

Law Enforcement / Mental Health Data Sharing

Delaware Police Department
Delaware Ohio



Introduction

- Background
- CIT experience
- CIT Task Force
- CSG / PERF Data Collection Project
- Ongoing initiatives and projects



CIT Task Force

- Created under [MOU](#) – allows for confidential info sharing
- Police, Board of Developmentally Disabled, Mental Health, Jobs and Family Services, Courts, Counseling services.
- Individual clients in crisis are assigned a team
 - Will only form if the client consents and signs an [authorization](#) that is revocable at any time.
 - Comprised of member of all disciplines the client is engaged with.
 - Develop support plans, check in regularly, become resource
 - Facilitates communication and earlier intervention when issues are presenting



CSG / PERF DATA COLLECTION PROJECT

- Early warning system
- Goal – to reduce numbers of repeat callers, and to identify people at risk and make resources available sooner.
 - Reduce officer contact, reduce the escalation of crisis and the potential for conflict, injuries and liability
- Key project accomplishments
 - Change code to BH (Behavioral Health) from Mental Health
 - Added CIT Disposition to CAD
 - All CIT dispositions compiled and sent to Central Ohio Mental Health each morning
 - COHM offers services



CSG / PERF DATA COLLECTION PROJECT

- Results
 - High percentage of identified persons were already known to mental health.
 - Many newly identified persons declined services, but some did accept and some later called back.
 - Lower frequency of calls from a handful of known frequent consumers
 - Lower frequency of calls from persons in crisis before intervention occurred.
- Involved with Attorney General's CIT Data Collection Project.
- Working with Criminal Justice Coordinating Center of Excellence, Northeast Ohio Medical University.
- Stepping Up – Delaware County



CIT Updates

- Added complexity of going from one mental health service provider to four.
- How do we coordinate between agencies?



CIT Updates

- Drop box

← Daily CIT.xls ☆
You edited today at 10:18 AM

Share Download ... 🔔

Daily CIT Report

CAD No	Type Comments	Date	Location	type	Name	Disq
2017-127332	Juvenile- Unruly/Runaway	10/15/17 18:14:45	444 W CENTRAL AVE DELAWARE	INPRI C	[REDACTED]	IR IR

CAD Comments: Incident Type: Juvenile Complaint Unruly Juvenile Unruly Enter 34A ... YES Priority: 34A What are they doing? ... out of control // throwing things, scratching and hitting and punching Age ... 17yom Name ... [REDACTED] Hair ... light brown NARRATIVE: does have mental health issues // developmentally delayed NARRATIVE: sitting outside on the porch right now NARRATIVE: has been verbal for a few hours // physical started about 30-45 mins ago How many juveniles are there? ... 3 others // not causing problems Do they have any weapon(s)? ... NO Are there any injuries? ... YES What type of injury? ... scratches but denying medics [REDACTED] IS DEVELOPMENTALLY L disabled

Officer Disposition: [DPD65 19:45:06]: [REDACTED] WAS VERBALLY AND PHYSICALLY AGGRESSIVE TOWARD GUARDIANS. HE HAS COGNITIVE DISABILITY AND MOOD DISORDER PER GUARDIANS BUT THEY FEAR HE IS MISDIAGNOSED OR HAS FURTHER ISSUES TO ADDRESS.

[DPD65 19:45:15]: FAMILY HX OF SCHIZOPHRENIA

[DPD65 19:45:33]: [REDACTED] WAS TAKEN TO GRADY MEMORIAL HOSPITAL FOR AN EVALUATION

Comments Activity →

PB Write a comment 😊 👤

PB 10-12-17 XCXXXXXX

PB 8-29 Test / XXXX

Questions

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IV. Effective Date and Termination

This MOU is effective upon signature by an official authorized to sign on behalf of the member. Member agencies may terminate membership by providing written notice to the other active members of the group. This MOU will be effective for a period of one (1) year. The MOU shall be reviewed each year by the Department Head of each member agency. The MOU shall renew automatically for an additional one (1) year term unless written notice of termination or a written request for formal review is received from any of the members. Upon written request for formal review, the member agencies shall consider any desired changes to the MOU at the next scheduled meeting.

Authorizing Representative (Printed): _____

Authorizing Representative (Signed): _____

Agency _____

Date _____

Multi-Agency Crisis Intervention Team

MEMORANDUM OF UNDERSTANDING

I. Purpose and Scope:

By entering this memorandum of understanding, the undersigned entities create a multiagency crisis intervention team. This agreement identifies the roles and responsibility of members of the team as it relates to clients in crisis. In particular, this MOU is intended to:

1. Establish the multiagency crisis intervention team
2. Increase efficiency of response to clients in crisis
3. Avert potential crisis when possible.

