to how Judge Robert Russell in Buffalo, New York, started the first Veterans Treatment Court in 2008¹, we are starting to see Chief Myhand's approach to training law enforcement officers to better handle a veteran in crisis, spread across the law enforcement landscape. Police and corrections officials are taking core pieces of Chief Myhand's innovative Veterans Crisis Intervention Training (VET CIT) program and adapting it to fit their law enforcement needs.

The programs highlighted in this publication are showing promise for improving the possibility of early intervention with veterans in crisis in their communities. Although there is need for improved data collection and formalized research into these programs, the state and local jurisdictions who have implemented specialized response teams and programs for veterans are reporting improved outcomes related to increased officer safety and improved harm reduction for the veterans they respond to in crisis. Through specialized training of law enforcement officers, collaboration with a wide variety of community partners, and early access to specialized services for veterans in crisis, communities can work together to increase community safety, create fewer victims, and provide effective front end interventions at the point of first contact.

For any local, state, or federal criminal justice agency that identifies a need to do better for such veterans in their communities, and thereby increase public safety, here are some suggested next steps:

- ▶ Develop a set of key performance and outcome measures and begin tracking data on incidents involving military veterans.
- ▶ Provide training and education to your law enforcement officers around military service related mental health issues such as PTSD, TBI, depression, and anxiety.
- ▶ Create and train Veteran Response Teams to engage veterans in crisis.
- ▶ Establish working relationships with area entities that can work collaboratively to improve public safety and outcomes for such veterans (e.g., VA medical centers and community-based outpatient clinics, along with local and state probation and parole officers, Veterans Treatment Courts, and local jails and state and federal prisons which have veteran-specific housing units).

¹ There are now more than 500 of these courts in jurisdictions across the country.

JUST AS OUR VETERANS SOMETIMES STRUGGLE TO ACCLIMATE
BACK INTO OUR COMMUNITIES, LAW ENFORCEMENT OFFICERS,
MANY OF WHOM ARE VETERANS THEMSELVES, ARE ENCOUNTERING
VETERANS WHO EITHER DID NOT GET THE HELP THEY NEEDED
DURING THEIR TRANSITION TO CIVILIAN LIFE OR HAVE STRUG-
GLED SINCE SEPARATING FROM THE MILITARY.



Resources

The following websites should provide additional information about various facets of specialized programming for veterans in the community, or jails and prisons, and veterans treatment courts.

For Practitioners

NATIONAL INSTITUTE OF CORRECTIONS

<http://nicic.gov>

CIT TRAINING THROUGH THE NIC JAILS DIVISION

<https://nicic.gov/jails-division>

JUSTICE-INVOLVED VETERANS MICRO SITE

<https://info.nicic.gov/jiv>

VETERAN INTERCEPTS IN THE CRIMINAL JUSTICE SYSTEM

<https://info.nicic.gov/jiv/node/113>

NATIONAL SHERIFF'S ASSOCIATION

<https://www.sheriffs.org>

INTERNATIONAL ASSOCIATION OF CHIEFS OF POLICE

<http://www.theiacp.org>

BUREAU OF JUSTICE ASSISTANCE

www.bja.gov

<https://www.bjatraining.org>

STRATEGIES FOR POLICING INTERVENTION (BJA AND CNA ANALYSIS & SOLUTIONS COLLABORATION)

<http://www.strategiesforpolicinginnovation.com>

U.S. DEPARTMENT OF VETERANS AFFAIRS

<http://www.va.gov>

VETERANS JUSTICE OUTREACH PROGRAM

<http://www.va.gov/homeless/vjo.asp>

HEALTH CARE FOR RE-ENTRY VETERANS SERVICES AND RESOURCES

<https://www.va.gov/homeless/reentry.asp>

VETERANS AFFAIRS POLYTRAUMA PROGRAM

<http://www.polytrauma.va.gov>

NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER

<http://www.ptsd.va.gov>

POST-TRAUMATIC STRESS DISORDER:

