Wayne/Holmes CIT Peer Review
June 2018

Michael Woody – CJCCOE Law Enforcement Liaison
Jeff Futo – Police Officer, Kent State University Police Services
Paul Lilley – NAMI Ohio Peer Review Consultant

Wayne/Holmes CIT Peer Review

Wayne/Holmes CIT Peer Review Contacts
Helen Walkerly and Dawn Ross with NAMI,
Jerome Fatzinger and Joshua Miller with Wooster PD

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A. **INTRODUCTION**

In volunteering for this Peer Review, Wayne/Holmes Counties is joining over 23 other counties who have undergone this same process and this can be an opportunity to make the CIT program better and stronger. Most developing CIT programs go through common growth stages. From its inception to a committed group of people that bring an initial training to their community, to a policy driven, data rich CIT program, the core elements provide a way to guide the growth of programs. While the success of CIT program development is impacted uniquely by each community’s leadership commitment and resources, the CIT Program Pyramid depicts these common developmental stages. As the illustration below shows, the Wayne/Holmes has achieved a significant milestone by reaching the fifth phase in their CIT evolution.
While the Wayne/Holmes counties have a long and consistent history of providing CIT trainings, CIT is more than just training. It is a program that saves lives. The reviewers believe that officer and consumer safety is increased and individuals with mental illness are diverted away from jails and gain quicker access to much needed treatment services. Where sound CIT program elements exist like the updating of CIT graduates and the collection and analysis of encounter data, then this impact of CIT programming on a community can be evaluated.

Given the reviewers assessment that the county is not yet at the point of having program elements like those listed beyond the 5th stage, this document will be formatted to stress the reviewers’ assessment of their training program and then provide recommendations on how to address the needed program elements.

B. THE PEER REVIEW PROCESS

The Ohio Criminal Justice Coordinating Center of Excellence (CJ CCOE) was established in May 2001 to promote jail diversion alternatives for people with mental illness throughout Ohio. The Center is funded by a grant from the Ohio Department of Mental Health to the County of Summit Alcohol, Drug Addiction and Mental Health Services Board. The ADM Board contracts with the Northeast Ohio Medical University to operate the Center.

The Criminal Justice Coordinating Center of Excellence (CJ CCOE) desires to work with Crisis Intervention Team (CIT) Coordinators across Ohio to strengthen our collective understanding of the core elements and emerging best practices with CIT. One vehicle of doing just that is through a “Peer Review Process” a voluntary, collegial process building on identifying and coalescing the best elements of CIT programs from across the state and country.

The Peer Review consists of four phases; a Self-Assessment conducted by the county under review; a Desk Audit that provides details on the program and training curriculum, a Site Visit by a team of reviewers; and a written report summarizing the reviewer’s observations.

A telephone conference call was held on Thursday, June 6 among the three reviewers and these representatives of the Wayne/Holmes CIT Program; Helen Walkerly and Dawn Ross with NAMI, Jerome Fatzinger and Joshua Miller with the Wooster PD. During this call the reviewers discussed the nature of the county’s crisis services, the law enforcement recruitment process for the trainings, the pink slip process, the difficulty in collecting encounter data and broader LE participation across the two counties. The issue of “mission creep” within the content of the training program was also discussed. This is a concept that means some sessions within the 40-hour training may not be in keeping with the overarching goal of a CIT course. These topics are addressed in more detail in this report.
The site visit was conducted on June 19th, 2018 by Michael Woody and Jeff Futo with the below members representing the local CIT program:

Helen Walkerly - Chair; Executive Director, NAMI Wayne and Holmes Counties
Jerome Fatzinger - co-chair; Wooster Police Department
Joshua Miller - co-chair; Wooster Police Department
Cindy Kuhl - Wayne County Courthouse, Mental Health Court; Senior ADPO
Betty Riggs - Assistant Director of 911 Dispatch Services, Wayne County Sheriff’s Office
Chief Matt Birkbeck - Orrville Police Department
Dawn Ross- NAMI Wayne and Holmes Counties

This report is a synthesis of what the reviewers found after studying the program self-assessment, conducting the telephone conference call, and attending the site visit. This review is organized into strengths and suggestions related to the C.I.T. training and program. The ultimate test of this Peer Review Process will be if the report helps the County’s CIT partnership to strengthen its program.

