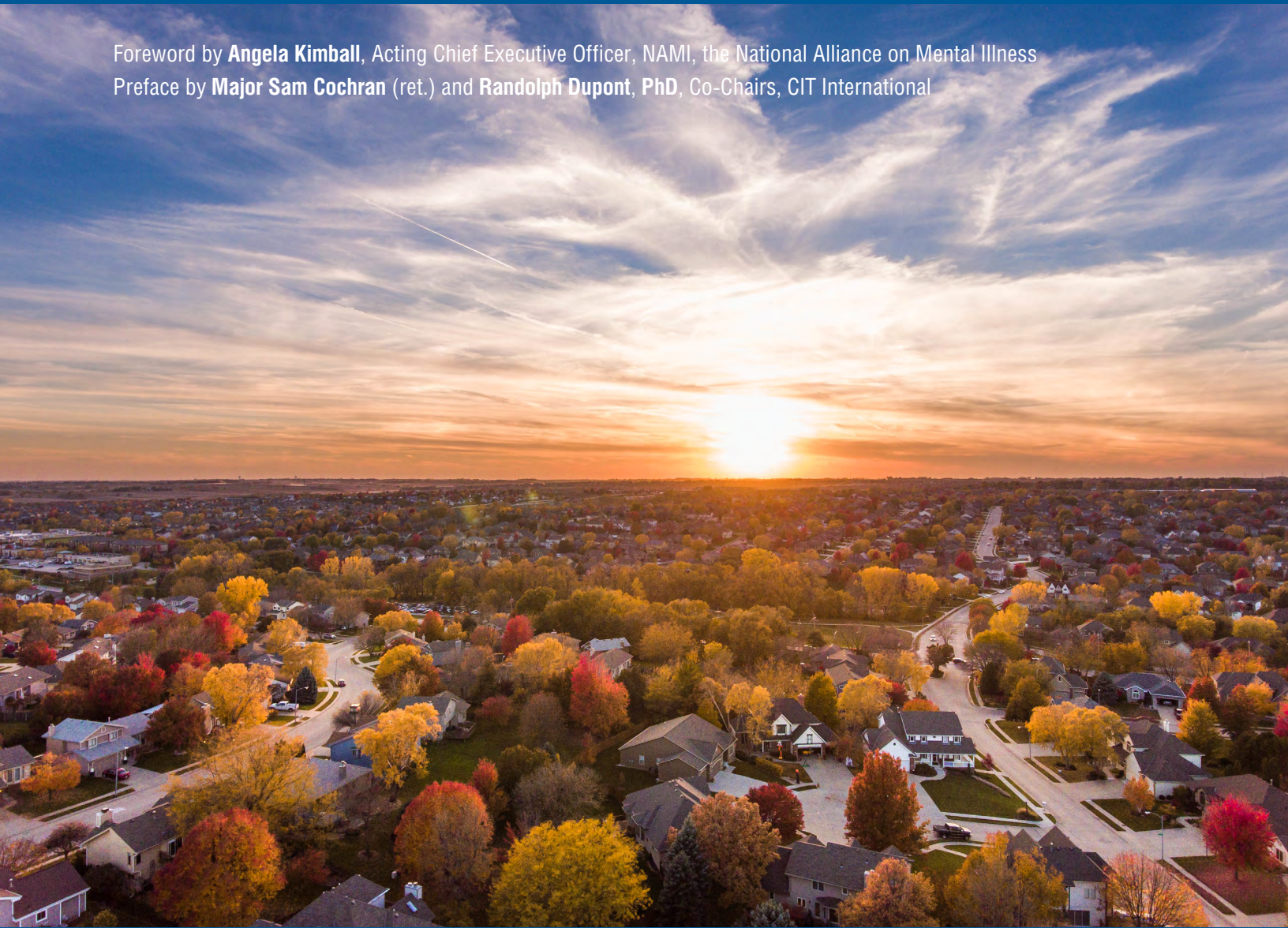


CRISIS INTERVENTION TEAM (CIT) PROGRAMS:

A BEST PRACTICE GUIDE FOR TRANSFORMING COMMUNITY RESPONSES TO MENTAL HEALTH CRISES

Foreword by **Angela Kimball**, Acting Chief Executive Officer, NAMI, the National Alliance on Mental Illness
Preface by **Major Sam Cochran** (ret.) and **Randolph Dupont, PhD**, Co-Chairs, CIT International



A Publication of CIT International

August 2019



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Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises
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CIT International aspires to be a leader in promoting safe and humane responses to those experiencing a mental health crisis. Our mission is to promote community collaboration using the Crisis Intervention Team (CIT) program to assist people living with mental illness and/or addiction who are in crisis.

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“Widespread crisis intervention strategies and techniques are critical to addressing rising rates of overdoses and suicides that continue to devastate families nationwide. Now, more than ever, we have to break the all-too-common cycle of sending those with mental health and substance use disorders through the criminal justice system. This guidebook is an essential resource for communities to do their part.”

— Patrick J. Kennedy, Former U.S. Representative and Founder of The Kennedy Forum, Rhode Island

Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises

A Publication of CIT International



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FOREWORD: CIT—A MENTAL HEALTH SOLUTION TO MENTAL HEALTH CRISES

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. An alliance of over 600 state organizations and local affiliates, we work to ensure that every person affected by mental illness has access to the services they need and is surrounded by a community that cares.

In 1988, NAMI provided the seed grant that would help Memphis build the first CIT program. We did so with the hope that people with mental illness would receive a safer and more humane response in times of crisis. More than 30 years later, we have seen tremendous strides in attitudes and responses to people affected by mental illness. At the same time, we still see too many people jailed, left to the streets, and with no place to go for care except the emergency department. Until we see mental illness treated with the same urgency and dignity as other medical conditions, we continue to stand with hundreds of partners, including law enforcement, to demand better.

We hope you will read this guide with the intention to go beyond merely training law enforcement officers. We hope, instead, that you use these tools to promote a mental health solution to mental health crises. The end result should be the creation of a robust crisis response and community mental health system that prevents people from entering the revolving door of the criminal justice system.

Please join NAMI in building a community that cares. We look forward to partnering with you.

Angela Kimball
Acting Chief Executive Officer
NAMI, the National Alliance on Mental Illness

PREFACE: RELATIONSHIPS ARE THE SECRET TO SUCCESS

When we met in 1988, we did not know that we were about to undertake our life's work. Community members had come to the City of Memphis and our police department with a problem—people with mental illness in crisis were being traumatized in police custody, and sometimes even dying. The community, in the form of the local NAMI Affiliate, had already proposed a solution: a community task force to examine training for police officers on keeping people with mental illness, and officers themselves, safe during a mental health crisis. Memphis ended up developing the Crisis Intervention Team.

In Memphis, the secret to our success was relationships. Month after month, mental health advocates, mental health professionals, police officers, and elected officials looked each other in the eye and talked through the challenges of the mental health crisis in our community. In the process, we built a strong network of relationships, all based on the conviction that this was our community and we were going to make it better.

Over the past thirty years, CIT has become a movement of change. Thousands of communities have been inspired to make their crisis response systems safer and help people on the path to recovery. Countless law enforcement officers and mental health professionals have joined the fight for mental health recovery. It has all been driven by relationships and a sense of local ownership for the challenges of mental health crises in their own communities.

In 2005, local and state CIT leaders from across the U.S. came together to begin the formation of CIT International. The mission was to support what is now over 3,000 CIT programs across the nation and around the world. The founders of this organization wrote the CIT Core Elements, developed the first statewide CIT networks, and represent a cross-section of the stakeholders involved in CIT at the local level. Our members are the law enforcement officers, mental health professionals, and advocates on the front lines every day working hard to improve the crisis response system.

We bring that accumulated knowledge and expertise to developing this guide. As leaders in the CIT movement, we have always promoted the uniqueness of each program. Your CIT program will be unique to your community and this guide will share with you the hard-won lessons we have learned from more than thirty years of practice. We will also share the research about what's effective and the innovations that are the future of CIT.

The hardest lesson we've learned is about the temptation of training. Law enforcement and jails continue to be the de facto system for responding to mental health crisis situations and housing people with mental illness. Law enforcement agencies are under immense pressure to address this systemic challenge. We hear daily from agencies eager to learn about CIT training, hoping it will be a solution to their problems. Training is an important step, but the goal of CIT is not to train officers to be kinder and gentler as they take people to jail.

“*The hardest lesson we've learned is about the temptation of training.*”

The goal of CIT is to keep people safe and that is not possible if jail is the only destination during a mental health crisis. A CIT program should help people get connected to treatment and services and offer hope for recovery. That can only be accomplished when law enforcement agencies build relationships with mental health professionals and agencies and work with advocates to fight for a better mental health system.

We have seen law enforcement agencies that focus solely on training face criticism for doing the things they hoped to avoid. Policing is risky and there are never guarantees of absolute safety—but training-only approaches do not improve safety and reflect a misunderstanding of the CIT model. The CIT model is not just about policing; it is about community responses to mental health crises.

To build a CIT program that is successful, you need to invest in strong relationships and partnerships. You need to be bold about recovery and including people living with mental illness, their families, and advocates at the table. You need to rethink the services available to people in crisis, and if there are gaps, demand something better. It is a challenging task, and it will take the commitment of your entire community. But you will be in the best of company. Working on CIT will connect you with caring and dedicated individuals in your community and around the country.

CIT International is confident you can do this. We are here to help.

Major Sam Cochran (ret.)
Randolph Dupont, PhD
Co-Chairs, CIT International
Memphis, Tennessee, USA

INTRODUCTION: WHAT YOU NEED TO KNOW ABOUT CIT

UNDERSTANDING CIT

Crisis Intervention Team (CIT) programs are community-based programs that bring together law enforcement, mental health professionals, mental health advocates (people living mental illness and their families), and other partners to improve community responses to mental health crises.

Let's break this definition down:

- CIT is **community-based** and improves **community responses** to mental health. The most visible faces of CIT are CIT officers, but CIT is not a law enforcement program. CIT is designed to bring mental health professionals, advocates, elected leaders, and others to the table to problem-solve and take responsibility for improving the mental health crisis response system—so that police and jails are not the default responders and locations. CIT programs work to build crisis response systems where law enforcement plays a supporting role and responds only when the level of danger or criminal activity warrants such a response. CIT programs also work to strengthen locations in the community where community members can walk in and receive the help they need without contact with the justice system.
- CIT includes **people living with mental illness and their families**. No one has a greater stake in the outcome of a mental health crisis than the person in crisis, followed closely by their family members. These stakeholders also have valuable insight into how the crisis response system works and what helps make it better. Only by engaging individuals with mental illness and their families can we build crisis response systems that people feel confident reaching out to in a crisis without fear of danger or incarceration.
- CIT is based on **partners coming together**. CIT partners are equal decision-makers who solve problems together, bring resources to the table, and hold each other accountable. Mutual commitment, trust, and respect are the bedrock of strong partnerships.
- CIT focuses on **responses to mental health crises**. CIT is not just about how law enforcement responds to mental health crisis situations. It also addresses how mental health professionals and other supports are involved in crisis response. CIT examines how systemic problems—like outdated policies or a lack of services—contribute to crisis situations and develops solutions to these systemic challenges.

THE GOALS OF A CIT PROGRAM

CIT has the same goals it had when the first program started in Memphis in 1988. However, as the program has spread across the United States, there has been incredible innovation at the local level and coordination among national partners. Many CIT programs are part of a greater national mental health movement that emphasizes recovery and the need for more robust community mental health systems.

The goals of a local CIT program are:

1. To improve safety during law enforcement encounters with people experiencing a mental health crisis, for everyone involved.
2. To increase connections to effective and timely mental health services for people in mental health crisis.
3. To use law enforcement strategically during crisis situations—such as when there is an imminent threat to safety or a criminal concern—and increase the role of mental health professionals, peer support specialists, and other community supports.¹
4. To reduce the trauma that people experience during a mental health crisis and thus contribute to their long-term recovery.

THE KEYS TO SUCCESS

“How do you measure CIT’s effectiveness? As the years unfold, does the community believe CIT is working? Is CIT connecting people to the services that they need to improve their lives?”

— Major Sam Cochran, Co-Chair, CIT International, Memphis, Tennessee

While the goals of CIT—safety, connection to mental health services, strategic use of law enforcement, reducing trauma—can be studied through research, the most immediate measure of your program’s success is the involvement of your community partners and your resilience.

Your success does not hinge on the size of your community or having a funding source. Communities have unique strengths and needs; CIT is designed to fit the needs of many communities.

¹ The CIT model acknowledges that there are times when an individual with mental illness commits a crime for which arrest is the appropriate response. Sometimes an individual with mental illness may display criminal behavior that is unrelated to mental health concerns or sometimes criminal behavior is so serious that an officer has no choice but to make an arrest.

Rather, the success of your program will be based on:

- **First, a network of relationships** among law enforcement officers, mental health professionals, mental health advocates, and other community members and leaders. Learn how to build that network in Chapter 1.
- **Second, an ongoing commitment from leaders** of your mental health system, law enforcement agency, and mental health advocacy organization. Learn how to build that commitment and create a steering committee to guide your CIT program in Chapter 2.
- **Third, an understanding of your community-wide response to mental health crisis situations**, including mental health services, emergency responders, law enforcement, and other resources that can help people during a crisis situation. Find out how to gain an understanding of your crisis response system in Chapter 3.
- **Fourth, building the infrastructure to strengthen your crisis response system and sustain your program**—including revised policies and procedures, staffing, and data collection. Learn about that infrastructure in Chapter 4.
- **Fifth, a training program for law enforcement officers and 911 call-takers and dispatchers** that prepares them to respond safely and compassionately to people in crisis, and helps them link people to mental health services. Learn about developing this training in Chapter 5.
- **Finally, a commitment to ongoing improvement and engagement with partners.** Every community has an opportunity to improve, whether it's by advocating for better access to mental health services, expanding training to other populations, or reaching out to support new CIT programs in another community. Learn about how to foster this commitment in Chapter 6.

CIT programs have found, again and again, that when they face challenges, the solution is often to return to basics: relationships and partnerships. When you hit a stumbling block, ask: Do we trust and value our three key partners (law enforcement, mental health agencies, and mental health advocates) equally? Do we share the same goals for our community? Could we bring in a new partner to help us think differently or overcome a challenge we're facing?

Your partners are your best resource, and you can strengthen your program by building on those relationships and commitments.

HOW TO USE THIS GUIDE

This guide is intended primarily to be a how-to for individuals and communities interested in starting a CIT program, providing practical suggestions, templates, and worksheets to help you work through the steps to building an effective program. It does not take the place of the *CIT Core Elements* (<http://www.citinternational.org/Memphis-Model-Core-Elements>) or state-specific CIT standards.

THE GUIDE IS FOR ANYONE INTERESTED IN CIT

Any mental health advocate, individual in recovery, family member, law enforcement officer, mental health professional, community leader, or other interested individuals should be able to pick up this guide and start from the beginning. The guide can also be used by agencies, organizations, coalitions, or existing CIT programs.

In general, Chapter 1 and Chapter 2 are addressed to an individual or a small group that are excited to start a CIT program. Chapters 3-6 assume the audience is a CIT steering committee and/or a CIT coordinator.

To get started, all you need is an interest in CIT and a willingness to build relationships with other individuals and groups in your community.

THIS IS A GUIDE, NOT A PRESCRIPTION

Some steps are absolutely vital to building an effective CIT program. For example, creating a steering committee with the support of some key leaders is non-negotiable. However, how communities accomplish these tasks varies among CIT programs. Throughout the guide, we try to provide a clear distinction between necessary steps and the array of suggestions, strategies, and examples for achieving them.

In addition, there's no timeline associated with a successful CIT program. Proceed at your own pace, taking on the next steps when you can.

THE CHAPTERS ARE IN ORDER

We recommend following the chapters in order. In general, each chapter is a prerequisite for the chapters that come after it. For example, you will need to build relationships before getting the commitment of leadership.

However, if you take the chapters out of order, don't panic. There's value in going back to revisit a previous step and you can still be successful. For example, if your police chief first sends officers to a neighboring community for CIT officer training, there will still be enormous value in building one-on-one relationships among leaders and front-line staff across your community, then creating your local steering committee and so forth.

CHAPTER SUMMARIES AND CHECKLISTS

If you are in the process of starting a CIT program, and you aren't sure where to begin in this guide, or whether to proceed to the next step, review the chapter summaries and checklists at the end of each chapter. They review what you need to know and do in each chapter.

ADDITIONAL RESOURCES

The guide includes an extensive Resources and Examples chapter with templates, worksheets, examples, and other resources. These are intended for you to adapt and use with partners, leaders, and community members. You can find more resources online at www.citinternational.org.

Please note: We list many resources and organizations throughout this guide that may be useful to communities in implementing and sustaining their CIT programs. This should not be interpreted as agreement with or endorsement of all opinions and products of those organizations.

CHAPTER 1:

LEARN ABOUT CRISIS INTERVENTION TEAM (CIT) PROGRAMS AND FIND ALLIES

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Introduction: CIT is Built on Relationships

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Successful CIT programs are built on partnerships among mental health advocacy organizations, the mental health system, and law enforcement agencies. These three partners are the foundation for a simple reason: they are ultimately responsible for managing and bear the impact of mental health crisis situations. Public mental health agencies have the responsibility to serve people living with serious mental illness, law enforcement agencies are responsible for responding to emergency situations of all types and have become the default first responders for many mental health crises, and advocacy groups represent the individuals and family members who directly experience crisis situations. Only by working together can these partners improve the crisis response system for everyone.

Supporting this organizational commitment is a rich network of personal and professional relationships. These connections are important because the mental health and criminal justice systems have different missions and approaches. Law enforcement and the entire criminal justice system are charged with protecting public safety. The mental health system's mission is to support people in their recovery from mental health conditions. Finding a common mission and shared language to address mental health crisis situations is a challenge.

At best, professionals in these systems are unaccustomed to working together. At worst, there is deep mistrust or miscommunication. Individuals involved in these systems at any level—people living with mental illness, family members, law enforcement officers, mental health professionals—can improve understanding, learn about CIT together, and be the driving force for starting CIT in their community.

These relationships are also vital for sustaining CIT. A CIT program is not a short-term commitment or a one-time training. Rather, it's a process that connects the right people, agencies, and organizations to continue making small changes to improve the community's response to people in mental health crisis, leading to long-term systems changes.

If you are an individual or a small group excited about CIT, this chapter is for you. It will help you learn more about the CIT model and how to build relationships and momentum for CIT.

Learn about the CIT Model



“The first goal of CIT programs is to transform the crisis response system to minimize the number of times that law enforcement officers are the first responders to individuals in emotional distress. If it’s a mental health crisis, there ought to be a mental health response. So, with the support of law enforcement, peer and family advocates, and other partners, service expansion is a natural outgrowth of CIT.”

— Don Kamin, PhD, Director, Institute for Police, Mental Health and Community Collaboration, Rochester, New York

To get started, it’s important to learn about the CIT model. There are misconceptions that CIT is a training program, or that it is a law enforcement program. In fact, CIT is a community-based program with multiple partners and several goals—only one of which is law enforcement officer training. Review the [Introduction: What You Need to Know About CIT](#) on page 4 for a refresher.

THE CIT CORE ELEMENTS

The [CIT Core Elements](http://www.citinternational.org/Memphis-Model-Core-Elements) (<http://www.citinternational.org/Memphis-Model-Core-Elements>), developed in 2006 by the University of Memphis CIT Center in partnership with CIT leaders around the country, is the definitive guide to the CIT model. The document is brief and you should read it carefully. The 10 Core Elements are comprehensive, describing CIT in detail. They are:

1. Partnerships among law enforcement, advocacy, and mental health systems
2. Community ownership over planning, implementation, and networking
3. Policies and procedures
4. CIT officers, dispatchers, and coordinators
5. CIT training for officers and dispatchers
6. Mental health receiving facility
7. Evaluation and research
8. In-service training²

² The term “in-service” is used in the Core Elements document. However, we use the term “continuing education” in this guide instead of “in-service” or similar terms to describe ongoing training for CIT officers. These terms should be considered interchangeable with respect to this guide.

9. Recognition and honors
10. Outreach to develop CIT in other communities

The CIT Core Elements document describes a fully-developed CIT program, not a starting point. There are some important things to keep in mind as you read it:

- Partnerships are the first core element of CIT because they are the foundation of everything else. CIT programs succeed when they have strong, active partnerships.
- Every community starts out small and builds the program at their own pace. Many communities have very few resources and worry that they can't have a CIT program if they don't already have a robust crisis response system. This is not the case. Strengthening the crisis response system incrementally is a long-term goal for CIT programs.
- Officer training is a step along the way, not an end goal. Many programs stall when they have carried out successful training sessions; this guide will help you move forward as a community to address challenges with your crisis response system.

NATIONAL AND STATE CIT ORGANIZATIONS

CIT International (<http://www.citinternational.org>) is the leading international organization focused on promoting best practices in CIT. CIT International hosts the largest and only international CIT conference and seeks to improve understanding of CIT while providing support to CIT programs across the U.S. and internationally.

Two other national organizations that also provide information and education on CIT are:

- NAMI (the *National Alliance on Mental Illness*, <http://www.nami.org/cit>), the nation's largest grassroots organization of people living with mental illness and their families. NAMI has over 600 state organizations and local affiliates that are often key partners in CIT programs, and the national office supports CIT as a way to overhaul communities' response to mental health crises.
- The *University of Memphis CIT Center* (<http://cit.memphis.edu/>), which grew out of the nation's first CIT program in Memphis. Among many other helpful resources, the Center's website includes details on the *CIT National Curriculum Matrix*, which is reproduced on page 128.

Most states have existing CIT programs, so reaching out to state-level agencies and organizations may be particularly helpful as you start to learn. Here are some state resources to check:

- Many states have a state CIT network that can help you connect to other CIT programs, learn whether there are state-specific standards or resources, and get support from neighboring communities. CIT networks have a variety of names and some exist under a larger organization. Visit www.citinternational.org/stateCITorgs to find the CIT network in your state.
- State advocacy organizations, including your [NAMI State Organization](http://www.nami.org/local) (<http://www.nami.org/local>), the state chapter of [Mental Health America](https://arc.mentalhealthamerica.net/find-an-affiliate) (<https://arc.mentalhealthamerica.net/find-an-affiliate>) or state [peer-run organization](https://www.ncmhr.org/members.htm) (<https://www.ncmhr.org/members.htm>), may be leading CIT efforts in your state and may be able to help you connect with local chapters and advocates.
- Your state mental health agency and/or your state department of criminal justice may provide training, funding, or technical assistance to CIT programs.
- Your state association of chiefs of police or state sheriff's association may be able to connect you with law enforcement leaders particularly involved in CIT.

ONLINE RESOURCES ABOUT CIT

CIT International developed this guide, in part, to ensure that there is reliable information available after seeing many instances of confusion about the CIT model. As you review other resources online, there are a few red flags that may suggest that a source is not familiar with CIT or not providing a complete picture. These include:

- Any resource that describes CIT simply as training and doesn't describe the important role of partnerships,
- Any resource that omits one of the three key partners (mental health advocates, mental health agencies, and law enforcement agencies),
- Any resource that describes standard CIT training as anything less than 40 hours (continuing education for officers who have already been through 40 hours of CIT training may be fewer hours),
- Any resource that does not include the perspectives of people living with mental illness and their family members, or
- Any resource from a for-profit company that is designed primarily to sell you a product or service.

Resources that raise these concerns may still include useful information but read them with a critical eye.

PEOPLE WITH MENTAL ILLNESS BRING A VITAL PERSPECTIVE TO CIT

“Everyone coming to the table has a different priority. I used to have family members say, ‘Don’t make me call police.’ A family’s intention is always to keep themselves safe and keep the person safe, but that doesn’t always happen. I was in active psychosis and in a different reality. For me, something different was happening than what was happening to everyone else. I think CIT is unique in that it’s bringing all of those components to the table and bringing them into the light.”

– Bill Carruthers, Certified Peer Specialist, CEO of Recovery on Fire and Board Member, NAMI Georgia

In the more than 30 years since the founding of the first CIT program, family advocates have played a central role in advocating for CIT programs in many communities. This powerful advocacy force has arguably been the driving force behind the national expansion of CIT. However, as the movement for mental health recovery has grown, and a greater number of people living in long-term recovery from mental illness have spoken out, it’s become clear that people living with mental illness have not always had a voice in CIT programs and on CIT steering committees.

This trend is concerning for many reasons. People living with mental illness, sometimes called peer advocates, have an important perspective to bring to understanding a mental health crisis situation. They are the only people who can explain the experience of mental health symptoms, and they can explain why they have responded positively to mental health providers and law enforcement—or why they have responded with anger or fear.

People living with mental illness can educate other partners about what kinds of support promote recovery, even among people in crisis for whom recovery seems out of reach. On the other hand, people living with mental illness may notice barriers to engagement in services that others do not—such as how certain language is stigmatizing, or how the location of a treatment center is inaccessible to someone without a car. Peers may know locations in the community where people in distress congregate.

Including people living with mental illness is also important to building broader community trust in CIT. Others in the peer community pay attention to whether

peer advocates are included in a CIT program and how they are treated. When peer representatives are included, they spread the word that CIT is a program that people can trust.

Finally, it's important for other partners to interact with a wide variety of people living with mental illness—including those who are in long-term recovery. There are many challenges to helping people engage in recovery—and those systemic challenges can contribute to mental health providers, law enforcement, and even families feeling frustrated and hopeless. Working alongside people in long-term recovery is an excellent reminder that supporting people in recovery is an important goal of CIT.

You Need Allies Across the Community to Start CIT

“I knew nothing about police work. I decided to attend our Citizens’ Police Academy. That really helped me understand more about policing and more about why police do the things they do. I had the opportunity to ask questions. Then I could speak a little bit of their language. Then you find someone from the law enforcement community who is willing to be a champion, like the New London Police Department’s Capt. Ken Edwards. And they see it as something not being imposed upon them, but something developed with them.”

— Louise Pyers, MS, BCETS, Founder and Executive Director, Connecticut Alliance to Benefit Law Enforcement, Newington, Connecticut

CIT programs are launched in a variety of ways. One of the most common is for a mental health advocate—a person living with mental illness or a family member—to take a personal interest in improving mental health crisis response, learn more about CIT, and begin lobbying leaders for the program. Momentum for the program can also come from a mental health professional, a law enforcement officer, or another community member who has seen the impact of mental health crisis situations in their professional or personal life.

These individual pioneers—whether they are advocates or professionals—find it helpful to identify allies, so that they can learn more about the challenges that others are facing around mental health crisis response in their community. A group of allies representing these different perspectives can access more resources and connections. Together, they can

approach a police chief, sheriff, the executive of a mental health agency, or other important community leaders as a powerful coalition.

Equally important, a diverse group of allies provides greater understanding and more opportunities to build trust. Mental health crisis situations are extremely complex and

“*Building these personal and professional relationships helps lay the foundation for improved partnerships between organizations and agencies at the systems level.*”

many individuals involved in these systems—the individuals in crisis, their families, police officers, mental health professionals—experience some frustration, regret, fear, or anger. It helps to hear about the challenges that others face and

come up with solutions together. Building these personal and professional relationships helps lay the foundation for improved partnerships between organizations and agencies at the systems level.

BUILDING RELATIONSHIPS WHEN LEADERS ARE DRIVING CIT

One important reason to find allies in your community is to more effectively convince community leaders that they should commit to CIT. However, in some communities law enforcement leaders, mental health agency leaders, and elected leaders are initiating CIT programs before that groundswell of community advocacy emerges.

Even with engaged and excited leadership, it is important to build relationships among front-line mental health professionals, law enforcement officers, people living with mental illness, and families. CIT programs have found that involvement and buy-in from these groups is essential to creating understanding and finding effective solutions to challenges with the crisis response system.

Identifying the Right Allies

Look for allies who have a different experience of the mental health crisis response system than you. For example, if you are a law enforcement officer, seek out other first responders, family members, people living with mental illness, and mental health professionals. There's nothing wrong with having others with a similar background as allies, but the more perspectives, the better.

Often the most helpful allies have a foot in two worlds—for example, a police officer who also has a mental health condition or a psychiatric nurse who is also the parent of a child with a mental illness. An ideal ally is also someone who is well-connected, understands local politics, and is accustomed to working collaboratively.

The **WORKSHEET: Identifying Allies to Advocate for CIT** on page 192 will walk you through the kinds of agencies and organizations where you might find potential allies. It also suggests how you can find information about these individuals.

Once you have identified potential allies, set up a coffee meeting or a brief phone call to start the conversation. When you first reach out, anticipate that it will take some time to build a relationship.

Here are some strategies for building these relationships.

DO YOUR HOMEWORK

Spend some time learning about the agency or organization that your potential ally works for. What is its mission? What services does it provide? How many people does it serve? What are their challenges? If you can find it, bring a copy of the person's biography with you.

When you reach out to an individual, explain why you chose them specifically. For example, a law enforcement officer could send an email to a mental health advocate saying: *"The biography on NAMI Springfield's website said you lead their criminal justice programs. I am a deputy with the Springfield Sheriff's Department and I lead our homeless outreach team. I'm hoping we could discuss ways to collaborate to support people with mental illness who are homeless and frequently in contact with police."*

BRING INFORMATION TO LEAVE BEHIND

Always bring some information that you can leave behind—no more than a few pages so that you don't overwhelm anyone. Review the **EXAMPLE: Fact Sheet** on page 198 and fill in the blanks with information specific to your state. You may also want to share a brochure or other information from your state CIT network.

PARTICIPATE IN EVENTS OR PROGRAMS

"In 2004, my department asked me to take over the agency's mental health training...One of the classes I went to was [NAMI] Family-to-Family, a course

offered by NAMI Dallas for families of people with mental illness. It was there that I learned that my mother had anxiety and depression, and so did I.”

— Snr. Corporal Herb Cotner (ret.), Dallas Police Department, Dallas, Texas³

If you cannot identify the right allies by searching online or reaching out to your existing professional network, you can participate in events or programs hosted by potential partner organizations. In addition to networking, you can show that you are committed to learning about the concerns of potential allies in your community.

Consider participating in events or programs that will help you connect with potential allies in your community. For example, you could:

- Contact your local law enforcement agency and request to participate in a citizens’ police academy. These programs offer you a chance to interact with law enforcement officers and learn about their daily responsibilities.
- Contact your local law enforcement agency and request to ride with a patrol officer for a shift (commonly called a ride-along).
- Contact a local provider agency and ask to shadow staff.
- Participate in an advocacy group’s fundraising event. You do not need to make a large donation, but it will benefit you to join the organization and attend an event.
- Take a class offered by the mental health agency or by the mental health advocacy group.
- Volunteer for your local advocacy group, police department, or mental health agency.
- Volunteer for your police-citizen advisory board, your advocacy organization’s board of directors, or the community mental health agency board. Or, attend a board meeting and ask for a few minutes on the agenda to talk about CIT.
- Attend a county council meeting and request to be added to the agenda for public comment.
- Follow your law enforcement agency, mental health agency, or mental health advocacy organization on social media to stay up-to-date on events, fundraisers, and opportunities for collaboration.

³ “For Dallas Mental Health Officer, issue hits close to home.” (2015, May 19). Herb Cotner. The Stepping Up Initiative. Retrieved from <https://stepuptogether.org/people/herb-cotner>

At any event or program, take time to get to know people, ask questions, and share your interest in CIT.

KEEP THE CONVERSATION GOING

It's possible you will find someone with an interest in CIT who is willing to partner with you after one conversation; however, it often takes more than one meeting to get someone's ongoing commitment. Make sure that you have a reason to stay connected after your first conversation. Here are a few ways to keep the connection going after an initial conversation:

- Follow up with information or resources.
- Offer your help with a project.
- Ask for advice on something minor.
- Schedule a follow-up meeting at a professional conference.
- Join a shared board or committee.

Strategize with Your New Allies



“When we started to develop regional programs throughout Utah, we would identify potential allies within that region and then host a one-hour lunch. After all, leaders and advocates have busy schedules but they find time for lunch most days. We would take advantage of this time to break bread and build relationships. We would then conduct a brief PowerPoint presentation about CIT and its benefits. We always enjoyed a constructive conversation and would answer questions with the goal of getting a commitment for a more formal future meeting of the group.”

— Sherri Wittwer, Former Executive Director, NAMI Utah

Once you have several allies interested in CIT, get to know each other. Over the course of several meetings, discuss the following issues:

- What have you learned so far about CIT programs?
- Is there any further research you need to do?
- Do you need any additional allies from other systems?

- What do you know about the agencies, organizations, and leaders in your community?
- Based on what you've learned so far, which law enforcement or mental health agency leader do you think you should approach first?

Once you all feel prepared, move on to Chapter 2 to make a plan for reaching out to community leaders.

Case Study: Building Relationships in Alamogordo, New Mexico



“Community involvement says that we’re going in the right direction. It’s not about ‘I’m doing this to be in charge,’ it’s about collaborating for success. It shows a great amount of buy-in for what we want to do, to have all these people in the room with no egos. It’s a great predictor of success.”

— Chief Brian Peete, Alamogordo Police Department, Alamogordo Police Department

When Chief Brian Peete came to lead the Alamogordo, New Mexico, Police Department in 2017, he had been a CIT officer in Chicago and had a background in counseling psychology. Mental health was never far from his mind. CIT was unfamiliar to the department, but not to the community: Peete soon found that a team of advocates, mental health professionals, and health care providers had been building momentum for CIT for years.

A CORE TEAM BUILDING RELATIONSHIPS

The individuals most excited to bring CIT to Alamogordo included Kimmie Jordan, vice president of NAMI Doña Ana County, Holly Mata with the Otero County Community Health Council, Jeanette Borunda, director of clinical services at Gerald Champion Regional Medical Center (GCRMC), and Maureen Schmittle with the New Mexico Department of Health in Otero County. Most have a personal connection to mental health, in addition to their professional interest, and they were already closely connected through the Health Council.

Their group of partners grew quickly. Jordan says they specialized in personal outreach—individualized emails, letters, phone calls, and visits. Having some empathy for everyone’s challenges helped convince people to come on board, says Jordan: “You have to come up with a solution, you can’t just come in with a problem. There’s a lot of empathy. ‘I don’t know how hard your job is, but I know my job is hard, so your job must be hard too.’”

Food is also a great way to build connections. When they hosted events, they offered healthy options provided in collaboration with a local program called Eat Well Otero.

SPREADING THE WORD THROUGH EXISTING COMMUNITY GROUPS

While Alamogordo is a small town, it’s a very active community with several organizations and coalitions that came to support CIT. The group of CIT allies reached out

to numerous community groups to talk about CIT, including NAMI Doña Ana County, the local behavioral health collaborative, the “Substance SAFE” community team, staff from GCRMC, Coalition to End Homelessness in Otero County, and several government and social service agencies. From those groups, Jordan and her allies invited individuals that they felt were passionate about CIT and well-established in their organizations to join a CIT steering committee.

It was also important to engage the local government, including state legislators, county commissioners, and the city government. At the county, they found another ally in Amber Mayhall, the Healthcare Services Director, who has been supportive in helping to find innovative ways to use community funds and to help align city and county priorities.

Finally, they reached out through the faith community, recognizing that many people in crisis first go to their pastor for help. Churches offer significant support to individuals who may need housing or other support, and it was important for faith leaders to have support from mental health and social services. Pastors have become fierce advocates for CIT.

A LAW ENFORCEMENT CHAMPION

Jordan says that launching Alamogordo’s CIT program would not have been possible without their enthusiastic champion, Chief Peete: “His energy and enthusiasm and passion make anyone feel like they would follow him.” Peete says that 80 percent of patrol work is psychology, so he saw the need for CIT immediately. With a master’s degree in counseling psychology, he is trained to see himself as a helper—but that doesn’t mean he sees himself as the expert. Rather, he sees his role as empowering the community team. Peete says to his fellow law enforcement leaders: “Don’t be a roadblock. All it takes is a police chief to say ‘ok’ and that team takes everything and runs with it. I just salute and do what I’m told.”

BRINGING PARTNERS TOGETHER

When an opportunity for technical assistance and funding to support a CIT program in Alamogordo became available from the Bureau of Justice Assistance (BJA) VALOR Initiative, it was “kismet”, says Peete. They applied for the grant and received it.⁴

In August 2018, Alamogordo convened its first official CIT strategic planning meeting with more than 40 stakeholders in attendance. The key CIT partners—people living with mental illness and their family members, law enforcement agencies, and mental health

⁴ Through the BJA/VALOR grant, the Alamogordo program received technical assistance from CIT International, Policy Research Associates, Inc., NAMI and the International Association of Chiefs of Police.

agencies—were represented, but so was a broader array of community partners. The hospital, crisis line, schools, churches, city and county government, veterans' organizations, and numerous community organizations also participated. The group moved quickly to support CIT and work with their technical assistance team on Sequential Intercept Model (SIM) mapping and officer training.

Alamogordo's CIT program is still building momentum: they are securing sustainable funding, and plan to offer officer training throughout the region. They are also working closely with regional partners, leveraging their progress and partnerships as they build their culture of CIT.



Summary: Learn About CIT and Find Allies



Lasting CIT programs are built on partnerships among mental health advocacy organizations, the mental health system, and law enforcement agencies. Supporting this organizational collaboration is a rich network of personal and professional relationships. Individuals involved in these systems at any level—people living with mental illness, family members, law enforcement officers, and mental health professionals—can improve communication and trust. When they learn about CIT together, these allies can be the driving force for starting a program in their community or enhancing an existing CIT program.

Before you get started, learn about the CIT model. It's vital to read and understand the CIT Core Elements and to use reliable sources of information about CIT, including [CIT International](http://www.citinternational.org/) (<http://www.citinternational.org/>), [NAMI](http://www.nami.org/cit) (<http://www.nami.org/cit>), and the [University of Memphis CIT Center](http://cit.memphis.edu) (<http://cit.memphis.edu>). You may find helpful it helpful to reach out to your statewide CIT network, state advocacy organizations, your state mental health agency, your state department of criminal justice, or your state association of chiefs of police or sheriff's association.

CIT programs often start because of the interest and excitement of one or two individuals—a mental health advocate, law enforcement officer, or mental health professional. These individual pioneers find it helpful to identify a group of allies so that they can learn more about the challenges that others are facing around mental health crisis response in their community. Together, they can approach an executive or community leader as a powerful coalition.

Building these alliances requires some investigation to find people across systems who share your interest in improving the crisis response system. It also involves a variety of strategies to engage potential allies.



Checklist: Learn About CIT and Find Allies



Review the checklist below to make sure you have completed the key steps in this chapter. Or, use this checklist if you think your community may be able to skip ahead to another chapter.

Move ahead to Chapter 2 if you:

- ☐ Have read the introduction to this guide and can define CIT, list its goals, and describe the keys to its success.
- ☐ Have read the *CIT Core Elements* (<http://www.citinternational.org/Memphis-Model-Core-Elements>) document.
- ☐ Can identify the types of individuals whose involvement is essential to the success of CIT.
- ☐ Have reached out to state-level organizations involved in CIT, if applicable in your state.
- ☐ Have identified allies within the mental health system, law enforcement agencies, and mental health advocacy organizations.
- ☐ Have reached out to several potential allies across your community, shared information with them, and discussed your concerns about crisis response in your community.

CHAPTER 2:

MAKE A COMMITMENT

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Introduction: Leaders Must Commit to Change

Once you have a network of allies interested in CIT and educated about how the program works, the next step is to secure the commitment of leaders. Specifically, you need buy-in from:

- The chief or sheriff of your target law enforcement agency or agencies,
- The director or CEO of your public mental health service or oversight agency, and
- The director or CEO of a local mental health advocacy organization.

If you are unsure, the **WORKSHEET: Leaders You Need at the Table** on page 204 will help you identify the specific individuals to engage.

These leaders have the unique power to change the way your community responds to mental health crisis situations. Since they are currently responsible for managing mental health crisis situations, they can redirect staff and resources within their agencies and organizations and appeal to elected officials for additional resources.

Once the partner organizations and agencies trust each other and have a commitment to working together, it's common to expand to other partners, but that process sometimes takes significant time. Initially, it's important to focus on continuing to build your network of allies and securing the commitment of these leaders. This chapter guides you through this process.

IDENTIFYING MENTAL HEALTH ADVOCATES IN YOUR COMMUNITY

“If there’s not a NAMI meeting, we schedule a community meeting called ‘Partners for a Healthy Community.’ We’ll bring in senior services, the Boys and Girls Clubs, food banks, adoption services, foster parenting, human services organizations, county commissioners, departments of education, court systems, law enforcement, local and state behavioral health systems, and faith leaders. They may not know about CIT, Georgia laws, or our community services. There may not be an organized advocacy organization—but every community has

advocates, and you have to help them identify themselves, and carve them out and focus them on mental health. In every community, there's a possibility. Every one."

– Pat Strode, CIT Advocate Coordinator, Georgia Public Safety Training Center, Forsyth, Georgia

Occasionally, an emerging CIT program is stymied by a lack of mental health advocacy organizations in the local community. There *are* people living with mental illness and their families in your community, and their participation is vital to your success. Make sure you are exhausting all options to find individuals with mental illness and supportive family members who can fill the advocacy role. Here are a few tips:

- First, while [NAMI](http://www.nami.org) (<http://www.nami.org>) and [Mental Health America](https://www.mentalhealthamerica.net/) (<https://www.mentalhealthamerica.net/>) are the most widespread associations, there are other national advocacy organizations with local chapters. Reach out to the [National Coalition for Mental Health Recovery](https://www.ncmhr.org/) (<https://www.ncmhr.org/>), [Compeer](https://compeer.org/) (<https://compeer.org/>), [Schizophrenia and Related Disorders Alliance of America](https://sardaa.org/) (<https://sardaa.org/>), as well as organizations that focus more on peer support, such as [Clubhouse International](http://clubhouse-intl.org/) (<http://clubhouse-intl.org/>) or [Depression and Bipolar Support Alliance](https://www.dbsalliance.org/) (<https://www.dbsalliance.org/>), to find local chapters.
- If an organization has an office in your state, reach out and find out if they can assist you. There may be members near you that are interested in contributing to their local communities, or state-based programs that could support you remotely.
- Reach out to mental health service providers in your community to help identify individuals and family members who might be interested in being advocates. Former clients may work for an agency as peer support specialists, or there may be family members who have a talent for pushing for exactly what's needed.
- Reach out to mental health courts and probation agencies to identify previous clients who could be great peer advocates.
- Reach out to other community organizations, such as those that advocate for people who are homeless, or for victims of domestic violence, to see if they know of individuals or organizations who could serve this role.

