Facilitated Discussion Notes
Law Enforcement & Children's Behavioral Health
June 2, 2014

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: info@plan4children.org.

General Notes

- Hosted by: Yale Child Study Center
- Location: Yale Child Study Center, New Haven
- Four people in attendance

Question 1: Strengths

- CDCP (Child Development – Community Policing Program) essential elements
    1. Intensive cross-training and riding with LE (Law Enforcement) for many hours
    2. On-call 24/7
    3. Weekly case conference to build and sustain relationships
    4. Protocols for how LE and clinicians respond
    5. Immediate intervention and longer-term interventions
- Two interfaces exist:
    - LE interfacing with acutely and/or chronically psychiatrically ill individuals; e.g. CIT training out of Nashville. Many communities have trained their LE workforce.
    - LE serve as first responders in which children are exposed to traumatic events; e.g., domestic violence, sexual abuse. Requires identification and early intervention, which improves outcomes.
- The collaboration in New Haven is viewed as very strong by New Haven PD and YCSC.
- Yale Child Study Center's CDCP model has been funded through grants and private money, bringing these services to the region at no cost to the state.
- Child Advocacy Centers exist to support children and adolescents.
- LE members are most often the first responders to children exposed to traumatic events. Their role involves an immediate response and there is also the potential for follow-up intervention from LE as well.
- The YCSC model has been adopted elsewhere, e.g., Charlotte ($700,000 in annual state funding) and Cleveland.
- The model in New Haven works in part because relationships have been developed between LE and mental health over 20 years. Many of the individuals involved meet weekly and consult each other frequently. Confidence in the model grows out of experience with the model.
- LE and clinicians learn to recognize each other's roles.
- There are two CIT-Youth (CIT-Y) Programs in the state: trains LE to deal directly with youth (traditional CIT is focused on adults). The program is linking LE to EMPS through 211. Clinicians then respond by phone or are deployed to the community. Exists, for example, in Manchester.
- Commissioner of DMHAS supports CIT and that support flows down through the regions. There are 9 CIT clinicians in the state. CIT clinicians get 40 hours of training to better understand LE and the interface with LE.

- Benefit of early identification. Some YCSC interventions address sources of problems, rather than having LE repeatedly provide a temporary fix.
- This collaborative model is an often-unidentified form of prevention/early intervention.
- LE may be the only set of eyes on a problem.
- DMHAS funds overtime pay for officers to go to CIT training IF the LE department has a CIT policy in place.

Question 2: Concerns

- In many locales there is not a comprehensive look at the potential role of LEs as first responders or in follow-up after traumatic/critical events.
- Doesn't work if behavioral health doesn't have a working relationship with LE. Such relationships do not exist in most of the Connecticut.
- YCSC model has never received any funding from the state.
- Most geographic areas in our state and across the nation are missing these opportunities for natural identification of children and youth who have been traumatized.
- Two categories of resistance from clinicians:
    - They believe they are the cavalry coming to the rescue of LE.
    - The issues encountered by LE are often disturbing and many clinicians are not cut out for exposure to these problems or to LE.
- Fidelity to any treatments offered is often poor.
- The number of teens that have existing relationships with LE is relatively small.
- Few staff, even in EMPS, are trained in responses to acute trauma.
- There are only 9 CIT clinicians in the entire state.
- Wishful thinking that the relationship between LE and behavioral heath is "just a handoff"
- Changes in leadership in LE and mental health often set the collaborations back.
- Implementation challenges, even when there is funding:
    - Either LE or mental health tries to grab the funding.
    - The model doesn't match up with current philosophy of either LE or behavioral health.
    - Money for initial training and early identification, but no resources for the treatment after identification. Agencies already strapped for resources and burdened with large caseloads will have little interest in expanding their mission.
- Disproportionate minority contact:
    - If LE can recognize an underlying issue (sadness, family problems, etc.) they are better prepared to work with the child/adolescent, families, teachers, etc. rather than reacting to stereotypes.
    - Multiple causes of differential contact were discussed.

Question 3: Recommendations

- State funding to implement the model throughout the state for both LE and mental health.
- Training of LE, not to be a clinician, but to be able to identify children and adolescents in need.
- Get the top LE brass to buy in or it will not work.
- Build on existing models, systems, capacities and talent --leverage what we have in the state.
- Mandates are not essential. Funding will lead states and localities to innovate. But the RFAs have to mandate the essential elements, such as partnerships.
- Invest only where there is the capacity and the will for collaboration. If LE departments don't "get it" then don't invest. LE departments will often develop an interest over time.
- Need to determine how to address resistance from top brass in LE

    - Need a good sales pitch for the work, ideally from another police officer. For example, "We care about these kids, we want to help them." Use real world examples.
    - Be clear about roles and responsibilities and don't blur the roles.
- The models have to make the work of the professionals involved easier and more effective; better clinical outcomes and greater public safety.
- Go slow. If you try and do this everywhere in the state it will fall apart. There has to be buy-in.
- Need the right people to serve as trainers. CABLE using co-trainers: mental health and LE.
- Don't use the word "mandate" in any legislation. It will scare LE away.
- Make sure all EMPS clinicians have the right kind of training and that there are enough of them.
- Distinguish between interventions related to acute psychiatric conditions vs. trauma exposure.
- Legislature should support a public awareness campaign about children's behavioral health and the evidence supporting mental health and LE collaboration.

Other Comments

- Overwhelming events are overwhelming for everyone, especially if not appropriately trained. The last time to build partnerships is in the middle of a crisis.
- Largest lesson not learned is that the majority of violence is not committed by psychiatrically ill individuals. The opposite idea has proliferated (more violence comes from the psychiatrically ill).