C. CIT TRAINING STRENGTHS

1. Mental Health/Criminal Justice Collaboration

Staff from the Wayne/Holmes NAMI program completed a self-assessment of their CIT training and noted these three strengths: Strong committee members who work closely together in planning and managing the training, the majority of speakers have been consistent for several years and have updated presentations as needed, and support of the mental health community evidenced by the ride-alongs, and speakers. The leadership of the local NAMI chapter is a critical aspect to the two-county program as is the commitment from the Mental Health and Recovery Services Board. Since the county began training, the Wayne/Holmes County Mental Health and Recovery Board has subsidized a portion of the training costs. And the program also relies on the State NAMI grants.

The LE commitment to the partnership is to recruit eligible volunteer patrol officers and make the training a priority for these officers just as they would other types of critical firearms or use of force trainings. The local program benefits from the support and involvement of the largest police department in Wayne County, the Wooster PD.

This partnership goes beyond CIT training as well. The area recently completed a Sequential Intercept Mapping process and has a specialized drug and mental health court in Wayne County.

2. Consistent History of providing CIT courses

Since 2005, twelve (12) week-long courses have been provided, graduating over 114 students. Wayne County has graduated 72% (99 out of 137 law enforcement officers) and Holmes County has trained 36% (15 out of 42) of law enforcement officers. Most of the officers trained come from the two largest law enforcement agencies in Wayne County: 24 deputies from the Wayne County Sheriff’s Office and 30 officers from Wooster Police Department (73%). The breakdown
of this data by department by County is provided as Attachment #1. In addition to the core classes, the program has also provided relevant CIT companion courses including most recently in 2017, a 1-day training on Blue Courage and in 2018 a 2-day, 12 hour training on Trauma, PTSD, and Crisis Debriefing.

3. Training content

A review of the week-long training schedule shows a broad range of topics including core trainings on mental illness from clinical, consumer, and family member perspectives. The program offers the opportunity to role-play specific scenarios early in the week as well as a concentrated role-playing block on Friday. Training sessions that scored highest on the last training evaluations from the October 2017 training was the role-plays and the presentation on Blue Courage. The Peer Reviewers want to also highlight the following aspects about the training:

❖ The content for the session on the Pink Slip process was very good and included an actual Pink Slip form with general guidelines on how to appropriately complete the form.

❖ The Developmental Disabilities presentation includes good information related to the scenarios officers are likely to face with an emphasis on behaviors.

❖ The presentation material on Suicide uses the QPR (Question Persuade Refer) acronym for identification of factors related to suicide and the model to assist officers in learning the steps to bring these types of encounters to a resolution.

❖ The use of the evaluation at the end of each day with a wrap-up and a preview of the next day is a nice aspect.

4. Recognition process of the training and program

The local NAMI of Wayne/Holmes Counties provides an annual meeting in which CIT officers are recognized. Such public ways to acknowledge the program strengthens the behavioral health/criminal justice partnership by bringing positive attention to the course. Some CIT programs also conduct award ceremonies and CIT celebrations in their own community. You could also consider recognizing outstanding instructors, chiefs, sheriffs, coordinators, dispatchers, correction officers, and agencies.

D. CIT TRAINING SUGGESTIONS

As Wayne/Holmes County works to improve its CIT Course it should be noted that the CJCCOE has collected many sample curriculum material from other programs throughout the state and has a lending library of videos and curriculum material available for loan to CIT programs. The website can be reached here http://www.neomed.edu/cjccoe/cit/. Specific recommendations provided below that end with the letters “CJCCOE” denote that samples exist if Wayne/Holmes is interested in learning more about the specific recommendation.
1. Review the training content for a balance between primary and secondary training sessions.

CIT programs should seek to develop the “right” balance of training sessions within the total 40 hours and the planning committee should review the overall curriculum to make sure that core training is offered in balance with other trainings. This is one way programs guard against “mission creep”. Primary offerings are generally those sessions that teach the de-escalation skills, role-plays and sessions related to mental illnesses from the consumer, family, and professional perspectives. Secondary sessions related to other types of disorders or populations and community events or services are important but should not crowd out the time dedicated to the core offerings.

