Brooklyn Park Police Department Suicide Risk Assessment of Call Subjects

Applied Policy Project

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Contents

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Honor Pledge: I pledge on my honor as a student that I have neither given nor received unauthorized aid on this assignment.

Joseph Boelsche 5/1/19

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Executive Summary

As the Brooklyn Park (Minnesota) Police Department's Mental Health Initiative gains momentum and their law enforcement officers develop new procedures for responding to mental health crisis, they are in a position to examine the interconnected issue of suicide risk. Currently, state and department policy adopts a broad definition of risk to self-harm as the standard for ordering an involuntary ambulance transport for emergency psychiatric evaluation. This broad definition favors immediate action for the benefit of citizen safety, but can incur other costs in terms of subject liberty, hospital and patient financial cost, and missed connection to outpatient treatment. With a more consistent and formalized model of suicide risk response, the department could better identify low risk suicide related calls and provide further justification to involuntary transports for higher risk calls. Possible options to address the issue include holding community meetings to publicize current efforts and collect citizen feedback, having officers assess risk using the Columbia Suicide Severity Rating Scale tool, launching a co-responder program with clinicians accompanying officers on-scene, and working with North Memorial Ambulance Services to establish a Mobile Crisis Unit with a mental health clinician. Primary criteria to assess these options are cost effectiveness, liability, and officer time spent on-scene. Case coverage and ability to connect call subjects to treatment are secondary criteria. Contingent on a set of highly sensitive implementation assumptions, this analysis recommends officer use of C-SSRS suicide risk assessment tools. More broadly, it identifies C-SSRS and the Community Meeting approach as the significantly most feasible options for the department given prioritized cost and time-on-scene constraints.

Problem Statement

Across the country, law enforcement officers are regularly called to the scene of individuals experiencing some form of suicide-related risk. In these situations, by default officers must determine the level of threat to self or others these individuals pose and take action accordingly. Suicide risk response and assessment procedures vary from department to department based on priorities and resources, but all departments are ultimately accountable to their public and the mandates of their legal system. A common first line of defense against suicidal threat and mental crisis in general is transport holds for emergency psychiatric evaluation, in which the police or magistrate orders an individual to an involuntary hospital inpatient admission for psychiatric evaluation for their own wellbeing. Nationwide, departments are individually grappling with this triage role at the intersection of mental health and public safety.

The Brooklyn Park Police Department's (BPPD's) on-scene assessment of suicide risk is too informal and inconsistent. These gaps leave the department in a position of liability due to assessment decisions that are unsubstantiated or limited in documentation. In general, mental crisis transport holds can be facilitated by a confirmation of mental illness and identifying symptoms presenting threat to the subject or others. Suicidal risk presents a more ambiguous dilemma as it can be informed but not wholly dictated by a subject's mental health history. Individuals often may not give any indication of threat to others, so safety considerations of the case leave narrower justification for transport. Suicidality requires a thorough on-scene understanding of the subject's current emotional state and contributing risk factors to make the appropriate disposition.

There are also significant external citizen and health system costs to consider in this issue. Local care provider North Memorial Hospital cites the subject cost of an emergency evaluation at

roughly $4,500[1] when accounting for ambulance services and inpatient psychiatric evaluation. While this may be an acceptable price for individuals at genuine threat of attempting suicide, it may be a large financial burden to those who are not at immediate risk of self-harm and could benefit from alternative interventions. BPPD can see the repercussions of this subject cost in fallout to citizen approval. The department finds itself in need of a standardized risk assessment system to navigate the tradeoffs of cost, civil rights, and public safety at play in responding to suicide-related calls.

[1] Estimate provided via BPPD Mental Health Unit

Background

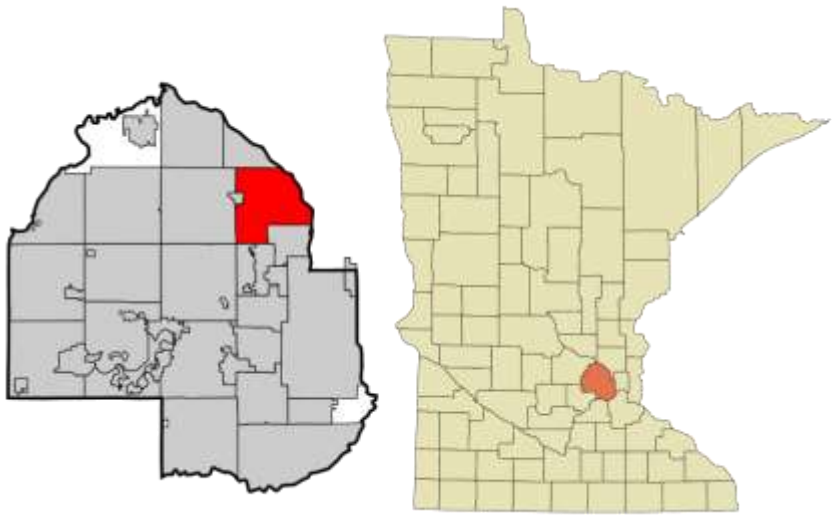
Suicide on the National and Local Scale

Completed suicides increased 25.4% nationwide from 1999 to 2016, and 40.6% in Minnesota (CDC, 2016). Based on post-mortem investigation by medical examiners and law enforcement, the top three factors contributing to suicide are relationship problems, crisis in the past or upcoming two weeks, and substance abuse problems (CDC, 2016). There is some local data tracking common indicators of suicide attempt. In a 2014 Hennepin County public health survey, 3.5% of respondents in the Brooklyn Park region reported experiencing "serious psychological distress" and 7.5% felt "hopeless all of the time, most of the time, or some of the time" in the past 30 days (Hennepin, 2014). The same survey found that "Nearly half (46%) of those who delayed seeing a health professional for mental health concerns did so because of concerns about cost" (HCPH 2018, 38). Brooklyn Park generally falls below Minneapolis in these categories, and above the less populated rural and suburban areas in the rest of the county.

Brooklyn Park Key Demographics

The overall demographics of Brooklyn Park can help frame BPPD's subject population and the challenges they face compared to suicidality as a national issue. It is the sixth largest city in Minnesota[2], with an estimated population of 80,581 (USCB, 2017). It is located in the southeastern portion of the state in Hennepin County—the same county as the major metropolitan city of Minneapolis. As such, Brooklyn Park Police experiences a ripple effect from events in the twin cities metropolitan area. For instance, when the Minneapolis Police Department was investigated by their city conduct review board for allegedly ordering emergency medical workers to administer ketamine to call subjects (Mele, 2018), BPPD conducted their own internal review of the issue to ensure they were engaging in safe and legal response methods[3].

Figure 1: Brooklyn Park within Hennepin County (left), and Hennepin County within Minnesota (right)



Accessed March 5, 2019 from https://en.wikipedia.org/wiki/Brooklyn_Park,_Minnesota

[2] https://www.brooklynpark.org/quick-facts/
[3] Observed during Summer 2018 BPPD internship

The US Census Bureau estimates Brooklyn Park's foreign-born persons population at 23.0%, over two thirds higher than the national average (UCSB, 2017). Brooklyn Park has the highest concentration of Liberians outside of Liberia itself, and the city population is estimated to be 10% Liberian[4]. Brooklyn Park is a racially diverse city overall, with the White alone population making up less than the majority of the total population. As the case data later in this background will show, ethnic and racial diversity may be an important local factor in suicidality.

Median household income is $68,274, and per capita income is $28,514, reflecting concentrated wealth distribution. While BPPD does not track income data on call subjects, this concentration is important to consider when anticipating subject cost for police interventions.

Table 1: Brooklyn Park 2017 US Census Annual Estimate Demographics

Category	**Value**
Population estimate, July 1, 2017	80,581
Race/Nationality	
White alone, percent	48.8%
Black or African American alone, percent	27.8%
American Indian and Alaska Native alone, percent	0.5%
Asian alone, percent	17.3%
Native Hawaiian and Other Pacific Islander alone, percent	0.1%
Two or More Races, percent	3.5%
Hispanic or Latino, percent	6.2%
Foreign born persons, percent, 2013-2017	23.0%
Language other than English spoken at home, percent of persons age 5 years+, 2013-2017	28.4%
Health	
With a disability, under age 65 years, percent, 2013-2017	7.2%
Persons without health insurance, under age 65 years, percent	10.1%
Economic	
Median household income (in 2017 dollars), 2013-2017	$68,274
Per capita income in past 12 months (in 2017 dollars), 2013-2017	$28,514
Persons in poverty, percent	10.5%

Reproduced from https://www.census.gov/quickfacts/brooklynparkcityminnesota

Current Policy Landscape

BPPD officers are bound by both Minnesota statute and internal department policy regarding the involuntary hold of subjects for emergency psychiatric evaluation.

Minnesota statute 253B.05, Subdivision 2 outlines officer authority to order involuntary transport holds (see Appendix A for full statute):

(a) A peace or health officer may take a person into custody and transport the person to a licensed physician or treatment facility if the officer has reason to believe, either through direct observation of the person's behavior, or upon reliable information of the person's recent behavior and knowledge of the person's past behavior or psychiatric treatment,

[4] https://www.brooklynpark.org/our-sister-city-kakata-liberia

that the person is mentally ill or developmentally disabled and in danger of injuring self or others if not immediately detained.

Threat to self is the standard threshold by which officers issue emergency evaluation transports for suicide-related calls. This is currently interpreted broadly by the BPPD, with high use of transport holds in both suicide-related and in general mental health crisis calls (incorporating "threat to self or others" in the latter decision).

BPPD policy 408 deals with emergency holds (see Appendix B for full policy), and mainly gives direct reference to the above 253B.05 statute. Section 408.4 clarifies that when deciding on whether to complete an application for 72-hour hold, officers should consider:

- Available information that might assist in determining the cause and nature of the individual's action or stated intentions
- Community or neighborhood mediation services
- Conflict resolution and de-escalation techniques
- Community or other resources available to assist in dealing with mental health issues.

