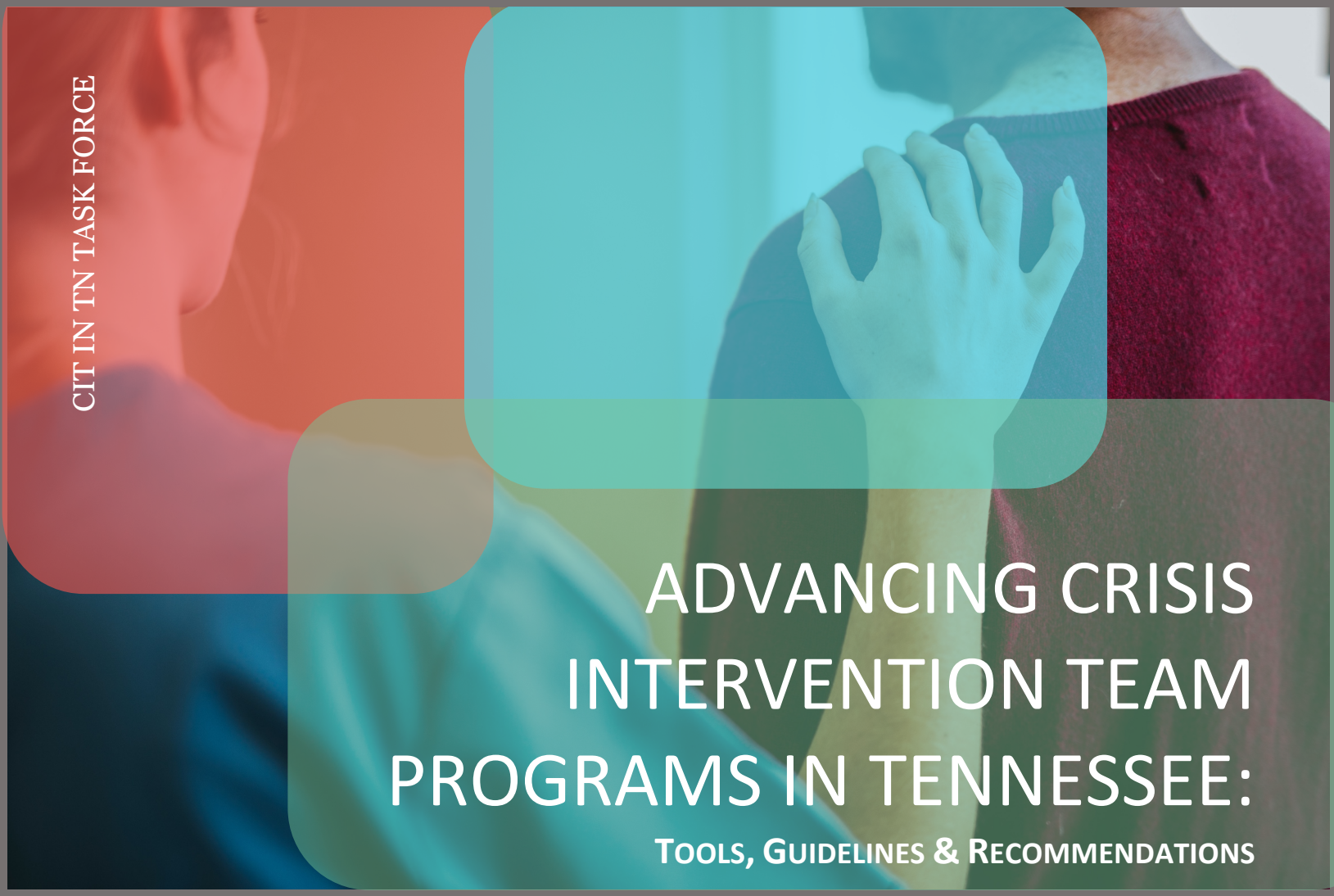
March 2019

CIT IN TN TASK FORCE



ADVANCING CRISIS INTERVENTION TEAM PROGRAMS IN TENNESSEE:

TOOLS, GUIDELINES & RECOMMENDATIONS

TN Department of Mental Health & Substance Abuse Services
TN Department of Correction
NAMI Tennessee
National Alliance on Mental Illness

From the CIT in TN Task Force

Advancing CIT in Tennessee offers a road map for the continued development and enhancement of Crisis Intervention Team (CIT) programs toward an effective statewide system in Tennessee. Created through a collaborative, multi-stakeholder approach, this report was designed as a guiding document for policymakers and practitioners in developing and sustaining a statewide network of local CIT partnerships.

The first CIT program was established in Memphis, Tennessee in 1988 and has grown to become a globally recognized model for safely and effectively responding to behavioral health crises in the community. This report builds on the pioneering work of the "Memphis Model." The recommendations offered are intended to complement the core elements of this gold standard CIT model with strategies that address the opportunities and challenges unique to our state. The report includes the latest CIT tools and resources to support local partnerships in developing and sustaining the CIT program that works best for their community.

The CIT in TN Task Force will continue to be a voice for the needs and priorities of the local partnerships between police, the behavioral health system and providers, and individuals and families affected by mental illness and substance use disorders that are central to the ongoing success of CIT programs. It is our hope that this report will contribute to the adoption of consistent guidelines and build broad support for the implementation of a statewide network of local CIT partnerships committed to enhancing both public safety and community health.

Planning Committee

TN Department of Mental Health & Substance Abuse Services

TN Department of Correction

NAMI Tennessee

CIT in TN Task Force Member Organizations

CIT International

Collierville Police Department

Davidson County Sheriff's Office

Disability Rights Tennessee

TN Division of TennCare

Hamilton County Sheriff's Office

Helen Ross McNabb Center

Madison County Sheriff's Office

Memphis Police Department

Mental Health America of Middle TN

Mental Health Cooperative

Volunteer Behavioral Health Care System

National Health Care for the Homeless Council

Ridgeview Behavioral Health

Rural Health Association of TN

Tennessee Association of Alcohol, Drug, and other Addiction Services (TAADAS)

TN Association of Recovery Court Professionals

Tennessee Emergency Communications Board

Tennessee Hospital Association

TN Association of Mental Health Organizations

Tennessee County Services Association

West Tennessee Healthcare

TN Disability Coalition

TN Mental Health Consumers' Association (TMHCA)

TN Office of Criminal Justice Programs

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Executive Summary

There is growing public support and bipartisan action focused on reducing the number of people with unmet behavioral health needs entering Tennessee's criminal justice system and improving access to community-based behavioral health services. Tennessee's renewed investment in pre-arrest diversion supports local efforts to connect Tennesseans in crisis to appropriate community-based services as an alternative to jail. By diverting individuals to appropriate care and avoiding the criminal legal system, local communities alleviate jail and courtroom overcrowding, while reducing the local tax burden, and achieving better health outcomes.

Despite increasing support for behavioral health and crisis services, Tennesseans experiencing a behavioral health crisis in the community are more likely to encounter police than health professionals. As the de facto first responders to behavioral health crises, law enforcement personnel play a critical role as system 'gatekeepers' to the spectrum of available community mental health and crisis services. Without the resources police officers need, such as specialized training and alternative diversion options, behavioral health emergencies can too often lead to unnecessary incarceration, serious injury or death. Recognizing these critical policing and behavioral health challenges, many Specialized Policing Responses (SPRs) have been developed to bridge the gap between systems. The most recognized and widely disseminated SPR is the Crisis Intervention Team (CIT) program, which has shown to improve officer and community safety, reduce costs associated with incarceration, and appropriately redirect individuals in a behavioral health crisis away from the criminal justice system to community-based behavioral health services.

Established in Memphis, Tennessee in the late 1980s, today there are more than 3,000 local and regional CIT programs across the United States and, increasingly, internationally. Despite its global reach, CIT's implementation across Tennessee has been varied and uneven. In the last year, work to expand CIT programs has been supported by the CIT in TN Task Force, which represents a broad range of stakeholders that have come together to create a strategic plan and road map for continued development of CIT programs toward an effective statewide system. Findings from key informant interviews with CIT partners, surveys of local police departments and sheriffs' offices, and input from the CIT in TN Task Force members, indicate the need and

broad support for greater law enforcement-behavioral health collaboration and the expansion and enhancement of CIT programs.