NATIONAL CENTER FOR PTSD: POLICE OFFICER TOOLKIT

<https://www.ptsd.va.gov/professional/toolkits/police/index.asp>

MEDIASITE BY SONIC FOUNDRY: POLICE TRAINING VIDEOS

<https://mediasite.paloaltou.edu/Mediasite/Catalog/catalogs/pau-police>

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

ADMINISTRATION (SAMHSA): MILITARY FAMILIES

<http://www.samhsa.gov/militaryFamilies>

UNIVERSITY OF MEMPHIS CIT CENTER

<http://www.cit.memphis.edu/aboutCIT.php>

CIT INTERNATIONAL

<http://www.citinternational.org>

WHITE HOUSE: VETERANS & MILITARY FAMILIES

<http://www.whitehouse.gov/issues/veterans>

CENTER FOR COURT INNOVATION (CCI)

<http://www.courtinnovation.org>

NATIONAL DRUG COURT ONLINE LEARNING SYSTEM (CCI)

<http://www.drugcourtonline.org>

JUSTICE FOR VETS

<http://www.justiceforvets.org/vet-court-con>

**10 KEY COMPONENTS OF A VETERANS TREATMENT COURT
(JUSTICE FOR VETS)**

<http://www.justiceforvets.org/sites/default/files/files/Ten%20Key%20Components%20of%20Veterans%20Treatment%20Courts%20.pdf>

**VETERANS TREATMENT COURT MENTOR PROGRAM
(JUSTICE FOR VETS)**

<http://justiceforvets.org/veteran-mentor-courts>

**NATIONAL CENTER FOR STATE COURTS:
VETERANS COURTS RESOURCE GUIDE**

<http://www.ncsc.org/Topics/Problem-Solving-Courts/Veterans-Court/Resource-Guide.aspx>

WASHINGTON UNIVERSITY JOURNAL OF LAW & POLICY

“Restorative Justice for Veterans: The San Francisco Sheriff’s Department’s
Community of Veterans Engaged in Restoration (COVER), 2011

http://openscholarship.wustl.edu/law_journal_law_policy/vol36/iss1/4

NATIONAL IMPLEMENTATION RESEARCH NETWORK

<http://nirn.fpg.unc.edu/learn-implementation/implementation-science-defined>

For Veterans

VETERANS CRISIS LINE

<http://veteranscrisisline.net>

This website provides information for veterans who have issues readjusting to society and who are in a state of mental or emotional confusion and upset, and who may have suicidal thoughts. Call the veterans crisis line, toll-free, at 1-800-273-8255, then press 1.

The toll-free number to reach the VA is 1-800-827-1000. Other helpful VA numbers include:

- Debt Management Center: 1-800-827-0648
- Homeless Prevention Line: 1-800-424-3838
- National Caregiver Support: 1-855-260-3274
- Women Veterans Call Center: 1-855-829-6636
- Vet Center Combat Call Center: 1-877-927-8387
- Health Benefits Customer Service: 1-877-222-8387
- Education Benefits: 1-888-442-4551
- Inspector General Hotline: 1-800-488-8244

VIETNAM VETERANS OF AMERICA

<http://www.vva.org>

Veteran in Crisis Trainer Officer Form

Please fill the following section out
if you are a Veteran in Crisis Trained Officer:

Consumer is a veteran (Check all that Apply)

- ☐ Consumer is a **COMBAT VETERAN**.
- ☐ Consumer is veteran who has **NOT SERVED IN COMBAT**.
- ☐ Consumer is **LINKED** to the **VETERAN AFFAIRS**.
(If applicable) Contact Name: Phone Number:
- ☐ Consumer has **OUTSTANDING WARRANT**
- ☐ **UNKNOWN** or **OTHER**

Jeremy Brogden,
Veterans Justice Outreach Specialist
(919) 286-0411 Ext. 5186
Raleigh Vet Center (919) 856-4616

