Union County CIT Peer Review

2014

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County Background

According to the 2010 census, Union County has a population of 52,300, which is an increase of 27.8% from 40,909 in 2000. Its county seat is Marysville and its name is reflective of its origins, it being the union of pieces of Franklin, Delaware, Madison, and Logan counties. Union County is part of the Columbus, Ohio Metropolitan Statistical Area.

Demographics

As of the census of 2000 there were 40,909 people, 14,346 households, and 10,888 families residing in the county. The population density was 94 people per square mile. There were 15,217 housing units at an average density of 35 per square mile. The racial makeup of the county was 95.25% White, 2.81% Black or African American, 0.18% Native American, 0.54% Asian, 0.02% Pacific Islander, 0.22% from other races, and 0.98% from two or more races. 0.76% of the population was Hispanic or Latino of any race.

There were 14,346 households out of which 38.50% had children under the age of 18 living with them, 64.40% were married couples living together, 8.00% had a female householder with no husband present, and 24.10% were non-families. 19.90% of all households were made up of individuals and 7.30% had someone living alone who was 65 years of age or older. The average household size was 2.70 and the average family size was 3.11.

In the county, the population was spread out with 27.60% under the age of 18, 7.50% from 18 to 24, 34.00% from 25 to 44, 21.20% from 45 to 64, and 9.60% who were 65 years of age or older. The median age was 34 years. For every 100 females there were 91.50 males. For every 100 females age 18 and over, there were 85.80 males.

The median income for a household in the county was $51,743, and the median income for a family was $58,384. Males had a median income of $40,910 versus $27,405 for females. The per capita income for the county was $20,577. About 3.60% of families and 4.60% of the population were below

the poverty line, including 4.30% of those under age 18 and 7.80% of those ages 65 or over.

Current State of Ohio CIT Statistics for Union County – 31 out of 68 L.E. officers + 3 Highway Patrol Troopers = 46%

Union County (3 L. E. Agencies)
12 officers from Marysville PD (39%)
4 officers from Richwood PD (57%)
15 deputies from Union County S.O. (41%)

Corrections
2 corrections officers from Central Ohio Youth Center

Dispatchers
2 dispatchers from Union County Sheriff's Office

Highway Patrol
3 troopers from the Marysville Post

Hospital/Mental Health
4 security officers from Memorial Hospital
2 employees of Consolidated Care Inc.
1 NAMI advocate

Other Counties
2 officers from Plain City PD (Madison County)

9/2/04 Expert Consensus Document: Core Elements for Effective Crisis Intervention Team (CIT) Programs

Developed by the Ohio CIT Coordinators Committee in Conjunction with the Ohio Criminal Justice Coordinating Center of Excellence

INTRODUCTION: CIT began in Memphis in the late 1980s and has been adapted widely around the country. As CIT has developed in different communities, local adaptations have been made in various elements of the program. Each community has its own unique issues that might effect CIT implementation. Rural communities are especially challenged to adapt CIT successfully. Rural law enforcement agencies are often small and cover extensive geographical regions. We believe that CIT can be successfully implemented in both urban and rural communities.

There is little research demonstrating those elements necessary for CIT programs to accomplish their goals. However, those of us that have been involved with developing CIT in our communities believe that there are certain critical elements that determine the effectiveness of these programs. There is a concern that absent these core elements, CIT will be less effective. For this reason, CIT experts from eight established CIT programs in Ohio have developed this document, a summary of those elements we believe are necessary for CIT programs to be maximally effective. We have attempted to identify specific aspects of CIT where adaptations are necessary for rural communities. We understand this is a work in progress. Eventually we

hope to turn these core elements into a fidelity self-assessment tool. Also, we hope these proposed core elements will promote future research to determine if the experts are correct.

Goals for CIT Programs:

CIT is a community partnership between law enforcement agencies, the local mental health system, mental health advocacy groups, and consumers of mental health services and their families.

Communities that establish CIT programs do so with the following goals in mind:

·Increase the feeling of safety in the general community

·Increase law enforcement officer safety

·Increase mental health consumer safety

·Better prepare police officers to handle crises involving people with mental illness

·Make the mental health system more understandable and accessible to law enforcement officers.

