OHIO
CIT
CRISIS INTERVENTION TEAM

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Bio Sketch – Lieutenant Michael S. Woody, Retired

Lieutenant Michael S. Woody retired from the Akron Police Department after serving 25 years. He spent the last 4 years of his career as the Director of Training (this was a good fit since in his previous life he was a high school teacher). He is credited with starting the first CIT program in Ohio and the fourth in the country. He currently sits on an Ohio Supreme Court Committee that is looking at the way the criminal justice system interacts with the mentally ill. He is the chairman of a subcommittee of the Supreme Court titled: "Police Training". This committee is committed to ensuring that all of Ohio's police officers get more training in how to deal with the mentally ill in crisis.

Lt. Woody has received national recognition and is an advisor to "The President's Commission on Mental Health" formed by President Bush and headed by Michael Hogan, the Director of The Ohio Department of Mental Health. Lt. Woody recently was summoned to Washington D.C. for his expertise in adult educational curriculum modules being proposed for the cross-training of agencies associated with substance abuse, criminal justice, mental health, and services that can be integrated for persons with co-occurring disorders.

Bio-Sketch - Mark R. Munetz, M.D.

Mark R. Munetz, M.D., is Chief Clinical Officer of the Summit County Alcohol, Drug Addiction and Mental Health Services Board and Professor of Psychiatry at the Northeastern Ohio Universities College of Medicine (NEOUCOM). Dr. Munetz received his B.A. from the University of Pennsylvania and is a graduate of the University of Pennsylvania School of Medicine. Dr. Munetz was an intern in psychiatry and internal medicine at the Lafayette Clinic and Hutzel Hospital in Detroit and completed his psychiatry residency at Western Psychiatric Institute and Clinic, University of Pittsburgh. He has held faculty positions at the University of Pittsburgh, University of Massachusetts and Case Western Reserve University. Dr. Munetz has been the Director of Community Psychiatry at NEOUCOM since 1992 where he established a model program for training psychiatric residents to work with individuals with serious mental disorders. He was honored as an Exemplary Psychiatrist by the National Alliance for the Mentally Ill in 1993 and as the NEOUCOM Psychiatry Residency Teacher of the Year in 1999. Dr. Munetz is currently the President of the Ohio Psychiatric Association, a distinguished Fellow of the American Psychiatric Association and a member of the Committee on Psychiatry and the Community of the Group for Advancement of Psychiatry. Dr. Munetz helped plan and implement the first Crisis Intervention Team training program in Ohio for the Akron Police Department and has collaborated with the Akron Municipal Court in its development of one of the first Mental Health Courts in Ohio. He is currently the co-director of the Ohio Coordinating Center of Excellence for Criminal Justice Jail Diversion Alternatives for the Mentally Ill at NEOUCOM..

Law Enforcement Perspective

By Lt. Michael Woody
Retired Director of Training – Akron Police Department
Police Liaison, Coordinating Center of Excellence for Jail Diversion Alternatives for the Mentally Ill

Forward:

This tool kit is a step by step instruction booklet of the necessary parts and pieces that must be in place in order for Crisis Intervention Team (CIT) training and implementation to be the most successful from the law enforcement perspective. It is in chronological order and hopefully easy to follow. It should save police agencies time, money and effort.

Learn from my mistakes.

Backing

First and foremost you must have the backing from the head of your organization. If the Chief of Police is not totally sold on the idea you have no trump card to play when someone above you tries to throw a monkey wrench into the machine.

So, how do you get his/her support? You must make them understand the term "deliberate indifference". They may say they totally understand it, but tell them anyway. I think you will find that they gain a better understanding. Be sure to refer them to the United States Supreme Court Case, Canton vs. Harris, a civil case where the term was first used. In that case the Supreme Court stated that to not teach police officers First Aid on a continuing basis made the city of Canton negligent. It is so likely that an officer will need this skill that to not instruct it on a regular basis was ludicrous.

Then tell the chief that nationwide 10% of the calls an officer goes on involves someone with a mental illness! Ask the chief how much training your department has had in dealing with persons in mental crisis? Ask him/her to show you the records of this training. My bet is that they can't.

Next tell the chief that you want to keep your department and city from being "deliberately indifferent" by giving officers great mental health training to de-escalate persons in mental crisis.

1. note

City of Canton, Ohio vs. Harris et al., 489 U.S. 378 (1989)

Ammunition*

Assure the chief that the training is state-of-the-art and is very cost-effective. The training is actually provided by the mental health system and National Alliance for the Mentally Ill (NAMI) organization in your community. They normally volunteer their expertise to provide this community service work.