Strategies for Engaging Leaders

“[A CIT program is] not something that happens overnight. It might take a year or two. You start to bring in folks who bring in other folks, who want to make things happen.”

— Louise Pyers, MS, BCETS, Founder and Executive Director of Connecticut Alliance to Benefit Law Enforcement, Newington, Connecticut

Keep in mind that agency and organizational leaders are busy people, with many demands on their time and resources. Gaining their trust and making the case for CIT may take time.

There are a few principles to keep in mind for approaching any leader:

- Be respectful of their time. Prepare what you want to say, and deliver your message efficiently.
- Be respectful of their position. You may become frustrated, but always choose to be respectful and polite. Demands or hostility will impede communication.
- Present research and solutions. Leaders want strategies that can address the challenges you raise as well as the competing needs of multiple stakeholders.
- Assume they have good intentions. You'll have more options to make a good case for CIT if you see yourself as someone who can support a leader who is overwhelmed, educate a leader who is unaware, or strategize with a leader who has resource constraints—rather than assuming they are unconcerned and have to be forced into compliance.

PREPARE FOR AN EFFICIENT AND RESPECTFUL MEETING

When you have an opportunity to meet with a mental health agency director, police chief, sheriff, or mental health advocacy leader, prepare to introduce yourself efficiently and cordially. Research the individual so that you have some material for small talk. Research the agency and tailor your talking points. Choose two or three people from your group of allies to attend your meeting and plan which documents to leave behind.

The **RESOURCE: Steps for A Successful Meeting with An Agency or Organizational Leader** on page 206 provides step-by-step guidance on planning your meeting.

THE IMPORTANCE OF CROSS-SECTOR LEADERSHIP

“Put your pride aside, and realize in every community there is a team of experts in every facet of policing. Together, you can make something amazing for the benefit of the community.”

– Chief Brian Peete, Alamogordo, New Mexico

Law enforcement leaders, mental health agency leaders, and advocacy organization leaders must work as a team of equal partners to guide their CIT program. Having one leader on board is a great start, but a single leader should not dominate the CIT steering committee. Without the balance of perspectives, CIT programs have focused solely on law enforcement training without changes to the crisis response system. Or they have excluded people living with mental illness and missed vital opportunities to reduce trauma and improve access to mental health services.

OFFER TO HELP

When you meet with a leader, explain that CIT is a program designed to help everyone—helping people with mental illness get access to mental health care safely; reducing injuries, frustration, and liability for law enforcement; and providing mental health professionals with a community approach to supporting their most complex clients. The **RESOURCE: CIT Talking Points** on page 202 will help you make these points.

Then, to demonstrate this principle, think about a concrete way you can assist them in the near future. For example:

- A mental health advocacy group may be able to offer a short awareness training to law enforcement officers
- Mental health professionals may be able to host free support groups onsite at a mental health facility.
- Law enforcement may be able to teach a class on crisis planning in conjunction with mental health advocates.

These are not a substitute for CIT; rather, they are goodwill gestures to show the value of partnership and to give potential partners an opportunity to interact with you firsthand.

DEMONSTRATE THAT YOU UNDERSTAND THEIR CHALLENGES AND ACCOMPLISHMENTS

In building your relationships with allies, you have learned about the concerns and challenges of the agencies and organizations you hope to partner with. Whenever you meet with an agency leader, prepare notes for yourself to show what you've learned about a specific agency. For example, when you meet with a police chief, find out: the number of crisis calls his agency responds to, the number of sworn officers, and the square miles they patrol. If you know that the chief has limited personnel or is facing cuts to his training budget, mention that. Make note of some of the chief's career accomplishments or leadership initiatives.

You do not need to overwhelm an executive with details or flattery. Instead, practice sharing just a couple of key pieces of information that show you've done research. The *EXAMPLE: Talking Points for Meeting with An Agency or Organizational Leader* on page 208 provides an example of the kinds of research to bring with you.

REACH OUT TO ADVOCACY LEADERS

If your group of allies finds that advocacy organizations in your community are reluctant to get involved or devote time to CIT, approach the organization as you would any other partner. Reach out to the executive director or board of directors to ask about their concerns around mental health crisis response and how you can address them.

Here are some additional strategies that may help:

- Acknowledge that many advocacy organizations are volunteer-run, with little or no paid staff. Ask for participation in the CIT steering committee and support with training, but don't pile on requests for volunteer time. If there are too few resources or people involved in the group, look for ways to support their recruitment and fundraising efforts.
- Ensure that you are using inviting and inclusive language about mental illness and people with mental illness. Check the organization's website for the terminology most preferred in your community.
- Ensure that you are clearly describing your intentions to partner as equals. Share your research about challenges in your community, and the description of the CIT model from the *RESOURCE: CIT Talking Points* on page 202.

RECRUIT A CHAMPION

"As a judge, we have a certain moral authority, in that when we ask people to sit down and talk about complex issues like this, they are more likely to come. We are seen as a neutral arbiter without a particular interest."

— Judge Steve Leifman, 11th Judicial Circuit of Florida, Miami, Florida

A champion is an individual who has a prominent position in the community and can gain the attention of leaders and decision-makers. A champion might be:

- A prominent sheriff or police chief who can bring other law enforcement leaders to the table,
- A judge or prosecutor,
- A celebrity,
- An athlete, or
- A local elected official, such as a mayor, county council member, or state representative.

Many champions do not have a professional connection to mental illness but may have a personal or family connection. With your allies, identify public figures who might be interested in supporting CIT. Sometimes advocacy organizations are particularly well-connected or aware of who has an interest in mental illness.

Once you have identified a potential champion, be discreet about making contact. Shame about mental illness is still very common, and many people do not want to discuss their personal experiences; nor do they want to feel like they are being exploited for their position.

Once you have a champion's buy-in, there are many ways that they can help. Judges and elected officials have enough authority that they can sometimes call a meeting with all the relevant stakeholders and provide a forum for you to make a strong case for CIT. Other champions can talk to agency or organizational leaders one-on-one, write an op-ed for a local newspaper, bring up CIT before the city or county council, mobilize the public on social media, or take other action.

HOST AN EDUCATIONAL MEETING ABOUT CIT

"I got everyone's emails and I followed up by calling everyone on the phone. Lots of people came and complained about the emergency room. Judge Humphrey

came and said, we've met before, but the only way we're going to deal with this is if everyone puts their issues on the table. He set a good tone. Also, we realized a good way to get people to come is to provide lunch!"

— Kathy Barnum, President, NAMI Southeast Indiana

Invite all the leaders and interested community members to a presentation about CIT. If possible, a champion should send out the invitations and give introductory remarks. An advocacy leader is also a good choice, as they are often seen as a neutral party between mental health agencies and law enforcement.

An outside expert who can speak directly about the benefits of CIT—such as a CIT coordinator, mental health director, or police chief from another community—is an ideal speaker. If possible, provide lunch or refreshments.

At the end of the presentation, the local champion or advocacy leader can invite leaders to a follow-up meeting to discuss local challenges. If local leaders are enthusiastic, that meeting can be the basis of a steering committee (see *Formalize your Commitment with a Steering Committee* on page 38 for more information about the purpose of the CIT steering committee).

ASK FOR ASSISTANCE FROM A LEADER ALREADY INVESTED IN CIT

Many agency or organizational leaders become excited about the opportunities offered by CIT by talking directly with a colleague who has had success with CIT in their own community. They may have specific concerns that you cannot address, or they may simply want to hear from someone who shares their experience.

Most CIT programs are happy to help spread the word and share their experiences—outreach is one of the CIT Core Elements. Contact state-level organizations, such as your state advocacy groups or *state CIT network* (<http://www.citinternational.org/stateCITorgs>), to find out which law enforcement leaders, mental health directors, and advocacy leaders are most enthusiastic about CIT. You can invite them to present to leaders in your community or to make a personal phone call to their counterparts in your community.

FACILITATE A DIALOGUE AMONG LEADERS

In some cases, mistrust or misunderstanding about the current system for responding to people in crisis will make it challenging for leaders to get excited about making a change. In that case, a private conversation among leaders is more likely to be productive than a large

public meeting. If one community leader is willing to be the host and extend an invitation to a small group to air concerns, that can go a long way to addressing the hesitancy about partnering. A champion who is perceived as neutral could also extend that invitation.

PRIVATELY LEVERAGE PUBLIC OUTCRY

Before the first CIT program started in Memphis, the city was reeling from the officer-involved shooting of Joseph Robinson, a man with schizophrenia. Many organizations were calling for the police chief's resignation.⁵ Advocates from the local NAMI Affiliate—despite their frustrations—did not add to the criticism; instead, they went to city leaders with a plan for the first CIT program.

No one advocates waiting until a tragedy occurs to start a CIT program. However, you should consider making a plan for what you would do in the case of an officer-involved shooting of a person with mental illness or another tragic event that shines a light on the gaps in the mental health crisis response system in your community.

Communities that have successfully advocated for CIT after a tragedy take a collaborative approach. If a law enforcement agency is receiving harsh criticism, reach out privately and offer to help the law enforcement executive start a CIT program—something that will be good for the community and good for their public relations. Be clear that CIT requires a long-term commitment to partnership and don't accept anything less than that level of commitment. When you are working together as partners, and fully satisfied that the agency is committed to CIT, your agency or organization can publicly praise efforts to address the problems that led up to the tragedy.

“Communities that have successfully advocated for CIT after a tragedy take a collaborative approach.”

While a tragic situation may have emotions running high in your community, always keep in mind that your long-term goal is to work with other agencies and organizations in your community. Speaking with contempt about your future partners or using threats to achieve a short-term goal risks poisoning your relationship.

5 Usher, L. (2013, October 4). Saving Lives, Changing Communities. Retrieved from <https://www.nami.org/About-NAMI/NAMI-News/2013/Saving-Lives-Changing-Communities>

ANTICIPATE CONCERNS ABOUT COST

Many leaders' first concern is how much CIT will cost. Many agency and organizational leaders may be concerned that they simply cannot shift funds around on a limited budget. Use the *CHART: Common Concerns about CIT Funding* on page 210 to address some of these concerns.

In general, it's important to share that, with numerous partners at the table, no agency or organization will be left on their own to bear all of the costs or solve all the problems. Together, the entire community can share costs or strategize about how to raise funds.

MAKE THE CASE WITH STORIES

Leaders can be moved to action by a personal story told well. Many mental health advocacy organizations offer training for their members on how to tell their personal story for advocacy. Check with your local organizations for training opportunities or review the resources from the *NAMI Smarts for Advocacy* (<https://www.nami.org/Find-Support/NAMI-Programs/NAMI-Smarts-for-Advocacy>) program.

A law enforcement officer can share a particularly challenging call for service, or a mental health professional can talk about a client that affected them.

Here are some general guidelines for sharing these stories:

- Match the speaker with the audience. For example, a law enforcement leader may immediately respect the perspective of an officer, and a mental health director may immediately respect another mental health professional. Mental health advocates, particularly if they've been through storytelling or advocacy training, can be a good choice for any audience because they are constituents and community members.
- Keep stories brief; no one can absorb all the details of a complex mental health history during a single meeting. It is ok to focus on one incident or episode. Practice until you can cover the important points in ninety seconds.
- Keep control of your emotions. It's fine to make your audience a little uncomfortable, but not so uncomfortable that they feel overwhelmed or defensive.
- Use "I" statements, focusing on your experience rather than on others' actions. For example, an individual who experienced a crisis should not blame a law enforcement officer for making an arrest, but they could describe how frightening the experience was. Similarly, an officer describing a call for service could describe

feeling like they had few options to assist an individual—without assigning blame to the mental health system for failing to offer additional services.

- Never assign blame to the person, agency, or profession of your audience.
- Finish your story with a specific request, such as, “It would mean so much to me as an officer to know that there were mental health services where I could take people during these difficult situations. We’re planning a meeting with other leaders to talk about improving the options in our community. Can I count on you to attend?”

ADVOCATING WITHIN YOUR OWN AGENCY OR ORGANIZATION

A leader may be most easily persuaded by a staff member in their own agency. For example, a law enforcement officer more readily knows the language and priorities of their executive and can translate the concerns of their allies into a persuasive argument for their chief. They also have access: scheduling a meeting with the chief or director may be as simple as walking down the hall.

On the other hand, when an individual has unexpected difficulty persuading their own executive or director, bringing in mental health advocates to make the case may be more effective. Law enforcement and mental health agency leaders view themselves as public servants and may respond best to requests from the public.

WHAT TO DO WHEN YOU HIT A ROADBLOCK

“It took about three years to get the first CIT program going in Marion County. Three NAMI people got together and wanted to do CIT, but we couldn’t seem to get people interested. Finally, we were able to get some mental health people. Then eventually, one of the police officers who was in charge of the academy, his son had bipolar disorder, and he came to take our NAMI Family-to-Family class. He became an entree into the whole system.”

— Donna Yancey, NAMI Greater Indianapolis, Indianapolis, Indiana

Sometimes a law enforcement leader or a mental health leader is simply unwilling to consider CIT. If you and your allies find yourselves in this situation, realize that circumstances and leadership eventually change and that there’s plenty you can do in the meantime to build support for CIT. Be persistent.

- Continue to build up your network of allies. You may identify a connection or champion with the influence to change the mind of your reluctant leader.

- Look for ways to provide assistance, such as sharing resource materials or offering to provide brief training. Look for opportunities to praise the leader for incremental progress. If there's an opportunity for you to volunteer, sit on an advisory committee, or take training from that agency, do it. All of these activities will keep you relevant in the eyes of the leader and show that you are invested in long-term change.
- Continue to learn. If possible, visit a CIT program in another community, go to state or national conferences, follow the research on CIT, and advocate for improved mental health services in your community.

Most importantly, don't become discouraged. Continue to stay involved.

Formalize Your Commitment with a Steering Committee

Once the executives of your mental health advocacy organization, law enforcement agency, and mental health agency have agreed that CIT is the right path for your community, it's time to invite them to come together and make a more formal commitment to working together. The commitment to CIT can evolve over time, but the foundation is a community steering committee. This section describes the steering committee and its early responsibilities.

ENSURE THE STEERING COMMITTEE HAS THE RIGHT MEMBERS

The steering committee members are the individual executives listed on the *WORKSHEET: Leaders You Need at the Table* on page 204 or designated staff from their agencies or organizations who have the authority to carry out their wishes. Agency and organization leaders may also include their supervisory or front-line staff.

The steering committee should include representation from both people living with mental illness and their family members. Some advocacy organizations represent both groups; if they do not, the partners may need to reach out to additional advocates to ensure that both perspectives are at the table.

In Chapter 3, you will learn about partners that may join your steering committee beyond this core group. Most CIT programs choose to build the steering committee around these three core partners first and expand later.

LOCAL AND REGIONAL PROGRAMS

As CIT programs form, they can take shape in one of two ways. Programs that include a single law enforcement agency and jurisdiction are local programs. Programs that include multiple law enforcement agencies and jurisdictions are often called regional programs. As you form your steering committee, it's helpful to decide what makes the most sense for your program.

Regional programs, where several smaller communities join together or several law enforcement agencies serve a county or other large geographical area, are common. Regional programs have the advantage of sharing resources and training. They may also be organized around the service area of the mental health system, so they can create consistent crisis response services across a region.

Some large cities may start out with a local program, because there is a single law enforcement agency responsible for a large population, or because only one law enforcement leader is excited about CIT. However, these programs may evolve into regional programs, with the largest city becoming a hub for training and expertise to share with smaller neighboring communities.

To learn more about the difference among local, regional, and state programs, review ***Levels of Coordination*** on page 82 and ***Network and Support New CIT Programs*** on page 169.

SELECT A COMMITTEE CHAIR

During the first few meetings, elect a committee chair from among the leaders on the committee. This individual should be an excellent communicator and problem-solver who has the influence to bring others to the table and help resolve conflict. The ideal individual will depend on the circumstances. For example, if your goal is to reach multiple law enforcement agencies within a region, it may be sensible to nominate the chief or sheriff of the largest or most respected law enforcement agency. If there's a lot of tension on the committee, it may make sense to nominate the leader who is the most diplomatic. If your champion is very engaged, they may make a good committee chair.

It's important to note that the individual or individuals who first started to advocate for CIT in your community are not necessarily the best fit to be the steering committee chair. They have an important role to play, sharing the research they have already conducted about organizations and experts in CIT, and can continue to support the committee's work.

AGREE ON A MEETING STRUCTURE

There's no prescribed schedule, but steering committee members should plan to meet regularly on an ongoing basis. Some CIT steering committees meet monthly; others meet less frequently. Frequency can change over time.

Your committee may also wish to develop a charter, a formal document describing the committee's mission, membership, ground rules for discussion, and a mechanism for a leadership change. While not a requirement for CIT programs, they can be helpful in setting the stage for working together productively.

PROACTIVELY ADDRESS CONFLICTS AND CONCERNS

"One of the things we did when we first met was ask each agency for its list of 'wishes, wants, and concerns,' which we carried over into low-hanging fruit and long-term goals. We'd air everything at one time, and agree where we're at and that we're going to move forward from here. We're not going to point fingers. If we can address it, we're going to do that."

— Carol Speed, Systems Integration Consultant for Criminal Justice and Behavioral Health, Athena, Oregon

There are likely misunderstandings or conflicts between the agencies and organizations represented on your steering committee. This is to be expected because each partner comes to the table with a different experience of the crisis response system. Spend some time in your early meetings addressing these challenges head-on.

An attitude of cooperation really matters in this discussion. Everyone has important knowledge and experience to contribute, and everyone has gaps in their knowledge about the community's response to mental health crisis situations. No matter the role you play in the CIT steering committee, you can lead by modeling respect and an open mind.

How To Address Challenging Topics

The committee chair should ask everyone to agree to work together to address challenges, then go around the table and ask each partner to share their concerns. Write everything as it's shared somewhere everyone can see the array of concerns.

Once everything is shared, organize the items into short- and long-term challenges. If there's anything that can be addressed immediately, do so. Otherwise, make some concrete plans to follow up on short-term items. These items will help you create an agenda for your early meetings.

Record the list in the meeting minutes, and repeat this exercise periodically. In six months, look back and appreciate the progress you've made.

AGREE ON SHORT-TERM GOALS

Based on the early discussions of conflicts and concerns, the steering committee should make a list of short-term goals. Generally, these are goals that could be addressed primarily through better coordination and communication, rather than with significant time and resources. However, small changes can still make a big impact on everyone involved in a crisis situation, and working on them will give everyone a sense of momentum.

Examples of short-term goals might include:

- Creating a glossary of terms, so that partners can become familiar with the language of mental health systems, criminal justice systems, and mental health advocacy.
- Learning more about crisis receiving centers and specialist officers by visiting a CIT program in your state.
- Creating clear guidance for officers on behaviors that qualify an individual for an emergency psychiatric evaluation, and guidelines for describing that behavior to emergency department or crisis center staff.

You can begin to note long-term goals as well but don't become intimidated by them. In the coming chapters, you will learn more about how your community can successfully make larger changes, and adopt the CIT Core Elements.

DEMONSTRATE COMMITMENT BY LEARNING TOGETHER

Building commitment to CIT is a gradual process. Partners on the steering committee can demonstrate their commitment to CIT by taking proactive steps to learn together. These steps require some commitment of time, expertise, or resources from one agency to the benefit of the entire group. For example, an agency could:

- Provide meeting space, supplies, and lunch for steering committee meetings.
- Arrange for partners to attend webinars or other online training together.
- Offer brief cross-training opportunities to steering committee members, like a peer and family presentation about the lived experience of mental illness, a ride-along with officers, or a tour of a mental health facility.
- Research and present best practices on a specific topic that the steering committee has identified as a challenge, such as model policies or crisis receiving centers.
- Pay for a small cross-agency team to attend a local or state conference on a topic related to mental health crisis response, such as homelessness or substance use disorders.
- Pay for a small cross-agency team to travel to a neighboring CIT program to observe their crisis response system in action.
- Pay registration fees for a small cross-agency team to attend a state CIT conference.
- Pay for a small cross-agency team to attend the CIT International Conference.

These activities have the dual benefit of building goodwill among the partners, and creating many opportunities for everyone to learn about CIT, crisis response systems, topics related to mental illness, and their new partners.

DISCUSS YOUR NEED FOR FUNDING

Early in the process of developing a CIT program, many communities become concerned about the need for funding to implement the program. Review the **CHART: Common Concerns about CIT Funding** on page 210 for a reminder about common concerns and ways to address them. There are many ways for the partners to work together to provide personnel, meeting space, and materials in-kind, seek donations from the business community, or share resources.

Typically, the next major phases of CIT are:

- Mapping your crisis response system (see **Sequential Intercept Model Mapping** on page 60),

- Coordinating with your partners to ensure smoother and safer crisis response (see *Identify Ways to Promote Seamless Communication During a Crisis* on page 88), and
- Revising policies (see *Review Policies and Procedures for Crisis Events* on page 101).

While there can be costs associated with these activities—for example, hiring an outside organization or individual to facilitate the system-mapping process—the overall cost is not typically high. As a steering committee, review Chapters 3 and 4 and strategize about how to get the resources needed for these activities.

In the long term, a dedicated funding stream through your state department of mental health or criminal justice is the most likely sustainable source of funding. However, that often takes a few years, after your program is successful and has widespread community support, and after you have networked with regional or statewide programs.

Plan to Fund Officer Overtime

One common concern is the cost of overtime to cover the shifts of officers who will be in CIT training. It may take your community a year or more before you're ready for officer training. Many communities would like to train officers as soon as possible, but a thorough mapping of your crisis system and planning process will set you up for long-term success.

In the meantime, there are a couple of approaches to cover overtime. First, reach out to your state CIT network, your state peace officer standards and training (POST) board, and state mental health agency to find out whether there's any state support for these expenses. Second, ask law enforcement executives to write a line item into their agency's next budget to cover officer overtime.

Seek Grant Funds Cautiously

If you are certain your community requires grant funding to move forward—perhaps because you are in a large city with so many partners that you require extensive planning—consider applying for grants with caution. Some new CIT programs have relied heavily on grants and then collapsed when their grant funding ran out. If you apply for a grant, follow these guidelines:

- Use grants funds for a specific, time-limited purpose, rather than for day-to-day operations.

- Ensure that the goals of the funder align with the CIT Core Elements.
- Ensure that your grant activities help your CIT program improve mental health crisis response in your community and serve the needs of all partners.

You and your partners may want to investigate the following sources of grant funding:

- Local civic organizations,
- Your state department of mental health or criminal justice,
- The federal *Substance Abuse and Mental Health Service Administration (SAMHSA)* (<https://www.samhsa.gov/grants>),
- The *Department of Justice, Bureau of Justice Assistance* (<https://www.bja.gov/funding.aspx>), particularly the *Justice and Mental Health Collaboration Grants* (https://www.bja.gov/ProgramDetails.aspx?Program_ID=66#horizontalTab1), and
- Private foundations. The *Council on Foundations* (<https://www.cof.org/community-foundation-locator>) can help you locate a community foundation near you.

Case Study: Creating a CIT Steering Committee in Malheur County, Oregon



“Getting everyone on board is really amazing. For example, we knew we were interested in getting a mobile crisis unit, but how? Having the brass on board, and the director of mental health and the hospital, made it happen.”

— Becky Wolery, PsyD, LCSW, Lifeways and Insight Counseling, Ontario, Oregon

In 2013, Greater Oregon Behavioral Health, Inc. (GOBHI) began to reach out to local communities to start CIT programs. In Malheur, a rural county of 30,000 in Eastern Oregon on the border with Idaho, CIT was a welcome innovation. Carol Speed, who helped organize the first community meeting around CIT in Malheur County, says she was able to help identify local leaders and stakeholders through two committees that exist in almost every Oregon community: the local community advisory council for Medicaid expansion and the local public safety coordinating council. Funding from the State of Oregon helped increase CIT outreach in other communities in 2016.

Even as GOBHI was reaching out, local interest was starting to build for CIT. Ridg Medford, at the time a police officer in Ontario, Oregon, had gone to CIT training in Idaho and was ready to pitch CIT to his chief.

THE FIRST MEETINGS

The first formal meetings for CIT in Malheur County provided opportunities to air frustration. With leaders of the county’s three largest law enforcement agencies, a state police representative, the hospital, crisis services, and the mental health director at the table, it was clear that agencies had been siloed off from each other. The agencies and organizations “were not communicating—were afraid of communicating because of HIPAA⁶ constraints,” says Medford. Becky Wolery, who served at the time as an after-hours crisis worker, says the message mental health professionals gave to law enforcement was: “We’re serving you. We want to fix some problems in mental health.”

Opening up communication had immediate benefits. Together, the partners made a list of concerns and tackled a big one: the relationship among the hospital, the mental health

⁶ The Health Insurance Portability and Accountability Act (HIPAA) is a federal privacy law designed to protect medical records and other health information shared by health insurance companies, doctors, hospitals, and other health care providers. To learn more about how HIPAA applies to mental health and law enforcement professionals, review the section [Privacy and Information Sharing](#) on page 176.

agency, and law enforcement around the transfer of custody of a person in crisis. This was particularly challenging because their small hospital is not certified to receive or hold people for involuntary psychiatric evaluations. Within a year, the partners had a Memorandum of Understanding describing a clear process for the transfer of custody, and the roles and responsibilities for each agency.⁷

STRUCTURING THE STEERING COMMITTEE

Malheur County's CIT steering committee comprises executives and leaders across the mental health and justice systems, including leaders of the county's largest law enforcement agencies: Ontario Police Department, Nyssa Police Department, and the Malheur County Sheriff's Department. It also includes representatives from the Oregon State Police, Lifeways (the behavioral health provider), St. Alphonsus Medical Center Emergency Department, the mental health jail diversion program, the crisis service supervisor, and the Veterans Services Office. Malheur County faces a challenge with including mental health advocates on the steering committee—they have not been able to identify any mental health advocacy organizations within their small county, but have had peer specialists sit on the committee at times. NAMI members from Idaho travel to assist with CIT training.

The steering committee meets quarterly to address big-picture issues in the community and has empowered a smaller "Action Team" to manage day-to-day issues. Currently co-chaired by Medford on the law enforcement side and Wolery on the mental health side, the Action Team includes staff from several organizations and agencies who have been assigned to support CIT. The Action Team organizes CIT training and works together as a tightly knit group of CIT coordinators.

PROBLEM-SOLVING

Having agency and organization leaders involved in the CIT steering committee led to creative problem-solving. For example, the partners agreed that it would be helpful to have a mobile crisis team, but with limited resources and almost 10,000 square miles to cover, it had seemed impractical. Once all the agencies and organizations in the county bought into the idea, one agency donated a vehicle, another provided staff, and a third offered a grant writer to seek funding. Ultimately, the state mandated and provided funding for mobile crisis services, but that willingness to pitch in carries across all their efforts.

⁷ Review the section *If Needed, Create a Memorandum of Understanding Among Partners* on page 106 and see the *EXAMPLE: Memorandum of Understanding* on page 217.

The program has expanded its reach to partner with agencies and organizations across state lines, in nearby Boise, Idaho. For example, Malheur has no homeless shelters, but for individuals interested in the nearby shelter in Boise, they can provide a bus ticket. There are even advocacy efforts to allow emergency detention across state lines, to allow for greater access to hospitals in Idaho.

RURAL CHALLENGES AND ADVANTAGES

Malheur County's isolation doesn't make it unique, but it does highlight challenges and opportunities that are specific to rural communities. With so few organizations and agencies involved, everyone knows all the partners and everyone is familiar with the individuals who frequently experience crisis.

However, Malheur lacks the mental health services that are present in some larger cities, including a hospital that is certified and equipped for emergency psychiatric evaluations. "The two worst places to take people in crisis are a jail and a hospital. And we have two places to take people: the hospital and the jail. We have a real lack of resources," says Medford. Rather than transport individuals many hours away to another hospital, the CIT program has worked with the local hospital to train clinicians and security officers to de-escalate crises that occur in the emergency department and ensure the safety of patients and staff.

The lack of resources is galvanizing. Up next for Malheur: Sequential Intercept Model mapping to identify gaps in the system that can be addressed. They hope the mapping process will highlight the most urgently-needed services so that their CIT program can continue transforming their crisis response system.



Summary: Make a Commitment



To be successful, your CIT program needs the support of leaders in your community. Specifically, you need buy-in from:

- The chief or sheriff of your target law enforcement agency or agencies,
- The director or CEO of your public mental health agency, and
- The director or CEO of a local mental health advocacy organization.

These individuals are busy and have many competing demands, so it may take time and a lot of engagement to gain their support. It's important to be respectful of their time and position. Leaders also appreciate solutions and facts, rather than complaints. Finally, always assume leaders are working in the best interests of their community and may need support to carry out best practices like CIT.

Once your leaders are on board, it's important to formalize your commitment by creating a CIT steering committee. On the steering committee, ideally, leaders from mental health advocacy organizations, mental health agencies, and law enforcement agencies make joint decisions and serve as equal partners in CIT. Committee members should select a chairperson and agree to meet regularly. The CIT steering committee is a venue for addressing conflicts and concerns with the crisis response system, learning about partners in the community, and setting goals.



Checklist: Make a Commitment



Review the checklist below to make sure you have completed the key steps in this chapter. Or, use this checklist if you think your community may be able to skip ahead to another chapter.

Move ahead to Chapter 3 if:

- ☐ You and your allies have buy-in for CIT from the law enforcement leaders, mental health agency leaders, and mental health advocacy leaders in your community.
- ☐ Your community has a formal CIT steering committee including law enforcement executives, mental health system executives, people living with mental illness, and their families.
- ☐ Your CIT steering committee has a committee chair and an agreement to meet regularly.
- ☐ Your CIT steering committee is proactively addressing conflicts and challenges among the partners.
- ☐ Partners are demonstrating their commitment to CIT by sharing time, resources, and expertise.
- ☐ Your steering committee has agreed to some short-term goals.
- ☐ Your steering committee has discussed whether any funding is needed in the short term for mapping your crisis response system or making systems and policy changes.

CHAPTER 3:

UNDERSTAND YOUR CRISIS RESPONSE SYSTEM

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Introduction: Why Focus on the Crisis Response System?

“We know that the majority of crisis calls that 911 centers receive do not require a law enforcement response. Law enforcement officers should not be the automatic first responders to all crisis situations; they should only respond to situations where there’s a warranted safety or criminal concern. We don’t want the crisis response to add to the trauma people experience with mental illness, add to stigmatization, or continue to accept that access to crisis care is only through law enforcement encounters.”

— Ron Bruno, Executive Director, CIT Utah, Salt Lake City, Utah

This chapter and Chapter 4 focus on understanding and improving your crisis response system. A crisis response system includes all the services and resources available to help a person experiencing a mental health crisis.

Focusing on the crisis response system is key because an effective crisis response can improve safety and reduce the number of people in the criminal justice system in the long term. When a crisis is resolved effectively, the individual is less likely to experience repeat crises. Over the long term, that leads to fewer encounters between officers and individuals with mental illness—improving safety for all.

Second, an important goal of CIT is to reduce the number of times that people spend interacting with police and increase connections to mental health services. This is only possible with a fully integrated crisis response system—so that mental health services can be the initial access point, whenever appropriate.

Finally, during a crisis response, CIT programs must work to reduce the trauma experienced by individuals in crisis. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”⁸

8 Substance Abuse and Mental Health Services Administration. (2014, July). *SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from <https://store.samhsa.gov/system/files/sma14-4884.pdf>

Traumatic events cause a variety of reactions—physical and emotional—and many people suffer no long-term effects. However, for some people, there are serious, long-term consequences, including post-traumatic stress disorder and health problems.

Some people in mental health crisis who have interacted with police, hospitals, and the mental health system report a wide array of traumatic experiences. These have included being forced into handcuffs and treated like a criminal inside the cage of a police vehicle; being shocked by a Taser; being left alone for hours without care in an emergency department; or being strapped to a gurney and forcibly medicated. As a result, many people are afraid of police or afraid to seek treatment.

“Some people in mental health crisis who have interacted with police, hospitals, and the mental health system report a wide array of traumatic experiences... As a result, many people are afraid of police or afraid to seek treatment.”

These traumatic events almost always spring out of the best intentions of officers and mental health professionals who are tasked to ensure safety, while following their organizations’ procedures or making do with limited resources. These types of incidents are not uncommon and are often brought to the attention of law enforcement and mental health services during the development of CIT programs. This chapter and Chapter 4 examine the systemic issues that lead to traumatic incidents and identify where changes can be made.

Throughout this chapter, you will learn about how to assess your community’s crisis response system and these factors: safety, time in the justice system, access to mental health services, and trauma.

What A Quality Crisis Response System Looks Like



“We can’t continue to strictly focus on law enforcement, because in doing so we’re creating an overreliance on the criminal justice system. The question is: how can CIT help us think about these larger system changes?”

— Shannon Scully, Senior Manager, Criminal Justice Policy, National Alliance on Mental Illness, Arlington, Virginia

A high-quality crisis response system is built on mental health services. These services are designed to stabilize a person experiencing a crisis and connect them with additional services to address their long-term needs. The Substance Abuse and Mental Health Services

Administration (SAMHSA) report *Crisis Services: Effectiveness, Cost-Effectiveness and Funding Strategies* (<https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848>) identifies the core crisis services as:

- **24/7 crisis hotlines:** A telephone-based direct service that provides support or referral to a person in crisis.
- **Warm lines:** A telephone-based direct service that provides empathic listening, information, and referral to a person in need of non-emergency support.
- **Mobile crisis services:** A team of mental health professionals that provides mental health assessment and acute crisis stabilization in a client's home or another community setting.
- **23-hour crisis stabilization/observation beds:** A service that provides up to 23 hours of care to assess, de-escalate, and refer a person in crisis to services. One purpose of crisis stabilization beds is to avoid unnecessary hospitalization.
- **Short-term crisis residential stabilization services:** A short-term service that provides housing and 24-hour observation and supervision paired with community-based supports to assist in de-escalating a crisis. One purpose of this service is to avoid unnecessary inpatient hospitalization.
- **Psychiatric advance directives:** A legal document valid in many states that describes an individual's wishes for future mental health care.⁹
- **Peer crisis services:** An alternative to short-term crisis residential services and inpatient hospitalization, peer crisis services are run by people who have experience living with mental illness and provide a calming environment to support an individual in crisis.

In addition to the core crisis services recommended by SAMHSA, CIT International recommends immediate access to walk-in clinic appointments.

SAMHSA's *Practice Guidelines: Core Elements for Responding to Mental Health Crises* (<https://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/sma09-4427>) provides guidance on how crisis services should be delivered. These guidelines emphasize values that are similar to those of CIT, such as reducing harm and trauma, engaging the person in their own care, and contributing to an individual's long-term recovery.

⁹ To learn more about psychiatric advance directives, visit the National Resource Center on Psychiatric Advance Directives at <https://www.nrc-pad.org/>.

The *Crisis Now* (<https://crisisnow.com/>) initiative, a project of several national mental health advocacy and provider organizations, offers similar recommendations to those of SAMHSA. It also includes tools and case studies to help communities understand best practices and implement comprehensive crisis services.

RESPONSIBILITY OF THE MENTAL HEALTH SYSTEM

In a well-functioning crisis response system, the mental health system is primarily responsible for educating the public about the availability of mental health services, reaching out to people who may need ongoing support, and responding to crisis events.

The *report to Congress* (https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf) from the Interdepartmental Serious Mental Illness

*“A person with SMI [serious mental illness] or SED [serious emotional disturbance] who is in crisis should be able to get adequate mental health care in the community without contact with law enforcement.”*¹⁰

Coordinating Committee, a group of federal agencies and national experts, states: “A person with SMI [serious mental illness] or SED [serious emotional disturbance] who is in crisis should be able to get adequate mental health care in the community without contact with law enforcement.”¹⁰

Law enforcement should play a supportive role in situations where there is a safety or criminal concern, but generally should not be the lead agency simply because a mental health crisis has occurred.

This ideal is far from the reality for many communities, where crisis services are inadequate and police play a significant role in crisis response. Changing those systems is a slow and gradual process. Historically, law enforcement, who are often very task-oriented, have tried to address the issue on their own, or have been reluctant to relinquish primary crisis response responsibilities to an evolving system of care. Unfortunately, it’s simply impossible for law enforcement to create a safe and humane crisis response system on their own or to take on permanent responsibility for managing every crisis call for service. Instead, law enforcement must work with their partners, look for strengths

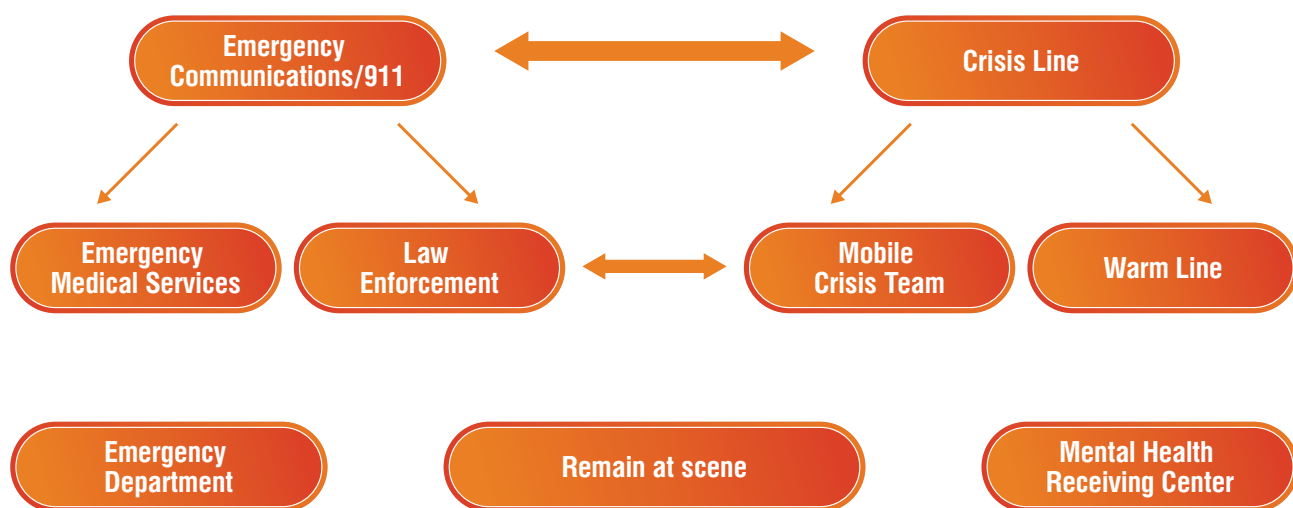
10 Interdepartmental Serious Mental Illness Coordinating Committee. (2017, December 13). The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers, 88. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf.

in the community, and support mental health system partners in shouldering primary responsibility of crisis response services.

INTEGRATED CRISIS RESPONSE

Developing an effective crisis response system that reduces law enforcement contact and increases connection to mental health services for people in crisis is at the core of CIT programs. The crisis response system must be flexible, to connect resources and services to the individual as their needs evolve, and provide the services in the least intrusive manner. The diagram, *Components of an Integrated Crisis Response System*, depicts a system with these features that has the goal of reducing law enforcement's role in crisis response.

COMPONENTS OF AN INTEGRATED CRISIS RESPONSE SYSTEM¹¹



In an integrated crisis response system, an emergency communications center (911) call-taker would decide whether a mental health crisis call warranted an immediate law enforcement response due to the level of danger or criminal activity. If so, the call-taker would dispatch CIT officers and possibly emergency medical services (EMS). If not, the call-taker would initiate a three-way call, to hand off the call to their local crisis line for a possible resolution. The crisis line could transfer the call back to the emergency communications center if, at any time, it deemed law enforcement or emergency medical services were needed.

11 Bruno, R.L. (2016, April). Crisis Response System Development. Paper presented at the CIT International Conference Coordinator Certification Course, Chicago, IL.

Crisis calls received by crisis lines are generally resolved at that level, but can also be resolved in several other ways. For example, the call could be transferred to a warm line where a certified peer specialist would provide support and resources. Or the crisis line could dispatch out a mobile crisis team comprised of a clinician and a certified peer specialist to address the crisis needs of the person in the community.

The majority of mental health calls for service received by emergency communication centers do not require a law enforcement response. However, if the call-taker believes that a level of danger exists warranting law enforcement response, and if appropriate, a co-response can be achieved by dispatching both CIT officers and mobile crisis team personnel to the scene to address that danger together. The advantage of this type of crisis response model over an embedded co-response model is that the mobile crisis team is able to respond independently of law enforcement for most mental health crisis calls.

The next level in the graphic demonstrates the resources available in this integrated crisis response system model. If the crisis is not resolved at the crisis line level, the warm line level, or the mobile crisis team level, then the person could be transported to an emergency department or another mental health receiving center.

However, as demonstrated by the center box on the bottom row, the best resolution for a crisis situation occurs when the individual receives appropriate support in the community without transport to another location.

“...a receiving center can be defined as any medical or mental health service provider that receives people in crisis transported by police or mobile crisis services. Examples include an emergency department (ED), psychiatric emergency room, crisis center, access center, triage center, or peer respite center.”

EMERGENCY DEPARTMENTS AND RECEIVING CENTERS

In addition to the components described by SAMHSA, and as referenced above, CIT programs often focus on the interaction between law enforcement and receiving centers. For the purposes of this guide, a *receiving center can be defined as any medical or mental health service provider that receives people in crisis transported by police or mobile crisis services*. Examples include an emergency department (ED), psychiatric emergency room, crisis center, access center, triage center, or peer respite center.

The most common receiving center is a general hospital emergency department. However, many emergency departments are not designed for mental health crises, and their staff is often not supported in dealing with these challenging situations. Too often, this results in the individual in crisis having to sit, handcuffed and accompanied by officers, for hours in a loud and crowded waiting room.

After admission, people in crisis often do not get timely care. Nationally, people in mental health crisis wait an average 7-11 hours in emergency departments for a bed after being admitted to the hospital, and many wait days.¹² People have reported receiving little care waiting on a gurney in a hallway or sitting in a waiting room long after admission. This phenomenon is called emergency department boarding, and it's the result of several factors: an inadequate crisis response system, emergency department overcrowding, and specific challenges having to do with mental health care. These challenges include the lack of crisis stabilization and inpatient psychiatric beds, and longer insurance processing times for many people with mental health conditions.

Due to frequent challenges in emergency departments, CIT programs often take a two-part approach.

- First, CIT programs encourage close collaboration among emergency departments, law enforcement, mental health agencies, and advocates to improve procedures in the ED for all concerned. At the same time, CIT encourages using other resources, such as mobile crisis teams, hotlines, and peer respite centers to serve some people in crisis—thereby avoiding contact with law enforcement and emergency departments altogether. Partners can often make significant progress by using the resources already available more effectively. Chapter 4 discusses these improvements in detail.
- Second, in the longterm, some CIT programs advocate for a third location—neither the ED nor the jail—that is a dedicated receiving center for mental health crisis situations. This process often takes several years of advocacy and development of a funding stream but can be a better option for all partners. The section **Advocate to Strengthen Mental Health Services** on page 179 provides suggestions about how to advocate for that option.

