OHIO CRISIS INTERVENTION TEAMS (CIT) STRATEGIC PLAN

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EXECUTIVE SUMMARY

Law enforcement officers are often first responders to individuals with mental disorders living in the community and in need of help. Historically the police were neither trained to safely resolve such encounters nor partnered with the mental health system to effectively access treatment services for those identified in need. Without a clear plan to address this gap, the risk is increased that police encounters with individuals with mental illness will end badly. Bad outcomes include injury or death to the individual, officers or others; arrest and incarceration in jail when referral to treatment is more appropriate; or missed opportunities to connect people in need with mental health treatment services.

The solution to this challenge is three pronged:

1. Assure adequate basic police training about mental illness and other special populations for all police officers, distinguishable from CIT, including
    a. understanding the different major mental health disorders,
    b. understanding brain and adolescent behaviors,
    c. understanding developmental disability behaviors, and
    d. understanding Traumatic Brain Injuries, Post-Traumatic Stress, and other veteran related mental health issues.
2. Provide ongoing police in-service training on responding to individuals with mental illness; and
3. Facilitate a change in community culture through the **Crisis Intervention Team (CIT)** model so that law enforcement, mental health, individuals with mental illness and their families work together to assure an effective specialized police response to individuals in mental health crisis or otherwise needing immediate help.

This strategic plan primarily addresses item 3 above. It was written by the Criminal Justice Coordinating Center of Excellence (CJ CCoE) in cooperation with the Ohio Department of Mental Health and Addiction Services (OhioMHAS), the National Alliance on Mental Illness of Ohio (NAMI Ohio), the Office of Criminal Justice Services (OCJS), and the Ohio Attorney General's Office in order to provide a roadmap to continue development of Crisis Intervention Teams in Ohio. Ohio has trained nearly 8,000 law enforcement officers since 2000. This plan identifies strategies beyond CIT ***training*** to build key elements that will strengthen CITs and their foundation for success. The ultimate goal is to have a fully developed **CIT program** in every county, with every law enforcement agency within the county participating.

OBJECTIVE OF THE PLAN

The objective of this plan is to identify next steps in the statewide evolution of CIT to bring about the culture change needed in every Ohio community. ***The core elements of an effective CIT program provide a clear framework for developing effective CIT programs that achieve the desired culture change.***

RISKS AND OPPORTUNITIES

There is a serious risk that police training alone will be seen as the solution to the problem, leaving out key elements of a specialized police response. Training everyone without having the full CIT program in place has failed in multiple cities around the U.S.

There is also great opportunity for shared vision and direction in Ohio right now, with increased attention on police-community relations and police training through the Governor's Ohio Task Force on Community-Police Relations, the Ohio Attorney General's Task Force on Police Training and Task Force on Mental Illness and Criminal Justice, and recent findings from the U.S. Department of Justice regarding the Cleveland Division of Police.

CRITICAL STRATEGIES

CIT programs inherently require time to develop in order to meet each of the core elements. Specific recommendations and objectives are provided for each of the core elements. We identify here three key areas of focus which we believe will require both investments from local communities and state funders and are most critical at this stage of CIT development in Ohio:

- Consider providing financial support through state funders to ensure that each of Ohio's multi-jurisdictional CIT programs has a law enforcement and mental health coordinator;
- Make state and county investments in mental health crisis assessment centers to ensure that every ADAMHS Board area has a means for CIT officers to transfer responsibility for specialized mental health assessment and care 24/7;
- Prioritize training for 911 call-takers and dispatchers in all Ohio counties.
- Maintain adequate support and infrastructure to continue the strong trajectory of Ohio CIT training (Appendix A)

OHIO CIT STRATEGIC PLAN

BRIEF BACKGROUND AND HISTORY

Law enforcement faces daily encounters in the community with individuals with serious mental illness, making up an estimated 7-10% of all encounters. *"The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships."* * Often referred to as "The Memphis Model," CIT was developed in Memphis, TN in 1988 and is being used increasingly throughout the United States and around the world to improve law enforcement responses to individuals with mental illness and collaboration among law enforcement, health care, consumers, family members, and advocacy groups.

Ohio implemented its first CIT training in Summit County in 2000. The state's CIT programs and training courses are primarily coordinated by ADAMHS Boards in partnership with law enforcement and advocacy groups, but the focus has been largely on the training element. CIT has emerged as the "gold standard" for Specialized Police Response (SPR) in Ohio with close to 8,000 trained CIT officers and nearly 50 training courses in 2013 and 2014, but to be successful Ohio must turn its attention to other aspects of CIT programs.

CIT, when implemented according to its core elements, brings about a change in community culture, a change that affects police culture, the culture of the mental health system and attitudes of consumers of mental health services and their families towards both the police and the mental health system. The outcome of this plan will be achieved when law enforcement officers throughout the state feel prepared to effectively respond to a person with mental illness; when mental health professionals know how to most effectively partner with law enforcement officers for their patients/clients who need police intervention; and when individuals and their families trust that a call to 911 will result in dispatching of a caring officer who is well prepared to safely respond and achieve the best outcome possible.

The call for all officers to be adequately trained in mental health awareness and intervention strategies is an important one, but should not be confused with CIT – a specialized response based on a team approach with select officers who develop specialized skills over time. **Ohio law enforcement officers receive training on crisis intervention with special populations through the OPOTA 16-hour course. New cadets going through academy after January 1, 20007 are required to complete the training, and arguably all law enforcement officers who completed academy prior to 1/1/07 should be required to complete the course.** In addition, **all police officers should receive regular in-service training on responding to individuals with mental illness**. CIT training, however, should be reserved for those officers and agencies committed to the core elements and philosophy of CIT.

In September 2007 The University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice CIT Center published "Crisis Intervention Team Core Elements," (Appendix B) outlining the key components that should be in place in order for a CIT program to be successful, i.e., to meet the goals of improving consumer and officer safety and redirecting individuals with mental illness from the criminal justice system to the health care system. These core elements

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* **Crisis Intervention Team Core Elements The University of Memphis** School of Urban Affairs and Public Policy Department of Criminology and Criminal Justice CIT Center **September, 2007** Randolph Dupont, Major Sam Cochran, Sarah Pillsbury

were in part informed by an expert consensus document developed in Ohio in 2004 (Appendix C). Subsequently, the CJ CCoE also developed a CIT Program Evolution pyramid to graphically display the progression of components in a CIT program (Appendix D). This plan is based on those core elements.

One of the challenges to this plan will be translating the statewide view of CIT to a local view and implementation of CIT, as the level of program development varies greatly across jurisdictions. For the purposes of this document, recommendations are based on trends across the state, with some local examples offered for illustration. It will be important to maintain a central organizing entity to assist in the elaboration of the plan. This has been accomplished in Ohio through the partnership of the CJ CCoE and NAMI Ohio with support from the Ohio Department of Mental Health and Addiction Services, the Ohio Attorney General's Office, and the Office of Criminal Justice Services.

MAJOR GOALS

All Ohio communities should have access to Crisis Intervention Teams or an equivalent Specialized Police Response for citizens experiencing crisis associated with mental illness, co-occurring addiction or developmental disability. For that to occur, we believe the **ultimate goal is to have a fully developed CIT program in every county, with every law enforcement agency within the county participating.**

For CIT to be successful, programs need to adhere to the core elements, summarized as follows with descriptions of current status in Ohio:

1) **Partnerships of Law Enforcement, Advocacy, and Mental Health: Bringing together a wide array of stakeholders in the community and professionally to identify core needs of the community.**

   At the state organizing level, partnership is modeled through the CJ CCoE, NAMI Ohio, and state mental health and justice agencies. Stakeholder planning meetings occur annually, and statewide CIT Coordinators meetings are held twice per year to provide learning and networking opportunities for local programs.

   It appears to be most efficient for CIT programs to be considered at the county level. County level CIT programs ideally need CIT Coordinators representing law enforcement, mental health, and advocacy. Additionally each law enforcement agency needs a contact to work with the county level coordinators. In the current environment it is difficult for law enforcement agencies, be they large urban departments or County Sheriff Offices, to have the resources to devote to a full time CIT Coordinator. Alcohol, Drug Addiction and Mental Health Services Boards may be similarly challenged. Whether local NAMI chapters need funding for a counterpart advocacy coordinator warrants additional consideration.

2) **Community Ownership: Planning, implementation and networking to ensure the partnership group is included in key decisions.**

   Ideally, local communities have a county CIT steering committee consisting of invested partners who meet on an ongoing basis to discuss issues associated with CIT development. The CIT steering committee will have representatives from at least the mental health and addiction treatment system, key law enforcement agencies, consumer and family advocates, and Veterans Administration or veteran related agencies. This committee may have sub-committees that address the 40-hour training, on-going advanced training, and programs for continuous quality

improvement. The committee may address CIT outreach and follow-up for individuals encountered but not transported to either an assessment center or jail (*Summit County partners a social worker with an off-duty CIT officer to follow-up on cases of concern to either the police or the mental health system*); or may address frequent users of CIT services, with comprehensive intervention and treatment planning for such "hot spotters" (*The city of Delaware does telephone follow-up on all CIT encounters involving individuals not known to the treatment system in an effort to engage them in treatment*).

3) **Policies and Procedures: Standardization of procedures for responding to a mental health crisis.**

Expectations, roles and responsibilities need to be clear for law enforcement and health care providers. This can be accomplished through policies and procedures developed at the county level to address the expectations of multi-jurisdictional CIT partners (*Union County Standard Operating Procedure for Crisis Intervention Team (CIT) Data reporting & Information sharing; Knox County Crisis Intervention Team Response Protocol for Criminal Justice Agencies Behavioral Health Emergencies; Licking County Response Protocol for Criminal Justice Agencies Mental Health Emergencies)* memoranda of understanding across systems or between organizations; common documentation with corresponding written procedures (Sandusky County uses a common encounter form and is working on procedures); and law enforcement agency policies for CITs or mental health calls for service (*Kent State University Police Services*).

We are aware of six ADAMHS Board areas that have some level of policies to address mental health crisis across systems, and two Board areas that are in the process of developing policies. Working partnerships and community ownership are important prerequisites to establishing cross-system policies. Individual law enforcement agencies, however, are able to establish policies that govern officer interactions.

4) **CIT Officer, Dispatcher, Coordinator: In larger agencies a senior-level law enforcement official stewarding the development, implementation, and sustainability of the agency specific CIT program. In smaller or moderately sized law enforcement agencies, an identified CIT lead or liaison.**

86 Ohio counties have CIT trained officers and varying levels of program investment. Seven Ohio ADAMHS Board areas do not host local CIT training; of those, two board areas participate in CIT training in neighboring counties or host abbreviated mental health training for law enforcement; three have had officers periodically attend a neighboring CIT training; and two have no history of CIT training.

Slightly more than half of Ohio law enforcement agencies have CIT-trained officers; however, roughly half of Ohio LE agencies are small, rural organizations. Four counties (Lucas, Cuyahoga, Franklin and Hamilton) are home to a significant portion of the state's population, making these areas important targets for ample CIT training. NAMI Ohio provides mini-grants to LE agencies for first-time participation in CIT training and in some cases for repeat participation when financial needs exist. With a goal to have all agencies involved with CIT (or an equally effective alternative program), the ongoing effort to recruit new agencies to participate in the program is essential. The growth in the number of officers trained annually in Ohio will need to continue. However, we believe that a focus on training numbers alone is not the wisest way to advance this cause. We believe instead a focus on

instituting all the core elements of CIT is the most effective approach to getting the outcomes we all desire. Having county level CIT coordinators dedicated to the CIT program will be most effective in recruiting additional jurisdictions to participate in CIT programs.

Ideally officers volunteer for CIT training and are vetted through an application, screening and selection process by agency administration.[†] Many jurisdictions do not use a volunteer process; even fewer screen and select CIT officers. We are aware of one jurisdiction that requires an application (*Columbus P.D.*).

It is estimated that for larger law enforcement departments, roughly 25% of patrol officers are needed on the CIT to ensure coverage on all shifts.[‡] Rural departments may need to train all officers to ensure 24/7 coverage. Another option is memoranda of understanding with neighboring jurisdictions to provide adequate coverage. The Ohio CIT map (Appendix E) provides an at-a-glance view of the lifetime saturation level of CIT officers per county; however, it does not represent the individual jurisdictions, so can be misleading in some counties (Cuyahoga and Montgomery), and the current map does not account for attrition. The CCoE, NAMI Ohio, and the Ohio Attorney General's Office are currently collaborating on a CIT Officer Roster Project to collect up to date information on the span of the CIT model across the State of Ohio and compile an accurate roster of trained sworn law enforcement officers in each jurisdiction and agency.

The agency-level law enforcement coordinator/lead should be the contact person for the mental health community, other stakeholders and community members, and be responsible for the CIT functions of the agency. NAMI Ohio recently began requiring law enforcement agencies to name a CIT contact person to be eligible for the mini-grants that support officer training.

Having CIT officers without 911 call-takers and dispatchers prepared to identify probable mental illness calls and know which CIT officers are on duty creates missed opportunities to provide the best possible response. Dispatchers need to be trained to identify mental illness calls, use verbal de-escalation skills, and have systems in place to dispatch CIT officers whenever a mental illness call is recognized. Ideally CIT officers will be involved in the curriculum development and delivery of dispatcher training to enhance mutual understanding.

5) **Curriculum: Standardized CIT Training, with a core curriculum and expert presenters and teachers.**

A. Patrol Officer: 40-Hour Comprehensive Training

Ohio CIT officers complete a 40-hour CIT training (may be 32 hours in a county with no mental health sites available for shadowing or field trips), and in most counties wear a CIT lapel pin upon graduation. CIT training content is strong and reasonably consistent across Ohio. When questions arise about the fidelity of a training curriculum, peer experts review the curricula and often observe the training to determine whether it will be classified as CIT. (*Columbiana County is an example of a county that holds cross-systems training for law enforcement but does not meet the core elements of CIT.*) Peer mentoring is also provided to new start-up counties. (*Washington, Mercer/Van Wert, e.g.)*

[†] While selected volunteers are preferred when possible, smaller departments may need to train all officers in order to provide 24/7 coverage.