Supply law enforcement officers with the resources to appropriately refer people in need of care to the mental health treatment system

Improve access to mental health treatment in general and crisis care in specific for people who are encountered by law enforcement

·Collaboratively, make the mental health system responsive to law enforcement to the greatest extent possible with community resources

·Divert people with a mental illness who are in crisis from the criminal justice system whenever possible and collaboratively work with the court systems to reduce the incarceration rate of people with a serious mental illness who are in need of treatment when applicable.

CORE ELEMENTS OF CIT

The following are what we believe to the core elements of successful CIT programs:

1. Selection of CIT officers-**For large law enforcement agencies**:

·There should be a formal selection process within the law enforcement agency. This could include:

·A written application to join the program.

·An interview to determine motivation to become a CIT officer.

·A background investigation process to ensure that CIT candidates are of the highest caliber.

·Whenever possible, CIT officers will be volunteers that have good communication and interpersonal skills. No officer should be forced or ordered to be a CIT officer against his/her will.

For Small law enforcement agencies:

In smaller agencies, all officers may ultimately need to be trained as CIT officers to ensure maximum coverage and availability. Since this may not be accomplished for several years, smaller agencies are encouraged to start their program using volunteers who are interested in becoming CIT officers as much as practicable. As the program develops all officers may be expected to become CIT officers.

For Medium-sized law enforcement agencies:

In medium-sized agencies, the law enforcement executive will have to decide whether to have a smaller team of specialists or train all to ensure coverage.

2. Size of CIT force

·The goal for all law enforcement agencies is to have enough CIT officers' to allow for maximum coverage on all shifts and all days of the week.

·For large agencies, it is estimated that this will require 20 to 25% of the patrol force to be part of the CIT.

·For large agencies, it is not wise to train significantly more officers than needed for maximum coverage. "Too many" CIT officers might reduce the frequency of CIT encounters that each officer has, thereby decreasing his/her ability opportunities to hone his/her skills

·Smaller agencies may have to train all or most of their officers to allow for adequate coverage.

·It generally takes several years for a department of any size to develop an optimal number of CIT officers.

3. A CIT officer committed to the CIT concept/program will be designated as the contact person for the mental health system.

·Ideally in large agencies this officer will be designated the CIT coordinator.

·The coordinator position should be filled by a law enforcement officer who would be given the authority to oversee the program in the agency.

- The rank of this person would be established by the agency and that person would be imbued with the "staff authority" needed to coordinate and oversee the activities of the team.

4. There will be a mental health coordinator(s) committed to the program that will serve as the contact person(s) for the law enforcement agencies in the jurisdiction(s) served by the mental health board or providers.

    - Ideally this coordinator will have enough authority to oversee the program from the MH system side.

    - This coordinator will be involved in planning and implementing the training as well as in the maintenance of the program.

5. The mental health system is responsive to CIT officers and will allow for a smooth transition for CIT officers as they refer patients for crisis services.

    - The mental health system will receive individuals identified by CIT officers as in need of crisis services:

    - Quickly so that law enforcement officers can return to their other duties as quickly as possible; and

    - Without hassle (i.e., "no reject policy")

    - Ideally a community will have one or several facilities clearly designated for mental health crises with a "no reject" policy.

    - Such facilities may be freestanding crisis centers or hospital emergency departments.

    - Such facilities would have 24/7 availability.

    - A mental health mobile crisis service with a quick response may serve in place of a facility.

    - Some rural communities will not have either a crisis center or hospital emergency department. In such cases, the community will develop an acceptable response mechanism for crises identified by the CIT officers.

    - The mental health system will have procedures in place so that if it is necessary for an individual to be arrested, the CIT officer can identify the person's mental health needs and be confident they will be addressed.

6. Trainers who are willing to learn about police work and to become "police friendly" as they

provide training to the officers. Trainers must include mental health professionals, family members of individuals with serious mental illness, individuals who themselves have serious mental illness ("consumers"), and people who are able to assist in role-playing to assist officers in developing their de-escalation skills.

- Efforts will be made to help trainers prepare for CIT presentations. Trainers need some basic knowledge about the nature of police work, police culture and how police officers best learn. These efforts may include:

  - A pre-class meeting with trainers.

  - A train the trainers meeting.

  - Written communication with the trainers.