12 Nazarian, D. (2017, July 10). ACEP Refines Its Clinical Policy on Psychiatric Boarding. Retrieved from <https://www.acepnow.com/article/acep-refines-clinical-policy-psychiatric-boarding/>

CAUTIONS ABOUT THE EMBEDDED CO-RESPONSE APPROACH TO MENTAL HEALTH CRISES

As law enforcement has learned more about mental health, criminal justice leaders have sometimes stepped forward to expand their role in providing service to people in crisis. Although this would, at first glance, appear to be a beneficial approach, it may have unintended harmful consequences in the long term. For example, some law enforcement agencies employ an embedded co-response model, meaning mental health clinicians ride with officers and co-respond to crisis calls. This approach raises many concerns.

Many mental health crisis situations do not require a law enforcement response. Relying on embedded co-response may further shift responsibility for providing mental health care from the mental health system to the criminal justice system.

If procedures are in place to respond to calls for service with some level of clinical intervention, mental health systems may not feel pressure to develop a vibrant crisis response system that allows access to crisis services without any law enforcement contact.

Embedded co-response also sends a message to individuals in crisis that help comes in a police car. Unfortunately, this may have the unintended consequence of encouraging people to wait and call for police when a crisis has become dangerous, rather than contacting a mobile crisis service or a crisis line before the situation reaches that level of concern. Or, it may frighten individuals away from calling for help at all due to the fear of officers.

Additionally, when a crisis response includes law enforcement, law enforcement policies can dictate the response. For example, one police department that utilizes embedded co-response has a policy that any response to a person in crisis requires the person to be handcuffed regardless of whether there is any true need for such restraints. Or, law enforcement policy may strongly encourage transporting an individual—either for mental health care or to jail—which could override the mental health professional's preference to leave a person at home with their natural supports and a plan for follow-up. These approaches can be traumatizing for the person in crisis, add to stigmatization, and further reduce the possibility

that the individual or family members will reach out for help when future crisis situations arise.

Finally, any time a law enforcement officer is involved in a crisis situation (even during embedded co-response), there is an opportunity for the individual in crisis to become further involved in the justice system. The officer may witness something that requires them to make an arrest. Or the presence of police may upset an individual in crisis and escalate the situation; even CIT officers who are highly trained to de-escalate a crisis may be frightening because of their vehicles or uniforms.

As an alternative to embedded co-response, some communities have a protocol that allows the option for mobile crisis teams to call for law enforcement backup when a safety concern arises, or for law enforcement to call for a mobile crisis team. In this way, a CIT program can strive to keep police out of the picture whenever safety allows, but also allow a co-response when needed.

Sequential Intercept Model Mapping

“A law enforcement officer has to be able to answer the question of divert to what? It’s incumbent when we do the mapping, and we talk about the crisis care continuum, that the officer can answer that question... Otherwise, we know the answer is going to be ‘take them to jail.’”

— Travis Parker, MS, LIMHP, CPC, Program Area Director, Policy Research Associates, Delmar, New York

Many communities undergo a process called Sequential Intercept Model (SIM) mapping, which brings together stakeholders to discuss and diagram how people living with mental illness move in and out of the criminal justice system and the crisis response system. Sequential Intercept Model mapping can bring clarity to the challenges you face, and provide clear steps to improving your crisis response system.

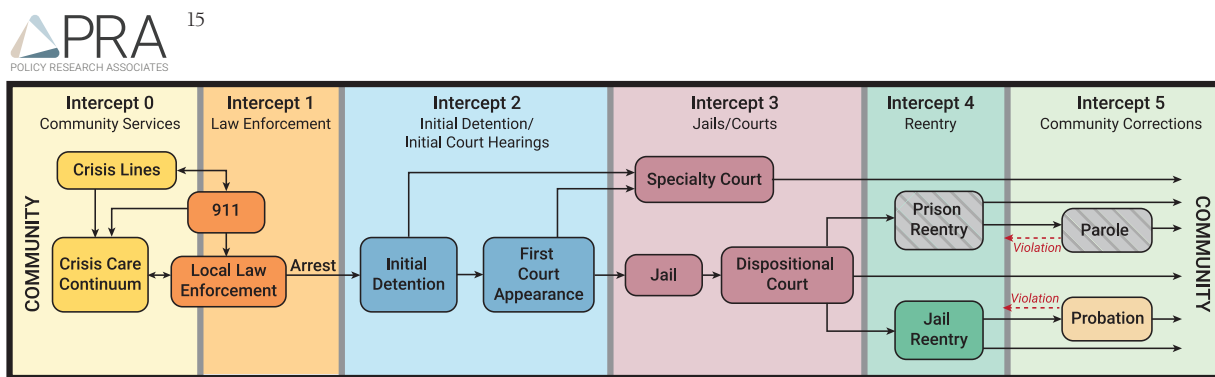
The mapping process produces a physical map of the systems and services involved when an individual is in crisis. It also produces a list of gaps and strengths in your system and recommendations for addressing systemic challenges.

The mapping process is an opportunity for education and buy-in. Seeing the big picture together helps agency and community leaders understand that most problems are truly systemic, so rather than blaming each other, they can focus on solutions together. Second, developing the map together creates buy-in about future recommendations. For example, if a recommendation coming from the mapping process is that the mental health agency should increase mobile crisis capacity, the mental health agency is more likely to agree because they were at the table sharing their challenges and hearing concerns from others.

LEARN ABOUT THE SEQUENTIAL INTERCEPT MODEL

Most mapping processes use the Sequential Intercept Model, a model for understanding the way people with mental illness interact with the criminal justice system. The Sequential Intercept Model was created in the early 2000s by Mark Munetz, MD, and Patricia Griffin, PhD,¹³ along with Henry J. Steadman, PhD, and subsequently further developed by Policy Research Associates, Inc.¹⁴ The model illustrates opportunities at every stage of the justice system (from crisis situations in the community to police involvement, jail, courts, prisons, etc.) for individuals with mental illness to be diverted away from the justice system.

As illustrated in the graphic below from Policy Research Associates, Inc., Intercept 0 is community services, including crisis lines and crisis services, Intercept 1 is law enforcement, including 911 and local law enforcement, Intercept 2 is detention and initial court hearings, Intercept 3 is jails and courts, Intercept 4 is reentry, and Intercept 5 is community corrections.



Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behavioral Sciences & the Law*, 35(5-6), 380-395. <https://doi.org/10.1002/bsl.2300>
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- 13 Munetz, M. R., & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness. *Psychiatric Services*, 57(4), 544-549. doi:10.1176/appi.ps.57.4.544
- 14 Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behavioral Sciences & the Law*, 35(5-6), 380-395. doi:10.1002/bsl.2300
- 15 Policy Research Associates, Inc (2018). *Sequential Intercept Model*. Delmar, NY.

A key lesson of the Sequential Intercept Model is that it's possible to assist a person with a mental health condition at any point in their involvement with the justice system and help them avoid future justice system involvement. However, it is most effective to have strong crisis services at Intercept 0 that allow access to mental health services without any contact with the justice system. It is also easier and more effective, if justice system involvement does occur, to serve people and get them on the path to recovery if they can be diverted from the justice system early, such as at Intercept 1.

HOW A MAPPING WORKSHOP WORKS

A mapping workshop typically includes the array of stakeholders listed in the section *Invite More Stakeholders to the Table* on page 63 and includes both agency and organization leaders and front-line staff. Agency and organization leaders ensure that any recommendations coming out of the process have more immediate buy-in, while front-line staff provides detailed feedback on day-to-day experiences.

During mapping of crisis services, the stakeholders work as a group to identify the current practices of their crisis response system, identify the gaps, identify the opportunities for improvement, and look for funding opportunities if needed.

Stakeholders typically discuss each intercept in turn, trying to gain a clear understanding of their community's services, strengths, and gaps. Then, they focus in on priority issues. The workshop concludes with a strategic action planning process to help communities tackle their top priorities.

Some communities have taken advantage of having a facilitator trained in the Sequential Intercept Model lead the workshop. Contact the [SAMHSA GAINS Center](https://www.samhsa.gov/gains-center) (<https://www.samhsa.gov/gains-center>) to help identify a trained facilitator in your state.

MAPPING THE ENTIRE SYSTEM VS. ONLY THE FRONT END

Traditionally, Sequential Intercept Mapping addresses the entire criminal justice system, from Intercept 0 through Intercept 5. However, some CIT programs choose to host a mapping session that focuses only on Intercepts 0 and 1, since that is where the crisis response system and law enforcement interact the most.

It is up to your steering committee where to focus. If there are other criminal justice/mental health reform efforts in your community, a mapping process that covers the entire criminal justice system may encourage greater collaboration and information-sharing.

However, if resources are limited and CIT is a pioneer for reform in your community, the more focused mapping makes more sense.

Keep in mind that whichever way you choose, you have the option of repeating the mapping process in a few years in a more focused or more comprehensive way.

INVITE MORE STAKEHOLDERS TO THE TABLE

For a successful Sequential Intercept Model mapping, seek input from a wide array of agencies and community organizations. Sometimes partners across a community do not understand each other's roles, so don't be afraid to invite agencies and organizations that may play a minimal role in the crisis response system. You may learn something new as you get to know them.

Criminal Justice: Invite agencies involved in crisis response, including those that might work with individuals who are cycling through jail due to repeat crisis situations.

- Lead law enforcement agency
- Additional law enforcement agencies, including municipal agencies, tribal agencies, military police, campus police, and transit police
- Emergency communications/911
- Jails
- Probation
- Reentry programs

Oversight Agencies and Service Providers: Include agencies that are, or could be, involved in supporting individuals in crisis. This includes agencies that oversee services, provide treatment, or provide supports.

- Assertive Community Treatment (ACT) teams and Forensic Assertive Community Treatment (FACT) teams
- Crisis centers
- Crisis stabilization and crisis residential services
- Emergency departments
- Emergency medical services/fire services
- Homeless service providers/housing agencies

- Hospital/crisis center security
- Hotlines and warm lines
- Local mental health authority
- Mobile crisis services
- Outpatient services
- Peer support agencies
- Private mental health providers
- Respite centers
- Substance use service providers
- Veterans Administration mental health providers
- Veterans Justice Outreach Programs
- Youth services

Advocacy/Community: Include organizations and agencies that represent specific populations, provide unique expertise about your community, or provide charitable services.

- Individuals with lived experience who are currently being served by the mental health and/or substance use treatment service system
- Additional mental health advocacy organizations (see a list on page 28)
- Civic organizations, such as United Way, Boys and Girls Clubs, or YMCA
- College or university counseling services
- College or university researchers
- Faith organizations
- Food banks
- Housing advocates
- Schools
- Veterans advocates

WELCOME NEW PARTNERS

Some of these new groups may become permanent members of your steering committee, while others will likely be involved only briefly. Members of the steering committee

should make an effort to engage those organizations and agencies that are most directly involved in your crisis response system or have the most to offer.

To welcome new partners, the steering committee can:

- Present about CIT and your vision for your community,
- Describe your planned next steps, such as policy and procedure review, and officer training,
- Ask for feedback and new ideas, and
- Offer new partners meaningful roles in your work.

Make sure to describe CIT as a collaborative process, for the benefit of all partners. Welcoming new partners may take some time. Remember that building these relationships is an important investment.

Getting Buy-in and Input from People on the Front Lines



“Who can best tell you how to improve the system? Those who are served by it and those providing the service.”

— Pat Strobe, CIT Advocate Coordinator, Georgia Public Safety Training Center, Forsyth, Georgia

Sequential Intercept Model mapping involves agency executives and leaders, as well as front-line staff. Some communities find that it’s important to spend extra time gathering input from front-line staff in a more relaxed environment when they are not being overseen by their supervisors and can, therefore, provide honest feedback about the impact and day-to-day implementation of policies. Patrol officers, emergency department nurses, case managers, mobile crisis clinicians, emergency communicators, and other front-line professionals can tell you how communication plays out in real-time, and whether current policies and procedures support quick access to mental health services. They can also describe whether training, capacity, and policies lead to unnecessary trauma in police custody or in treatment settings.

At the same time, seeking and using input from these groups will help them feel included in the process. Their buy-in will make your CIT program a greater success.

FEEDBACK SESSIONS WITHOUT SUPERVISORS

“Those officers and case managers are going to go back to their peers and they are going to say, ‘They are listening to us, and they care.’”

— Major Sam Cochran, Co-Chair, CIT International, Memphis, Tennessee

One way to get input from a broader array of front-line workers is to conduct a second, less formal discussion, without supervisors. In this discussion, you should include representatives from:

- Patrol officers, particularly those who work the night shift or weekends,
- Emergency department staff, including intake and triage nurses, and particularly those who work night shifts,
- Mobile crisis team members, if applicable, and
- Emergency communications personnel and crisis line staff.

Ensure that a neutral facilitator leads the conversation and creates an environment where everyone can contribute. The participants should be reassured that their individual comments will be kept confidential (though a list of participants may be shared with the steering committee). Front-line staff is more likely to speak honestly if they know their comments will not be shared with supervisors or have an impact on their job.

The facilitator might ask the following questions, many of which would have been addressed during the more formal mapping exercise:

- When a crisis call comes into 911, what are the options for addressing the call? Are they different during the day shift versus the night shift?
- During a crisis event, who are the responders? Can mental health professionals respond in person, or provide phone support?
- If the individual needs transportation, voluntarily or involuntarily, to a hospital or crisis center, how are they transported?
- At the receiving center, what’s the protocol for a handoff? Is it different for someone coming in voluntarily versus involuntarily? Must the individual wait in law enforcement custody and for how long?
- If a person is transported involuntarily, are they transported in handcuffs?
- What criteria are medical and mental health staff looking for in order to admit an individual for mental health care?

- How are safety concerns addressed at the hospital or crisis center? How can the hospital or crisis center support recovery starting at intake?

Using the **WORKSHEET: Crisis Response System Feedback Tracker** on page 211, the facilitator should summarize the group's feedback and recommendations, and share them with the steering committee.

FOCUS GROUPS WITH INDIVIDUALS LIVING WITH MENTAL ILLNESS AND FAMILY MEMBERS

“No one who is not personally involved with someone with mental illness can understand the depths of worry, fear, and despair the family goes through... Once mental illness strikes, however, family members live in constant fear that both the child and the police may overreact if they come into contact with each other—one from paranoia or delusions; the other from fear and ignorance.”

— Donald Turnbaugh, Past President, NAMI Pinellas County, Tampa, Florida

It is also important to gather input from additional individuals living with mental illness and family members who did not attend the initial mapping session. The steering committee should follow the lead of advocacy representatives about the best way to do this. For example, in some cases, experienced peer specialists may wish to participate in the process described above alongside patrol officers, emergency department staff, and other professionals.

At other times, people living with mental illness and their family members may be more comfortable speaking freely about their experiences in a separate meeting. This is particularly true because individuals and families who have interacted with the crisis response system may be frightened, angry, or traumatized, and may not wish to discuss their experiences in a large group alongside law enforcement officers and medical and mental health professionals.

A focus group, led by an advocacy leader or a trained facilitator, can be a helpful way to get feedback. An ideal focus group is:

- Small, having no more than 10 participants.
- Diverse. For example, participants are not related, don't know each other, and represent different demographic groups and geographic areas. (An exception might be made if individuals are uncomfortable participating without a friend to support them, or if you have a very small community.)

- Informal. While a facilitator guides the discussion, the aim is to engage the participants in a free-flowing conversation with each other about the topics at hand.

The facilitator could raise the following topics and questions:

- Tell me about your experience with police and mental health professionals during a mental health crisis. What went well? What went poorly?
- What options were you aware of, aside from calling 911?
- If you made the call to 911, what was going through your mind? What do you wish you had said, or that the call-taker had said?
- How did police or crisis clinicians treat you? Did you understand what they were doing?
- How were you treated at the hospital or crisis center? Did you get the help you needed? How long did it take until you got help?
- When did you feel safe and when did you feel unsafe?
- How could the crisis response system work better for you?

Using the **WORKSHEET: Crisis Response System Feedback Tracker** on page 211, the facilitator should summarize the group's feedback and any recommendations coming from the process, and share them with the steering committee. To ensure privacy, individual names should not be attached to specific comments.

Using Feedback and Recommendations

The steering committee should combine the recommendations from your Sequential Intercept Model mapping and reports from more informal feedback sessions. Use the **WORKSHEET: Crisis Response System Feedback Tracker** on page 211 to help your steering committee create a comprehensive list of concerns, and generate a list of potential solutions. As your work continues into Chapter 4, the steering committee should continue working on the feedback tracker and thinking through solutions.

Case Study: Sequential Intercept Model Mapping in Miami-Dade County



“The reality of this problem is that no one party or individual or institution created it, and it requires a collaborative of all the traditional or nontraditional partners to fix it. Law enforcement can’t do it alone, courts can’t do it alone, providers can’t do it alone, but working together they can substantially improve the system and the lives of people they are trying to help.”

— Judge Steve Leifman, 11th Judicial Circuit of Florida, Miami, Florida

In 2000, before the Sequential Intercept Model (SIM) was developed, Miami Judge Steve Leifman gathered stakeholders in Miami-Dade County to address the crisis of people with mental illness in the justice system in the county. Leifman refers to that gathering as the first “mapping” in the community because it revealed that police were the first responders to people in crisis and brought the community together to make a plan. As part of that initiative, law enforcement agencies, jails, and mental health agencies countywide signed onto a cooperative agreement to provide services that advanced diversion and recovery.

In 2014, Miami-Dade’s CIT program had been in operation for almost 10 years when the community conducted its first formal Sequential Intercept Model mapping. Habsi Kaba, Miami-Dade’s CIT program coordinator, recalls that many partners from across the criminal justice and mental health systems were already at the table together in their regular CIT advisory committee meetings. But they wanted to find out how the entire system, from pre-arrest all the way through reentry and community mental health services, was working and find opportunities for improvement.

A CHAMPION FOR BROADER REFORM

CIT is an important part of a broader criminal justice/mental health reform effort championed by Judge Leifman of Florida’s 11th Judicial Circuit. It’s unusual for CIT programs, but in Miami, the court is the lead agency for the CIT program. The court’s Criminal Mental Health Program also manages a post-booking diversion program and a reentry program and offers supportive services for people with mental illness involved in the criminal justice system in the county.

For the 2014 Sequential Intercept Model mapping process, Judge Leifman invited leaders across the criminal justice and mental health systems to a two-day summit to learn about the local systems. His invitation brought a wide range of partners to the table.

LEADERS AND FRONT-LINE STAFF

In Miami, it was important to have both agency and organizational leaders and front-line staff at the table for mapping. Agency leaders have the authority to make changes and their buy-in is crucial. At the same time, the front-line staff sees the challenges on a day-to-day basis. Kaba says, “If we speak to those on the front lines, they are going to have the solutions. They are doing it every day, and they ask, ‘Why don’t we just do this instead?’”

Kaba emphasized that some patrol officers are not comfortable speaking openly about challenges in front of their command staff, so she personally invited officers who she knew would be candid. The same principle holds true with other systems, whether it was mental health agencies, criminal justice agencies, the local NAMI—the intention was to have representation from both leaders and individuals on the front lines.

THE PROCESS

Much of the work for a successful mapping occurs beforehand and behind the scenes, says Cindy Schwartz, the director of the court’s Criminal Mental Health Project. “You have to keep the stove hot. You have to engage your partners all the time. You can talk about what you’re doing with the SIM mapping, but there’s so much more that goes on before that meeting. There are partners, there’s the media. Because we work behind the scenes developing these relationships, everyone wants to come.”

During the 2014 two-day summit, a team of expert facilitators from the [SAMHSA GAINS Center](https://www.samhsa.gov/gains-center) (<https://www.samhsa.gov/gains-center>) guided the conversation. With 50 stakeholders in the room, facilitation was essential!

On the first day, stakeholders described the local criminal justice and mental health systems, starting out with crisis and law enforcement response and finishing up with community corrections and community-based services. Meanwhile, facilitators created a visual map of the system. During the second day, the group focused on developing goals for improvement. Kaba says, “Mapping helped us conclude what the greatest needs are in the community—and it’s not just one entity with challenges, but everyone consistently, across the board.” Prior to the mapping summit, many agencies and organizations may have been working on the same problem, without realizing that they could work together.

SUCCESSES

After the mapping summit, Miami stakeholders formed several workgroups to work on their goals at each intercept. Some successes were immediate. For example, the process

revealed that veterans being transported by police to Veterans Affairs (VA) facilities for an emergency psychiatric evaluation faced extra delays compared to people transported to other facilities. Once Kaba facilitated communication between the VA and law enforcement and the problem was brought to light, the lines of communication were open. The VA and law enforcement agencies began to collaborate on an expedited process.

2018 MAPPING

In 2018, Miami revisited SIM mapping. The Criminal Mental Health Project had received a grant through the Department of Justice's Justice and Mental Health Collaboration Program and the mapping process was designed to support strategic planning. The grant was intended to help Miami develop community-wide goals around crisis response, so this mapping focused on Intercepts 0 and 1.

For the CIT program, one major priority emerged from the discussion: the creation of an information-sharing system. The thirty-six law enforcement agencies in the county have no centralized way to share information about high utilizers of the system or to convey concerns to mental health providers. Law enforcement will enter information about mental health calls, which the mental health agency can access to identify individuals whose needs aren't being adequately addressed. For example, a mental health agency would be able to see if an individual had been transported by police for involuntary psychiatric evaluations in several different jurisdictions in the county. Then a mental health agency could decide the safest and most effective approach for a person—for example, sending out a peer specialist and/or mobile response team, as well as appropriate services and follow-up care.

Kaba recalls that a man recently passed away after cycling through the local criminal justice and mental health systems for twenty-three years: "There have been so many people trying to help him from so many entities, especially law enforcement. Maybe if there was an information-sharing system to help us navigate through the system, maybe we could save a life."



Summary: Understand Your Crisis Response System



A crisis response system includes all the services and resources available to help a person experiencing a mental health crisis. A high-quality crisis response system offers an array of mental health supports that help stabilize the crisis and connect the person to treatment, services, or support to address their long-term needs.

One important goal of CIT is to reduce the frequency that people in crisis encounter police and increase connections to mental health services. CIT programs also work to improve safety throughout the crisis response and lessen the trauma that individuals experience during a crisis.

There are several ways to learn and make improvements to your crisis response system: Sequential Intercept Model mapping, getting feedback from front-line staff, and getting feedback from individuals living with mental illness and their families. Partners can often improve their crisis response system by using the resources already available in the community more efficiently.



Checklist: Understand Your Crisis Response System



Review the checklist below to make sure you have completed the key steps in this chapter. Or, use this checklist if you think your community may be able to skip ahead to another chapter.

Move ahead to Chapter 4 if:

- ☐ Your steering committee understands the components of a high-quality crisis response system. For example, your committee has reviewed [guidelines](https://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/sma09-4427) (<https://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/sma09-4427>) from the Substance Abuse and Mental Health Services Administration (SAMHSA), your state department of mental health, or the [Crisis Now initiative](https://crisisnow.com/) (<https://crisisnow.com/>).
- ☐ Your steering committee has invited additional partners from the criminal justice system, mental health service system, and community to contribute to mapping the crisis response system. When applicable, you have welcomed additional partners into your CIT steering committee.
- ☐ Your steering committee, including new stakeholders, has gone through Sequential Intercept Model mapping.
- ☐ Your steering committee has sought feedback about the crisis response system from front-line staff, including patrol officers, emergency department staff, 911 call-takers, and mobile crisis team clinicians.
- ☐ Your steering committee has sought feedback about the crisis response system from people living with mental illness and their family members.

CHAPTER 4:

BUILD THE INFRASTRUCTURE FOR SUCCESS

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Introduction: Making Systemic Changes

“When we started out years ago in Chicago, I didn’t realize that it was the community-wide effort that was at the core of success. We found out quickly. As soon as we trained the officers, they started coming back to us, saying, ‘What about this? What about that?’ We didn’t realize that it was about the service system and that there were little improvements that could be made easily.”

— Suzanne Andriukaitis, MA, LCSW, Chicago, Illinois

One key to success for CIT is having an infrastructure that supports an improved crisis response system. This chapter is about continuing to examine your system and building that structure. CIT’s infrastructure includes several major components:

- Assigning CIT coordinators, the individual(s) who run the program and serve as liaisons among CIT partners,
- Reviewing procedures that dictate the responses to a crisis event, and identifying changes that can improve communication, reduce trauma, and more quickly connect individuals to mental health care,
- Aligning law enforcement and receiving center policies with the goals of CIT, and
- Planning for program monitoring—the process of using data to improve your program’s day-to-day operations.

It may be tempting to jump ahead to CIT training for officers, but these four components are essential to supporting CIT officers and other front-line staff in the field. Otherwise, you will have officers become frustrated because they are doing their best, but policies, procedures, and resources may not fully support their efforts. Likewise, officers may be eager to help people connect to mental health services during a crisis, but find that there are barriers to timely and effective care that do not allow the outcomes that they were told a CIT program could bring.

Your success as a CIT program relies on making these systemic changes.

COMMITTING TO A GRADUAL IMPROVEMENT PROCESS

For most CIT programs, improvement is gradual. This chapter asks your steering committee to consider an array of difficult issues, many of which came to light during your mapping process. Even working with your partners, you may not yet have good solutions.

The key is to commit to improving what you can now and to revisit bigger challenges periodically. No community has a perfect crisis response system, but a great CIT program has partners who continue pushing for improvements.



No community has a perfect crisis response system, but a great CIT program has partners who continue pushing for improvements.

Discussing—and sharing the struggle through—these challenging issues will continue to strengthen your relationships and partnerships.

Select CIT Coordinators



CIT COORDINATORS: THE PEOPLE AT THE HEART OF A SUCCESSFUL PROGRAM

“The focus [of the coordinator] is not taking minutes at the monthly meeting. The focus is developing trust, relationships, and contacts among your mental health, law enforcement, and medical personnel. Do you have the cell number of all your taskforce members in your phone? If so, you’re doing it right.”

— Thomas von Hemert, CIT Coordinator, Thomas Jefferson Area CIT Program, Charlottesville, Virginia

Every successful CIT program has at least one individual who is at the heart of the program, facilitating the relationships and managing the day-to-day aspects of the program. This individual—a dedicated mental health professional, law enforcement officer, or advocate—is the CIT coordinator. A coordinator’s most important role is to build trust and improve communication among CIT partners, including members of the steering committee, as well as CIT officers, front-line service providers, families, people in crisis, elected leaders, and the public. While coordinators do not need to do everything, they need to know all the partners, including their strengths and weaknesses.

As a coordinator learns and grows in their role, he or she becomes the point of contact for addressing a wide array of challenges. For example, the coordinator may notice that a particular sergeant is making disparaging comments about the CIT program, and invite him to attend the CIT training day featuring the stories of individuals and families with lived experience of mental illness. Or, the coordinator may hear complaints about long waits in the emergency department, with officers waiting with a person in handcuffs for hours at a time. The coordinator could request to walk through the ED’s intake process and

meet with all the staff involved, to look for opportunities to improve communication and streamline procedures.

Coordinators are the linchpins of successful CIT programs.

QUALITIES OF SUCCESSFUL COORDINATORS

The most important quality of a coordinator is passion and excitement about the CIT program. Many CIT programs have started their successful CIT programs with a coordinator that was driven to work for continuous improvement. When an agency or community selects a CIT coordinator, they should be supporting and investing in someone who they hope will have a long-term commitment to the program.

Other qualities of successful coordinators include:

- **Excellent communication skills.** A coordinator needs to be able to communicate with all different types of partners and translate challenges and concerns across systems. For example, if call-takers complain about a particular patrol shift consistently having too few CIT officers, a coordinator needs to understand the concern, communicate it constructively to the patrol supervisor, and report recommendations or solutions to the steering committee.
- **Interpersonal skills.** A coordinator needs to build trust and work well with everyone so that he or she can get things done quickly. He or she knows the officers and crisis clinicians by name and rank or title. It is also helpful to know who has influence and who has helpful skills, so a coordinator keeps track of who is a great grant writer, and who plays golf with the county commissioner. They are also responsible for marketing the program and need to be comfortable public speaking and representing the CIT program on community committees and councils.
- **Ability to problem-solve and delegate.** A coordinator will face a range of challenges day-to-day and they need to know which resources to call on for assistance. For example, on Monday, a coordinator might hear news about a potential loss of funding and reach out to the advocacy organization for a plan to advocate for funding with the legislature. On Tuesday, a trainer might cancel at the last minute, leaving a gap in an upcoming officer training. In that case, the coordinator might reach out to the mental health agency and private providers to find a substitute who can present on that topic.
- **Organizational skills.** CIT coordinators organize officer training and are the main point of contact for the program, so they have to efficiently track timelines,

contacts, and tasks. They also provide staff support to the steering committee, so they have to schedule regular meetings and take meeting minutes.

- **A high-level of independence.** CIT coordinators have a wide array of responsibilities, so they must have maturity and the trust of their agency or organization to operate with a high level of independence. While a CIT coordinator doesn't need to be high-ranking, they should be seen as a leader in the community and among the partners.

One area where agencies and organizations should be cautious when assigning coordinators: ambition. An individual who is primarily focused on advancing their career may not be the best fit for CIT, especially if they are likely to get promoted out of the position in a couple of years. Replacing a coordinator who embodies passion and excitement about CIT with someone who is just meeting their job requirements, or who sees CIT as merely a stepping-stone in their career, is hazardous to the success of a CIT program.

TYPES OF COORDINATORS

“As a law enforcement coordinator, you’ll need to be persistent and understand the reasons for resistance. ‘We’re not saying you’re doing something wrong; we just want to make the process better.’ Nine times out of ten you can make it better.”

— Officer Kurt Gawrisch, Chicago Police Department, Chicago, Illinois

A local CIT program can have a coordinator in any of the three key partner organizations or agencies: law enforcement, mental health, or advocacy. A local CIT program can have one, two, or all three types of coordinators. Ideally, there are three coordinators to ensure that each partner has a strong investment in the program. In reality, most communities do not have the resources to staff three positions and must choose one or two.

The key is to ensure that all the responsibilities are met and that multiple coordinators, if they exist, are on the same page and working closely together. If there's just one coordinator, it's important that their agency doesn't come to dominate the program. The section **Choosing the Right Person to be a Solo Coordinator** on page 83 offers some suggestions for ensuring a solo coordinator represents the needs of the program and all the partners.

THE COORDINATORS' RESPONSIBILITIES

Regardless of the agency they work for, coordinators have a set of responsibilities to the partners and the broader community. If there are multiple coordinators, these

responsibilities can be divided up among the coordinators in the community. Coordinators work with the steering committee and other community partners to:

- Develop, nurture and sustain the steering committee,
- Develop new crisis response procedures,
- Organize CIT officer training and other trainings,
- Educate community members about CIT,
- Coordinate with mental health professionals and law enforcement to provide proactive outreach to people who are the subject of frequent calls for service,
- Monitor community resources for accessibility, effectiveness, and reliability,
- Monitor program data and report back to the steering committee,
- Connect with state or regional CIT associations and ensure compliance with state CIT standards,
- Connect with state-level law enforcement and mental health agencies,
- Track state and federal laws related to mental health and criminal justice,
- Monitor state emergency psychiatric evaluation laws,
- Monitor grant opportunities,
- Plan ahead for program sustainability,
- Represent the program with elected officials and the media,
- Advocate for funding to attend CIT conferences,¹⁶ and
- Keep updated on best practices and emerging issues.

In addition, if a coordinator is based in a specific agency, they take on an important internal role.

A *law enforcement coordinator* has access to their agency's chain of command and understands the culture of law enforcement. They can persuade law enforcement leaders and colleagues more easily than a mental health advocate or professional might. Many of their internal roles stem from that capacity. Internally, the law enforcement coordinator will:

- Serve as the liaison between the law enforcement agency and CIT partners,

¹⁶ Many CIT programs find it helpful to send representatives to the CIT International Conference to share knowledge with other programs and learn from experts. To learn more, visit <http://www.citconferences.org>.

- Advocate directly with law enforcement leaders,
- Review and revise law enforcement policy,
- Recommend changes to law enforcement procedure,
- Provide updates to law enforcement leaders,
- Maintain internal information channels, such as a newsletter for CIT officers,
- Help to select CIT officers,
- Support CIT officers responding to particularly challenging crisis calls, often by telephone or by coordinating directly with mental health services,
- Provide ongoing mentoring to CIT officers, and
- Educate supervisors about how to support their CIT officers.

A *mental health coordinator* also has an internal role, stemming from their familiarity with the culture of health and mental health systems, and their familiarity with the mental health agency. Their internal responsibilities include:

- Serve as the liaison between the mental health agency and CIT partners,
- Review and revise mental health agency and receiving center policies,
- Recommend changes to receiving center procedure,
- Provide updates to mental health agency leaders,
- Identify expert instructors for training CIT officers,
- Maintain internal information channels, such as a newsletter for clinicians,
- Educate clients about CIT,
- Support CIT officers or clinicians responding to particularly challenging crisis calls, often by telephone, and
- Educate supervisors and administrators about the CIT program.

An *advocacy coordinator* has a slightly different role, with both internal and public-facing tasks. Advocacy organizations, because they aren't government agencies, have more flexibility to push an agenda with elected officials or the media if needed, or to reach out to a broader network of contacts. Their responsibilities are:

- Serve as a liaison between the advocacy organization and other CIT partners,

- Reach out to people living with mental illness and their family members to promote CIT,
- Identify individuals and family members to present during CIT training,
- Educate members and the public about law enforcement procedures, mental health services, and CIT,
- Educate members about proactive crisis planning,
- Advocate with elected officials for funding for crisis services,
- Advocate for relevant local, state, and federal policy changes that support the mission of CIT,
- Plan recognition for CIT officers, such as award ceremonies,
- Reach out to the media to promote the success of CIT,
- Welcome new leaders (such as chiefs, sheriffs, and mental health directors) and demonstrate community support of CIT, and
- If necessary, hold other CIT partners accountable when they stray from the mission of CIT.

LEVELS OF COORDINATION

Some CIT programs are organized regionally, with multiple law enforcement agencies working together. To learn more about regional programs, see *Local and Regional Programs* on page 39. If your local CIT program is part of a regional program or statewide network, you should divide responsibilities among coordinators at different levels of the program.

Local coordinators—at least one with each law enforcement agency—should focus on their law enforcement agency and their locality. Their focus can be on activities like:

- Communicating directly with their agency leaders,
- Providing 40-hour CIT training or supporting a regional 40-hour CIT training,
- Maintaining rosters and training records while supporting CIT officers in their agency,
- Local outreach to others in their community, and
- Reporting program data from their agency.

Regional coordinators—ideally three, as described above—work together to improve the overall crisis response system and support the broader goals of CIT. For example, they may:

- Work with regional mental health agencies, hospitals, crisis centers, and other mental health service providers to improve communication, partnerships, and crisis services,
- Provide 40-hour CIT training,
- Support local coordinators,
- Develop CIT continuing education, and
- Reach out to the broader community to promote CIT.

In states with statewide networks, state coordinators can provide additional support and strategize about state-based issues. For example, they can:

- Help develop statewide guidelines for training or program development,
- Track state laws and grant opportunities,
- Support regional coordinators,
- Plan statewide events for learning and networking among programs across the state,
- Build relationships with state agencies and organizations,
- Identify and apply for funding for regional and local programs, and
- Advocate with elected officials and represent the interests of the statewide CIT program with the state legislature.

With several layers of coordination, it's important to have regular communication and clear roles. Steering committees at every level should work with their coordinator(s) to ensure that roles and lines of communication are clear and work for everyone.

To learn more about regional programs and statewide networks, read [*Network and Support New CIT Programs*](#) on page 169.

CHOOSING THE RIGHT PERSON TO BE A SOLO COORDINATOR

“As a CIT Coordinator, I am a student in the classroom, as well as on the road.”

— Habsi Kaba, MS, MFT, CMS, Director of CIT, Miami-Dade and Police Mental Health Collaboration, 11th Judicial Circuit Criminal Mental Health Project, Miami, Florida

If your community only has resources for one CIT coordinator, think about ways to ensure that they have a connection with more than one agency or group. Some communities choose one type of professional but have them employed by another organization or agency. For example:

- A mental health professional or advocate employed by the law enforcement agency or
- A retired law enforcement officer employed by a mental health agency or advocacy organization.

Another option is to look for an individual whose personal experience or professional background gives them credibility, even if they currently work in a different field. For example:

- A law enforcement officer who is a former emergency department nurse,
- An advocate who is a former military police officer,
- A law enforcement officer who lives with a mental health condition, or has a family member with a mental health condition, or
- A mental health professional who previously worked as a police or probation officer.

Finally, some communities share the cost of a coordinator, employing them at one agency, but shifting funds among partners to share costs.

“*Ultimately, it is the person with a passion for CIT that will do the best job as a solo coordinator.*”

If none of these options are possible, it's even more important to choose someone with great skills at building relationships across the

partner organizations. Ultimately, it is the person with a passion for CIT that will do the best job as a solo coordinator.

SUPPORTING COORDINATORS

CIT coordinators have a big job, made even more daunting if they are doing the job solo. All CIT coordinators need to be set up for success so they do not get overwhelmed or burned out. The steering committee should ensure the following supports are in place for their coordinator(s):

- The trust of the steering committee. They should be empowered to make day-to-day decisions and have a regular structure for reporting back to the steering committee on major issues.

- A clear job description that describes the coordinator’s relationship and responsibility to the steering committee and the program—even if he or she works in a particular agency or organization.
- The support of their agency. They should have time, resources, and supervisory support to carry out their responsibilities.
- The support of partners. When major tasks or challenges come up—a week of officer training, a high-profile media event, a major conflict among partners—it should be an “all hands on deck” event. Steering committee members and staff from other agencies and organizations should step up to support the coordinator(s).
- Clear lines of communication. Partners should designate an individual as a point of contact so that the CIT coordinator(s) have a liaison for serious questions or concerns.

CITI COORDINATOR COURSE

CIT International offers a certification course for current and future CIT coordinators. This full-day (8-hour) course is designed to teach CIT coordinators about the Memphis Model Core Elements and their leadership role in CIT.

The course is open to coordinators from law enforcement, mental health, advocacy and other partners who have attended a 40-hour CIT training. With significant interest, the coordinator course can be brought to your region, or you can attend a pre- or post-conference course at the annual CIT International Conference.

Upon completion, participants receive a certificate, lapel pin, and a thumb drive with extensive resources. For more information, visit the [CIT International](http://www.citinternational.org/) (<http://www.citinternational.org/>) website or email us at coordinator@citinternational.org.

The Goals of an Effective Mental Health Crisis Response

Many systemic factors contribute to the outcome of a mental health crisis. CIT officers and front-line medical and mental health staff cannot be asked to overcome systemic problems; that’s a role for the CIT steering committee and community leaders. It is helpful to focus your efforts to improve the crisis response system around three overarching goals:

1. Improving safety for everyone involved, including individuals in crisis, officers, and mental health professionals.
2. Resolving the crisis with as little criminal justice involvement as possible, combined with a speedy connection to mental health services.
3. Reducing the trauma experienced by individuals in crisis. CIT programs are particularly concerned that people who experience trauma in the process of seeking mental health care will be too traumatized to seek care in the future.

These goals should be familiar—they are the same issues you addressed when examining your crisis response system in Chapter 3. In this chapter, we focus less on the challenges and more on problem-solving. The creative solutions in this chapter come from CIT programs around the country that have accumulated small changes to their crisis response systems for major improvements in outcomes.

As the steering committee identifies potential solutions, record them in the **WORKSHEET: Crisis Response System Feedback Tracker** on page 211.

Identify Timely, Safe Alternatives to Jail

“When teaching officers to recognize mental health crises, you also need to provide them with reliable resources that then become responsible for providing the help individuals need. Services need to be available 24/7 in order to reduce the numbers of people who would be in jail without these services. Behavioral health professionals are better equipped to navigate the crisis response system than officers and provider services should accept hand-offs of persons in crisis from officers as quickly as possible. We need to remember, people matter.”

— Detective Sabrina Taylor, CIT Training Coordinator, Phoenix Police Department, Phoenix, Arizona

During your mapping process, you likely learned that the responsibility for crisis response falls mostly on law enforcement, which leads to frustration for everyone. For example:

- 911 call-takers, when receiving a call about a mental health crisis, may not be empowered to do anything other than dispatch a law enforcement officer.
- Patrol officers, when responding to a crisis call, may not be aware of any alternatives to arrest.
- Officers may say that the hospital or crisis center is too far away, and they have to wait hours to transfer custody.

- Receiving center staff may be overwhelmed.
- Individuals in crisis may feel traumatized and ultimately get little support or treatment.

It is essential to make connections to mental health services as easy as possible at every point during a crisis. Otherwise, dispatching a law enforcement officer to a mental health crisis may be the only option, and for the officer, taking a person to jail is the fastest way to resolve a call. Many officers also mistakenly believe jail is a humane short-term solution. (Sadly, many jails fail to meet the most basic standard of providing needed mental health care.)

FINDING SOLUTIONS

As a steering committee, take what you've learned about your crisis system to identify improvements that might help get someone to care—and out of the criminal justice system—as quickly and safely as possible. For example:

- When there's not an imminent public safety issue, are there options for mental health crisis calls to 911 to be diverted to a mobile crisis team or crisis hotline?
- Can mobile crisis teams respond to crisis calls, independently if safety allows, or co-respond with CIT officers if there's a safety issue?
- Are there community-based clinics, peer respite centers, or other supports that can provide additional locations for triage outside of emergency departments?
- Once an immediate crisis is resolved, can some people remain at home? Through mobile crisis, telehealth, or phone support, can a mental health agency provide timely follow-up for people who do not warrant an emergency psychiatric evaluation?
- Could a policy change at the emergency department or other receiving center speed the transfer of custody from officers to mental health providers, or help de-escalate situations at the receiving center?
- Do emergency department or receiving center staff need additional training or personnel to support them in helping a wider array of individuals in crisis?
- Is there any mechanism in place that allows follow-up from the mental health system a day or two after a person experiences a crisis?

Record the challenges and potential solutions you have identified in the **WORKSHEET: Crisis Response System Feedback Tracker** on page 211.