[‡] The exact percentage needed is unknown and likely varies across departments. The goal is to have enough CIT officers to ensure 24/7 coverage throughout the jurisdiction.

B. Dispatch Training:

Companion courses designed for call-takers and dispatchers vary in length from 6 to 16 hours. Dispatch supervisors are well advised to participate in the full 40-hour course. Video recorded dispatch training is available on the CJ CCoE website. Several CIT programs offer dispatcher training or are in the process of developing local curriculum, but many have not yet developed this area of training.

6) **Mental Health Receiving Facility, Emergency Services: Identified partners who operate under shared principles and procedures.**

A major challenge in Ohio is having secure, safe, trauma informed, "police friendly"[§] places, such as crisis assessment centers or specialized areas of hospital emergency departments to serve as a drop-off site for the police. CIT officers need a facility that welcomes their referrals, operates under a no-wrong-door philosophy, can confine an individual under an order for an emergency evaluation (i.e., a pink-slip), allows for rapid transfer of information from the CIT officer to assessment staff, and allows for a rapid hand-off in responsibility, so that the CIT officer can get back on patrol. The assessment centers in turn need inpatient, crisis stabilization and/or other short-term residential options for individuals who either meet commitment criteria or are willing to avail themselves of needed intensive treatment. This can also include the possible veteran resources, such as VA facilities and clinics that can provide, or should develop, similar units. Not all Ohio communities have the drop-off assessment or inpatient/crisis stabilization services to meet the demand.

As of 2/26/15 there are 17 OhioMHAS licensed residential facilities that provide crisis stabilization services, 15 adult facilities and 2 child facilities. (*Hamilton and Lucas Counties have both adult and child units).* There are many other agencies that provide crisis intervention services that are not residential. Of the seven Ohio counties that have completed Sequential Intercept Mapping and Action Planning – a stakeholders workshop to address the over-representation of individuals with mental illness in the local criminal justice system – five do not have crisis stabilization or 24/7 crisis drop-off services within their jurisdiction, and all five identified the need for crisis services as one of the top five local priorities.

7) **Evaluation and Research: Ongoing program and training evaluation efforts for the purposes of continuous quality improvement, as well as opportunities for external evaluators who can legitimize the training product and establish fidelity to the principles of the CIT model.**

Training evaluations are commonly completed in Ohio CIT programs and used to make improvements in training content and process. (*Hamilton County surveys CIT officers at six months post training to evaluate how CIT training translates to patrol work. Evaluation beyond the training phase is less common, however. Hamilton County has a fairly new website where community members, mental health practitioners and law enforcement can provide feedback and input to the CIT experience.*) Those counties that have established multi-jurisdictional policies and procedures spend some time in their steering committees discussing program elements outside of training.

A Peer Review process is available to Ohio programs through the CJ CCoE. The process is designed to assess the quality and fidelity of CIT programs and training through a combination of self-assessment,

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[§] "police friendly" refers to a site that is prepared to receive referrals from law enforcement officers 24/7, receive the information that officers have to share and then quickly release the officer back to street.

desk audit by peers, and on-site meeting of peer reviewers and steering committee members. A written report highlights strengths and areas for improvement of the program. The CCoE tries to engage up to three programs in peer review each year, but it is a voluntary process. Thirteen peer reviews covering 20 counties have been completed to date, and one review is in the planning stages.

CIT data collection efforts and use of police encounter forms vary across the state but have been increasing over time, in part reflecting the stage of program development in each county. (*Kent State University (KSU), Findlay Police Department, and Bowling Green State University use CIT stat sheets and issue annual CIT/mental health encounter reports comprised of data and narrative analysis. Akron Police Department, Champaign/Logan Counties, and Union County use similar stat sheets and provide data summaries but no analysis or narrative report. By reviewing CIT encounter data, the City of Delaware and Champaign/Logan Counties are able to identify individuals with high law enforcement utilization, and hold mental health-law enforcement meetings to address the needs of these individuals.*) Sample CIT data collection/encounter forms (Appendix F), along with supporting documentation on the value of data collection have been distributed to CIT Coordinators around the state. An important data collection element is capturing information on the outcome of the CIT interaction (e.g., divert to treatment, arrest, taken home, etc.); however, for outcome measures to be meaningful, police must have options for diverting to mental health treatment and a partnership with mental health and consumer advocates to analyze and effectively use the data for improved responses.

NEOMED and Kent State University are currently engaged in the Ohio CIT Data Collection Initiative funded by the Ohio Attorney General's Office to identify trends in encounters among people who are repeatedly coming into contact with law enforcement and provide information about these people to treatment agencies, with the goal of enhancing individualized police response to people with mental illnesses, adapting policies and procedures, and informing training. This initiative will use two tools to collect data: a modified encounter (stat) sheet and Computer Aided Dispatch (CAD) systems.

Ohio has been the source of several CIT research efforts and published reports. A summary of that research is attached (Appendix G), along with a bibliography of published reports compiled by the CIT International Research Committee. (Appendix H)

8) In-Service Training: Continuing education – refresher and advanced - for CIT officers and companion training for community partners.

Advanced trainings are becoming more commonplace for Ohio CIT programs. Last year NAMI Ohio began including the schedule of advanced trainings on the annual CIT training calendar that is distributed to CIT Coordinators. NAMI provides mini-grants to assist with advanced trainings. The CCoE hosts several video-recorded advanced trainings on its website, along with other training resources. Advanced training courses can also include dealing with youth and understanding their brain and adolescent development issues in responding to their call, and advanced training on dealing with calls involving veterans, particularly de-escalation techniques unique to a veteran call. Fifteen Board areas have CIT-Y (Youth) trainers, although this curriculum has been minimally used in Ohio. The revised youth curriculum was recently released, which may present a good opportunity to promote this advanced training.

Consideration should also be given to developing local training for supervisors in law enforcement agencies so that they are fully aware of the CIT program and the intention that on scene the CIT officer is in charge.

9) **Recognition and Honors: Recognition of officers who complete CIT training and effectively implement CIT principles and techniques in a crisis situation.**

While variable in manner and frequency, many Ohio CIT programs recognize and honor CIT officers and successful partnerships. Fairly common practices include certificates, pins, graduating class pictures, and news releases upon graduation from training. (*Specific examples of recognition include the Portage County CIT Officer of the Year and CIT Facebook page, Columbus P.D. intranet CIT web page, and Miami/Darke/Shelby ADAMHS Board CIT web page*). Statewide recognition occurs annually at the Advanced CIT Training Conference with awards for officers, programs, and leadership. The CIT Coordinators email distribution list is also used to highlight successes and best practices around Ohio.

10) **Developing CIT in Other Communities: Promoting the CIT principles and techniques in neighboring towns and counties and around the state.**

Ohio does an excellent job of promoting CIT around the state. Statewide CIT Coordinators meetings are held twice a year with opportunities for networking and sharing of best and innovative practices. A statewide email distribution list is managed by the CJ CCoE and used in like manner to distribute current news and updated resources, promote best practices, and generate discussion around timely issues. The annual Advanced CIT Training Conference is coordinated by NAMI Ohio and funded by the Ohio Attorney General's Office.

SPECIFIC RECOMMENDATIONS AND ACTION STEPS

1. Partnerships of Law Enforcement, Advocacy, Mental Health

a. **We propose that state funders consider providing financial support to ensure that each of Ohio's multi-jurisdictional CIT programs has a law enforcement and mental health coordinator.**
   i. Continue supporting established partnerships through technical assistance, statewide training and networking opportunities. (CJ CCoE)
   ii. Assist new or developing communities through technical assistance and resources. (CJ CCoE, NAMI Ohio, Peer Mentors)

b. Strategize ways to get the following counties to participate in CIT, beginning with partnership discussions: Carroll/Tuscarawas, Scioto/Lawrence/Adams, Jefferson, Putnam, Ashland, and Ashtabula. (all state partners)

c. Encourage implementation of CIT in state (DRC) and local correction facilities.

2. Community Ownership: Planning, implementation and networking

a. Each multi-jurisdictional CIT program should have a Steering Committee comprised of key stakeholders that meets regularly to discuss program development and training improvement. The Steering Committee should be led by the mental health, law enforcement, and advocacy coordinators and should include representatives from the Veterans Administration or veterans related agencies. (technical assistance, CJ CCoE)

b. Each CIT program should have regular meetings of healthcare providers and law enforcement representatives for the purpose of case planning around problem cases, especially frequent users of CIT services or individuals of concern to the police, mental health workers or advocacy groups. This is separate from the steering committee and logically follows the implementation of CIT encounter forms.

3. **Policies and Procedures: Standardization of procedures for responding to a mental health crisis.**
    a. Identify multi-jurisdictional CIT programs that have established partnerships to develop policies or MOUs around mental health crisis response and CIT
    b. Provide sample policies to CIT Program Coordinators and law enforcement agencies
    c. Emphasize record keeping, data collection, and outcomes reporting as important aspects of program policies
4. **CIT Officer, Dispatcher, Coordinator: A senior-level law enforcement official providing oversight to agency development, implementation, and sustainability of the CIT program.**
    a. Officers: access to 24/7 CIT coverage in all Ohio jurisdictions and selection of officers
        i. **Maintain adequate support and infrastructure to continue the strong trajectory of Ohio CIT training.** Use the results of the CIT Officer Roster Project to identify jurisdictions that should be prioritized for officer training, in addition to the following:
            1. Cuyahoga County – suburbs of Cleveland
            2. Montgomery County – jurisdictions outside of the city of Dayton
        ii. Collaborate with CIT coordinators to target recruitment efforts and maintain an accurate statewide roster of active CIT officers by jurisdiction and county
        iii. Continue financial support to jurisdictions that cannot afford to release patrol officers for training, and determine if greater needs exist
        iv. Encourage use of an application, screening, and selection process for CIT officers in jurisdictions where only a portion of the force is required to provide 24/7 CIT coverage.
        v. Encourage law enforcement agencies to institute scheduling patterns that provide 24/7 CIT coverage and set goals for training that support this.
    b. **Dispatchers: Provide ample companion training around the state for all call takers and dispatchers to understand their role in CIT and be proficient at managing crisis calls**
    c. Coordinators: Each LE agency should identify a CIT lead to ensure fidelity to the core elements and work closely with the local mental health coordinator and county-level law enforcement coordinator.
5. **Curriculum: Standardized CIT Training, with a core curriculum and expert presenters and teachers.**
    a. Encourage the development of local companion courses, especially for dispatchers. Recommend that local CIT officers have input to the curriculum and are used as trainers whenever possible.
6. **Mental Health Receiving Facility, Emergency Services: specialized mental health emergency care**
    a. **Establish police friendly crisis drop-off sites**
        i. **For CIT to be successful, law enforcement officers need access to 24/7 specialized mental health emergency care for individuals in crisis**
    b. **Establish a sufficient number of crisis stabilization units to provide access to short-term stabilization services for all counties/ADAMHS Board areas**

c. Establish sufficient detox facilities and options to provide access to inpatient and outpatient alcohol and drug detox services for all counties/ADAMHS Board areas

7. Evaluation and Research

a. (Re)distribute the Core Elements document and Ohio Consensus document through the CIT Coordinators email distribution list (CJ CCoE)
b. Encourage the use of Peer Review to assist CIT programs in planning next steps (all state partners)
c. Distribute the Ohio CIT research summary and CIT International Research bibliography to all CIT Coordinators, Police Chiefs, and Sheriffs (CJ CCoE and CIT Coordinators)
d. Distribute the results of the Ohio CIT Data Collection Initiative upon completion and provide recommendations for next steps

8. In-Service Training: Continuing education – refresher and advanced - for CIT officers and companion training for community partners.

a. Strongly encourage CIT programs to hold regular refresher training for CIT officers
b. Continue to offer incentives for CIT communities to host advanced CIT officer training. These trainings should reflect local needs.
c. There is a general need for more training related to interacting with youth, including adolescent development and special needs. CIT-Youth warrants further discussion and planning. With the newly released curriculum, this may be a good time to consider expanding the pool of available Ohio trainers, i.e., host Train the Trainer in collaboration with the CJ CCoE, the Center for Innovative Practices, and possibly Wayne/Holmes trainers who have the most direct experience using the curriculum.
d. Explore distance learning initiatives with both OPOTA and the CJ CCoE.
e. CIT coordinators and officers should be encouraged and supported to attend the annual CIT Advanced training organized by NAMI Ohio with the CJ CCoE and the CIT International meeting held annually or every other year.

9. Recognition and Honors:

Encourage all 88 counties to hold annual recognition programs thanking both the CIT officers for their commitment and courage and the myriad of mental health professionals, individuals with mental illness and family members who commit , without compensation, to planning and implementing CIT training and the other elements of the CIT program.

10. Outreach: Developing CIT in Other Communities

CIT coordinators from law enforcement, mental health and advocacy should participate actively in the Ohio CIT Coordinators group both by attending in-person twice yearly meetings and by participating in the CIT Coordinators email list. CIT coordinators should offer best practice ideas and other support to neighboring communities so that every program in Ohio can benefit from the expertise of their peers.

Resources

Compton, M. T., Broussard, B., Munetz, M., Oliva, J. R., & Watson, A. C. (2011). *The Crisis Intervention Team (CIT) Model of Collaboration between Law Enforcement and Mental Health.* New York: Nova Science Publishers, Inc.

Council of State Governments Justice Center. (2012). *Statewide Law Enforcement/Mental Health Efforts: Strategies to Support and Sustain Local Initiatives.* New York: Council of State Governments Justice Center.

Council of State Governments Justice Center and the Police Executive Research Forum. (2010). *Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Individual Jurisdictions.* New York: Council of State Governments Justice Center.