Case report narratives give minimal insight on an exclusively proof-positive basis to the frequency at which officers investigate these information pieces—an officer explicitly mentioning community mediation in a report confirms that they explored this option, but not mentioning mediation does not confirm they didn't look into it. The policy also notes that officers may ask subjects if they would like to go the hospital voluntarily, but "If at any point the individual changes his/her mind regarding voluntary evaluation, officers should proceed with the application for a 72-hour hold, if appropriate." This section of the policy complicates the status of "voluntary" transport holds. While many voluntary transports may be the result of officers encouraging an open conversation with the subject to help them realize they would like to go to the hospital for evaluation, many subjects may opt to voluntarily commit themselves on the basis that they would be sent involuntarily otherwise. For cases involving a minor as the call subject, the subject's guardian has authority to consent to a

Response Options

Consider a "welfare check" call BPPD receives from 911 dispatch with non-specific claims from the caller that her brother is agitated and off his depression medication. An officer arrives on-scene and interviews the call subject, who confirms he hasn't been taking his medication and states that he's "just can't go on like this." This situation presents a decision point for the officer to discern the extent of suicidal risk. Under the four proposed models:

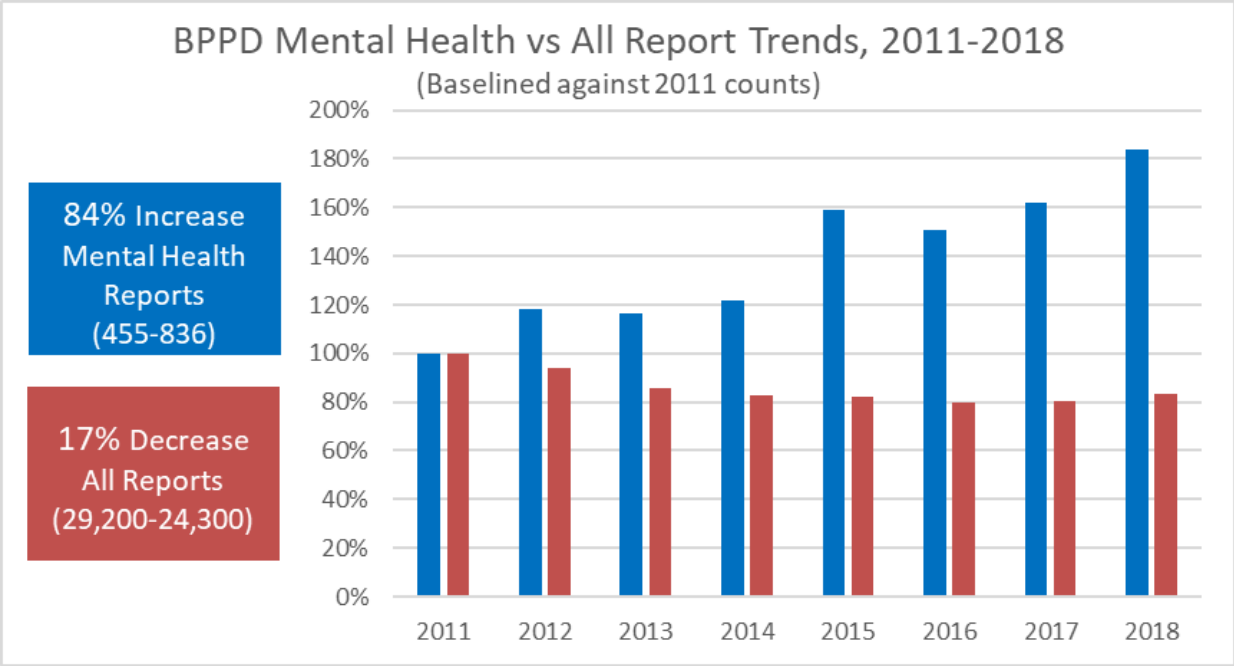
1) A CIT officer would interview the subject, using interpersonal skills as vetted by their training and the community to decide whether to order a transport hold.
2) An officer would conduct C-SSRS tool questioning, and initiate a transport in the case of a medium to high risk result where the subject states intent to harm themselves.
3) An on-scene clinician based out of the PD would oversee subject risk assessment, using their certified authority and expertise.
4) North Ambulance would be called to the scene, and a clinician based out of the ambulance would oversee interviewing and observing the subject for risk assessment, using the same authority and expertise.

"voluntary" transport hold even when the subject does not wish to go to the hospital voluntarily. Involuntary transports in the case of minors occur only when the subject's guardian does not agree to the transport. Given these complexities to voluntary transport status, the community and legal system may ultimately view the values at tension in the two dispositions in the same lens.

BPPD Mental Health Initiative[5]

After discovering a disproportionate increase in mental health related reports compared to their overall caseload, BPPD began a mental health initiative to respond to this growing need.

Figure 2: BPPD Mental Health Report Trends



Their 2019 plans include enlisting a dedicated mental health clinician to the department for case follow-up, a full-time mental health assigned detective, and a part-time data intern for data analysis. In 2018, they amended their involuntary transport hold form to clarify reasons for hold and improve trackability of hold data (see Appendix C for form). These plans can be expected to impact suicide-related call response. The dedicated mental health clinician can triage prioritized subjects to mental health services based on local capacity, the detective can oversee training and compliance for mental crisis/suicide-related changes in policy and protocol, and the data intern can assist in establishing the frequency of suicidal risk in BPPD calls through historical case review. The new transport hold form has specific checkboxes to indicate subject "suicide attempt" and "suicidal ideation", as well as related signs of suicidal risk such as "indicators of depression," "expresses no hope," and "recent/pertinent hospitalizations." The form was developed in tandem with ambulance directors of North Memorial Hospital and nearby city police departments to ensure consistency across the local hospitals' areas of service.

[5] Information and data presented in this section and "Existing Departmental Case Data" were gathered in person during my 2018 summer internship with BPPD, or in follow-up conversations with the department.

Fifty-three (49%) of the department's 108 sworn officers are trained in nationally recognized 40-hour Crisis Intervention Team (CIT) training, focusing on interpersonal and analytical skills to manage on-scene mental crisis and suicide risk situations. Trained officers are evenly distributed across the department's patrol shifts. For context, the National Alliance on Mental Illness recommends that 25% of sworn officers in every police jurisdiction complete CIT training (NAMI, 2019). The department is currently training officers at a rate of roughly 10-12 per year.

Existing Departmental Case Data

Trackable BPPD data on "suicidal threat/ideation" and "subject injure/attempt to injure self" is currently available for 2017, following an initial manual review of "mental health-related" cases categorized as "mental health/crisis hold," "overdose," "suicide," or "suicide attempt" (this set of 2017 reviewed cases will be referred to as MH2017 from this point onward). Designations were based on case report narratives written by officers on-scene for each encounter. Future suicidality calls will largely be captured under the revised transport hold form, where officers mark reason for hold order. Suicidal ideation was involved in 353 of the 731 MH2017 cases, and 197 cases included the "subject injure/attempt to injure self." Accounting for overlap 366, of these cases involved either ideation or injure/attempt to injure. Note that during the date range of these cases, 27 officers had completed CIT training.

Table 2: BPPD MH2017 Suicide Related Case Data Summary (N=366)

	No. Cases	Percent of Cases
CIT Officer On-scene	208	56.8%
Call Type		
Suicidal Ideation	353	96.4%
Injure/Attempt to Injure Self	197	53.8%
Both	184	50.3%
Disposition		
Transport (Total)	342	93.4%
Involuntary Transport	189	51.6%
Voluntary Transport	153	41.8%
Resolved on scene	19	5.2%
Deceased on arrival	4	1.1%
Mobile Crisis Referral	1	0.3%
Subject Profile		
Female	233	63.7%
Adult	252	68.9%
Repeat	90	24.6%
Non-white/race unspecified	187	51.1%

The vast majority of case dispositions (93%) for MH2017 cases identified as suicide-related (N=366) resulted in a hospital transport—either voluntary or involuntary. Among these transports, 55% were involuntary. Cases with and without a CIT trained officer on-scene have the same likelihood of resulting in a transport, and the same ratio of voluntary to involuntary transports (see Appendix D for Stata regression results). Five percent of cases were resolved on scene, and in the 4 "suicide" case types, subjects were deceased upon officer arrival.

Sixty-four percent of cases involved a female primary subject, and 69% involved subjects age 18 or older. Thirty-eight percent of cases involved a black subject—a disproportionately high rate considering that Brooklyn Park's overall population is 28% black, and that national statistics indicate suicidality occurs most frequently among white and Native American populations (CDC, 2016). This disproportion may be because immigrants tend to have higher rates of suicidal risk than native-born citizens (Forte *et al*, 2018), and Brooklyn Park's black population has a higher proportion of immigrants than average. BPPD does not have data to confirm this theory, but regardless the trend indicates that culturally relevant intervention methods of tackling suicide risk are necessary. Twenty-five percent of cases involved a repeat subject. Some of these repeat subjects may remain high utilizers regardless as to BPPD's policy decisions, but others may benefit from connection to services other than the emergency department and lower their police utilization under a new response plan.

Fifty-seven percent of calls included a CIT trained officer on-scene. The exact relationship between the proportion of officers CIT trained and the proportion of suicide-related cases covered is uncertain; based on the 57% on-scene rate with a 25% officers trained rate, I assume that the on-scene rate will approach 100% by 2023 as training increases, with a decreasing per-unit trained rate benefit gained to account for diminishing marginal returns (see attached Cost Effectiveness Analysis for details on annual assumptions).

While the MH2017 data offers insights to cases that were explicitly labeled as mental health related, these cases do not inform the larger prevalence of mental health crisis and suicidal risk across other case types. A second manual case review was performed to gauge frequency of mental health issues in BPPD's overall caseload. Initial findings based on case narrative text searches and follow up narrative reviews suggest that the top 3 case types most frequently associated with mental crisis components are welfare checks, assault, and misdemeanor domestic assault. While these cases track suicidality to some degree, the department has not historically tracked suicidal risk data aside from cases marked as "suicide" or "suicide attempt." Cases of marginal suicidal threat without clear evidence of attempt are not captured within these case types. As BPPD has not historically used formal suicide risk assessment models, it is impossible to say what the "true" rate of transports should be for this population. It is also difficult to sort true voluntary transports from cases where the subject's only choice was to go voluntarily rather than involuntarily.

The MH2017 dispositions include one "mobile crisis referral." Hennepin County Health Services oversees Community Outreach for Psychiatric Emergencies (COPE), a 24/7 mobile crisis unit of mental health clinicians that respond to crisis calls[6]. They are able to perform on-scene clinical assessments, refer subjects to inpatient treatment and local services, and on a limited basis admit patients to a crisis shelter for case management. Because the service is county-wide, they see a much higher call volume and have longer transportation times than city services. COPE receives roughly the same number of suicide-related calls in a month that BPPD sees per year and is operating at full capacity (Healthy Hennepin, 2015).

North Memorial-Robbinsdale is the main hospital for Brooklyn Park[7]. Within the same business network, North Memorial Ambulance Service (NMAS) is the designated ambulance services provider for Brooklyn Park and much of the surrounding county region (see Appendix E). Fire, rescue, and police share overlapping scope of first-responder service in response to medical emergencies. BPPD

[6] https://www.hennepin.us/residents/emergencies/mental-health-emergencies
[7] https://northmemorial.com/

and NMAS often respond to the same calls to ensure the fastest subject coverage possible; typically, this involves the responding BPPD officer assisting in interviewing subjects and related parties, ruling out criminal activity, and confirming that NMAS or fire responders have taken control of the situation. In the case of mental health and suicidal risk calls, BPPD completes a transport hold form for EMS to transport subjects to the evaluating hospital of choice. EMS responders are then responsible for the subject's wellbeing for the duration of the ambulance ride.