Identify Ways to Promote Seamless Communication During a Crisis

During a crisis event, effective communication can make the difference between tragedy and helping someone access life-saving care and support. While CIT training teaches officers to communicate effectively with a person in crisis during a crisis event, there's also a need to enhance communication among callers, call-takers/dispatchers, officers, mental health professionals, and other service providers, families, and sometimes jail staff. The officer or mental health professional may be face to face in the moment of crisis with the individual, but they are just one piece of the puzzle. They should be part of a flow of seamless communication.

As a steering committee, look for ways to enhance communication across the entire crisis response system.

THE ROLE OF CALLERS

Callers may be family members witnessing a loved one in crisis and they may be stressed themselves. Or the caller may be a bystander with little information about the individual. In either case, the caller may not say that the individual is experiencing a mental health crisis or provide details about the circumstances and history. Callers may need education about which information to provide when calling 911 to ensure the most helpful and safe outcome.

Together, the steering committee should consider what they have learned so far about callers in their community and discuss the following issues:

- How will callers know about the availability of other resources, such as warm lines and crisis lines?
- How will callers know when it is best to call a crisis line and when they should call 911?
- When callers need to call 911, how will they know to ask for a CIT officer?
- How will callers know which details about the individual and the crisis situation to share with the call-taker?

Steps to Enhance Communication

Together, CIT partners can work towards some solutions to improve communications between callers and call-takers. For example:

- Advocacy organizations, civic organizations, the business community, and local governments can help spread the word about common signs and symptoms of mental health crisis, educate the community about crisis hotlines and warm lines, and encourage community members to ask for CIT if they do need to call 911.
- Advocacy organizations can prepare their members for crisis events. NAMI provides a comprehensive guide, *Navigating a Mental Health Crisis* (<https://www.nami.org/crisisguide>), which includes a downloadable crisis plan and other resources. In Dallas, the local NAMI created a checklist, telling families and individuals with mental illness what information to provide if they ever have to call 911. The **EXAMPLE: NAMI North Texas 911 Checklist** on page 213 provides a sample of the type of resource your community could develop.
- Mental health providers can distribute a brochure with crisis resources at clinics and receiving centers. The brochure should describe when it's appropriate to call a warm line, crisis line, or call 911 and ask for CIT officers. The brochure can help callers understand alternatives to calling 911 when safety is not a concern.
- Law enforcement and mental health professionals can provide presentations on crisis planning. In some communities, a CIT officer and a mental health professional go to advocacy organization meetings to familiarize families and individuals with the crisis response system.

The section **Build Community Awareness and Support** on page 156 provides additional suggestions for community outreach.

THE ROLE OF CALL-TAKERS AND DISPATCHERS¹⁷

Call-takers play a vital role in CIT. They are the first contact during a crisis and they make critical decisions about the appropriate resource to send or transfer the call to. It is their responsibility to listen for signs that a call involves a mental health crisis and ask follow-up questions to gather information about the subject's history, the circumstances of the call, and whether the individual poses an imminent threat to themselves or to others. They decide whether a law enforcement response is needed, and if so, gather mental health

¹⁷ "Call-takers" are the individuals at an emergency communications center or 911 call center who receive calls for service. "Dispatchers" are the individuals who deploy law enforcement officers, emergency medical services, and other resources to an emergency. Sometimes one person carries out both functions.

information to help prepare the responding officers. They build a rapport with the caller that can carry forward to the officers that arrive at the scene.

Finally, whenever call-takers have identified a call as involving a mental health crisis, they should code it as such, or document that element of the call.

Together, the steering committee should consider what they have learned so far about their emergency communications system. For example:

- Do policies permit dispatchers to resolve a call by transferring to a crisis line?
- Do call-takers and dispatchers have the training needed to identify, transfer, and/or dispatch mental health crisis calls?

Steps to Enhance Communication

Together, CIT partners can discuss solutions to improve communications at call-taking and dispatch. For example:

- CIT programs should train all 911 call-takers and dispatchers in identifying, de-escalating, and triaging mental health-related calls. Agencies have created specialized call-taker and dispatcher trainings and offered slots in standard 40-hour CIT training for supervisors and others interested in additional content.
- Emergency communications and law enforcement policy should describe the dispatch procedures for a mental health call.
- If there is not a code in the 911 system for mental health calls, law enforcement and emergency communications should work together to create a procedure for documenting this information and designating a call as a CIT call.

THE ROLE OF OFFICERS

Through a rigorous selection process, CIT officers are chosen for their suitability to become specialists in responding to mental health crisis situations. In CIT training, they learn the communication skills and resources needed for effective crisis response. Chapter 5 describes officer selection and training in detail.

During a crisis event, officers gather information from dispatch and interact with family members, bystanders, and medical or mental health professionals at the receiving facility. They also coordinate on-site with other officers. They de-escalate the crisis situation while managing the safety of the person in crisis, family members, and bystanders. Officers must

know how to link a person to services when needed, including to a mobile crisis team, voluntary transport to the individual's service provider, or involuntary transport for an emergency psychiatric evaluation. In addition, officers must be able to communicate key information to medical or mental health staff at a receiving facility.

Together, the steering committee should consider what they have learned so far about officers working in their community and discuss the following issues:

- How will officers know which information to seek from dispatchers, callers, family members, and others on-scene during a crisis situation?
- What skills do officers currently have to de-escalate a mental health crisis situation?
- How can officers fully understand the criteria for an emergency psychiatric evaluation?
- Are officers familiar with policies and procedures for safely transporting voluntary patients to a service provider?
- How will officers know who is taking the lead during a crisis call?
- How will officers know when to ask for mobile crisis services to co-respond to a call for service?

Steps to Enhance Communication

Together, CIT partners can discuss some steps to improve communication for officers during a crisis event. For example:

- Law enforcement agencies can update their policies to clarify that a CIT officer is generally the lead officer on a mental health call—regardless of their seniority or when they arrive on the scene.
- Law enforcement agencies can provide basic mental health awareness training to all officers so that an officer knows when to call for CIT backup. IACP's *One Mind Campaign* (<https://www.theiacp.org/projects/one-mind-campaign>) recommends providing *Mental Health First Aid-Public Safety* (<https://www.mentalhealthfirstaid.org/>) or similar mental health awareness training for all officers. To learn more about the *One Mind Campaign*, see page 158.
- The steering committee can discuss issues to prioritize during the CIT training.

THE ROLE OF FAMILY MEMBERS

If the crisis occurs in a home, family members may be present and may also be in crisis. While family members cannot be expected to have the training of a professional, they may have valuable information about their loved one. In addition, sharing information with family members can provide comfort to families, reduce their trauma and fear, and promote continuity of care for the individual. Time and safety may not always permit this exchange of information.

Together, the steering committee should discuss feedback from family members on their experiences with the crisis response system (see *Getting Buy-In and Input from People on the Front Lines* on page 65 for information on how to gather this feedback):

- What do families know about the crisis response system and crisis planning?
- Have families been able to access support for their loved one prior to calling 911 or involving law enforcement? Have they been able to find relevant information about crisis services?
- When law enforcement is involved, are officers taking the time to ask family members for information about their loved one's condition that might contribute to everyone's safety—such as what might have triggered the most recent crisis, what has helped in the past, and whether the individual has a history of violence?
- Are officers explaining emergency detention procedures to individuals and families in simple terms?
- Are officers explaining, if applicable, why handcuffs or transportation in a police vehicle are necessary?
- At receiving centers, what information is shared with families?

Steps to Enhance Communication

Together, CIT partners can discuss some steps to improve communication between families, officers, and receiving centers, and consider how to support families in preparing for a crisis. For example:

- Advocacy organizations can provide crisis planning workshops to individuals and families, using tools such as psychiatric advance directives and *Wellness Recovery Action Plans* (<https://copelandcenter.com/wellness-recovery-action-plan-wrap>).

- Advocacy organizations and law enforcement agencies can collaborate to provide education sessions and written resources to individuals and family members about what to expect during a crisis call.
- Advocacy organizations can advertise crisis resources that prevent law enforcement involvement and reduce trauma, such as warm lines, crisis lines, and mobile crisis services.
- CIT officer training can include scenarios in which officers interact with family members in distress.
- Receiving centers can specify in policy what information can be released to family members. The Department of Health and Human Services provides [guidance](https://www.hhs.gov/hipaa/for-individuals/family-members-friends/index.html) (<https://www.hhs.gov/hipaa/for-individuals/family-members-friends/index.html>) on how the HIPAA federal privacy law applies to this issue.

THE ROLE OF MENTAL HEALTH AND MEDICAL PROFESSIONALS

“At drop-off, the officers usually speak with the crisis worker because the police are the eyes and ears of the community. That’s the best way that we can assess the situation and keep the patient and everyone around them safe. We will play detective to find out the information that we need. Everybody’s safety is impacted when we do not have the right information about somebody who was acting unsafe in the community.”

— Jamie Kach, LCPC, Manager Crisis Services, Behavioral Health, Advocate Aurora Health, Chicago, Illinois

Mental health and medical professionals, whether they interact with a person in the community or at a receiving facility, have a responsibility to provide care and assess for other serious health problems. To do so, they need information. The individual in crisis may be able to share information about their physical and mental health. Law enforcement officers may also have crucial information about an individual’s behavior and the circumstances around the crisis.

Together, the steering committee should discuss what they have learned so far from front-line clinicians, officers, family members, and individuals in recovery (see [Getting Buy-In and Input from People on the Front Lines](#) on page 65 for information on how to gather this feedback):

- When medical and mental health professionals are on-site with law enforcement at a crisis call, can they communicate clearly about mental health symptoms? Do they

have a common vocabulary to describe the criteria for an involuntary psychiatric hold?

- Do people in crisis feel they have been treated with respect and dignity while receiving care?
- At receiving facilities, do law enforcement officers communicate about safety issues and mental health symptoms with clinical staff?
- At receiving facilities, do medical and mental health staff help individuals feel safe and calm enough to answer questions about their conditions?

Steps to Enhance Communication

Together, CIT partners can discuss some steps to improve communication among medical and mental health professionals, officers, and individuals in crisis. For example:

- CIT officers and crisis teams can work together to create a glossary of frequently used terms. Mental health professionals can also commit to reducing the use of technical jargon.
- Receiving centers can work with the CIT coordinator to develop a standardized protocol for law enforcement drop-offs that includes which information law enforcement officers should share with clinical staff.
- Key medical and mental health staff can be invited to attend CIT training along with officers. Review CIT International's [policy statement](http://www.citinternational.org/resources/Documents/Position%20Statement%20for%20Non%20LE%20Participants%20in%20training.pdf) (<http://www.citinternational.org/resources/Documents/Position%20Statement%20for%20Non%20LE%20Participants%20in%20training.pdf>) on the inclusion of non-law enforcement personnel in CIT training for more guidelines.
- Receiving centers can implement trauma-informed care practices to help continue de-escalation while in care and improve communication with people experiencing a crisis. [SAMHSA](https://www.samhsa.gov/) (<https://www.samhsa.gov/>) and the [National Council for Behavioral Health](https://www.thenationalcouncil.org/) (<https://www.thenationalcouncil.org/>) are excellent sources of information on trauma-informed care.
- Receiving centers can host staff training featuring the lived experience of people with mental illness, such as the [NAMI In Our Own Voice](https://www.nami.org/Find-Support/NAMI-Programs/NAMI-In-Our-Own-Voice) (<https://www.nami.org/Find-Support/NAMI-Programs/NAMI-In-Our-Own-Voice>) presenter program, and family members who have participated in the [NAMI Family-to-Family](https://www.nami.org/Find-Support/NAMI-Programs/NAMI-Family-to-Family) (<https://www.nami.org/Find-Support/NAMI-Programs/NAMI-Family-to-Family>) program.

THE ROLE OF JAILS

Sometimes, due to the severity of a criminal offense, an officer must arrest an individual whom they suspect has a mental illness. The responsibility of law enforcement and jails to connect people with needed mental health care does not end simply because an arrest has occurred.

Together, the steering committee should discuss what they have learned so far from sheriffs' departments, officers, jail staff, mental health professionals, family members, and individuals living with mental illness about procedures in the jail:

- If an officer suspects mental illness, how would they communicate that concern to jail staff?
- If the individual self-reports a mental health condition, how does the jail assess and treat that condition?
- If a family member has information about mental health history or medication, is there a mechanism for sharing that information with jail mental health staff?

Steps to Enhance Communication

Together, CIT partners can discuss some steps to improve communication at the jail. For example:

- Ideally, jails would screen all inmates for mental illness, with the *BriefJail Mental Health Screen*¹⁸ (<https://www.prainc.com/?product=brief-jail-mental-health-screen>) or a similar validated screening tool.
- If the booking officer has a concern about a detainee's mental health or the individual reports a mental health condition, jail procedure could require a prompt outreach to the community mental health agency for relevant information.
- If the booking officer has a concern about a detainee's mental health or the individual reports a mental health condition, jail procedure could push the individual to the front of the queue for a psychiatric evaluation.
- Jails can post a brief mental health and medication history form on their website that family members can send directly to the jail mental health director.

18 Steadman, H.J., Scott, J., Osher, F., Agnese, T., & Robbins, P.C. (2005). *BriefJail Mental Health Screen*. Policy Research Associates, Inc. Delmar, NY.

Record the challenges and potential solutions you have identified in the **WORKSHEET: Crisis Response System Feedback Tracker** on page 211.

Identify Ways to Reduce Trauma During A Mental Health Crisis

“As a CIT officer, I’ve been able to go out on a scene, talk the person down, complete a pat-down for weapons, and talk them into the ambulance. Through all that, even though they were emotionally escalated, I’ve seldom had to go hands-on. However, when I did have to go hands-on, it was more often in the emergency departments due to the facility requiring an immediate blood draw or wanting the person to undress and change into a gown. The person escalated and resisted physically, turning it into a police matter once again where I had to re-engage and physically control the person. Now the person has been traumatized by the situation, sometimes criminally charged, and subsequently will be much less likely to compliantly receive help the next time. Once we transitioned our community to a mental health receiving center instead of using emergency rooms, the entire procedure became a more welcoming environment for those I sought help for.”

— Ron Bruno, Executive Director, CIT Utah, Salt Lake City, Utah

An individual in crisis is already experiencing a frightening and upsetting event. Sometimes, the person is considering suicide or self-harm. Other times, hallucinations or delusions may be extremely frightening, and the individual may believe their life is being threatened, even by an officer or mental health professional who is there to help.

“...reducing trauma builds trust, so that individuals will feel safe asking for help from a CIT officer, a mental health professional, or a mental health treatment center in the future.

CIT programs should work to reduce the amount of trauma that the individual experiences during the crisis response. In the short term, this is the kind and humane thing to do. It also helps the individual calm down and cooperate with a process they may find confusing or scary. Finally, reducing trauma

builds trust, so that individuals will feel safe asking for help from a CIT officer, a mental health professional, or a mental health treatment center in the future.

While your steering committee is discussing ways to reduce trauma, it will be particularly helpful to review feedback from individuals living with mental illness and family members in your community. The section ***Focus Groups with Individuals Living with Mental Illness and Family Members*** on page 67 provides suggestions about how to gather this feedback.

Here are some general recommendations.

COMMUNICATE WITH COMPASSION AND RESPECT

Individuals who experience a mental health crisis report that interactions with police and mental health and medical professionals sometimes feel frightening or cruel because they don't know what is happening to them, feel the situation is entirely out of their control, or feel unheard.

While there are some circumstances that cannot be changed, CIT officers and medical and mental health professionals can improve the experience of an individual in crisis through respectful and compassionate communication. Even when an individual is not able to engage in the conversation, professionals should proceed with respect. For example:

- **Providing explanations, particularly about any physical contact.** For example, if hospital staff need to draw blood, they could narrate the process: “We need to draw blood to make sure you don’t have any health problems or drugs in your system. Is there anything I can do to make you more comfortable?” An officer can explain that they have to use handcuffs or do a pat-down and talk through the process.
- **Offering choices.** If an individual must be transported to the hospital in a police vehicle, the officer can ask, “Would you like the window up or down? Do you want the radio on or off?” At a receiving center, staff can ask if the person would like the light on or off, which arm they prefer for a blood draw and so forth.

To support this approach, the steering committee can:

- Ask law enforcement, mobile crisis, EMS, and receiving centers to review policies and procedures to ensure staff is given enough time to communicate effectively.
- Provide general de-escalation training for all law enforcement, mobile crisis, EMS, and receiving center personnel.

REDUCE USE OF FORCE AND USE OF RESTRAINTS

During an encounter with law enforcement officers, an individual in crisis may be injured. Often the individual—even if fully cooperative—is handcuffed and transported in a police vehicle to a receiving facility.

At the receiving facility, individuals may remain handcuffed in a waiting room for hours before being treated. Or, their first contact with mental health and medical professionals may include being restrained on a gurney and given medication against their will, sometimes called chemical restraints. All of these experiences can be humiliating, frightening, and deeply upsetting, particularly if the individual has a history of physical or sexual assault.

While CIT training equips officers with tools to reduce use of force during a crisis event, it is also important to address other systemic issues that might increase use of force or use of restraints.

To support this approach, the CIT steering committee can:

- Explore cooperation among EMS, the mental health agency, and the law enforcement agency to enable transport by ambulance.
- Ask law enforcement agencies to review policies around detention and transportation.
- Ask receiving centers to revise policies that require officers to restrain all individuals who are waiting for care in law enforcement custody but are not combative.
- Ask receiving centers to train security officers and clinical staff in de-escalation skills that could reduce the need for restraints.
- Ask receiving centers to review factors that might reduce the use of restraints, such as the environment in which individuals are treated, the use of peer supports, and the sequencing of medical procedures.
- Ask receiving centers to review best practices for reducing the use of restraints. The *National Association of State Mental Health Program Directors* (<https://www.nasmhpd.org/search/google/restraints>) is an excellent source of information about reducing the use of restraints.
- As part of program monitoring, track use of force, including the use of restraints.

USE THE LEAST STIGMATIZING METHOD OF TRANSPORT

“We could avoid a lot of primary trauma in the caregivers and the people in crisis that we assist if we first attempted to transport—when safe to do so—in a non-law enforcement vehicle.”

— Dara N. Rampersad, PhD, LPC, NCC, First Responder and Forensic Psychologist, BluePaz, LLC, Phoenix, Arizona

Many communities transport individuals experiencing a mental health crisis via police vehicle. For an individual in crisis, this experience often feels frightening and humiliating. CIT programs should promote the least stigmatizing method of transport possible, such as an ambulance service, and avoid the appearance that having a mental health crisis makes an individual a criminal.

To support this approach, the steering committee can:

- Explore cooperation among EMS, the mental health agency, and law enforcement to enable transport by ambulance.
- Ask law enforcement agencies and mobile crisis teams to revise policies to permit family members to transport via a personal vehicle in some circumstances.

REDUCE WAIT TIMES AT RECEIVING FACILITIES

When an individual in crisis arrives at a receiving facility, they are experiencing a medical emergency, but often must sit for many hours in a waiting room. The experience is worse if the individual is handcuffed and accompanied by law enforcement officers during this wait. It's not just uncomfortable, it's painful, humiliating, and most importantly, could lead to lasting trauma.

It is important to reduce the time that an individual is in law enforcement custody, as well as the amount of time before they are assessed and receive treatment. The sections *Identify Ways to Promote Seamless Communication During a Crisis* on page 88 and *Common Changes to Policy* on page 102 provide recommendations about how law enforcement and receiving facilities can improve this process.

PROVIDE PEER SUPPORTS

“A peer specialist is different than a regular mental health provider because they have the lived experience of mental illness and/or substance use, which

in turn can make the peer intervention more effective. There's nothing like the experience of someone who has walked and lived in their shoes. People in all trades and aspects of life identify and relate with someone with similar experience to look up to for support. It's a great example to have someone who is the successful result of treatment, to show the client that they can do it."

— Justin Volpe, Certified Recovery Peer Specialist, 11th Judicial Criminal Mental Health Project Jail Diversion Program, Miami, Florida

Peer specialists are individuals who have lived experience of mental illness as well as training on supporting others through challenging situations. Peer specialists can be particularly helpful for individuals in crisis because they relate well to the individual's experience and help ensure their comfort.

A robust peer support workforce exists in many states, and peer support can be deployed throughout your crisis response system, such as in emergency departments and co-responding with clinicians to crisis calls. You can identify peer specialists through your state department of mental health or through peer advocacy organizations.

To support this approach, the steering committee can:

- Ask receiving centers to revise policies to employ peers to support people in crisis.
- Ask the mental health agency to budget for peer specialist positions throughout your crisis response system: on warm lines and hotlines, in emergency departments and other receiving centers, at detox clinics, or to co-respond on calls with clinicians.
- Lobby for the creation of peer-run services, such as crisis respite centers, which can provide an alternative to emergency departments.

PEER SUPPORT: AN ALTERNATIVE TO EMBEDDED CO-RESPONSE

Some communities have opted for an embedded co-response model that uses a law enforcement officer and a mental health provider responding to calls together in a police vehicle. There are a number of concerns about the embedded co-response model, described on page 59. As an alternative, a mental health agency that might be providing a clinician for such a team could increase its funding to develop a mobile crisis team consisting of a mental health professional and a certified peer

specialist. Such a team responding independently from law enforcement, when a law enforcement response is not warranted, will enable a more effective crisis response.

CREATE A WELCOMING ENVIRONMENT

If individuals in crisis must wait for significant periods of time in receiving centers, providing a relatively quiet and private space with comfortable seating will reduce the stress of the experience. Access to something to eat and drink is essential—keeping in mind that individuals may have been transported for care without their wallet or personal items.

For children, toys, coloring books, and age-appropriate books to read are also essential.

The steering committee can support this approach by:

- Asking receiving centers to designate an entrance and/or mental health waiting room separate from a general emergency department.
- Asking receiving centers for a wishlist of items needed to enhance their environment.
- Seeking donations to furnish a waiting area.

Record the challenges and potential solutions you have identified in the **WORKSHEET: Crisis Response System Feedback Tracker** on page 211.

Review Policies and Procedures for Crisis Events



“Individuals will come and go over time. You may have a different coordinator or a different CIT officer, but with policy in place, your program will be sustained. The rules of engagement, program guidelines, and responsibilities remain consistent.”

— Officer Kurt Gawrisch, Chicago Police Department, Chicago, Illinois

Once your steering committee has discussed procedural changes needed to make sure a crisis encounter is safer, smoother, and less traumatic, it's time to review agency policies. This process includes all the agencies involved in responding to a crisis event—law

enforcement, mental health agencies, emergency departments, emergency medical services, and others—and involves bringing them into alignment with the goals for CIT. There are three important reasons to review and revise policies:

- **First, the current policy can be a barrier to effective crisis response.** Law enforcement or receiving center policies that add to the person's trauma or appear to criminalize a crisis need to be reviewed and revised. For example, law enforcement policies requiring that police must respond to any mental health crisis call to 911 (even if some calls could be transferred to a crisis line) or requiring handcuffing an individual in crisis regardless of the need for such restraints should be reevaluated.
- **Second, updated policies provide guidance and uniformity across an agency.** For example, CIT officers are generally the lead officers during a mental health call. Describing the CIT officer's role in policy provides clarity for CIT officers, their fellow patrol officers, and their supervisors.
- **Finally, policy provides continuity in case of leadership or personnel changes.** For example, if the policy at a receiving center states that psychiatric evaluations must occur within two hours of admission, a new clinic director or psychiatrist has to abide by that policy. The process of revising policy gives partners time to weigh in about why the policy was developed in the first place.

COMMON CHANGES TO POLICY

There is no one-size-fits-all approach to revising policy because policy looks different for different law enforcement agencies and medical or mental health service providers. For example, some law enforcement agencies consolidate all of their mental health-related policies into one place, while others scatter them throughout policy documents.

Law Enforcement

When revising law enforcement policy, it can be helpful to think sequentially about opportunities to divert a person in crisis from criminal justice involvement. So, policy changes focus not only on the actions that an officer can take but on how the agency can support connecting an individual to appropriate mental health care as soon as possible. This connection to services occurs in partnership with community mental health services and supports, so the process needs to be described for officers. This is especially true for new changes emerging from your review of procedures during a crisis event.

Here are some common issues to address as your CIT program strives to improve crisis response:

- **Call-taking and dispatch.** Policy should describe the call-taker's role in gathering mental health information from callers and transferring calls to crisis lines, if appropriate. It should describe the requirement to code calls appropriately as mental health crisis calls, and dispatch a CIT officer when indicated.
- **Procedures in case a CIT officer is not available for a crisis event.** Policy should guide dispatchers in case all CIT officers are responding to calls. Many agencies choose to dispatch a supervisor or cast a wider call for CIT officers outside the district where the call for service originated.
- **On-scene role of the CIT officer.** Policy should clearly describe the leadership role of a CIT officer. In general, a CIT officer takes control of a mental health event either as the initial responding officer or at the request of the responding officer. However, if the scene is safe and mental health providers are on-site, the officer can play a supporting role or go back into service to handle other calls.
- **External resources available to CIT officers.** Policy should describe for officers any resources they are empowered to call upon, such as a CIT coordinator, a liaison from the mental health agency, or mobile crisis services.
- **Procedures for voluntary and involuntary psychiatric evaluations, including for children.** Policy should describe the criteria and procedures for emergency detention and emergency psychiatric evaluation for a person in crisis.
- **Transport for voluntary or involuntary psychiatric evaluation.** Officers should receive guidance on when they can use discretion to reduce trauma and humiliation to the individual being transported—for example, by allowing transport in a family car or ambulance, or avoiding restraints. In addition, officers should have guidance on the procedure for coordinating with other agencies involved in transport, such as EMS.
- **Coordination with receiving centers.** Policy should describe any procedure that facilitates the transfer of custody with a receiving center, such as an emergency department, clinic, or crisis center. Officers also need to know whether there's facility-specific paperwork, a law enforcement liaison, or a specific entrance. Clarity about this information will help officers and medical/mental health staff create a faster, more humane process for the transfer of custody.

Other issues may need to be addressed in law enforcement's mental health policy. These topics include broader program issues and help to create clarity across the agency. Examples include:

- **Defining the CIT program, including identifying community partners.** Your policy might also clarify the role of CIT officers: they self-select into the role, they have specialized training, and they continue regular patrol duty.
- **Offensive language about mental illness.** Strip out offensive terms like “disturbed” and “deranged” from your policy. Community standards are different across the country, and it’s best to talk with mental health advocates about appropriate language for your community.
- **Arrest procedures for people with mental illness.** Policy should describe how officers can reduce trauma and promote connection to services, even during an arrest. There may be cases where officer discretion can reduce the trauma experienced by an individual during an arrest. In addition, officers should be informed of any procedure for sharing their observations about mental health status with the jail in those situations where officers have utilized their discretion to effect an arrest.

The **EXAMPLE: Law Enforcement Policy** on page 214 illustrates many of these policy changes. Your state CIT association may also have an example CIT policy that is tailored to your state laws and CIT standards. Finally, the International Association of Chiefs of Police (IACP) offers a model policy on *Responding to Persons Experiencing a Mental Health Crisis* (<https://www.theiacp.org/resources/policy-center-resource/mental-illness>).

Mental Health Receiving Centers

“We take people with behavioral health crisis very seriously, so we have a standardized process. The patients are never placed in the waiting room. The officers are typically back on the street within 10-15 minutes.”

— Eddie Markul, MD, EMS Medical Director, Chicago EMS, Advocate Illinois Masonic Medical Center, Chicago, Illinois

Hospital emergency departments, crisis centers, clinics, peer respite centers, and other service providers that receive people in crisis and provide services, supports, or referral may also need to review their policies. Some common issues to review in these policies include:

- **Communication and coordination with incoming law enforcement officers, mobile crisis, or emergency medical services.** Policy should give staff guidance on any procedures for receiving clients from law enforcement, such as specific paperwork or guidelines for the use of handcuffs and restraints. Staff should also be

aware of situations in which they are permitted, although not compelled, to share information with law enforcement officers.¹⁹

- **Expected wait times for handoff.** Policy can describe procedures to reduce wait times or include expected wait time.
- **Entry and waiting locations.** If there's a specific entrance for individuals being transported by law enforcement, the policy should note that. It should also describe where individuals in mental health crisis should wait.
- **Reducing the use of physical or chemical restraints.** Policy should describe procedures to transfer custody as soon as possible in order to reduce the time an individual is in law enforcement custody and restrained in handcuffs. It should also describe support, training, and procedures medical and mental health staff use to reduce the use of physical and chemical restraints.
- **Communication with the individual in crisis.** Policy should describe how the receiving facility will support continued de-escalation in the receiving facility. It should also describe support and training for staff to ensure they have the skills and time for this process.
- **Communication with family members.** Policy should provide medical and mental health staff guidance on what information they can provide to family members of an individual experiencing a mental health crisis. If the individual has a psychiatric advance directive, this legal document may allow a family member or other involved person to receive information and provide guidance on the individual's care.
- **Role of peer support.** If peer support specialists provide support at the receiving center, policy should give them as much freedom as possible to create a welcoming environment for people in crisis. It should also provide the opportunity for a peer support specialist to stay with an individual through the intake process, at the individual's request.
- **Intake procedures.** Policy should describe how intake for a mental health emergency differs from a typical medical emergency.
- **Expected wait times.** If an ED has set any time benchmarks to reduce boarding, the policy should describe steps that will be taken to meet those benchmarks.

19 Guidance from U.S. Department of Health and Human Services can help health care providers and law enforcement agencies develop policies around privacy during mental health emergencies. See: U.S. Department of Health and Human Services. (1996). Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule: A Guide for Law Enforcement [PDF]. Retrieved from https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf

ENGAGE PARTNERS IN THE REVIEW PROCESS

“NAMI members have value in this process, enhancing and improving what a community can do. Their advocacy and collaboration hold leaders accountable.”

— Shannon Scully, Senior Manager, Criminal Justice Policy, National Alliance on Mental Illness, Arlington, Virginia

The agency in question should take the lead on revising its policy. However, it should provide other partners on the steering committee, including advocates, opportunities to comment and make suggestions. Partners may notice opportunities for greater collaboration or identify points of confusion before the policy is finalized. Reviewing other agencies' and organizations' policies is a way for the partners to double-check that everyone is in agreement about their roles during a crisis event. Partners can also help ensure that offensive terms are not unintentionally used to refer to people living with mental illness.

Partners should keep in mind that an agency has final say over its personnel and responsibilities. Productive and realistic suggestions should be the priority.

IF NEEDED, CREATE A MEMORANDUM OF UNDERSTANDING AMONG PARTNERS

Some CIT programs develop a Memorandum of Understanding (MOU) in addition to changes in individual agency policy. An MOU is a document describing the roles and responsibilities of multiple organizations and agencies. While it may be structured similarly to a contract, it is not a legally binding document; rather, it's a statement of intent.

A MOU covers many of the same issues identified above. It may be particularly helpful if numerous agencies and organizations coordinate to provide crisis response and services, or if multiple law enforcement agencies coordinate on calls. It can also be helpful if money or resources change hands to ensure the smooth operation of the CIT program. For example, in addition to topics in law enforcement and receiving policies, a MOU might address:

- How law enforcement, EMS, mobile crisis, and peer support interact on the scene of a crisis,
- How multiple agencies and organizations coordinate follow-up to individuals who have been the subject of repeated calls for service,
- Joint governance of the CIT steering committee, and/or
- The roles of partner organizations in providing training coordination, program monitoring, community outreach, and advocacy for mental health services.

The decision about whether to create a MOU belongs to your steering committee. Some communities find that they accomplish the same goals through frequent communications and steering committee meetings. Some find it's a helpful process to ensure that they are all on the same page. Others find that is a valuable tool for sustainability, as personnel changes are made at the coordinator level all the way to the administrative level of the partner agencies.

In any case, the MOU should not replace regular communication and problem-solving.

The **EXAMPLE: Memorandum of Understanding** on page 217 provides a sample of how one community coordinates crisis response with multiple agencies.

PLAN TO REVIEW POLICY PERIODICALLY

The first time that agencies involved in your CIT program review their policies, they may only make a few changes. Limited resources or requirements from leadership may restrict how rapidly you can change. For that reason, you should plan to review policies periodically. As CIT becomes integrated into the agency culture, practices will change and new ideas will emerge. See the section **Assess Your Program Using the CIT Core Elements** on page 152 for more information.

Plan for Program Monitoring

When your officers are trained, how will you know how many CIT officers you need on duty? Or that the right officers are dispatched to mental health calls? How will you know the outcomes of those calls? That's what program monitoring is for. Collecting some key data and periodically reviewing it with your partners will help your CIT program quickly identify problems and make improvements.

PROGRAM MONITORING VS. CIT RESEARCH

"You don't need to do a randomized-controlled trial if you just want to know how your program is operating. You should still use data to help your program be more effective."

— Amy Watson, PhD, Professor, Jane Addams College of Social Work, University of Illinois at Chicago, Chicago, Illinois

Program monitoring is different than research about the effectiveness of the CIT model. Research about the model is carried out by trained researchers, who often have significant experience studying CIT. Research studies whether CIT, including the training and the partnerships, is an effective practice. This type of research often requires significant funding, takes years, and requires studying multiple communities.

Program monitoring, on the other hand, is more like a feedback loop. It's faster, easier, and requires far fewer resources. You can still ask for assistance from a researcher, such as from a local university department of social work, community psychology, or criminology, to set up your data monitoring system and interpret your data. However, it may be possible to manage in-house at the law enforcement agency, or with assistance from partners.

If you are interested in being involved in research on the CIT model, contact CIT International at admin@citinternational.org.

WHICH DATA TO MONITOR

Often, data collection falls to 911 call-takers and law enforcement officers. However, mental health receiving centers, mobile crisis teams, crisis lines, emergency medical services, and jails may be able to collect data that provides a more complete picture of the crisis response system.

Communities have varying data collection systems, from fully-integrated electronic systems to simple paper forms. If you must use paper forms, make the form as short as possible and provide an incentive for returning them. Even dedicated professionals balk at extra paperwork.

To start out, most communities attempt to collect the following data points:

- The number of mental health calls for service (coming into 911 and officer-initiated),
- The number of 911 calls transferred to a crisis line,
- The number of mental health calls to which a CIT officer is available to respond,
- Injuries during mental health calls (to the officer, person in crisis, or bystanders),
- Use of force during mental health calls,
- Disposition of calls (transport to a receiving center, voluntary or involuntary psychiatric evaluation, transfer to mental health services, arrest or resolution at the scene),
- Use of emergency departments for emergency psychiatric evaluation, versus a mental health service,

- Number of individuals arriving at a receiving center via police transport or emergency medical services, and
- Number of individuals booked into the local jail who screen positive for mental health conditions.

CODING CRISIS EVENTS

If there is an integrated electronic data system, it is ideal to create a code for mental health calls, and train call-takers and officers how to use it. For electronic systems, it's important to integrate any additional CIT-related questions into the required incident report.

The criteria for categorizing a crisis call should be intentionally broad. Call-takers and officers are not able to diagnose a mental health condition. However, they can determine if certain indicators are present that suggest the encounter is mental health-related. For example, the caller may provide information that the person has a mental illness or describe behavior that suggests someone is symptomatic or otherwise in crisis. Likewise, the officer may gather such information or observations on the scene.

USING YOUR DATA TO PROBLEM-SOLVE

Periodically, a CIT coordinator or a designated data analyst should report to the steering committee about the data. This is not a report on how law enforcement is performing. Rather, it's an opportunity to engage all the stakeholders in problem-solving about the program as a whole.

For example, data may show that there is a high percentage of calls where officers are neither arresting individuals nor directing them to care. This may indicate that there are barriers to officers using the mental health system. Or, this may be perfectly appropriate, because some crises can be resolved in the home or community. These encounters may also be an opportunity to provide some type of referral to services. The issue could be a discussion point for the committee, and for follow-up with a focus group of CIT officers. Could officers use additional training on how to support people in coming in for treatment voluntarily? Are more mental health outreach options needed, to follow up with these individuals at home? Could advocacy groups provide a one-page sheet of referrals that officers can leave with individuals or their family members?

As another example, your data may show that there's been a recent increase in the number of mental health-related calls. Perhaps your efforts to reach out to the community and raise awareness of CIT are working! Alternatively, maybe mental health calls are now

being recognized and coded more accurately. It is also possible that the local mental health system has recently lost resources or programs, leaving people without alternatives to calling 911. That data will help you determine whether you need additional CIT officers on some shifts to cover the call volume. It may also suggest that some of your calls could be redirected to a mobile crisis team, a crisis hotline, or a warm line.

As your program grows, you may decide to collect and use additional data. Examples of other data you might collect include:

- Time officers and individuals in crisis wait in emergency departments before transferring custody to medical staff and
- The number of people transported for emergency psychiatric evaluation who have repeat law enforcement encounters.

TAKING SPECIAL CARE WITH ARREST AND USE-OF-FORCE DATA

Be cautious about jumping to conclusions about changes in arrests and use of force that appear in your data. While research about the CIT model has shown that the program can decrease both arrests and use of force, those are rare events relative to all police calls for service. It's very hard to study them without significant time, money, and skilled researchers.

However, you can still use this information for program improvement. Look at trends: Is there a spike in arrests of individuals in crisis in a particular neighborhood? Perhaps a group of concerned business owners is noticing an increase in loitering, so they are making a concerted effort to call the police more often. Or a mental health receiving center has gone off-line, leaving officers with fewer non-arrest options.

Is there a spike, then a leveling off, in transports to the ED following a CIT training? Perhaps officers were eager to connect people to care and over time became more nuanced in their understanding of what situations require transport.

Also, consider whether the totality of the data tells a story. For example, is use of force increasing because officers are being much more proactive in transporting people for involuntary psychiatric evaluations, rather than leaving them at the scene? Could it help to provide further training or mental health support that enables mental health follow-up on the scene of a crisis call?

CAUTIONS ABOUT SOME TYPES OF DATA

Sometimes your data will show an interesting change, but it's impossible to know whether that change is the result of your CIT program. For example, officer-involved shootings and SWAT team call-outs are rare events, statistically speaking. There's no way to prove that an increase or decrease in these events in your local department has anything to do with CIT. Be very cautious about using this type of data to tout your program in the media or with public officials, because it could easily change in the next year with no explanation.

It's also important to note that sometimes changes in data trends are simply due to changes in documentation practices. Perhaps there were changes in policies and procedures, or a new supervisor started monitoring compliance with documentation procedures more carefully. Some blips or spikes in data are just that—blips that defy explanation. Thus, it is important to monitor trends over time and examine changes when they occur.

COLLECTING INFORMAL FEEDBACK

In addition to collecting data on CIT, most programs find it helpful to collect informal feedback about the program. This feedback can help reinforce the data you collect or put it into the appropriate context. It can also be helpful when you are trying to promote the program with elected leaders, funders, policymakers, or the community members you are trying to reach.

Consider collecting the following feedback:

- News stories about your program
- Testimonials from individuals and family members
- Concerns from individuals and family members
- Letters of support from individuals and family members
- Officer feedback about training

SAMHSA RECOMMENDATIONS FOR PROGRAM MONITORING

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency that defines best practices in substance use and mental health

services and provides funding for services. In 2018, SAMHSA released *Crisis Intervention Teams: Methods for Using Data to Inform Practice* (<https://store.samhsa.gov/product/Crisis-Intervention-Team-CIT-Methods-for-Using-Data-to-Inform-Practice-/sma18-5065>), a guide for local CIT programs on program monitoring. The report goes into detail, particularly about how CIT programs can gather data beyond the call for service.

Prioritize and Set One-Year Goals for System Change

As your steering committee has worked through Chapters 3 and 4, you've gathered an enormous amount of information about your crisis response system and your community. You should have gathered:

- Recommendations from systems mapping (*Sequential Intercept Model mapping* on page 60),
- Feedback from front-line staff (*Feedback Sessions without Supervisors* on page 66),
- Feedback from individuals and family members (*Focus Groups with Individuals Living with Mental Illness and Families* on page 67),
- Information about alternatives to jail in your community (*Identify Timely, Safe Alternatives to Jail* on page 86),
- Information about challenges with communication during a crisis event and possible solutions (*Identify Ways to Promote Seamless Communication During a Crisis* on page 88),
- Information about the trauma that individuals experience during a crisis and ways to reduce it (*Identify Ways to Reduce Trauma During a Mental Health Crisis* on page 96), and
- Information about how current policies help—or hinder—effective crisis response (*Review Policies and Procedures for Crisis Events* on page 101).

Your steering committee should be tracking all of the challenges and potential solutions in the **WORKSHEET: Crisis Response System Feedback Tracker** on page 211. Don't assume that every solution requires new resources. A solution might involve:

- A change in policy or procedure,
- Empowering staff,
- Information-sharing or public education,
- Staff training, or
- Increased service capacity.



For the coming year, set no more than five specific one-year goals. Share responsibility among the partners, so that a single agency is not bearing all the burden of change.

Your CIT program cannot address every challenge immediately. Instead, as a steering committee, divide your list into urgent one-year goals and five-year goals. For the coming year, set no more than five specific one-year goals. Share responsibility among the partners, so that a single agency is not bearing all the burden of change.

Some examples of one-year goals are:

- The advocacy partner will educate 500 community members about how to plan for a crisis event, including proactive steps to prevent a crisis, alternative numbers to call instead of 911, information to provide to 911 call-takers, and what to expect if police or mobile crisis respond to their homes.
- Emergency communications will create a new code for mental health calls, send three call-takers to every CIT officer training, and develop protocols to divert calls from law enforcement to mental health crisis services, when possible.
- The mental health agency will request state funding to provide peer support specialists in the two most high-traffic emergency departments.
- The hospital will provide a separate entrance and expedited triage process for mental health clients coming in accompanied by law enforcement.
- The law enforcement agency will provide roll-call training to all officers, and brief (2-hour) training for all supervisors, informing them of their role in supporting the CIT program.
- The program will send a minimum of two key personnel to the next CIT International Conference.

Once your goals are set, each agency should work with the CIT coordinators to create a timeline of activities. Regular steering committee meetings will be an opportunity to report on progress, continue to problem solve, and begin planning for CIT training.

Case Study: 911 Diversion Program in Broome County, New York



“Prior to the 911 diversion program, every mental health call got a police response every single time—whether it was zero risk, low risk, or high risk.”

— Lt. Michael Hatch (ret.), Mental Health Association of the Southern Tier, CIT Coordinator, Broome County, New York

As Broome County, New York, launched its CIT program in 2015, it received support from the New York State Office of Mental Health and its technical assistance provider, the Institute for Police, Mental Health and Community Collaboration, to do Sequential Intercept Model mapping. The mapping process brought to light a concern that there was an over-response to some crisis calls, with some partners concerned about the unnecessary use of force and incarceration during a crisis. There was also a need for updated mental health training for 911 personnel.