  - Trainers are offered an opportunity to go on one or more "ride-alongs" with a law enforcement officers assigned to the patrol function, to give the trainer an opportunity to observe first hand what it is like "walking in an officer's shoes".

  - Trainers are informed about officer and community safety issues and about the use of force continuum that is used by law enforcement agencies in the area.

  - There will be an evaluation process so that ineffective trainers can get feedback and/or be replaced as necessary.

7. The mental health system must be willing to provide the trainers to the officers at no or low cost.

   - The training must be accessible and sustainable for both the police and the mental health system.

   - Ideally the training will be offered free to the law enforcement officers within the jurisdiction.

   - It is reasonable to expect officers from other jurisdictions (e.g., from outside Ohio) to pay the cost of materials.

   - If there is a charge for all attendees, it should be minimal, e.g., to cover the costs of materials and meals

8. A law enforcement agency must be willing to provide release time so that its personnel can attend the training.

·For smaller agencies this may mean arranging payment of officers who attend training while off duty.

·It may also mean arranging for overtime coverage of regular duties to allow personnel to attend training

9. An intensive CIT core training class that should be held at least once a year. For urban communities, this training should be a weeklong, 40-hour training. (Some rural communities believe they can accomplish the goals of the training in less than 40 hours. There is a lack of consensus among this group on this issue.)

The course emphasizes that CIT is a partnership between law enforcement, the mental health system, mental health advocacy groups, and consumers of mental health services and their families. As such, trainers include representatives of all identified stakeholders. The intensive training attempts to provide a common base of knowledge about mental illness; a basic foundation from which officers can build. The course is not aimed at making CIT officer's mental health professionals. The course is intended to provide officers with skills to:

·Recognize signs and symptoms of mental illness

·Recognize whether those signs and symptoms represent a crisis situation

·De-escalate mental illness crises

·Know where to take consumers in crisis

·Know appropriate steps in following up these crises such as: contacting case managers or other treatment providers or providing consumers and family members referral information to mental health treatment agencies or advocacy organizations like the local NAMI chapter. The training emphasizes development of communication skills, practical experience and role-playing. Also officers are exposed to mental health professionals, consumers and family members both in the classroom and in the field during site visits. No two CIT curricula will be identical, as each will reflect the unique aspects of the given community. Still all courses will include the following:

·An overview of mental illness from multiple perspectives.

·Persons with mental illness

·Family members with loved ones with mental illness

·Mental health professional's These perspectives may be provided by individual consumer and family presentations or by panels of several consumers or family members. Substantive amounts of interaction between CIT officers-in-training and mental health consumers and their families will make the core training session more effective.

·Specific signs and symptoms of serious mental disorders.

·The kinds of disturbed behavior officers will see in people in a mental illness crisis should be emphasized.

·The common problem of co-occurring disorders including co-occurring substance abuse and mental illness, along with co-occurring developmental disability and homelessness.

·The influence of culture and ethnicity on the topic of mental health and how it is dealt with inside those cultures and ethnicities should be discussed as it applies to the cultural and ethnic make up of the particular community.

·Panel discussions and role-plays of cultural differences may be particularly effective.

·Obtaining trainers from those various cultures and ethnicities (if possible) may also be effective

·An overview of psychiatric medications.

·An overview of the local mental health system and what services are available.

·An overview of mental health commitment law.

·Comprehensive training in how to de-escalate a mental illness crisis.

·Sufficient practice, through role playing, in the de-escalation of mental illness crises so that all students are involved directly in the role-playing

·Field trips which give officers an opportunity to talk with consumers and emergency mental health personnel, and to ride-along with case managers so officers get to experience what it is like walking in a case manager's shoes.

·A graduation ceremony with awarding of pins and certificates.

10. Training is provided to dispatch/phone call takers so that they are knowledgeable about the CIT program and able to identify probable mental illness crisis calls.

11. Ongoing or advance training is offered to CIT officers on at least an annual basis.

·Officers are regularly provided with reading material and other updates on mental illness issues by the mental health and/or police CIT coordinator/contact person.

·With input from the CIT officers in the field, advanced CIT training is offered annually.

12. The law enforcement department will develop policies and procedures to effectively interact with people in a mental illness crisis. This will address the roles of dispatchers,

CIT officers, and non-CIT officers. These policies will include:

- A simple documentation process for tracking of encounters between CIT officers and individuals with mental illness ("the Stat sheet");

- Stat sheets and other information are shared on a regular basis with the mental health system.