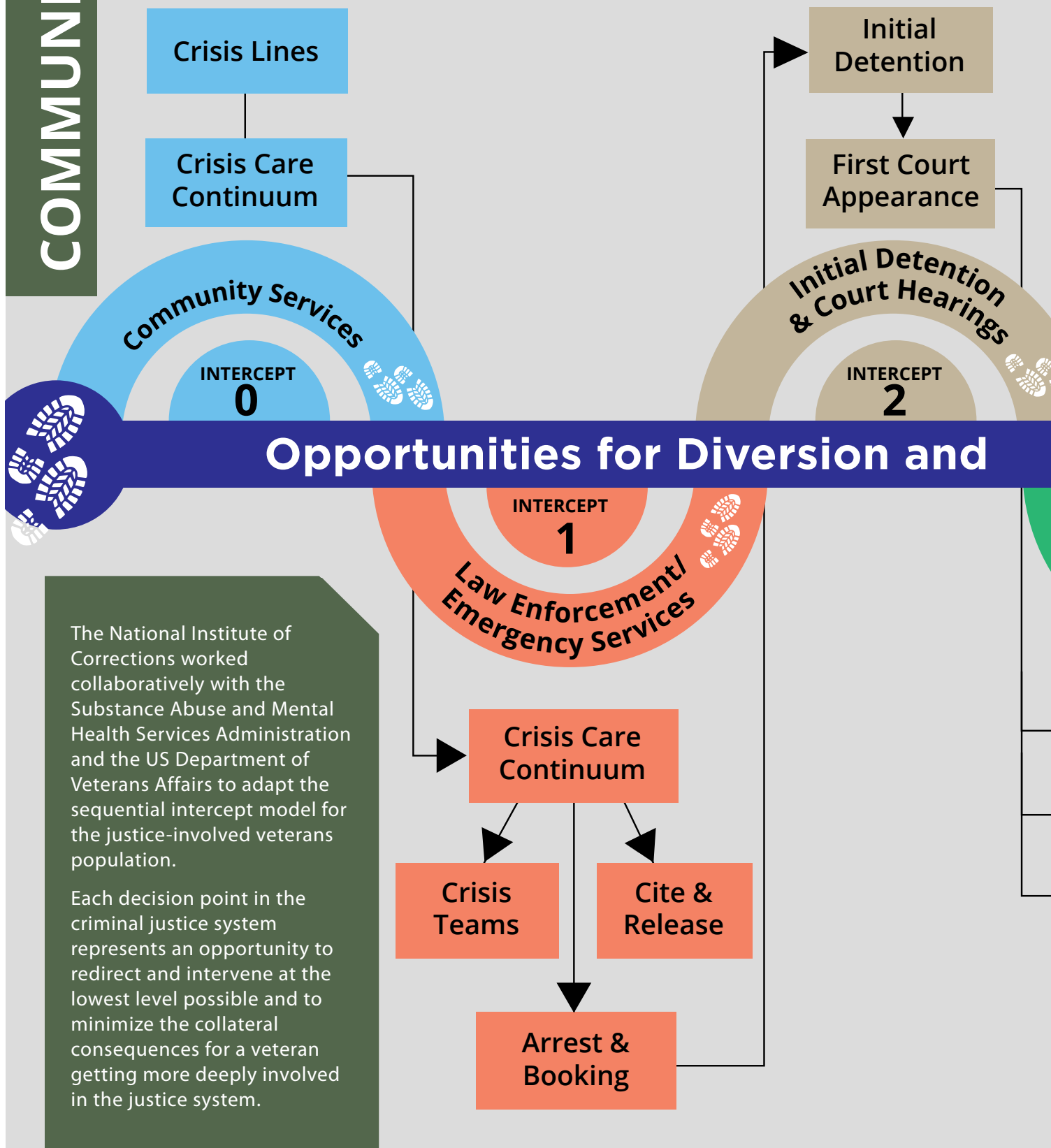
NOTE: This form is only for Veteran in Crisis CIT officer's use