Advancing CIT in TN provides the latest tools and resources to support local partnerships in developing and sustaining CIT programs, describes the current status of CIT programs and training in Tennessee, summarizes the planning initiative's activities and findings, and makes recommendations to expand and sustain CIT programs and infrastructure in alignment with ongoing criminal justice and behavioral health reform efforts. Several next steps in expanding and enhancing CIT programs statewide are recommended, including:

1. Identify stable funding to support CIT program development and implementation activities, including support for a full-time statewide CIT coordinator and increased training and train-the-trainer programs.

2. Promote the adoption of CIT programs in all communities served by existing and future pre-arrest diversion centers. Promote the better integration of behavioral health- justice programs in counties or communities with multiple interventions, including liaison and diversion services, CIT, and mobile crisis services.

3. An online CIT toolkit of action steps, best practices, and resources for local community partnerships in Tennessee interested in developing or strengthening CIT programs.

4. Formalize the CIT in TN Task Force as the guiding body for local CIT partnership development and implementation.

5. Build broad support for recommended minimum standards for developing, implementing and sustaining CIT programs.

6. Organize and provide regional trainings and guidance on program evaluation to monitor outcomes of the local and state efforts.

7. Facilitate local participation in national initiatives like the Stepping Up Initiative and the One Mind Campaign that are dedicated to helping communities assess and revise local systems and resources to respond and treat people with behavioral health concerns outside the justice system when possible.

Introduction

Background

The chronic underfunding of community mental health services nationally, along with the longstanding lack of collaboration between justice and public health systems, has resulted in law enforcement serving as the nation's de facto first responders to behavioral health crises. More than a quarter of people with mental illnesses have been arrested and people experiencing a behavioral health crisis in the community are more likely to encounter police than a health professional. Research shows that between 7-10 percent of all police calls involve a person with mental illness.[1–3] Nearly all states have some minimum training standards related to police encounters involving people with mental illnesses and de-escalation strategies. There is, however, tremendous variability in the number of hours and types of training approaches used and significant challenges to integrating specialized training.[4] Police themselves are affected by their encounters with individuals in crisis and often report insufficient training and frustration in accessing alternative diversion options.[5]

Without the resources police officers need, such as specialized training and accessible community behavioral health services, behavioral health emergencies too often lead to unnecessary incarceration, serious injury, or death. While national data on police-involved shootings are not systematically tracked, a number of reports and independent initiatives estimate that at least one in four people fatally shot by police has a serious mental illness.[6–9] In response, there has been growing support for law enforcement agencies to have specialized police responses (SPRs) to behavioral health crises and for improved collaboration between police and behavioral health providers and system partners.

The most recognized and widely disseminated SPR is the Crisis Intervention Team (CIT) program model, which is founded on a partnership approach between police, treatment providers and behavioral health agencies, and individuals and families affected by mental illness and substance use disorders. According to the University of Memphis CIT Center, there are more than 3,000 local and regional CIT programs and the model's widespread use has been endorsed by a long list of law enforcement, behavioral health and advocacy organizations.

CIT National Endorsements and Initiatives

American Medical Association: Mental Health Crisis Interventions H-345.972 support for crisis intervention training programs for assisting individuals with mental illness, such as the Crisis Intervention Team model programs…supports federal funding to encourage increased community and law enforcement participation in CIT programs.

CIT International: a nonprofit membership organization whose primary purpose is to facilitate understanding, development, and implementation of Crisis Intervention Team (CIT) programs throughout the U.S and worldwide by providing technical assistance, disseminating recommended standards, support research and holding an annual conference

International Association of Chiefs of Police (IACP): It's *One Mind Campaign* asks agencies to sign on and to agree to: providing CIT training to a minimum of 20% sworn officers, establishing partnerships with mental health agencies, implementing a model mental health crisis response policy, and training 100% of sworn officers in mental health first aid.

Mental Health America Position Statement 59 supports the adoption of CIT training to police officers so that officers with CIT training are available on every shift. CIT training and implementation should incorporate collaboration with local mental health providers and advocates.

National Alliance on Mental Illness (NAMI): Affiliates and State Organizations have a long commitment to CIT and have helped expand CIT programs to over 2,700 communities. Local NAMIs serve a key role in bringing together partners, advocating for needed services, cheering on progress and ensuring the inclusion of people living with mental illness and their families. NAMI has online toolkit for developing and sustaining CIT programs

National Criminal Justice and Public Health Alliance A national convening of 60 criminal justice advocates and public health practitioners co-convened by the Vera Institute of Justice and Human Impact Partners. Its *Healthy Solutions Create Safety* identifies CIT programs as justice system innovation that supports health among a menus of replicable programs and interventions that respond to social challenges with public health solutions.

President's Take Force on 21st Century Policing (2015): Report recommends Peace Officer and Standards Training (POST) boards include mandatory Crisis Intervention Training…as part of both basic recruit and in-service officer training. [I]

Substance Abuse and Mental Health Services Administration: Published *Crisis Intervention Team Methods for Using Data to Inform Practice: A step-by-step Guide* (2018) to support CIT partnerships in improving data collection efforts

U.S. Department of Justice, Bureau of Justice Affairs: Has long promoted CIT as best practice specialized policing response. The Police-Mental Health Collaboration Toolkit provides resources for law enforcement agencies to partner with mental health providers to establish CIT programs and effectively respond to mental health crisis events.

Vera Institute of Justice: Serving Safely is a national initiative designed to improve interactions between police and persons affected by mental illnesses and developmental disabilities. In partnership with BJA, Vera is offering free remote and on-site assistance to PDS through training, evaluation and guidance. Participating subject matter experts and partner organizations include: the American College of Emergency Physicians, The Arc, CIT International, NAMI, the National Disability Rights Network, UIC Jane Addams College of Social Work, and the Prosecutor's Center for Excellence.

[I] The report endorses mandatory CIT training for officers, which is contrary to the CIT model and to this initiative's guidance and recommendations for Tennessee.

Figure 1: *National endorsements and initiatives supportive of CIT*

What is CIT?

The CIT program model was developed in the wake of the 1987 Memphis police shooting death of Joseph DeWayne Robinson, a 27-year-old black man with schizophrenia who was wielding a knife outside his home and threatening to harm himself. [10] In response to public outrage, the city convened a task force of representatives from law enforcement, the mental health system, advocacy organizations, and academic institutions. Building on this collaborative approach, the CIT program model was created to be a partnership among police, behavioral health providers, and individuals and families affected by mental illness with the aim of preventing violence, avoiding unnecessary arrests, and improving access to mental health services. [11,12]

The CIT model's core components for safely and effectively responding to behavioral health crises in the community include: 1) 40-hr voluntary training for police officers (and other key stakeholders, including other first responders, hospitals, and treatment providers); 2) the availability of a "no refusal" therapeutic drop-off center where law enforcement can bring individuals as an alternative to jail; 3) coordination and partnerships with other health and crisis response systems; and 4) the leadership of and meaningful participation of advocacy groups, families, and individuals with mental health conditions and substance use

Enhanced CIT Program Spotlight:
San Antonio's Smart Justice

San Antonio, Bexar County, Texas, *developed a multi-pronged, public health-oriented policing model they call "smart justice." The Bexar County police, county jail, mental health department, criminal courts, hospitals, and homeless programs pooled their resources* ***to develop a 40-hour crisis intervention training (CIT) curriculum*** *to include in police training, establish six-person mental health squads who answer emergency calls where mental illness might be an issue, and create two drop-off centers—both a short-term crisis center and a restoration center, which is a separate facility that houses a 16-bed psychiatric unit, a medical clinic, and a "sobering room." These two centers give law enforcement options other than arrest and booking into jail when dealing with people with mental illness or substance use disorders who are in crisis.*

Outcomes:

- Diverted more than 20,000 people from jails and emergency rooms since 2003
- County jails under capacity;
- Diversion has saved San Antonio more than $50 million;
- Pre-booking programming, **including CIT training** and drop-off centers, save the criminal justice system and community treatment system more than $1.2 million during the 6 months immediately following diversion;
- Helped reduce the amount of time police spend escorting people to emergency rooms.