Ultimately, the community began to explore the option of diverting some calls from 911 to the county crisis line. It was an idea that Neal Haight, the deputy director of the county’s emergency services, had long hoped to implement. “A lot of people will call 911 because their counselor doesn’t pick up and they want to talk to someone. We would send two or three patrol cars and mobile crisis,” recalls Haight.

PARTNERS

After the mapping process, the County’s CIT coordinator, retired Lt. Michael Hatch, continued working on the diversion idea with a small group of partners from Broome County Mental Health and the Binghamton Police Department. They worked closely with the Institute for Police, Mental Health and Community Collaboration to learn more about 911 diversion strategies, and also learned from a similar program run by Houston Police Department’s Mental Health Division.

A larger group of community partners was soon included in the process, including Broome County Emergency Services, the Mental Health Association of the Southern Tier and their mobile crisis team, United Health Services, which runs the 24/7 crisis line, and Care Compass Network, a not-for-profit organization created to help implement New York’s Medicaid redesign plan. The buy-in of these partners was essential to success.

The group met for about a year to discuss the scope of diversion and formalize the process. Their goal was to provide better service to the community, reduce trauma to the

individuals in crisis, and keep police officers available for calls for service. The process they developed was designed to resolve some calls by diverting them to the crisis line, avoiding the need for police and mobile crisis response and a subsequent emergency department visit.

STARTING SMALL

The partners decided to start small. In 2017, their project started by diverting only calls that had zero or low risk of harm. To ensure that, they created a risk assessment tool and workflow to guide dispatchers through the diversion process. Any caller indicating that they (or the person they are calling about) is a risk to themselves or others still has law enforcement and/or mobile crisis dispatched. Other callers are transferred to the crisis line. In the first year, about 2 percent of mental health calls were transferred to the crisis line, and the few that were transferred back to 911 were those where the individual asked for a ride to the emergency department. (See the ***EXAMPLE: Broome County 911 Call Diversion: Emotionally Distressed Caller Risk Assessment*** on page 219 to learn more about their process for screening calls.)

ADDRESSING LIABILITY CONCERNS

As the partners discussed eliminating police and mobile crisis dispatch for some calls, the county attorney and the risk manager were concerned about liability: what if someone got hurt, and emergency services and the county were liable? To address this concern, the partners argued that the crisis line would directly connect an individual with a trained professional, rather than adding a police transport to services to the process. Haight wrote a memo describing the process they had developed and the partners involved. The safeguards in the process, as well as the engagement of so many partners, reassured the county.

DISPATCHER TRAINING

To be effective, all 911 dispatchers needed to be trained in the new diversion strategy. The first step was getting the support of the 911 supervisors, four of whom were invited to attend a full 40-hour CIT training. Updated training for dispatchers had already been a priority identified during the Sequential Intercept Model mapping process, so the group designed an 8-hour training that included the new diversion procedure for all fifty-six dispatchers. The training also aimed to reduce stigma and misconceptions about a person with mental illness.

Crisis line call-takers were also invited to participate in the training, so they could become familiar with the diversion process and build stronger relationships with 911 dispatchers. Care Compass Network paid the overtime needed to train the dispatchers—an investment in reducing unnecessary emergency department admissions.

NEXT STEPS

After a year of success, the partners in Broome County are discussing ways to expand the diversion process. They are working to identify other types of calls that might be suitable for crisis line response, including situations where a parent calls about a child's behavior and the parent needs coaching through the situation. Another scenario that comes up regularly is a person calling 911 concerned about the welfare of someone else, but without any details about their location, where the caller might need support but there's not enough information for a police dispatch. Finally, they may identify frequent mental health callers and come up with a strategy to address their needs starting at dispatch, rather than sending out police.

While those plans are in discussion, there have been some side benefits to this process. Through their inclusion in this process, dispatchers have gotten to know and trust the mobile crisis service much better. As a result, the mobile crisis team is dispatched more frequently than before.

Haight sums up the entire approach best: “At 911, we try to get people the proper help, not over-respond or under-respond.”



Summary: Building the Infrastructure for Success

One key to the success of CIT is the program infrastructure. CIT addresses systemic challenges, which require the coordination of multiple partners to be addressed properly.

Many communities struggle to address the array of challenges raised in this chapter. No community has a perfect CIT program or a perfect crisis response system, but the hallmark of a great CIT program is an ongoing commitment to improvement.

The infrastructure for CIT programs includes:

1. CIT coordinators. These individuals manage the program and maintain relationships among all the partners. They know all the partners, solve problems, support officers and front-line mental health clinicians, and reach out to the community.
2. Streamlined procedures across all agencies and organizations. These are designed to improve safety, reduce trauma, and take advantage of every opportunity to connect individuals in crisis to mental health services.
3. Revised policies for law enforcement agencies and receiving centers. These updated policies bring all agency staff in line with new procedures, provide program continuity in case of staff changes, improve safety and access to services, strengthen communication, and reduce trauma.
4. Program monitoring. Most CIT programs can collect some data about their day-to-day operations. Trends in the data can be helpful for making adjustments to officer training, staffing, mental health resources, or policy.



Checklist: Building the Infrastructure for Success



Review the checklist below to make sure you have completed the key steps in this chapter. Or, use this checklist if you think your community may be able to skip ahead to another chapter.

Move ahead to Chapter 5 if:

- ☐ At least one of your key partner organizations has assigned a CIT coordinator.
- ☐ Any key partner without a CIT coordinator has designated a single point of contact for their agency.
- ☐ Your CIT coordinator(s) have the support of their agency leaders and system partners to make decisions on behalf of the CIT program.
- ☐ Your CIT coordinator(s) have a job description and a formal process for regular communication with the steering committee.
- ☐ Your steering committee has identified timely, safe alternatives to jail. At a minimum, this includes a smooth, fast process at an emergency department.
- ☐ Your steering committee has examined communications challenges throughout the crisis response process among callers, call-takers/dispatchers, officers, family members, mental health and medical professionals, and jail staff.
- ☐ Your steering committee has identified opportunities to reduce the trauma experienced by people in crisis throughout the crisis response system.
- ☐ The law enforcement agency, in consultation with steering committee partners, has reviewed and revised its policies and procedures.
- ☐ The receiving center(s), in consultation with steering committee partners, have reviewed and revised their policies and procedures.
- ☐ If your steering committee members decide to use a memorandum of understanding, it is drafted and signed.
- ☐ Your steering committee understands the purpose—and limitations—of data collected for program monitoring.

- ☐ Your computer-aided dispatch system has a code for mental health calls and includes all the relevant data you would like to capture for program monitoring. Or, if your law enforcement agency files hard-copy reports, your CIT coordinator(s) have developed a brief paper form for officers to file after mental health calls.
- ☐ Your steering committee or law enforcement agency has appointed an individual—a CIT coordinator, a data analyst, or another individual—to compile reports on a regular schedule.
- ☐ Your steering committee has set no more than five short-term goals for the coming year. These goals might improve safety, reduce trauma, increase connections to mental health services, or reduce the amount of time individuals in crisis spend in law enforcement custody.
- ☐ The steering committee and CIT coordinator(s) have created timelines for accomplishing one-year goals.

CHAPTER 5:

PLAN AND DELIVER OFFICER TRAINING

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Introduction: Bringing Community Support to the Officers on the Front Lines

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In building your CIT program so far, your most important task has been getting to know partners in your community, strengthening ties and making changes to the crisis response system together. CIT officer training continues that process, bringing the new relationships and innovation of your CIT program to support the front-line officers who respond to many crisis situations.

CIT training is unique among law enforcement training, in that it has significant community involvement. Instructors are drawn from an array of advocate and mental health provider partners, and officers spend some of the training out in the community. Balanced with this community engagement, instructors frequently return to the issues that concern officers on a daily basis: safety, the availability of community resources, and making their jobs easier. While there are models and examples to follow, this delicate balance requires preparation from a team of community partners working with law enforcement.

The payoff is that officers finish training not just with new knowledge and skills, but also with a new understanding of their role in their agency and community.

Understanding the Purpose and Structure of CIT Training

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The purpose of CIT training is to prepare a select group of patrol officers to continue their patrol duties, now with a specialization in assisting people in crisis. Officers learn how to identify and most effectively respond to mental health crisis situations, divert individuals from the criminal justice and juvenile justice systems when appropriate, and help individuals access local mental health services.

Research has shown that officers who self-select for the role of CIT officer—and are treated as specialists with an important leadership role—perform significantly better than those who are mandated to participate in CIT training.²⁰ **This is called the volunteer-specialist model.**

THE CIT OFFICER'S ROLE AS A VOLUNTEER-SPECIALIST

When officers complete CIT training, they return to regular patrol duties with an additional responsibility as a CIT officer who will be dispatched to crisis calls that arise

20 Compton, M. T., Bakeman, R., Broussard, B., Dorio, B., & Watson, A. C. (2017). Police officers volunteering for (rather than being assigned to) Crisis Intervention Team (CIT) training: Evidence for a beneficial self-selection effect. *Behavioral Sciences & the Law*, 35(5-6), 470-479. doi:10.1002/bsl.2301

during their patrol shift. While CIT training is highly specialized, CIT officers are not dispatched in a special unit, but as regular patrol officers. During a mental health crisis call, the CIT officer will typically assume responsibility for the scene, even if they are not the first responding officer or the most senior.

This model allows law enforcement agencies to have highly-trained, rapidly-responding officers for crisis situations but does not reduce patrol capacity.

When CIT officers respond to mental health crisis calls, they often spend significant time using de-escalation skills. These situations require patience, self-awareness, and compassion. Once a crisis scene is calm, the officer can problem-solve and use community resources to help the individual (and their family members where possible) get connected to mental health services and supports.

The CIT model demands a high level of independence, self-motivation, and interest in working with this special population from officers to safely and effectively resolve mental health crisis situations. Furthermore, CIT training is advanced training—it requires officers who have experience on the job, and are able to integrate complex new skills into their current skillset for responding to calls for service. For that reason, CIT training is not appropriate for new recruits. Options for providing mental health awareness training to new recruits are discussed in the section *Alternatives to Mandatory CIT Training* on page 165.

HOW MANY OFFICERS NEED TO BE CIT-TRAINED?

There is no specific percentage of officers a law enforcement agency should seek to train through their CIT program. An agency should recruit and train officers until there are enough CIT officers to provide coverage for all districts and all patrol shifts, 365 days a year. In large agencies, this may come out to 20 or 25 percent of officers. In very large urban agencies, the percent may be even higher. In very small agencies, almost all officers may need to be trained to provide adequate coverage.

However, training officers who do not have the specific interest, personal motivation, or skills to be CIT officers is not encouraged. It is more important that the officers trained have self-selected and volunteered to be CIT officers.

Through program monitoring (see page 107) your program can track whether more CIT officers are needed or whether specific shifts need additional coverage.

CIT TRAINING FOCUSES ON OFFICER SAFETY

Even though the majority of CIT instructors are mental health professionals and community members, every aspect of CIT training is tailored to emphasize officer safety and the safety of community members. Non-law enforcement instructors must work hard to present topics in a way that's practical and relevant to daily policing and does not contradict sound tactics.

For example, when officers learn about psychiatric medication, the instruction does not focus on memorizing a list of medications and the biochemistry behind them. Officers might learn the names of some common medications because they provide a clue that a person has a mental health condition versus another medical condition. In addition, they learn about the benefits of medications for mental health conditions and about unwanted side effects that might lead a person to stop taking medication. The instructor might share statistics about how hard it is for people to remember to take any type of medication or the challenges of accessing any type of mental health care.

After presenting the information, the instructor would discuss with the class how this information can be used when talking with a person in crisis. An officer can ask empathetic questions about medication that could help build a rapport and de-escalate a situation, such as: Did you stop taking medication because you were having side effects? Were you on a different medicine at some point that helped you feel better?

Since officers frequently encounter people who are not receiving effective treatment, these questions can help them build trust and show that they want to understand and help. This, in turn, helps the individual feel safe and calm down, de-escalating the encounter and supporting the safety of officers and individuals in crisis.

For topics like psychiatric medications and mental health diagnoses, CIT training provides practical knowledge that helps officers recognize a mental health condition, gather information, and build rapport, all for the purpose of improving the safety of everyone involved. It's never about asking officers to diagnose a specific condition or substitute for a mental health professional.

This focus on officer safety allows officers to integrate CIT training into their field experience.

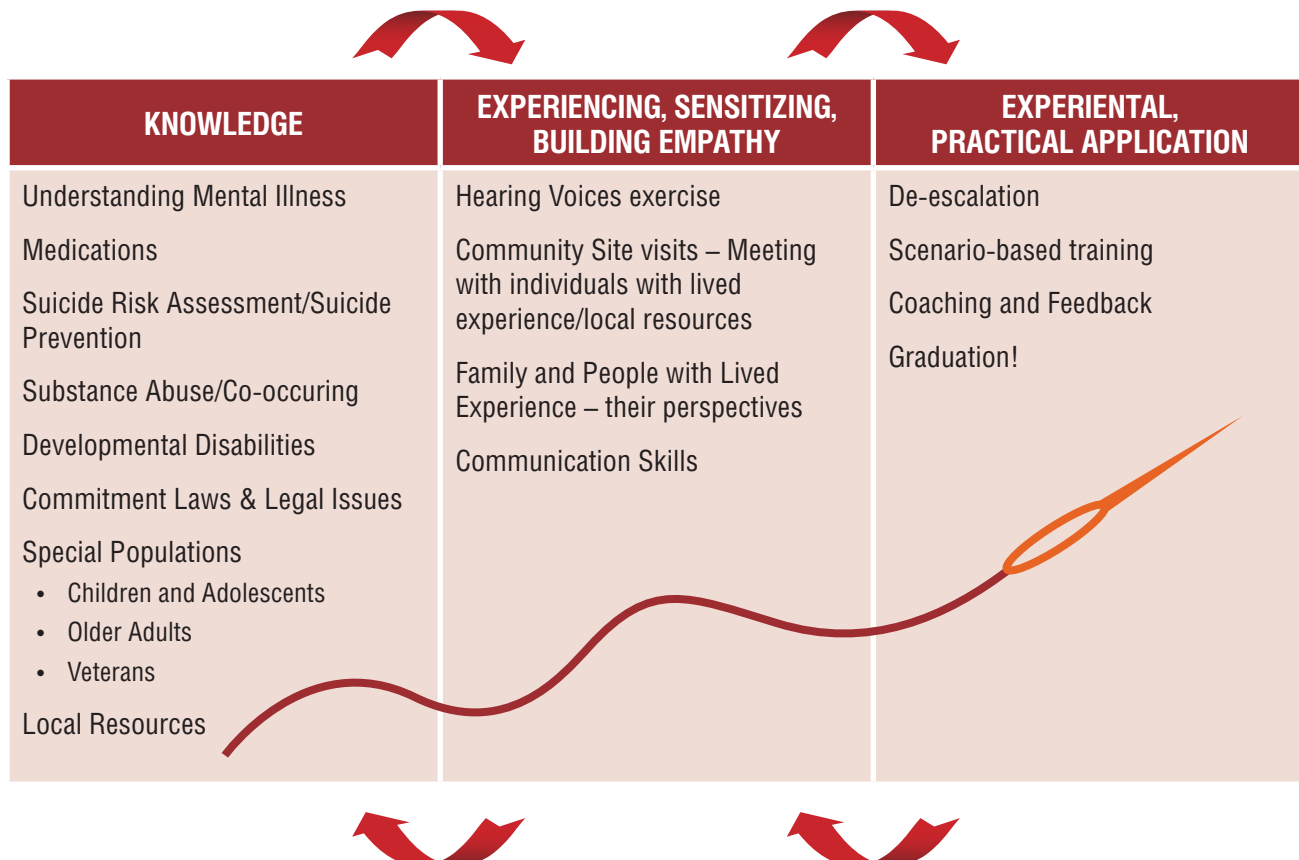
THE STRUCTURE OF CIT TRAINING

“The nature of being an officer means that we don’t often see people having a good day. Being an officer in an urban environment may mean that the people which you encounter on a regular basis are those who are reaching out for help over and over. This can lead an officer to feel that the system is broken and may feel frustration on how to fix it. That is the beauty of CIT, that is why CIT training takes the time to introduce officers to individuals who have succeeded and were helped by the system. It is also why CIT training follows a very specific pattern of building knowledge first to address these perceptions so that when you finally get to the resources, the officers have more trust in the system and are ready to use them.”

— Detective Sabrina Taylor, CIT Training Coordinator, Phoenix Police Department, Phoenix, Arizona

The structure of CIT training is designed to help officers learn in a specific way. The approach is described in the CIT Training Building Blocks. The Building Blocks concept and the related graphic were developed by Michele Saunders, LCSW, the chair of the Florida CIT Coalition, to describe course material in a way consistent with adult learning strategies.

CIT TRAINING BUILDING BLOCKS



It includes three major blocks:

1. **Knowledge:** First, officers learn the basics about mental health conditions, so they understand what mental illness is, why people may experience a crisis, and what the signs and symptoms are. They also learn about mental health services and nonprofit organizations that can support people in crisis. These services and supports can make the officers' jobs easier and assist the individual in crisis.
2. **Experiencing, Sensitizing, and Building Empathy:** Once officers have a foundation of information about mental health conditions, they are able to move on to part two, where they have informal conversations with people with mental illness and hear directly about the life experience of people living with mental illness and their family members. Because they know the basics of mental health conditions, officers are able to listen with newfound understanding and empathy and ask thoughtful questions. Officers continue to build knowledge even as they are building empathy.
3. **Experiential, Practical Application:** Finally, officers apply their knowledge about mental health conditions, mental health services, and community resources, along with empathy for people in crisis, to learn and practice crisis de-escalation skills. Officers integrate their knowledge with practical skills for safely resolving a crisis situation. These skills include empathetic communication, non-threatening body language, and tactical management of a scene to ensure safety while helping the person in crisis come to a resolution. Officers practice realistic scenarios, often drawn from actual calls for service. Officers also learn about how law enforcement policy and state laws around emergency detention apply in these situations.

At the end of the training, officers are honored in a graduation ceremony and given a CIT pin and certificate—symbols of their new role as CIT officers.

According to Saunders, “The officers see that a thread runs through the training and it pulls forward what they have learned from day one to day five when they have to apply their knowledge and skills with the scenarios.”

THE 40-HOUR TRAINING WEEK

CIT training takes place over the course of a 40-hour week.²¹ The *CIT National Curriculum Matrix* (see page 128) represents the consensus of the types of topics CIT programs cover, as well as the time breakdown for each topic. It was developed through an

21 Dupont, R.T., McCuddy, T., & Cochran, C.S. (2012). Crisis Intervention Team Curriculum Analysis: Technical Report submitted to the Department of Justice, Bureau of Justice Assistance, 1-10

analysis of 250 curricula from CIT programs nationwide by the University of Memphis, with support from the Bureau of Justice Assistance. While some topics in the CIT National Curriculum Matrix connect neatly with the concepts in the CIT Training Building Blocks, the latter is a conceptual model for understanding how officers learn during training, not a guide to planning your training week.

The CIT National Curriculum Matrix offers some specific standards for developing your CIT curriculum:

- **Mental Health Topics**, during which officers learn about mental health conditions, signs, and symptoms; special populations in their community; and special topics like suicide assessment or veterans' issues; should consist of approximately 13-14 training hours and should be presented early in the training week.
- **Site Visits**, which are visits with people living with mental illness in community settings, should consist of approximately 7-8 hours.
- **Community Support**, which includes presentations by people living with mental illness and family members, other community advocates, and a panel of community mental health resources; should consist of 3-4 hours.
- **De-Escalation**, which includes the practical skills officers learn to respond to a crisis situation; should consist of approximately 9 hours.

The remaining training hours are focused on administrative tasks, law enforcement policy and procedure, liability, and graduation.

CIT NATIONAL CURRICULUM MATRIX²²

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	
800	Administration: Welcome and Overview	Mental Health Topics: Personality Disorders	Mental Health Topics: Autism and Developmental Disabilities	Mental Health Topics: Posttraumatic Stress Disorder	De-Escalation: Scenario-Based Skills Training	
830	Administration: Pre-Training Evaluation					
900	Mental Health Topics: Serious Mental Illness	Mental Health Topics: Cognitive Disorders (Dementia, Delirium, and TBI)	Mental Health Topics: Medications	Mental Health Topics: Suicide		
930						
1000		Site Visits: Facilitated Conversations with People with Lived Experience	Mental Health Topics: Assessment and Commitment	Community Support: Panel of Community Resources		
1030						
1100	Mental Health Topics: Thought Disorders and Mood Disorders		Law Enforcement: Policy and Procedure	Break	Law Enforcement: Question and Answers	
1130		Law Enforcement: Liability				
1200	Lunch 1200-1300					
1230						
1300	Mental Health Topics: Substance Use Disorders and Co-occurring Disorders	Site Visits: Facilitated Conversations with People with Lived Experience	Community Support: Advocacy Perspectives, Veterans Issues, Homeless Issues, Cultural Awareness ²³	De-Escalation: Scenario-Based Skills Training	Community Support: Advocacy Perspectives	
1330						
1400						
1430			De-Escalation: Scenario-Based Skill Training		Administration: Post-Training Evaluation	
1500	Mental Health Topics: Children, Youth, and Adolescents					Administration: Graduation
1530						
1600	Community Support: Advocacy Perspectives					
1630						
1700						

22 This project was supported by Grant #2010-DB-BX-K047 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the U.S. Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime. Points of view or opinions in this document are those of the author and do not necessarily represent the official positions or policies of the U.S. Department of Justice.

23 Multiple topics are presented here as options. See the section *Flexibility within the Training Structure* on page 129 for details on how to tailor your training.

FLEXIBILITY WITHIN THE TRAINING STRUCTURE

“Staying true to the core content of CIT training is important, as is allowing for flexibility within that content. We are always updating our CIT training to stay current with the times. That sometimes puzzles people, that you could have so much flexibility.”

— Sgt. John Wallschlaeger (ret.), Appleton, Wisconsin

While the overall structure of CIT training is important, there is some flexibility in how communities use the time within the larger training structure. For example, the majority of the Mental Health Topics are generally the same across communities, but you can vary the emphasis if your community has a concern you feel needs greater focus.

For example, if your community has a large military and veteran population, you may have a Mental Health Topic class dedicated to veterans’ mental health issues, even if related issues are touched on in other modules. You can also invite a speaker from a veterans service organization (VSO) or a Veterans Justice Outreach Program to present during the Community Support class. If homelessness is of specific concern, you can place greater emphasis on housing issues during several Mental Health Topic classes, and also bring in your homeless outreach service as part of a Community Support presentation.

Similar shifts can allow you to focus more attention on opioid use, children and youth, issues of aging and older adults, developmental disabilities, or other issues.

However, it’s important not to include too many special topics, or you will not have enough time for the basics. Instead, note where officers and partners express an interest and plan continuing education. See the section **Plan CIT Continuing Education** on page 168 for more guidance.

WHEN SEQUENCING MATTERS

In addition to fitting your training into the overall structure, it’s important to recognize when specific topics should be presented in sequence. For example, an overview of mental illness should be presented before topics on specific mental health conditions. Presentations about involuntary transport and emergency psychiatric assessment typically come after most other Mental Health Topics, so that officers have a solid foundation to recognize most mental health conditions before they discuss the legal criteria for initiating an involuntary transport to a hospital. For topics that must be presented in sequence, it’s

particularly important to confirm scheduling with instructors with significant advance notice so that you can find a substitute if needed.

On the other hand, it generally doesn't matter whether cognitive disorders are presented before or after personality disorders, or whether post-traumatic stress disorder is presented before or after suicide. These topics don't build knowledge on each other in a specific sequence, and a good instructor can tie the topics together regardless of the order in which they are presented.

THE TRAINING REINFORCES A CIT OFFICER'S NEW ROLE

Throughout the training week, it is important for the training to reinforce the officers' new role as a volunteer-specialist and their importance to the broader community. Officers should learn about legal issues as they relate to a mental health crisis, and that they have a special role during a crisis event.

At the end of the training week, the officers should have time for discussion with the CIT coordinator about what is expected from them in their new leadership role as a CIT officer, and what support they can expect to receive from the community and their agency. If possible, a law enforcement executive or member of the command staff can make a brief appearance to reinforce this message.

Officers and the Community

In addition to highlighting the stories of people living with mental illness and family members, the training reinforces the officer's important role in the community in several ways. Some programs have a community leader, such as a county commissioner, law enforcement leader, or mental health director, speak briefly on Monday morning of the training week to highlight the benefit of CIT and thank officers.

During graduation ceremonies, officers hear how important their role as a CIT officer is to the broader community and how much gratitude the community has for their commitment. An advocacy leader is ideal to share this message, but it can also be offered by a mental health director or another partner. Officers should receive a certificate for their service record and be pinned with their new CIT pin. Officers' families can be invited, refreshments should be provided, and formal photographs may be taken.

Many CIT programs invite local media to graduation, reinforcing the importance of the event.

THE CIT PIN

“The CIT pin means something to the officers. It means something to the family members. It means something to the person with lived experience. It’s about purpose, pride, and ownership.”

— Major Sam Cochran (ret.), Co-Chair, CIT International, Memphis, Tennessee



It is traditional for CIT programs to design a lapel pin for CIT officers to wear. For the officers, it’s an honor to be recognized when they are awarded their CIT pin at the conclusion of the training. It also creates a sense of unity among the officers; although they serve throughout an agency and across shifts, they are all part of something greater.

CIT officers wear the CIT pin out of pride, just as they would wear a SWAT pin, K9 pin, or a Motor Officer pin. The pin can also be a de-escalation tool because it’s an easy way to identify a CIT officer, even in the midst of a crisis, and can be reassuring to both the person in crisis and their family members. Since so many programs have them, even a person traveling across their state or across the country knows to look for the CIT pin if they have occasion to interact with an officer.

Some states have a statewide pin, while others have agency- or community-specific pins. CIT International holds a contest at our annual conference where community and state CIT programs compete for the distinction of Best Pin.

How to Develop Your CIT Training

Every community develops its CIT curriculum based on national and state standards and tailors it to its specific needs. While there are many guidelines and resources, putting together the first training takes a community effort.

ASSIGN A CURRICULUM DEVELOPMENT SUBCOMMITTEE

CIT training is not typical law enforcement training, so the approach to curriculum development may be unfamiliar to some law enforcement agencies. The CIT steering committee can create a curriculum subcommittee. This subcommittee should include a representative from each of the key partner organizations: law enforcement, mental health agencies, and mental health advocates. It should also include your CIT coordinator(s).

REVIEW NATIONAL CURRICULUM GUIDELINES

Your subcommittee should start by reviewing two national guidelines.

- The *CIT National Curriculum Matrix* (see page 128). Developed by the University of Memphis with support from the Bureau of Justice Assistance, this curriculum was developed through an analysis of 250 curricula from CIT programs nationwide. It represents the consensus of the types of topics CIT programs cover, as well as the time breakdown for each topic. For more in-depth information about the curriculum topics, visit the *University of Memphis CIT Center* (<http://cit.memphis.edu/curriculum.php?id=0>).
- *Effective Community Responses to Mental Health Crises: A National Curriculum for Law Enforcement Based on Best Practices from CIT Programs Nationwide*. Based on the CIT National Curriculum Matrix, this curriculum was developed through the Bureau of Justice Assistance (BJA) and piloted by a grant through the VALOR Initiative to Policy Research Associates, Inc., with the support of CIT International, NAMI, and the International Association of Chiefs of Police. This 40-hour curriculum includes additional resources and guidance for planning each module in the curriculum. You can access these resources on the *BJA website* (<https://www.bja.gov/default.aspx>).

Both resources are intended to support communities in the training development process. Your CIT program should use them as a starting point and modify materials to meet your specific needs, or to develop new training materials.

REVIEW STATE STANDARDS AND RESOURCES

Reach out to your state peace officer standards and training (POST) agency to find out whether there are CIT officer certification standards in your state. In addition, if your state has a statewide CIT network, check with them for state-specific standards for CIT training and instructors. Visit www.citinternational.org/stateCITorgs to find the CIT network in your state.

CONSIDER ATTENDING ANOTHER PROGRAM'S TRAINING²⁴

Ask your state CIT network and your state POST about training opportunities, the best curriculum examples in your state, and the best programs in your state.

Your curriculum development subcommittee should consider sending a small team—at least one officer and one mental health professional—to attend a training of trainers in your state, if available. If not, consider sending a team to one of the best programs near you.*

When you plan to attend another program's training, look for the following characteristics:

- First, a CIT program that has strong involvement of all three key partners: law enforcement, mental health, and advocacy.
- Second, a program with an excellent reputation for their de-escalation and scenario-based training. This is the most challenging part of the training to teach, so you want to learn from the best.
- Third, a program that values and includes people with lived experience of mental illness, and includes site visits to recovery and treatment programs in their curriculum.
- Finally, if possible, a community that is similar in size and demographics to your community.

* If you are unsure which program to visit, contact CIT International at admin@citinternational.org for a recommendation.

PLAN YOUR 40-HOUR TRAINING WEEK

Using the guidance in this chapter and what you've learned from visiting a neighboring CIT program, develop your own 40-hour training schedule tailored to your community's specific needs.

The **EXAMPLE: Thomas Jefferson Area CIT Program Training Schedule** on page 220 provides one perspective on how a community took the structure of CIT training, tailored it for their own needs, and identified local instructors.

²⁴ If your search for nearby programs reveals that there are CIT programs in your region, consider whether it makes sense to share resources for a regional training. To learn more about regional programs, see the section **Local and Regional Programs** on page 39.

RECRUIT A COMMUNITY-WIDE TEAM OF INSTRUCTORS

It's important that your trainers and presenters are drawn from your local community or region. In addition to providing officers the training content, CIT instructors help build familiarity and trust in the local crisis response system. The training introduces the officers to individuals and organizations in their community that can serve as resources and supports as they address problems and challenges during a mental health crisis.

CIT instructors help build familiarity and trust in the local crisis response system. The training introduces the officers to individuals and organizations in their community that can serve as resources and supports as they address problems and challenges during a mental health crisis.

For example, the clinician who co-teaches de-escalation may also be a supervisor for the mobile crisis team. A family presenter may staff the helpline at the local NAMI and know all the classes and support groups available to families and individuals living with mental illness across your county.

CIT training is taught by a team of professionals and community members, including law enforcement officers, mental health professionals, people living with mental illness and their family members, mental health advocates, community advocates, attorneys, and actors. In general, here is the breakdown of teaching responsibilities:

- Overall training management and administrative topics: law enforcement CIT coordinator.
- Mental health topics: mental health professionals, with some co-teaching by law enforcement officers.
- Law enforcement policy and procedure: law enforcement CIT coordinator or another law enforcement officer.
- Legal issues and liability: attorney or a law enforcement officer with specialized knowledge.
- Community resources: people living with mental illness, their family members, mental health advocates, community advocates, and social service providers.
- Site visits: facilitated by a CIT coordinator, peer specialist, or service provider, with engagement by people living with mental illness.
- De-escalation: co-taught by a law enforcement officer and a mental health professional. Actors assist with the scenarios.

- Graduation: presentations by advocacy leaders, community champions, and law enforcement leaders are highly encouraged. Participation by officers' families and community members is also welcome.

PREPARE TRAINERS FOR A LAW ENFORCEMENT AUDIENCE

“When you prepare instructors, you give them the big picture of what CIT training is and the expected outcomes of the training, so they can see how their topic fits in and connects to the outcomes. Sometimes a trainer will come in for just their training block, and they are coming in in a vacuum and it’s clear they’re in a vacuum. As an instructor, it’s important to know how to tie your topic both backward and forward with the other topics for relevancy.”

— Michele Saunders, LCSW, Chair, Florida CIT Coalition, Orlando, Florida

“As a mental health professional, I came in thinking that I was an expert in my field, and I would share all this information with the officers. Immediately, I was reminded that my audience is police officers and I need to know about how they best learn. There are many pieces: police culture, the challenges that come with their jobs, and also the sarcasm, dark humor, and cop talk.”

— Habsi Kaba, MS, MFT, CMS, Director of CIT Miami-Dade and Police Mental Health Collaboration, 11th Judicial Circuit Criminal Mental Health Project, Miami, Florida

Once you have recruited trainers who are familiar with their topics, here are some steps to preparing them for the training week.

1. First, trainers need orientation to the entire training week, including who is present and the topics that other presenters will cover. Since the week includes many different presenters, trainers need to practice transitioning smoothly from one topic to the next. For example, a presenter on veterans' issues should know whether the class has already heard about traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). The speaker can either briefly review a related topic, or remind the class that they will be hearing more about it in the future. In addition, knowing the roles of the officers attending, and the agencies that they are coming from, will help the presenter tailor their presentation.
2. Second, while presenters generally do not specifically address officer safety tactics, they need to know that every training topic links back to officer safety. In some cases—such as presentations by people living with mental illness and their family members—the presenter may not make this connection directly, but the

interaction reduces officers' fear of people with mental illness and increases the officers' confidence in dealing with crisis situations. A CIT coordinator can also help transition at the beginning and end of training blocks by putting a topic into the context of officer safety.

3. Third, trainers need to keep information practical and relevant to the officers' needs. For example, a presentation on children, youth, and adolescents should focus on the subset of children and situations that officers are likely to encounter. In this

“ Spending a shift with an officer on patrol (a ride-along) is an excellent way to learn about the officer's day-to-day experiences.

situation, instructors could talk with school-based officers to find out about common situations and questions they encounter with children and youth in schools, and with other officers about situations that occur in the home and community.

If instructors aren't familiar with law enforcement culture, provide opportunities for them to learn. Spending a shift with an officer on patrol (a ride-along) is an excellent way to learn about the officer's day-to-day experiences.

4. Finally, remind presenters to keep their presentations interesting and engaging. Small group activities, exercises, props, short videos, question and answer, and discussion can all keep officers' attention and help them learn in different ways.

WORK WITH ADVOCACY GROUPS TO DEVELOP A PEER AND FAMILY PERSPECTIVE PANEL

“One of the biggest issues in our society is stigma, and society is where we find our cops. When you're listening to what happened to a person with mental illness or their loved one, you don't even realize that there is some stigma-busting going on inside of you. It wasn't until I returned to the street that I realized my attitude and insight had changed.”

— Sgt. A.D. Paul, CIT Coordinator, Plano Police Department, Plano, Texas

“It's important to have peers present in the 40-hour CIT training. They give the officers a different view of recovery that they have not had in the community. It shows the officers a human face and tells the backstory to better relate and connect to the individuals they serve in the community.”

— Justin Volpe, Certified Recovery Peer Specialist, 11th Judicial Criminal Mental Health Project Jail Diversion Program, Miami, Florida

Each CIT training includes presentations by people living with mental illness and family members, often called a peer and family perspective panel. The purpose of the presentation is to share real-life stories about the impact of mental illness and allow the officers to gain a deeper understanding of what it's like to have a mental illness or care for someone who has a mental illness. Stories often include details about barriers to accessing treatment and services, interactions with law enforcement, and feelings about the stigma of mental illness.

These presentations are also an opportunity for officers to see that mental health recovery is possible. Often, officers see an individual only during a crisis situation, and sometimes the same individual repeatedly. It can seem like mental illness is hopeless and unmanageable. For officers, hearing from people who are experiencing recovery, and from their family members, provides a clearer picture that a person with mental illness is a whole person and a valuable member of their community.

As an added benefit, individual and family presenters gain a new understanding of police, which helps to break down the fear and mistrust they may have had about interactions with officers.

Here are a few key points about individual and family presentations:

- CIT programs should ensure that officers hear from at least one person living with mental illness and one family member. Hearing multiple stories is preferable. Often this can be accomplished with several short presentations and then a group question and answer session. The site visits, described below, are also an important venue for this.
- Individuals and family members are experts in their own life story and experience. They should not duplicate the mental health topics and de-escalation training officers are also taught.
- Individuals and family members may comment about what helped and didn't help in their specific circumstances, including how they felt about officers' actions. However, they should not place blame or give officers advice on how to do their jobs.
- Individual and family presenters should be screened in person and rehearse their presentation prior to presenting.
- Officers should be encouraged to ask questions and engage in dialogue with the presenters. This provides an opportunity for officers to gain a deeper understanding of that person's experience and the experience of living with a mental illness.

Advocacy organizations can help identify individuals and family members who have the experience and training to offer these presentations. For example, [NAMI Sharing Your Story with Law Enforcement](http://www.nami.org/find-support/nami-programs) (<http://www.nami.org/find-support/nami-programs>) trains

people with mental illness and their family members to present their personal stories during law enforcement training. To find a trained individual or family speaker, reach out to your local [NAMI state organization or affiliate](http://www.nami.org/local) (<http://www.nami.org/local>).

Supporting Presenters

It is normal for first-time individual or family presenters to be nervous about presenting to law enforcement. A CIT coordinator should make a special effort to ensure that presenters are comfortable. The coordinator can offer to show them the training site in advance, and if possible, to attend another training presentation to become accustomed to being in the room with law enforcement officers.

The CIT coordinator should also prepare presenters for blunt questions from officers and help facilitate the question and answer period.

UNDERSTAND THE PURPOSE OF SITE VISITS

“The officers need to get out of their comfort zone. This happens during the site visits. I explain very clearly that we are guests visiting other people’s safe places.”

— Thomas von Hemert, CIT Coordinator, Thomas Jefferson Area CIT Program, Charlottesville, Virginia

“The purpose of site visits is for officers to spend time interacting face-to-face and informally with people living with mental illness who are not in crisis.”

Site visits take up most of a training day but are frequently misunderstood. The purpose of site visits is for officers to spend time interacting face-to-face and informally with people living with mental illness who are not in crisis. The best way to accomplish this is to take officers to treatment and recovery centers where people are in recovery or receiving care. Some options include community mental health centers,

drop-in centers, [Clubhouses](https://clubhouse-intl.org/) (<https://clubhouse-intl.org/>), peer-led programs, or intensive outpatient treatment programs. Visits to psychiatric inpatient units and crisis assessment centers are not recommended, because patients in those settings may not have the option to opt out of interacting with officers.

Prior to the site visits, the officers should be reminded that many individuals they will interact with have had negative experiences with law enforcement in the past. Some individuals may be uncomfortable, and officers should strive to be kind and respectful.

When officers arrive at a site visit, they should be placed in small groups for discussion with individuals living with mental illness. A facilitator can start out the discussion with questions designed to help individuals feel comfortable sharing their life experiences, including their experience with mental illness and recovery. However, it's not important to stick to a strict agenda, and when the conversation goes off-topic, that's a sign that everyone is becoming comfortable.

It is ideal for the conversation to become quite informal and for both individuals and officers to share about their lives, challenges, goals, and achievements. A certified peer specialist is an ideal facilitator, but any experienced facilitator can take on this role.

A second purpose of the site visits is for officers to see the mental health agencies and resources in their community. Officers can tour facilities and meet mental health professionals. However, this should be a secondary activity to spending time with people with lived experience of mental illness.

Preparing the Sites

Prior to the site visits, a CIT coordinator should contact the site and request that program staff discusses the visit with clients. Clients should know what to expect when the officers visit, including that they will be engaging in informal conversation and may be asked personal questions. Clients should know that participation is optional and that if they become uncomfortable, they can leave at any time.

Each site should have a facilitator available to start the conversation and to assist any individual who becomes uncomfortable.

INVITING OFFICERS TO WEIGH IN ON SYSTEMS ISSUES

In New York's statewide CIT program, Don Kamin, PhD, Director of the Institute for Police, Mental Health and Community Collaboration, encourages officers attending CIT training to note challenges they have encountered in their interactions with the mental health system. Officers are instructed to write those down during the week on a sheet that is included in their training binders.

On Thursday afternoon, Kamin gathers their observations. He includes a brief summary of the officers' experiences on Friday morning during his presentation

about the recommendations from the Sequential Intercept Model mapping exercise that was conducted in that community. A summary of the officers' concerns is passed on to the CIT steering committee for consideration.

This practice serves several purposes and is valuable even when a community has not recently done Sequential Intercept Model mapping. It reinforces to the officers that CIT programs are about crisis system transformation, not just training, and it connects all officers in the training to that process. In addition, officers feel respected and valued, because they are asked to share their observations and concerns.

CREATE AN OFFICER SELECTION PROCESS

“To recruit officers for the first training, I posted it in our daily bulletin, and I asked them to type up a request and come in for a sit-down interview. I conducted interviews and took twenty officers assigned to the Patrol Division. I was looking for emotionally mature officers who had shown good judgment in the past.”

— Lt. Michael Woody (ret.), Ohio CIT Coordinator, Akron, Ohio

Law enforcement agencies should create a selection process that allows them to choose candidates for CIT training who are experienced, independent, and motivated. In addition, the selection process should convey to all officers that CIT is a highly-skilled specialization and it's an honor to be chosen.

Depending on their size and structure, agencies go about the officer selection process by one or more of the following:

- **A written application.** Officers can describe in writing their interest in CIT, as well as their service record and any special qualifications. At a minimum, officers should have two years of service as a patrol officer.
- **An interview.** Officers should be able to describe why they want to become a CIT officer. For many, it will be a desire to better address the mental health crisis situations that they frequently encounter. For others, it might be because of a personal or family experience with a mental health condition. For yet others, it will be because of a critical incident involving a mental health crisis that they felt could have gone better.

- **A supervisor's recommendation.** Supervisors should know which officers display independence and leadership skills. A supervisor can formally or informally support an officer's interest in training.
- **A review of the officer's disciplinary record.** CIT training should never be used as a punishment or corrective action for an officer who has disciplinary problems.

Whichever method you choose, at the end of the selection process, it's important to have confidence that the officers have the patience and compassion to succeed.

RECRUITING OFFICERS FOR YOUR FIRST TRAINING

Occasionally, a CIT program has a difficult time recruiting enough officers to fill a class. If this happens, take time to persuade officers to sign up, rather than assigning officers to take the class. Your program does not want a reputation as another training that officers are forced to attend. Nor do you want a few skeptics making the training environment uncomfortable for everyone else.

Some strategies that have helped other CIT programs recruit officers include:

- **Emphasizing officer safety.** In your recruitment materials, emphasize that CIT is a unique officer safety program.
- **Including advocates in recruitment.** For example, invite an advocacy leader to speak for a moment at roll-call training, providing a personal perspective about why CIT is so important to the broader community.
- **Making sure your training is certified to meet continuing education requirements for peace officers.** Officers will hesitate to take a class that doesn't fulfill their required training hours.
- **Finding an officer-champion.** Identify an officer who is eager to take the training and ask him or her to recruit colleagues. If possible, try to identify officers who are emerging young leaders and well-respected among their colleagues, and give them some personal encouragement to apply.
- **Considering your timing.** No timing is perfect for everyone, but consider whether your schedule conflicts with other agency activities, holidays, or popular vacation times.
- **Offering a teaser.** Provide a brief demonstration from the training—an activity or an individual or family presentation that will stick with the officers—along with a Q&A about the training. Serve light refreshments and bring community partners to help answer questions.