When the chief balks because he/she believes that overtime will have to be paid for officers to fill-in while people are in school, remind them of what is done during the summer when officers need vacations. The time-off book is blocked out so that no one can have off other than those on vacation. This is during the summer when you are the busiest. Surely, this is no problem in the other seasons when it is less busy and officers traditionally do not ask to be off as much. (The chief must think outside the box).

If all else fails, remind the chief that by working with the mental health community and NAMI organization the police department is taking community oriented policing to its highest level. Inform him/her that the Akron Police Department received $1.3 million dollars from the federal government for starting a CIT team; and, they were picked as one of 500 grantees out of 18,500 to police agencies as the best use of monies to be showcased by the Department of Justice Services.

If he/she is really hardheaded, just pull out your department's Mission Statement and read it to him/her. I'm sure somewhere in there it talks about "Doing the Right Thing" or forming partnerships with the community! Are these just idle words or does the head of the organization stand behind them? I also bet there is no mention of money standing in the way etched in that "Statement."

If your department has a Vision Statement instead of a Mission Statement, I am positive that linkage to the communities' wishes and doing police work as efficiently and safely as possible are engrained in that expensive plaque! CIT training not only saves injuries to those that have this illness, but also to the officers that use the learned techniques.

**note*

If you are the chief, disregard the first three pages. You must truly be a visionary and committed to making your department the very best. That's probably why you were promoted to this position. You would not dream of letting down the community. You are proactive, not reactive. You are not going to be the one responsible for the million-dollar lawsuit!

Mental Health System Support

If the other non-police parts needed to implement a CIT program are doing their job, it should then be easy for you to find your very much needed counterpart from the mental health system. This person has to have clout and be well respected. Most of all, you must have good chemistry with them. This will make things run much smoother.

This "partner" should be able to line up the necessary speakers to teach the officers. You must add your input to this selection process. Granted, you probably do not know the presenters, but you need to at least get a feel for the kind of person they are. Try to find out how they feel about police officers. Try to make sure they will not bore the officers with technical jargon that wastes the student's time. And, above all, strongly encourage each and every instructor to do an 8-hour ride-a-long in a cruiser before they write up their lesson plans. I believe this will change the thrust of their presentations and make the teaching/learning experience more enjoyable for everyone.

Remind instructors to try to provide time for role-playing on the subject they just taught. Officers love this type of learning, just as most adults do. And, they will remember the role-play long after they have forgotten the lecture.

Role-Playing

A big part of the training involves role-playing. This usually gets the highest ratings on evaluation forms done by the students. You want this to be as realistic as possible. I recommend that you set up a room as an apartment. Set pill and alcohol bottles around and make the place look messy. Find actors that are good.

Try to have several scenarios that cover all the different mental illnesses that an officer is likely to run into out on the street. If using non-police actors, as Akron does, make sure they understand police tactics. I tell the officers to wear their uniforms on this day because I want them to act exactly as they would in real life with the exception of using these new-found skills. Therefore, I warn the actors not to touch the officers – I do not want to see them taken to the ground and cuffed.

The object is for the officers to get the actor to go with them to seek help at an emergency mental health facility. This should not be easy! The actors are also prepped as to negative approaches and words that should set the situation back. We need the officers to learn from their mistakes.

Because role-playing eats up a lot of time, it is best to partner officers up for this training. You and someone from mental health need to monitor the scenarios. If you see that one of the officers is letting the other one de-escalate the situation make sure that the quiet officer is made to interact in the next scenario by telling the actor(s) to key on him/her.

You do not need to let the pair of officers take the scenario from beginning to end. This would not be efficient, as the rest of the students would have a tremendous amount of "down time." In fact, ideally the rest of the class would monitor what is going on in the scenario from another room equipped with visual and auditory abilities. Therefore, this would necessitate a camera and microphones in the scenario room. In Akron we (meaning the monitors) let the scenario go on from 5 to 10 minutes in hopes that the officers will experience a breakthrough with the actor(s). Then we call "break." The officers then leave the room.

We then send in two more officers to pick up from the point that the last two left off. They pretend to be the same two officers so as not to have to keep introducing themselves and starting over.

In this way you can usually put 3 to 4 sets of officers through one scenario with one or two actors. A scenario should not run any longer than 20 - 30 minutes total. All the students get to learn from each others mistakes and a good time is had by all.

As a good rule-of-thumb, I have found that twenty-four (24) officers are about all you can handle in a class because of the time restraints when conducting such comprehensive training. Pairing up officers means that 12 sets of officers need to go through role-play training at least twice. Do the math! Each set of officers in the scenario for 5 to 10 minutes, plus the added down time for such things as scene changes, etc. It adds up. We even have the actors come out after the scenarios are over and give feedback to the several sets of officers they had to interact with.