Reuland, M., Schwarzfeld, M., & Draper, L. (2009). *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed POLICY AND PRACTICE.* New York: Council of State Governments Justice Center.

APPENDIX A

To: NAMI Ohio
From: Michael Woody - Law Enforcement liaison; Criminal Justice Coordinating Center of Excellence
Ref: Number of people having gone through a CIT (Crisis Intervention Team) course in Ohio since its inception

Introduction - The ADM Board of Summit County sent Lt. Michael Woody who at that time was the Director of Training for the Akron Police Department to Memphis, Tennessee in 1999 to explore their CIT Program for possible implementation in Summit County. He went through the 40-hour course there and brought materials back that would be used for the very first CIT Course to be held in Akron, Ohio. That course took place in May of 2000. Because of the positive publicity the course had and the successful use of skills learned by the volunteer Akron police officers that went through it, it came to the attention of the Ohio Supreme Court. It also came to the attention of ODMH and NAMI of Ohio. ODMH provided a grant to fund the Criminal justice Coordinating Center of Excellence (CJCCOE) to at that time try to garner interest in CIT around the state.

Here are the statistics (not thoroughly accurate but close)of the fruits of these efforts:

2000: **49** persons went through the Summit County CIT course held twice that year

2001: **84** persons went through the course held in Lucas and Summit counties

2002: **165** persons went through the course held in Lorain, Lucas & Summit counties

2003: **179** persons went through the course held in Athens, Hancock, Lucas, Stark & Summit counties

2004: **618** persons went through the course held in Summit, Lucas, Athens, Cuyahoga, Licking, Richland, Brown, Montgomery, Medina, Hamilton, Franklin & Lake counties

2005: **445** persons went through the course held in Summit, Athens, Cuyahoga, Delaware, Franklin, Licking, Lucas, Richland, Six County, Montgomery, Lake, Hancock & Wayne counties

2006: **429** persons went through a course held in Summit, Athens, Clark, Cuyahoga, Franklin, Geauga, Licking, Lucas, Miami, Portage, Richland, Seneca, Six County, Stark, Trumbull & Wayne counties

2007: **615** persons went through a course held in Summit, Athens, Clark, Cuyahoga, Delaware, Franklin, Geauga, Licking, Lucas, Mahoning, Miami, Portage, Richland, Seneca, Six County, Trumbull, Montgomery, Lake, Huron, Hancock, Fairfield & Wayne counties

2008: **572** persons went through a course held in Summit, Athens, Champaign, Cuyahoga, Delaware, Franklin, Geauga, Lucas, Mahoning, Medina, Miami, Portage, Richland, Seneca, Six County, Stark, Trumbull, Lake, Huron, Fairfield, Crawford & Wayne counties

2009: **647** persons went through a course held in Summit, Athens, Champaign, Clark, Cuyahoga, Delaware, Franklin, Geauga, Hamilton, Licking, Lorain, Lucas, Mahoning, Medina, Miami, Portage, Richland, Seneca, Stark, Trumbull, Lake, Fairfield & Crawford counties

2010: **791** persons went through a course held in Summit, Athens, Champaign, Clark, Cuyahoga, Delaware, Franklin, Geauga, Hamilton, Licking, Lucas, Mahoning, Medina, Miami, Montgomery, Portage, Richland, Seneca, Stark, Trumbull, Wayne, Brown, Lake, Huron & Henry counties

2011: **709** persons went through a course held in Summit, Allen, Athens, Champaign, Clark, Cuyahoga, Delaware, Gallia, Geauga, Hamilton, Hancock, Licking, Lorain, Lucas, Mahoning, Medina, Miami, Portage, Richland, Seneca, Six County, Stark, Trumbull, Warren & Wayne counties

2012: **809** persons went through a course held in Summit, Athens, Champaign, Clark, Clermont, Cuyahoga, Delaware, Franklin, Gallia, Geauga, Hamilton, Hancock, Licking, Lorain, Lucas, Mahoning, Medina, Miami, Portage, Preble, Richland, Seneca, Six County, Stark, Trumbull, Union, Warren, Wayne, Wood & Henry counties

2013: **687** persons went through a course held in Clermont, Summit, Belmont, Clark, Cuyahoga, Delaware, Franklin, Gallia, Hamilton, Lucas, Mahoning, Medina, Preble, Seneca, Six County, Stark, Trumbull, Union, Lake, Henry, Geauga, Warren, Licking, Lorain, Wood, Ross, Champaign, Four County, Wayne, Richland, Athens, Jackson, Miami & Portage counties

2014: **951** persons went through a CIT course held in 47 locations (some more than once per year)

TOTAL: 7,750

Respectfully Submitted
March 3rd, 2015
by Michael Woody

APPENDIX B

CRISIS INTERVENTION TEAM CORE ELEMENTS

Crisis Intervention Team
Core Elements

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September, 2007

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SECTION 1

CIT Model
Core Elements: Summary

The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. The CIT Model was first developed in Memphis and has spread throughout the country. It is known as the "Memphis Model." CIT provides law enforcement-based crisis intervention training for assisting those individuals with a mental illness, and improves the safety of patrol officers, consumers, family members, and citizens within the community.

CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with a mental illness. The CIT Model reduces both stigma and the need for further involvement with the criminal justice system. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system and creates the context for sustainable change.

Basic Goals:

- *Improve Officer and Consumer Safety*
- *Redirect Individuals with Mental Illness from the Judicial System to the Health Care System*

In order for a CIT program to be successful, several critical core elements should be present. These elements are central to the success of the program's goals. The following outlines these core elements and details the necessary components underlying each element.

CORE ELEMENTS

Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health
2. Community Ownership: Planning, Implementation & Networking
3. Policies and Procedures

Operational Elements

4. CIT: Officer, Dispatcher, Coordinator
5. Curriculum: CIT Training
6. Mental Health Receiving Facility: Emergency Services

Sustaining Elements

7. Evaluation and Research
8. In-Service Training
9. Recognition and Honors
10. Outreach: Developing CIT in Other Communities

SECTION 2

CIT Model
Core Elements: Outline

Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health
    A. Law Enforcement Community
    B. Advocacy Community
    C. Mental Health Community
2. Community Ownership: Planning, Implementation & Networking
    A. Planning Groups
    B. Implementation
    C. Networking
3. Policies and Procedures
    A. CIT Training
    B. Law Enforcement Policies and Procedures
    C. Mental Health Emergency Policies and Procedures

Operational Elements

4. CIT: Officer, Dispatcher, Coordinator
    A. CIT Officer
    B. Dispatch
    C. CIT Law Enforcement Coordinator
    D. Mental Health Coordinator
    E. Advocacy Coordinator
    F. Program Coordinator (Multi-jurisdictional)
5. Curriculum: CIT Training
    A. Patrol Officer: 40-Hour Comprehensive Training
    B. Dispatch Training
6. Mental Health Receiving Facility: Emergency Services
    A. Specialized Mental Health Emergency Care

Sustaining Elements

7. Evaluation and Research
    A. Program Evaluation Issues
    B. Development Research Issues
8. In-Service Training
    A. Extended and Advanced Training
9. Recognition and Honors
    A. Examples
10. Outreach: Developing CIT in Other Communities
    A. Outreach Efforts

SECTION 3

CIT Model
Core Elements: Detailed

3.1 Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health

A. Law Enforcement Community

Participation and Leadership within the Law Enforcement Community

Central to the formation and success of CIT is the role of the law enforcement community. Trained CIT Officers are able to interact with crisis situations using de-escalation techniques that improve the safety of the officer, consumer, and family members. In addition, the law enforcement community is able to provide care and help to consumers by transporting individuals in need of special treatment to appropriate facilities. It is also critical that all law enforcement participate in the formation of CIT and engage in all elements of the planning and implementation stages. Often those involved in the formation of the CIT program will become or help select the CIT coordinator for a particular law enforcement agency. The two main components within the law enforcement partnership are the operational Crisis Intervention Team within a law enforcement agency and general criminal justice system participants.

1) Law Enforcement: CIT Operational Component
   - Police Department
   - Sheriff's Department

2) Law Enforcement: Criminal Justice Partnership Component
   - Corrections
   - Judiciary
     Public defender, State Attorney, Judges, Probation/Parole
   - Crime Commission/Public Safety Commission

3) Law Enforcement: Policy Development Component
   - Law enforcement command staff
   - Training and Standards

1. Partnerships: Law Enforcement, Advocacy, Mental Health

B. Advocacy Community

Participation and Leadership within the Advocacy Community

Participation from the Advocacy Community is critical to the success of CIT. This partnership provides strong support from passionate and dedicated people whose goal is to improve the quality of life for individuals affected by a mental illness. Leadership roles should develop in the form of liaisons that help voice the support, ideas, and concerns of consumers and family members. This aspect of CIT brings the program to life by adding insight from those directly affected. This important partnership should be established early in the planning process and should continue as an ongoing operational element of CIT.

1) Consumers/Individuals with a Mental Illness
   The personal accounts of individuals with a mental illness greatly enhance the planning process, officer training, and on-going support for CIT. Officers are able to gain an improved understanding and more realistic view of mental illness through these first-hand presentations. As a result, the involvement of individuals with a mental illness in the development, implementation, and ongoing sustainability of CIT is essential.

2) Family Members
   Due to their first-hand knowledge and experience in dealing with mental illness, family members have a great deal to offer CIT. Family members also have much to gain from CIT, as the program encourages treatment instead of incarceration. In both the development and implementation phases of building a CIT program, this interdependency allows family members to provide direct guidance and assistance to the planning process, training and community education. Therefore, the involvement of family members is a critical hallmark of the CIT program.

3) Advocacy Groups
   Advocacy groups may consist of family members, consumers, friends, and/or other individuals or groups that advocate for important issues surrounding mental illnesses and aim to improve the quality of life for those affected. Partnerships with advocacy groups, much like the partnerships with consumers and family members, are critical to the success of CIT. They provide strong support systems not only for members of the community, but also for law enforcement and mental health communities, as well as consumers. Advocacy groups may help by providing a voice for individuals with a mental illness; they also assist family members and consumers by providing services and guidance.

3) Advocacy Groups (continued)

Below is a list of some of the advocacy groups that have been critical to the initial development of CIT programs across the nation.

- National Alliance on Mental Illness (NAMI)
  NAMI is a nonprofit, grassroots, advocacy organization whose mission is to eliminate mental illnesses and improve the quality of life for those who are affected. NAMI members consist of consumers, family members, and friends of individuals with a mental illness. www.nami.org

- National Mental Health Association (NMHA)
  NMHA is a nonprofit organization that seeks to address all aspects of mental health and mental illness. NMHA works to improve the mental health of all Americans through advocacy, education, research, and service. www.nmha.org

- *Many other advocacy groups have participated in the initial development of CIT programs throughout the nation. These groups include those representing individuals with mental illness, as well as those representing local and state government, mental health agencies, and the judiciary.*

1. Partnerships: Advocacy, Law Enforcement, Mental Health

B. Mental Health Community

Participation and Leadership within the Mental Health Community

The mental health community plays an important role in the successful implementation, development, and ongoing sustainability of CIT. These professions provide treatment, education and training that result in a wide dissemination of knowledge and expertise to both individuals with a mental illness and patrol officers undergoing CIT training. This partnership is essential to maintaining access to the health care system and quality treatment.

1) Providers, Educators, Practitioners, and Trainers

- Professionals
  Psychologists, Psychiatrists, Physicians, Social Workers, Counselors, Pastoral Counselors, Alcohol/Drug Counselors, Educators, Trainers, and Criminologists

- Public, Non profit & Private Agencies; Institutions; & Universities
  Hospitals, Mental Health Centers, Emergency Intake Facilities, Universities, Colleges, and Medical Schools

- Trainers
  Local professionals and agencies are encouraged to provide instruction during CIT training voluntarily as a service to the community. This is strongly suggested in an effort to minimize the training costs for local law enforcement agencies.

2. Community Ownership: Planning, Implementation & Networking

Communities both large and small are seeking solutions to crisis issues and situations. Community collaborations and partnerships are essential to this effort. Additionally, it is important to establish community ownership, which may be described as a dedicated investment that individuals within the community have in the CIT program. Individuals and organizations within the community must have a stake in the initial planning stages; the implementation of the CIT program and its training curriculum; and ongoing feedback in order to maintain, improve, and ensure the success of CIT. Also, local professionals and agencies, who dedicate their time without charge to assist in training the patrol officers, help to increase the sense of community ownership for CIT.

A. Planning

1) Advocates
2) Citizens
3) Consumers/Individuals with a Mental Illness
4) Family Members
5) Government
6) Judiciary
7) Law Enforcement Community
8) Mental Health Community

B. Implementation

1) Leadership from Law Enforcement, Mental Health, and Advocacy Community
2) Training Curriculum

C. Networking

1) Feedback
2) Problem Solving

3. Policies and Procedures

Policies and procedures are a necessary component of CIT. They provide a set of guidelines that direct the actions of both law enforcement and mental health officials. Due to the large number of stakeholders in CIT, it is important that these guidelines be designed by all those affected. Within the law enforcement community, policies exist in order to provide guidelines regarding how to properly transport consumers and how to develop an infrastructure through a system of partnerships and inter-agency agreements. These law enforcement policies address the actions of both emergency dispatchers and CIT patrol officers. The emergency dispatchers identifies the nearest available CIT Officer to respond to the crisis. The CIT Officer then responds to the crisis event and leads the intervention. CIT Officers should be allowed to integrate their wide range of law enforcement training when handling CIT calls. Within the mental health community, policies exist in order to provide guidelines regarding how to handle referrals from CIT Officers. The mental health community also plays a key role in training and feedback for the CIT program. The role of the advocacy community in policies and procedures are often more informal but involve the critical element of networking and feedback for the overall program.