Figure 2: Excerpt from Cloud D, Davis C. *First Do No Harm: Advancing Public Health in Policing Practices*. Vera Institute of Justice; 2015.

disorders in the training and program operation. Ongoing, operational, and sustaining elements of the CIT program model are described in detail in *Crisis Intervention Team Core Elements*.[13] See **Figure 3** for a summary of the core components.

As the CIT program model has developed and expanded across diverse communities, there has been considerable variation in the implementation of the core elements. Many jurisdictions are unable to adopt every component of the CIT model, either because they lack the resources or capacity or because they do not consider particular components essential.[14] Other jurisdictions have implemented further enhancements to CIT programs, including:

- **Earlier interventions to prevent police contact:** In the Neighborhood Outreach Scheme (NOS) program, a community psychiatric nurse accepts referrals from police and mental health specialists to follow up with vulnerable people who do not meet thresholds for mental health/criminal intervention.[15]
- **Hiring full-time clinicians into law enforcement** as well as other co-responder models of police behavioral health triage, and follow-up linkage teams
- **Information sharing tools:** Seattle, WA and Albuquerque, NM PDs use the RideAlong app, which provides first responders with key background information about people with behavioral health conditions to help officers more effectively de-escalate situations.
- **Implementing CIT and Mental Health First Aid (MHFA) for Public Safety training conjointly:** See **Figure 4** for a comparison of CIT and MHFA.
- **Warm lines:** Many jurisdictions use "warm lines" that can serve as a resource for people struggling with behavioral health issues. Unlike hotlines, warm lines hope to help people before they reach a point of crisis.
- **Continued education, training and support:** The Vera-led Serving Safely initiative offers free remote and on-site assistance to local law enforcement agencies through training, evaluation and guidance around related to people living with mental illness and developmental disabilities. In New Mexico, the CIT ECHO program connects law enforcement agencies across the state and country to an online classroom where CIT experts and psychiatrists review behavioral health topics and debrief complex cases with officers. Additional recommended behavioral health education beyond the core curriculum includes homeless challenges, ACEs and juvenile issues, officer wellness, and returning veterans needs/PTSD/Traumatic Brain Injuries.

CIT Core Elements

Ongoing Elements

1. Partnerships
   - *Law enforcement:* leadership, dispatch, CIT officers, regular patrol officers, corrections
   - *Other first responders:* Emergency medical services (EMS), criminal justice liaisons
   - *Health service providers:* behavioral health treatment providers, case workers, hospital emergency departments, spectrum of crisis services (mobile, walk-in, CSUs)
   - *Individuals and families affected by mental or behavioral health disorders,* particularly those with history of criminal justice involvement to provide valuable insights about lived experience and policing

2. Community ownership: Local advocacy organizations, individuals and families directly affected by CIT program serve in a leadership capacity in all aspects of the program

3. Policies & procedures: Guidelines that direct CIT program actions and support coordination among and between law enforcement, behavioral health providers, and other stakeholders (Training, PD policies regarding: # of CIT-trained officers, role and protocols for dispatchers, transport, BH receiving facilities, data sharing)

Operational Elements

1. CIT: Officer, dispatcher, coordinator: Voluntary personnel required to effectively operate a CIT program to include CIT officers, emergency dispatchers, CIT Coordinators (law enforcement coordinator, behavioral health coordinator, advocacy coordinator, program coordinator)

2. Voluntary CIT training: 40-hour training for CIT patrol officers & training for emergency dispatchers

3. Behavioral health receiving facility: Designated therapeutic receiving facility as alternative to jail

Sustaining Elements

1. Data collection: To document program activities, inform program improvements, demonstrate effectiveness, etc.

2. In-service training: Regular and ongoing training and education for CIT trained officers

3. Recognition & honors: Award ceremonies, certificate of recognition, annual banquets as an incentive for specialized work
4. Outreach: Outreach efforts with local communities and regional and state stakeholders to strengthen and expand program activities.

Figure 3: *Crisis Intervention Team Core Elements*

Evidence for CIT

Research shows that CIT programs are an effective intervention for diverting people in crisis from jail. Police who receive CIT training are significantly more likely to transport a person to a treatment facility or refer them to services in community and less likely to make an arrest than officers without training (although this is influenced by the nature of the incident and the availability of behavioral health services).[15–17] Research shows that CIT programs:

Improve officer-level attitudinal & behavioral outcomes

Participation in CIT improves officers' knowledge, attitudes and stigma regarding certain mental health conditions.[18,19] Several studies have demonstrated significant reductions in use of force preferences and perceived effectiveness of physical force among CIT-trained officers.[20,21] Several studies examining dispatch and police call data pre/post CIT program implementation found significant increases in identified mental health calls, transports to emergency treatment, and proportion of transports that were voluntary.[22] In a study comparing arrest rates of three separate police-led mental health diversion programs —in Birmingham, AL, Knoxville, TN and Memphis, TN—the lowest arrest rates were found in the CIT model. Among all three jurisdictions, between 2 and 13 percent of mental health-related calls resulted in arrest.[23]

Produce cost savings

It is difficult to estimate exactly how much diversion programs can save communities, but incarceration is costly compared to community-based treatment. A study of a CIT program in Louisville, Kentucky indicated modest savings, estimating that CIT saved $3.5 million annually in deferred hospital and jail costs, with net savings of over $1 million annually after accounting for program costs.[24] Implementing CIT programs have also shown to reduce costs associated with the use of SWAT call-outs.[25]

Reduce officer injury

Adopting CIT improves occupational health outcomes of police officers by improving their ability to safety de-escalate situations without resorting to the unnecessary use of force.[26–28]

Keep law enforcement's focus on crime

Some communities have found that CIT has reduced the time officers spend responding to a mental health call. This puts officers back into the community more quickly.[29]

CIT or Mental Health First Aid?

Crisis Intervention Team (CIT) programs and Mental Health First Aid (MHFA) are two of the most widely utilized mental health/ crisis training programs for law enforcement and other first responders. Both programs can be effective tools for improving police responses to community behavioral health issues. The two programs can supplement each other, and it is important to recognize their differences and similarities.

CIT	MHFA
40-hour advanced officer training, which includes deeper immersion in behavioral health issues and peer participation in the classroom. Recognized as the 'gold standard' response model. CIT is a community collaborative partnership program, and training is one component. Partnership with behavioral health and public health systems is central to CIT. CIT is designed to prepare and transform the outcomes of a community's day-today crisis response through providing law enforcement 24/7 accessibility to care without 'triage' Most effective when experienced officers attend voluntarily. Programs aim to train 20-25% of a department's patrol officers By using these complementary programs conjointly, communities can eliminate gaps, leading to a large-scale, sustainable systems response.	8-hour codified training to provide general awareness of mental health issues. Includes information and skills to support someone in a behavioral health crisis *Benefits include:* Evidence-based best practice run by the National Council for Behavioral Health; Short training commitment; System in place for vetting adequately trained instructors The National Council has long held that MHFA is not a replacement for CIT and should instead be incorporated into existing CIT programs as an enhancement. In addition to specialized CIT response, all law enforcement should possess basic behavioral health education. MHFA provides adequate basic mental health and substance use disorder education. Providing department-wide MHFA training during in-service, academy, or other times, is an effective complement to a CIT program.

Figure 4: Comparison of CIT and Mental Health First Aid training. Adapted from *Mental Health First Aid or CIT: What Should Law Enforcement Do?* CIT International and the National Council for Behavioral Health, 2017.

The CIT program is widely recognized among policymakers, scholars and practitioners as an established gold-standard model that has proven effective across a variety of communities and jurisdictions. Depending on the outcome of interest, CIT can be considered an evidence-based practice. Yet devising practicable approaches to more rigorously assess CIT remains a challenge. One of the primary challenges is that the flexibility built into the CIT model has resulted in tremendous variation in the program's implementation. While it is difficult to disentangle the effects of CIT training versus the implementation of other core elements of the model, there is general consensus in the literature that the two key factors of program success are the existence of a therapeutic drop-off or receiving facility and the strength of the community and interagency partnerships.[11,23,30] Statewide CIT efforts can play an important role in supporting program fidelity and are often uniquely positioned to address the moderating factors that underlie program success.