Minneapolis Police Department Lawsuit

In the ongoing case *Graham v. Barnette*, a US District Judge has initially ruled that the Minneapolis Police Department's mental health involuntary hold policy is a violation of the Fourth Amendment protection against unlawful seizure because "reasonable belief" of threat to self or others is a "less exacting standard than probable cause.[8]" Per the presiding judge's ruling, the case includes a constitutional challenge to the above cited MN statute 253B.05 under the same reasoning.[9] If upheld in trial, this decision would hold police departments to a higher standard of judgment for involuntary transports, requiring that harm would *probably* occur (greater than 50% chance) without the intervention. The presiding Minnesota District court holds jurisdiction over Brooklyn Park, so rulings in this case will directly affect BPPD. This judicial action motivates BPPD to ensure that their standards and justifications for emergency holds are satisfactory not only to their public but also in the eyes of the courts.

[8] http://www.startribune.com/ex-minneapolis-officer-mohamed-noor-dismissed-as-defendant-from-mental-health-hold-lawsuit/502813802/

[9] Per conversation with the prosecuting attorney representing Graham in this case, April 29 2019.

Review of the Literature

Introduction

This review of the literature examines the role of police intervention in incidents in which the call subject exhibits suicidal risk factors such as performed or intended self-harm, suicidal threat or ideation, or actual suicide attempt. As police are often externally constrained by the capacity of local mental health services in successfully referring subjects to treatment, it is reasonable to focus on initial risk assessment as an intervention point where the police do have a large degree of control. While there is a large body of literature advocating for wholly removing police from the role of mental health crisis response, this review will operate under the assumption that this paradigm shift is not achievable in the short term. An understanding of the scholarly landscape at the current real-world scope for police roles in suicidality within the emergency response system is necessary. Randomly assigning suicide prevention and assessment services presents a stark ethical concern. Over-assessing suicide risk can strain psychiatric service capacity, accumulate unnecessary financial costs to call subjects, and interfere with the civil liberties of individuals sent to hospitals against their will. Under-assessing suicide risk could most notably lead to increased suicides and limited ability to connect individuals in crisis to services. Also due to the decentralized structure of police departments across America, the external validity of other departments' efforts is always a relevant question. Different budgets, officer protocols, jurisdictional sizes, local and state policies, and community needs are involved from department to department with limited federal regulatory oversight, which imposes a limit on intervention impact conclusions we can carry from one department to another.

While a critical knowledge gap in this issue is the precise prevalence of suicidal risk in police call subjects, an estimated 10% of police encounters involve people with mental illness (Watson *et al*, 2010), a population at high risk for suicidal intent (Schwartz-Lifshitz *et al*, 2012). Furthermore, suicidality is not limited to individuals with a history or current diagnosis of mental illness; 54% of suicide deaths occurred among individuals without a known mental health condition (CDC, 2016). Regarding the rate of suicide risk as call type from total mental health related calls, Brooklyn Park's 49% rate from the MH2017 analysis is consistent with a 49% mobile crisis unit call response rate for suicidal ideation out of total calls in existing literature on the Nova Scotia Police (Kisely et al 2010), and 55% for welfare check due to suicidal behavior with the Victoria, Australia Police (Lee et al 2015). Departments often do not have suicidal risk response strategies distinct from general mental health crisis response which can prove inadequate to the unique challenges of suicidal call subjects. Current and increasingly prevalent methods to assess suicidal risk include implementing standardized suicide risk assessment tools, training officers in nationally recognized Crisis Intervention Team (CIT) response strategies, and collaborating with mental health clinicians on-scene. A recurring theme in the literature is that downstream success in any assessment method is most directly tied to the ability to connect suicidal subjects to sustained treatment and support services.

The Landscape of Suicide Risk Assessment

It is helpful to first frame current models of clinical and emergency-based suicide risk assessment. The literature universally recognizes suicide attempt as reason for call with persistent intent to die as the highest indicator of suicide risk, meriting mandatory emergency hospital evaluation. A primary struggle in field assessment is finding the appropriate connection between "ideation" and "intent." This margin is important for evaluating situations where lower-tier responses than emergency

transport may be appropriate. Terminology and categorical distinction around suicide-related thoughts and behavior is highly variable, complicating the relationship between scholarly studies and consistent indicators of suicidal attempt. In 1979, Beck *et al* developed the 19 item Scale for Suicide Ideation (SSI) as an early attempt to quantify and assess intent. They categorized 3 broad factors of "active suicidal desire," "preparation," and "passive suicidal desire" for ideators. In a meta-analysis of 37 longitudinal studies, Ribeiro *et al* (2015) found that consistently across clinical settings and general populations, and controlling for publication bias, suicidal ideation had a weighted-mean odds-ratio of 1.89 in predicting suicide attempt. "Ideation" itself is a subjective term and does not necessarily incorporate expression of intent versus the simple cognitive process of thinking about suicide, and the individual studies comprising this meta-analysis used different lines of questioning at different levels of predictive validity to define ideation.

The most commonly used assessment tool is the Columbia-Suicide Severity Rating Scale (C-SSRS, see Appendix F) developed in 2007 (Columbia Lighthouse Project, 2018). The C-SSRS has risen to the status of "gold standard" in the field of suicide assessment and is the most commonly utilized tool in hospital, EMT, and school settings. Although at least 10 police departments have reached out to the tool's developers to discuss adoption, there is no verified use of the C-SSRS by law enforcement at this point. The assessment focuses on the evaluator directly asking the subject about details regarding patterns in suicidal thoughts/intent, depressive moods, and available means of self-harm. The instrument has been validated for: strong inter-rater consistency between mental health assessors and first responders[10] (Lucas *et al,* 2014); increased suicide attempt detection in hospital settings (Arias *et al,* 2014); and high sensitivity and specificity for classification (Posner, *et al*, 2011). Giddens *et al* (2014) express doubts about the C-SSRS due to ambiguous wording/category structuring and failure of the tool to examine the full range of suicidal ideation, leading to liability for frequent false negatives (overstating subject risk for suicide). There is not universal consensus that suicide risk assessment is an effective or valuable intervention for individuals presenting warning signs. Harris *et al* (2017) find that defining risk based on binary measures of suicidal thoughts and/or suicidal attempts is inadequate in predicting risk of future suicidal behavior. The authors prefer assessment models that incorporate "intent to die" scales into measures on thoughts and attempts. Tanguturi *et al* (2017) find that even among clinically trained psychiatry residents using the C-SSRS in a hospital evaluation setting, there is a large documentation gap in recording suicidal ideation and relevant diagnostic covariates. Viewing these findings in conjunction, the C-SSRS and other tools which assess risk beyond a binary scale and incorporate intent to die can be effective in on-scene response, under the caveat that officers are careful to provide full documentation and ask appropriate questions to complete the assessments.

General Police On-Scene Response Options

Police can assess suicide risk on-scene in the presence of subjects by the immediacy of intent, specificity of the plan, availability of means, and lethality of means (Clark, 1998; Gilliland & James, 1993; Greenstone & Leviton, 2001; Miller, 2006). Bryan and Rudd (2006) emphasize the importance of immediacy in assessment to maximize the efficacy of intervention and clarity of suicidal intent.

While first responders are unavoidably *de facto* mental health assessors when they arrive on scene (Petrila and Swanson, 2010) and often have vast experience in informal assessment, they do not take the place of mental health experts and clinicians. Often, official police authority allows them to:

[10] i.e., mental health clinicians will give a subject roughly the same score a first responder would give, and vice-versa

A) arrest subjects who they believe have demonstrated a threat to others,
B) place subjects on a mandatory hold for psychiatric evaluation,
C) informally de-escalate the situation by communicating with the subject, referring to appropriate resources or developing a crisis plan on scene, or
D) designate the call unfounded/resolved on scene if the call encounter establishes firm evidence that there was no true suicidal intent.

While clinicians have no authority in the area of A, they are better equipped to make decisions surrounding B, C, and D. Mental health literature has thoroughly established the exacerbating effects of arrest and imprisonment on people in mental crisis (Binswanger *et* al, 2011; Oliffe *et al*, 2018; Schnittker *et al*, 2012). Psychiatric evaluation, while more guided toward a treatment model, has its own shortcomings in long-term care and preservation of patient wellness when used as a blanket response to suicidality. Options C and D in the above provide an avenue of least potential harm to subjects when carried out appropriately. Wood *et al* (2016) find that these "gray zones" of police resolution which do not involve an official disposition against the subject are effective when the officers involved use local knowledge of the situation, communicate empathetically to negotiate peace, and focus on improving short-term subject outcomes with follow-ups in place. When enlisted, on-scene clinicians are able to provide expert assessment to encourage informed, impactful action and resolution. However, even on-scene clinicians are constrained by the availability of local mental health resources in providing referrals to services, leading to emergency psychiatric evaluation as a pragmatic default for resource-strained communities.

Mandatory hospital transport for psychiatric evaluation itself suffers from capacity issues, and limits on long-term effect. In the US, there are about 11 psychiatric hospital beds available for every 100,000 people (Torrey, 2016). Minnesota ranked 49th of the 50 US states for psychiatric bed capacity at 3.5 per 100,000 (Fuller *et al*, 2016). Due to this extremely limited capacity, hospitals are positioned to prioritize immediate triage of mental health crises over long term psychiatric planning and care. This service constraint is particularly problematic for suicidal patients, when suicidal ideation and past suicide attempts are a strong predictor of future suicide attempts (Nordström *et al* 1995; Brown *et al* 2000; Posner *et al* 2011). It is important to note that low socioeconomic status is an acknowledged factor in increased suicidality risk (Li *et al*, 2011). Given this pattern, we must examine possible intervention models for their impact on subject cost, considering the compounding effect of costly services on this target population. Mandatory ambulance transport and emergency room hospital stays for evaluation can have severe budgetary consequences for patients with low SES. Guzman *et al* (2018) note that while emergency department (ED) treatment can lead to positive outcomes for suicidal patients, there are also frequent down sides. Disparities in treatment and evaluation, and underutilization of therapeutic care referral resources may lead to worse outcomes for this population. Stressors within the ED system may contribute to negative downstream impacts on suicide risk.

A common referral intervention strategy is to connect subjects to suicide prevention "hotlines" as a means of triage. In a follow-up study on National Suicide Prevention Lifeline (NSPL) callers, 80% claimed that using the NSPL prevented them from killing themselves and 90% claimed that it kept them safe (Gould *et al*, 2018). In 2007, all NSPL network hotlines adopted a risk assessment model based on 4 key facets of suicidal desire, capability, intent, and barriers to execution (Joiner *et al* 2010). The literature notes a pattern that positive impact from hotline referral is contingent upon access and empathetic quality of the hotline representative (Rhee *et al,* 2005). Hotlines present one referral method available for officers on-scene, when suicide risk is present but not immediate enough

to merit mandatory hospitalization. Unfortunately, a general lack of data on this method given caller confidentiality protections limits conclusions on effect.