A. CIT Training

1) Inter-Agency Agreements

2) Size and Scope

The number of trained CIT officers available to any shift should be adequate to meet the demand load of the local consumer community. Experience has shown that a successful CIT program will have trained 20-25% of the agency's patrol division. There are differences that exist between large urban communities and small rural communities. Smaller agencies may need to train a higher percentage of officers. Ultimately, the goal is to have an adequate number of patrol officers trained in order to ensure that CIT-trained officers are available at all times.

All dispatchers should be trained to appropriately elicit sufficient information to identify a mental health related crisis.

B. Law Enforcement Policies and Procedures

1) Dispatch Policies and Procedures

The nearest CIT Officer is identified and dispatched to the crisis event.

2) Patrol Policies and Procedures

Policies that maximize the officer's discretion are critical. In addition, a policy should address the issue of the lead CIT Officer, who guides the resolution of the crisis event.

C. Mental Health Emergency Policies and Procedures

1) Law Enforcement Referral Policies

The policies in place should allow for a wide range of inpatient and outpatient referral sources in order to accommodate law enforcement agencies with a CIT program. Barriers that prevent officers from accessing immediate mental healthcare for an individual with mental illness should be eliminated. This should be a priority as important as any other in the CIT process. In addition, policies should be set to ensure minimal turnaround time for the CIT Officers, so that it is less than or equivalent to the turnaround time in jail.

4. CIT: Officer, Dispatcher, Coordinator

Individuals within the law enforcement community primarily consist of CIT Officers, Dispatchers, and a CIT Coordinator. The following core element addresses the personnel required to effectively operate a CIT program.

A. CIT Officer

Officers within a patrol division should voluntarily apply for CIT positions. Each candidate then goes through a selection process, which is assessed according to the officer's application, recommendations, personal disciplinary police file, and an interview. Once selected, each of the CIT Officers maintains their role as a patrol officer and gains new duties and skills through the CIT training, serving as the designated responder and lead officer in mental health crisis events.

1) Voluntary
2) Selection Process
3) Patrol Role
4) CIT Role
5) CIT Training and CIT Skills
6) Safety Skills

B. Dispatch

Emergency dispatchers are a critical link in the CIT program and may include call takers, dispatchers, and 911 operators. The success of CIT depends on their familiarity with the CIT program, knowledge of how to recognize a CIT call involving a behavioral crisis event, and the appropriate questions to ask in order to ascertain information from the caller that will help the responding CIT Officer. Finally, dispatchers should know how to appropriately dispatch a CIT Officer. Dispatchers should receive training courses (a minimum of 8-16 hours) in CIT and additional advanced in-service training.

1) CIT Training
2) Familiarity with CIT
3) Recognize Call as CIT Crisis Event
4) Ask Caller Appropriate Questions
5) Dispatch Nearest CIT Officer
6) Additional/Advanced In-Service Training

4. CIT: Officer, Dispatcher, Coordinator

C. CIT Law Enforcement Coordinator

The CIT coordinator is part of the law enforcement community and acts as a liaison by maintaining partnerships with program stakeholders in order to ensure the success of CIT. The coordinator's involvement with CIT should start from the beginning and continue through the planning, implementation, and evaluation stages. The CIT coordinator provides support to CIT officers through training and feedback. The qualifications should include leadership ability and experience as a law enforcement officer. The job responsibilities include program development, training coordination, and maintenance of relationships with community partnership. The CIT coordinator also is a point of contact with the law enforcement agency for the community and brings stability to the program.

D. Mental Health Coordinator

The mental health coordinator is part of the mental health community who provides leadership and serves as a liaison with the advocacy and law enforcement communities. This position may be established or developed informally. When it is left as an informal liaison there may be several individuals who serve this function. It is important that each of them work with the overall community effort. This position has a significant operational component involving the training, curriculum and the function of the receiving facility or receiving facilities

E. Advocacy Coordinator

The advocacy coordinator is part of the advocacy community, which includes advocates, family members, and individuals with mental illness. As with the mental health coordinator, the position may be established or developed informally. When it is left as an informal liaison there may be several individuals who serve this function. It is important each of them work with the overall community effort. This position often involves the operational components such as training, curriculum and ongoing problem solving.

F. Program Coordinator

Multi-agency CIT programs may have a need for a Program Coordinator who is largely responsible for the day to day logistics of inter-departmental communication, data collection and management, records keeping and scheduling training. This person should be familiar with the roles of three primary components of the CIT program and comfortable and effective in communicating in all three environments. Much of the role of this person will be diplomatic in nature. They may have additional duties in identifying and securing sustaining programmatic resources.

5. Curriculum: CIT Training

The CIT program is an innovative national model of police-based crisis intervention with community mental health care and advocacy partnerships. Police officers receive intensive training to effectively respond to citizens experiencing a behavioral crisis. Patrol officers already have training and a basic understanding of the proper safety skills. Officers are encouraged to maintain these skills throughout the course, while incorporating new de-escalation techniques to more effectively approach a crisis situation. It is important that the individuals from the mental health, law enforcement, and advocacy communities play a critical role in the training curriculum in order to bring experience, ideas, information, and assistance to the CIT Officers in training. Additionally, all training faculty are encouraged to complete the 40-hour comprehensive course and participate in a ride-along in order to fully understand the complexities and differences that exist between mental health care and law enforcement.

A. Patrol Officer: 40-Hour Comprehensive Training

The 40-hour comprehensive training emphasizes mental health-related topics, crisis resolution skills and de-escalation training, and access to community-based services. The format of a 40-hour course consists of didactics/lectures, on-site visitation and exposure to several mental health facilities, intensive interaction with individuals with a mental illness, and scenario based de-escalation skill training. Experience has shown this is a minimum level of training hours. The material covered is complex. The desired learning outcomes go beyond simple cognitive retention of material. The outcome desired is the retention of behavioral changes learned as part of the training.

1) Didactics and Lectures/Specialized Knowledge

- Clinical Issues Related to Mental Illnesses
- Medications and Side Effects
- Alcohol and Drug Assessment
- Co-Occurring Disorders
- Developmental Disabilities
- Family/Consumer Perspective
- Suicide Prevention and Practicum Aspects
- Rights/Civil Commitment
- Mental Health Diversity
- Equipment Orientation
- Policies and Procedures
- Personality Disorders
- Post Traumatic Stress Disorders (PTSD)
- Legal Aspects of Officer Liability
- Community Resources

5. Curriculum: CIT Training

A. Patrol Officer: 40-Hour Comprehensive Training (Continued)

2) On-Site Visits and Exposure

- On-Site Visits

3) Practical Skill Training/Scenario Based

- Crisis De-Escalation Training Part I
  Basic Strategies
- Crisis De-Escalation Training Part II
  Basic Verbal Skills
- Crisis De-Escalation Training Part III
  Stages/Cycle of a Crisis Escalation
- Crisis De-Escalation Training Part IV
  Advanced Verbal Skills
- Crisis De-Escalation Training Part V
  Advanced Strategies: Complex Scenarios

4) Questions and Answers

5) Commencement and Recognition

B. Dispatch Training

All dispatchers receive a specialized course detailing the structure of CIT. The training course also addresses how to properly receive and dispatch calls involving individuals with a mental illness and crisis situations. Additional and advanced in-service training courses should also be incorporated. Topics that are covered in the dispatcher's training course are listed below.

1) Recognition and Assessment of a CIT Crisis Event

2) Appropriate Questions to Ask Caller

3) Identify Nearest CIT Officer

4) Policies and Procedures

6. Mental Health Receiving Facility: Emergency Services

A designated Emergency Mental Health Receiving Facility is a critical aspect of the CIT Model. It provides a source of emergency entry for consumers into the mental health system. To ensure CIT's success, the Emergency Mental Health Receiving Facility must provide CIT Officers with minimal turnaround time and be comparable to the criminal justice system. The facility should accept all referrals regardless of diagnosis or financial status. Additionally, the facility will need access to a wide range of emergency health care services and disposition options, as well as, alcohol and drug emergency services. Finally, the Emergency Mental Health Receiving Facility is part of the operational component of the CIT Model that provides feedback and engages in problem solving with the other community partners, such as Law Enforcement and Advocacy Communities.

A. **Specialized Mental Health Emergency Care**

1) Single Source of Entry (or well-coordinated multiple sources)
2) On Demand Access: Twenty-Four Hours/Seven Days A Week Availability
3) No Clinical Barriers to Care
4) Minimal Law Enforcement Turnaround Time
5) Access to Wide Range of Disposition Options
6) Community Interface (Feedback and Problem Solving Capacity)

7. Evaluation and Research

Evaluation and research can help measure the impact, continuous outcomes, and efficiency of a community's CIT program. More specifically, it may help to identify whether the program is achieving its objectives and should be an ongoing part of CIT. Outcome research has shown CIT to be effective in developing positive perceptions and increased confidence among police officers; providing very efficient crisis response times; increasing jail diversion among those with a mental illness; improving the likelihood of treatment continuity with community-based providers; and impacting psychiatric symptomatology for those suffering from a serious mental illness, as well as substance abuse disorders. This was all accomplished while significantly decreasing police officer injury rates. The following components are being studied within CIT, some currently and others in the planning stages of evaluation.

A. Research and Evaluation Issues

1) Development of Community Consensus
2) Improved Law Enforcement Perception of Individuals with Mental Illness
3) Increased Confidence in Interacting with Individuals with Mental Illness
4) Decreased Crisis Response Times
5) Decreased Law Enforcement Injury Rates
6) Decreased Citizen Injury Rates
7) Improved Health Care Referrals
8) Decreased Arrest Rates
9) Jail Diversion Impact
10) Increased Treatment Continuity
11) Improved Treatment Outcomes
12) Decreased Psychiatric Symptomatology
13) Impact on Recidivism Rate
14) Improved Community Perception of Law Enforcement

8. In-Service Training

In-service training provides CIT Officers with additional knowledge and skills. In-service trainings should be offered regularly for current CIT Officers who have completed the 40-Hour Comprehensive Crisis De-Escalation Training course. The following is a list of several topics that have been used in previous In-service trainings:

A. Extended and Advanced Training

1) Extended/Advanced Suicide Crisis Intervention Training
2) Advanced Developmental Disabilities
3) New Developments in Psychiatric Medications
4) Advanced Verbal Skill Training (*Crisis Hotline)*
5) Advanced Scenario Training

9. Recognition and Honors

Recognizing and honoring CIT Officers provides a sense of accomplishment and ownership toward the program. It also gives officers an incentive to continue in their line of work. Recognition and honors can be awarded through local media, newsletters, program websites, or annual banquets. Such honors should be given to CIT Officers who have served the community in crisis situations with exceptional care and compassion, while ensuring the safety of themselves and others.

A. Examples

1) Awards
   Departmental commendation for successfully de-escalating a crisis event

2) Certificate of Recognition
   During monthly advocacy meetings, CIT Officers may be introduced to the community and given a Certificate of Recognition.

3) Annual Banquet
   CIT Officers may be recognized and honored at an Annual CIT Banquet. The following are examples of the awards that can be given:

   - CIT Officer of the Year
   - Precinct CIT Officer of the Year
   - Five- or Ten-Year CIT Service Awards
   - New CIT Officer of the Year
   - Certificate of Appreciation/Recognition
     For Individuals within the Mental Health Community
     For Individuals within the Advocacy Community
     For Other Individuals within the Community

10. Outreach: Developing CIT in Other Communities

Developing CIT programs in other communities, through partnerships and outreach efforts, will help to ensure that individuals who suffer from a mental illness receive the proper care needed, while increasing the safety of the community, patrol officers, family members, and consumers. Outreach efforts may include the involvement of other local communities in a 40-Hour CIT Comprehensive Training Course. The following are possible outreach efforts:

A. Outreach Efforts

1) Local Communities/Agency Development
   Provide 40-Hour CIT Comprehensive Training Course for local communities and agencies.

2) Regional Community/Agency Development
   Help other communities develop a CIT program and their own 40-Hour CIT Comprehensive Training Course.

3) Statewide CIT Development
   Develop a statewide CIT effort to establish CIT programs in police and sheriff's departments.

4) Legislative Development
   Develop a strong lobbying effort to educate policy makers and help secure adequate funding for program development

APPENDIX C

EXPERT CONSENSUS DOCUMENT:

CORE ELEMENTS FOR EFFECTIVE CRISIS INTERVENTION TEAM (CIT) PROGRAMS

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 which 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 who 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 free standing 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 officers 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 professionals

  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.