13. Regular feedback is given to both CIT officers and mental health system providers and administrators when problem situations arise.

- Each community will articulate means of both formal and informal communication between law enforcement and the mental health system. These may include:

- Sharing of statistics kept on various aspects of the program

- Sharing of stat sheets (see 12.b above)

Regular conversations between identified CIT and mental health personnel. Discussions at the CIT steering committee meetings. (See below.)

14. There is a regularly scheduled meeting of a CIT steering committee with representatives of the key stakeholder groups to assure that the program stays on course.

15. When feasible, the mental health community provides ongoing recognition to the CIT program and honors particular CIT officers for their excellent work. One or more officers from each CIT program are recognized as "CIT Officer(s) of the Year". A local NAMI chapter (or ADAMHS Board) may want to take the lead in organizing and sponsoring these community celebrations.

THE UNION COUNTY CIT COURSE/TRAINING

BACKGROUND: Representatives from Union County, including L.E. officers were invited to the Champaign/Logan County established CIT Course in early 2012. This was the impetus for Union County to explore having they're own CIT Course(s). Jean Shoemaker from Mental Health and Sgt. Matt Henry a Patrol Supervisor from the Union County Sheriff's Office became the CIT Coordinators. Later that year Union County held their very own CIT Course. To date 3 CIT Courses have been conducted in Union County averaging 12-17 students. Invited were probation & parole officers, dispatchers, hospital security, corrections, mental health professionals, and Highway Patrol & Madison County Plain City PD officers. All L.E. agencies in Union county have sent representatives. The Peer Reviewers are extremely impressed that Union County has moved so quickly and competently. Getting all law enforcement agencies on-

board this soon is unheard of! And, inviting other non-county L.E. officers is commendable!

THE CURRICULUM: It is advertised as a 32-hour training for Law Enforcement, Parole, Probation, Corrections, Security Officers, Dispatchers and Mental Health Providers.

Day #1: Welcome & Intro (30 min.) followed by "What Mental illness is" (90 min.) is the logical sequence for a CIT Course. This is followed by the "Hearing Voices" exercise (110 min.). Lunch is one hour and the afternoon agenda includes the "E.A.R Model" of de-escalating persons in mental health crisis (110 min.). This is followed with a role-play demonstration (20 min.) to end the day. Evaluations for all three CIT courses indicated that the students found the classes good.

Day #2: The Legal Block presentation (100 min.) is followed by a class on Excited Delirium (50 min.) presented by a renowned Instructor (Sam Faulkner). A class on Substance Abuse & Co-existing Disorders (50 min.) follows. After lunch Lethality Assessment (30 min.) and then Stress Management (140 min.) ended the day. Stress Management is not a course normally given in a CIT course, but every community is different and may have a particular need in an area. This course is highly rated and much needed for officers and others in general. It is often in an Advanced CIT Course as research is showing that CIT Officers (if you have a CIT Program and not just CIT training for everyone) suffer "burnout" at a higher rate than those officers who are not members of the TEAM! Evaluations of Day #2 from all three courses indicate the Legal Block and Excited Delirium & Stress Management as excellent! Overview of Substance abuse varied from fair to good, while the rest were rated good.

Day #3: This day starts off with Commitment Protocols and an explanation of The LOSS Model of identifying MH issues (50 min.). De-escalating Teens (50 min.), followed by Developmental Disorders & Spectrum Disorders (50 min.) comes next. An Alzheimer's & Dementia presentation leads into the lunch break. Veterans & PTSD (50 min.) is followed by a Consumer Panel presentation (50 min.). The day ends with a Family Panel discussion (50 min.). Evaluations from the three courses were mixed. Adolescents from fair to good; Alzheimer's/DD good; Vets & PTSD from good to excellent; Consumer Panel as good; and the Family Panel went from really good to fairly good.

Day #4: The first half of this day is spent on Role-Play scenarios practice and De-escalation Skill building. After lunch a Debriefing takes place. Evaluations of the course are completed and Graduation takes place starting at 1pm. The Evaluations on the Role-Plays are excellent with the most recent one getting the highest possible rating of a 4!