Police Mental Health Collaboration Models

Police Mental Health Collaboration has been a general movement toward expanding the mental health capabilities of police departments through a variety of models: Crisis intervention teams, co-responding law enforcement officers and mental health clinicians, mobile crisis teams composed of mental health responders, case management teams who review cases post-encounter for services referral, and hybridized models drawing from the aforementioned (Police-Mental Health Collaboration Toolkit, 2017). The Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA) is a major federal indication of police mental health trends expanding, as it appropriated funds for police mental health training and resourcing and led to many mental health collaboration grants under agencies such as the Bureau of Justice Assistance (CSG, 2008). Landmark case studies for these models include the 1998 Memphis CIT model, the 1993 Los Angeles Mental Evaluation Unit co-responder program, Houston's 2009 Chronic Consumer Stabilization Initiative, and Toronto's 2000 Mobile Crisis Intervention Teams (Police-Mental Health Collaboration Toolkit, 2017). CIT is considered state of the art law enforcement officer training for mental health crisis management. Case management teams are less valuable in suicide risk assessment, as they would not be available for initial on-scene evaluation or decisions regarding hospital transport. However, they are available for post-encounter connection to services. The core philosophy behind all of these collaborative approaches is that law enforcement officers will divert mental health related case response to clinical experts who can conduct individualized assessments and dispositions for call subjects. Due to the highly decentralized structure of police departments throughout the nation, adoption of these models has been piecemeal based on local priorities and resource capacity.

The most widespread mental health crisis training program for law enforcement officers is Crisis Intervention Team (CIT) training. The University of Memphis CIT Center estimates that there are 2,645 local CIT programs across the nation, with varying levels of officer training rates.[11] Scholars have noted mixed results on this program as it relates to the broader population of subjects with mental illness. Also, the availability of both CIT and non-CIT groups to compare impact is rare due to departmental policies either requiring CIT training for the entire police force, or delegating mental crisis response to CIT officers. Most scholarly work around CIT has focused on use of force and arrest rates. The original Memphis CIT model prioritized pre-booking jail diversion of mentally ill subjects to treatment services, an issue which is less frequent in suicide-related subjects who often have not committed a crime. Officers with CIT training tend to utilize arrest less often in encounters with mentally ill and suicidal subjects (Kubiak *et al*, 2017; Compton *et al*, 2014). CIT training can also improve officer knowledge, perception, and attitude regarding mental illness, contributing to improved communication and outcomes with call subjects (Ellis, 2014). A study by Morabito *et al* (2012) which was able to separate officers into clustered district-level CIT treatment and control groups reached an illuminating conclusion that while CIT training did not lead to a statistically significant reduction in force against mentally ill subjects in general, CIT reduces officer use of force against subjects with mental illness who physically resist officers on-scene. This distinction speaks to the ability of trained officers to maintain composure under pressure in escalated situations. Watson *et al* (2011) found no effects on arrest outcomes by CIT status for Chicago PD, and emphasized the positive impact from CIT derives from officers' increased ability to connect subjects to local mental

[11] http://www.cit.memphis.edu/

health services and resources versus "resolving on scene" and taking no additional action for subjects. The positive findings on empathetic interaction and ability to connect to services are most relevant and important to suicide risk. While CIT training is a promising intervention for general mental health crisis triage, it does not qualify law enforcement officers as expert clinicians or comprehensively prepare them to diagnose and assess suicidality on an individual level. The evidence does present a clear preliminary indication that CIT training leads to better on-scene communication, awareness, and empathy with mental crisis subjects compared to officers without such training. It is reasonable to predict that as a department expands the proportion of their force trained in CIT, they will more consistently respond to mental crisis calls with stronger interpersonal skills and situational understanding.

There is evidence that CIT works best in combination with mental health expert engagement. Holland and Tran (2010) discuss the frequency of hospital transport hold subject linkage to mental health services through Mobile Crisis Teams (MCTs) consisting of on-scene social worker and police collaborative responders trained in CIT. Compared to MCTs, CIT-trained officers alone had a lower linkage rate. Suicidal risk as the reason for hold also reduced the likelihood of linkage. The study notes that the data did not differentiate suicidal risk, and further specificity in future analyses could reveal a difference in linkage outcomes among cases of suicidal thought only, inflicted self-harm, stated intent to die, etc. Takeaways from this study are that a) suicidality is a specifically complicated case for emergency psychiatric evaluators to connect to further treatment and services, so policymakers cannot conflate intervention success with other diagnosis linkages to success in suicide risk and b) even when officers are CIT-trained, successful subject linkage is more likely when police respond in conjunction with mental health clinicians.

An alternative non-clinical collaboration model for mental health policing is community engagement. Community policing is a broadly defined and widespread theory emphasizing citizen trust building and engagement (Bureau of Justice Assistance, 1994). Involving the citizenry as co-creators of policy by soliciting their input and answering questions in public meetings can improve buy-in toward police action. Literature on procedural justice notes that public perception of police legitimacy can derive just as much from a sense of fairness in officer procedure as from fairness in disposition outcomes (Tyler & Huo, 2002; Tyler, 2004). Poythress *et al* (2002) found that this framework of procedural justice influencing legitimacy holds true to police subjects with mental illness. Separate from on-scene patrol procedure, departments can engage with the issue of suicide risk assessment on an administrative level and solidify policy alongside the community.

Project Alternatives

Informed by BPPD's background around the Mental Health Initiative and policy landscape as well as the preceding academic literature in suicidology, I propose the following alternatives to address the issue of assessment inconsistency and informality. Alternatives are designed to be implemented exclusively, selecting one for final recommendation based on evaluation against criteria outlined later in this analysis.

As an overarching immediate-term recommendation, BPPD should consider a protocol to check if on-shift CIT officers are available to respond when suicide-related calls occur. Understanding that the on-duty Patrol Sergeant will have the best in-the-moment understanding of factors contributing to this decision, the protocol may be most valuable as a loose "if possible" objective to place the most thoroughly trained officers on-scene. Setting this priority at the Sergeant level may increase CIT officer coverage of suicide-related cases at minimal cost to operational efficiency. Under all models, officers could continue to follow current policy best practices to determine the subject's family/community resources, attempt a plan to contact their physician, etc. They could also ask the subject if they would like to voluntarily go to the hospital for psychiatric evaluation. The BPPD clinical case manager would be available based on capacity to connect the subject to further support services.

There are multiple contingencies and developing efforts that could merit a *status quo* trend toward improving suicide risk assessment. Primary internal developments include: the newly formed "mental health unit" consisting of the dedicated officer, clinician for case follow-up, and intern managing case data; more detailed forms and documentation practices for the Request for Emergency Evaluation; and ongoing expansion of CIT officer training. If the projected positive impact of these events is high enough, BPPD may not need to commit further resources to on-scene suicide risk management at this time and could instead focus on raising public awareness of current efforts.

Alternative 1: Host Community Meetings to Publicize Current Developments

The first alternative largely hinges on current momentum positively impacting the consistency of assessment. This option is close to the traditional policy analysis approach of a "Let Present Trends Continue" alternative that involves proposed action, with an added initiative to incorporate existing personnel resources and slightly build upon present trends. Instead of changing on-scene interventions beyond current developments, the community meetings approach focuses on process transparency and trust-building with the community to improve formality and reduce liability. The Joint Community Police Partnership (JCPP) is a Hennepin County sponsored collaboration involving six local cities. The Partnership includes among its goals to: "act as the bridge between the police and the community; facilitate/lead community meetings, and organize events and training for both police and the community; and act as personal 'ambassadors/eyes/ears' to and for community groups" (Governor's Council 2017, 8), making it an appropriate venue for publicly vetting BPPD's risk response strategies. While anyone could attend, City Hall could extend an invitation to Minnesota's NAMI branch and advertise the events specifically for friends and family of those with mental illness. BPPD administrators and the district attorney's office would present an overview of CIT response and assessment strategies, relevant departmental policy and Minnesota statues, and subject rights involved in mental health related calls. They could summarize the developing trends expected to improve assessment, and address the concerns of the public in person. In this way, they will formalize their assessment policy by publicizing and clarifying their strategies to the citizenry. The community

outreach officers could hold ongoing, less formal community meetings every two months thereafter to keep an open dialog with citizens over this issue. This intervention is critical because expanded CIT training is not immediately apparent to the public as a formal response to suicide risk calls, compared to clinicians on-scene or formal clinically vetted suicide assessment forms. In addition, the meetings could build co-operation and information sharing with friends and family of subjects. BPPD could partner with public health educators, mental health experts, and local medical centers to develop free public programming to improve on-scene communication in mental health cases. Officers could then have more productive investigations when asking on-scene third parties to report on subjects' suicidal behavior, reducing the risk of an imprecise assessment. This strategy could be especially useful in pediatric cases where the parents have consistent and intimate daily interaction with their children, but do not necessarily know how to look out for or interpret signs of suicidal risk. The broader mental health scope of the programming may help attract community members who wouldn't attend a session that only covered suicide risk, and the subject matter experts involved between the two topics often overlap. Additionally, the department could expect improvements to non-suicide mental health encounters as a benefit to this programming.

Potential downsides of this option include lack of actual change of response methods, beyond fine tuning tactics based on citizen input. Meetings may increase community tension if their expectations for assessment don't align with police intervention authority. Because CIT coverage of suicide-related cases will potentially not reach 100% until the entire department is trained, there is a lingering coverage consistency issue that must be negotiated with the public. This option also relies on the community trusting CIT training, transport documentation updates, and case manager triage as sufficient response formalization—or at least be able to express and internalize any gap between what they expect and what current strategy provides.

Alternative 2: Implement a Formal On-Scene Suicide Risk Assessment Tool

If officers use the Columbia-Suicide Severity Rating Scale to perform on-scene suicide risk assessment, they will have more consistency and formalized supporting documentation in their disposition decisions. This option would not require expanding the current police force/supporting personnel, but rather training the existing police force in tool use. The department's Mental Health Unit could oversee training sessions in the rollout of the tool, and work through field implementation issues as officers adapt to this new practice. Officers would have a standard measure of designating the risk level of suicide-related cases, and pre-defined strategies and questions to use on-scene. Officers could share completed assessments with emergency medical services and give them some initial documentation to assist in psychiatric evaluations. They would also provide a copy of the assessment to the subject, consistent with procedure for the current transport hold form. For tracking and archival purposes, BPPD could keep record of completed assessments in the case file system. Prior to full BPPD CIT training completion, department policy could either grant assessment authority to all patrol officers, or give preferential responsibility to CIT-trained officers. There would be clearly documented evidence that a subject was asked about suicidal thoughts and intents on-scene, with their provided response.

A key downside of this approach is that expertise would reside in the assessment *tool* versus the actual *assessor*. The form would not reach the threshold of clinical assessment when used by law enforcement officers, and the public would still have to trust police as triage agents in mental health decisions. BPPD would be relying on external feedback from nationally recognized law enforcement best practices or local mental health agencies to inform them if the C-SSRS became replaced by another assessment tool, as BPPD officers and administrators themselves are not able to clinically

validate the tool against new instruments as they emerge. The department may have to re-train and re-implement a new tool if the C-SSRS does become outdated.

Even in best-case use where officers are well-trained in the tool and using it according to its intended purpose, there is a degree of subjectivity in assessing that somewhat compromises consistency. Officer personalities and the necessary amount of situational adjustment involved in empathetic human interaction could impact assessment results.