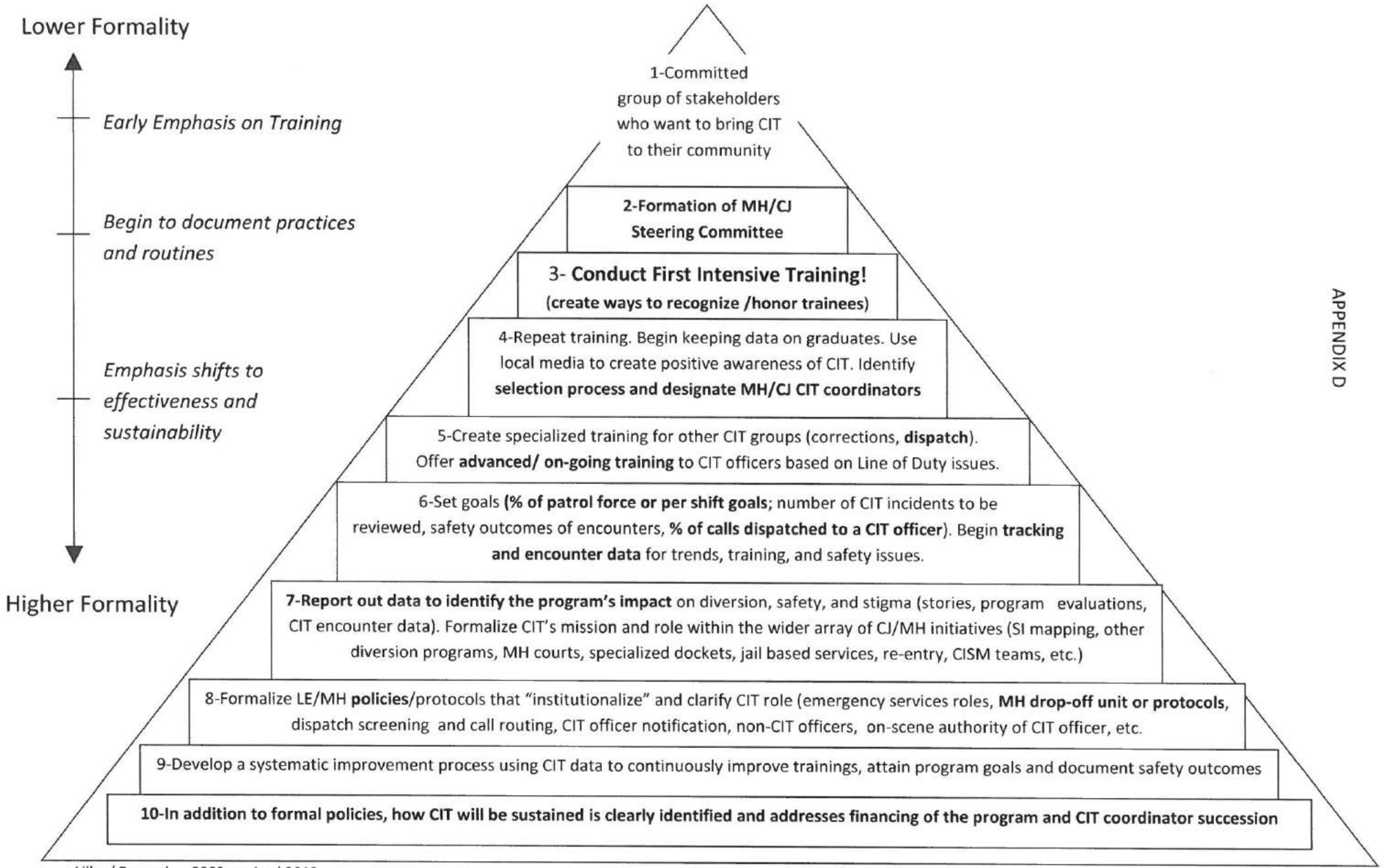
12. The law enforcement department will develop policies and procedures to effectively interact with people in a mental illness crisis. This will address the roles of dispatchers, CIT officers, and non-CIT officers. These policies will include:

    - 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)

CIT PROGRAM EVOLUTION



Lilley/ December 2009, revised 2012

APPENDIX D

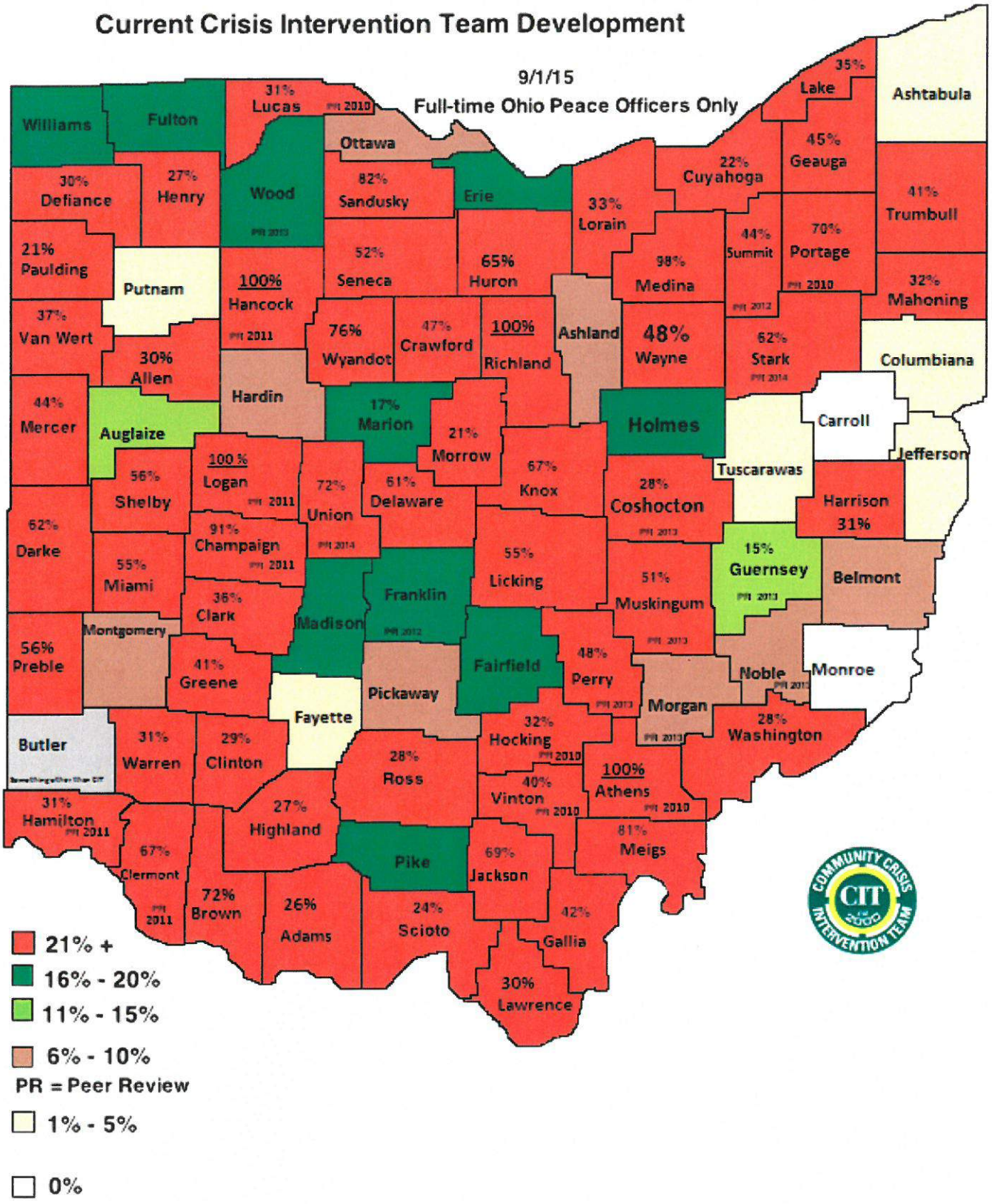
APPENDIX E

CURRENT CRISIS INTERVENTION TEAM DEVELOPMENT

OHIO CIT COLOR MAP

9/1/15

FULL-TIME OHIO PEACE OFFICERS ONLY


Current Crisis Intervention Team Development
9/1/15
Full-time Ohio Peace Officers Only
Williams
Fulton
31% Lucas PR 2010
Ottawa
35% Lake
Ashtabula
30% Defiance
27% Henry
Wood PR 2013
82% Sandusky
Erie
22% Cuyahoga
45% Geauga
41% Trumbull
21% Paulding
Putnam
100% Hancock PR 2011
52% Seneca
65% Huron
33% Lorain
98% Medina
44% Summit PR 2012
70% Portage PR 2010
32% Mahoning
37% Van Wert
30% Allen
76% Wyandot
47% Crawford
100% Richland
Ashland
48% Wayne
62% Stark PR 2014
Columbiana
44% Mercer
Auglaize
Hardin
17% Marion
21% Morrow
Holmes
Carroll
Jefferson
Tuscarawas
56% Shelby
100% Logan PR 2011
72% Union PR 2014
61% Delaware
67% Knox
28% Coshocton PR 2013
Harrison 31%
62% Darke
91% Champaign PR 2011
55% Licking
15% Guernsey PR 2013
Belmont
55% Miami
36% Clark
Madison
Franklin PR 2012
51% Muskingum PR 2013
Montgomery
56% Preble
41% Greene
Fairfield
48% Perry PR 2013
Noble PR 2013
Monroe
Pickaway
Morgan PR 2013
Fayette
Butler
31% Warren
29% Clinton
32% Hocking PR 2010
28% Washington
28% Ross
40% Vinton PR 2010
100% Athens PR 2010
31% Hamilton PR 2011
27% Highland
Pike
69% Jackson
81% Meigs
67% Clermont PR 2011
72% Brown
26% Adams
24% Scioto
42% Gallia
30% Lawrence
21% +
16% - 20%
11% - 15%
6% - 10%
PR = Peer Review
1% - 5%
0%
COMMUNITY CRISIS INTERVENTION TEAM
CIT
2000

APPENDIX F

AKRON POLICE DEPARTMENT

CRISIS INTERVENTION TEAM

STAT SHEET

After Hours Voicemail: CSS 330-996-9141 / 8 / ext. 911 Portage Path 330-253-3100 ext. 205

AKRON POLICE DEPARTMENT
CRISIS INTERVENTION TEAM
STAT SHEET

Date _____ Nature Code _____ Time of Call _____ On Scene Time _____

Location _____ District _____ Did you volunteer for call: Yes/No

Subject:
Last Name _____ First Name _____ M.I. _____
Address _____ Phone: _____
Sex/Race _____ Age _____ Height _____ Weight _____ Hair Color_____ Hair Type _____
Eye Color _____ Complexion _____ Beard/Mustache _____ DOB _____ SSN _____
Emergency Contact (family/friend): _____ Phone: _____

CIT Officer(s): (1)_____ (2)_____

Were you requested by (circle): other officers EMS subject's family case worker other (explain on back)

Supervisor(s) on the scene: ( ) yes ( ) no Report # _____

EQUIPMENT/TECHNIQUE USED:
( ) Verbal de-escalation techniques
( ) Handcuffs
( ) OC spray
( ) M26 Advanced Air Taser: ( ) presented only ( ) laser sight only ( ) stun only ( ) fired
( ) Other (baton, takedown, firearm, etc.)_____

SUBJECT INJURIES:
( ) Prior to Police arrival
( ) During Police involvement
( ) None/Unknown

OFFICER(S) INJURIES:
( ) None
( ) Slight_____
( ) Severe_____

DISPOSITION OF PATIENT/EVENT:
( ) Arrested ( ) Arrested and referred to MH Court ( ) Pink Slipped to PES ( ) Voluntary to PES
( ) Pink Slipped to Hospital ER ( ) Voluntary to Hospital ER
( ) Referred for outpatient mental health treatment (C.S.S., Portage Path, etc.) (summarize on back)
( ) Complaint unfounded requiring no police action (summarize on back)
( ) Subject stabilized requiring no further action (summarize on back)
( ) Other (summarize on back)
( ) EMS handled

ADDITIONAL COMMENTS:
( ) Officer left message on MH agency voicemail line
( ) Individual needs Mental Health Outreach
( ) Drugs suspected
( ) Alcohol suspected

TRANSPORTING:
( ) Subject transported by APD unit #: _____ to: _____
( ) Subject transported by EMS to: _____
( ) Subject transported by private ambulance/self or others to: _____

If transported by APD how long did you spend at the Mental Health/ER facility:_____

What was your experience with the above facility: ( ) Good ( ) Fair ( ) Poor (summarize on back)

NARRATIVE

APPENDIX G

SUMMARY OF OHIO CRISIS INTERVENTION TEAM (CIT) RESEARCH

Summary of Ohio Crisis Intervention Team (CIT) Research

1) CIT connects individuals with mental illness in crisis to mental health services.

In Ohio[1], Criminal Justice CCoE research has found:

- CIT officers are significantly more likely than non-CIT officers to transport people with mental illness to psychiatric emergency services
- CIT officers are more likely to transport people in crisis to treatment on a voluntary basis
- A CIT encounter is far more likely to result in transport to treatment (62%) than arrest (4%)

2) CIT officers use their training and experience to inform their decisions about dispositions.

CIT research in Ohio[2] shows that:

- Officers are more likely to take individuals to a mental health treatment facility if the officer perceives signs of substance abuse, violence towards self or others, signs and symptoms of mental or physical illness or non-adherence to medication
- Dispatch training is an important element of a CIT program to prepare officers before arriving on-scene
- CIT officers are able to identify individuals in crisis in need of mental health treatment regardless of how calls are dispatched

3) CIT prepares officers to better respond to calls involving people with mental illness in crisis.

Ohio Criminal Justice CCoE research[3] has found:

- Before CIT, officers who volunteered for CIT felt significantly less prepared to respond to calls involving persons with mental illness in crisis when compared to officers who have not participated in CIT
- CIT training and experience in the field prepares CIT officers to feel better equipped when responding to such calls (26% before CIT compared to 97% after feeling at least moderately prepared)

4) CIT has improved community partnerships.

The Criminal Justice CCoE's ongoing focus group study shows that:

- In many Ohio communities, CIT has helped develop a sustainable, cross-system steering group for jail diversion efforts
- CIT has led to cross-system understanding and awareness of issues between law enforcement and mental health providers
- Improved communication between criminal justice and mental health has increased trust and improved efficiency in working across systems
- CIT has positively impacted the ways that police officers and jail administrators interact with individuals with mental illness
- Consumers and family members help spread awareness of the CIT program throughout the community

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[1] Teller, J.L.S., Munetz, M.R., Gil, K.G., and Ritter, C. "Crisis Intervention Team training for Police Officers Responding to Mental Disturbance Calls." *Psychiatric Services* 57: 232-237, 2006.

[2] Ritter, C., Teller, J.L.S., Marcussen, K., Munetz, M.R. and Teasdale, B. 2011. "Crisis Intervention Team Officer Dispatch, Assessment, and Disposition: Interactions with Individuals with Severe Mental Illness." *International Journal of Law and Psychiatry* (34): 30-38.

[3] Ritter, C., Teller, J.L.S., Munetz, M.R. and Bonfine, N. 2010. "Crisis Intervention Team (CIT) Training: Selection Effects and Long-Term Changes in Perceptions of Mental Illness and Community Preparedness." *Journal of Police Crisis Negotiations* (10): 133-152.