Faces with the Illness

Some of the most powerful teachers in CIT training are persons who are cursed with mental illness. They put a face with the illness and make a lasting impression. You must screen these potential presenters thoroughly. You need to make sure they are articulate and comply with their medication schedule. And, above all, they must truly like police officers even if they have had a bad experience. NAMI is a good source to find speakers as well as beat officers that work an area with a large amount of group homes or homeless populations.

We have been fortunate to have a psychologist who has schizophrenia and is nationally known and well respected to put a face to this illness. His story shows the brightness of those with this disorder. It is always enlightening for the officers.

We bring in a former homeless person who is very candid about his dual diagnosis and bouts with liquor and drugs to self-medicate. He tells how, when he thinks he is better, he goes off his medication only to find himself back in the deep black hole of his illness.

I also bring in a very good friend of mine who just happens to have bipolar disorder. I met him when our beat officers brought him to me a few years ago. I have learned more about mental illness from him than all the lectures I have listened to over the years.

NAMI

Make sure that the National Alliance for the Mentally Ill (NAMI) is involved with the CIT training. They are very big stakeholders and a valuable ally. You will find them to be wonderful people with hearts of gold. They will be thrilled to help provide a graduation ceremony. Invite them to say a few words of appreciation and let them give the officers the CIT pin while you give them their Certificate of Completion.

It will not be hard for you to find a NAMI parent of someone who is mentally ill who will come forward and tell their heartbreaking story about their child, or children. This disease appears to be hereditary.

The speaker we use has 5 children, but only one has mental illness. She talks about her fear of calling the police when her son is “acting out.” Until CIT, she did not know if the responding officer(s) would over-react and hurt her son. She no longer worries – she just makes sure that CIT trained officers respond by requesting them through the police dispatcher.

Be sure to invite the media to the role-playing and graduation. They eat this stuff up. You will get a positive story about partnering with the community and being proactive. Give all the credit to your visionary chief and the mayor. This will ensure that CIT does not go away in the near future due to politics.

Selecting Officers

This step deals with selecting potential CIT officers to go through the training. Do yourself a big favor and choose wisely. What you want are individuals who want to be involved with the mentally ill and, above all, already have really good communications skills. By picking these types of quality people, the classroom will be alert and active. Stand your ground with the chief or others above you that want everyone trained. "Special people deserve special officers" is our motto.

Let's be realistic here; 40 hours of training on how to deal with the mentally ill is not going to make an officer an expert. To accomplish this, the officer needs the experience. In Akron, CIT officers handle about 4 times as many mental illness calls as they did before they were certified. This experience turns them into experts in time.

If all of your department officers receive the training, they will handle the same amount of calls as they did in the past. They will have more knowledge, but will not become experts. The rule-of-thumb is that one-fourth of your patrol force should be CIT trained. This gives you 24-hour coverage. Non-CIT trained officers can call for a CIT officer to respond to the scene or the dispatcher can funnel these calls to them at the get-go.

In Akron, I took an approach to selecting CIT officers that had never been tried before. I put a brief description of what a CIT officer was in our Daily Bulletin. I further stated that, "If you think you have the qualifications to be a CIT officer, you must type a paper explaining those qualifications. You will then be scheduled for an interview."

My thoughts were that if an officer would put himself/herself though this amount of work and time, they must be truly interested. Three years later, after three annual CIT classes, we have a standing list of potential CIT officers. They are considered by others as the crème of the crop. As a side note, they seem to get promoted more often than other non-CIT officers.

**note*

To keep from being <u>deliberately indifferent,</u> all your officers need more training in how to deal with the mentally ill on calls. In Akron, we mandate that all our personnel (including dispatchers) receive more training. We accomplish this through the relationships we have built with the mental health profession and our own CIT officers who have become experts. An 8-hour course is completed and knowledge learned is tested at the end of the day. If they pass, the officers are given a Certificate of Completion and their test papers attached to a copy. This goes into their personnel file.

Feed & Nurture

You cannot start-up a CIT program in your department and expect it to run smoothly on its own. This is a commonly made mistake. This is your baby! Help it to grow in a positive way. If the officers sense that they have been forgotten, they will lose the incentive to "keep up the good work". They must feel that they actually are a part of a TEAM!

How do you do this? By feeding and nurturing them. If you are not in charge of your Training Bureau, contact them and request any articles that they run across that have to deal with the police and the mentally ill. Log onto websites (such as psychlaws.com) and look for interesting articles. Put these articles in the CIT officers' mailboxes on a regular basis. Line up yearly up-dated training for them. Be sure to ask their input as to what type of further training they would like. Make them a part of the selection process for future CIT hopefuls. In short, keep them involved. Make them feel ownership.