Alternative 3: Hire BPPD Co-Responding Clinicians

This approach diverts assessment responsibility to co-responding licensed mental health clinicians such as social workers and counselors. Clinicians would arrive on-scene with officers, and would be available on-call if an encounter develops into a suicide/mental health related case. Because of their licensure, they would be professionally certified not only to perform formalized suicide risk assessment but also to perform general mental health clinical assessments and connect subjects to mental health services aside from emergency department psychiatric evaluation. Officers would maintain law enforcement authority over encounters, but would not be required to determine the need for an involuntary transport when a clinician is present. In cases that escalate and present a safety threat to clinicians, officers could take over and use appropriate de-escalation methods. Following implementation trends from other departments[12], BPPD could begin with a one-year pilot program consisting of 2 co-responding clinicians and expand toward full coverage capacity after the pilot. This option incurs the most upfront financial cost by far for the department. As part of their Behavioral Health Justice Initiative, the Hennepin County Health Services Department has entered a cost-sharing agreement with the Minneapolis Police Department to support their co-responder pilot program (City of Minneapolis, 2019). BPPD could enter a similar agreement with the county, but would still need to secure funding for additional personnel in this scenario. The Mental Health Unit would need to budget to train clinicians and selected co-responding officers on field tactics[13]. This alternative hinges on the responding capacity of newly enlisted clinicians and a cost/consistency tradeoff in the number of clinicians hired as the program expands. The department may still need to require officer suicide risk assessment via CIT officers when clinicians are not available.

Alternative 4: Cost-Sharing Agreement for Mobile Crisis Unit

This alternative leverages potential hospital cost and liability savings to outsource suicide risk assessment to ambulance responders. Hospitals could dispatch co-responding mental health clinicians with EMTs. Mobile Integrated Healthcare is an EMS model emphasizing on-scene clinical treatment. Seeking to justify their own transport and intake decisions, North Memorial has been receptive to initial communications on this strategy[14]. The limited capacity of emergency room beds for mental/behavioral health patients is a standing item in the Ambulance Medical Directors Subcommittee of the Hennepin County Emergency Medical Services Council.[15] North Memorial is both the primary ambulance service and hospital for adult emergency psychiatric referral in Brooklyn Park, and their ambulances provide transport to all main hospitals in the Brooklyn Park service area. Assuming they would consider bottom-line business driven analysis of their liability, they may feasibly

[12] Citing recent local examples, St. Paul, Minneapolis, and Duluth police departments all initiated co-responder pilots which later expanded. BPPD's newly hired clinical case manager is also in place as a 2-year pilot project.
[13] Per correspondence (April 2019) with Colorado's Office of Behavioral Health Co-Responder Services Manager, it is standard practice under this model to concentrate training on co-responding officers versus the entire department.
[14] Per correspondence with North Memorial Risk Management Director, Aug. 2018
[15] https://www.hennepin.us/-/media/hennepinus/business/work-with-hennepin-county/ems/amd-proposed-agenda-2-26-19.pdf?la=en&hash=897700CDA635A0703AFCE2B40F898FF849EBDFA7

implement the desired policy changes if city police departments within their service area bear some of the costs. This option would require police or 911 dispatchers to make an initial determination that ambulance services should arrive to perform risk assessment, and the EMS directors would then assign a co-responder ambulance to the scene.

North Ambulance's Primary Service Area (the legal designation for ambulance service boundaries) covers a third of the county population and includes only 10% of the Minneapolis population (EMSRB, n.d.). Brooklyn Park is the largest city in their service, offering greater capacity for BPPD collaboration compared to Hennepin County COPE. Projected outcomes could be similar to Alternative 3, but in this scenario clinician oversight would largely be external to the police department in return for lower costs. North Memorial would take oversight of details for risk assessment, limiting BPPD opportunity to fine tune methods as a tradeoff for distancing their liability. The BPPD Mental Health Unit and administration would need to continue negotiations with North Memorial and provide police-housed information on suicide risk encounters to encourage hospital action.

Evaluative Criteria

The following five criteria will be used to consistently assess the relative merit of the project alternatives and select an ultimate policy recommendation. Options are evaluated on a 5-year (2019-2023) timeline, based on the Brooklyn Park city budget's 5-year lifecycle. Criteria scores are structured so that a "perfect" score for any alternative would be 100. Liability and cost (both in terms of cost effectiveness and time on-scene) are the highest priority for BPPD by a significant degree, so those three alternatives are weighted on a 25-point scale. Treatment impact and coverage are unweighted and considered secondary criteria in this analysis; while the ability to connect subjects to services and reach a broad population are important considerations, the Department currently needs to prioritize financial cost containment and expedient use of officer response time while maintaining public approval of suicide risk response methods. These secondary criteria are both scaled at 12.5 possible points, half the value of the primary criteria. Note that cost effectiveness and coverage are determined using a full cost effectiveness analysis (CEA), attached with this report. A budget narrative detailing assumptions of this CEA is attached is included in the appendix (Appendix G).

Treatment Impact

Many suicide-related call subjects have latent or diagnosed mental illness with unmet treatment needs. While the primary issue for BPPD is formalizing assessment to reduce liability and the capacity constraints of local mental health services are largely beyond their control, interventions toward suicide risk assessment should also be valued based on their potential to connect subjects in need of treatment to appropriate services. "Limited" impact alternatives would primarily determine only the appropriateness of a transport for emergency psychiatric evaluation, while "Clinical" impact alternatives have a clinical support component with an additional likelihood of connecting subjects to other appropriate mental health services and resources. Because there are encouraging present trends in this category with the addition of the BPPD Case Manager, Limited options will receive a score of 6.25 in this category versus a 0. In recognition of reaching best practice level of treatment impact, Clinical options will receive a 12.5.

Cost Effectiveness

This criterion will determine which alternative is expected to yield the highest quantified net benefit in terms of volume of formalized assessments against intervention costs (essentially, cost-to-coverage). Costs accounted for will include pre-committed expenses such as time spent by current staff, as well as new financial costs that would need to be incorporated into future budgets. This will be measured using a full cost effectiveness analysis appended to this report, deriving price estimates from appropriate academic literature, BPPD internal estimates, and government data reports.

Consistency of Coverage

Distinct from but related to cost effectiveness, this criterion examines the proportion of the department's suicide related cases each alternative is able to engage with over the next five years. This will be measured by the projected coverage rate of each option as calculated in the supplemental cost effectiveness analysis, and expressed as a percentage of total cases. A good alternative maximizes the proportion of cases which receive intervention, and minimizes variation in risk assessments from shift to shift, officer to officer, etc.

Time On-Scene

As BPPD expands the services they perform to assess suicide risk, officers will spend more time in subject encounters. This is a critical cost to the department, limiting capacity to respond to other calls. This criterion will be measured as the additional time spent on-scene per call for each intervention, compared to the baseline. The score for each option will be scaled relative to the other options. Due to the lack of available data on this criterion, I will draw time estimates from existing anecdotal input from other departments.

Public Liability

Tied to the formality of assessment, this criterion gauges the level of risk BPPD incurs in terms of community approval of the intervention. To gauge liability, I will compare the components of each intervention against NAMI's official "Criminal Justice and Forensic Issues" platform as a placeholder for the local mental health/suicide-affected community. A high scoring option for this criterion will have strong alignment with relevant NAMI positions and minimal conflict with their stated values.

Outcomes Matrix

	Treatment Impact (12.5 pts)	Cost Effectiveness (25 pts)	Consistency of Coverage (12.5 pts)	Time on-scene (25 pts)	Liability (25 pts)	Total
Community Meeting	No change against baseline, but new Mental Health Unit and expanded CIT training offer promising developments for "present trends" in this criterion. **(6.25)**	$20 Per case **(20)**	1826 cases NPV from 2019-2023 (91%) **(11.25)**	No additional time required **(25)**	NAMI recommends 20% police force CIT trained, BPPD is at 50% and climbing so baseline is moderate. NAMI also supports community-shaped policy for this option. **(15)**	**77.5/100**
C-SSRS	No change against baseline, but new Mental Health Unit and expanded CIT training offer promising developments for "present trends" in this criterion. **(6.25)**	$14 Per case **(25)**	2006 cases NPV from 2019-2023 (100%) **(12.5)**	Marginal (~5 minutes) extra time for assessment completion **(20)**	NAMI supports consistent officer identification and documentation of suicidal risk, if officers must be the ones assessing. **(15)**	**78.5/100**
BPPD Co-Responders	Ideal opportunity to connect to services on-scene via clinician assessment. **(12.5)**	$574 Per case **(5)**	1336 cases NPV from 2019-2023 (67%) **(8.75)**	Anticipated 20 mins extra time for clinician response methods **(7.5)**	Replaces officers with licensed clinicians on-scene to majorly mitigate liability, but retains administrative oversight. **(20)**	**53.75/100**
Mobile Crisis Unit	Ideal opportunity to connect to services on-scene via clinician assessment. **(12.5)**	$202 Per case **(15)**	1794 cases NPV from 2019-2023 (89%) **(11.25)**	25 mins extra time due to clinician interview and ambulance wait **(5)**	Ideal state for removing police from the equation, both on-scene and administratively. **(25)**	**68.75/100**

Evaluation of Alternatives and Recommendation

I recommend C-SSRS Assessment (Alternative 2) based on my analysis against the outlined criteria. Below is a summary of each alternative's scoring against all chosen criteria, to provide the basis for this recommendation.

Community Meeting

The on-scene response method for this option will be to maintain the status quo, so ability to connect subjects to treatment on-scene will not change from the baseline. Personnel costs for community outreach planning, hosting meetings, and follow-up contribute to the total option cost of $36,000 or $20 per case. Basing the measure on the CIT on-scene rate of suicide risk calls and incorporating the rising rate of officer training, coverage will be roughly 91% total with ascending year-to-year coverage. Because on-scene methods are not changing Time on Scene will not change from the present. Liability is somewhat high due to counting on community buy-in with present methods, but BPPD's CIT training rate is 2.5 times NAMI's recommended level.

C-SSRS

Treatment impact for this option is low. The CSSRS will identify low risk individuals for follow-up, but no additional support or assessment of mental health needs will be provided. Personnel costs consisting largely of department wide time spent in officer training contribute to a relatively low $28,000 total or $14 per case cost. Because the CSSRS is simple to universally adopt once introduced, we can expect full Coverage for this option. Additional Time Spent would be up to 5 minutes to perform the relatively brief assessment, and some of this time may substitute for current subject interview methods. Liability is somewhat high as non-clinicians are using a form that's relatively new to the field of law enforcement.

BPPD Co-Responders

This model present Clinical opportunity to impact treatment as co-responders are able to perform full diagnostic mental health assessments and recommend appropriate treatment on-scene. Due to the costs of hiring embedded clinicians and unmarked responder cars, cost is high at $766,000 total or $574 per case. Following the standard co-responder pilot model to gradually reach full implementation, coverage is medium at 67% across the 5-year lifecycle. Based on an anecdotal estimate provided by the Los Angeles Police Department, these calls would involve an extra 20 minutes of officer time on-scene to allow for full clinical assessment. Liability is medium low for this option; having licensed clinicians on-scene greatly reduces liability, but their position under police administration may still lead to risk issues.