APPENDIX H

CRISIS INTERVENTION TEAM (CIT) INTERNATIONAL

RESEARCH COMMITTEE

BIBLIOGRAPHY OF PUBLISHED REPORTS ON CIT

Crisis Intervention Team (CIT) International Research Committee

Bibliography of Published Reports on CIT

1999

Deane, M., Steadman, H.J., Borum, R., Veysey, B.M., & Morrissey, J.P. (1999). Emerging partnership between mental health and law enforcement. *Psychiatric Services, 50,* 99-101.

Police departments in the 194 US cities with a population of 100,000 or more were surveyed to identify strategies they used to obtain input from the mental health system about dealing with mentally ill persons. A total of 174 departments responded (90%). 96 departments had no specialized response for dealing with mentally ill persons. Among the 78 departments with special programs, three basic strategies were found: a police-based specialized police response, a police-based specialized mental health response, and a mental-health-based specialized mental health response. At least two-thirds of all departments, even those with no specialized response program, rated themselves as moderately or very effective in dealing with mentally ill persons in crisis.

2000

Cochran, S., Williams Deane, M., Borum, R. (2000). Improving police response to mentally ill people. *Psychiatric Services, 51*(10), 1315-1316.

This article is a short piece that provides a detailed description of CIT training and the makeup of the CIT team in Memphis, Tennessee. It briefly discusses the relationship with the mental health system and one early study conducted, providing some of the earliest empirical support for the CIT model.

Dupont, R., Cochran, S. (2000). Police response to mental health emergencies -- Barriers to change. *Journal of the American Academy of Psychiatry and the Law, 28,* 338-344.

Discusses the development, implementation, and evaluation of crisis intervention teams (CIT). The CIT model originated in Memphis in 1998. It was developed in response to a crisis in which an individual with a history of mental illness and substance abuse was fatally shot while holding a knife. The CIT program focuses on the need for advanced training and specialization with patrol officers, immediacy of the crisis response, emphasis on officer and consumer safety, and proper referral for those in crisis. The authors note that, while the CIT model appears to be an effective intervention strategy, communities can have a difficult

time implementing the program. Many of the requirements of a program seem basic in theory, but are often difficult to meet in practice.

Steadman, H.J., Deane, M. W., Borum, R., & Morrissey, J. P. (2000). Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services, 51*, 645-649.

Compared 3 models of police responses to incidents involving people thought to have mental illnesses to determine how often specialized professionals responded and how often they were able to resolve cases without arrest. Three study sites representing distinct approaches were examined: Birmingham, Alabama; and Knoxville and Memphis, Tennessee. At each site, records were examined for approximately 100 police dispatch calls for "emotionally disturbed persons" to examine the extent to which the specially trained professionals responded. Records were also examined for 100 incidents at each site that involved a specialized response. Results show differences across sites in the proportion of calls that resulted in a specialized response: 28% for Birmingham, 40% for Knoxville, and 95% for Memphis. All 3 programs had relatively low arrest rates when a specialized response was made. Birmingham's program was most likely to resolve an incident on the scene, and Knoxville's program predominantly referred individuals to mental health specialists.

2001

Lee-Griffin, P. A. (2001). The criminalization of individuals suffering from symptoms of mental illness: An exploratory study. *Dissertation Abstracts International Section B: The Sciences and Engineering, 62*(1-B), 156.

The purpose of this study was to explored the criminalization of individuals suffering from symptoms of mental illness. This study was designed to gather the following: (a) the knowledge and perceptions of experts in the field of mental health and jail diversion programs, (b) perceptions and experiences of police officers handling incidents involving people with symptoms of mental illness, and (c) the knowledge and perceptions of mental health consumers who have experienced an arrest, incarceration, and jail diversion services. Three data collection methods were used in this study: (a) a survey questionnaire mailed to experts in the field of mental health and jail diversion programs, (b) face-to-face individual interviews with mental health consumers, and (c) a focus group discussion with police officers. Five major themes emerged from all three participant groups: (a) the preferred use of both medication and therapy as treatment modalities, (b) the perceived value of jail diversion services, (c) the perceived value of crisis intervention team (CIT) training of police officers, (d) the perceived necessity for the coordination of services for mental health treatment, and (e) the perceived need for additional available resources for mental health treatment. This study points to the need for further investigation into the criminalization of individuals suffering from symptoms of

mental illness and the need for crisis intervention team (CIT) training of police officers who are becoming the first line in handling mental health crises.

Steadman, H.J., Stainbrook, K.A., Griffin, P., Draine, J., Dupont, R., & Horey, C. (2001). A specialized crisis response site as a core element of police-based diversion programs. *Psychiatric Services, 52,* 219-222.

Transporting an individual in psychiatric crisis to an emergency department is often frustrating for both law enforcement and mental health professionals. To facilitate collaboration between police and mental health professionals in crisis cases, some communities have developed prebooking diversion programs that rely on specialized crisis response sites where police can drop off individuals in psychiatric crisis and return to their regular patrol duties. These programs identify detainees with mental disorders and work with diversion staff, community-based providers, and the courts to produce a mental health disposition in lieu of jail. This paper describes 3 of the diversion programs participating in the Substance Abuse and Mental Health Services Administration jail diversion knowledge development application initiative that demonstrate the importance of specialized crisis response sites. The article describes important principles in the operation of these programs: being a highly visible, single point of entry; having a no-refusal policy and streamlined intake for police cases; establishing legal foundations to detain certain individuals; ensuring innovative, intensive cross-training; and linking clients to community services

2005

Addy, C. (2005). An examination of the development of standardized training protocols for law enforcement crisis intervention teams for the mental health consumer. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 65*(11-A), 4111.

This study provides an overview of the development of the Memphis Crisis Intervention Training program, evaluates the program based on the relevance of the training material in today's world, and assesses whether or not the program has contemporary validity. The research provides the established standards of five national law enforcement agencies and one state agency, as well as, the current protocols used by 13 law enforcement agencies around the United States and comments provided by the some of the developers and trainers of the Memphis Crisis Intervention Team training program and eight current CIT officers from the eight precincts around the City of Memphis. Conclusions reached indicated that the Memphis program was found to lack contemporary validity. Subsequent recommendations were made to provide standardized training protocols in order to prepare the training program for accreditation with the Commission on Accreditation of Law Enforcement Agencies, which the Memphis Police Department is currently seeking.

Strauss, G. Glenn, M., Reddi, P., Afaq, I., Podolskaya, A., Rybakova, T., … El-Mallakh, R. S. (2005). Psychiatric disposition of patients brought in by crisis intervention team police officers. *Community Mental Health Journal, 41*(2), 223-228.

In an effort to determine the characteristics of the individuals brought to the emergency psychiatric service (EPS) by CIT officers, a comparative (CIT vs. mental inquest warrant [MIW, a citizen-initiated court order to bring someone for psychiatric evaluation because of concerns regarding dangerousness] vs non-CIT/non-MIW), descriptive evaluation was performed. With the exception of a higher rate of schizophrenic subjects brought in by CIT (43.0% vs. 22.1%, non-CIT, P = .002), the demographics, diagnosis, and disposition of CIT-referred subjects were not different in any way from non-CIT patients. Subjects referred on MIWs were more likely to be admitted to a psychiatric hospital than non-MIW patients (71.6% vs. 34.8%, P < .0001), but CIT-referred hospitalization rates were not different from hospitalization rates of self-referred subjects (20.7% vs. 33.3%, ns). CIT officers appear to do a good job at identifying patients in need of psychiatric care.

2006

Compton MT, Esterberg ML, McGee R, Kotwicki RJ, Oliva JR (2006) Brief reports: Crisis intervention team training: Changes in knowledge, attitudes, and stigma related to schizophrenia. *Psychiatric Services,* 57:1199–1202.

In this pre-training / post-training survey involving 159 officers going through CIT trainings in the metropolitan Atlanta area, CIT training was found to lead to improved knowledge, better attitudes, and less social distance stigma pertaining to schizophrenia.

Compton MT, Kotwicki RJ, Editors (2006) *Responding to Individuals with Mental Illnesses.* Sudbury, Massachusetts: Jones and Bartlett Publishers, Inc., 228 pages, ISBN-13: 978-0-7637-4110-5.

This book was written as a study guide and manual for CIT officers and other law enforcement and public safety officials, based partly on the Georgia CIT curriculum.

Teller, J.L.S., Munetz, M.R., Gil, K.G., & Ritter, C. (2006). Crisis Intervention Team training for police officers responding to mental disturbance calls. *Psychiatric Services, 57,* 232-237.

In recognition of the fact that police are often the first responders for individuals who are experiencing a mental illness crisis, police departments nationally are incorporating specialized training for officers in collaboration with local mental health systems. This study examined police dispatch data before and after

implementation of a crisis intervention team (CIT) program to assess the effect of the training on officers' disposition of calls. The authors analyzed police dispatch logs for two years before and four years after implementation of the CIT program in Akron, Ohio, to determine monthly average rates of mental disturbance calls compared with the overall rate of calls to the police, disposition of mental disturbance calls by time and training, and the effects of techniques on voluntariness of disposition. Since the training program was implemented, there has been an increase in the number and proportion of calls involving possible mental illness, an increased rate of transport by CIT-trained officers of persons experiencing mental illness crises to emergency treatment facilities, an increase in transport on a voluntary status, and no significant changes in the rate of arrests by time or training. The results of this study suggest that a CIT partnership between the police department, the mental health system, consumers of services, and their family members can help in efforts to assist persons who are experiencing a mental illness crisis to gain access to the treatment system, where such individuals most often are best served.

2007

Dupont, R., Cochran, S., Pillsbury, S. (2007). Crisis Intervention Team core elements. Retrieved from www.vacitcoalition.org.

The Virginia Crisis Intervention Team (VACIT) Coalition is a collaborative membership group. Members include individuals interested in learning about or supporting CIT initiatives as well as representatives from CIT programs throughout Virginia. Regardless of whether a program is in its initial stages of development, still working to implement various aspects of the CIT program or a fully operational CIT, we share ideas, resources and information all for the betterment of the citizens of the Commonwealth.
The mission of VACIT is to promote and support the effective development and implementation of CIT programs in Virginia in order to improve the criminal justice and mental health systems and to help prevent inappropriate incarceration of individuals with mental illness.

2008

Bahora M, Hanafi S, Chien VH, Compton MT (2008) Preliminary evidence of effects of Crisis Intervention Team training on self-efficacy and social distance. *Administration and Policy in Mental Health and Mental Health Services Research*, 35:159–167.

In this pre-training / post-training survey involving 58 officers before training and 40 officers after training, as well as a group of 34 non-CIT control officers, CIT training was shown to bring about better confidence in interacting with, and less social distance stigma related to, persons with schizophrenia, depression, alcoholism, and drug abuse, as depicted in brief vignettes. Pre-CIT officers did not

differ from controls before entering training, indicating that the training, not selection bias, accounted for the differences.

Compton MT, Bahora M, Watson AC, Oliva J (2008) A comprehensive review of extant research on Crisis Intervention Team (CIT) programs. *Journal of the American Academy of Psychiatry & the Law*, 36:47–55.

In this review article, published together with the preceding article, an in-depth overview was given, summarizing all published research on CIT conducted to date.

Compton MT, Chien VH (2008) Factors related to knowledge retention after Crisis Intervention Team (CIT) training for police officers. *Psychiatric Services*, 59:1049–1051.

In this online survey of 88 trained CIT officers, knowledge about mental illnesses was found to decrease slightly but significantly in the months following CIT training, though officers with more years of service as an officer had a lesser decline in knowledge scores. The study suggested a need for continuing education for CIT officers, and that more experienced officers may be more appropriate, at least in terms of knowledge retention.

Geller, J. L. (2008). Commentary: Is CIT today's lobotomy? *The Journal of the American Academy of Psychiatry and the Law, 36*(1), 56-58.

This brief commentary discusses the issues surrounding CIT as it relates to current research findings and social influences.

Hanafi S, Bahora M, Demir BN, Compton MT (2008) Incorporating Crisis Intervention Team (CIT) knowledge and skills into the daily work of police officers: A focus group study. *Community Mental Health Journal*, 44:427–432.

In this focus group study, officers' positive comments about CIT training and their use of CIT-related knowledge and skills during routine patrol interactions was reported.

Oliva JR, Compton MT (2008) A statewide Crisis Intervention Team (CIT) initiative: Evolution of the Georgia CIT program. *Journal of the American Academy of Psychiatry & the Law*, 36:38–46.

This review article provided an-depth description of the development of Georgia CIT.

Skeem J. & Bibeau, L. (2008). How does violence potential relate to Crisis Intervention Team responses to emergencies? *Psychiatric Services, 59,* 201-204.

This study explored whether a crisis intervention team (CIT) promotes public safety and diversion from jail to treatment. Police reports (N=655) were analyzed for CIT events that occurred between March 2003 and May 2005 to determine each subject's potential for violence to self or others. Some 45% of CIT events involved suicide crises, 26% involved a threat to others, and average violence potential ratings suggested minor to moderate risk. Officers' use of force related strongly to violence potential (eta of .54). Nevertheless, officers used force in only 15% of 189 events posing serious to extreme risk of violence and used low-lethality methods. Of events, 74% were resolved through hospitalization, whereas only 4% were resolved through arrest. Although the study lacked a comparison group, the results are consistent with some studies suggesting that CIT holds promise in meeting safety and jail diversion goals.

Watson, A.C., Schaefer Morabito, Draine J., & Ottati, V. (2008). Improving police response to persons with mental illness: A multi-level conceptualization of CIT. *International Journal of Law and Psychiatry, 31,* 359-368.