TIPS FOR A SUCCESSFUL TRAINING

“We feed the officers lunch at training to keep them topic-focused. We have a light breakfast in the morning and coffee and snacks mid-afternoon. There aren’t enough thank yous in the law enforcement business. We want to empower the officers with as many positive experiences as possible during the training week, so they bring it forward and pay it forward. One officer summed it up best at graduation, “Not only have you changed the way I will do my job, you have changed the way I will live my life.”

— Sgt. John Wallschlaeger (ret.), Appleton, Wisconsin

Create a Logistics Checklist and Divide Responsibilities

Leading up to your training, there are a variety of tasks to complete. While the CIT coordinator(s) play a lead role in organizing training, they will need the support of other members of the subcommittee. Early on, create a checklist and divide up responsibilities so everything can get done. The **EXAMPLE: CIT Training Logistics Checklist** on page 221 is a starting point for some of the common tasks that you will need to complete.

In addition to your regular planning meetings, meet with the subcommittee two weeks prior to your training to go over the last details, and two weeks after the training to de-brief.

Ask for In-Kind Donations

When you’re identifying a training site, vendors for printed materials, or caterers for food, keep costs down by asking for in-kind donations. Public facilities, such as high schools, community colleges, libraries, and community centers sometimes rent free or low-cost space that would be suitable for training. Businesses and restaurants may also be willing to support a community-oriented program.

Feed the Officers

While it’s not necessary to feed officers a full breakfast and lunch every day, we recommend at least providing coffee and snacks. Often lunch is sponsored by an

advocacy partner, which shows officers that the community truly values their time in training and their commitment to the program. Refreshments also create opportunities for informal conversation among officers, instructors, and other visitors during breaks. Place some tissues next to the coffee pot for those presentations that might have officers tearing up.

Schedule Frequent Breaks

Officers are accustomed to frequent breaks during a training day. A break every hour is ideal. Changing the style of instruction also helps to keep officers engaged.

Keep Class Sizes Small

Classes between 20-30 officers often work best. Any class larger than that will not have time for all officers to effectively practice scenarios. Smaller class sizes also allow students to feel more comfortable practicing new skills and asking difficult questions.

Invite Other First Responders to Participate, and Community Partners to Observe, When Appropriate

While CIT training is designed specifically for sworn law enforcement officers, other professionals who have a role in the crisis response system—such as emergency medical services and emergency communications—may benefit from joining the training. Likewise, community partners, including community leaders, champions, and researchers, may be invited to observe a class to educate the community or build support for CIT. In order to ensure the integrity of the class, sworn officers should make up at least 80 percent of the class. For more details, read our policy statement on [Non-Law Enforcement Participants in CIT Training](http://www.citinternational.org/Position-Papers) (<http://www.citinternational.org/Position-Papers>).

Set the Tone with the Welcome and Graduation Speakers

High-impact speakers during the Monday morning welcome and during the graduation ceremony, can reinforce the importance of the CIT officer's role.

During the welcome, a law enforcement executive, judge, or another champion can emphasize to officers how important the training is and how much their agency appreciates their dedication. At graduation, an advocacy leader or another community leader can express the gratitude—and high expectations—of the community.

Invite the Media to Graduation

Send out a news release and invite members of the local media to your graduation. This shows officers how important their work is to the community. It will also help spread the word about CIT to the broader community.

TRAIN EMERGENCY COMMUNICATORS

A core element of CIT is training emergency communications to ensure that call-taking and dispatch are aligned with the goals of CIT. All emergency communicators have several responsibilities in an agency with a CIT program:

- To gather information from a caller and determine whether there might be a mental health crisis occurring,
- To begin de-escalating callers and situations,
- If applicable, to transfer a call to a crisis line or warm line, or to dispatch a CIT officer,
- To communicate with mental health services or the CIT officer all the available information about the mental health crisis, and
- To code the call in the dispatch system as a mental health call, so that data can be reported about mental health-related calls.

Review Chapter 4 for a more thorough explanation of how call-takers and dispatchers are integrated into CIT operations.

Options for Training Emergency Communicators

There are two options for training call-takers and dispatchers. First is to include them in standard CIT officer training, a few at a time. The advantage of this approach is that officers and emergency communicators can learn from each other about what happens on the other end of the line during a crisis event.

The other option is to develop a short version of CIT training specifically for emergency communications. A number of communities have developed such trainings. Visit <http://www.citinternational.org/911resources> for the latest recommendations and updates.

EVALUATE YOUR TRAINING

Rigorous research has demonstrated that CIT training that is consistent with the CIT Core Elements improves officer knowledge, attitudes, self-efficacy, and call disposition decisions.^{25,26} Most CIT programs cannot conduct a rigorous research study of their specific training to determine the impact of the training on officer knowledge and attitudes.

However, CIT programs should conduct a training evaluation to track trends and report progress back to community partners and instructors. There are a couple of brief training evaluations you can conduct:

- **An instructor evaluation, to learn whether officers find specific instructors to be engaging and informative.** The **TEMPLATE: CIT Training Instructor Evaluation** on page 223 is a simple example that programs can use to evaluate instructors.
- **A pre- and post-test of officer knowledge and attitudes about mental illness.** We recommend measuring pre- and post-training knowledge and attitudes for the first few trainings to make sure the content and delivery are on target. In addition, this data can be helpful in looking for trends. If there's a major drop in officers' understanding of a particular topic, the steering committee may wish to discuss whether an instructor is effective. The **EXAMPLE: Pre/Post Training Evaluation** on page 224 can help you develop your own.
- **Skills testing, to determine whether officers have learned the most challenging part of CIT training—de-escalation skills.** If your program would like to test officers to evaluate their skills in de-escalation, the best way is to run them through new scenarios, and evaluate whether they are able to integrate their new skills to address the situation. Contact CIT International at admin@citinternational.org for more information about skills testing.

25 Compton, M. T., Esterberg, M. L., Mcgee, R., Kotwicki, R. J., & Oliva, J. R. (2006). Brief Reports: Crisis Intervention Team Training: Changes in Knowledge, Attitudes, and Stigma Related to Schizophrenia. *Psychiatric Services*, 57(8), 1199-1202. doi:10.1176/appi.ps.57.8.1199

26 Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., . . . Watson, A. C. (2014). The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest. *Psychiatric Services*, 65(4), 523-529. doi:10.1176/appi.ps.201300108

Case Study: Training CIT Officers in Memphis

“Probably our greatest recruiters are other CIT officers. The officers see that CIT officers are so cool, calm, and performing. You just want a part of that.”

— Lt. Colonel Vincent Beasley, Memphis Police Department, Memphis, Tennessee

Managing the nation’s oldest and most revered CIT program comes with some very high expectations. But Officer James Lash and Lt. Colonel Vincent Beasley, of the Memphis Police Department, are focused more on the advantages. Every officer at the Memphis PD is familiar with CIT. The program’s founders are still involved, and they have the best of the best when it comes to trainers. Strong community support from NAMI Memphis, as well as the enduring reputation of the program, mean that the entire community knows that CIT officers are a special group.

OFFICER SELECTION PROCESS

Forty percent of Memphis CIT officers have a family member with mental illness. Others may apply because they have experience with people in crisis, and empathize with these experiences. Memphis officers apply to the CIT program with a thorough application that allows them to highlight relevant accomplishments or related studies. Officers must be experienced and have a clean disciplinary record.

After the application process, the officers are interviewed by a panel of three veteran CIT officers to ensure they understand the expectations for being involved in CIT. They even respond to a question about what they would do in a crisis situation. After considering the interview, application, and disciplinary record, the panel selects officers to recommend for the training.

LEARNING FROM PEOPLE WITH MENTAL ILLNESS

Interacting with people living with mental illness is a highlight of the training week for officers. When individual and family presenters first come into the classroom, officers are often hesitant to ask questions, but once the conversation starts, the officers become fully engaged and the time goes by quickly.

Officers have a similar appetite for site visits. Officer Lash says that when officers are surveyed after the training, “There are two things they wish they spent more time with—people with mental illness and site visits. They say we should have more site visits. We

do eight hours of site visits!” During site visits, the officers have time to sit and talk with individuals who have been through a mental health crisis and ask honestly how they could do a better job.

SCENARIOS

Officer Lash says that trainees really start to understand the practical application of CIT when they go through scenarios. They learn basic de-escalation skills, then have to use them. As the scenarios progress, they get more complicated, eventually touching on all the topics from the 40-hour training week.

Scenario training is a team effort. When an officer gets stuck, the instructor pauses the scenario and asks the class for suggestions. When an officer is having a hard time establishing a rapport with an individual in crisis, they are encouraged to “tap out” and give their partner in the scenario a chance to take over. “It’s not about me as a CIT officer, it’s about us as CIT officers,” says Lt. Colonel Beasley. “Ultimately, it’s about getting that person in crisis to somewhere they can get some help. It doesn’t matter who gets that person in the car. It just matters that we can get them help.”

GRADUATION

Officer Lash tells CIT officers, “The training is serious and in-depth. It’s not to be taken lightly.” That gravity is reflected in the graduation ceremony at the end of CIT training. There’s a guest speaker—usually Major Sam Cochran, the founder of the Memphis program, or a presenter from NAMI Memphis. Officers stand at attention, alphabetically, and are called one-by-one to be pinned with the CIT pin by a member of their department. There are formal photographs. Afterward, the new CIT officers and their families enjoy cake and networking.

“They’ve done something that not everyone can do, and you want to show them respect,” says Beasley.



Summary: Plan and Deliver Officer Training



CIT officer training is an essential component of a CIT program that brings the partnerships and policy and procedure changes to the front-line officers who respond to many crisis situations. CIT training is unique among law enforcement trainings in that it includes significant community involvement. The training also emphasizes officer safety and practical skills.

CIT officers are selected and trained for a specific role: the volunteer-specialist who is highly trained for mental health crisis situations but also carries out regular patrol duties. The training is structured over the course of a 40-hour week to help officers build knowledge, gain empathy, practice skills, and understand their new role. This structure supports the officers' learning and helps them integrate the training with their past experience.

There are national resources to support the development of your CIT training, and some states have specific training requirements, but every community does it a little differently. CIT allows communities the flexibility to create training that works for them.

CIT training is taught by a team of law enforcement, local mental health professionals, and community members who spend a significant amount of time understanding the needs of law enforcement and the concerns of their community. Advocacy groups, people living with mental illness, and family members are integral to the training as well.

Training all 911 call-takers and dispatchers is also vital to the success of CIT. Communities can do this by including them in standard officer training, or by developing a shorter, specialized training for emergency communications.

While the CIT training model is already backed by research, communities will find it helpful to evaluate the training as a means for tracking trends and providing feedback to partners. There are many ways to evaluate your training. We suggest, at a minimum, that programs conduct an evaluation of pre-and post-training changes in knowledge and attitudes after the first two or three trainings. SAMHSA's *Crisis Intervention Teams: Using Data to Inform Practice* (<https://store.samhsa.gov/product/Crisis-Intervention-Team-CIT-Methods-for-Using-Data-to-Inform-Practice-/sma18-5065>) can be particularly helpful in guiding communities through evaluating their training.



Checklist: Plan and Deliver Officer Training



Review the checklist below to make sure you have completed the key steps in this chapter. Or, use this checklist if you think your community may be able to skip ahead to another chapter.

Move ahead to Chapter 6 if:

- ☐ Your steering committee and your law enforcement agency understand the volunteer-specialist role of a CIT officer.
- ☐ The law enforcement agency has developed a selection process to identify officers who are experienced, independent, and have self-selected to participate in the CIT training.
- ☐ Your steering committee understands that CIT training focuses on officer safety because safety is a goal of CIT, and so that officers can integrate their new knowledge and skills into their existing training and experience.
- ☐ Your steering committee understands that the structure of CIT training is designed to build knowledge first, then build empathy, and finally bring everything together in practical application.
- ☐ Your steering committee has assigned a subcommittee to develop your community's training that includes the CIT coordinators, as well as representatives from law enforcement, mental health, and advocacy.
- ☐ Your subcommittee has reviewed national curriculum guidelines, including the CIT National Curriculum Matrix and the BJA VALOR CIT curriculum.
- ☐ Your subcommittee has reviewed standards and resources from your state's CIT network and peace officer standards and training (POST) board.
- ☐ Your subcommittee has planned a 40-hour training week that is tailored to meet your community's needs.
- ☐ Your subcommittee has recruited a community-wide team of instructors.
- ☐ Your subcommittee has prepared instructors for presenting to a law enforcement audience, including tying their topic to the theme of the training.

linking to officer safety, keeping their presentation practical and relevant to officers, and keeping presentations engaging.

- ☐ Your subcommittee has worked with advocacy groups to develop individual and family presentations.
- ☐ Your subcommittee understands the purpose of site visits and has planned visits that allow officers to interact face-to-face and informally with people living with mental illness.
- ☐ Your subcommittee has created a logistics checklist and divided responsibilities among partners to ensure a smooth training week.
- ☐ Your subcommittee has plans to train all call-takers and dispatchers in CIT.
- ☐ Your subcommittee, in consultation with the steering committee and law enforcement agency, has determined the approach that will be used to evaluate the training.

CHAPTER 6:

SUSTAIN AND GROW YOUR CIT PROGRAM

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Introduction: CIT is More than Just Training

After your first CIT training, your steering committee deserves time to rest and celebrate. It's a major accomplishment!

This is also a good time for CIT partners to remind themselves of the goals of CIT during a mental health crisis:

- To improve safety,
- To increase connections to mental health services,
- To use law enforcement strategically and increase the role of other services and supports, and
- To reduce the trauma that people experience during a crisis.

Our experience with thousands of CIT programs shows that—in order to make a lasting impact in your community—your program needs to remain committed to your community partnerships. Successful CIT programs also address challenges and pitfalls head-on and strive to improve and innovate.

This chapter is about two things: first, how to ensure your program's sustainability, by supporting the key partnerships and people involved. Second, it is about innovation and growth. Many CIT programs find that they are inspired to use their program as a springboard for changes that go beyond a traditional CIT program. We want to offer you a selection of ways to think about the potential of your CIT program.

Lessons Learned about Sustaining Your Program

"I've watched programs start and die in parts of the state. Their focus was always on training. We've always focused on the community response. The programs that last focus on the community first."

— Captain Wade Borchers, Lenexa Police Department, Lenexa, Kansas

ASSESS YOUR PROGRAM USING THE CIT CORE ELEMENTS

The most important thing you can do to stay on track is to make sure your program is following the *CIT Core Elements* (<http://www.citinternational.org/Memphis-Model->

Core-Elements). At least once a year, your steering committee should review the CIT Core Elements and assess your progress. As a reminder, here are the ten CIT Core Elements, and where you can find guidance on them throughout this guide:

1. Partnerships among law enforcement, advocacy, and mental health (Chapters 1 and 2)
2. Community ownership over planning, implementation, and networking (Chapters 2 and 3)
3. Policies and procedures (Chapter 4)
4. CIT officers, dispatchers, and coordinators (Chapters 4 and 5)
5. CIT training for officers and dispatchers (Chapter 5)
6. Mental health receiving facility (Chapters 3 and 4)
7. Evaluation and research (Chapters 4 and 6)
8. In-service training (Chapter 6)
9. Recognition and honors (Chapters 5 and 6)
10. Outreach to develop CIT in other communities (Chapter 6)

As you review each item, consider what you have in place, what you have planned, and what's missing. If you don't have a core element in place, generate ideas with your partners and look throughout this guide for resources.

CIT International is developing a detailed self-assessment to help CIT programs stay on track. The self-assessment will also allow programs to receive accreditation. Visit <http://www.citinternational.org/programassessment> for the latest updates.

REVISIT YOUR GOALS ANNUALLY

When you assess your program using the Core Elements, it's also a good time to revisit the goals you set in Chapter 4 (*Prioritize and Set One-Year Goals for System Change* on page 112).

As a steering committee, discuss your progress and your shared priorities for the coming year. Have you accomplished the goals you set to improve your crisis response system? What would you change or add? What incremental goals do you have for the next year? Can you get support for achieving your goals from your regional or state CIT network, your state advocacy organization, or national organizations?

Use the **WORKSHEET: CIT Goal-Setting Discussion** on page 227 and the **WORKSHEET: CIT Goal Action Planning** on page 228 to help guide these annual discussions.

MAINTAIN YOUR PARTNERSHIPS

“Even if you’re struggling in a relationship with a community partner, you still need to work with them. You need to invest time. It’s very powerful, being able to have a lot of people on your team.”

— Dara N. Rampersad, PhD, LPC, NCC, First Responder and Forensic Psychologist, BluePaz, LLC, Phoenix, Arizona

When you assess your program, you will probably be reminded that partnerships among the three key stakeholders—law enforcement, mental health provider agencies, and mental health advocates—are the bedrock of a successful CIT program. Here are some ways to maintain those relationships.

Meet Regularly

Your steering committee should continue to meet on a regular basis to make program improvements, problem-solve, build community awareness, plan training, and provide updates. You can also celebrate small victories—whether it’s a successful outcome with a particular individual or a change in policy that affects the entire crisis response system.

The CIT coordinator(s) should also meet regularly with all the crisis system partners in the community. These meetings can help everyone keep updated about changes with mental health services, provide feedback, problem-solve, coordinate around complex cases, and ensure you have strong relationships.

Continue Learning Among Partners

After your first CIT training, your CIT coordinator(s) and steering committee may have a long list of new questions and concerns to address together. It’s common for partners to realize that they still have a lot to learn about the systems in their community.

For example, there may be a need for additional cross-training, such as:

- Emergency communicators or mental health professionals riding along with officers,

- Officers walking through the admission process at emergency departments or other receiving centers,
- Officers or mental health professionals observing operations at the 911 call center, or
- Hospital or receiving center clinicians and security staff receiving training in de-escalation to reduce some of the challenges they experience when individuals in crisis arrive for treatment.

In addition, the process of developing training may have brought attention to a specific population or challenge in the community that the steering committee has not previously addressed. For example, you may discover that there's little coordination between Veteran's Administration (VA) Medical Centers, VA police, local mental health services, and local police when it comes to serving veterans in crisis.

As long as the steering committee continues to meet and be transparent about their concerns, these questions will naturally come up. Your committee does not need to address every concern immediately, but it's important to listen to everyone's concerns and come to a decision together about your priorities.

Include New Partners and Champions

“After Akron’s first CIT training, when the officers hit the streets, the news media was all over it. It got in a lot of newspapers in Ohio. I’m sitting in my office, feeling pretty proud, then the phone rings. It was Ohio Supreme Court Justice Evelyn Lundberg Stratton and she said, ‘Lt. Woody, I think you’re on to something.’ With her immense power and help, we put together a team with all the movers and shakers in Ohio.”

— Lt. Michael Woody (ret.), Ohio CIT Coordinator, Akron, Ohio

Your first training and the appearance of new CIT officers may attract new partners and champions. It is natural at this stage in a program to expand your steering committee, or if you think it is appropriate, to create a larger community advisory committee. This can be an opportunity to think more broadly about what your program would like to accomplish—whether it's assisting other communities in starting CIT, or expanding to specialized training, or advocating for mental health services. New partners can bring new ideas and new resources. See **Welcome New Partners** on page 64 for guidance on bringing new partners into the steering committee.

New champions can also help your program immensely. However, if your program gains a lot of attention, there's a possibility that an eager elected official or leader will champion your cause before fully understanding the goals of CIT or your program. Work with a new champion proactively by bringing them into the fold of CIT and explaining the successful record of the CIT Core Elements.

BUILD COMMUNITY AWARENESS AND SUPPORT

It will help your CIT program if the broader community can see your successes and support your efforts. If there are unexpected shifts in your steering committee or changes in agency leadership, broad-based community support can help keep the program steady. As a steering committee, create a strategy for building community support. It might include some of the following elements.

Reach Out to Local Media

Search your network for a reporter with an interest in mental health or criminal justice based out of a local newspaper, TV news station, or online publication. Make a point of keeping this individual informed of successes with the program—invite them to observe a CIT class graduation and award banquets. Invite them to ride-along with a CIT officer, tour a crisis center, or interview an advocacy leader. Cultivating this relationship can help get the word out about your program.

Collect Success Stories

Work with your advocacy partners to collect success stories of interventions that go well, individuals who get access to services, family members who are grateful, officers who find training transformative, and mental health professionals who report improved outcomes with clients. These stories can be used in any number of ways to promote your program: as part of testimony before your county council when the budget comes up; in a letter to the editor to encourage people to ask for a CIT officer; as a way to educate a new law enforcement executive; as an example of what's possible, when you're fighting for funds for a dedicated crisis receiving center.

Raise Awareness so People Know to Ask for CIT

One way to ensure that crisis calls resolve safely is to make sure callers across the community know their options during a crisis.

First, come up with a simple message, such as, “Need help during a mental health crisis? Call the crisis line at 800-XXX-XXXX. If someone is in immediate danger, call 911 and ask for a Crisis Intervention Team (CIT) officer.”

Then, make sure that the information is shared on websites and fliers, through many avenues:

- On a card that CIT officers can hand out to individuals and family members that they interact with,
- During support and education programs offered by mental health advocacy groups,
- At faith-based meetings,
- At hospitals, emergency departments, clinics, crisis centers, and other treatment settings,
- At hospital or jail discharge,
- With civic organizations, such as the Boys and Girls Club and United Way,
- At Chamber of Commerce meetings, and
- With related service providers, such as substance use providers, homeless outreach services, and schools.

Participate in Public Events

As a CIT program, find ways to participate in public events. Mental health advocates, mental health professionals, and law enforcement together, or at each other’s events, can raise awareness and make an important public statement.

For example, CIT officers at a mental health awareness event, such as the [NAMI Walks](https://www.namiwalks.org/) (<https://www.namiwalks.org/>) or [Out of the Darkness Community Walks](https://afsp.donordrive.com/) (<https://afsp.donordrive.com/>) for suicide prevention, show that mental health is truly a mainstream issue and that there’s nothing to fear from people living with mental illness. They also provide people in the mental health advocacy community more opportunities to learn about CIT.

Mental health advocates and mental health professionals can also participate in community policing events, such as the [National Night Out](https://natw.org/) (<https://natw.org/>), to promote CIT.

IACP'S ONE MIND CAMPAIGN

“I spend a lot of time on the phone with small departments who are chipping away at this stuff and I don’t want to dissuade them. If you’ve already trained your officers, but don’t yet have relationships with providers, I am sure there are providers eagerly awaiting partnering with you. I want to congratulate chiefs on taking a step to providing their officers with the tools they need to be safe and effective in their communities.”

— Bryan Gibb, Director of Public Education, National Council for Behavioral Health, Washington, DC

CIT International is proud to partner with the International Association of Chiefs of Police (IACP) on their One Mind Campaign. The mission of the One Mind Campaign is to bring together the community, mental health providers, and law enforcement “to ensure successful interactions between police officers and persons affected by mental illness.”

The One Mind Campaign is also supported by [Mental Health First Aid](https://www.mentalhealthfirstaid.org/) (<https://www.mentalhealthfirstaid.org/>), the [National Constables and Marshals Association](http://nationalconstablesandmarshalsassociation.com/index.html) (<http://nationalconstablesandmarshalsassociation.com/index.html>), the [Hispanic American Police Command Officers Association](http://hapcoa.org/) (<http://hapcoa.org/>), the [Major Cities Chiefs Association](https://www.majorcitieschiefs.com/) (<https://www.majorcitieschiefs.com/>), and the [National Organization of Black Law Enforcement Executives](http://noblenational.org/) (<http://noblenational.org/>).

Law enforcement agencies that pledge to join the One Mind Campaign agree to implement four promising practices:

1. Develop a sustainable partnership with a community mental health agency,
2. Develop and implement a model policy on police response to people with mental illness,
3. Train and certify all officers (and select non-sworn staff) in Mental Health First Aid or an equivalent mental health awareness training, and
4. Provide CIT training to a minimum of 20 percent of sworn officers (and select non-sworn staff, such as dispatchers).

CIT International supports the goals of the One Mind Campaign and looks forward to assisting law enforcement agencies that make the pledge. For more information, visit: <https://www.theiacp.org/projects/one-mind-campaign> or contact CIT International at admin@citinternational.org.

SUSTAIN LEADERSHIP

Anticipate Leadership Changes

“In CIT training, we want people there who want to be there. It’s the same for the steering committee—we want people on the steering committee who want to be there. All it takes is good people that want to work hard.”

— Captain Wade Borchers, Lenexa Police Department, Lenexa, KS

Committed and engaged leaders are key to a successful CIT program. Sometimes, a change in leadership can be a major challenge for CIT programs. A new sheriff is elected, or a new chief brought on board, and they have new priorities. Or an advocacy leader who served as a champion for the program moves on to a new position, and no one is equipped to take on that leadership role. A mental health director retires and the new director cannot engage with the CIT program as much as the previous director.

In general, the best way to ensure smooth leadership transitions is to share the work of a CIT program across partners and within agencies and organizations, rather than relying on a small group to do all the work.

Here are some proactive steps to prevent leadership changes from negatively affecting your program:

- When possible, leaders can bring their successors into the CIT steering committee and introduce them to the partners and the program.
- CIT should be incorporated into agencies’ and organizations’ policy, including procedures, staff assignments, and resources that are dedicated to CIT.
- Partners should continuously engage multiple levels within an agency to identify internal champions. For example, advocates and mental health partners can reach out to command staff, supervisors, and front-line officers within a law enforcement agency. That way, in case of a change in law enforcement leadership, CIT is deeply embedded in the culture of the law enforcement agency.

During a leadership transition, CIT partners should reach out proactively to the new leader with an invitation to join the steering committee. The first meeting with a new leader should include a special introduction and welcome, and praise for the organization or agency's role in CIT so far. If there's a concern that a leader may not maintain support for CIT, partners can take the following steps during a transition:

- Partners can reach out to the new leader and request a specific representative to serve on the steering committee. This simplifies a choice for the new leader and provides an opportunity to recommend someone who has an interest in or experience with CIT.
- Advocates and community members can make a concerted effort to welcome the new leader. This might include attending community meetings or scheduling a private appointment and sharing a record of positive stories about the impact of CIT.
- If possible, partners can work with a member of the media to highlight a positive story about CIT. Share that, and other news stories, with the new leader.
- Partners can share program data with the new leader, highlighting positive trends from CIT.
- Partners can offer to temporarily reassign responsibilities or resources. A new leader may be overwhelmed by their agency's level of involvement in CIT, and welcome short-term help.

Stay positive, and if needed, return to some of the approaches in Chapter 2 to remind leaders about why CIT benefits their agency and the entire community.

Sustain the Coordinator Position

“It is important for CIT programs to talk about and develop a succession plan for the CIT coordinator(s). CIT work takes commitment and passion. Not just anyone can step into this role and be successful. The wrong person, or someone not interested, can hurt the program. It is important to grow and engage good people who understand and believe in CIT, not someone who has been assigned one more thing to do.”

— Michele Saunders, LCSW, Chair, Florida CIT Coalition, Orlando, Florida

Just as the commitment of agency leaders is important, coordinators are vital to the sustainability of CIT. So much of CIT's day-to-day operations hinges on the relationships that the coordinators build and maintain.

A coordinator who is planning to move on can set up their successor for success. For example, they can:

- Handpick and mentor a new coordinator, bringing that individual to steering committee meetings, CIT training, and other meetings, and introducing them to important contacts. The more time available for this process, the better.
- Document processes and contacts. These could be logistical details, such as where to photocopy training materials and order certificates, or lists of contact details. Or they could be more strategic, like notes on which steering committee members have a personal connection to legislators, or which media contacts have a record of reporting positively on the program. The coordinator can store this documentation on a thumb drive, in a binder, or online and share copies with the steering committee.

Your steering committee, along with the agency or organization where the coordinator is housed, can take proactive steps to ensure the sustainability of the coordinator position. For example:

- The agency or organization can create a job description.
- The agency or organization can write the coordinator position into policy, ensuring that it's a permanent position.
- The agency or organization can provide a clear supervisory structure for the coordinator, to ensure that they are reporting relevant information to a supervisor. In a large community, the coordinator can have support staff or colleagues who share some responsibilities.
- The steering committee can ensure that there are multiple coordinators at different agencies and organizations.
- The steering committee can work together to identify funding for the coordinator position.
- The steering committee can work with their regional or state CIT network to help create a coordinator network.
- Periodically, the steering committee can send partner representatives to job-shadow coordinators and document their contacts and procedures. This will help share knowledge about the coordinators' responsibilities and create additional documentation.

Support Advocacy Leaders

“For advocates, CIT is very time-consuming, and when your loved one is in crisis, you aren’t available. You’re always sitting on the edge.”

— Donna Yancey, NAMI Greater Indianapolis, Indianapolis, Indiana

In some CIT programs, advocacy leaders do a significant amount of unrecognized work to keep the program running smoothly—particularly community outreach, advocacy for services, fundraising, logistics, and similar time-consuming tasks. Their commitment to the program is for good reason: people living with mental illness and their family members have the most to lose without a CIT program. However, this can occasionally lead advocacy leaders to becoming solo coordinators without a lot of backup among their partners, or without a lot of recognition for their work. As a steering committee, make sure that advocacy leaders are getting sufficient support.

Support Leadership by People Living with Mental Illness

While many advocacy leaders are involved in CIT, it’s common for CIT programs to have a lack of leadership by people living with mental illness. Look for this gap in your steering committee. While people living with mental illness make invaluable contributions, they face significant barriers to taking leadership positions: others may not take their contributions seriously, they may have financial challenges that make it difficult to participate in volunteer work, or they may have occasional mental health setbacks.

Despite these challenges, ensure that you are including people with mental illness on your steering committee and in other leadership roles. You can nurture the leadership of people living with mental illness by supporting peer specialist programs and placing trained peers in positions throughout your program. You can also ensure that people are able to take breaks for the sake of their health, then rejoin the group.

THE PITFALLS OF A TRAINING-FOCUSED APPROACH

Mandatory CIT Training Can Damage Your Program

“...Not every officer is well suited to effectively deal with people with mental illness. For example, during our investigation a patrol officer

stated that his job was ‘to put people in jail, not to provide social services.’ This officer would not be the appropriate officer to conduct a welfare check on person with mental illness[sic]... Crisis intervention training done with experienced patrol officers and the leadership of a dedicated police-based crisis intervention coordinator also creates a culture change among officers, which often then permeates an agency.”²⁷

— Letter to Portland, Oregon, Mayor Sam Adams from the U.S. Department of Justice Civil Rights Division

Sometimes the feedback about CIT training may be so positive that a chief or sheriff will decide to train all their officers. Law enforcement leaders may also feel under pressure to address liability concerns and want to use the best training available. Sometimes advocates or mental health agencies may push for this approach because they see the benefits of the CIT program and believe mandatory training will bring even greater benefits.

The train-all approach, while driven by an admiration for CIT, can be quite damaging to your CIT program. Here’s why: research shows that officers who volunteer for the training learn and perform better.²⁸ Researchers looked at officers’ knowledge, skills, attitudes, self-confidence in dealing with crisis situations, use of de-escalation, and use of force—and found that volunteers performed better across the board.

A mandatory training approach also puts all your program’s focus on the role of law enforcement officers, when time and resources could be spent improving crisis services before officers get involved, or improving receiving centers to serve people after law enforcement leaves. Officer training is expensive and time-consuming when CIT partners could be dedicating their energy to improving other aspects of the crisis response system.

- 27 Perez, T.E. & Marshall, A. (2012, September 12). RE: Investigation of the Portland Police Bureau [Letter to Mayor Sam Adams]. U.S. Department of Justice Civil Rights Division, 20. Retrieved from <https://www.portlandoregon.gov/police/article/469399>
- 28 Compton, M. T., Bakeman, R., Broussard, B., Dorio, B., & Watson, A. C. (2017). Police officers volunteering for (rather than being assigned to) Crisis Intervention Team (CIT) training: Evidence for a beneficial self-selection effect. *Behavioral Sciences & the Law*, 35(5-6), 470-479. doi:10.1002/bsl.2301

Some poorly-performing CIT officers might seem like a small price for a better-trained force overall, but a CIT-trained officer who does not believe in the mission of CIT is a liability. Forced to take on the role, reluctant officers might act with indifference or even cruelty towards a person with mental illness. A few officers who create hostility during the training week can sour the experience for other officers, as well as that of the mental health professionals, individuals with mental illness, and family members who help teach the course.

With mandatory training, any officer misconduct towards a person with mental illness undermines your entire CIT program, because community members see a CIT-trained officer who is behaving badly and may assume that the program is a failure.

Department of Justice investigations of law enforcement agencies in Portland, Oregon and Cleveland, Ohio²⁹ specifically cited the shift to a train-all approach as the beginning of the end of CIT programs—with a focus on training, the programs stopped focusing on the volunteer-specialist role of the CIT officer (see page 122), and stopped investing in their partnerships. These law enforcement agencies that moved to train-all didn't get the results they had hoped. Despite their efforts, Department of Justice investigations found that they violated the civil rights of people with mental illness through excessive use of force. Ultimately, we believe the volunteer-specialist model gives officers and agencies the best tools to address liability concerns and provide safe, compassionate, and effective response.

To learn more about the importance of avoiding mandatory training, read CIT International's [position statement](http://www.citinternational.org/resources/Documents/Position%20Statement%20on%20Generalist_Specialist%20Model.pdf) (http://www.citinternational.org/resources/Documents/Position%20Statement%20on%20Generalist_Specialist%20Model.pdf).

Avoid Moving CIT Training to the Pre-Service Academy

Similar to the desire to train all officers, sometimes CIT partners will propose moving CIT training to the pre-service academy. This has not been shown to be an effective approach, and it's not consistent with the CIT model. CIT requires officers that have patrol experience as a point of reference and the self-motivation to volunteer for CIT training. This is called the volunteer-specialist officer

29 Gupta, V. & Dettlebach, S.M. (2014, December 4). Investigation of the Cleveland Division of Police [Letter to Mayor Frank G. Jackson]. U.S. Department of Justice Civil Rights Division, 54. Retrieved from https://www.justice.gov/sites/default/files/opa/press-releases/attachments/2014/12/04/cleveland_division_of_police_findings_letter.pdf

(see page 122 for more information about the volunteer-specialist model). Training in the academy does not support the volunteer-specialist officer or the broader goals of CIT.

Specifically, CIT training in the pre-service academy:

- Removes the important selection process that identifies motivated and independent officers.
- Trains officers before they have experience in the field, making it challenging for officers to integrate their skills. CIT training relies on officers to have their decision-making and tactical skills already developed, and then integrates mental health awareness and de-escalation, giving officers an array of skills to use during crisis situations.
- Overloads officers with information. The typical pre-service academy is several months long; a week-long CIT training will get lost in the shuffle and will not be integrated well with all of the other skills taught in the academy.
- Fails to rejuvenate officers and remind them that they can make a difference. For experienced officers, CIT training often lifts some of the weight of secondary trauma that accumulates over the years of police work and provides them with new purpose. This benefit is lost on new recruits.
- Removes CIT training from the community setting, making it more of a law enforcement training with less access to community trainers, community resources, and site visits.

To learn more about why CIT International opposes CIT training in the pre-service academy, read our [position statement](http://www.citinternational.org/resources/Documents/Position%20Statement%20on%20CIT%20in%20PreService%20Academy.pdf) (<http://www.citinternational.org/resources/Documents/Position%20Statement%20on%20CIT%20in%20PreService%20Academy.pdf>) on the issue.

Alternatives to Mandatory CIT Training

If your law enforcement agency would like to have all officers receive some mental health training, CIT International recommends providing a shorter training focused on mental health awareness and response. At times, there may be officers who are not trained in CIT dispatched to mental health calls—though, through dispatcher training and policy changes, these should be less common.

Therefore, the goal of agency-wide mental health training should be to help officers recognize a mental health crisis, call for a CIT officer, and keep the scene safe in the meantime.

There are a few options for delivering this training:

- You can draw from your CIT course and offer briefer training focused on mental health topics. See page 127 to learn more about the mental health topics in CIT training.
- You can provide *Mental Health First Aid-Public Safety* (<https://www.mentalhealthfirstaid.org/population-focused-modules/public-safety/>), an 8-hour awareness training, as recommended in IACP's One Mind Campaign. See page 158 for more information about the One Mind Campaign.
- You can provide the Police Executive Research Forum's *Integrating Communications, Assessment, and Tactics (ICAT)* (<https://www.policeforum.org/about-icat>), a 2-3-day training designed to integrate crisis communication skills with officer safety tactics.

SUSTAIN THE CIT OFFICER PROGRAM

Being a CIT officer can be incredibly rewarding—helping a person get access to services, hearing the gratitude of family members, preventing injury or trauma. However, it can also be incredibly frustrating and exhausting, because officers are responding to difficult situations and using all of their emotional resources. In addition to practical support, officers need regular reminders that the community values them and the work that they do. CIT officers also need ongoing support from their agencies to be effective.

Recognize the Important Role of CIT Officers and Other Responders

Part of supporting the volunteer-specialist role of CIT officers is honoring them for their role in the community. Many CIT programs host an annual awards banquet, where mental health advocates celebrate all CIT officers and honor a CIT officer of the year. During the awards ceremony, community members and leaders may be invited to speak. Advocates or law enforcement leaders can share a brief account of successful CIT interventions.

It is also appropriate to celebrate others' actions during these awards: outstanding mental health professionals, peer specialists, advocates, and champions. These honors recognize the individuals and organizations that help to shift crisis response from law enforcement to mental health professionals and support services.

CIT officers also deserve recognition from their agency. Law enforcement agencies can create new awards and honors for the kind of service that distinguishes a CIT officer: community service, compassion, and successfully de-escalating a crisis situation.

There are other ways to ensure that CIT officers see that the community recognizes how important their role is. For example:

- Advocacy organizations can encourage members who have had a successful interaction with a CIT officer to write a letter of thanks for the officer's personnel file.
- Advocacy organizations can present certificates of appreciation to a visiting CIT officer at their regular advocacy meetings.
- CIT programs can plan a special event where officers interact with individuals in recovery, particularly those who have been served by the CIT program.
- Advocates can write letters to the editor praising CIT officers and the program.

Ensure CIT Officers Have Their Agency's Practical Support

Officers also need practical support from their agency to ensure that they can carry out their responsibilities effectively. Agencies should provide this support in several ways:

- The CIT coordinators should be available to help problem-solve and coordinate with partners during challenging crisis events. Even experienced officers will need support and coaching with more complex situations.
- Regularly review law enforcement agency policy on responding to people in mental health crisis. This can be part of the annual self-assessment of your CIT program. See page 152 for more on program self-assessment.
- Ensure that officers have the buy-in and support of their supervisors. Supervisors should support the goals of CIT and understand the role that a CIT officer plays on-scene during a crisis event. To ensure that supervisors are supportive, invite them to observe part of the CIT training, and share program data that shows improved outcomes.

- Keep law enforcement executives engaged in showing support for officers. Small gestures can go a long way, such as having the chief or sheriff speak for a few minutes at the beginning of CIT training, attend graduation, or write a brief word of appreciation in the department's CIT newsletter.

Plan CIT Continuing Education

Continuing education is a core element of CIT. It enables officers to keep their skills current, focus on advanced topics, and receive reminders of their role as a CIT officer. It is vital for CIT officers to reinforce their skills and reinforce their identity as CIT officers.

If scheduling training hours is a challenge for law enforcement agencies, you should remind them that all officers need periodic continuing education to stay certified as a law enforcement officer; CIT continuing education can fulfill that requirement.

There are several ways to make your continuing education successful:

- Ask officers for input on topics. Continuing education can cover a wide array of topics, from advanced training in skills like de-escalation and suicide intervention to addressing the needs of specific populations, including people with developmental disabilities, veterans, children, older adults, people with epilepsy, and many other groups.
- Work with service providers and advocacy organizations in the community to develop continuing education. CIT programs have successful relationships with local chapters of the [Epilepsy Foundation](https://www.epilepsy.com/) (<https://www.epilepsy.com/>), [The Arc](https://www.thearc.org/) (<https://www.thearc.org/>), the [Alzheimer's Association](https://www.alz.org/) (<https://www.alz.org/>), [Veterans Administration Medical Centers](https://www.va.gov/health/vamc/) (<https://www.va.gov/health/vamc/>), veteran service organizations, and many other groups that provide community education, support, and services.
- Attend local conferences and events to identify talented instructors and new topics.
- Network with CIT programs in your region or state to share ideas and resources for continuing education.

For more information about collaborating with other organizations on continuing education, including the results of CIT International's four-city pilot, please visit the [CIT International website](http://citinternational.org/training-in-service-training) (<http://citinternational.org/training-in-service-training>).

Plan Additional 40-Hour Training

Most CIT programs need to plan regular 40-hour CIT classes, either at the local or regional level. It's important to plan for future needs since CIT officers can receive new assignments, move to different agencies, and retire—like all other officers. See the **How Many Officers Need to be CIT-Trained?** on page 123 for more information on ensuring that you have the right number of officers trained, and review the section **Plan for Program Monitoring** on page 107 for a reminder about how to use your program data to adjust your staffing.

NETWORK AND SUPPORT NEW CIT PROGRAMS

“We have encouraged helping each other through outreach from the start. Just as professionals and advocates volunteer to share their time with the police department, we look for CIT programs to share what they have learned with other CIT programs throughout the country. When we were discussing the Core Elements, we said you have an obligation to share this knowledge just as the knowledge was shared with you. Helping other CIT programs is a part of advocacy.”

— Randolph Dupont, PhD, Co-Chair, CIT International, Memphis, Tennessee

Nationally, states have wide variation in the level of regional and statewide coordination among their CIT programs. For example, as of this writing, every county in Ohio has a CIT program, and they coordinate efforts through a statewide center of excellence and numerous statewide organizations. On the other hand, in a few states, there is a single pioneering program just getting started.

Outreach and networking are part of the CIT Core Elements because they help your program, and they help spread the benefits of CIT to other communities. So, if your program is not part of a regional and state CIT network, make a plan to broaden your scope or network with other programs.

Build or Join a Regional Network

“We have a lot of mental health services in Northeast Wisconsin, but people don't know how to connect. So, we created a website based on what other states have done, Northeast Wisconsin Mental Health Connection. The idea is to make it three

clicks to find services near you. Having the tool on this website made it so much easier for people to connect to services. Our goal is to see it go statewide.”