Mobile Crisis Unit

As with the Co-Responders model, the MCU would provide full Clinical Treatment Impact with on-scene clinicians. With a cost sharing agreement including North Memorial and the greater Hennepin region, cost falls in the mid-range of the other alternatives at $362,000 total or $202 per case. This analysis assumes that the clinical assessment portion of extra officer time on-scene would be reduced to an average of 10 minutes because MCU responders would be able to clear officers from the scene in many cases prior to finishing their own assessment. However, time spent waiting

for the MCU ambulance to arrive would incur an estimated extra 15 minutes on-scene[16] to a total additional time of 25 minutes on average. Liability is very low for this option; responsibility for assessment falls on a clinician with healthcare system oversight, indicating both ideal professional response and no police administration involved. Because of startup time required to implement this alternative, lifecycle case Coverage is medium high at 89%.

Implementation

Between the two lower cost options in this analysis, the C-SSRS scores higher because it is projected to cost slightly less and does not rely on CIT officers responding to each case to reach full coverage. This ranking is highly sensitive to the specific implementation details of the options. If BPPD opted to hosted community follow-up meetings every 4 months as opposed to every 2, projected costs would undercut the C-SSRS option by $8,000 and become the highest-ranking option under the current model. BPPD may also decide to place higher value than the model assumes on the fact that the community meeting option should not increase officer time on-scene. This analysis accounts for cost as a major constraint in department action. The co-responder and MCU options would greatly benefit the overall state of suicide risk response in the broad interest of mental health public policy, versus the police's primary objective of maintaining public safety. This difference in priorities is enough to shift favor toward the less expensive options with less mental health impact. Assumptions on costs for clinical response programs are largely tied to existing examples of cost-sharing agreements; if BPPD is able to negotiate more favorable agreements or justify public and private partners to bear full personnel costs, a mobile crisis unit model would be the best chance to improve subject mental health outcomes. In the long-term, partners who internalize public mental health costs more directly than the police may be more responsive to cost sharing as more data on existing programs nationwide becomes available. If BPPD commits to a financially feasible option in the short term, they should revisit the issue as the landscape of available data improves. The ultimate results of this analysis should therefore not be taken as a conclusive ruling on the best course of action, but rather a recognition of the key decision points at play and a starting point for a more in-depth departmental weighing of priorities.

The key assumption to success for C-SSRS screening tool use is successful transition to law enforcement officer use, given a lack of current police use cases. LAPD's SMART Co-Responder team uses the C-SSRS for suicide risk calls, and they may be a valuable source of input for additional implementation suggestions.[17]

The volume of voluntary transports in the MH2017 dataset hints that even non-CIT trained officers are skilled in navigating crisis calls with subjects. Even factoring for the complications of the "voluntary" term, the data indicates there are officers who are exceptionally adept at creating a trusting environment with subjects and helping them opt for psychiatric evaluation in the midst of crisis. BPPD could leverage this institutional value by ensuring that when officers reach a trusting rapport with subjects, they are regularly asking about their support environment and assessing alternatives to hospitalization.

Internal data tracking and analysis could also improve BPPD's ability to understand the issue. The MH2017 data served as the sole source of information for the frequency of suicidal risk in BPPD's case history; a similar multi-year case review including tracking against the new transport hold form will more firmly establish the long-term prevalence of this problem versus a single year

[16]Approximate ambulance travel time to Independence, the farthest area from Brooklyn Park in North Memorial's service area, is 30 minutes (30 miles at 60mph). Assuming even distribution of MCU calls across their service area, this equates to a 15-minute average wait.

[17] Per email communication with the Admin/Training Detail Officer at LAPD's Mental Evaluation Unit, April 25, 2019.

point estimate. It will also allow for an impact analysis of the chosen intervention on disposition outcomes. Key outcomes of interest to study could include suicide risk rates by areas of the city similar to "hotspot" policing methods, ability of the case manager and Mental Health Unit to connect subjects with services, transport rates once an intervention is implemented, and actual time spent on suicide risk calls using the C-SSRS.

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Appendices

- A: MN Statute 253B.05
- B: BPPD Policy 408
- C: BPPD Application by Peace Officer for Emergency Evaluation
- D: BPPD MH2017 CIT Regression Output
- E: Hennepin County Ambulance Primary Service Areas
- F: C-SSRS Law Enforcement Tool
- G: Cost Effectiveness Analysis Budget Narrative

253B.05 EMERGENCY ADMISSION.

Subdivision 1. **Emergency hold.** (a) Any person may be admitted or held for emergency care and treatment in a treatment facility, except to a facility operated by the Minnesota sex offender program, with the consent of the head of the treatment facility upon a written statement by an examiner that:

(1) the examiner has examined the person not more than 15 days prior to admission;

(2) the examiner is of the opinion, for stated reasons, that the person is mentally ill, developmentally disabled, or chemically dependent, and is in danger of causing injury to self or others if not immediately detained; and

(3) an order of the court cannot be obtained in time to prevent the anticipated injury.

(b) If the proposed patient has been brought to the treatment facility by another person, the examiner shall make a good faith effort to obtain a statement of information that is available from that person, which must be taken into consideration in deciding whether to place the proposed patient on an emergency hold. The statement of information must include, to the extent available, direct observations of the proposed patient's behaviors, reliable knowledge of recent and past behavior, and information regarding psychiatric history, past treatment, and current mental health providers. The examiner shall also inquire into the existence of health care directives under chapter 145, and advance psychiatric directives under section 253B.03, subdivision 6d.

(c) The examiner's statement shall be: (1) sufficient authority for a peace or health officer to transport a patient to a treatment facility, (2) stated in behavioral terms and not in conclusory language, and (3) of sufficient specificity to provide an adequate record for review. If danger to specific individuals is a basis for the emergency hold, the statement must identify those individuals, to the extent practicable. A copy of the examiner's statement shall be personally served on the person immediately upon admission and a copy shall be maintained by the treatment facility.

(d) A patient must not be allowed or required to consent to nor participate in a clinical drug trial during an emergency admission or hold under this subdivision or subdivision 2. A consent given during a period of an emergency admission or hold is void and unenforceable. This paragraph does not prohibit a patient from continuing participation in a clinical drug trial if the patient was participating in the drug trial at the time of the emergency admission or hold.

Subd. 2. **Peace or health officer authority.** (a) A peace or health officer may take a person into custody and transport the person to a licensed physician or treatment facility if the officer has reason to believe, either through direct observation of the person's behavior, or upon reliable information of the person's recent behavior and knowledge of the person's past behavior or psychiatric treatment, that the person is mentally ill or developmentally disabled and in danger of injuring self or others if not immediately detained. A peace or health officer or a person working under such officer's supervision, may take a person who is believed to be chemically dependent or is intoxicated in public into custody and transport the person to a treatment facility. If the person is intoxicated in public or is believed to be chemically dependent and is not in danger of causing self-harm or harm to any person or property, the peace or health officer may transport the person home. The peace or health officer shall make written application for admission of the person to the treatment facility. The application shall contain the peace or health officer's statement specifying the reasons for and circumstances under which the person was taken into custody. If danger to specific individuals is a basis for the emergency hold, the statement must include identifying information on those individuals, to the extent practicable. A copy of the statement shall be made available to the person taken into custody. The peace or health officer who makes the application shall provide the officer's name, the agency that employs the officer,

and the telephone number or other contact information for purposes of receiving notice under subdivision 3, paragraph (d).

(b) As far as is practicable, a peace officer who provides transportation for a person placed in a facility under this subdivision may not be in uniform and may not use a vehicle visibly marked as a law enforcement vehicle.

(c) A person may be admitted to a treatment facility for emergency care and treatment under this subdivision with the consent of the head of the facility under the following circumstances: (1) a written statement shall only be made by the following individuals who are knowledgeable, trained, and practicing in the diagnosis and treatment of mental illness or developmental disability; the medical officer, or the officer's designee on duty at the facility, including a licensed physician, a licensed physician assistant, or an advanced practice registered nurse who after preliminary examination has determined that the person has symptoms of mental illness or developmental disability and appears to be in danger of harming self or others if not immediately detained; or (2) a written statement is made by the institution program director or the director's designee on duty at the facility after preliminary examination that the person has symptoms of chemical dependency and appears to be in danger of harming self or others if not immediately detained or is intoxicated in public.

Subd. 2a. [Repealed, 1997 c 217 art 1 s 118]

Subd. 2b. **Notice.** Every person held pursuant to this section must be informed in writing at the time of admission of the right to leave after 72 hours, to a medical examination within 48 hours, and to request a change to voluntary status. The treatment facility shall, upon request, assist the person in exercising the rights granted in this subdivision.

Subd. 3. **Duration of hold.** (a) Any person held pursuant to this section may be held up to 72 hours, exclusive of Saturdays, Sundays, and legal holidays after admission. If a petition for the commitment of the person is filed in the district court in the county of financial responsibility or of the county in which the treatment facility is located, the court may issue a judicial hold order pursuant to section 253B.07, subdivision 2b.

(b) During the 72-hour hold period, a court may not release a person held under this section unless the court has received a written petition for release and held a summary hearing regarding the release. The petition must include the name of the person being held, the basis for and location of the hold, and a statement as to why the hold is improper. The petition also must include copies of any written documentation under subdivision 1 or 2 in support of the hold, unless the person holding the petitioner refuses to supply the documentation. The hearing must be held as soon as practicable and may be conducted by means of a telephone conference call or similar method by which the participants are able to simultaneously hear each other. If the court decides to release the person, the court shall direct the release and shall issue written findings supporting the decision. The release may not be delayed pending the written order. Before deciding to release the person, the court shall make every reasonable effort to provide notice of the proposed release to:

(1) any specific individuals identified in a statement under subdivision 1 or 2 or individuals identified in the record who might be endangered if the person was not held;

(2) the examiner whose written statement was a basis for a hold under subdivision 1; and

(3) the peace or health officer who applied for a hold under subdivision 2.

(c) If a person is intoxicated in public and held under this section for detoxification, a treatment facility may release the person without providing notice under paragraph (d) as soon as the treatment facility determines the person is no longer a danger to themselves or others. Notice must be provided to the peace officer or health officer who transported the person, or the appropriate law enforcement agency, if the officer or agency requests notification.

(d) Notwithstanding section 144.293, subdivisions 2 and 4, if a treatment facility releases or discharges a person during the 72-hour hold period or if the person leaves the facility without the consent of the treating health care provider, the head of the treatment facility shall immediately notify the agency which employs the peace or health officer who transported the person to the treatment facility under this section. This paragraph does not apply to the extent that the notice would violate federal law governing the confidentiality of alcohol and drug abuse patient records under Code of Federal Regulations, title 42, part 2.

(e) A person held under a 72-hour emergency hold must be released by the facility within 72 hours unless a court order to hold the person is obtained. A consecutive emergency hold order under this section may not be issued.

Subd. 4. **Change of status.** Any person admitted pursuant to this section shall be changed to voluntary status provided by section 253B.04 upon the person's request in writing and with the consent of the head of the treatment facility.