The large numbers of people with mental illness in jails and prisons has fueled policy concern in all domains of the justice system. This includes police practice, where initial decisions to involve persons in the justice system or divert them to mental health services are made. One approach to focus police response in these situations is the implementation of Crisis Intervention Teams (CIT). The CIT model is being implemented widely, with over 400 programs currently operating. While the limited evidence on CIT effectiveness is promising, research on CIT is limited in scope and conceptualization--much of it focusing on officer characteristics and training. In this paper we review the literature on CIT and present a conceptual model of police response to persons with mental illness that accounts for officer, organizational, mental health system and community level factors likely to influence implementation and effectiveness of CIT and other approaches. By moving our conceptualizations and research in this area to new levels of specificity, we may contribute more to effectiveness research on these interventions.

2009

Compton, M.T., Berivan, Demir, B.N., Oliva, J.R., & Boyce, T. (2009). Crisis Intervention Team training and special weapons and tactics callouts in an urban police department. *Psychiatric Services, 60,* 831-833.

This study tested a hypothesized inverse correlation between the number of crisis intervention team (CIT) officers and the number of Special Weapons and Tactics (SWAT) callouts in an urban police department. Data for the number of accrued CIT-trained officers were combined with administrative data on the number of SWAT callouts during 27 four month intervals. There were no significant correlations for the relationships examined, and implementation of

CIT training was not associated with a decrease in SWAT callouts. Conclusions: Although the CIT model may yield important benefits in other domains, this study found no evidence of declining SWAT utilization as the number of CIT-trained officers accrued. The absence of association is likely due to the relatively low prevalence of SWAT use and the very different nature of CIT versus SWAT responses.

Compton MT, Demir B, Oliva JR, Boyce T (2009) Crisis Intervention Team training and Special Weapons and Tactics callouts in an urban police department. *Psychiatric Services,* 60:831–833.

Using administrative data from the Atlanta Police Department, it was found that as the number of CIT officers grew, there was no corresponding decrease in SWAT call-outs, suggesting that CIT and SWAT are two very different types of specialized police response to crisis events.

Demir B, Broussard B, Goulding SM, Compton MT (2009) Beliefs about causes of schizophrenia among police officers before and after Crisis Intervention Team training. *Community Mental Health Journal*, 45:385–392.

In this article, using data from a pre-training / post-training survey of 159 officers, CIT training was found to change officers' beliefs about the causes of schizophrenia, so that their beliefs are better aligned with the accepted causes within the mental health profession.

Hails, J., & Borum, R. (2009). Police training and specialized approaches to respond to people with mental illness. *Crime and Delinquency, 49,* 52-61.

Eighty-four medium and large law enforcement agencies reported the amount of training provided on mental-health-related issues and the use of specialized responses for calls involving people with mental illnesses. Departments varied widely in the amount of training provided on mental-health-related topics, with a median of 6.5 hours for basic recruits and 1 hour for in-service training. Approximately one third of the agencies (32%) had some specialized response for dealing with calls involving people with mental illnesses. Twenty-one percent had a special unit or bureau within the department to assist in responding to these calls; 8% had access to a mental health mobile crisis team.

Watson, A.C., Ottati, V.C, Morabito, M., Draine, J., Kerr, A.N., & Angell, B. (2009). Outcomes of police contact with persons with mental illness: the impact of CIT. *Administrative Policy and Mental Health, DOI: 10.1007/s10488-009-0236-9*

The Crisis intervention team model (CIT) is possibly the most well known and widely adopted model to improve police response to persons with mental illness. A primary goal of CIT programs is to divert individuals with mental illness from

the criminal justice system to mental health services. In this paper we examine the effectiveness of fielding CIT trained and supported officers for influencing call outcomes using data from patrol officers (n = 112) in four Chicago Police districts. Results from regression analysis indicate that CIT certified officers directed a greater proportion of persons with mental illness to mental health services than their Non-CIT certified peers. CIT did not have an immediate effect on arrest. Moderator analysis indicates that CIT had its biggest effect on increasing direction to services and decreasing "contact only" among officers who have a positive view of mental health services and who know a person with mental illness in their personal life. Additional moderators of the CIT effect on call outcomes include level of resistance and the presence of a weapon. Findings from this study have important implications for policy, practice and future research.

2010

Broussard B, McGriff JA, Demir Neubert BN, D'Orio B, Compton MT (2010) Characteristics of patients referred to psychiatric emergency services by Crisis Intervention Team police officers. *Community Mental Health Journal* 46:579–584.

This study was a chart review of 300 patients brought in to the Grady Memorial Hospital psychiatric emergency service in downtown Atlanta. CIT officers were found to bring in appropriate types of patients, and that such patients generally do not differ from those brought in by non-CIT officers or family members.

Canada, K, Angell, B & Watson. AC (2010). Crisis Intervention Teams in Chicago: Successes on the ground. *Journal of Police Crisis Negotiations.* 10 (1-2) 86-100.

In this article, we present findings from qualitative interviews with police regarding the implementation of Crisis Intervention Teams (CIT). Results indicate that police, irrespective of whether they received CIT training, perceive an array of benefits of CIT implementation in their district.

Compton MT, Broussard B, Hankerson-Dyson D, Krishan S, Stewart T, Oliva JR, Watson AC (2010) System- and policy-level challenges to full implementation of the Crisis Intervention Team (CIT) model. *Journal of Police Crisis Negotiations* 10:72–85.

Published in the same policing journal as the preceding article, this review article described a number of challenges that jurisdictions often face when implementing CIT.

Doulas, A. V., & Lurigio, A. J. (2010). Youth crisis intervention teams (CITs): A response to the fragmentation of the educational, mental health, and juvenile justice systems. *Journal of Police Crisis Negotiations, 10*(1/2), 241-262.

This article discusses one of the newest, specialized law enforcement programs in the United States: Crisis Intervention Teams (CITs) for youths with mental illness. Adapted from adult CIT models, youth CITs are designed to divert and refer for services adolescents with suspected psychiatric disorders, who have a higher prevalence of psychiatric and substance-use disorders (and their co-occurrence), compared with youths who have no mental health problems. As we suggest in the current article, the failure of the school, mental health, and juvenile justice systems to provide seriously distressed youths with coordinated and comprehensive assessment and treatment services has increased the likelihood that they will encounter the police and further penetrate the juvenile and adult criminal justice systems. We provide an early look at three programs in diverse geographic areas: Denver, Chicago, and San Antonio. We conclude with observations regarding the need for such programs as well as the challenges that police departments are likely to face in the implementation and continuation of such initiatives.

Kerr, AN, Morabito, MS & Watson, AC (2010). Police encounters, mental illness and injury: An Exploratory study. *Journal of Police Crisis Negotiations* 10 (1-2) 116-132.

This study explores injuries to people with mental illness and officers to determine the extent to which situational and individual factors predict injuries. Findings suggest that injuries during police calls involving persons with mental illness are infrequent and rarely require medical attention. Predictors of injuries in these calls are similar to those in police encounters with the general population.

McGriff JA, Broussard B, Demir-Neubert B, Thompson NJ, Compton MT (2010) Implementing a Crisis Intervention Team (CIT) police presence in a large international airport setting. *Journal of Police Crisis Negotiations* 10:153–165.

This focus group study presented officers' comments about implementing a CIT presence at the Atlanta Hartsfield-Jackson International Airport.

Oliva JR, Morgan R, Compton MT (2010) A practical overview of de-escalation skills in law enforcement: Helping individuals in crisis while reducing police liability and injury. *Journal of Police Crisis Negotiations* 10:15–29.

In this review article, de-escalation skills, and how such skills are taught during the CIT training week, were described.

Ritter, C., Teller, J. L. S., Munetz, M. R., & Bonfine, N. (2010). Crisis Intervention Team (CIT) training: Selection effects and long-term changes in perceptions of mental illness and community preparedness. *Journal of Police Crisis Negotiations, 10*(1/2), 133-152.

Survey data were used to assess how training affects changes in officers' perceptions of persons with mental illness as well as perceptions of police and the mental health system's preparedness in addressing their needs. Officers' confidence in their ability

to handle calls involving people with mental illness in crisis increased most over time. Exploratory analysis indicated that this increase was positively associated with the pretraining degree to which people with mental illness in crisis present a problem for the police department. This increase was positively associated with the perception that the police department's overall effectiveness in meeting the needs of people with mental illness in crisis and negatively associated with the degree to which mental illness was believed to be caused by parental upbringing. These findings suggest that initial salience of the problem for the police department posed by those with mental illness is critical to CIT officer eventual "success."

Stewart, C. (2010). Police intervention in mental health crisis: A case study of the Bloomington Crisis Intervention Team (CIT) program. *Dissertation Abstracts International Section A: Humanities and Social Sciences,* 71(2-A), 723.

This study examines the larger community context of one CIT program through interviews and focus groups with police officers, medical personnel and community members. In addition, this study utilizes data from officer-completed incident response sheets to examine the effects of CIT training. Specifically, the study addresses (1) whether CIT training affects how frequently officers report persons as having a mental illness, (2) how officers respond to and resolve incidents involving persons whom they believe to be in mental health crisis, and (3) whether there are differences in responses between CIT and non-CIT trained officers.

Watson, AC (2010) Research in the real world: Studying Chicago Police Department's Crisis Intervention Team (CIT) program. *Research on Social Work Practice.* 20 536-543.

In this article, the author reviews the emerging literature on CIT, presents a conceptual model of CIT effectiveness, and describes a study of CIT in Chicago. Findings from Chicago suggest that CIT is increasing linkage to services and reducing use of force in encounters with persons with mental illness.

Watson, A.C, Ottati, V.C., Morabito, M., Draine, J., Kerr, A.N., Angell,B. (2010). Outcomes of police contacts with persons with mental illness: The impact of CIT. *Administration and Policy in Mental Health and Mental Health Services Research.* Vol 37 (4) p302-317. DOI10.107/s10488-009-0236-9.

In this study, we examined the effectiveness of fielding CIT trained and supported officers for influencing call outcomes using data from patrol officers (n = 112) in four Chicago Police districts. Results indicate that CIT certified officers directed a greater proportion of persons with mental illness to mental health services than their Non-CIT certified peers. CIT did not have an immediate effect on arrest. CIT had its biggest effect on increasing direction to services and decreasing "contact only" among officers who have a positive view of mental health services and who know a person with mental illness in their personal life.

2011

Broussard, B., Krishan, S., Hankerson-Dyson, D., Husbands, L., Stewart-Hutto, T., & Compton, M. T. (2011). Development and initial reliability and validity of four self-report measures used in research on interactions between police officers and individuals with mental illnesses. *Psychiatry Research, 189*(3), 458-462.

This study tested reliability and validity of four newly designed measures of the constructs of self-efficacy (Self-Efficacy Scale; SES), referral decisions and de-escalation skills (Behavioral Outcomes Scale; BOS), attitudes toward psychiatric treatment (Opinions about Psychiatric Treatment; OPT), and social distance (Adapted Social Distance Scale; ASDS) in a sample of law enforcement officers. Self-administered, anonymous surveys, which included the measures of interest, were completed by 177 officers—68 of whom were undergoing Crisis Intervention Team (CIT) training and 109 of whom were not—at the beginning and end of week-long trainings. Analyses examined the internal consistency reliability, test–retest reliability, and construct validity of the instruments. The four measures of interest were found to be reliable and valid. Specifically, internal consistency coefficients and test–retest reliability correlations were generally acceptable, all four demonstrated sensitivity to change, and validity correlations were significant and in the expected direction. Findings demonstrated the ability to measure key constructs related to attitudes and intended behaviors in law enforcement officers utilizing psychometrically sound instruments. Further testing and the development of additional reliable and valid instruments focused on attitudinal and behavioral domains among officers who have frequent interactions with individuals with mental illnesses would be of great value.

Chopko, B. A. (2011). Walk in balance: Training crisis intervention team police officers as compassionate warriors. *Journal of Creativity in Mental Health, 6*(4), 315-328.

Crisis Intervention Teams (CIT) were developed to enable law enforcement officers to effectively and compassionately respond to calls involving people experiencing psychiatric distress. Mental health professionals responsible for training CIT officers are in a unique position to promote the compassionate treatment of those experiencing psychiatric distress as well as the well-being of the police officers themselves. Fostering spiritual connections and a compassionate-warrior mindset may enhance the training of CIT officers. This article includes descriptions of creative interventions including the use of historical compassionate-warrior comparisons, fictitious stories, and spiritual symbols. These techniques are based on warrior codes of groups such as samurai warriors, martial artists such as Shaolin Kung Fu, medieval knights, Native Americans, and the U.S. military.

Compton MT, Demir Neubert BN, Broussard B, McGriff JA, Morgan R, Oliva JR (2011) Use of force preferences and perceived effectiveness of actions among Crisis Intervention Team (CIT) police officers and non-CIT officers in an escalating psychiatric crisis involving a subject with schizophrenia. *Schizophrenia Bulletin*, 37:737–745.

Using a three-stage, vignette-based survey of an escalating psychiatric crisis situation, 48 CIT officers were found to opt for a lower level of force and reported that non-physical force was more effective once the situation became escalated, compared to 87 non-CIT officers. CIT officers also perceived physical force to be less effective at resolving the situation across all three scenarios, compared to non-CIT officers.

Compton MT, Broussard B, Hankerson-Dyson D, Krishan S, Stewart-Hutto T (2011) Do empathy and psychological mindedness affect police officers' decision to enter Crisis Intervention Team training? *Psychiatric Services*, 62:632–638.

In a survey of 68 CIT and 109 non-CIT officers, it was reported that officers who had volunteered into CIT training did not have greater empathy or psychological mindedness compared to officers assigned to the training, or officers not in CIT training, though they were more likely to have had a family history of experience with the mental health profession. This argues against a needed self-selection bias, at least in terms of empathy and psychological mindedness.

Compton MT, Broussard B, Munetz M, Oliva JR, Watson AC (2011) *The Crisis Intervention Team (CIT) Model of Collaboration between Law Enforcement and Mental Health*. Nova Publishers, ISBN-13: 978-1-61122-308-8.