It is a very good idea to establish a form that CIT officers fill out when they handle mental illness calls. This should be funneled to you. In this manner, you can monitor what's going on with each CIT officer and identify problems, etc., as well as keep statistics you can show the chief. Encourage the CIT officers to include any problems they encountered with the hospital, etc., so that you can iron things out with the help of your new-found partner (the mental health system).

Less-Lethal Option

The police are never called “heroes” when they are forced to take the life of a mentally ill person. After all, the public sees them as sick, not as criminals. All of us in police work know that the public thinks we can handle anything and we get that knowledge through osmosis. We are not allowed to make mistakes!

A former police trainer from Salt Lake City, Utah named Dennis Teuller proved a theory he had a few years ago. He proved that an average person holding an edged weapon could run 21 feet and stab an officer before that officer could unsnap his/her holster, draw their gun, aim it and fire one shot. This fact has been highly publicized in police magazines over the years and routinely taught to police officers. But guess what? The public is largely unaware of this important fact!

Through my research and experience I have come to the conclusion that persons with mental illness in crisis oftentimes use an edged weapon as their “protection” against whatever they are being delusional about. Where the “normal” person would drop the weapon when confronted by police officers with drawn guns, the person in mental crisis may not. When told not to come any closer, it’s hard for a “normal” person, let alone a person in mental crisis, to perceive that getting closer than 21 feet from an officer puts them in “imminent danger” and justifies the use of deadly force.

It is my opinion that the mentally ill in crisis have been getting shot in ever increasing numbers because of the “21 ft. Rule” in policing. Now, since CIT officers are going to significantly increase their chances of running into such situations, I believe they need a viable alternative to deadly force. Hence, Akron CIT officers carry the M26 Advanced Air Taser. I ordered this $400 device in yellow (it comes in black also) so that it is easily recognizable and would never be confused as a real, bullet shooting gun. Two probes that are tethered to the Taser can penetrate up to 2” of clothing and make contact with the subject. It delivers 26 watts of electricity that immobilizes the individual immediately. This gives the officers enough time to approach safely and cuff the threat.

When confronted with an edged weapon and given the time, one officer covers the situation with deadly force while the other one uses the Taser. There are no lasting effects from Taser use, except that you usually never have a problem again with this individual on a call. It does leave a lasting impression.

The Taser has been used many times now by our CIT officers with fantastic results. No less-lethal device is full-proof but this is as close as I have been able to find. It definitely has saved officers grief as well as suspects death in our community. I highly recommend it.

**note*

Be wary in interviewing candidates for CIT training that having the "yellow gun" is not their motive. Also, make sure you have meetings with NAMI and give demonstrations of the Taser to put them at ease and get them in your corner on this issue. "Electricity" and "mental illness" are terms that have stereotypes connected with them due to electric shock treatments given to patients in mental facilities (remember the movie "One flew Over the Cuckoo's Nest"?).

Final Thoughts

- There are bound to be items in this tool kit that I forgotten. So, I want you to think of me as a Sears Department Store. I am readily available to send you the needed tools via e-mail (michael.s.woody@earthlink.net) or phone (Home: 330-896-4001 or Work: 330-762-3500). I also make house calls.

  If I do not have the answers to your questions, I can get them from the numerous police and mental health professionals I have built lasting relationships with.

- "Special People Deserve Special Officers"

- "CIT – It's More Than Just Training"
  Major Sam Cochran – Memphis police Department – founder of CIT

The Mental Health System's Perspective

Mark R. Munetz, M.D.
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Co-Director, Coordinating Center of Excellence for Jail Diversion Alternatives for the Mentally **Ill**

CIT: More Than Just Training

There is increasing momentum for communities across Ohio to develop Crisis Intervention Teams with their local police and sheriff departments. We believe strongly in the value and effectiveness of the CIT model and want to encourage communities to start and grow these programs. But a critical caution is necessary at the start. CIT is not a police-training program. CIT is a community partnership and a commitment to community change. This is almost a mantra recited by Major Sam Cochran, of the Memphis Police Department, the first CIT program in the U.S. Sam wants each community to understand that simply training officers about mental illness is not what CIT is about and is not enough. CIT is a commitment for a true partnership between the law enforcement and mental health communities (providers, consumers and family members). It is a commitment from both systems to do things differently. For the mental health system this means:

- Acknowledging that we can no longer afford to avoid working collaboratively with law enforcement, whom we have made unofficially first responders to many mental health crises;

- Acknowledging that people with mental disorders are being arrested and going to jail and prison because of behaviors resulting from untreated or under-treated symptomatic mental illness;

    - It is not acceptable to simply say that people with mental illness need to be held accountable for their actions just like everybody else. A distinction needs to made between holding people accountable for criminal behavior (with criminal intent), and behavior (without criminal intent) resulting from symptomatic illness.