Statewide CIT Programs

While the CIT program model is designed as a local community partnership—and law enforcement training decisions are mostly under local agency/ training academy control—states can assume a leadership and coordinating role for CIT program and training development and implementation. Statewide efforts can play a supportive role for local CIT efforts by encouraging programs to adhere to CIT core components and best practices, organizing regional approaches when needed, recruiting new jurisdictions, coordinating efforts of smaller jurisdictions, supporting uniform data collection, developing standardized curriculum, and coordinating CIT training activities.[31]

Today there are nearly 20 states implementing statewide CIT efforts. Whether led by an advocacy organization, state behavioral health agency, law enforcement agency, or some combination, state-led efforts can address some of the major obstacles to implementing the CIT model with full fidelity, such as community size, staff and time constraints, the lack of financial and community mental health resources (particularly evident in small, rural jurisdictions with fewer available behavioral health services), and limited collaboration or distrust between community stakeholders. See **Figure 5** for examples of statewide CIT efforts. For more examples, see the Bureau of Justice Assistance's *Statewide Law Enforcement/ Mental Health Efforts: Strategies to Support and Sustain Local Initiatives* (2012).

State	Lead Agency (Type)	Overview
Connecticut	Connecticut Alliance to Benefit Law Enforcement (Advocacy)	• CABLE is 501c3 grassroots research & training collaborative • Leads CIT and peer support training • Is an associate member of the state police association & includes law enforcement on board
Georgia	NAMI GA (Advocacy) & Georgia Bureau of Investigation (Law enforcement)	• 2 co-admins (NAMI GA & GBI) • Developed standardized CIT curriculum • Coordinate trainings, including annual refresher • POST approved CIT training and in-service training provided the GA Public Safety Training Center
Ohio	Criminal Justice Coordinating Center of Excellence (Behavioral health agency)	• Dept Mental health developed and funds the CJCCE, a center dedicated to promoting sequential intercept mapping • Embedded within state mental health system, which have influence over distribution of funds and types of services delivered • State strategic plan to have fully developed CIT program in every county (with every law enforcement agency in the county participating)
Oklahoma	OK Dept of Mental Health & OK City Police Department (Joint behavioral health/ LE)	• BJA grant-funded training administered through Dept of Mental Health in partnership with OK City PD • Officer and dispatcher training to over 1,000 LE personnel since 2003
Utah	Salt Lake City Police Department (Law enforcement agency)	• Salt Lake City PD serves as lead administrative agency for state CIT program • Chosen as CSG DOH Law Enforcement/ Mental Health Learning site • Buy-in from law enforcement. However, some resistance to a single local agency trying to coordinate statewide program
Virginia	Virginia Crisis Intervention Team Coalition (multi-stakeholder) & Virginia Department of Behavioral Health and Developmental Services	• State funded. State program works alongside leadership from Coalition, who co-developed CIT guidance document to establish consistent minimum requirements • Originated as nation's first rural, multi-jurisdictional CIT program before expanding statewide
Wisconsin	NAMI Wisconsin (Advocacy) See FAQ	• CIT/CIP Expansion grant: WI state legislature created a statute to support CIT/CIP (corrections training) that provides $250,000 biannually to expand and develop CIT program to NAMI WI

Figure 5: Statewide CIT Efforts. Other documented statewide CIT efforts include- California, Florida, Illinois, Kentucky, Maine, Minnesota, Missouri, New York, North Carolina, Pennsylvania and Washington

CIT in TN: Statewide CIT Planning Efforts

Since its formation in Memphis in 1988, the CIT program's implementation across Tennessee has been varied and uneven despite the ongoing need. There have been earlier attempts to expand the use of CIT programs across the state, but there has not been a sustained or coordinated statewide effort to support CIT programs or to integrate the model in the planning and development of behavioral health crisis response strategies. However, in response to

Tennessee's opioid crisis and its morbid and mortal consequences, there has been increasing support for investments in the behavioral health crisis care continuum including treatment-based alternative responses to arrest. Renewed interest in CIT, as one component of the range of services provided to those experiencing a behavioral health crisis, led the state to establish a strategic collaboration between Tennessee's justice and behavioral health systems to expand and sustain CIT programs. Through the support of the U.S. Department of Justice's Justice and Mental Health Collaboration Program (JMHCP), *CIT in TN* partnered TDMHSAS, TDOC and NAMI TN for a planning initiative and collaborative task force to create a strategic plan and road map for continued development of CIT programs toward an effective statewide system.

Beginning in the spring of 2018, the *CIT in TN* planning initiative led a series of activities toward better understanding the state's CIT practices and practice gaps. These activities included: convening a task force composed of representatives from law enforcement, behavioral health, advocacy organizations, and other key CIT stakeholders across the state; developing specialized work groups to establish CIT component guidelines and recommendations; interviewing key informants and CIT partner participants to develop an inventory of all CIT programs statewide; conducting a survey of all 95 county sheriff's offices and municipal police departments across the state on their interest, usage and capacity for developing or enhancing CIT; and researching CIT best practices and practice gaps in other parts of the country.

CIT practices in Tennessee

Thousands of Tennessee law enforcement officers, 911 and crisis line operators, behavioral health clinicians and other medical staff, peer support specialists, consumer advocacy organizations, and individuals and families affected by mental illness have participated in CIT program and training activities since the model's inception in Memphis in the late 1980s. Yet the extent of the program's adoption and implementation statewide has not been systematically studied. In 2009, the University of Memphis' CIT Center led a DOJ-funded initiative to support local communities across the state in developing and implementing new CIT programs. Five years later, the Center estimated that there were 4 multi-jurisdiction or regional CIT programs, 3 county programs, and dozens of local programs (municipal or university) across 18 of the state's 95 counties. The findings tell us something about the program's penetration across the state, but little about the characteristics, constraints and the fidelity of individual programs.

Law Enforcement Mental Health and Crisis De-escalation Standards: National vs. Tennessee

According to the results of a recent national survey of State Peace Officer Standards and Training Authorities (POST) entities and other state training authorities, despite consistent recognition of the value of mental health and crisis de-escalation training there is tremendous variability in those standards among states and the focus is mostly on entry-level training (*The Variability in Law Enforcement State Standards: A 42-State Survey of Mental Health and Crisis De-Escalation Training,* Council of State Governments Justice Center in partnership with the International Association of Directors of Law Enforcement Standards and Training, 2017)

Governor Lee has appointed Franklin Police Chief Deborah Faulkner to the Tennessee Peace Officers Standards and Training Commission, which is responsible for developing and enforcing standards and training for all Tennessee Police Officers. The Commission also promotes continuing law enforcement training. The Commission is comprised of 18 members and includes local law enforcement personnel, legislators, and Tennessee citizens who are not connected with law enforcement.

National

- Nearly all responding states have standards for mental health (41 of 42) and de-escalation (40 of 42) training.
- 18 states report having plans to expand the number of mental health and de-escalation training hours
- The average number of training hours spent on mental health and de-escalation topics is 14 hours.
- 21 of the 41 responding states require in-service and/or specialized training
- 11 of 42 responding states certify or provide officers with 40-hr CIT training; 9 of 42 states provide 8-hr MHFA training
- Funding for officer training (and in some cases, training for Field Training Officers, trainers, supervisors, dispatchers, or other personnel) is a significant concern.
- Survey results indicate that training is supported fully or partially by local agencies or officers in many states (offset by state grant funding, and to a lesser degree federal grant funding).
- Comments suggest that any training mandates should be accompanied by adequate funding supports (for personnel and trainers), as well as investments in behavioral health services in the community to support efforts that result from successful training.