In this brief, easy-to-read, 80-page, soft-cover book, the CIT model was described in terms of its history, core elements, implementation, dissemination, and evaluation/research.

Compton MT, Broussard B, Munetz M, Oliva JR, Watson AC (2011) The Crisis Intervention Team (CIT) Model of Collaboration between Law Enforcement and Mental Health, in *Advances in Sociology Research, Volume 9*. Jaworski JA (Ed.). New York: Nova Science Publishers, 1–38.

This is a book chapter that provides the same description of CIT noted above (published as a chapter rather than a small book).

Watson, A.C., Ottati, V.C., Draine, J.N., Morabito, M. (2011) CIT in context: The Impact of mental health resource availability and district saturation on call outcomes. *International Journal of Law and Psychiatry, 34* (4) 287-294.

Using data from 112 patrol officers in four Chicago Police districts, we consider the impact of mental health services availability and CIT saturation (the percentage of district personnel that are CIT certified). Findings indicate that CIT training increased direction to mental health services primarily in districts with greater availability of mental health services. In districts with low service availability, higher CIT saturation increased direction to mental services. The opposite pattern emerged for contact only or informal call resolution. No effects

were found for arrest as a call outcome.

2012

Canada, K, Angell, B, Watson, AC (2012). Intervening at the Entry Point: Differences in How CIT Trained and Non-CIT Trained Officers Describe Responding to Mental Health-Related Calls. *Community Mental Health Journal*, 48 (6) 746-755. DOI: 10.1007/s10597-011-9430-9

Qualitative interviews were conducted with 20 officers from four Chicago police districts. We found difference in CIT and non-CIT officers' response tactics to mental health-related calls and assessments of danger. CIT officers described a broader understanding of exhibited behaviors and considered more options when deciding the outcomes of calls.

Morabito, MS, Kerr, AN, Watson, AC, Draine, J, Angell, B (2012). Crisis Intervention Teams and People with Mental Illness: Exploring the Factors that Influence the Use of Force. *Crime & Delinquency, 58* (1) 57-77. **DOI 10.1177/0011128710372456**

Data from 216 officers in four Chicago police districts were used to examine factors that influence use of force in encounters between police and persons with mental illnesses. Findings indicate a CIT officer is likely to respond with less force for an increasingly resistant demeanor in comparison with non-CIT officers.

Tucker, A. S., Mendez, J., Browning, S. L., Van Hasselt, V. B., & Palmer, L. (2012). Crisis intervention team (CIT) training in the jail/detention setting: a case illustration. *International Journal of Mental Health, 14*(3), 209-215.

Research has documented the over-representation of persons with severe and persistent mental illness (SPMJ) in jails and prisons. Further increased attention has been directed to jail diversion programs and other attempts to prevent incarceration of adults with SPMI. Yet, regardless of available diversion programs, and recent trends in mental health within correctional settings, jails continue to see a disproportionate increase in inmates with SPMI. Thepurpose of this paper is to provide an overview of the research, public policy, and current best practices for the development and implementation of Crisis Intervention Team (CIT) Training as an in-house intervention in jail/detention-based settings. Our review provides support for deploying this specialized law enforcement response program to address the needs of mentally ill persons within jail settings. Strategies and issues in the utilization of the CIT model in detention contexts are discussed.

Tyuse, S. W. (2012). A crisis intervention team program: Four-year outcomes. *Social Work in Mental Health, 10*(6), 464-477.

Crisis intervention training has become a popular strategy to educate first responders about mental illness and techniques to safely and effectively de-escalate

individuals experiencing a mental health crisis. This article presents outcomes of the first four years of a Crisis Intervention Team program in St. Louis, Missouri. Findings of this evaluation suggest that the Crisis Intervention Team program is effective in diverting individuals in crisis to treatment.

Watson, AC & Fulambarker AJ (2012) The Crisis Intervention Team Model of Police Response to Mental Health Crisis: A Primer for Mental Health Practitioners. Best Practices in Mental Health, 8 (2) 71-81.

This primer for mental health practitioners serves as an introduction to a model that may already be available in their communities or it may serve as a springboard for the development of CIT programs where they do not currently exist.

2013

Kasick, D. P., & Bowling, C. D. (2013). Crisis intervention teams: A boundary-spanning collaboration between the law enforcement and mental health communities. In Yeager, K. R. (Ed), Cutler, D. L. (Ed), Svendsen, D. (Ed), & Sills, G. M. (Ed). *Modern community mental health: An interdisciplinary approach,* pp. 304-315. New York, New York: Oxford University Press.

2014

Compton MT, Bakeman R, Broussard B, Hankerson-Dyson D, Husbands L, Krishan S, Stewart-Hutto T, D'Orio BM, Oliva JR, Thompson NJ, Watson AC (2014) The police-based Crisis Intervention Team (CIT) model: I. Effects on officers' knowledge, attitudes, and skills. *Psychiatric Services*, 65:517–522.

The sample included 586 officers, 251 of whom had received the 40-hour CIT training (median of 22 months before the study), from six police departments in Georgia. CIT-trained officers had consistently better scores on knowledge, diverse attitudes about mental illnesses and their treatments, self-efficacy for interacting with someone with psychosis or suicidality, social distance stigma, de-escalation skills, and referral decisions. Effect sizes for some measures, including de-escalation skills and referral decisions pertaining to psychosis, were substantial. CIT training of police officers resulted in sizable and persisting improvements in diverse aspects of knowledge, attitudes, and skills.

Compton MT, Bakeman R, Broussard B, Hankerson-Dyson D, Husbands L, Krishan S, Stewart-Hutto T, D'Orio BM, Oliva JR, Thompson NJ, Watson AC (2014) The police-based Crisis Intervention Team (CIT) model: II. Effects on level of force and resolution, referral, and arrest. *Psychiatric Services*, 65:523–529.

A total of 180 officers (91 with CIT training and 89 without) in six departments in Georgia reported on 1,063 encounters, including level of force and disposition

(resolution at the scene, referral or transport to services, or arrest). CIT training status was generally not predictive of level of force, although CIT-trained officers were significantly more likely to report verbal engagement or negotiation as the highest level of force used. For CIT-trained officers, referral or transport was a more likely outcome and arrest was less likely than for officers without CIT training; these findings were most pronounced when physical force was necessary. CIT training appears to increase the likelihood of referral or transport to mental health services and decrease the likelihood of arrest during encounters with individuals thought to have a behavioral disorder.

Ellis, H. A. (2014). Effects of crisis intervention team (CIT) training program upon police officers before and crisis intervention team training. *Archives of Psychiatric Nursing, 28*(1), 10-16.

In communities across the United States and internationally, police officers frequently come into contact with individuals experiencing mental health crisis despite not having the skills to safely intervene. This often results in officers resorting to excessive or even deadly force. The Crisis Intervention Team (CIT) is heralded as a revolutionary and transformative intervention to correct this gap in practice. Several previous interdisciplinary national and international studies, including criminology and sociology, have examined these concepts using quantitative and qualitative methodological designs, however, no prior nursing studies have been done on this topic. The purpose of this study was to determine the effect of CIT training on police officers' knowledge, perception, and attitude toward persons with mental illness. Twenty five police officers participated. An explorative, quasi experimental, descriptive design was used to collect the data on the three major concepts. Results on knowledge about mental illness improved at $p <$ .0125 ($p <$ .05 after Bonferroni correction). Perception scores improved at $p <$ .0125 ($p <$ .05 after Bonferroni correction), and attitudes were more favorable at $p <$ .0125 ($p <$ .05 after Bonferroni correction). The results of this study validated the CIT program as an innovative community health program that benefits law enforcement, consumers, mental health professionals, and stakeholders.

El-Mallakh, P.L., Kiran, K., & El-Mallakh, R.S. (2014). Costs and savings associated with implementation of a police crisis intervention team. *Southern Medical Journal, 107*(6), 391-395.

Police crisis intervention teams (CIT) have demonstrated their effectiveness in reducing injury to law enforcement personnel and citizens and the criminalization of mental illness; however, their financial effect has not been fully investigated. The objective of the study was to determine the total costs or total savings associated with implementing a CIT program in a medium-size city. The costs and savings associated with the implementation of a CIT program were analyzed in a medium-size city, Louisville, Kentucky, 9 years after the program's initiation. Costs

associated with officer training, increased emergency psychiatry visits, and hospital admissions resulting from CIT activity were compared with the savings associated with diverted hospitalizations and reduced legal bookings. Based on an average of 2400 CIT calls annually, the overall costs associated with CIT per year were $2,430,128 ($146,079 for officer training, $1,768,536 for hospitalizations of patients brought in by CIT officers, $508,690 for emergency psychiatry evaluations, and $6823 for arrests). The annual savings of the CIT were $3,455,025 ($1,148,400 in deferred hospitalizations, $2,296,800 in reduced inpatient referrals from jail, and $9825 in avoided bookings and jail time). The balance is $1,024,897 in annual cost savings. The net financial effect of a CIT program is of modest benefit; however, much of this analysis was based on estimates and average length of stay. Furthermore, the costs and savings associated with officer or citizen injuries were not included because there was inadequate information about their prevalence and costs. Finally, this analysis does not take into account the nonmonetary gains of a CIT program.

Prince, J. L. (2014). A phenomenological study of the impact of crisis intervention team training on Washington, D.C. police officers. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 74*(7-B)(E).

Deinstitutionalization resulted in many consumers (individuals with mental illnesses) to transition into the community. Some of these individuals commit crimes and are arrested when mental health care is the more appropriate disposition. A promising alternative to arrest is the Crisis Intervention Team (CIT) model of training, which teaches police officers how to safely link consumers to mental health care when appropriate. The purpose of this study was to examine how CIT training has potentially impacted the Washington, D.C., crisis intervention officers in their personal and professional lives to include their interactions with consumers. The author used a phenomenological approach and applied the theories of social constructivism and procedural justice to conceptualize the data. The data was corroborated by the author and a doctoral-level phenomenological researcher using Moustakas's (1994) modified version of van Kaam's (1959, 1966) analysis method. The author interviewed five participants with 10 pre-determined, open-ended questions, and subsequently identified 40 sub-themes clustered into five core themes: disposition, policies and protocol, professional awareness, skill set, and training. The results suggest that CIT training has had a positive impact on the participants including improved communication with consumers, increased officer confidence, decreased officer apprehension, and the appropriate diversion of consumers from the law enforcement system to the mental health system. The data supports the social constructivism and procedural justice theories. Areas for future research include further studies examining officers' experiences as CIT officers, exploring consumers' experiences with CIT officers, and assessing demographic differences within and across CIT officers throughout various geographic locations.

Watson, A.C., Swartz, J., Bohrman, C., Kriegl, L.S. & Draine, J.(2014). Understanding how police officers think about mental/emotional disturbance calls. *International*

Journal of Law & Psychiatry, 37 (4) 351-358.

In this study, we examined police officer schema of mental/emotional disturbance (M/EDP) calls. A survey measure covering four types of police calls (call to home involving a juvenile, call to home involving an adult, public disturbance and repeat crime report) was administered to 147 officers in Chicago and Philadelphia. Schema groups tended to be differentiated by ratings of level of resistance/threat and substance use. Contrary to our expectations, CIT and law enforcement experience did not predict officer schema group. While the CIT model emphasizes de-escalation skills to reduce resistance and the need for officers to use force, CIT and other training programs may want to consider increasing content related to factors such as co-occurring substance use and managing resistance.

2015

Compton, M. T., Broussard, B., Reed, T. A., Crisafio, A., & Watson, A. C. (2015). Surveys of police chiefs and sheriffs and of police officers about CIT programs. *Psychiatric Services*, pp. appips201300451.

Two surveys were conducted on the crisis intervention team (CIT) model, a police-based program designed to improve responses to individuals with mental illnesses. Data were collected between July and September 2013 from 171 police chiefs and sheriffs (42 had implemented CIT in their agency), and 353 law enforcement officers (273 had CIT training) in Georgia. Police chiefs and sheriffs reported barriers to implementing CIT, such as not having enough officers and insufficient access to mental health services. CIT-trained officers differed from non-CIT-trained officers only with regard to being less likely to use force in response to a man with psychotic agitation described in a vignette, when the analysis controlled for whether the officer carried an electronic control device. Some hypothesized differences, such as in job satisfaction and work burnout, were not observed. However, CIT-trained officers appeared to be less likely to revert to force in a situation involving psychotic agitation.

Kohrt, B. A., Blasingame, E., Compton, M. T., Dakana, S. F., Dossen, B., Lang, F., Strode, P., & Cooper, J. (2015). Adapting the crisis intervention team(CIT) model of police—mental health collaboration in a low-income, post-conflict country: curriculum development in Liberia, West Africa. *American Journal of Public Health, 105*(3), 73-80.

We sought to develop a curriculum and collaboration model for law enforcement and mental health services in Liberia, West Africa. Methods. In 2013 we conducted key informant interviews with law enforcement officers, mental health clinicians, and mental health service users in Liberia, and facilitated a 3-day curriculum workshop. Results. Mental health service users reported prior violent interactions with officers. Officers and clinicians identified incarceration and lack of treatment

of mental health service users as key problems, and they jointly drafted a curriculum based upon the Crisis Intervention Team (CIT) model adapted for Liberia. Officers' mental health knowledge improved from 64% to 82% on workshop assessments ($t = 5.52$; $P < .01$). Clinicians' attitudes improved ($t = 2.42$; $P = .03$). Six months after the workshop, 69% of clinicians reported improved engagement with law enforcement. Since the Ebola outbreak, law enforcement and clinicians have collaboratively addressed diverse public health needs. Collaborations between law enforcement and mental health clinicians can benefit multiple areas of public health, as demonstrated by partnerships to improve responses during the Ebola epidemic. Future research should evaluate training implementation and outcomes including stigma reduction, referrals, and use of force.