II. Member Responsibilities

By signing this MOU, members agree to:

- A. Members will assign a staff member to represent the group at quarterly meetings. Members will attempt to send someone with knowledge of the work of the group to facilitate participation and decision making. Agency Heads will attend at least one meeting per year.
- B. Members agree to share information with the group relating to clients that may be in crisis, or may be at risk of a future crisis unless prohibited by statutory or judicial confidentiality requirements.
- C. Individual Teams: The Multiagency crisis intervention team will establish a team for each individual identified as a client in crisis. This team will be tailored to that client's needs and will develop a strategy for each client.
 - a. Members agree to provide a staff member to an individual team when relevant to the client's needs.
 - b. Members agree to obtain waivers to permit the sharing of information about the client to other members of the client's individual team. The Standard Waiver Form adopted by the Team will be used as the accepted waiver for all Member Agencies. All Member Agencies agree that the Standard Waiver Form will be considered as an acceptable waiver for their Agency's release of information.
 - c. Members agree to share information obtained about the client with other members of the team.
 - d. Individual teams will meet as needed, depending on the circumstances of the client.
- D. Law Enforcement Agencies: In addition to the member responsibilities listed above, the agency will do the following:
 - a. Provide CIT trained officers to work with the team.
 - b. Maintain records of crisis calls and the outcome of the calls.

III. Funding

Each member will bear the cost of participation in the group. This MOU does not include reimbursement of funds between the member agencies.

Authorization to Use and Disclose Protected Health Information

I understand that by initialing and signing below, I authorize the Delaware County Multi-Agency Crisis Intervention Team and its member agencies to disclose, request, and exchange my/my ward's information with each other for the purpose of coordinating community services and developing effective methods to prevent and/or intervene in crisis situations.

I understand that my authorization will remain in effect for 365 days from the date of my signature. My authorization may be withdrawn in writing at any time, except to the extent that action has already been taken. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law.

I understand that this release may authorize the Delaware County Multi-Agency Crisis Intervention Team to disclose protected information to persons who are not required by Federal or State law to keep that information confidential and that these persons may disclose the protected health information to others without my consent or authorization. The Delaware County Multi-Agency Crisis Intervention Team will not be responsible for the misuse or re-release of information by another individual, agency, or entity. The Delaware County Multi-Agency Crisis Intervention Team does not authorize the further disclosure of the Protected Health Information.

Individual's Name: _____ Date of Birth: _____

(Initial and date agencies to be involved)

- Delaware City Police Department _____
- Genoa Township Police Department _____
- Powell Police Department _____
- Delaware County Sheriff's Office _____
- Delaware County Emergency Communications _____
- Delaware County Board of Developmental Disabilities _____
- Delaware-Morrow Mental Health & Recovery Services Board _____
- Delaware County Job & Family Services _____
- Delaware County Municipal Court _____
- Delaware County Prosecutor's Office _____
- Delaware County Probate Court _____
- Delaware County Common Pleas Court _____
- Delaware County EMA / Special Needs Registry _____
- Central Ohio Mental Health Center _____
- Maryhaven _____
- Helpline _____
- SourcePoint _____
- Other (Please Specify) _____
- Other (Please Specify) _____
- Other (Please Specify) _____

Information To Be Used/Disclosed

Diagnostic Assessment/Intake Information _____ Other Assessments/Evaluations _____
 Treatment/Service Plan _____ Court Reports/Records _____
 Psychological/Psychiatric Evaluation _____ Team Meeting Minutes _____

Other (Specify) _____
 Other (Specify) _____
 Other (Specify) _____
 Other (Specify) _____
 Other (Specify) _____
 Other (Specify) _____

Individual/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

-OR-

Notice of Revocation

I hereby revoke authorization for further use and disclosure of my/my ward's protected health information effective immediately.

Individual/Guardian Signature: _____ Date Revoked: _____

Notice to Recipient of Alcohol and Drug Related Information: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit the recipient of this information from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Name:	
Address:	

Submitted By:		Date Submitted:	
Date Case Opened:		Release:	<input type="radio"/> Yes <input checked="" type="radio"/> No

Background & History: Relevant Diagnoses, Services & Supports:	<small>Convert image to .pdf and insert below</small>

Why Law Enforcement Might Be Contacted; Why These Situations Might Be Dangerous; What Has Been Attempted Prior to Contacting Law Enforcement; Requested Response of Law Enforcement:

Other Unique/Relevant Information, Useful Strategies, Known Triggers, and/or Anticipated Reaction to Law Enforcement:

CONTACT INFORMATION

Primary (Crisis):	
Name:	
Title/Relationship:	
Agency:	
Phone #:	
24 Hour Phone #:	
Email:	

Additional:	
Name:	
Title/Relationship:	
Agency:	
Phone #:	
24 Hour Phone #:	
Email:	

Additional:	
Name:	
Title/Relationship:	
Agency:	
Phone #:	
24 Hour Phone #:	
Email:	

Date Case Closed:

Closure Disposition (Indicate any team members who do not agree with case closure):