Union County CIT Training Observations:

Usually one day (sometimes divided into two half-days) is dedicated to field trips in the 40-hour model. The most beneficial of these endeavors is when the student gets to go with Case Managers on their home visits. The student develops a greater understanding of the hard work and possible dangers these dedicated individuals face each day and it builds empathy with the clients. The officers always talk extensively about this experience. Another field trip possibility is to an actual mental health facility or to the county jail to experience the Mental Health Pod or

what other arrangements (if any) are made for arrestees with MH problems. Or, there may be a clubhouse for people with a mental illness that can be visited. Another recommendation would include "bring the site visit to the training." Have speakers, staff, and clients from agencies travel to the class and share information about themselves and the agency. This would build the relationship between law enforcement and the agencies and the staff who work there.

In rural counties, often there are just not enough facilities or they are too far away to make it practical to go on field trips. To compensate, Brown County, as an example, at one time required students to spend time with a crisis hotline worker within one year of graduating from their 3-day CIT Course.

The first Union County CIT Course had a presentation on "Managing the Suicidal Inmate" which did not get great evaluations, as it was not germane to most of the students. This course was not repeated in the last two courses, as correction officers did not attend. An extensive presentation specifically on suicides incorporating signals, techniques for intervention, safety precautions, etc. could be extremely useful to the class as traditionally CIT officers in the field when asked "What do you need more knowledge on?" overwhelmingly state "more knowledge on what to say and how to handle suicidal people" along with "how to handle juveniles with mental illness & how do the symptoms differ from adults?"

A separate presentation on the Borderline Personality Disorder may also be worthy of the students attention as this illness can at times put officers in awkward situations where they need to be careful and cautious, documenting everything they say and do.

REALLY LIKED: The E.A.R. Model PowerPoint slides; The Alzheimer's slide on "What draws officers attention" and tips for de-escalation skills along with what to look for in driving observations. We agree with Union County's self-identified strengths; it is especially obvious that they listen to and use the feedback given from previous classes as they have made changes in speakers as necessary. We commend the detail in the segment on legal issues.

POSSIBLE IMPROVEMENTS: Commitment Protocols/Hospital slides were not very colorful and attention getting; Managing Adolescents in Crisis PowerPoint could stand to be freshened up and look more interesting; DD & Autism Awareness PowerPoint had way to many words per slide; Substance Abuse & Co-existing Disorders PowerPoint just did not seem to give enough detail on substances. We would suggest that the committee look at the course objectives on their evaluation form to make sure they match up to the program content, especially when speakers/presentations change.

Finally, with a rising number of individuals who are dually diagnosed with a mental illness and a developmental disability (DD) it is encouraged that the Steering Committee continue to invite the Board of DD to present at the trainings. This will allow officers the opportunity to learn about different DD characteristics that an individual with DD may display such as a non-verbal communication or echolalia. Typical command and control methods are ineffective with this population and officers could benefit from learning successful interactions that could prevent a DD person from entering the justice system.

Union County CIT Program:

It is recognized by the peer reviewers that the Union County CIT Program has not been in existence for very long and still is a work-in-progress. Sending the future Steering Committee to a well established CIT Program and learning from them was invaluable. It is obvious in the MISSION STATEMENT provided to the Reviewers that it along with the Vision Statement; Core Values; & five objectives that you are striving for a true Program in which there are varied stakeholders that will benefit from forming a partnership to better serve and better protect everyone when the issue is mental illness and especially a mental illness crisis.

The Union County Standard Operating Procedure for Crisis Intervention team (CIT)/Data reporting & Information sharing document exceeds all expectations. If your county can gain compliance from all law enforcement agencies in following these SOP's and data collection standards your county will be on the cutting edge of truly having an all-inclusive CIT Program with data to back it up. However, we have not seen a distinction made between "Mental Health Crisis" and "Behavioral Health Crisis" in other agencies/programs. We wonder about including substance use/withdrawal, which we would presume in your definitions would be included as a behavioral health crisis?