Tennessee

- Tennessee does have minimum mental health training standards for all law enforcement officers.
- TN's POST Commission requires a minimum 4 hours for mental health training for all law enforcement personnel
- In the last several years, local police departments have integrated Mental Health First Aid (MHFA) and modified CIT training into their training curriculum
- Tennessee requires 2 hours mental health training annually as part of in-service
- There is no state funding to support CIT inside or out of the academy

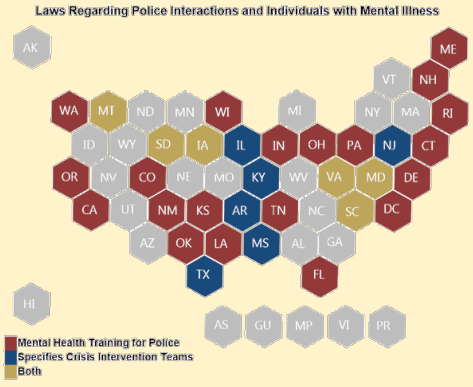


Figure 6: Comparison of Tennessee and National Law Enforcement Mental Health Training Standards

One of the goals of the CIT in TN's planning initiative is to provide an updated, comprehensive assessment of the status and characteristics of existing CIT programs to assist in strategic planning and expansion of CIT across the state.

TN law enforcement agencies that reported CIT trained officers (municipal and university police departments, county sheriff's offices, and Veterans Affairs)	66
Number of CIT programs	18
Number of law enforcement CIT-trained in 2018	453
Number of firefighters, EMTs and paramedics CIT-trained in 2018	40
Number of TN Department of Correction staff CIT-trained	257 TDOC staff, 20 Davidson County Sheriff's Department officers

Through the summer and fall of 2018, we conducted 12 in-person interviews of CIT program partners and staff, and we conducted a statewide survey of local and county law enforcement agencies, receiving responses from 25 percent of the 270 municipal and university police departments (n=68) and 23 percent of the state's county sheriff's offices (n=22).

According to our findings, Tennessee has 18 CIT programs at various levels of operation. See **Figure 7** for details. In 2018, there were an estimated 500 law enforcement and other first responders that received CIT training, the majority concentrated in urban counties in jurisdictions with established CIT programs. Penetration of CIT remains uneven; with a few agencies having all of their officers CIT-trained, many having between 20-30 percent of their officers trained, and many more having few or no CIT trained officers. There are no reported CIT trained officers in 65 of Tennessee's 95 counties. Many agencies with officers participating in CIT training have not formed their own local CIT program. Of the 18 local or regional CIT programs, half have established protocols, implemented procedures, and provide training to local 911 dispatch/emergency communications. The ability of local behavioral health systems to

provide a designated therapeutic drop-off location and a quick turnaround for law enforcement varies across the state, and this remains the most significant barrier to CIT program fidelity and expansion. The more robust programs are those based in communities served by pre-arrest diversion infrastructure programs. The recent funding for the expansion of pre-arrest diversion program activities will strengthen and support CIT development.

CIT partnerships

Strong partnerships between law enforcement, the local behavioral health system, and community advocacy organizations and peers are foundational to CIT, and the maintenance of a local or regional CIT steering committees is central to program success. Of the 18 CIT programs, 8 indicated having an active steering committee that meets monthly or quarterly. The 10 other programs indicated their participation in other justice-behavioral health system collaboratives or less formal convenings of local stakeholders that support law enforcement, behavioral health, and community collaboration. Several CIT program coordinators indicated a need to reinvigorate community partnership meetings. Partnership activities include: developing and implementing CIT training curriculum; developing 911 dispatcher protocols; establishing procedures for stabilization and disposition of crisis calls; reviewing crisis incidents; and providing program evaluation.

Policies, protocols and data collection

Memphis remains the model for CIT programs across the country and its policies, protocols and data collection methods have heavily influenced other program's adoption of CIT (See the **Step by step guide for developing and sustaining CIT programs** section for Memphis' and other program's policies and protocols). Across the state, procedures for stabilization, disposition of crisis calls, and alternative transportation vary widely.

Training

At least 10 percent of all law enforcement calls involve a person with mental illness. Yet, in Tennessee less than 1% (4 hours) of the required basic training law enforcement personnel receive addresses behavioral health education and responses. The Tennessee Law Enforcement Training Academy has recently developed a new specialized, interactive training course that covers additional behavioral health training (See the ***Additional Resources*** section for a description of the Academy's basic and specialized training courses). Many agencies, with or

Mobile Crisis Team Provider	CIT program (Status)	Program Type	Localities Served	Therapeutic Drop-Off
Volunteer Behavioral Health	Rutherford CIT (Operational)	Multi-jurisdiction	Rutherford County, Murfreesboro, Smyrna	Yes
Alliance Healthcare Services	Collierville CIT (Operational)	Local	Collierville	Yes
Ridgeview	Oak Ridge CIT (Operational)	Multi-jurisdiction	Oak Ridge, Anderson County	Yes
Alliance Healthcare Services	Memphis CIT (Operational)	Multi-jurisdiction	Shelby County, Memphis, University of Memphis, Christian Brothers University, Memphis Airport PD	Yes
Alliance Healthcare Services	Germantown CIT (Operational)	Local	Germantown	Yes
Alliance Healthcare Services	Memphis Veterans Affairs CIT (Operational)	Local	Memphis VA	Yes
Pathways of Tennessee	Madison County CIT (Operational)	Multi-jurisdiction	Madison County, Jackson	Yes
Helen Ross McNabb	Knoxville CIT (Operational)	Multi-jurisdiction	Knoxville, Knox County, Knox County Schools Security Division, UT-Knoxville, Blount County, Alcoa	Yes
Volunteer Behavioral Health	Hamilton County CIT (Operational)	Multi-jurisdiction	Hamilton County, Signal Mountain, Soddy-Daisy, UT Chattanooga. Chattanooga	Yes
Frontier Health	Greene County CIT (Operational)	Multi-jurisdiction	Greene County, Greene	
Frontier Health	Washington CIT (Developing)	Multi-jurisdiction	Johnson City, Washington County, East Tennessee State University, Erwin	
Frontier Health	Sullivan County (Operational)	Multi-jurisdiction	Sullivan County, Bristol, Northeast State Community College	
Volunteer Behavioral Health	Putnam CIT (Developing)	Multi-jurisdiction	Putnam County, Cookeville	
Volunteer Behavioral Health	Brentwood CIT (Developing)	Local	Brentwood	
Volunteer Behavioral Health	Franklin (In Planning)	Local	Franklin	

Pathways	Dyer CIT (Lapsed, In Planning)	Multi-jurisdiction	Dyer County, Dyersburg	
Centerstone	Estill Springs CIT (In Planning)	Local	Estill Springs	
Volunteer Behavioral Health	McMinnville CIT (In Planning)	Local	McMinnville	
Pathways of Tennessee	Obion CIT (Lapsed)	Local	Union City	
Pathways of Tennessee	Weakley CIT (Lapsed)	Local	Martin	
Ridgeview	LaFollette (Developing)	Local	Lafollette (Campbell County)	

CIT Program Status Typology

Operational: Formation of a steering committee and/or CIT coordinator. 40-hour CIT training; At or near 24/7 CIT response capability. Process and protocols developed for therapeutic drop-off to enhance linkage to care

Developing: Partnership and/or steering committee established. Significant number of CIT-trained officers in jurisdiction. Working toward implementation of a therapeutic drop-off location.

In Planning: Working toward formation of local partnership. May have CIT-trained officers.

Lapsed: CIT program no longer exists. There may be institutional history of the program and interest in developing a program may remain.

Figure 7: Overview of TN CIT Programs

without a CIT program, require or encourage additional behavioral health training beyond what the Tennessee Peace Officers Standards and Training (P.O.S.T.) Commission mandates, incorporating Mental Health First Aid (MHFA) and modified CIT training components into supplemental training. At least one jurisdiction (Knoxville), requires all incoming recruits to participate in the full 40-hour CIT training. See **Figure 6** for a comparison of Tennessee and National Law Enforcement Mental Health Training Standards.

All of the CIT programs deliver the full 40-hour training. Although there is local flexibility and variation for special populations, topics and resources, trainings across the state follow the Memphis Model's curriculum design—five consecutive days, including didactic, experiential and practical components. The state's CIT programs average two trainings per year. Memphis conducts four trainings per year. Most training programs attract officers from neighboring jurisdictions and encourage participation of 911 dispatch and other first responders.