    - It is not acceptable to accept that the mentally ill in the criminal justice system is "their problem" and not our problem.

    - It is not acceptable to use the criminal justice system as a respite from treating the most seriously mentally ill. Out of sight, out of mind simply won't cut it anymore.

- Acknowledge that most mental health professionals have a poor understanding of the nature of police work.

Embarking on a CIT program requires a community to be prepared to work over the long haul, collaboratively, with local law enforcement agencies. This means bringing law enforcement representatives to the table and problem solving together. It means a willingness to be open to learn from each other and to expose each other's limitations ("dirty laundry").

The mental health system that is planning to establish a CIT program must have core mental health services available and accessible. This includes a facility where CIT officers can bring individuals which they have identified in the community as in need of crisis mental health

services. This facility must be open 24 hours per day and have a no reject policy with the CIT officers. The facility must allow CIT officers to drop individuals off and be back on the street within minutes.

Core Element of CIT

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

1. **<u>Volunteer</u>** patrol officers: For large departments, approximately 25% of the patrol force should volunteer and receive CIT training in the first two or three years.

2. A CIT coordinator committed to the program within the police/sheriff department with enough authority to oversee the program within the law enforcement department.

3. A mental health coordinator committed to the program with enough authority to oversee the program from the mental health system side.

4. A mental health system with adequate core services to address the needs of people with serious mental disorders, including a crisis facility open 24 hours per day, 7 days per week. The crisis center must have a no-reject policy and allow officers rapid turn-around time to be back on the street.

5. Trainers who are willing to learn about police work and to become "police friendly" as they provide training to the officers. Trainers must include mental health professionals, family members of individuals with serious mental illness, individuals who themselves have serious mental illness ("consumers"), and people who are able to assist in role-playing to assist officers in developing their de-escalation skills. Trainers should go on "ride-alongs" with police officers to experience what it is like walking in the shoes of police officers.

6. A mental health system willing to provide the training to the officers free of charge.

7. A police/sheriff department willing to provide release time so that officers can attend the week-long training.

8. A week-long initial CIT training class to be repeated annually, at a minimum. The course must include (but is not limited to):

    a. An overview of mental illness from multiple perspectives:
        i. Persons with mental illness
        ii. Family members with loved ones with mental illness
        iii. Mental health professionals
    b. Specific signs and symptoms of particular serious mental disorders.
    c. An overview of psychiatric medications.
    d. An overview of the local mental health system and what services are available.
    e. An overview of mental health commitment law.
    f. Extensive training in how to de-escalate a mental illness crisis.
    g. Extensive practice, through role playing, in the de-escalation of mental illness crises.

h. Field trips which give officers an opportunity to talk with consumers, emergency mental health personnel and to ride-along with case managers so officers get to experience what it is like walking in the shoes of a case manager.
i. A graduation ceremony with awarding of pins and certificates

9. Policies and procedures for the police/sheriff department, dispatch, non-CIT and CIT officers in regards to dealing with the mentally ill. This should include:

   a. A simple documentation process for tracking of encounters between CIT officers and individuals with mental illness ("the Stat sheet").
   b. Policies around the use of force and the availability of less lethal weapons in encounters with the mentally ill.
   c. Stat sheets and other information to be shared on a regular basis with the mental health coordinator.

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

11. Periodic "advanced" training is provided to trained CIT officers. On no less than an annual basis, all CIT officers are offered updates and additional training on new issues related to dealing with persons with mental illness in crisis.

12. Regular recognition is given to CIT officers ("CIT Officer(s) of the Year"). A CIT steering committee of key stakeholders to meet periodically to assure the program stays on course. A local NAMI chapter may want to take the lead in organizing and sponsoring these community celebrations.

Buy In: Backing

CIT may be a hard sell to your mental health community. While deciding to establish a CIT program may seem like a "no-brainer", it actually may require a great deal of courage. Deciding to have the mental health system provide training to police officers so that officers are better equipped to deal with the large numbers of individuals with mental illness that they encounter every day seems like an appropriate thing to do. However, it suggests:

- That the mental health system has been neglectful of this responsibility in the past.
- It can be an expensive time investment of critical clinical staff.

The reality is, however, that it is far more expensive to continue to neglect these important partnerships. Perhaps the most effective advocates for CIT programs are local NAMI groups. Many family members have first hand experience with their ill relatives and law enforcement. One of the hardest and most frightening things a family member may have to do in the course of trying to get help for a loved one is to place a call to the police. If the mental health system is reluctant to embrace CIT, family advocates may be most persuasive.