Subd. 5. [Repealed, 1997 c 217 art 1 s 118]

History: *1982 c 581 s 5; 1983 c 251 s 8,9; 1986 c 444; 1991 c 64 s 1-3; 1995 c 189 s 4,5,8; 1996 c 277 s 1; 1997 c 217 art 1 s 30-34; 1998 c 313 s 4; 1Sp2001 c 9 art 9 s 29; 2002 c 335 s 1; 2002 c 379 art 1 s 113; 2003 c 108 s 3; 1Sp2003 c 14 art 6 s 46; 2005 c 56 s 1; 2005 c 165 art 3 s 3; 2009 c 159 s 88; 2010 c 300 s 19; 2010 c 357 s 3; 2016 c 120 s 1-3; 2017 c 85 s 1*

Civil Commitments

408.1 PURPOSE AND SCOPE

This policy provides guidelines for when officers may place an individual in protective custody and request a 72-hour hold under the Minnesota Commitment and Treatment Act (Minn. Stat. § 253B.05).

408.2 POLICY

It is the policy of the Brooklyn Park Police Department to protect the public and individuals through legal and appropriate use of the 72-hour hold process.

408.3 AUTHORITY

An officer, having reason to believe that any individual because of mental illness, chemical dependency or public intoxication is in danger of injuring him/herself or others if not immediately detained, may take, or cause to be taken, the individual to a treatment facility for a 72-hour evaluation (Minn. Stat. § 253B.05, Subd. 2).

The officer shall make written application for admission of the individual to a treatment facility. The application shall contain the officer's reasons for and circumstances under which the individual was taken into custody. If danger to specific individuals is a basis for the requested emergency hold, the statement must include identifying information for those individuals to the extent reasonably practicable. The officer shall also provide the department contact information for purposes of receiving notice if the individual is released prior to the 72-hour admission or leaves the facility without consent. The facility shall make a copy of the statement available to the individual taken into custody (Minn. Stat. § 253B.05, Subd. 2).

408.3.1 TRANSPORTATION

Persons who are encountered and placed on a 72 hour hold will normally be taken into custody and sent via an ambulance to an appropriate treatment facility. In general the transport will not be made in a departmental vehicle other than in the rare circumstances where no other alternative exist. This does not prohibit officers from transporting individulas to a detox center in a patrol car.

408.3.2 RESTRAINTS

If the officer reasonably believes the patient is violent or potentially violent or that restraints are otherwise appropriate, the officer may apply appropriate restraints to the person. If reasonably practicable, the officer should communicate with facility staff as to whether specific restraints, if available, should be used. If a patient is to be transferred from one facility to another and specific restraints are desired, the officer should permit their application by staff and may assist in physical control of the patient, if needed (Minn. Stat. § 253B.03 Subd. 1 (a)).

408.3.3 WRITTEN DOCUMENTATION

The officer will complete an application for admission and provide it to the staff member assigned to that patient. The officer will retain a copy of the application for the emergency admission form for inclusion in the case report.

Officers shall provide an application for admission in writing, including the circumstances under which the person's condition was called to the attention of the officer, the circumstances under which the person was taken into custody, and describing probable cause to believe that the person, because of mental illness, chemical dependency or intoxication, is likely to harm him/herself or others if allowed his/her liberty. If the probable cause is based on the statement of a person other than the officer, or other individual authorized by statute, such person may be informed that he/she may be liable in a criminal and/or civil action for intentionally giving a statement which he/she knew to be false.

If danger to specific individuals is a basis for the emergency hold, the statement must include identifying information of those individuals to the extent practicable.

A copy of the statement shall be made available to the person taken into custody (Minn. Stat. § 253B.05 Subd. 2 (a)).

The officer shall also provide a verbal summary to a receiving facility staff member regarding the circumstances leading to the involuntary detention.

408.3.4 VOLUNTARY EVALUATION

If officers encounter an individual who may qualify for a 72-hour hold, they may inquire as to whether the person desires to voluntarily be evaluated at an appropriate facility. If the individual so desires, the officers should:

(a) Arrange for transportation (normally an ambulance) for the individual to an appropriate facility that is able to conduct the evaluation and admit the person pursuant to the Minnesota Commitment and Treatment Act.

(b) If at any point the individual changes his/her mind regarding voluntary evaluation, officers should proceed with the application for a 72-hour hold, if appropriate.

(c) Document the circumstances surrounding the individual’s desire to pursue voluntary evaluation and/or admission.

408.4 CONSIDERATIONS AND RESPONSIBILITIES

Any officer handling a call involving an individual who may qualify for a 72-hour hold should consider, as time and circumstances reasonably permit:

(a) Available information that might assist in determining the cause and nature of the individual’s action or stated intentions.

(b) Community or neighborhood mediation services.

(c) Conflict resolution and de-escalation techniques.

(d) Community or other resources available to assist in dealing with mental health issues.

While these steps are encouraged, nothing in this section is intended to dissuade officers from taking reasonable action to ensure the safety of the officers and others.

408.5 CRIMINAL OFFENSES

Officers investigating an individual who is suspected of committing a minor criminal offense and who is being taken into custody for purposes of a 72-hour hold should resolve the criminal matter by issuing a warning or a citation, as appropriate.

When an individual who may qualify for a 72-hour hold has committed a serious criminal offense that would normally result in an arrest and transfer to a jail facility, the officer should:

(a) Arrest the individual when there is probable cause to do so.

(b) Notify the appropriate supervisor of the facts supporting the arrest and the facts that would support the 72-hour hold.

(c) Facilitate the individual's transfer to jail.

(d) Thoroughly document in the related reports the circumstances that indicate the individual may qualify for a 72-hour hold.

In the supervisor's judgment, the individual may be arrested or booked and transported to the appropriate mental health facility. The supervisor should consider the seriousness of the offense, the treatment options available, the ability of this department to regain custody of the individual, department resources (e.g., posting a guard) and other relevant factors in making this decision.

408.6 FIREARMS AND OTHER WEAPONS

Whenever an individual is taken into custody for a 72-hour hold, the handling officers should seek to determine if the individual owns or has access to any firearm or other deadly weapon. Officers should consider whether it is appropriate and consistent with current search and seizure law under the circumstances to seize any such firearms or other dangerous weapons (e.g., safekeeping, evidence, consent).

Officers are cautioned that a search warrant may be needed before entering a residence or other place to search unless lawful warrantless entry has already been made (e.g., exigent circumstances, consent). A warrant may also be needed before searching for or seizing weapons.

The handling officers should further advise the individual of the procedure for the return of any firearm or other weapon that has been taken into custody.

Brooklyn Park Police Department
5400 - 85th Avenue North Brooklyn Park, MN 55443 ● Phone (763) 493-8222 ● www.brooklynpark.org

Application by Peace Officer for Emergency Evaluation

In the Matter of: Brooklyn Park Case Number: _____ Event ID #:_____

First Name | Middle Name | Last Name | Date of Birth

Address | City | State | Zip Code

Alleged (check applicable):

- ☐ Unable to safely care for self
- ☐ Mentally Ill
- ☐ Developmentally Disabled
- ☐ Intoxicated/Impaired

I, the undersigned, being a Peace Officer, have taken the above named person into custody and hereby direct that he/she be transported to a licensed provider or treatment facility. I believe this person is mentally ill, developmentally disabled or intoxicated/impaired, and is in danger of injuring self or others if not immediately detained. This person was taken into custody under the following circumstances and for the following reasons:

Behaviors:	Thinking:	Health:	Communication:	History:
☐ Suicide attempt*	☐ Hears voices not present*	☐ Alcohol/Drug use*	☐ Repeats same topics/ thoughts excessively*	☐ Recent/ pertinent hospitalizations *
☐ Suicidal ideation*	☐ Sees objects not present*	☐ Drug paraphernalia found*	☐ Inappropriate*	☐ Prior call(s) involving weapons*
☐ Disregard for personal safety*	☐ Confused or disoriented*	☐ Misuse of medication*	☐ Non-communicative	☐ Assaultive history*
☐ Isolating self*	☐ Forgetful	☐ Medical complications	☐ Mania (rapid speech, flight of ideas, agitation)	☐ Level offender*
☐ Endangering or threatening others*	☐ Suspicious or paranoid	☐ Not eating	☐ Quickly changes or avoids topics	
☐ Violent, belligerent, or hostile behavior*		☐ Weight loss/ gain	☐ Expresses no hope	
☐ Indicators of depression		☐ Not sleeping		
☐ Lack of self-care		☐ Dressed inappropriately for conditions		
☐ Mood swings				
☐ Anxious or fearful				☐ Unknown/checks not made

Specify why emergency evaluation is appropriate and **explain checked asterisked*** observations: _____

Other Information Source: _____ Relationship: _____ Phone #:_____

I hereby apply for the emergency evaluation of the above named person transported to:

Name of Treatment Facility | Transported By | Run #

Signature | Officer Name/Badge # | Phone # | Date/Time

☐ **HIGH PRIORITY: Law Enforcement requests notification of release as soon as practical.**

☐ Please contact the Brooklyn Park Police Department if the above named person leaves without permission or is released sooner than 72 hours. Contact can be made through Hennepin County Dispatch. Call and ask to notify the Brooklyn Park on-duty supervisor (952-258-5321).

If a treatment facility releases a person during the 72-hour hold period, the head of the treatment facility shall immediately notify the agency which employs the peace or health officer who transported the person to the treatment facility under M.S. 253B.05 Subd.3(d).

Revised 11/13/18

First Copy: Treatment Facility **Second Copy:** Person Taken Into Protective Custody **Third Copy:** Transporting Agency **Fourth Copy:** Brooklyn Park Police Department