— Sgt. John Wallschlaeger (ret.), Appleton, Wisconsin

If your CIT program focuses on coordination with one law enforcement agency, consider reaching out to other law enforcement agencies in the service area of your public mental health agency to form a regional program. Often the service area is a county, but sometimes it may be multiple counties or a large city.

Working on the scale of your mental health system will allow your CIT program to better coordinate crisis response across a broader area because all the law enforcement agencies will be working with the same mental health system. A regional program will also allow you to coordinate with more community partners.

Finally, a regional program will allow for the possibility of sharing training resources, including instructors. This may help you avoid burning out talented instructors in your region. Not all regional programs share training, but as long as you’re staying within your mental health agency’s service area, it’s possible to have multiple law enforcement agencies train together (including having continuing education together).

For a regional program, you will need to assign regional CIT coordinators—at least one from the region’s public mental health system and one from law enforcement—to support coordinators based out of individual law enforcement agencies and coordinate with partners across the county. Learn more about regional coordinators in [Levels of Coordination](#) on page 82.

Build or Join a Statewide Network

“In law enforcement, we think we’re limited by boundaries, but the people we serve aren’t limited by boundaries. That’s what’s great about our statewide CIT pin—our people in crisis, they know to look for that pin.”

— Major Darren Ivey, Kansas City Police Department, Kansas City, MO

Many states have a statewide CIT network. These can take several forms: an association of programs that coordinate but don’t have a formal relationship with each other, a separate nonprofit organization that serves as the statewide technical assistance center, or a lead program or agency that serves as a training and standards hub for the rest of the state. While somewhat law enforcement-centric, the document [Statewide Law Enforcement/](#)

*Mental Health Efforts*³⁰ (https://www.bja.gov/publications/csg_statewidelemh.pdf) describes several forms that a statewide network can take. Some communities have found that having a law enforcement agency responsible for a statewide program, as demonstrated in this report, proved challenging for maintaining fidelity to the CIT Core Elements. However, the examples provided may be useful to programs considering developing a statewide program.

Benefits of Statewide Networks

“As a statewide advocacy organization, we have thousands of local advocates. It’s our role to educate our members about what the essential elements of CIT are, and to educate the broader community through our networks—so people ask for CIT when they have an emergency and so they support it and advocate for it in their community.”

— Kate Farinholt, Executive Director, NAMI Maryland, Columbia, Maryland

There are enormous benefits to being part of a statewide network. First, they can help new programs get started, and help existing programs when they struggle. For example, coordinators from across the state can share ideas and strategies, or support new coordinators when they come on board. Similarly, law enforcement executives can reach out to new law enforcement executives, and mental health leaders to new mental health leaders.

Statewide networks can share information and ideas through annual meetings, a website, newsletter, or email listserv. They can also create state standards for programs and training, taking some of the guesswork out of interpreting your state laws and navigating your state POST bureaucracy.

Statewide networks can build significant political clout, by combining the local grassroots power of mental health advocates, mental health professionals, and law enforcement with state agencies, state advocacy organizations, and state law enforcement associations. With this political clout, they can monitor state and federal laws, seek funds to help local programs, lobby to change state laws, and push for the creation of more robust crisis response systems and community mental health services.

Finally, statewide networks can help coordinate services statewide, making the experience safer and less traumatic for people in crisis and their families, no matter where they are in the state.

30 Reuland, M., Draper, L., & Norton, B. (2012). *Statewide Law Enforcement/Mental Health Efforts: Strategies to Support and Sustain Local Initiatives*. Council of State Governments Justice Center. doi:10.1037/e528322013-001

Lessons Learned from Statewide Programs

Whatever form your statewide CIT network takes, you should insist on equal partnership and transparency. For practical purposes, your statewide network may be managed by one agency or organization. If that's the case, there should be a steering committee or board of directors representing all three key partners to ensure engagement and transparency.

One note of caution: a statewide program can sometimes devolve into a law enforcement training initiative, particularly if a state law enforcement agency takes a leadership role without the full partnership of mental health and advocacy partners. While regional training can work and still retain access to local resources and address local needs (as described above), a statewide initiative focused on training is no longer CIT.

Expand and Innovate



Sustaining a CIT program is a lot of work. It's common to take a few years to ensure that your program is on solid footing.

If your program and your community decide that you want to do more, there are many examples to follow from CIT programs around the country. From expanding your partnerships and training to creating a better process for managing the most complex cases in your community to advocating for a stronger community mental health system—there's always more work to do. As you continue the work of CIT, there are two important things to remember: your new endeavors should be in line with the goals of CIT and they should be driven by the needs of your community.

EXPAND TO OTHER PARTNERS AND POPULATIONS

Some CIT programs see a need to expand CIT to serve the needs of specific populations. This involves more than continuing education. Instead, your CIT program can take the CIT Core Elements and translate them to serve other populations. In all cases, it's important to remember that CIT expansion includes bringing in new partners, thinking through new policies and procedures, and revising or adding training.

CIT for Youth

The most common expansion of CIT is a special focus on the needs of children and youth. While standard CIT programs include some training on child and youth mental health, there are significant differences in the way that young people experience mental health conditions

and mental health crises. In addition, children interact with several different systems than adults: the children's mental health system, schools, family court, juvenile court, and juvenile detention. Finally, the laws pertaining to emergency detention and emergency psychiatric evaluation of children and adolescents are different than those for adults.

There are some well-developed resources to help you in learning more about CIT for Youth.

- NAMI's guide *Responding to Youth with Mental Health Needs: A CIT for Youth Implementation Guide* (<http://www.nami.org/citforyouth>), provides step-by-step guidance on starting a CIT for Youth program. It includes sections on building partnerships, community asset mapping, planning, training development, evaluation, and sustainability.
- The National Center for Youth Opportunity and Justice's CIT-Y curriculum is an 8-hour continuing education training designed for CIT officers based in the community. Their *Trainer Network* (<https://ncyoj.policyresearchinc.org/trainer-network/>) provides information about training and training-of-trainer opportunities.

Corrections

Many CIT programs also find there is a demand to translate the successes of CIT to serve corrections officers and inmates in jails and prisons. Some research shows that corrections officers who participate in CIT training have improved skills and knowledge when dealing with mental health crisis situations.^{31,32} More research is needed to show which model has the best outcomes.

In the meantime, there are some lessons learned from CIT programs that have expanded to work with corrections:

- Ensure that correctional department leaders are on board; otherwise, it will be very challenging to access the staff and facilities to make any changes to policy or procedure or conduct training.
- Partner closely with corrections officers as well as correctional health and mental health staff to understand their needs, policies, and procedures.

31 Crisis Intervention Team (CIT) Training for Correctional Officers [PDF]. (2007, December 21). The Center for Health Policy, Planning and Research, University of New England. Retrieved from <http://www.pacenterofexcellence.pitt.edu/documents/Maine%20NAMI%20CIT-3.pdf>

32 Davidson, M. L. (2014). A criminal justice system-wide response to mental illness: Evaluating the effectiveness of the Memphis crisis intervention team training curriculum among law enforcement and correctional officers. *Criminal Justice Policy Review*, 1-30

- Recognize that it will take significant time and planning to get permission to bring community members into a correctional setting to conduct training. Individuals with lived experience who are part of the training team and have a history of incarceration may need special permission to enter the jail or prison or may experience trauma at reentering a correctional environment.
- In training, adapt scenarios so that they focus specifically on the types of situations that occur in correctional environments.

If you are considering expanding to CIT to corrections, there are some resources available to help you:

- Contact CIT International at admin@citinternational.org and request technical assistance with development.
- The CIT International Conference frequently has presentations from CIT for corrections programs. Consider attending, or check www.citinternational.org for the archives of prior years' presentations.
- Your state CIT network may be able to connect you with programs in your state, or even with corrections-specific standards in your state.
- The [National Institute of Corrections](https://nicic.gov/) (<https://nicic.gov/>) offers resources on CIT for corrections training.

Other Populations

While CIT for Youth and CIT for corrections are the most common expansions of CIT, CIT programs have expanded to include many new partners and training populations. This creativity and innovation are how CIT is supposed to work: community partners see a need and reach out to new partners to problem-solve. Sometimes problem-solving involves training for new partners; other times it involves negotiating a change in policy at an important point in the system.

Some examples of this kind of innovation include:

- CIT programs partner with Veterans Administration (VA) medical centers, VA police, and veteran service organizations to ensure that veterans in crisis receive coordinated crisis response—whether they prefer to access the VA health care system or another health care system.
- CIT programs partner with fire and emergency medical services to coordinate crisis response and provide training in mental health awareness and de-escalation.

- CIT programs partner with colleges and universities, campus police, and campus mental health services to improve responses to crisis situations on campus.
- CIT programs partner with local chapters of *The Arc* (<https://www.thearc.org/>) to develop training on the co-occurrence of mental illness and intellectual/developmental disabilities.
- Hospital security officers receive CIT training to help improve safety and reduce the trauma experienced during the transfer of custody between law enforcement and emergency department staff.
- CIT programs work with community corrections programs to identify and train specialized probation officers who handle a specialized caseload of people coming out of jail with mental illness. These officers coordinate with law enforcement and the mental health system to help people succeed on probation and reduce technical violations that could send them back to jail.
- CIT programs provide brief training to people living with mental illness and family members on preventing a crisis, and how to interact with law enforcement and mental health professionals during a crisis.
- CIT programs provide de-escalation training to community members who work with the public. Once these community members are trained to recognize an emotionally-escalated individual and have confidence in basic skills to de-escalate the situation, many situations can be resolved without the need for law enforcement involvement.

This sort of innovation and inclusion is a hallmark of a mature CIT program.

GET INVOLVED IN CIT RESEARCH

As explained in *Plan for Program Monitoring* on page 107, it's important to make a distinction between research, which is intended to produce generalizable knowledge about the CIT model, and evaluation, which is focused on understanding the operation or impact of a local program. Communities should conduct evaluations of their CIT programs so that they can provide feedback to partners, make improvements, and use resources wisely.

However, individual CIT programs rarely conduct research on the CIT model. Research on the model requires skilled researchers, funding, and often multiple sites or programs. A regional or statewide program is generally better equipped to participate in research than a local program. If your regional or statewide network is interested in participating in research, please reach out to CIT International at admin@citinternational.org to learn about opportunities.

PROBLEM-SOLVE ABOUT COMPLEX CASES

In the course of their day-to-day work officers, mental health clinicians, advocates, and other partners may interact with individuals who need extra care or attention. For example:

- Individuals who frequently call 911 because of mental health concerns or whose loved ones frequently call 911,
- Individuals with mental illness who frequently commit crimes of survival, such as shoplifting food,
- Individuals who have cycled through jails or hospitals multiple times but don't seem to be getting effective mental health support,
- Individuals who are homeless, have a mental health condition, and repeatedly commit petty crimes that bring them to the attention of local business owners, or
- Individuals leaving jail who have little support and are not engaged in treatment.

Most CIT programs problem-solve to address the needs of these individuals and reduce harmful cycles. The approach that works best for your program depends on your capacity, the volume of complex cases you encounter, and the resources available. You may also shift strategies as your needs change.

Here are a few options that communities have used to coordinate responses to these individuals:

1. The CIT coordinator(s) serves as the main point of contact and each partner organization designates liaisons to stay in frequent communication. As situations arise, the CIT coordinator triages and helps devise a plan that includes multiple partners.
2. The partners create a complex cases review team, described below, that meets regularly to address these challenging cases.
3. The partners review complex cases as part of the regular CIT steering committee or as part of another local criminal justice/mental health taskforce meeting.

Privacy and Information Sharing

“Each month, our 911 center prints out all the mental health calls, and we go through them and talk about concerns that come up. We talk about the ripple effects. If a woman was in crisis, was she a vet and could we connect her with

the VA? Does she have kids and do her kids have support in school? Was she homeless and does she need support from housing services? We are all working with the same people, just from different perspectives. 911 is not under HIPAA.”

— Thomas von Hemert, CIT Coordinator, Thomas Jefferson Area CIT Program, Charlottesville, VA

One of the best ways to serve people more effectively is to share information about individuals who are cause for particular concern.

Under most circumstances, the HIPAA federal privacy law prevents medical and mental health professionals from sharing health information about individuals receiving care without a signed consent for release of that information. (Learn about the [limited situations](https://www.hhs.gov/hipaa/for-professionals/faq/505/what-does-the-privacy-rule-allow-covered-entities-to-disclose-to-law-enforcement-officials/index.html) (<https://www.hhs.gov/hipaa/for-professionals/faq/505/what-does-the-privacy-rule-allow-covered-entities-to-disclose-to-law-enforcement-officials/index.html>)—primarily emergencies—when medical and mental health professionals can share health information with law enforcement.)

However, when emergency communications, law enforcement, and other criminal justice professionals have concerns about an individual, they can generally share information with mental health professionals without violating privacy laws. That information may, in turn, allow service providers to take action or provide general advice.

This type of information-sharing can occur on an as-needed basis, or it can be part of a formal team for addressing complex cases.

Creating a Formal Team for Complex Cases

For communities with a high volume of complex cases, or for whom less formal communication isn't working, a formal team may be a good option. The team can meet to share information and problem-solve individual cases. The team should include a representative from any partner organization that interacts with people in crisis. Depending on your community and your CIT program, that might include:

- Law enforcement
- 911/Emergency communications
- Jails
- Probation
- Courts/prosecutors
- Reentry programs

- Emergency medical services
- Emergency departments
- Mobile crisis teams
- Peer support services
- Advocates
- Mental health agencies
- State and/or county departments of mental health
- Hospitals and clinics
- ACT or FACT teams
- Homeless advocates or homeless service providers
- Substance use disorder providers
- Veteran services and the VA
- Schools

What a Complex Cases Team Can Accomplish

The team can take a variety of steps or make connections among service providers.

Here are some scenarios and how the case review team could address them:

- Emergency communications shares a log of mental health-related calls, noting that there are multiple calls from a particular address. As a result, the mental health agency agrees to do some pro-active outreach. Meanwhile, advocacy groups agree to reach out to the individual and their family, offering access to their warm line, support groups, or education classes.
- A prosecutor reports that an individual has multiple misdemeanor charges for public intoxication, from multiple incidents in the business district. The arresting officer suspected a mental health condition as well. The individual is currently out awaiting the resolution of his case and frequenting the same business district where he's previously been arrested. With agreement from the prosecutor, a CIT officer and a substance use provider agree to intervene, giving the man the option of completing a substance use treatment program instead of jail time.
- Jail staff informs the group that an individual is due to be released from jail, but he's currently experiencing psychosis and refusing his medication. He's been evicted from his apartment and his Medicaid benefits have been terminated. Jail mental

health staff will evaluate him prior to release to determine whether transfer to a hospital is appropriate. If hospitalization is not warranted, the probation agency will assign an officer familiar with mental illness to his case. The mental health agency will assign a caseworker to coordinate his care, match him with an intensive outpatient treatment program or a crisis stabilization bed, and reapply for Medicaid. Housing services might proactively seek a shelter bed for him.

Managing a Complex Cases Team

A CIT coordinator generally manages the team: scheduling, setting the agenda, keeping time. A regular schedule and structure can help with meeting attendance; however, they can also be scheduled as needed.

In the first few meetings, the team may dedicate some time to set expectations for the group. For example, if there are concerns about privacy, reviewing guidance from the Council of State Governments Justice Center report *Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*³³ (<https://csgjusticecenter.org/cp/publications/information-sharing-in-criminal-justice-mental-health-collaborations/>) and consulting with an attorney can help clarify what information each agency can share. If the group decides to develop a written agreement about how they will work together, the **EXAMPLE: CIT Case Review Team Guidelines** on page 229 may be a good starting point for your discussion.

A CIT coordinator may also have separate conversations with the law enforcement and mental health agencies about incorporating the team into agency policy.

The *Data-Driven Justice Initiative* (<https://www.naco.org/resources/signature-projects/data-driven-justice>), managed by the National Association of Counties, also provides a variety of resources for collaborative efforts focused on addressing complex cases.

ADVOCATE TO STRENGTHEN MENTAL HEALTH SERVICES

“Peace officers are the only people in most states who are allowed to take someone against their will to the doctor. That’s for two reasons: to provide emergency first aid, or ensure community safety. Our expectation is that the person is going to have a good shot at getting into recovery, that the person is going to be safe, and the community is going to be safe. But we find that because

33 Petrila, J., & Fader-Towe, H. (2010, September 30). *Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*. The Council of State Governments Justice Center.

our mental health system is broken, a lot of times the person doesn't get the long-term and/or supportive services they need to be successful. And they go back into the community and they get sick again, and we take their liberty away again. I think it's imperative to educate legislators, because without those sorts of services, by default law enforcement becomes part of the broken system."

— Sgt. A.D. Paul, CIT Coordinator, Plano Police Department, Plano, Texas

CIT partners can be a powerful force for strengthening the broader mental health system, beyond the crisis response system. It is important to better understand the mental health system and prioritize where you see gaps and challenges in your community.

Understand Essential Mental Health Services for People at Risk of Crisis and Arrest

People who experience repeated mental health crises and come to the attention of law enforcement need access to a wider array of mental health services than can be provided during a crisis response. Unfortunately, no one type of service is a panacea. Understanding the standard for mental health systems serving people with mental illness who are at risk of arrest can help your community decide where you have service gaps.

In NAMI's vision of mental health services for people at risk of arrest,³⁴ the essential services fall into four main categories:

- **Crisis Care**, including crisis stabilization, crisis centers, mobile crisis, crisis hotlines, non-law enforcement transport, and related services.
- **Outpatient Care**, including therapy, medication management, screening, intensive multidisciplinary programs (such as assertive community treatment (ACT) and assisted outpatient treatment (AOT)), case management, and other care.
- **Inpatient Care**, including both short-term and long-term care, crisis stabilization, and competency restoration.
- **Social Supports**, including housing, income supports, supported employment and education, support groups and education programs for individuals and family members, and many other services.

Cutting across all service categories should be two services:

- **Care coordination** and
- **Peer and family support.**

³⁴ Scully, S. (2019, May 15). Personal communication.

NAMI also describes core principles for all service providers, saying they should be accessible, equitable, effective, and collaborative. In other words, the existence of a mental health service is not enough: it must be available to the people who need it, it must be effective, and it must collaborate with other systems that serve the individual.



In other words, the existence of a mental health service is not enough: it must be available to the people who need it, it must be effective, and it must collaborate with other systems that serve the individual.

Understand Challenges to Mental Health Access, Including Lack of Medicaid Expansion

There are many reasons people are unable to access this array of mental health services. Among the most common are:

- Lack of the appropriate services and providers, including the array of services described above.
- Lack of coverage to pay for services.
- Lack of awareness about services.
- Lack of affordable transportation.
- Lack of culturally responsive services that people feel comfortable engaging with.

Often, even when services are available, they are not engaging. Engagement is the quality of care that helps people feel comfortable and benefit from support. NAMI defines it: “Engagement is the strengths-based process through which individuals with mental health conditions form a healing connection with people that support their recovery and wellness within the context of family, culture, and community.”³⁵

CIT programs support engagement by reducing the trauma that people experience during a crisis and helping them get more quickly to the front door of the mental health system.

CIT partners, working together, can also address the other challenges and help prevent crisis situations in the first place. By knowing which services to ask for, CIT partners can go to legislators together and demand the services that are missing in their communities.

35 Engagement A New Standard for Mental Health Care [PDF]. (2016, July). NAMI, 6. Retrieved from: https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/Engagement-A-New-Standard-for-Mental-Health-Care/NAMI_Engagement_Web.pdf

When it comes to lack of coverage, CIT partners in many states can help improve access to Medicaid, the state-federal program that provides health care for low-income and disabled individuals and families. In some states, Medicaid has been expanded to cover very low-income adults, many of whom have mental illness and have fallen through the cracks. If your state does not have expanded Medicaid, expanding coverage could make services accessible to many of the people who experience repeated crisis situations. Find out whether your state has expanded Medicaid by visiting the [Kaiser Family Foundation](https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/) (<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>) website.³⁶

Follow the Lead of State and National Advocacy and Professional Organizations

Your mental health advocacy partners may be able to advise your efforts to improve your community mental health systems. State and national mental health advocacy organizations also provide education about challenges specific to your state, and how to work with state legislators to get the resources your community mental health system needs. Reach out to the state organizations of [NAMI](http://www.nami.org/) (<http://www.nami.org/>), [Mental Health America](https://www.mentalhealthamerica.net/) (<https://www.mentalhealthamerica.net/>), or other mental health advocacy organizations, for more information.

Similarly, organizations representing mental health professionals may have campaigns to increase access to services or improve the quality of services. Follow the advocacy priorities of the [National Council for Behavioral Health](https://www.thenationalcouncil.org/) (<https://www.thenationalcouncil.org/>), [American Psychological Association](http://cqrcengage.com/apapolicy/home) (<http://cqrcengage.com/apapolicy/home>), [American Psychiatric Association](https://www.psychiatry.org/psychiatrists/advocacy) (<https://www.psychiatry.org/psychiatrists/advocacy>), and other groups.

Finally, learn about the priorities of [Mental Health for US](https://www.mentalhealthforus.net/) (<https://www.mentalhealthforus.net/>), a national campaign to educate elected officials and build broad-based support for mental health and addiction recovery.

Coordinate with Other Reform Initiatives and Coalitions

Across your community or state, there may be other efforts to strengthen social services, improve health care, or reform the criminal justice system. Take advantage of opportunities to work with an existing coalition or initiative whose priorities you can support.

For example, many states and counties have signed on to the national [Stepping Up Initiative](https://stepuptogether.org/) (<https://stepuptogether.org/>), which challenges county leaders to reduce the

36 “Status of State Medicaid Expansion Decisions: Interactive Map.” (2019, May 13). Retrieved from <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

number of people with mental illness in local jails. The policy changes, services, and public awareness needed for a successful Stepping Up Initiative align with the priorities of CIT, and provide opportunities for collaboration.

As another example, there may be significant advocacy in your state to increase funding for supported housing for people with disabilities. Partnering with housing advocates can increase access to housing for people with mental illness.

Create an Advocacy Strategy

With leadership from your state advocacy partners and your state CIT network, consider creating an advocacy plan that supports improvements to your mental health system and aligns with the goals of CIT.

For example, your program could advocate for:

- Funding for a dedicated crisis receiving center, to avoid the use of emergency departments and provide quicker assessment and connection to longer-term services.
- Medicaid expansion in your state, allowing more very low-income people with mental illness to access health care—including many people who are at risk of involvement in the justice system,
- Creation of supported housing, to provide people with mental illness proven access to housing and services that support long-term recovery, or
- Creation of a statewide certified peer specialist program, to provide training and access to peer support services throughout your service system.

As you develop an advocacy strategy, keep in mind:

- You want to advocate for something that will have an impact, but that is also practical considering the political and funding realities in your state or county.
- You want to stay focused, so it's best to have a few priorities (perhaps one or two to start). You can develop a longer-term strategy to tackle more if you wish.
- Relationships and champions are just as important to advocacy as they are to building a CIT program.
- There are many ways to make changes at the local or state level: a public awareness campaign, a change in statute, a change in the state or county budget, a change in regulation, or a change in leadership at an agency.

- You may be able to work with other important partners—such as other leaders in the justice system, important business interests, veterans’ groups, or other coalitions of organizations working towards similar goals.

Educate State Legislators and County Officials

“We’ve been able to turn those relationships with officers into partnerships to advocate for more community services, including having officers who are authorized provide case studies of where they’ve done everything right and the services have not followed through and been available. When a public servant in a uniform is by our side raising these issues, it is always more powerful. They have become advocacy partners for us.”

— Kate Farinholt, Executive Director, NAMI Maryland, Columbia, Maryland

Most advocacy efforts involve educating state legislators or county officials—depending on where you’re hoping for the change. Speaking directly with decision-makers is the most effective way to achieve change.

The advocacy process may be unfamiliar to many partners involved in CIT, so advocacy leaders should make an effort to orient their partners to the kinds of actions they might take, and find advocacy roles that feel appropriate to the people involved.

Here are some examples of the types of advocacy that CIT partners have been involved in:

- As a team, a CIT officer, mental health professional, and advocate meeting with a legislator or county commissioner. During the meeting, each person can briefly describe their experiences and expertise, and then an advocacy leader will deliver the “ask” at the end.
- A law enforcement executive and a mental health director co-writing an editorial about the need for mental health services in a local newspaper.
- A law enforcement executive testifying before a legislature regarding a bill or a budget measure affecting mental health services.
- A judge or other prominent CIT champion making a private call to a county commissioner or legislator in support of a particular policy.

It’s important for law enforcement officers and leaders to know that when they describe the public safety burden of responding to people in crisis, it can be extremely eye-opening for decision-makers. Law enforcement doesn’t need to prescribe the solution, particularly if that seems outside of their purview; they can defer to advocacy and mental health partners.

Case Study: Sustainability through Ohio's Statewide CIT Network



“I really don’t want to force CIT on any chief, sheriff, or officer. If I get any resistance, all I say is, ‘Ohio leads the entire world in CIT. If you don’t have it, and you have a tragedy, what are you going to say?’ Sometimes the officers are thinking this is going to get somebody hurt, but no—this is going to keep you safe.”

— Lt. Michael Woody (ret.), Ohio CIT Coordinator, Akron, Ohio

In 1999, Akron-based psychiatrist Dr. Mark Munetz cold-called Major Sam Cochran in Memphis, hoping to learn a little bit about their CIT program. “I was hoping for five minutes, but we were talking like old friends and I got an hour.” As Dr. Munetz recalls the list of individuals and organizations involved in starting Ohio’s first CIT program, it becomes clear that CIT is truly a collaborative effort: the Summit County Alcohol, Drug Addiction and Mental Health Services Board (ADM Board), Akron Fire/EMS, Akron Police Department, NAMI Summit County, Northeast Ohio Medical University, the Ohio Department of Mental Health and Addiction Services, Portage Path Psychiatric Emergency Services, and Major Cochran and his partner, Dr. Randolph Dupont, from Memphis. Lt. Michael Woody was the training director at Akron PD, and Dr. Munetz’ close ally.³⁷

In 2019, Ohio celebrated having CIT-trained officers in all of its eighty-eight counties. Seventy-two percent of Ohio’s law enforcement agencies participate in CIT and 48 percent of Ohio’s officers are trained. They got there through strong partnerships, combined with a statewide infrastructure, support and outreach to local communities, clear standards, and the passion of some great champions.

CHAMPIONS

Shortly after the first CIT training in Akron, then-Ohio Supreme Court Justice Evelyn Lundberg Stratton created Ohio’s Advisory Committee on Mental Illness and the Courts. Impressed with Akron’s efforts, Justice Stratton threw her support behind CIT, brought it to statewide leaders, and helped to promote CIT statewide.

37 Munetz, M. R., Morrison, A., Krake, J., Young, B., & Woody, L. M. (2006). State Mental Health Policy: Statewide Implementation of the Crisis Intervention Team Program: The Ohio Model. *Psychiatric Services*, 57(11), 1569-1571. doi:10.1176/appi.ps.57.11.1569

Ohio is also fortunate to have two dedicated champions in Dr. Munetz and Lt. Woody. Now retired from Akron P.D., Lt. Woody continues to serve as a liaison to law enforcement around the state, while Dr. Munetz works closely with the Ohio Department of Mental Health and Addiction Services and Northeast Ohio Medical University to support CIT efforts statewide.

GRASSROOTS ENERGY AND STATE SUPPORT

Much of Ohio's success in sustaining and growing CIT lies with the *Ohio Criminal Justice Coordinating Center of Excellence* (CCoE) (<https://www.neomed.edu/cjccoe/cit/>), a statewide technical assistance center founded in 2001 "to promote jail diversion alternatives for people with mental illness throughout Ohio." The CCoE is housed at Northeast Ohio Medical University's Department of Psychiatry and supported by a grant from the Ohio Department of Mental Health and Addiction Services. It partners closely with NAMI Ohio, the Ohio Office of Criminal Justice Services, and the Ohio Attorney General's Task Force on Criminal Justice and Mental Illness.

One early project that the CCoE undertook was to gather leaders from the handful of early CIT programs in Ohio and develop a set of Ohio core elements that they felt were true to the CIT model—a precursor even to the national CIT Core Elements. The Center also invited new programs to travel to Akron for their first CIT training and, in collaboration with NAMI Ohio, made a statewide push to promote CIT.

Much of the strength of Ohio's network is driven from the grassroots up. The CCoE promoted a county-based model, with coordinators in each law enforcement agency, as well as county-based coordinators and steering committees that served the entire county. The county-based approach allows counties to share training resources and coordinate crisis response across law enforcement agencies.

Local coordinators drive much of the innovation—for example, developing a peer review process to assist other programs, and providing informal peer support through a vibrant email list-serv. They volunteer time and resources to mentoring neighboring communities. When the CCoE develops statewide coordinators' trainings or continuing education programs, local coordinators step up to contribute.

Today, the CCoE's staff supports CIT programs across Ohio through technical assistance, semi-annual coordinators' meetings, a coordinators' list-serv, a newsletter, training of trainers, and continuing education. The CCoE also partners with NAMI Ohio to host an annual CIT conference and celebrate statewide awards for CIT Officer of the Year, Chief /

Sheriff of the Year, Mental Health Professional of the Year, Advocate of the Year, and others.

PEER REVIEWS

One service that the CCoE offers to CIT programs is a voluntary peer review process. A small team of CIT coordinators and leaders from across the state, typically including Lt. Woody and two other individuals, review a program and make recommendations for improvement. The review process examines CIT training separately from CIT program issues and considers the latter in terms of the CIT Core Elements. The county CIT coordinator conducts a self-assessment, and reviewers examine program documents, visit the program, and attend training if possible. The report includes an analysis of the program's strengths, as well as suggestions for improvement. Reviewers take into account the program's current stage of development and tailor their recommendations to guide programs to the next stage.

At statewide coordinators' meetings, the reviewed programs are asked to present what they learned through their review—allowing programs across the state to learn from the process.

DIVERSE FINANCIAL SUPPORT

While the Ohio Department of Mental Health and Addiction Services has supported the CCoE with SAMHSA block grant funds, it is not the only supporter of CIT in Ohio. NAMI Ohio receives grants from the Ohio Attorney General's office and the Ohio Office of Criminal Justice Services, and uses those funds to provide mini-grants to law enforcement agencies that struggle to cover the costs of sending officers to training as well as to CIT county programs to underwrite costs of CIT training, companion trainings, and advanced trainings. Meanwhile, the CCoE has received funding from a private community foundation. Still, says Munetz, "While the core funding is modest, it has allowed us to do all this. It's a huge return on the State's investment."



Summary: Sustain and Grow Your CIT Program



The most important thing you can do to ensure the success of your program is to follow the *CIT Core Elements* (<http://www.citinternational.org/Memphis-Model-Core-Elements>). When you assess your program using the Core Elements, it's also a good time to revisit the goals you have set in the past and set new goals.

Partnerships among mental health, law enforcement, and advocates are the foundation of CIT. It's important to maintain these relationships, including maintaining a strong steering committee that meets regularly.

Build broader community awareness of CIT, so that your community knows how to access the crisis response system. Building community support will also help you weather any challenges that come in the future, such as changes in leadership or loss of funding.

Ensure that your leadership structure is sustainable by planning in advance for the departure of supportive law enforcement or mental health executives, or crucial CIT coordinators. Also, support advocacy leaders to prevent burnout and to encourage leadership by people living with mental illness.

Avoid mandatory CIT training, and avoid moving CIT training to the pre-service academy. Evidence supports the volunteer-specialist model, not mandatory training. Programs that have mandated training have not had the results they hoped for.

Support CIT officers and other community partners through awards and honors. Ensure that CIT officers have practical support in their agency and that agencies train the right number of officers to provide CIT coverage.

Share the benefits of CIT by joining or building a regional or statewide CIT network. These networks help spread CIT and support your program, and they also help create a better crisis response system across your region or state. They also have the political clout to achieve a variety of goals at the statewide level.

If your program is strong and the partners want to think about expansion or innovation, you have many options. Many programs expand their partnerships and training to other populations, such as corrections or children and youth. Other programs are interested in getting involved in research on the CIT model and link up with other sites and researchers. Many programs create teams that develop approaches to individuals with particularly complex cases. Finally, many CIT programs advocate for mental health services that help prevent mental health crisis situations in the first place.



Checklist: Sustain and Grow Your CIT Program



Once a year, review the checklist below to make sure you have completed the key steps in this chapter.

- ☐ Your CIT steering committee holds regular meetings.
- ☐ At least once a year, your steering committee reviews the CIT Core Elements to assess the status of your program.
- ☐ At least once a year, your steering committee meets to discuss and set goals.
- ☐ Your CIT steering committee is open to new partners and new ideas.
- ☐ Your CIT steering committee has a strategy for building community awareness and support of CIT.
- ☐ Your steering committee has a plan for managing changes in law enforcement, mental health, or advocacy leadership.
- ☐ Your steering committee has a plan for sustaining the coordinator positions.
- ☐ Your steering committee has a plan for supporting advocacy leaders, especially people living with mental illness.
- ☐ Your steering committee has a plan to avoid the train-all approach to CIT.
- ☐ Advocates and law enforcement agencies have a plan to honor and celebrate CIT officers and recognize other individuals and programs that have contributed to positive changes in the crisis response system.
- ☐ CIT officers have practical support from their agencies, including access to a CIT coordinator, up-to-date policy and procedures, support from their supervisor, and support from the law enforcement executive.
- ☐ Your steering committee has a plan for officer continuing education.
- ☐ Your steering committee has a plan for recurring 40-hour officer training.
- ☐ Your steering committee is networking with or supporting other CIT programs.

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WORKSHEET: Identifying Allies to Advocate for CIT

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Use this worksheet to help identify individuals in your community who may be natural allies in building momentum for CIT. Save the information you've learned to share with your new connections. [LinkedIn](https://www.linkedin.com) (<https://www.linkedin.com>), a professional networking website, may be particularly helpful as it can help you identify connections with others in your community.

MENTAL HEALTH ADVOCATES

Identify mental health advocacy organizations in your community, review their websites, and read news articles about their work. Reach out to your professional contacts to learn about people involved in these organizations. If you are having trouble identifying advocacy organizations, see the section *Identifying Mental Health Advocates in Your Community* on page 28.

As you learn more about mental health advocates in your community, use the worksheet below to write down any names and other details you find in your research. A good ally may be someone who:

- Has interest or experience advocating for criminal justice issues,
- Has a personal connection to criminal justice, such as a family member in law enforcement, and
- Has successfully collaborated with multiple partners in the past.

WORKSHEET: POTENTIAL ADVOCACY ALLIES

Organization	Information Source			
	Board and staff members biographies, LinkedIn pages	Programs and initiatives featured on their website	News articles	Professional contacts
<i>Local NAMI</i> (National Alliance on Mental Illness) (http://www.nami.org/local) Affiliate				
<i>Local Mental Health America affiliate</i> (https://arc.mentalhealthamerica.net/find-an-affiliate)				
Local peer organizations (<i>National Coalition for Mental Health Recovery</i> (https://www.ncmhr.org/members.htm) lists many organizations)				
Local diagnosis-specific groups, such as the <i>Depression and Bipolar Support Alliance</i> (https://www.dbsalliance.org/) or <i>Schizophrenia and Related Disorders Alliance of America (SARDAA)</i> (https://sardaa.org/)				

MENTAL HEALTH PROFESSIONALS

Identify mental health agencies in your community and spend time networking and reviewing biographies to identify someone who might be interested in helping start CIT.

***Note:** If you are unfamiliar with the local mental health system, it may help to know that there are several types of mental health agencies. Public mental health agencies are typically supported by government funds and sometimes required to serve clients regardless of their ability to pay. Private mental health agencies (or individual providers in private practice) generally accept clients with a mix of public and private insurance or self-pay clients.*

In many cases, people who come into repeated contact with the police are served by the public mental health system because they have few resources. Or, they may be receiving no services for a variety of reasons but could benefit from connection to the public mental health agency.

As you learn about mental health professionals in your community, use the worksheet below to write down any names or other details you find in your research. A good ally may be someone who:

- Has experience serving people in mental health crisis (e.g., as part of a mobile crisis team, inpatient unit, emergency department, assertive community treatment (ACT) team³⁸, or other intensive or emergency service), or
- Works with clients who have a history of homelessness or incarceration.

38 “Assertive community treatment (ACT) is a team-based treatment model that provides multidisciplinary, flexible treatment, and support to people with mental illness 24/7. ACT is based around the idea that people receive better care when their mental health care providers work together. ACT team members help the person address every aspect of their life, whether it be medication, therapy, social support, employment, or housing.” Definition from: Psychosocial Treatments. (2019). NAMI. Retrieved from <https://www.nami.org/Learn-More/Treatment/Psychosocial-Treatments>

WORKSHEET: POTENTIAL MENTAL HEALTH PROFESSIONAL ALLIES

Agency	Information Source			
	Board and staff member biographies, LinkedIn pages	Programs and initiatives featured on their website	News articles	Professional contacts
Local public mental health agency ³⁹				
Mobile crisis team, psychiatric emergency room, or hospital emergency department				
Assertive community treatment (ACT) team, first-episode psychosis program, or another intensive outpatient treatment program				
Community mental health centers (to find a center, use the National Council for Behavioral Health's (https://www.thenationalcouncil.org/) "Find a Provider" menu)				
Jail or court with embedded mental health staff (such as mental health courts (https://www.samhsa.gov/gains-center/mental-health-treatment-court-locators), Veterans Treatment Courts (https://justiceforvets.org/what-is-a-veterans-treatment-court/), and Assisted Outpatient Treatment (AOT) courts)				
Veterans Affairs (VA) Medical Centers (https://www.va.gov/find-locations/)				
Mental Health First Aid (https://www.mentalhealthfirstaid.org/) instructors				

39 This agency has different names in different states. For example: Department of Behavioral Health, Department of Mental Health, Community Services Board, Department of Behavioral Health and Recovery Services. It is the government-funded agency, often run by the county or parish, to provide and/or oversee public mental health services.

LAW ENFORCEMENT

“The first thing I recommend for a police agency implementing a CIT program is to identify an upper-level supervisor that has a connection to mental illness through a family member or friend. The police officer has to have compassion for those suffering from mental illness and the motivation to start a program to make a difference in the way police interact with someone in crisis. The reason I suggest upper management and someone who is motivated is because you need the buy-in from all officers. You simply can’t randomly pick an officer or choose who you think is a good fit, because if you do, your program will not be successful.”

— Captain Stacey L. Owens, Greenville City Police Department, Greenville, South Carolina

There are likely at least two—and possibly several—law enforcement agencies that serve your community or region. Most communities are served by a local police department, which enforces laws in a city or town, as well as a county sheriff’s department, which runs the local jail and may assist local departments or enforce laws in unincorporated areas. In some areas, you may want to bring together several local police departments, or include campus police departments that serve local colleges and universities. Even if all agencies do not join your efforts initially, you can reach out to them again as your program grows.

Law enforcement allies are essential because they can serve as ambassadors to others in the law enforcement community, in a way that advocates and mental health professionals cannot.

As you learn more about law enforcement agencies in your community, use the worksheet below to write down any names or other details you find in your research. A potential law enforcement ally may be someone who:

- Is highly respected among other members of the law enforcement community (he or she doesn’t necessarily have to be high-ranking),
- Is familiar with mental health issues, for example, by being open about having a mental health condition, having a family member with a mental health condition, a child with a mental health condition or an intellectual or developmental disability, or a spouse who works as a mental health professional,
- Is assigned in their agency to their community outreach team, homeless outreach unit, substance use response team, or similar unit, or
- Has been recognized for their service working with any vulnerable population (such as children, victims of domestic violence, or individuals who are homeless).

WORKSHEET: POTENTIAL LAW ENFORCEMENT ALLIES

Agency	Information Source			
	Staff biographies, LinkedIn pages	Programs and initiatives featured on the agency website	News articles	Professional Contacts
County sheriff's office				
Largest county, city, or town police department				
Other local municipal police departments				
Campus police departments, transit police departments, park police departments, military police, tribal police, and other agencies				
Local jail, prosecutor, public defender, probation or parole department, reentry program, or other criminal justice agency				

EXAMPLE: Fact Sheet

*This sample fact sheet is designed to help you share why CIT programs are needed and how CIT addresses challenges with the community's response to mental health crises. **Please note:** the second section includes a number of fill-in-the-blanks, where you can insert information about your state or community system. Not all data is available in every state or community, but it helps to learn as much as possible about the specific challenges faced by your community. Once you have found information related to your state and community, share the facts with potential partners.*

THE MENTAL HEALTH SYSTEM, LAW ENFORCEMENT, AND CIT

Across the U.S., individuals with serious mental illnesses are often unable to access services that could support their recovery. The outcomes are tragic for people with serious mental illness and place a great burden on the criminal justice system. Here are the facts:

- An estimated 2 million people with mental illness are booked into jails each year, mostly on non-violent charges.^{40,41}
- Many individuals who are chronically homeless have mental illness and other disabilities.
- While effective treatments exist, in a given year one-third of adults with serious mental illness receive no treatment.⁴²
- Suicide is a leading cause of death, with more than twice as many people dying by suicide (almost 45,000) as by homicide each year (about 19,000).⁴³
- People with serious mental illness are eleven times more likely than the general population to be victims of crime.⁴⁴

40 Minton, T.D. (2013, May 22). Jail Inmates at Midyear 2012 - Statistical Tables. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics

41 Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of Serious Mental Illness Among Jail Inmates. *Psychiatric Services*, 60(6), 761-765. doi:10.1176/ps.2009.60.6.761

42 "Mental Illness" (2019, February). Retrieved from <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>

43 Suicide. (2019, April). Retrieved from <https://www.nimh.nih.gov/health/statistics/suicide.shtml>

44 Teplin, L. A., McClelland, G. M., Abram, K. M., & Weiner, D. A. (2005). Crime Victimization in Adults With Severe Mental Illness. *Archives of General Psychiatry*, 62(8), 911. doi:10.1001/archpsyc.62.8.911

LOCAL COMMUNITIES STRUGGLE TO ADDRESS A CYCLE OF CRISIS

Most communities do not have a crisis response system adequate to help people during a mental health crisis, or services to help prevent future crises. Instead, police become the first responders to a crisis and too many people go to jail instead of receiving treatment and support.

- In our county, an estimated XX percent of people in jail have a mental illness. *(Contact your local sheriff or check their website to find out whether they track this number.)*
- *If applicable, include:* Our state has a shortage of mental health service providers, ranking XX nationally.⁴⁵
- Our state has a crisis of affordable housing for people with disabilities that contributes to homelessness and instability for many people with mental illness. With the average price of housing, people receiving Supplemental Security Income—a program designed to provide income for a person with a disability who cannot work—would have to spend XX percent of their income to afford a one-bedroom apartment in our state.⁴⁶
- In 2017, XX of our residents died of drug overdoses, with many times more experiencing untreated substance use conditions.⁴⁷ Co-occurring, untreated substance use conditions and mental illness lead to high risk of police involvement.