Mental health agencies may voice concerns about partnering with law enforcement. Agencies and their clinicians may believe:

- They will be asked to see an increasing number of "forensic patients".
- They will be asked to turn their crisis facilities into jails.
- They will become unwitting parties to creation of a "mental health police force".

Mental health systems/boards may believe:

- They will be unable to afford CIT:
    - Systems already have more priority patients than they can currently serve.
    - Systems cannot afford to increase utilization of the state hospital.

The Data: Ammunition

In fact CIT appears to be a remarkably cost effective community program. It is remarkably cost-ineffective to have individuals revolve in and out of county jails, state prisons and psychiatric hospitals. CIT may help slow this process. The Akron CIT experience may help address some of the concerns expressed by the mental health community:

"Forensic patients": The idea that CIT leads to increasing numbers of forensic patients is a misunderstanding of CIT. Forensic patients are people who have been charged with a crime and have been found incompetent to stand trial or not guilty by reason of insanity. CIT is a pre-arrest diversion program, so it is expected that fewer persons with mental illness in a given community will enter the mental health forensic system.

- **In the Akron CIT program only 5.4% of encounters have resulted in arrest.**

Patients with serious mental illness are already encountering the police and going to jail. The police estimate that 10% of their encounters on patrol involve people with mental disorders.

- **In Summit County, in 1996, four years before CIT, 7.9% of people known to have a serious mental disorder had at least one incarceration in the County jail.**

- **Encounters between law enforcement and people with serious mental disorders can be dangerous for both the officers and the consumers. The Memphis CIT program was a direct result of an incident in which a person with schizophrenia was shot and killed by a Memphis police officer.**

The concern that CIT officers will turn our mental health crisis facilities into jails is unfounded. Police officers are committed to public safety above all else and are very capable of distinguishing sociopathy and malingering from real psychopathology. The Akron experience suggests emergency mental health facilities will not be over-run by patients.

- In its three years of operation, CIT officers bring a person to the Psychiatric Emergency Services facility about once every other day.

- About once every three days a person is taken to a local hospital Emergency Department.
  - CIT individuals brought to emergency facilities are much more likely to be calm and cooperative, rather than aggressive and out of control.
  - Emergency facilities do not report **<u>any</u>** inappropriate referrals from the police.

The concern about a "1984"-like mental health police force has proven unfounded as well. Consumers in Summit County are extremely supportive of the CIT program. Members of the consumer-run social center, Choices, take pride in participating in the training and have become comfortable calling for a CIT officer if a member is experiencing a crisis at the Center.

Similarly, family members are very pleased with their encounters with CIT officers. Families feel they can call the police and not fear that harm will come to their loved ones.

The individuals who come in contact with the police are the same individuals targeted as priority populations by the mental health system in Ohio. Individuals with severe and persistent mental disorders, when symptomatic, are at high risk of coming into contact with the criminal justice system. Such people who are encountered by CIT officers can be "intercepted" before they go further into the criminal justice system. If effective treatment is offered following such an encounter, they may be less likely to end up in jail or hospitals again.

- **A prudent mental health system would consider people who have had contact with the police as one of their highest priority populations.**

CIT in Summit County has not led to an increase in state hospital bed utilization. In fact, since CIT began, the ADM board has continued to reduce its contracted bed day utilization with the state.

Police Department Support

Obviously, CIT requires police department support. A "**CIT champion"** must be found to sell CIT within the department. While this could be the Chief of Police, in most large departments it is more likely to be a training officer or other "middle-management" officers who appreciate the need to change how things are done. The mental health community should embrace this police officer and give him or her as much support as possible. There will be no CIT program without a committed leader within the law enforcement department. In Summit County, Lt. Michael Woody became the CIT champion after being invited to join the Board of Directors of a local mental health agency. While on the board he was introduced to the CIT program; he was invited to meet Sam Cochran from Memphis; and his way was paid by the Board to attend the week-long CIT training in Memphis.

Often line-officers and training officers see the value of CIT, but the Chief does not. The mental health community should be willing to use whatever leverage it can to influence the Chief to accept CIT. Board directors, NAMI leaders and/or Board members may use their political influence to convince a mayor, city or county council member, prosecutor or law director that CIT is worth adopting in the given community. Once the Chief sees the effectiveness of CIT, resistance will disappear.