Appendix D: CIT Regression Outputs – MH2017 Suicide Related Cases

Table 1: Voluntary Transport Rate by CIT On-Scene Status

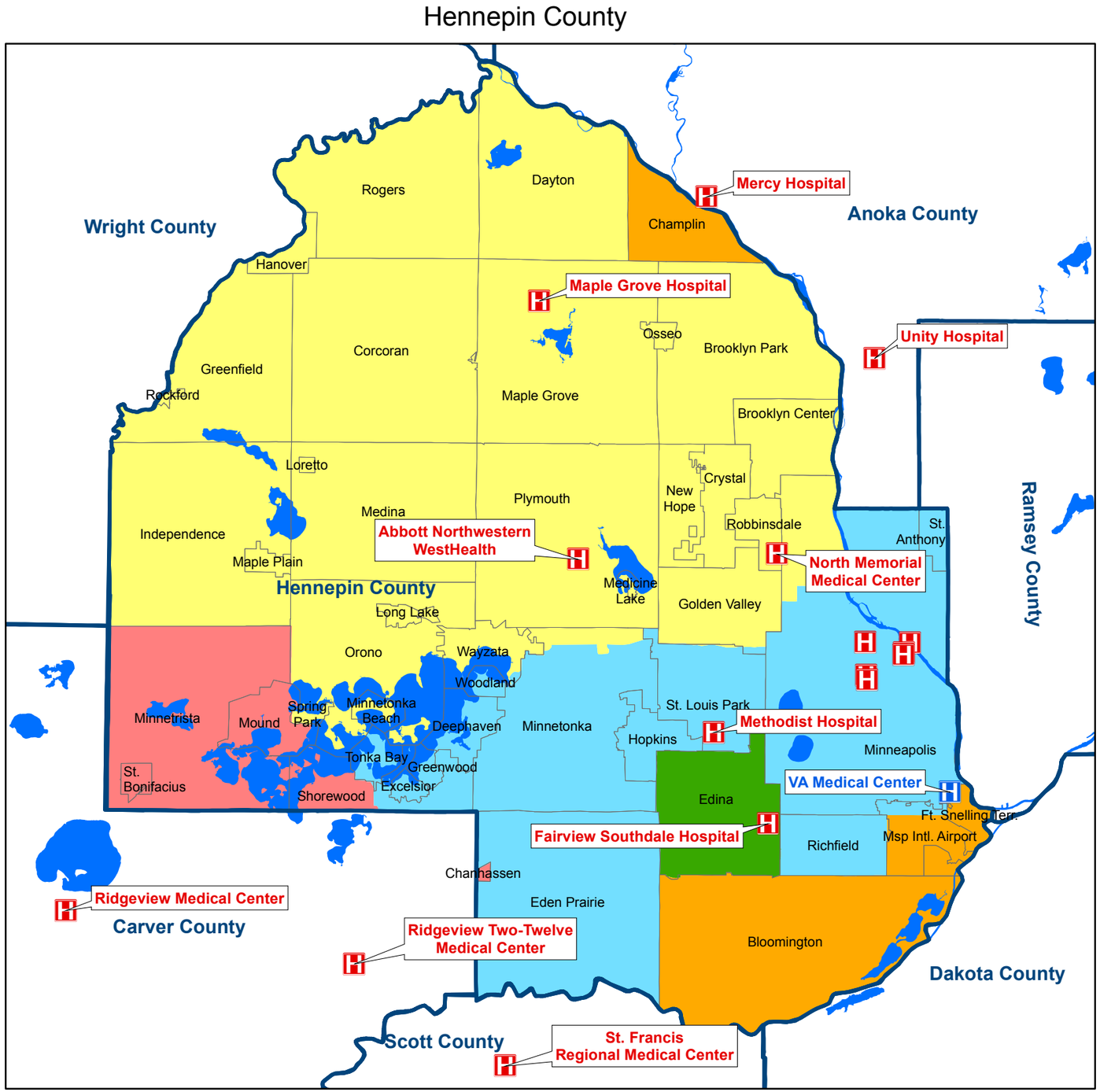
Variables	Voluntary Transport rate
CIT	-0.022
	(0.053)
Officers on Scene	-0.047
	(0.013)***
Control	0.559
	(0.039)***
Observations	366
Standard errors in parentheses	
*** p<0.01, ** p<0.05, * p<0.1	

Table 2: Involuntary Transport Rate by CIT On-Scene Status

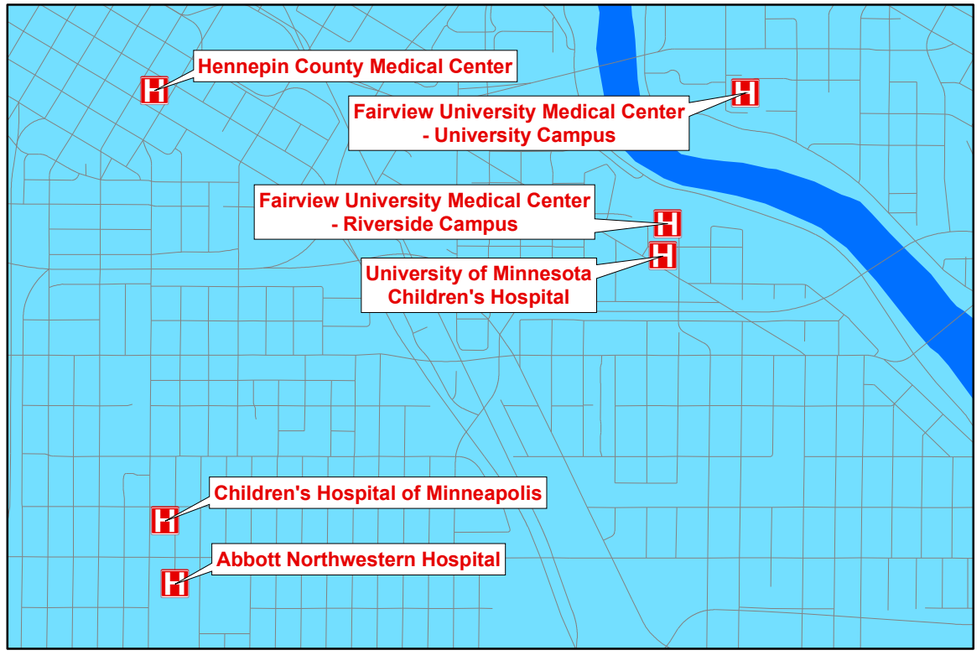
Variables	Involuntary Transport rate
CIT	-0.024
	(0.054)
Officers on Scene	0.028
	(0.013)**
Control	0.442
	(0.039)***
Observations	366
Standard errors in parentheses	
*** p<0.01, ** p<0.05, * p<0.1	

Note here that the odds of a CIT officer being on scene inherently increases as more officers are on scene. Therefore, these regressions control for the number of officers on scene to eliminate differences in transport rates that may be caused by this relationship. The key finding in these outputs is that there is no statistically significant ($p<.05$) effect of CIT officers being on-scene on the rate of voluntary or involuntary transports within the BPPD MH2017 data.

Ambulance Primary Service Areas



Downtown Minneapolis



Ambulance Service Areas

- Allina Medical Transportatation
- Edina Fire Dept.
- Hennepin EMS
- North Memorial Ambulance Servce
- Ridgeview Ambulance Service

- Med Control Hospital
- Non-Med Control Hospital
- County boundaries
- City boundaries
- Water

0 1 2 3 4 Miles

N

Source: Hennepin County HSPHD Public Health / EMS, 09/2014
Prepared by: Hennepin County HSPHD IPA / DMA Team_TJZ_10/02/2014
ambulance service areas_hospital emergency rooms_09-30-2014.mxd

Appendix F: C-SSRS Form

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen with Triage Points for Law Enforcement

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past 3 months?***	**Lifetime** **Past 3 Months**	

Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral and Crisis Numbers
Item 2 Behavioral Health Referral and Crisis Numbers
Item 3 Consider Further Mental Health Evaluation
Item 4 Urgent Mental Health Evaluation with Escort
Item 5 Urgent Mental Health Evaluation with Escort
Item 6 Over 3 months ago: Consider Further Mental Health Evaluation
Item 6 3 months ago or less: Urgent Mental Health Evaluation with Escort

Appendix G: Budget Narrative

Project Alternatives Cost Overview

Community Meeting

This option mainly entails meeting planning and hosting costs in terms of Chief, Mental Health Unit Detective, and Community Engagement Officer time spent. 2020-2023 personnel time is budgeted for follow-up community relations and less formal meetings every two months in subsequent years, based on the BPPD community outreach team's suggestion.

C-SSRS

Similar to the community meeting option, the C-SSRS will incur the majority of costs on the front end for training and implementation. Columbia offers free online-based module training for using the C-SSRS, so training costs will consist of officer time spent and Mental Health Unit planning costs for additional internally developed training. The full 108 officer force will need to be trained in 2019, over the course of 3 sessions to accommodate differing work schedules. The MHU detective and intern will each spend roughly 12.5 hours preparing and hosting training. Future year training will be either entirely module-based, or incorporated into orientation training at negligible marginal time cost. Five minutes of additional officer time spent per call is assumed based on the brief length of the assessment form, with Yes/No responses and anticipated overlap with current interview tactics.

BPPD Co-Responders

This option assumes an initial 2-year pilot, expanding to full 24/7 coverage (4.2 FTE) in year 3. Co-Responders will be embedded with BPPD under a cost-sharing agreement with Hennepin County Health Services, at a BPPD cost of $50,776 per clinician. The department will purchase unmarked vehicles at $24,000 per car for initial purchase and $6,000 per car in ongoing maintenance costs. The mental health unit detective will host officer training for co-responding officers on how to interact with the clinician.

North Memorial Mobile Crisis Unit (MCU)

This option largely mirrors the BPPD Co-Responder costs, minus vehicle and equipment costs which North Memorial would bear. The trade-off is extra time spent on-scene waiting for the MCU to arrive. The mental health unit will host department-wide training to cover officer interaction with clinicians.

Assumptions

Suicide-Related Caseload Projection + Baseline Trends

This analysis assumes that the Mental Health Unit will be renewed in 2021 following the initial 2-year pilot, with a rough effect of 30 fewer suicide-related cases per year if the case manager prioritizes "high utilizer" mental health related subjects (based on Houston Police Department's 2014 impact data per Webb, 2017). Mental health cases trends are otherwise assumed to follow the current linear annual growth rate of 47 cases per year. CIT officer training continues at pace of 11 officers per year for the

length of this analysis. Total force is assumed to remain constant at 108 officers per 2019-2023 city budget allotment.

Wages

BPPD Salary costs incorporate benefits, supplies, phone and computer use, and professional services fees as averaged per-FTE calculations of reported Brooklyn Park 2019 Adopted Budget items (see "BPPD Wage Calculations" sheet for details). The department Chief salary is based on 2013 Bureau of Justice Statistics survey data, using the average chief salary for similarly-sized police jurisdictions. BPPD co-responder rates are sourced from the Minneapolis Police Department 2019 budget, assuming the same cost-sharing structure between Brooklyn Park PD and Hennepin County Behavioral Health. The Mobile Crisis Unit option assumes the same total personnel cost per clinician as the BPPD co-responder, but with BPPD paying a rate based on the city's proportion of North Memorial Ambulance's total service population (20%). Weekly personnel capacities (hours per week) are standard 40-hour full-time weeks, with the exception of the Mental Health unit intern continuing at the 2019 contracted allotment of 12 hours per week.

Planning and Administration Time

Planning and meeting time costs for options are largely vetted from direct client input. They are noted accordingly in the analysis spreadsheet. Marginal clerical case documentation and recordkeeping costs are included based on a rough 10 extra hours in annual time spent by support services staff. Clinician hires for either BPPD or North Memorial would require city and county budget allocation, so these clinicians would not be active until 2020.
For future year training, departmental turnover is assumed to be five officers per year, with all departing officers' positions refilled.

Facilities and Equipment

Marginal office facilities costs per person are near-zero as proportions of current market facility rental rates. Training room opportunity cost of $60 per hour is included based on City Hall's rental rate for a 125-person room. Co-responder vehicle costs are based on Minneapolis PD 2019 budget.

General Conventions

The project span of 2019-2023 is assumed based on the Brooklyn Park city budget forecasting horizon. All costs reported in 2019 dollars; the Bureau of Labor Statistics CPI calculator is used for inflation adjustments. Costs occur at year-end. Discount rates of 3% are applied for future years based on standard rate of return on public investment, and all options are insensitive to an alternative 7% rate.