CRISIS INTERVENTION TEAM (CIT) PROGRAMS HELP DE-ESCALATE TODAY'S CRISIS AND PREVENT TOMORROW'S

CIT programs bring together people living with mental illness, their families, mental health agencies, and law enforcement to address mental health crisis situations in local communities. CIT programs address short-term goals, such as:

-
- 45 Review the chart on page 28 of Mental Health America's report *The State of Mental Health in America 2019* to see how your state ranks. Available online at: <http://www.mentalhealthamerica.net/sites/default/files/2019%20MH%20in%20America%20Final.pdf>. Or search the *Health Resources and Services Administration's database* (<https://data.hrsa.gov/tools/shortage-area/hpsa-find>) for information about provider shortages in your county.
- 46 See the Technical Assistance Collaborative's *Priced Out* report, page 44, for a breakdown of housing costs as a percentage of SSI income for each state. Available online at: <http://www.tacinc.org/media/59493/priced-out-in-2016.pdf>
- 47 To find the number of overdose deaths for your state, go to the *Centers for Disease Control data site* (<https://www.cdc.gov/drugoverdose/data/statedeaths.html>), choose the tab for the most recent year, hover your mouse over your state, and record the Number of Deaths.

- Helping police officers safely de-escalate a crisis situation,^{48,49}
- Improving officers' knowledge of mental illness and developing empathy for a person in crisis,⁵⁰
- Reducing the use of law enforcement to address mental health crisis situations by diverting some crisis calls to resources like mobile crisis teams or crisis hotlines,
- Connecting a person in crisis to mental health services,^{51,52} and
- Avoiding taking people with mental illness to jail, when appropriate.^{53,54}

At the same time, CIT partners work together towards long-term change. For example, CIT programs:

- Create case review teams to bring all service providers and criminal justice officials to strategize about how to help those individuals who most frequently come in contact with police due to their mental illness. Several counties in Oregon, including Malheur, use case review teams to assist people who come in frequent contact with law enforcement—assigning mental health professionals to follow up with individuals in their homes, facilitating court-ordered treatment, communicating with the courts, and taking other action to break a cycle of repeated police contacts and proactively connect people to needed treatment.⁵⁵

48 Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., . . . Watson, A. C. (2014). The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest. *Psychiatric Services*, 65(4), 523-529. doi:10.1176/appi.ps.201300108

49 Compton, M. T., Neubert, B. N., Broussard, B., Mcgriff, J. A., Morgan, R., & Oliva, J. R. (2009). 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(4), 737-745. doi:10.1093/schbul/sbp146

50 Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., . . . Watson, A. C. (2014). The Police-Based Crisis Intervention Team (CIT) Model: I. Effects on Officers' Knowledge, Attitudes, and Skills. *Psychiatric Services*, 65(4), 517-522. doi:10.1176/appi.ps.201300107

51 Watson, A. C. (2010). Research in the Real World: Studying Chicago Police Department's Crisis Intervention Team Program. *Research on Social Work Practice*, 20(5), 536-543. doi:10.1177/1049731510374201

52 Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., . . . Watson, A. C. (2014). The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest. *Psychiatric Services*, 65(4), 523-529. doi:10.1176/appi.ps.201300108

53 Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., . . . Watson, A. C. (2014). The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest. *Psychiatric Services*, 65(4), 523-529. doi:10.1176/appi.ps.201300108

54 Watson, A. C. (2010). Research in the Real World: Studying Chicago Police Department's Crisis Intervention Team Program. *Research on Social Work Practice*, 20(5), 536-543. doi:10.1177/1049731510374201

55 Speed, C. (2019, March 16). Personal communication.

- Identify and address gaps in mental health and supportive services. In Virginia, after CIT programs in many jurisdictions lobbied the state legislature to support freestanding crisis assessment centers, the state provided funding for more than thirty such centers that provide safe and humane mental health assessment and referral outside of emergency departments and jails.⁵⁶
- Educate legislators and elected officials about the need to fully fund services that support mental health recovery. In Florida, a coalition of mental health professionals, law enforcement leaders, and advocates successfully appealed to the state legislature over several years to avoid cuts to state mental health funding, as well as to provide funding increases.⁵⁷

56 Virginia Department of Behavioral Health and Developmental Services Office of Forensic Services. (2016). CIT Assessment Files and CIT Programs: A Report on Status [PDF]. Retrieved from <http://www.dbhds.virginia.gov/library/forensics/ofof%20-%20fy2016%20cit%20assessment%20site%20annual%20report.pdf>

57 Saunders, M. (2019, May 6). Personal communication.

RESOURCE: CIT Talking Points



Use these talking points to describe CIT when you are meeting with potential allies or partners, or when you are writing documents to share with others.

OVERVIEW OF CRISIS INTERVENTION TEAMS (CIT)

- There are more than 3,000 Crisis Intervention Team (CIT) programs across the US, in almost every state and the District of Columbia.
- CIT is built on—and managed by—a community steering committee of law enforcement agencies, mental health agencies, and mental health advocates.
- CIT goes beyond law enforcement training to improve policy, system coordination, and mental health services.

CIT HELPS LAW ENFORCEMENT

- By developing the mental health crisis response system, CIT reduces the reliance on police to respond to mental health crisis events.
- In a CIT program, mental health advocates and mental health agencies support law enforcement agencies by helping to identify the best community resources to respond to difficult mental health crisis calls. These partners also help develop specialized training for officers and dispatchers on recognizing and responding to mental health crisis situations.
- CIT training helps officers and deputies safely de-escalate a mental health crisis situation and divert individuals to services, instead of jail, when appropriate.
- CIT improves crisis system coordination, reducing the time that an officer or deputy has to spend in transferring a person for an emergency psychiatric evaluation. Instead of waiting many hours in the emergency department, officers can get back to patrol more quickly.
- CIT helps people with mental illness access mental health treatment and recovery supports, reducing the need for repeat calls for service.

CIT HELPS MENTAL HEALTH AGENCIES

- By partnering with advocates and law enforcement, public mental health agencies have a unique path to educating legislators about the need for mental health services, and avoiding damaging cuts to mental health services.

- Criminal justice partners, advocates, and other service providers support mental health agencies in identifying people with complex needs and strategize together about ways to proactively reach out and avoid repeat crisis situations.
- CIT program partners identify gaps in the crisis response system and supportive services and mobilize a strong group of allies to lobby for the needed services in a community.

CIT HELPS INDIVIDUALS IN CRISIS AND THEIR FAMILIES

- CIT enhances access to crisis services, reducing contact between people in crisis and law enforcement and the criminal justice system.
- CIT raises community awareness about mental illness and provides opportunities to advocate for needed mental health services and support.
- CIT training helps law enforcement officers respond to a person in crisis more safely and empathically, reducing the trauma that individuals and their families experience.
- CIT promotes recovery by reducing trauma, keeping people out of the justice system, and connecting people to needed mental health services and support.
- CIT officers avoid taking people to jail whenever possible.
- CIT reduces the stigma associated with mental health conditions by reducing the role of law enforcement and the criminal justice system in crisis response.

WORKSHEET: Leaders You Need at the Table

.....

Use this worksheet to identify leaders in your community whose commitment to CIT is essential. In many cases, these individuals will also make up the core of your CIT steering committee—the organizing body for a CIT program. Sometimes an executive will assign a staff member from their agency to represent them on the steering committee.

MENTAL HEALTH ADVOCATES

One or more of the following:

CEO or executive director of the local NAMI Affiliate

Name: _____

CEO or executive director of local Mental Health America chapter

Name: _____

CEO or executive director of another advocacy group representing people living with mental illness and their family members

Name: _____

Individual with mental illness (if not otherwise represented)

Name: _____

MENTAL HEALTH SYSTEM REPRESENTATIVES

CEO or director of your county public mental health agency

Name: _____

In addition, if applicable:

Director of your local public hospital emergency room

Name: _____

Director of the nearest forensic psychiatric hospital

Name: _____

LAW ENFORCEMENT AGENCIES

One or more of the following, depending on the jurisdiction:

The county sheriff

Name: _____

A county, city, or town police chief

Name: _____

Additional law enforcement executives

Name: _____

Name: _____

Name: _____

RESOURCE: Steps for A Successful Meeting with An Agency or Organizational Leader

Many people find it intimidating to meet with a police chief, sheriff, mental health director, or the director of a mental health advocacy organization. Some specific steps will help you prepare and have a successful meeting.

1. Use the **EXAMPLE: Talking Points for Meeting with An Agency or Organizational Leader** as a guide to prepare a one-page document with some key information for your meeting. Include information about the leader with whom you are meeting, their accomplishments, and their agency. Also, add a few talking points about your organization or agency, the most relevant talking points about CIT, and your “ask” for the meeting. Use the **EXAMPLE: Fact Sheet** on page 198 along with the **RESOURCE: CIT Talking Points** on page 202 to help tailor your one-pager.
2. Assemble a team of two or three individuals to meet with the leader. Make sure that everyone has a role. For example, a law enforcement officer could start by thanking the leader for their time, and sharing some of the facts they have researched. Then, an individual in recovery or a family member could share a brief story about how traumatic it is to call police during a crisis, or how much it helps to access appropriate services. Finally, a mental health professional could explain how CIT would help address common challenges related to mental health crisis. Practice until you are relaxed, polite, and can keep your comments brief.
3. Practice your “ask.” An ask can be as simple as, “Would you read through this brochure about CIT and meet with us in two weeks?” or it could be a request to join your steering committee.
4. Always leave the official with something to read or a follow-up meeting scheduled. Some examples of materials you could leave behind include:
 - Brochures describing your organization or describing mental illness,
 - Documents from the [International Association of Chiefs of Police](https://www.theiacp.org/resources/policy-center-resource/mental-illness) (<https://www.theiacp.org/resources/policy-center-resource/mental-illness>) on the importance of law enforcement agencies partnering to respond to people with mental illness in crisis,
 - Personal stories from the [Stepping Up Initiative](https://stepuptogether.org/people) (<https://stepuptogether.org/people>) that focus on officers, mental health professionals, peers, and family members involved in CIT, and

- A [joint statement](https://www.mentalhealthfirstaid.org/cs/wp-content/uploads/2016/01/FINAL-MHFA-CIT-White-Paper-Announcement.pdf) (<https://www.mentalhealthfirstaid.org/cs/wp-content/uploads/2016/01/FINAL-MHFA-CIT-White-Paper-Announcement.pdf>) from the National Council for Behavioral Health and CIT International clarifying the differences between Mental Health First Aid for Public Safety and Crisis Intervention Teams. This may be especially helpful to share if a law enforcement leader believes that they have done everything necessary by offering Mental Health First Aid training.
5. Follow up. In your email or note, make sure to include:
- A thank you for the leader's time.
 - A reminder about your ask.
 - Any upcoming events or opportunities to further engage with your group.

EXAMPLE: Talking Points for Meeting with An Agency or Organizational Leader

.....

Use this example as inspiration for developing talking points for a meeting with an agency or organization leader, such as a police chief, sheriff, mental health agency director, or the executive director of a mental health advocacy organization. In this example, members of a fictional advocacy organization, NAMI Springfield, are meeting with Sheriff Smith.

FACTS ABOUT THE SPRINGFIELD COUNTY SHERIFF'S OFFICE

- Each year, the agency responds to 21,000 calls for service.
- The sheriff's department website estimates that 40 percent of inmates in the county jail have a mental illness.
- The sheriff's office serves a county with a population of 80,000, spread over 715 square miles, and deputies have to drive long distances to take people to the hospital or mental health center.

FACTS ABOUT SHERIFF SMITH

- Sheriff Smith has served in law enforcement for thirty years, and as sheriff for the past six years.
- Prior to his service in law enforcement, the sheriff served in the US Army.
- In 2012, he received an award for his dedication to community policing.
- He serves on a regional task force to prevent domestic violence.

FACTS ABOUT NAMI SPRINGFIELD

- NAMI Springfield has provided education and support to residents living with mental illness and their family members for the past twenty years.
- NAMI Springfield serves thousands of people countywide each year through its education programs.
- NAMI Affiliates partner with the sheriff's department in a neighboring county to support officers in responding to mental health crisis calls (and in communities nationwide).

FACTS ABOUT CIT

- There are more than 3,000 Crisis Intervention Team (CIT) programs across the country in almost every state and the District of Columbia.
- In a CIT program, mental health advocates and mental health agencies support law enforcement agencies by helping to deliver specialized mental health response training and identifying the best community resources to respond to difficult mental health crisis calls.
- CIT training helps officers and deputies safely de-escalate a mental health crisis situation and avoid taking people with mental illness to jail unnecessarily.
- Better system coordination helps reduce the time an officer or deputy has to spend in transferring a person for an emergency psychiatric evaluation. Instead of waiting many hours in the emergency department, officers can get back to patrol more quickly.

OUR ASK

- Sheriff Smith, we've asked the CIT coordinator from King County to present to us about CIT. We would love for you to join NAMI Springfield and the CEO of Springfield Behavioral Health for lunch and the presentation. We can work around your schedule. Would you join us?

CHART: Common Concerns About CIT Funding

This resource describes some of the concerns about cost commonly expressed by mental health and law enforcement leaders and briefly summarizes ways that many communities have addressed these challenges.

ADDRESSING COMMON CONCERNS ABOUT CIT FUNDING

Concern	Community Strategies to Address the Concern
Costs of officer training, including trainer fees, travel costs, facilities, training materials, and food.	These costs are often minimal and shared across all the partner organizations. There are numerous trainers for any 40-hour CIT week. Most trainers are asked to volunteer a couple of hours of their time, or teaching is incorporated into their duties as a law enforcement officer or mental health agency staff. Ideally, trainers are from the partner organizations and agencies or the local community, so there are minimal travel costs. A public facility, such as a library, community college, or police academy can be used for a training facility, at minimal or no cost. Food for the officers in training is important, and often mental health advocates can ask local companies to donate catering.
The cost of overtime for officers who fill in the shifts of officers attending training. (This is particularly common in small agencies, where there's less flexibility in scheduling.)	In some states, CIT training is certified by the state peace officer standards and training board (POST) to meet continuing education requirements. In these states, CIT need not add to the total number of training hours officers undertake. Several law enforcement agencies may be able to join together into a regional CIT program. To spread out costs, each agency can send a few officers at one time. (To learn more about partnerships and training in regional programs, review the section Local and Regional Programs on page 39.) Mental health advocates may be able to lobby the city or county government to add a line item to the law enforcement agency budget to cover overtime costs. It may be beneficial to invite state legislators to attend the CIT training graduation ceremony. These legislators can become champions and help you develop a state funding stream to cover training costs.
The cost of increased demand for mental health services, if there are more referrals from law enforcement.	In the past, mental health agency directors may have asked for desperately needed services, and been denied. However, with mental health advocates, law enforcement, and mental health professionals standing together and asking county leaders and state legislators for needed mental health funding, the odds of success are improved. There is a track record of CIT programs successfully advocating to fill gaps in the crisis response system. Through better coordination with law enforcement and other mental health system partners, mental health agencies may be able to more effectively target services at the times when they will help people avoid repeated, costly crisis events.

WORKSHEET: Crisis Response System Feedback Tracker

.....

Use this feedback tracker to collate all the feedback and recommendations from Sequential Intercept Model mapping, feedback sessions with front-line staff, focus groups with individuals living with mental illness and family members, and review of policy and procedures (Chapter 4). Once you have all this information, discuss solutions with the steering committee.

The first line, “Connection to mental health services” is filled out as an example.

CRISIS RESPONSE SYSTEM FEEDBACK TRACKER

Area of Review	Challenges	Possible Solutions (e.g., information and education, change of procedure, change in policy, training, or increased service capacity)
Connection to mental health services	• <i>Patrol officers are unaware of any mental health clinics, hotlines, or other services except emergency departments</i> • <i>Individuals in crisis report boarding in EDs for 12-24 hours</i>	• <i>The steering committee (or a subcommittee) could create pocket-sized cards listing local mental health resources for law enforcement officers to carry</i> • <i>The mental health agency could increase mobile crisis capacity</i> • <i>The mental health agency could advertise the crisis hotline more</i> • <i>911 call-takers could be empowered to transfer some crisis calls directly to the crisis hotline</i> • <i>Hospitals could network together regionally to track the availability of inpatient beds, to more quickly connect people in ED's to beds, if needed</i>
Access to timely and safe alternatives to jail		
Time that an individual in crisis spends in law enforcement/ criminal justice custody		
Safety, for the individual in crisis, officers, professionals, and bystanders		
Trauma experienced by the individual in crisis		
Communication throughout the crisis response system		
Other concerns		

EXAMPLE: NAMI North Texas 911 Checklist⁵⁸

This checklist, also available on the [NAMI North Texas' website](https://www.naminorthtexas.org) (<https://www.naminorthtexas.org>), shows an example of the kinds of resources that CIT programs can develop to educate individuals, family members, and community members. The checklist is designed to help callers to 911 share as much information as possible about a mental health crisis.

911 CHECKLIST

If you or a loved one are a danger to yourself or others, please dial 911. Hold this list in your hand, and give the dispatcher the following information:

- | | |
|---|---|
| ☐ Your name | ☐ Diagnosis |
| ☐ Address law enforcement should come to | ☐ Drug use (current or past) |
| ☐ "This is a mental health crisis. Can you send a Crisis Intervention Team trained officer?" | ☐ Medications (on or off?) |
| ☐ Name of the person in crisis | ☐ Prior violent behavior |
| ☐ Any weapons that are present | ☐ Past psychosis |
| ☐ Age | ☐ Details about past delusions or hallucinations |
| ☐ Height and weight | ☐ Triggers |
| ☐ Clothing description | ☐ Things that have helped in the past |

Keep in mind: *You are asking an unknown professional to come to your home to help you resolve a crisis. The more information you can provide about the individual and the situation, the more they can help keep everyone safe.*

OTHER HELPFUL NUMBERS:

- ADAPT Mobile Crisis Team: 1-XXX-XXX-XXXX
- Suicide & Crisis Center of North Texas: 1-XXX-XXX-XXXX
- Dallas PD Mental Health Liaison: XXX-XXX-XXXX
- National Suicide Prevention Lifeline: 1-800-273-8255

⁵⁸ Adapted with permission from NAMI North Texas.

EXAMPLE: Law Enforcement Policy

.....

Use this sample law enforcement policy for inspiration as you review your law enforcement policy. Does your policy describe the CIT program? Does it describe dispatch procedures and the responsibility on-scene if multiple officers respond? Does it address how officers will interact with other agencies and organizations in the community? Does it describe laws and procedures for emergency psychiatric evaluations in your state?

MENTAL HEALTH-RELATED INCIDENTS⁵⁹

Crisis Intervention Team (CIT)

The Crisis Intervention Team (CIT) is a cadre of volunteer officers who have received specialized training with regard to situations involving persons with mental illness and the community's resources to assist such individuals. CIT Officers are certified by the State of Utah Division of Substance Abuse and Mental Health as Crisis Intervention Team Officers. CIT Officers assigned to a patrol division will respond to regular calls for service. In addition, patrol CIT Officers will respond to mental health-related calls for service.

Response to Calls for Service

On all calls for service involving subjects with mental illness, suicidal subjects, disoriented persons, ungovernable juveniles, or any other mental health-related call for service, the dispatch call-taker will follow protocols to determine if an immediate police response is required. If it is determined that an immediate police response is not required, the call-taker will implement a three-way call with the complainant and the countywide Crisis Line to determine if the call can be resolved by the crisis line, or to determine the most appropriate response. Appropriate response includes independently by officers, independently by a Mobile Crisis Outreach Team (MCOT), or a co-response by both.

On all mental health-related calls for service that require a police response, the dispatcher will assign the call as follows:

- A minimum of one patrol CIT Officer from the appropriate patrol division.
- If the above is not available, a minimum of one patrol CIT Officer from another patrol division.

⁵⁹ Adapted with permission from CIT Utah.

- If the above is not available, the dispatcher will inquire on all airs if a CIT Officer can become available.
- If a CIT Officer is not immediately available, dispatch will assign the call by standard procedures and notify the patrol Sergeant of the situation.

The patrol CIT Officer will have the initial responsibility for the call. If a patrol officer responds to a call for service or on-views an incident and then discovers that it is a mental health-related call, the patrol officer should consider requesting the assistance of a CIT Officer.

A Detailed Report will be made on all mental health-related calls.

Temporary Commitment Procedures

Police Assessment

An officer must assess by observation, or by report of a Mental Health Officer's observation, whether a person's conduct gives the officer probable cause to believe that there is substantial likelihood of serious harm to that person or others due to a mental disorder.

If the officer has probable cause to believe the person is at a substantial likelihood of serious harm to self or others due to a mental disorder, the officer will take the person into protective custody. Physical restraints will be utilized at the discretion of the officer.

Officers will follow the appropriate procedures as directed below:

EMS Assessment

Many life-threatening medical conditions may present as psychiatric symptoms or be present with psychiatric symptoms. If the person is not under the immediate on-scene care of a licensed physician (e.g., when they are in the hospital), Emergency Medical Services (EMS) personnel will be called to the scene to assess for medical conditions.

If EMS personnel believe a significant medical condition exists, EMS protocol will dictate the disposition of the person. Officers will assist EMS personnel as necessary. It is recommended that officers respond to the hospital and complete the necessary paperwork for an emergency involuntary application to be certain the person receives mental health care.

If EMS personnel have released the person, the officer will have the person transported by ambulance to a mental health receiving center, mental health access center, or a hospital and complete the emergency involuntary application procedure.

Emergency Involuntary Application Procedure

If it is determined that the emergency involuntary application procedure is going to be completed, the officer will work with EMS and the patient to determine the most appropriate receiving center, access center, or hospital for an evaluation.

Upon arrival at the facility, the officer will complete an Emergency Involuntary Application (DSA&MH Form 34-2). The officer will write the case number in the upper right corner of the application and have a copy made. The original will remain with the facility. The copy will be turned into the records unit to be scanned into the case.

The officer should attempt to speak with the crisis worker in person or by telephone if feasible.

Follow-up of Mental Health Cases

All cases involving mental health-related incidents will be given the NCIC Code of 5399-23 as either the primary or secondary NCIC code. All cases with this NCIC code will be routed to a CIT follow-up detective for review.

EXAMPLE: Memorandum of Understanding

Use this example Memorandum of Understanding (MOU) to inspire your CIT program's development of a MOU. Does your MOU describe the partnership across law enforcement and mental health agencies? Does your MOU describe a shared procedure for responding to mental health crisis situations?

MARION COUNTY LAW ENFORCEMENT AGENCIES AND MARION COUNTY ADULT BEHAVIORAL HEALTH RESPONSE TO MENTAL HEALTH ISSUES IN THE COMMUNITY⁶⁰

Items in this Memorandum of Understanding are a result of the parties coming together and agreeing to general protocols in responding to individuals presenting mental health issues to law enforcement. As law enforcement is sometimes called upon to respond to individuals with mental health issues, a common protocol serves the community well both in terms of community safety and accessing appropriate individual services.

Nothing in this MOU shall be construed as an absolute protocol in every instance. The understanding amongst the parties is developed with the intention of providing appropriate levels of intervention and available resources to persons in crisis.

1. We are committed to providing training to first responders in order to recognize and respond appropriately to individuals experiencing mental health impairment and/or crisis. This would include initial training when hired and ongoing relevant updated training throughout a first responder's career.
2. We will partner, as resources allow, with other agencies and Marion County Mental Health to develop a follow-up response team to cases that have come to the attention of law enforcement on a referral/screened basis. This will be an attempt by the team to engage community resources in order to avoid future law enforcement contacts.
3. The following options should be considered when responding to an individual experiencing a mental health crisis:
 - a. When there is no criminal offense and the individual is experiencing a mental health crisis not rising to the level of a Police Officer Custody (POC), law enforcement can offer voluntary transport to the Psychiatric Crisis Center in order to access services. Basic information should be provided to the Crisis Center personnel to assist them in the assessment of the individual.

⁶⁰ Adapted with permission from the Marion County, Oregon, Sheriff's Department.

- b. When there is no criminal offense and the individual is experiencing a mental health crisis meeting the criteria for a Police Officer Custody (POC) as a danger to self or others, the officer should initiate the POC process.
 - c. When there is sufficient information for a POC and there is probable cause to believe the individual has committed a crime that does not require mandatory custody, or the crime is a C felony or lesser offense, the officer should cite and release the individual and proceed with the POC process. (Cite and release at the jail is not appropriate in this situation.)
 - d. When there is sufficient information for a Police Officer Custody (POC) and there is probable cause to believe the individual has committed a crime requiring mandatory custody, the individual should be taken into custody, transported, and lodged at the Marion County Jail. Notification and details of the mental health crisis should be provided to the jail staff. Jail staff should make appropriate notifications to Marion County Mental Health.
4. Marion County Health Department, Marion County Sheriff's Office, and Salem Police Department are providing two mobile crisis teams funded by the Oregon Health Authority. These two teams will respond to crisis calls in all jurisdictions in Marion County. If agencies in Marion County respond to calls that meet the criteria in 3 (a and b), the mobile crisis teams may be called to respond and assist.
5. The mobile crisis teams may also be called to respond and assist with calls that meet the criteria in 3 (c); however, the primary jurisdiction responding agency will need to issue the citation. Calls that fall into the criteria in 3 (d) should be handled by the primary jurisdiction agency. The mobile teams are available for consultation if needed.
6. These teams are not to be used for negotiations. Negotiations should be handled by the primary agency.

Signatures:

Agency

Date

Agency

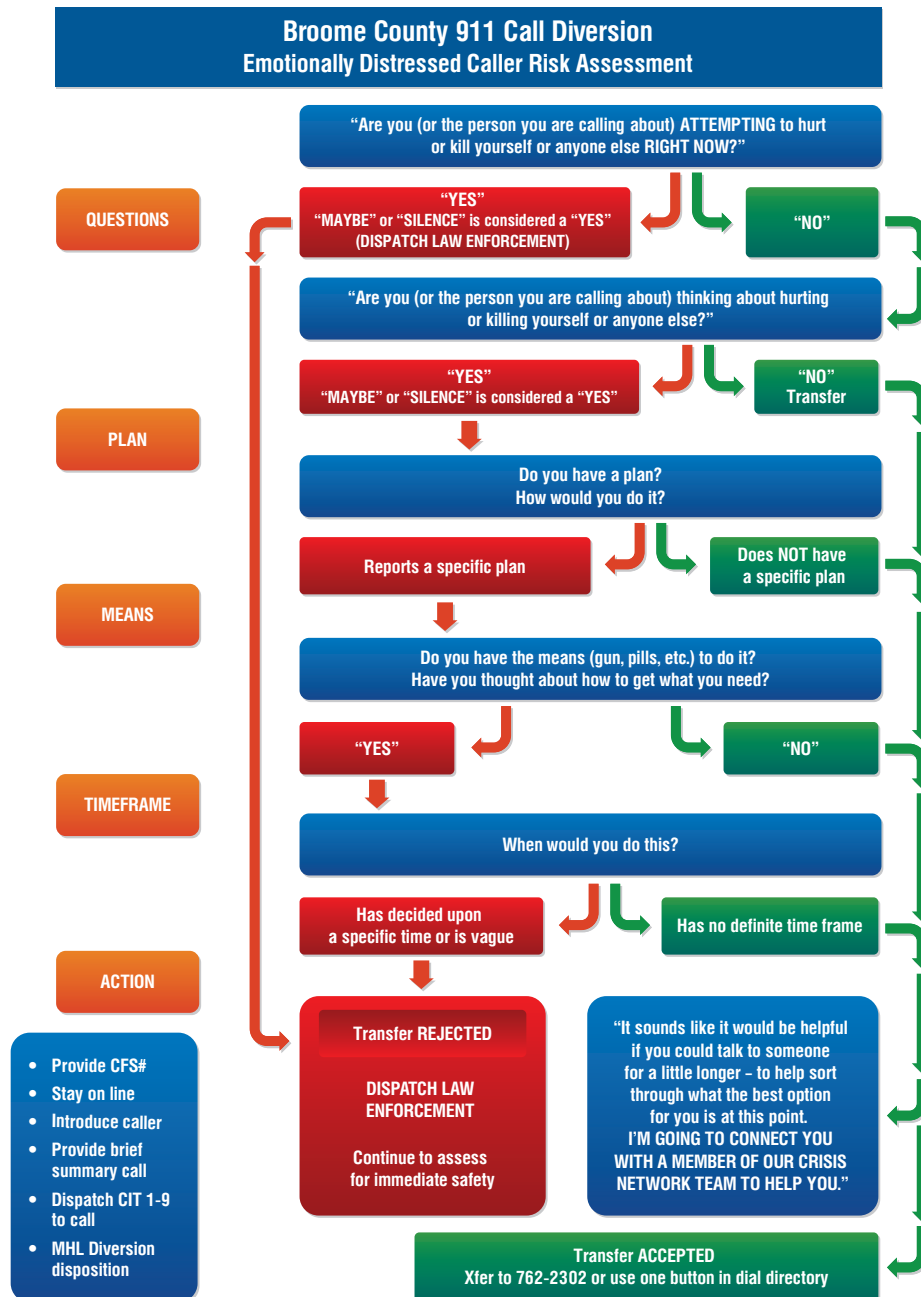
Date

Agency

Date

EXAMPLE: Broome County 911 Call Diversion: Emotionally Distressed Caller Risk Assessment⁶¹

Review the *Case Study: 911 Diversion in Broome County, New York* on page 114 and use this example of a 911 risk assessment to start a discussion with partners in your community about low-risk mental health calls. Are there options in your community for assisting callers who need support but do not need a law enforcement response?



61 Used with permission from the Broome County, New York, CIT program.

EXAMPLE: Thomas Jefferson Area CIT Program: Training Schedule⁶²

Use this example to note how one CIT program used the CIT National Curriculum Matrix and built a community-wide team of instructors to create a training week that met their community's needs.

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 a.m.	UNIT 1: Introduction to CIT and Awareness of Mental Health Issues <i>(Presented by a police chief, CIT officer, and CIT coordinator)</i>	UNIT 7: Pre-Site Visit Meeting at 7:40, located at Region Ten CSB, Charlottesville, VA Site Visits - Region Ten Clubhouse - On Our Own - Western State Hospital - Region Ten Wellness and Recovery Center - SHE (Shelter Help and Emergency) - Kids Ready <i>(Led by CIT Officers)</i>	UNIT 8: Verbal De-Escalation Techniques <i>(Presented by a CIT officer)</i>	UNIT 11: Civil Commitment Procedures <i>(Presented by a judge)</i> Emergency Custody Order/Temporary Custody Order Procedures <i>(Presented by magistrates and a mental health professional)</i>	UNIT 13: Adolescent Issues <i>(Presented by a mental health professional)</i>
8:30 a.m.					
9:00 a.m.					
9:30 a.m.					
10:00 a.m.	UNIT 2: Introduction to Clinical States <i>(Presented by a public mental health agency director)</i>		UNIT 9: Four Plays <i>(Presented by CIT officers)</i>	UNIT 12: Professional Liability and Legal Issues <i>(Presented by an attorney)</i>	UNIT 14: Developmental Disabilities <i>(Presented by a developmental disability service provider)</i>
10:30 a.m.					
11:00 a.m.					
11:30 a.m.					
12:00 p.m.	Lunch <i>(on your own)</i> 11:30-12:30		Lunch <i>(on your own)</i> 11:00-12:00	Lunch <i>(provided by PBA)</i> 12:00-1:00	Community Resources <i>(Presented by CIT coordinator)</i>
12:30 p.m.					
1:00 p.m.					
1:30 p.m.					
2:00 p.m.	UNIT 4: Introduction to Psychopharmacology <i>(Presented by a psychiatrist)</i>		Crisis Scenarios <i>(Led by CIT officers and mental health professionals)</i>	Crisis Scenarios <i>(Led by CIT officers and mental health professionals)</i>	Lunch (12:00-12:30)
2:30 p.m.					
3:00 p.m.					
3:30 p.m.					
4:00 p.m.	UNIT 5: Hearing Voices-Audio Exercise <i>(Led by CIT coordinator)</i>		UNIT 10: Basic Crisis Intervention Skills <i>(Led by a public mental health agency director)</i>		Crisis Scenarios <i>(Led by CIT officers and mental health professionals)</i>
2:00 p.m.					
2:30 p.m.					
3:00 p.m.					
3:30 p.m.	UNIT 6: Introduction to Psychological Effects on War Veterans <i>(Presented by CIT officers, veterans and a representative from the Virginia Wounded Warrior Program)</i>	Site Visit Review			Crisis Scenarios <i>(Led by CIT officers and mental health professionals)</i>
4:00 p.m.					
04:30 PM					
5:00 p.m.					

⁶² Used with permission from the Thomas Jefferson Area CIT program.

EXAMPLE: CIT Training Logistics Checklist⁶³

Use this example logistics checklist to identify tasks, deadlines, and responsible parties leading up to your first CIT training.

Pre-Training Tasks	Due By	Assigned To	Completed
Create a CIT curriculum development workgroup			☐
Review national and state training guidelines			☐
Develop your 40-hour training schedule			☐
Reserve training site (confirm audiovisual capacity, space for scenarios, and tolerance for noise)			☐
Design CIT pin			☐
Advertise and recruit officers			☐
Recruit a community-wide team of trainers from mental health agencies, law enforcement agencies, and mental health advocacy groups			☐
Prepare your trainers to present to a law enforcement audience			☐
Identify locations and facilitators for site visits, and create contact lists			☐
Work with advocacy groups to arrange peer and family presentations			☐
Select officers			☐
Identify actors for scenarios			☐

⁶³ Adapted with permission from materials provided by the Florida CIT Coalition.

Review instructor presentation materials			☐
Reconfirm time slots with each instructor			☐
Secure refreshments			☐
Identify a printer for manuals and other materials (diplomas, handouts, sign-in sheets, etc.)			☐
Identify vendor for CIT pins			☐
Create rosters, name tags, sign-in sheets, evaluation forms			☐
Order pins and diplomas			☐
Write and send out a news release			☐
Copy manuals (either on paper or electronically)			☐
Copy other materials			☐
Post-Training Tasks	Due By	Assigned To	Completed
Review evaluations and debrief			☐
Implement program improvements			☐
Schedule next 40-hour class			☐

TEMPLATE: CIT Training Instructor Evaluation⁶⁴



Use this template to develop a form for officers to evaluate each instructor. Forms should be short and simple.

CRISIS INTERVENTION TEAM TRAINING: INSTRUCTOR EVALUATION

Course Topic _____

Instructor Name _____

Please rate how educational you found this instructor (1 is not educational at all, 5 is very educational).

1

2

3

4

5

Please rate how engaging you found this instructor (1 is not engaging at all, 5 is very engaging).

1

2

3

4

5

Do you have any comments or suggestions about this instructor or topic?

⁶⁴ Adapted with permission from materials provided by the Florida CIT Coalition.

EXAMPLE: Pre/Post-Training Evaluation⁶⁵

Use this example pre/post-training evaluation to help you develop an evaluation for your training that tests changes in officer attitudes, self-efficacy (the degree of confidence they have in responding to mental health crisis calls), and knowledge. **Please note:** Before use, you should confirm statistics are up-to-date and facts about legal issues or procedures are accurate and relevant to your jurisdiction.

CHARLOTTESVILLE CIT PROGRAM: PRE-TRAINING EVALUATION

The following survey is for evaluation purposes only. Your responses will remain anonymous and no identifiable information will be provided to your supervisor or head of department.

Please indicate your position:

☐ Consumer Advocate

☐ Law Enforcement

☐ Communications

☐ Mental Health Professional

To answer each question, please **circle** a number:

1. How comfortable are you with your current knowledge of mental illness?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

2. How aware are you of community resources available to people with mental illness?

1	2	3	4	5
Not at all		Moderately		Very Aware

3. How would you rate your knowledge of civil commitment laws?

1	2	3	4	5
Poor		Moderate		Excellent

⁶⁵ Adapted with permission from the Thomas Jefferson Area CIT program.

4. How would you rate your knowledge of the professional liability that can arise when responding to people with mental illness who are in crisis?

1**2****3****4****5**

Poor

Moderate

Excellent

5. How familiar are you with the roles of various actors in the mental health system (e.g., Region Ten, the hospitals, the courts)?

1**2****3****4****5**

Not at all

Moderately

Very Aware

6. Do you believe the average person with a mental illness is more or less aggressive (such as temper outbursts and verbal threats) than an individual without a mental illness?

1**2****3****4****5**

More Aggressive

The Same

Less Aggressive

7. Do you believe the average person with mental illness is more or less likely to commit a violent crime than an individual without a mental illness?

1**2****3****4****5**

More Likely

The Same

Less Likely

8. How well prepared do you feel when responding to people with mental illness in crisis?

1**2****3****4****5**

Not at all

Moderately

Very Prepared

9. Overall, how well prepared do you think other law enforcement officers are to respond to people with mental illness in crisis?

1**2****3****4****5**

Not at all

Moderately

Very Prepared

10. How would you rate your comfort level in responding to people with mental illness in crisis?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

Please complete the following questions by checking either true or false in response to each question.

11. Most people who have a mental illness are receiving some kind of treatment.

☐ True ☐ False

12. Mental Illness is more common than cancer, diabetes, or heart disease.

☐ True ☐ False

13. Most people with schizophrenia do not recover even with treatment and medication.

☐ True ☐ False

14. People with schizophrenia are more dangerous and violent than people without this disorder.

☐ True ☐ False

15. People with bipolar disorder are at risk of committing suicide when moving from the depressive to the manic phase of the disorder.

☐ True ☐ False

16. Some symptoms of mania include; inflated self-esteem, an explosive temper, impaired judgments, and increased spending.

☐ True ☐ False

Please answer the following questions only if you are a law enforcement officer:

Considering the last year, on average, how many arrests per month do you think you had involving a person with mental illness? _____

WORKSHEET: CIT Goal-Setting Discussion

As a steering committee, set aside a meeting each year to discuss your progress and set new goals for the year ahead. Each steering committee member should have equal time to raise their concerns.

Discussion Questions	
What progress have we made towards last year's goals?	
What lessons have we learned in the past year that might help us improve goal-setting in the year ahead?	
Are there goals from last year that we want to carry forward?	
Did our review of the CIT Core Elements reveal any area where we should focus?	
In terms of crisis response, what have been the greatest challenges in the past year?	
In terms of day-to-day operations, what are the greatest challenges we have experienced?	
What challenges has the community shown the most interest in addressing over the past year?	
Reviewing the topics raised during this discussion, which 2-5 top issues can we agree are our top priorities?	
What can we accomplish in the next year to address these 2-5 priorities? (Phrase these as goals)	

WORKSHEET: CIT Goal Action Planning

Based on your goal-setting discussion, take each goal and make a plan for putting it into action. Fill out this worksheet for each goal. We recommend 2-5 goals annually.

Action Planning Discussion	
Goal	
Which partners and individuals will be responsible for achieving this goal?	
How will other partners support those primarily responsible?	
What other resources or support might be helpful? (e.g., regional or statewide network, national conference, state organizations, or agencies)	
When will the goal be achieved?	
How will you measure success?	

EXAMPLE: CIT Case Review Team Guidelines⁶⁶

THOMAS JEFFERSON AREA CIT: CIT MONTHLY REVIEW TEAM

Purpose: Where representatives from local law enforcement agencies (police, jail, 911, probation) meet monthly with community agencies (hospitals, mental health agencies, wounded warrior program, etc.) to proactively review critical mental health cases and develop support and accountability plans to reduce incarceration and recidivism.

Reason: We (law enforcement, mental health, and medical agencies, and departments) are all working with mostly the same clients, just from different perspectives and usually working within our own “silos.” To build and provide better communication and trust among law enforcement, mental health, and medical establishments.

Confidentiality: Each agency must follow its own rules/policies and state/federal laws about confidentiality.

Communication: In addition to sharing information and updates, the agencies have each other’s contact information (phone, cell, email addresses) to contact each other between meetings.

Meeting notes: The CIT Coordinator writes up the meeting notes without the last name of any clients. The notes go to each representative on the team. The representative then forwards any relevant information out to all the staff members within own agency.

Support and Accountability Interventions: A trained CIT officer and a CSB mental health counselor work together to meet with a person to review what community resources and support that person needs and discuss the accountability of any of their negative or illegal behavior.

AGENCIES REPRESENTED:

University of Virginia (UVA) Police
Emergency Communications - 911
Probation & Parole
Charlottesville Police
Region 10 Community Service Board (CSB)

⁶⁶ Adapted with permission from the Thomas Jefferson Area CIT program.

Wounded Warrior
Albemarle Police
Magistrate – 16th Judicial District
Mental Health America (MHA)
UVA Hospital
PACEM/Homeless Coalition
On Our Own
Albemarle-Charlottesville Regional Jail
CIT Coordinator/Evaluator
Martha Jefferson Hospital
Region 10 CSB – PACT Team
OAR - Community Corrections
Albemarle Commonwealth Attorney
Veteran Services
Schools
Social Services

“There are absolutely no reasons not to do CIT. It benefits the law enforcement officer directly; it benefits the community, the courts, the local government, and the individuals in crisis. It changes lives.”

- Judge Steve Leifman, 11th Judicial Circuit of Florida, Miami, Florida

“As parents of someone with mental illness, we are so grateful for the efforts our community has made in creating its CIT program. There’s more attention being paid to enhancing our crisis response system to avoid having the police respond, but when they have had to – we have witnessed increased knowledge, skills, and compassion by law enforcement responding to people with mental illness.”

- Terri and Bart Wasilenko, Co-Presidents, NAMI Cayuga County, New York

“The advantage of working with mental health agencies and advocates is identifying those resources that are available and local to your community, that you can call upon when you are dealing with someone in a crisis, and that can help you provide better policy guidance to your officers. By doing this, you reduce repeat calls and reduce the risk of injury to someone affected by mental illness or injury to an officer.”

- Chief Louis Dekmar, LaGrange Police Department, LaGrange, Georgia

“On our CIT committee, we had family members and we developed value statements. One of our values was “people shouldn’t have to go to jail for being ill” so when we wrote our grant, it was different than all the other grants. When we started CIT training to teach the officers to recognize the signs and symptoms and de-escalation strategies, there had to be alternative to taking the person to jail or taking them to the ER so they could be released right back onto the street. We opened a little crisis unit. When we opened up that crisis unit, we noticed a marked decrease in the number of people going to jail and the number of people going to the emergency room.”

- Leon Evans, Co-Founder, BHealthle, LLC, San Antonio, Texas