While there is no core element that defines what the balance is, the Bureau of Justice Assistance has published: *Effective Community Responses to Mental Health Crisis: A National Curriculum for Law Enforcement Based on Best Practices from CIT Programs Nationwide* which offers this overview:
The reviewers recommend that the local committee review the current training within the context of this best practice model and the consideration of the primary and secondary offerings. By way of example, several blocks of the training included programs available in the community (Specialized courts, Juvenile Justice System, the LOSS team) or included non-core subject matter (Death scene investigations, Determining competency to stand trial) that may be better dropped or key sections integrated into other presentations like the recovery system of care or the legal block.

<table>
<thead>
<tr>
<th>Primary Content</th>
<th>Secondary Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>De-escalation Techniques (3 hours)</td>
<td>Juvenile Justice System</td>
</tr>
<tr>
<td>Role Play (4 hours)</td>
<td>Developmental Disabilities</td>
</tr>
<tr>
<td>Family/Consumer Panel and Recovery Services (2 hours)</td>
<td>Children’s Mental Health Issues</td>
</tr>
<tr>
<td>Suicide</td>
<td>Mental Health Court</td>
</tr>
<tr>
<td>Hearing Voices</td>
<td>Psychotropic Medications</td>
</tr>
<tr>
<td>Emergency Hospital/Commitment process (2 hours)</td>
<td>Expectations of Officers at Death</td>
</tr>
<tr>
<td>Overview of Major Mental Illnesses (3 hours)</td>
<td>Scenes and Loss Team</td>
</tr>
<tr>
<td>Ride-Alongs (3 hours)</td>
<td>Determining Competency to Stand Trial</td>
</tr>
<tr>
<td>Total of 22.5 hours</td>
<td>Addictive Disorders (75 minutes)</td>
</tr>
<tr>
<td></td>
<td>Blue Courage (3 hours)</td>
</tr>
<tr>
<td>(sessions generally 50 minutes unless otherwise noted)</td>
<td>Total of 11.5 hours</td>
</tr>
</tbody>
</table>

2. Review all training for its relevance to the street encounter.

While the first recommendation is related to what is taught, this recommendation is related to how the sessions are taught. All sessions should be filtered through lens of its relevancy to the officer during the street encounter with someone with mental illness. A general example, CIT programs that teach officers about mental illnesses by emphasizing clinical conditions, labels, medications, or diagnoses without an emphasis on the observable characteristics of the conditions. This is particularly critical when it comes to teaching officers about the potential unpredictability related to psychosis. This focus on observable characteristics and officer responses goes to the goal of any CIT course: to increase safety by teaching officers what to look for and the verbal and non-verbal communication skills needed to diffuse the situation. By way of example, the reviewers noted that several of the role-plays centered around the use of alcohol or drugs. The Planning committee should review its role-play selection to make sure that the four major types of crisis are well represented (Depression/Anxiety/Psychoses/Anger). So, while knowledge about the various types of personality disorders, or the definition of the different stages of offender risks may be interesting, focus should be on what officers need to know in identifying and calming someone in a crisis.

One of the reasons the Peer Reviewers noted the Developmental Disabilities presentation is because of the relevancy of what these behaviors look like rather than just an emphasis on the definition of the condition. Also, the outline for the suicide presentation was framed as “what
officers need to know”. By contrast, the training on addictive disorders did not provide information framed this way. Usually these sessions include treating such encounters as medical emergencies and officers can be taught what the observable characteristics of withdrawal from different substances looks like and an emphasis on quickly involving medical services. And the session on children’s mental health issues (no information was provided to the reviewers on this session) should explore how de-escalating kids/families is different than adults and how family interactions and peer influences may affect the officers’ ability to engage in a family crisis.

In addition to a focus on observable characteristics and what it means to the officer to diffuse the encounter, programs are enhancing the quality of training content by adopting a more formal curriculum approach to the training. This is covered in more detail below.

3. Consider “formalizing” the CIT Curriculum (CJCCOE).

Making the training more explicit aids in clarifying what each block of the course aims to accomplish and also makes for easier transitions should CIT instructors and coordinators change over the years. Formalization includes creating “lesson plans” and training objectives (Student Performance Objectives) for each block of training, as well as writing up how the role-plays are facilitated and evaluated. Such formalization can help address mission creep and relevancy to the street encounter as the sessions become more explicit and justified based on the adopted student learning objectives. As an example, a session on Adolescent Issues is presented.