It is realized that all law enforcement officers in your county are to receive the 32 hour CIT Course and that is understandable due to having such small agencies that to have 24/7 coverage of a CIT officer available it must be accomplished in this manner. However, we would hope that as you travel this path you ask for volunteers to be the first wave of the "face" of CIT. We have found that usually the best of the best officers volunteer and set the example. A paradigm shift takes place and over a short time all officers see the value in responding to mental illness/crisis calls in this much safer and caring manner. One has to wonder how many law enforcement officers have been hurt or lost their lives all because of the way in which some previous officer treated them. But, of course one cannot be a CIT officer until the scene is safe!

It is impressive that the Sheriff's Office has assigned not one but two deputies (one being a Sergeant) to be CIT Coordinators. Hopefully as the other two L.E. agencies progress they too will assign an officer to coordinate with and be on the CIT Steering Committee. It is also impressive that the mental health system has also provided two coordinators to the Steering Committee. It would behoove you to consider inviting a consumer and/or advocate to be on this committee "Nothing about us without us" comes to mind. Additional membership on the planning committee would be beneficial for sustainability as well.

It is also impressive that the mental health system does receive persons in crisis in an efficient manner from the officers so that they can get back out on the streets. We see that the usual receiving entity may be the emergency room at the hospital. It may be helpful to get the ER supervisory staff involved with your CIT program. Some programs carve out a 50-minute class

in a CIT course to have a panel discussion with the head of the Emergency room, EMS personnel, MH service providers and Alcohol Detox Centers so that officers can ask questions about services, etc. This also impresses upon these entities that the officer is learning quite a bit about mental health issues and treatment protocols.

Since your mentally ill subjects that are arrested are not housed in your county you have little to no control as to how they are treated/serviced. There is no mental health docket established by your magistrate as of yet. This would be a common occurrence we believe in smaller communities.

A second recommendation would be for the Steering Committee to familiarize itself with the Sequential Intercept Model (Mark Munetz and Patricia Griffin in 2006). The Peer reviewers agree that without even knowing it, Union County is replicating the framework especially in regards to jail diversion for individuals who have a mental illness. The recommendation is not for the county to change what it is doing, just label the steps differently and promote the model in the county. In addition, a comprehensive plan would address the entire spectrum of criminal justice involvement and would add value beyond CIT. An unintended positive consequence of the SIM is a reduction of repeat calls to the same individual. Without a SIM there's a high likelihood that the individual will ultimately come back into contact with law enforcement during another crisis and repeat the cycle.

At this time there is no process in which to give officers and the mental health system feedback when a problem situation arises. It will become crucial to create such a mechanism. Officers who do not get answers will quit asking questions. The same is probably true for mental health entities. The biggest reason for having a partnership is so that troubleshooting can take place and so that everyone is on the same page. Problems get solved in a timely manner in this fashion and no one is "stewing". Where CIT is voluntary if an officer keeps running into the same roadblock they become disillusioned. They then turn in their CIT pin and get off the Team (the "T" in CIT stands for Team – not Training).

Finally, the Review Committee recommends that the Steering Committee adopt a long-term commitment to the program by seeking formal support from the agencies that they represent.

Furthermore, the Steering Committee should adopt a commitment to working with all law enforcement departments and probation departments to get "buy-in" to the program.

When you get to the point where your community recognizes outstanding CIT officers work you should also recognize outstanding class instructors and coordinators, etc. This solidifies the CIT Program in the hearts and minds of the community.

It is quite impressive that the students are given ample opportunity with well thought-out questions to answer on their satisfaction with the CIT Course. And, they have the opportunity to add other observations and suggestions.

A concern is that the two individuals that are coordinating the training are an essential part to its success. Having said that, we would like to get a stronger commitment/buy-in from the systems

they represent. If either one of them or both leave will the program be able to continue?

We are impressed with the goals stated: Having CIT training twice a year for the next 3 years and then annually; having 98% trained in 5 years; beginning advanced and refresher trainings.

We are also impressed with where Union County is in regards to beginning data collection, given that they are just 3 training classes into their program development. As this process progresses, attention will need to be made to reviewing CIT incidents, identifying safety and training trends/issues, etc. and share the feedback with CIT Officers, the mental health and developmental disabilities systems on a regular basis.