The overwhelming majority are post-certified. Less than half of the CIT training programs have an evaluation component, and none have a pre/post assessment.

Law Enforcement Survey Responses

The overwhelming majority of law enforcement agencies indicated both that it was very important that officers be trained in how to safely interact with people experiencing behavioral health crises and that their department or agency would be strongly in favor of enhanced mental health training for its personnel.

Fewer than 20 percent of both the municipal police department and sheriff's office respondents were unfamiliar with the CIT program model.

Thirty-one (45%) of the municipal and university police department respondents stated they were currently operating a CIT program while nearly 60 percent had at least one CIT-trained officer at their department. Seven (32%) of the county sheriff's office respondents identified having a CIT program, with more than 40 percent retaining at least one CIT-trained officer.

Thirty-three municipal police departments and 12 sheriff's offices, representing almost all of the respondents currently without a CIT program, expressed interest in establishing a program. Figure X provides a list of all the responding law enforcement agencies that indicated interest in a establishing a local CIT program.

Perceived Barriers

Among a list of 7 offered barriers to CIT implementation, the municipal police department respondents' top 3 issues were: cost of training (65%); lack of trainers and training resources (57%); and tied for third, inadequate community mental health services (52%) and issues related to transportation between law enforcement and health facilities (52%).

The sheriff's office respondents' top 3 were: the cost of training (57%) and inadequate community mental health services (57%); lack of trainers and training resources (48%); and issues related to transportation between law enforcement and health facilities (43%).

Respondents' self-identified barriers largely echoed these major issue areas. The great majority of responses can be grouped into three major categories: limited accessibility to training opportunities; constraints that come with a small, rural law enforcement agency; and issues related to the mental health system.

Training

Almost all respondents mentioned the financial and logistical barriers to training law enforcement personnel. Many respondents indicated that they simply did not have the staffing resources necessary to allow personnel to be absent for 40 hours of training.

"Staff and funding are our primary barriers"

"Staffing shortages make it difficult to pull officers from primary assignments [for the training]"

"Funding is a major issue with training. The CIT model could not be listed as a mandatory class for in-service, unless the curriculum was reduced drastically, which would not be an option in my opinion."

"We would like to provide the training to at least 20 percent of our officers and dispatchers, but we don't have the capacity."

Others described the limited number of training opportunities and the lack of local, qualified trainers.

"A limited number of slots are available for CIT Certification because the Memphis Police Department trains officers from several agencies and as a result can only give each department a certain number of spots. Even

though this is listed as a barrier, our agency is typically given several spots a year but would gladly accept more, if more spots were available."

"We would like to train our entire department [100+] but would need to do it in small groups over a couple years."

"Finding qualified CIT Trainers who truly understand the CIT program/concepts and can teach others the proper techniques, skills and procedures to handle [crisis] situations/ encounters is a real challenge"

"As a trained CIT officer I recognize the importance of this training. A small agency such as ours cannot deplete our working schedule to send officers away for training. Training needs to be either internet based or near our agency."

Many respondents discussed the lack of opportunities for more advanced and ongoing CIT training, as well as the challenges in addressing additional content or sub-populations. One respondent wrote: "Expanding the program to incorporate people with disabilities would reach more people and create more partnerships within the community."

Rural constraints

The majority of respondents are based in relatively small departments or agencies in rural locales. Respondents perceived that the realities of operating in this environment impose many challenges to implementing and sustaining a CIT program. Many respondents discussed how the small size of the department made it difficult to sustain a CIT program. Many others talked about police shortages and high turnover, particularly in rural areas of the state.

"This department is like many, we work with limited resources and a small staff. Although I see the benefit of this program and would support it as far as our means would allow, our means are limited."

"I'm a new chief here, and this is one of many catch-up things the Department needs to implement."

"We have a strong commitment from local law enforcement. We just need to determine how to expand."

"Due to size of our small department, it's almost impossible to have a program like this in place."

One of the greatest perceived challenges of implementing and sustaining a CIT program in rural locales is the lack of adequate mental health services.

"[Our department] recognizes the need and we are prepared to get the individuals the help they need, however in our area there are not enough facilities and employees to care for their needs."

"We have limited health and mental health services outside of the university. Students have access to services within the university system. For our community members there are limited resources in our area."

"Our Department (and other agencies in our area) struggle due to the lack of available beds at area mental hospitals. The shortage results in the local hospital emergency room becoming a de facto holding facility, which they

are not equipped for. This, in turn, results in our agency being called to the ER repeatedly at times as they try to house patients awaiting a bed."

Mental health system

Beyond concerns about mental health capacity at the local level, respondents raised broader concerns about collaborating with mental health agencies and the need for policy and legislative improvements as barriers to CIT implementation.

Many respondents discussed the need for greater collaboration with mental health agencies and discussed the perceived resistance on the part of the mental health system.

"Establishing trust between provider agencies and staff and the police department is needed"

"There is a lack of understanding and/ or training on just how the Mental Health Community operates when it comes to interfacing with law enforcement"

"There is a lack of willingness by established external mental health organizations to formulate a viable partnership and to address the concerns they're responsible for in a timely manner."

"There is a lack of cooperation from mental health agencies and caregivers."

"The mental health system itself is a huge barrier, there is little cooperation with law enforcement."

Many respondents identified systemic challenges to providing mental health services as a major barrier, concluding that "our mental health system is lacking in all areas."

"CIT is great, but lack of mental health hospital beds is the main barrier to prompt mental health treatment."

"There is a lack of commitment on the part of the State of Tennessee to possess a degree of ownership in the mental health crisis and ear-mark necessary funding and/or facilities to appropriately impact this problem."

"There is a need for greater funding mental health consumer programs and funding for mental health courts."

Addressing several policy concerns, one respondent wrote:

"*There is a need for legislation to assist law enforcement in transportation or detention of persons with mental illness. Also there is a general lack of crisis teams and hospital attention to mental health illnesses."*

"There is a lack of mental health services from private and state providers. Further cut backs in substance abuse services for the community and cut backs in community advocacy are another barrier to CIT success. Too frequently state hospitals will divert people in crisis."

Another respondent addressing requirements in state laws regarding the circumstances under which officers are permitted to transport or take into custody individuals with mental illnesses:

"*The almost nonexistent laws that would allow law enforcement to get someone help prior to them harming themselves or another person. TN is one of only a few states that don't allow for preemptive measures in dealing with people with mental health issues. The imminent harm standard is too high and not workable."*

Several respondents also discussed the lack of clear guidelines or criteria for establishing and maintaining a CIT program, as well as cultural or institutional characteristics of law enforcement that made discussing mental health issues a challenge.

"Having guidelines to establish a program is so necessary but neglected"

"Not all officers are suited to perform the duties and skills effectively to assess an individual that is in a crises state just as not all officers are suited to be tactical/swat officers or criminal investigators."

"Getting officers to have a different mindset and approach these types of calls [is a challenge]"

"Finding dedicated personnel to fill this type of role…"

Findings highlight the variability in how CIT is being implemented across the state, mirroring the broad regional differences in access to behavioral health care. Funding for the expansion of pre-arrest diversion program activities will strengthen and support CIT development, but not without the adoption of minimum program standards and more deliberate regional and state planning and coordination in the implementation of CIT programs.

Recommendations

These recommendations are made incorporating best practices research, current crisis services and pre-arrest diversion programs in Tennessee, and community stakeholder input. These recommendations include a variety of actions that can be implemented over time. All recommendations are made toward the goal of expanding the number of Crisis Intervention Team (CIT) programs across the state, and strengthening pre-arrest diversion for Tennesseans with mental health and addiction issues in ways that improve safety for all. The CIT in TN Task Force provides the recommendations with the understanding that any implementation of such recommendations would be subject to support and funding by the state and federal government.

The implementation of these recommendations should be monitored by the CIT in TN Task Force. Actions and performance measures will be supported, when possible, by the TDMHSAS, TDOC and NAMI TN and completed by the proposed CIT Coordinator.