**Topic: ADOLESCENTS**

**Why is this topic relevant to the STREET ENCOUNTER?**

1. Law Enforcement will encounter youth with emotional and behavioral problems. An alarming number of youth with mental health needs struggle in school and at home with undiagnosed and untreated conditions. Increasingly, these youth enter the juvenile justice system. Seventy percent of youth in the juvenile justice system have one or more psychiatric disorders and at least 20 percent of these youth live with a serious mental illness that significantly interferes with their day-to-day functioning.
2. Officers may believe that bad parenting only is the cause of youth with emotional or behavioral.
3. There are some unique differences when de-escalating juveniles than with adults.
4. Command and control approaches with some juveniles may actually escalate the encounter.

**Proposed learning objectives to prepare the officers for such encounters?**

1. Introduce officers to the extent and effects of trauma with respect to youth and families.
2. Learn about the major emotional and behavioral disorders that affect adolescents, including the age of onset for most mental illnesses.
3. Understand how the adolescent brain is wired with respect to the developing frontal lobe (judgment is learned, impulsivity and immaturity in consequential decision making).
4. Learn how adolescent anger is expressed differently than adult anger, address the issue of self harm among adolescents.
5. Explore the tensions around bad behavior equals bad parenting.
6. Identify de-escalation strategies different then the EAR strategies officers can use when they find themselves in an adolescent encounter.
4. Provide more interactive learning opportunities (CJCCOE)

It appears there is a lot of reliance on the use of a PowerPoint and on the lecture type of presentation as a way to relay information. To enhance participant learning it may be helpful to work with each presenter to add other types of learning methods into their presentations such as demonstrations (role-plays), small group learning, visuals and/or interactive learning exercises. There are several videos in the CJCCOE lending library that show such conditions and the officers response to individuals who are suicidal, psychotic, autistic, or a veteran. Another example is to incorporate more the consumer perspective on some of the core training topics of suicide or medication adherence. For example, the presentation on medications could be enhanced by having several consumers who are on various medications talk with the officers on why they take (or don’t want to take) their prescribed doses and the side effects they experience.

5. Review the focus of the various legal blocks (CJCCOE).

While there is emphasis on crisis services and a focus on the pink slip process, there is no legal block that reviews relevant case law related to the legal standards and deliberate indifference, (Olsen v. Layton Hills – 1980), (Walker v. City of New York – 1992) and court decisions on diminished capacity and use of force. Reviewing case laws also provides the context for CIT’s less authoritative de-escalation approach and sheds light on the actual de-escalation skills in such encounters e.g., (Fisher v. Hardin) and corroborations of unconfirmed suicide/mental illness calls; (Griffin v. Coburn) and application of the force continuum on an unarmed, orally ill subject; or (Byrd v. Long Beach) as it relates to expectations around verbal de-escalation. Some legal blocks also cover high-risk cases officers may face, including Excited Delirium. Such cases help to define CIT as liability reduction training.

6. Evaluate the impact of training on officer knowledge/attitude (CJCCOE)

The Wayne/Holmes County program may consider the use of a pre-test/post as part of its class to identify the change in knowledge and attitudes of the officers going through the course. This is an important evaluation on the overall impact the training is having on officers.

7. Site Visits

For the site visits prepare both the officers and the agencies. A 15-20 minute prep talk to the officers advising them of what to expect at the locations, the purpose of why those locations were chosen, and how it relates to C.I.T. is recommended. The agencies would also need an explanation of why they were chosen and how they can communicate information about their services would enhance the site visit. In addition, the speakers at the locations might need an outline of what the officers are learning for them to make the connection between their agency and the C.I.T. training. The C.I.T. site visits are an opportunity for officers to learn about the resources in the community, for them to have a chance to communicate with mental health consumers who are not in a crisis, and for them to increase their empathy towards people with a
8. Diversity training block

The C.I.T. Planning Committee might consider adding a segment on cultural issues as they relate to the police encounter. While it is acknowledged that this is a difficult topic for most C.I.T. programs, it is one of the core training elements. Some C.I.T. programs are exploring this topic through the issue of the culture of poverty and personal bias and how such bias can affect police work.