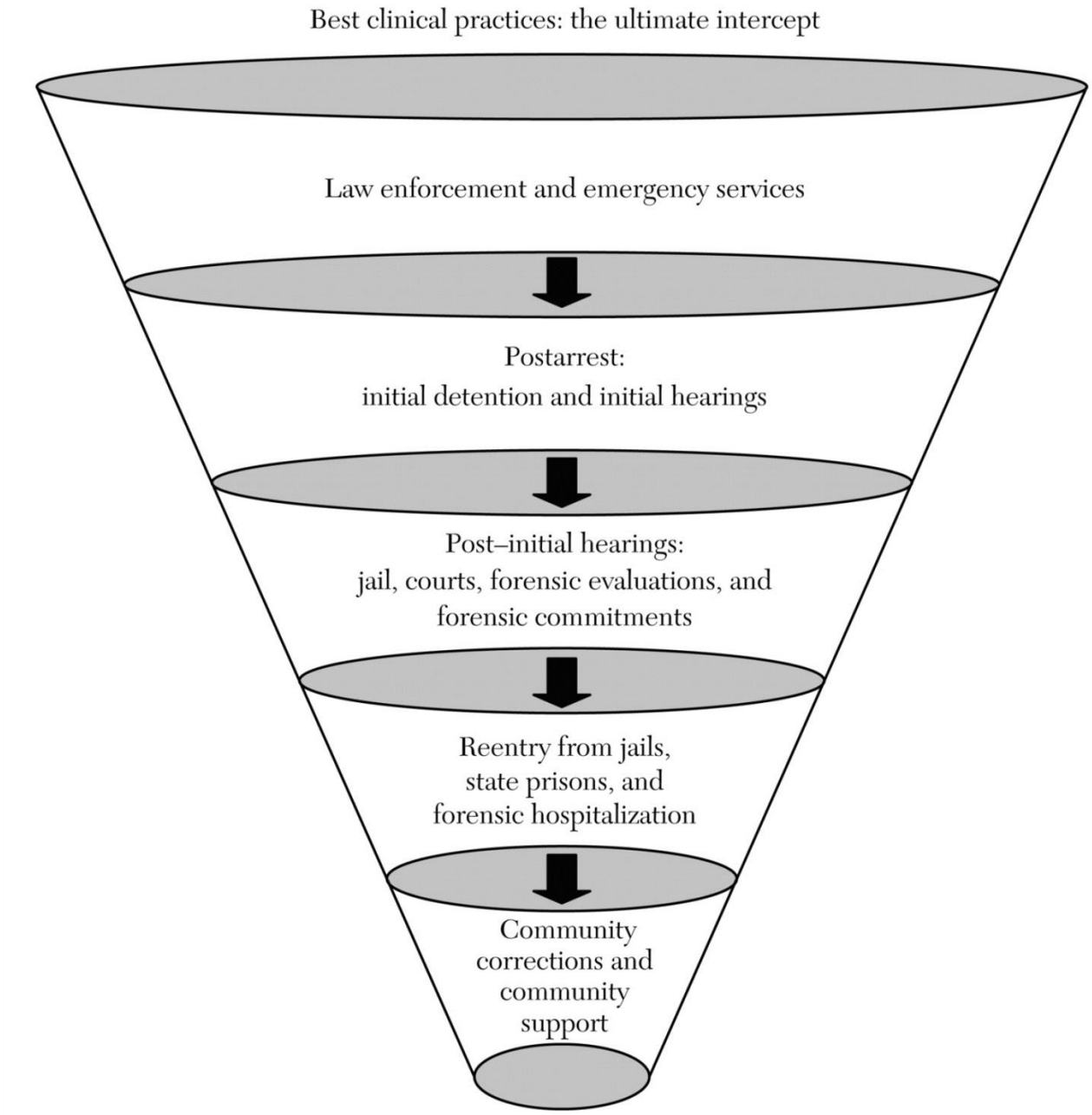
Even with an established CIT program in place, without the community knowing of its existence it will not be called into service. Therefore, the Steering Committee should work on ways to build awareness of the program across the county. A combined marketing effort between NAMI, the hospital, the Union County Mental Health Board, Maryhaven, United Way 2-1-1, and dispatchers would raise the awareness of the CIT program. It would also build confidence in the mental health system and improve the community's perception of law enforcement.

Thank you for going through this voluntary Peer Review Process

Michael S. Woody – Ohio Criminal Justice Coordinating Center of Excellence Law Enforcement Liaison

Figure 1

The Sequential Intercept Model viewed as a series of filters



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2006