Leadership, Coordination and Advocacy

The CIT in TN Task Force will provide a strong voice representing the needs and priorities of the local collaborative partnerships between law enforcement, behavioral health providers, and community stakeholders that are central to the ongoing success of CIT programs.

Strategies

1. Identify funding opportunities to strengthen coordination of CIT community partnerships and to support a state CIT coordinator

2. Where possible, funding for new pre-arrest diversion projects around the state may include support for the development and implementation of CIT program and training activities.

3. Support community CIT partners in adopting and implementing standard CIT policies and protocols related to behavioral health call responses

4. Establish and disseminate recommended standards for developing, implementing and sustaining CIT programs based on the "Core Components of Tennessee CIT programs"

5. Develop education and outreach activities based on "Core Components"

6. Develop communications strategy to promote, support, and sustain CIT programs

7. Explore the regionalization of CIT programs in rural areas and/or funding to support local law enforcement travel costs for training

8. Facilitate the initial convenings of the local steering committee/ task force when CIT programs are forming; and provide ongoing guidance or technical assistance as needed

9. Use established local entities and existing Mental Health and Recovery Courts to convene planning interest groups to support CIT program development

10. Support local partners in identifying local CIT Coordinator(s) and position responsibilities

11. Support the formation of new CIT programs throughout the state and support developed programs to implement program enhancements (co-responders, preventive outreach with vulnerable individuals, "warm lines")

12. Include individuals and families/caregivers affected by mental health conditions and substance use disorders who have had encounters with the criminal justice system in the planning process, which greatly enhances the sustainability, success, and impact of CIT programs

Training and Education

Expand CIT training and train-the-trainer program opportunities to improve crisis intervention/ de-escalation knowledge and skills of police, dispatchers and other first responders

Strategies

1. Encourage local CIT communities to meet established minimum training standards through periodic review

2. Develop a statewide approach to evaluating the impact of CIT training on key outcomes.

3. Work with and encourage established CIT trainers in West, Middle, and East TN to coordinate at least 3 train-the-trainer program/year in each region with law enforcement and behavioral health representatives of identified communities interested in starting a program

4. Actively work with new and developing CIT programs to identify training resources and technical assistance opportunities

5. Encourage CIT training curriculum to address issues related to the state's opioid epidemic, including the role of Medication Assisted Treatment (MAT) options

6. Actively work with established CIT programs to identify advanced and in-service training courses and continued education for CIT-trained personnel

7. Manage a public calendar of all CIT trainings and educational opportunities

8. Raise public and stakeholder awareness of CIT through education and outreach activities

9. Encourage all CIT training to include Certified Peer Specialists, ideally with lived experience of not only mental illness but also criminal justice involvement

10. As the TN Department of Correction (DOC) is core partner, ensure CIT training is provided to correctional officers and community corrections staff

Governance and Evaluation

The CIT Task Force will be a strong and responsive body that will encourage CIT programs to meet program standards

Strategies

1. Formalize the CIT in TN Task Force's mission, structure, and decision-making framework through a Memorandum of Agreement

2. Provide best practice knowledge on CIT implementation and facilitate local participation in national initiatives such as the Stepping Up Initiative and the One Mind Campaign

3. Meet bi-monthly and serve in advisory capacity, review program implementation and sustainability, identify funding opportunities

4. Serve as the certifying body for CIT in TN programs, a voluntary designation based on recommended guidelines in the "Core Components of Tennessee CIT programs" document

5. Define role and responsibilities of CIT Coordinator

6. Work with the CIT Coordinator to administer and review findings from annual survey assessment of the status of CIT programs across the state

7. Convene annual conference & awards ceremony of CIT programs

8. Encourage consistent collection of uniform data elements that CIT programs should use to inform program improvements, demonstrate program effectiveness, and help ensure program sustainability. See *Guidelines for Expanding and Enhancing CIT in TN* document for data collection recommendations

9. Local CIT steering committees: Meet regularly and provide oversight of the program's operation and sustainability, critical incident review, funding and community outreach and education, and training coordination.

Core Components for Tennessee's CIT Programs

In order to maintain fidelity to the CIT model, to encourage the basic structure and principles of all CIT programs to be consistent across the state of Tennessee, and to support the program's growth and sustainability, the CIT in TN planning initiative has developed guidelines for core components for Tennessee's CIT programs. Building on the University of Memphis *CIT Core Elements (2007)* document, Virginia's *Essential Elements for the Commonwealth of Virginia's CIT Programs (2011)*, and Ohio's *CIT Strategic Plan (2015)*, the Task Force members and CIT partners have worked together to recommend these core components for the development and implementation of CIT programs in Tennessee:

1. Community stakeholder collaboration and guidance;
2. Local CIT coordinator;
3. 40 hour standardized CIT training for law enforcement personnel;
4. Dispatcher training;
5. Train-the-trainer classes for CIT program sustainability;
6. Policies and procedures;
7. Therapeutic receiving facility, Crisis Walk-In Center, Stabilization Unit, Respite Services or other procedure/partner to access services in lieu of incarceration (as appropriate); and
8. Collection of data to monitor CIT program outcomes

These core components are central to the success of CIT programs. What follows are brief descriptions of the necessary elements of each component.

1. Community stakeholder collaboration and guidance

Central to the development and ongoing success of CIT programs is the formation of a local community steering committee/advisory group/task force that meets on a regular basis in order to:

- guide initial planning and implementation;
- provide ongoing guidance and oversight of the program's implementation, including review of crisis incidents, funding support, and outreach and education activities;
- develop oversight and review plan; and
- review and support the data collection process

These local partnerships should include representatives from:

- *Law Enforcement:* local police departments, sheriff's offices, TN Department of Correction (TDOC) and community corrections, university police departments, dispatchers and other first responders. Judges, attorneys and other criminal justice stakeholders should be encouraged to participate.
- *Behavioral health:* TDMHSAS representatives, behavioral health providers, and educators and private providers within the local treatment community. Emergency department directors, local EMS, hospital administrators and health department representatives should be encouraged to participate
- *Community:* Community participants should reflect the local community, with particular emphasis on the inclusion of individuals with mental health conditions, substance use disorders, and developmental disabilities with history of criminal justice involvement.

NAMI has been and should remain highly involved, when possible, in the development of local CIT programs.

2. Local CIT Coordinator

Each local CIT program should have an appointed individual or individuals to serve as CIT Coordinator(s) whose role may include:

- Managing and scheduling training facilitation and logistics
- Managing day-to-day program elements, such as inter-departmental communication, scheduling and leading local steering committee/task force meetings
- Overseeing the development of local policies and procedures
- Regularly convening steering committee/community stakeholder group per oversight plan
- Supporting data collection efforts

3. 40 Hour CIT Training for law enforcement personnel

CIT is "more than just training." However, the CIT training is important and there are core elements of the training which should be consistent across programs. Different communities have different needs and capacities, which allows for some flexibility in the program. The following are minimum standards, and programs are encouraged to expand or enhance their training as they develop and grow.

- *40 consecutive hours:* The standardized CIT training program is 40 consecutive hours of training delivered over five days
- *Maximum class size of 30*: Class size will vary from community to community, but experience in Tennessee demonstrates that a class size over 30 is unmanageable and core elements of the training prove too challenging to facilitate.
- *Didactic component*:
    - De-escalation techniques
    - Basic mental health diagnoses or clinical states
    - Basics of substance abuse and the medical model, including information about opioid use disorder, overdose awareness and MAT options
    - Basics of intellectual and developmental disabilities
    - Psychiatric medications and side effects
    - Legal issues (e.g. liability, CIT code provisions, etc.) & Civil Commitment
    - Trauma informed care (including ACEs)
    - CIT Policies and Procedures
    - Overview of special populations and cultural diversity
    - Community resources
        - Other topics such as Officer Self-Care, Veterans issues, Adolescent issues or region-specific components should be added as needed.

- *On-site visits and experiential component:* An important goal of CIT training is to increase awareness and sensitivity of the lived experience of behavioral health issues through direct experience. Training modules must include presentations from individuals with lived experience and family members. Site visits and other activities to facilitate interaction with individuals with behavioral health issues is a required component of the

training. NAMI Tennessee and their local affiliates can be critical in leading and organizing this component of the training.