9. Post-training survey (CJCCOE)

One of the areas of improvement that NAMI noted on the self-assessment was that sometimes there seems to be a disconnect between the training and implementation on the streets. Consider sending a post training survey 4-8 weeks after training to CIT graduates to solicit their feedback on the course in general and the use of their new skill set. Questions to consider for the post-training survey include:

A. Do you believe you are better equipped to respond to a person in mental health crisis and connect them with appropriate mental health treatment, supports and services?
B. Do you believe CIT training has improved your safety on the job? Ask for examples.
C. What Advanced Training topics would be helpful?
D. Would you be interested in serving as an instructor for a future CIT training?
E. Please share an instance where the training you received has been useful in your job. (And ask if you may share that information to help promote your CIT course – on training flyers, letters, newsletters, etc.).

10. Conduct specialized training for dispatchers (CJCCOE)

It should be noted that there is NO Core elements related to specialized training for dispatchers and/or call-takers. That being said, call-takers usually are the first ones to engage an individual with mental illness or possibly a loved one reporting someone in crisis. Wayne/Holmes noted that they are planning their first specialized dispatch training and they should be commended for this. Training call-takers on how to de-escalate these often-emotional calls, keep the person on the line and know when to dispatch a CIT officer is important and is not often part of the 40-hour course for officers. Through specialized training, dispatchers learn not only how to better route such calls but what vital information they can provide to the responding officer related to the special population condition (E.g.: is there a weapon or if the subject is currently taking their medication). The reviewers recommend using actual dispatch calls in their training that reflect the major crisis states of depression, anxiety, psychosis, anger.
E. CIT PROGRAM DEVELOPMENT RECOMMENDATIONS

The CIT pyramid mentioned earlier in this report, illustrated how these Program development phases become more formalized with written policies, procedures, protocols, data collection, and evaluation processes that help build a solid foundation that can better position the program to weather funding and leadership cycles. While all of the phases depicted in the pyramid are relevant to Wayne/Holmes County’s growth of the program, the Peer Reviewers will provide some additional recommendations on where the county may be able to start. As was the case with technical assistance to strengthen the training, recommendations that include “CJCCOE” signifies that sample program materials are available that can benefit the Wayne/Holmes County program.

1. Collect Encounter DATA (CJCCOE)

The Peer Reviewers think this should be one of the first priorities that the law enforcement and behavioral health systems commit to. Formal tracking mechanisms to collect and summarize CIT encounter data across participating departments will serve as a way to evaluate the programs (by encounter outcome), review trends related to these encounters (how the calls initiated and what are the observable characteristics officers are facing), and prepare the content for future core/advance training. This would be helpful in cases of litigation and Grant requests. This could also include annual reports based on analysis of encounter data as well as training numbers. These types of reports can be provided to the Sheriffs and police chiefs and mental health funders supporting the program. It can also be used as a recruitment tool for those law enforcement jurisdictions not yet participating. The CJ CCOE has several examples of encounter data sheets and sample reports available for the Wayne/Holmes County program.

2. Implement policies and procedures that support the CIT program (CJCCOE)

The reviewers did not see any LE CIT policies but were told that Wooster has developed some. Policies and procedures that support the implementation of CIT should be developed across participating LE agencies. Such policies often touch on the role of the crisis intervention officer and scene management, the implementation of encounter data collection, goals related to the percent of officers trained, how dispatchers route calls to CIT officers, the involuntary commitment process, and the hand-off of individuals with mental illness to the mental health system when hospitalization is not warranted. The CJ CCOE has several sample polices available for review. Some of these policies can help LE agencies who are seeking or maintaining CALEA certification. This will help move their training into a true diversion/risk reduction program. In addition, more formalization related to how both law enforcement and the behavioral health system delineate the roles and functions of each system’s CIT coordinator, including how new ones are recruited to keep continuity across the program.
3. Review liability with respect to emergency hospitalization

The reviewers suggest that the counties get legal consultation on its implementation of 5122.10 ORC to see if law enforcement liability can be lessened. The concern is that uniformly across the two counties, officers do not always provide written statements after taking individuals involuntarily to a hospital to be evaluated. The detaining officer should do the required documentation of probable cause when breaking the civil liberties of an individual with mental illness. The form provided by the Ohio Department of Mental Health and Addiction Services is one way to accomplish this. The peer reviewers have noted some instances in other counties where LE completing the emergency hospitalization form even on voluntary clients who meet the criteria provides leverage in those rare cases when someone changes their mind while at the hospital.