CIT Officer's Name: _____ Date Completed: _____

CIT Supervisor: _____ Date Reviewed: _____

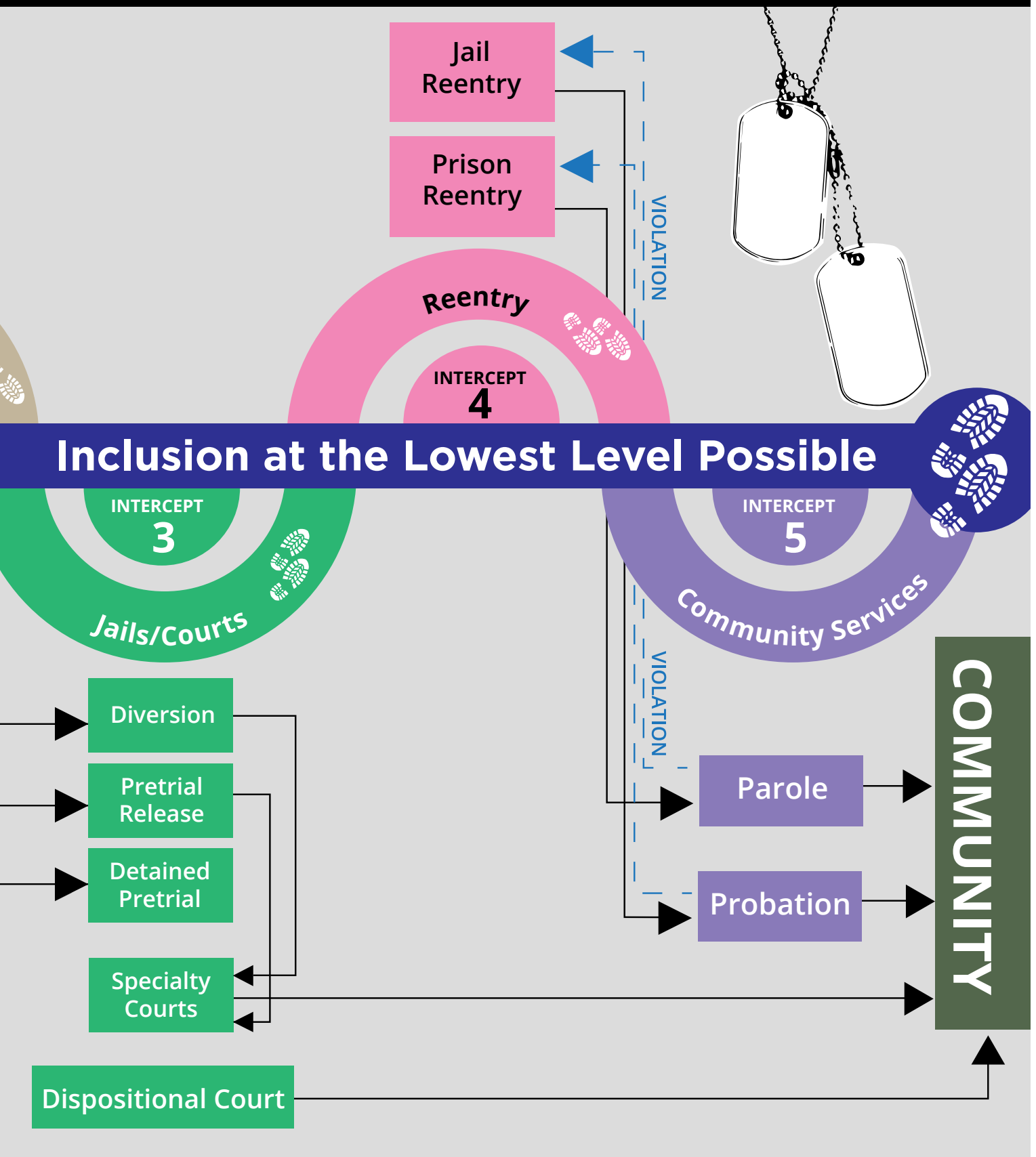
Veteran Intercepts in the

COMMUNITY



Criminal Justice System

Sample Decision Points



Acknowledgments

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LAW ENFORCEMENT SITES

Raleigh (Apex), North Carolina

Dayton, Ohio

New Castle, Delaware

Salt Lake City, Utah

Fairfax, Virginia

Epilogue

Compared to other jail diversion programs, officers say Crisis Intervention Team training is better at minimizing the amount of time they spend on mental disturbance calls, more effective at meeting the needs of people with mental illness, and better at maintaining community safety.



LEAVE NO VETERAN BEHIND

NATIONAL INSTITUTE OF CORRECTIONS

WWW.NICIC.GOV