CIT Committee

CIT is a community partnership involving law enforcement, the mental health (and addiction) treatment system, consumers and family members. To plan, implement and maintain CIT, a CIT committee with representatives of the four groups is advisable. This group should ideally begin meeting as a community starts its CIT planning process so that potential barriers can be identified and solved by members of the group. The CIT committee process may help in the final stages of "buy-in" for partners who may still have reservations about going forward with CIT. In addition to barrier busting the committee can be used to begin curriculum development; to assure ongoing "feeding and nurturing' of the program; and to plan for data collection for the purposes of program evaluation.

Curriculum Development

There is no prepackaged CIT curriculum. The 40 hours of training serves multiple purposes:

- It provides basic information about mental illness, mental health, and specific mental disorders, and their treatment to the officers.

- It provides training in specific skills that officers may use to encourage de-escalation of mental illness crises.

- It provides an opportunity for the officer to practice and demonstrate these skills through extensive role-playing exercises.

- It provides an overview of the local mental health system.
    - What services are available.
    - How to access available services.
    - Local interpretation/implementation of the mental health law.

- It provides officers with an opportunity to get to know key players in the local mental health system: providers, consumers and family members.

- It provides officers with an opportunity to experience consumers of mental health services when they are well and able to function as teachers and peers.

- It provides officers with a chance to walk in the shoes of a mental health worker by shadowing a case manager as he/she performs usual duties.

While all CIT curricula have these basic elements, details may look different in various communities. Decisions need to be made as to how much content is emphasized versus process. Some curricula tend to use more panel discussions while others use individual presentations. Some use 90 minute or two hour blocks, while others use shorter, hour-long blocks. The curriculum in Summit County has continuously evolved. For the basic teaching, we have used 50-minute hours. The officers are not accustomed to sitting, and appreciate short breaks between sessions. The de-escalation skills training is given an entire afternoon. We have been adding short sessions with special topics of 30 minutes. A sample curriculum is attached.

The pharmaceutical industry is interested in promoting programs like CIT. One opportunity this presents that we have taken advantage of is the "virtual hallucination" equipment that has been developed by one of the makers of a new generation anti-psychotic medication. All officers are offered an opportunity to understand first hand what it is like to experience hallucinations while trying to carry out an activity. This has been a very well received experience and is worth replicating.

Faculty Development: Selecting Faculty

Just as CIT officers must want to be CIT officers, faculty must want to participate in the CIT training program. Faculty need to be "police friendly". Essentially this means straight talking, without excessive jargon. Faculty is strongly encouraged to go on a ride-along with the local police department before participating in the training. This helps the trainer better understand the nature of police work and conveys to the police the level of commitment of the trainer.

Mental health professionals present most of the didactics; however, we have found that it is most effective to have presentations by consumers and family members very early in the first day of training. This effectively grabs the attention of the CIT trainees and puts a real "human face" on the training. Having a person with mental illness far along in recovery describe his/her experiences with law enforcement when ill is powerful as is hearing first hand from a family member what it is like to call the police concerning a loved one. The consumer presentations are uniformly the best received of all the training and we continue to expand the number of such presentations in our curriculum. Currently we have three different consumer presentations, with one being a consumer-provider working with our system's homeless outreach team.

It is wise to introduce as many of the mental health disciplines to the training as possible. While Summit County is fortunate to have a large number of staff psychiatrists in its agencies and through its affiliation with Northeastern Ohio Universities College of Medicine, most of the didactic lectures can be given by other mental health professionals. The session on the use of psychiatric medications is probably the most critical to be presented by a psychiatrist. In a smaller community with little psychiatric support, it does appear crucial to permit the officers an opportunity to meet that community's psychiatrist(s). In the Summit County curriculum, classes are taught by psychiatric nurses, psychiatric social workers and clinical psychologists. While most of the lecturers come from the local mental health system, we also draw on experts from the Veteran's Administration and neighboring universities.

Summit County has been fortunate to have a psychiatric nurse with previous experience as a law enforcement officer. Such a person is the ultimate in "police friendliness" in that he and officers in the class have an immediate bond based on their shared experience. Many communities may be surprised to learn that such people are available and enjoy participating in the training.

In addition to didactics about mental disorders, it is important that the faculty include people from the legal community who can address such issues as civil commitment and criminal court issues. Enlisting local Probate Court and Municipal Court judges, magistrates and/or probation officers can be very helpful. Early on in the Summit County CIT program, officers had many questions about liability and their legal standing to initiate involuntary hospitalization. The participation of the city prosecutor or law director is critical to address such issues.

Role Playing

A critical part of the training is giving the officers an opportunity, under scrutiny and some pressure, to test out the skills imparted in the classroom. This is best done through role-playing. Role-playing exercises comprise the bulk of our last day of training. Other CIT programs disperse role-playing throughout the week. Either is acceptable.