4. Review ways to foster and sustain CIT programming throughout both counties

The Planning Committee should continue efforts to reach out to the larger law enforcement offices in Holmes County, especially the county Sheriff’s office to gain greater buy-in to attend the training and subsequent program development. Overall since the two county areas began training, Holmes County has trained 36% of available peace officers and only 4 of those have been from the S.O. since 2005. Currently the CIT training committee meets monthly but has no representation on it form any LE agencies in Holmes County.

There does not seem to be a mechanism to grow the CIT programs throughout the two county areas. While Wooster PD is on the planning committee and is well represented in the training, no other LE jurisdictions have developed CIT policies and none have collected and reported data on CIT encounters.

5. CIT officer recruitment process

There is a core element related to voluntary recruitment of officers. A recruitment process could include a priority given to full-time patrol officers who want CIT training to set the tone for the rest of the patrol officers that would also need to attend the CIT course to garner a full class size.

Full-Time Patrol Assigned officers & School Resource officers should be a priority in filling out a formal application to become a CIT officer. They should have at least 3 years experience, have leadership skills, be emotionally mature, and be recommended by one or more supervisors. Their personnel file should not have recent disciplinary actions or founded complaints. An interview process should take place with one or more supervisors before being accepted into the 40-hr. course (one of which should be the departments CIT Coordinator). They also would agree to wear the CIT pin, handle these additional calls for service, and diligently fill-out and turn in CIT Stat Sheets when handling mental health calls.
One of the areas of improvement noted by NAMI for the Wayne/Holmes training was that “officers don’t always get to choose if they want to attend CIT, some are just told to attend, which doesn’t always make them receptive to the teaching or using the skills they are taught”. Refining the recruitment process as well as implementing the recommendation below could hopefully address this concern.

6. Involve CIT graduates

Consider creating opportunities for the CIT graduates to give back like the Wooster PD has done for the training. Creating opportunities for CIT officers to teach, return to future CIT courses being held, and have a voice in their local CIT program will further deepen the commitment and support of CIT within the departments. Many CIT programs have “graduates” come in on the very first day of the training to talk about how the training has impacted their skill-set and provide examples. Peer to peer learning is one of the most effective tools for CIT. This will create opportunities for the class to hear about how the information they are learning directly relates to being a street officer. CIT graduates can take a larger role in the training, they could be facilitators/evaluators for the de-escalation role-playing block. This latter suggestion is critical for the two county program to develop their own expertise with respect to teaching de-escalation tactics. It may also be helpful to create several positions on the training committee that can be filled by recent CIT graduates.

7. Strengthen how CIT officers are being routed to CIT calls

The Wayne/Holmes communities do not have a crisis stabilization or drop off center available to officers. The emergency rooms at the closest hospitals are being used as the place where officers are taking clients in crisis. Because of the lack of a no-rejection drop off point available to law enforcement, sometimes jail may be used to address individuals with mental illness that have engaged in disorderly conduct or related crimes. Short of having such a facility, the planning committee should ensure that the trained officers are the ones responding to the most difficult special populations’ calls. With specialized training for dispatchers in the planning stages, the requests for CIT officers will likely increase and making sure dispatchers are clear on when to send a CIT officer will be crucial to having that officer work within the system to divert individuals with mental illness from jails.
Attachment #1: Wayne/Holmes County CIT Training Stats

**Holmes County** (4 L. E. Agencies) partner w/Wayne County (12 courses held)
3 officers from Glenmont PD (100%)
4 deputies from Holmes County S.O. (13%) 1 is an Adult Probation officer also.
7 officers from Millersburg PD (78%)
1 officer from Nashville PD (100%)
**Court/Corrections**
4 Adult Probation officers
2 County Juvenile Probation Officers

**Wayne County** (13 L. E. Agencies) partner w/Holmes County (12 courses held)
2 officers from Apple Creek PD (50%)
8 officers from Creston PD (100%)
3 officers from Dalton PD (100%)
5 officers from Doylestown PD (83%)
7 officers from Orrville PD (47%)
2 officers from Rittman PD (25%)
1 officer from Shreve PD (33%)
3 officers from Smithville PD (75%)
24 deputies from Wayne County S.O. (46%) *(1 trained in Medina County)*
2 officers from West Salem PD (100%)
30 officers from Wooster PD (73%)
*1 officer from Medway Drug Enforcement Agency*
Non-Participating L. E. Agencies: Marshallville PD (1); Mount Eaton PD (0)
**Colleges**
2 officers from Ohio State University PD Wooster Branch (66%)
10 Security officers from College of Wooster PD *(3 trained in Medina County)*
**Court/Corrections**
2 officers from Wayne County Municipal Probation Dept.
**Dispatchers**
1 Dispatcher from Wayne County S.O.
**Hospital**
1 E.R. nurse from Wooster Community Hospital
**Other Counties**
1 probation Officer from Ashland & Holmes Counties
1 Ohio State Trooper from Richland County
1 officer from Glenmont PD in Holmes County
INTRODUCTION:

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

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

Goals for CIT Programs:

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

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

Increase the feeling of safety in the general community
Increase law enforcement officer safety

Increase mental health consumer safety

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

Make the mental health system more understandable and accessible to law enforcement officers. Supply law enforcement officers with the resources to appropriately refer people in need of care to the mental health treatment system.

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

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

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

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

1. **Selection of CIT officers:**

   **For large law enforcement agencies:**

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

   A written application to join the program.

   An interview to determine motivation to become a CIT officer.

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

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

   **For small law enforcement agencies:**

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

For Medium-sized law enforcement agencies:

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

2. Size of CIT force

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

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

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

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

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

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

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

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

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

4. There will be a mental health coordinator(s) committed to the program that will serve as the contact person(s) for the law enforcement agencies in the jurisdiction(s) served by the mental health board or providers.
Ideally this coordinator will have enough authority to oversee the program from the MH system side.

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

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

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

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

Without hassle (i.e., “no reject policy”)

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

Such facilities may be free standing crisis centers or hospital emergency departments.

Such facilities would have 24/7 availability.

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

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

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

6. Trainers who are willing to learn about police work and to become “police friendly” as they provide training to the officers. Trainers must include mental health professionals, family members of individuals with serious mental illness, individuals who themselves have serious mental illness (“consumers”), and people who are able to assist in role-playing to assist officers in developing their de-escalation skills.
Efforts will be made to help trainers prepare for CIT presentations. Trainers need some basic knowledge about the nature of police work, police culture and how police officers best learn. These efforts may include:

A pre-class meeting with trainers.

A train the trainers meeting.

Written communication with the trainers.

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

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

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

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

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

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

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

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

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

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

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

9. An intensive CIT core training class that should be held at least once a year.

For urban communities, this training should be a weeklong, 40-hour training. (Some rural communities believe they can accomplish the goals of the training in less than 40 hours. There is a lack of consensus among this group on this issue.) The course emphasizes that CIT is a partnership between law enforcement, the mental health system, mental health advocacy groups, and consumers of mental health services and their families. As such, trainers include representatives of all identified stakeholders. The intensive training attempts to provide a common base of knowledge about mental illness (a basic foundation from which officers can build). The course is not aimed at making CIT officers mental health professionals. The course is intended to provide officers with skills to:

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

  - An overview of mental illness from multiple perspectives.
  - Persons with mental illness
  - Family members with loved ones with mental illness
  - Mental health professionals These perspectives may be provided by individual consumer and family presentations or by panels of several consumers or family members. Substantive amounts of interaction between CIT officers-in-training and mental health consumers and their families will make the core training session more effective.
  - Specific signs and symptoms of serious mental disorders.
The kinds of disturbed behavior officers will see in people in a mental illness crisis should be emphasized.

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

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

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

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

An overview of psychiatric medications.

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

An overview of mental health commitment law.

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

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

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

A graduation ceremony with awarding of pins and certificates.

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

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

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

   With input from the CIT officers in the field, advanced CIT training is offered annually.
12. The law enforcement department will develop policies and procedures to effectively interact with people in a mental illness crisis. This will address the roles of dispatchers, CIT officers, and non-CIT officers. These policies will include:

   a. Simple documentation process for tracking of encounters between CIT officers and individuals with mental illness (“the Stat sheet”);

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

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

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

   Sharing of statistics kept on various aspects of the program

   Sharing of stat sheets (see 12.b above)

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

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

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