We believe it is best to use role-playing as a form of final exam. We are fortunate in Summit County to have access to the Center for the Study of Clinical Performance at NEOUCOM. This provides a site and staff that can optimize the role-playing exercises.

The CIT curriculum committee, with a great deal of input from the police departments, develops a series of scenarios in which the CIT officers are asked to intervene. Officers are instructed that these scenarios may or may not involve persons with mental illness. In the Summit County training, the staff of the Performance Center recruits "standardized patients" who are then trained by police and mental health coordinators to play out the role. These patient actors are scripted to a degree and trained about the mental illness that they are asked to portray such that they can improvise based on the CIT officers performance.

CIT officers in training come to the Performance Center in full uniform. They sit together in a large room wired to monitor the room in which the actual role-playing takes place. The role-play room is staged to appear like the apartment or public place described in each scenario. Officers work in pairs, are given a basic sketch of the situation, and then asked to intervene. The goal of the intervention is voluntary acceptance of an emergency or outpatient evaluation. Each pair is given an opportunity to resolve the crisis. Actors are trained to be challenging, so that most scenarios are not easily resolved by the first pair of officers. The police coordinator of the training determines when to "freeze" the scene, at which point the first pair of officers leave the scene and are replaced by another pair. The officers and actors are instructed to resume the scene at the same point in time (i.e., they do not start over). At the conclusion of each scenario, feedback is given and the situation is discussed. The actors also give their feedback about how they found the experience interpersonally with each pair of officers.

We generally have ten scenarios planned and each officer is expected to participate in at least two scenarios during the course of the day. All officers watch all interactions on a video monitor.

Consumer Involvement

As noted above, consumer involvement is critical to the success of CIT. Consumers can and should be involved in a number of ways:

- As members of the CIT Planning Committee;
- As presenters during the week-long and advanced trainings;
- As hosts for site visits at consumer operated service sites; and
- As “trouble shooters” providing feedback should there be problems with the CIT program.

NAMI

In their advocacy role, local and state NAMI chapters may be the catalyst for selling CIT to local law enforcement, mental health, or both. NAMI should clearly be at the CIT planning table; may use the media to push CIT; and should be active participants in the training.

NAMI of Summit County helped our mental health system see the need for CIT. Our local NAMI chapter arranged for the design and creation of the CIT pins that all CIT officers wear on their uniforms after they complete the training. NAMI also hosts the CIT graduation ceremony, awarding pins and certificates and providing light refreshments. NAMI may also choose to hold an annual CIT celebration honoring one or more CIT officers of the year.

Feeding and Nurturing

Lt. Michael Woody (retired) of the Akron Police Department emphasizes that one week of training doesn't make a CIT officer an expert. The ongoing experience is what really makes for the expertise. A critical additional factor is ongoing knowledge and support, what Sam Cochran calls feeding and nurturing of the program. There are several ways the mental health system can contribute to this ongoing program maintenance.

As articles, web sites and other material that might be of interest to CIT officers becomes available the mental health coordinator of CIT should forward these to the police coordinator and request the material be passed on to the CIT officers. As noted above, continued education programs should be offered. We have found it helpful to poll the CIT officers to learn what areas they were interested in getting additional training.

Trouble Shooting

The CIT program needs constant monitoring. We have found that CIT officers identify holes or gaps in the system that will need attention. It is critical that the mental health system address these gaps as best it can to maintain its credibility with the CIT officers. CIT officers are asked to complete a one-page, two-sided form, called a Stat Sheet, whenever they have an encounter with a person they believe to be mentally ill. These forms include ample room for narrative and also request feedback on how they were treated by the facility receiving the patient. Copies of these Stat Sheets are provided to the mental health coordinator of CIT monthly and on an immediate basis if a major problem is identified. The mental health coordinator then follows through, as appropriate, with identified areas of concern brought out by reviewing the Stat Sheets. The CIT officers are very pleased when they identify a problem and learn that it has been addressed and, in some cases, solved. In other cases, mental health and CIT share their mutual frustration that an apparently unsolvable situation has been identified and commit to continue to try to solve the problem.

Program Evaluation

How do we know if CIT is "working"? It is critical to do at least a basic program evaluation. We have found the Stat Sheets very helpful to use as a framework for such an evaluation. We have been able to keep a running cumulative tally, and to compare by month and year the number of CIT encounters and the disposition of the encounters. At the same time we are tracking the arrests and incarcerations of people with known serious mental illness and the admission rate and bed day utilization of the state hospital. More elaborate evaluation of patient outcomes and officer knowledge and attitudes about mental illness are desirable so we better understand "how" or "why" the program is working. The Ohio Department of Mental Health is supporting such research in Summit County and hopes that the information will be useful to your community as you proceed to develop CIT.