- *Practical/Scenario based component*: Crisis De-Escalation training and role play scenarios, including basic strategies, basic verbal skills, stages/cycles of crisis escalation, advanced verbal skills, and advanced strategies-complex scenarios

- *Commencement and recognition:* Upon completion of the training, the training program should have some form of recognition for the graduates.

4. Dispatcher training

Dispatcher training is an important component of CIT that ensures dispatchers are knowledgeable of the basics of CIT, aware of CIT trained officers in their jurisdiction, and prepared to utilize their expertise in a crisis situation. Dispatchers may sit in on a full 40-hour CIT training or an abbreviated course curriculum (See Memphis or Hamilton County) that at minimum should include: Basic mental health diagnoses or clinical states; de-escalation overview and techniques; recognition and assessment of a CIT crisis event; appropriate questions to ask a caller; identify nearest CIT officer; and CIT policies and procedures.

- Training would focus on listening, verbal de-escalation and triage, to determine the need to dispatch CIT officers or other first responders.
- Dispatch supervisors should attend the training
- Dispatchers should receive a refresher course and/or annual education on issues of mental health and addiction

5. CIT train-the-trainer classes

Just as the CIT training has basic, standard elements, so should the train-the-trainer program. Train the trainer curriculum TBD.

6. Policies and procedures

Policies and procedures are an important component of CIT. They can provide a set of local guidelines that direct the actions of law enforcement, dispatch and providers. All agencies and stakeholders in a CIT program should have the opportunity to participate in the development of these guidelines.

Each CIT program or law enforcement agency will develop their own policies regarding:

- The size of their CIT-trained patrol division: There are differences that exist between large urban communities and small rural communities. Smaller agencies may need to train a higher percentage of officers. The ultimate goal is to have an adequate number of patrol officers trained in order to ensure that CIT-trained officers are available 24/7

- Officer selection: self-selected, supervisor approved, and experienced

- How to safely and effectively respond in the field to a behavioral health crisis in a trauma-informed manner

- How to safely and respectfully transport people experiencing a behavioral health crisis in a trauma-informed manner

- How to develop supportive program infrastructure the interagency agreements and informal partnerships

- The role of dispatchers in the CIT program

All policies and procedures should maximize the CIT officer's discretion. CIT officers should integrate their wide range of law enforcement training when responding to CIT calls.

CIT partners within the behavioral health community should develop policies and procedures that:

- Accommodate individuals in the least restrictive setting and allow for a wide range of inpatient and outpatient referral sources

- Address barriers that might potentially prevent officers from accessing immediate care for an individual

- Encourage data sharing and program evaluation

7. Therapeutic receiving facility

Each community must assess their available resources, context, and the practicality or reality of operating a fully functioning, non-criminal justice, therapeutic receiving facility. Each CIT program should at a minimum develop a diversion mechanism or protocol to divert individual into community care and treatment while also reducing officer involved time. This may consist of a non-criminal justice facility where individuals experiencing a behavioral health crisis may be taken for emergency treatment or stabilization or some set of alternative means for responding to individuals in crisis.

The ideal components necessary to achieve the most successful type of assessment/triage would include, for example:

1. 24/7 availability of the assessment site for law enforcement to use as an access point for services which is an alternative to incarceration
2. 24/7 availability at that site of emergency services/clinical personnel who can determine clinical status and assess treatment needs for the individual
3. 24/7 availability of security to support the site/program in accepting transfer of the individual and to provide for the safety of all persons involved
4. 24/7 ready availability of medical screening
5. 24/7 ready access to dispositional options including beds, crisis stabilization, detox, and other community-based service

6. 24/7 availability of peer support for individuals awaiting evaluation or transportation to dispositional options (In, Tennessee, peer support provided by Certified Peer Recovery Specialists)

8. Data collection

Data collection is critically important and can be used to document CIT program activities, inform program improvements, demonstrate program effectiveness, help ensure program sustainability, maximize utilization of scarce resources, and support the development of other community-based resources.

CIT partnerships' data collection efforts should be an integral part of CIT program development and implementation. Program partners will need to consider if they are currently collecting data that can be used to evaluate their program or if they will need to design new strategies to capture the data needed. Mission critical data elements that all CIT programs should collect include:

Community Partnerships:

- Number of formal (MOU) and informal partnerships.
- Number of participants from different stakeholder groups participating in different program activities.
- Number of community stakeholder meetings
- Number of CIT programs in planning/development stage

CIT Training Participation:

- Number/percent of law enforcement rank and file personnel and command staff completing the 40hour CIT training.
- Number/percent of dispatch personnel completing CIT for telecommunications training.
- Number of specialized trainings, as provided.
- CIT training outcomes (pre/post)

Counts of Mental Health Calls for Service/Encounters:

- Number of calls for mental health reasons.
- Number of calls for other reasons that result in a "mental health" encounter that ends up addressing a mental health need.
- Number of mental health encounters, with no preceding call from dispatch, that address a mental health need.
- Number of CIT calls leading to arrests
- Number resolved on scene
- Voluntary transport to treatment
- Involuntary transport to treatment

Counts of Mental Health Calls Responded to by CIT Officers:

- Number of mental health calls and encounters responded to by CIT-trained officers.
- Number of mental health calls and encounters responded to by non-CIT-trained officers.

Step-by-step guide for developing and sustaining CIT programs*

The purpose of this guide is to outline the necessary steps for developing and sustaining a successful CIT program

The development of a CIT program requires a thoughtful planning approach and is a process. This guide is not exhaustive but offers detailed steps and resources local partners can use as they develop and strengthen CIT programs.

This guide is intended to provide those in the position of planning and implementing a CIT program with specific strategies based on best practices. Our goal in compiling this guide is to further the use of the CIT in TN Core Components document and other best practices across the state.

Step 1: Identify and Build Key Partnerships

Step 2: Establishing a Steering Committee

Step 3: Assess Your Community's Crisis Care Continuum

Step 4: Planning and Coordination

Step 5: Training

Step 6: Using Data to Inform Practice

***This guide is indebted to the work of many CIT practitioners and other CIT planning tools, most especially NAMI's *Responding to Youth with Mental Health Needs: A CIT Youth Implementation Guide* (2011) & SAMHSA's *CIT Methods for Using Data to Inform Practice: A Step-by-Step Guide* (2018)**

Identify and Build Key Partnerships

Step 1

One of the fundamental strategies of CIT programs is developing strong cross-sector partnerships between law enforcement, behavioral health providers, and individuals and families affected by mental illness and substance use disorders.

Successful cross-sector CIT partnerships:

Are built on trust: Trust is critical to the success of cross-sector partnerships. Lack of time for relationship-building, limitations in service capacity, and negative personal experiences or interactions with participating partner can be barriers to trust.

Address underlying problems: The underlying problem is that too many people with serious mental illnesses do not have adequate access to behavioral health services, become critically ill, and cannot get adequate crisis services. The fact that too many people with serious mental illnesses are encountering law enforcement is a symptom of this problem and cannot be solved by simply training officers to respond more effectively.

Partnerships can boost capacity to build sustainable justice-health systems change. CIT partnerships can also address inequities through their impact on the ability of community members most directly affected by crisis care services (or lack thereof) to be active in improving crisis responses where they live.

Are adequately resourced: Many CIT programs rely on volunteer staff time and in-kind donations to provide training materials, facilities for meetings and trainings, honoraria for law enforcement personnel who participate in trainings and training instructors. Strong partnerships can be valuable in getting funding from private and government sources to deliver enhanced services. The CIT in TN Task Force is a statewide effort designed to support the development and implementation of CIT programs.

Encourage accountability: Each group – law enforcement, individual and families affected by mental health conditions, and behavioral health providers – have a responsibility to others in the partnership and to those experiencing behavioral health crises or who are chronically in contact with the criminal justice system for behavioral health reasons. This accountability increases the likelihood that partners will stay involved and uphold their end of the bargain, so the program succeeds. Building strong working relationships is the key to productively and equitably resolving your current problems and avoiding difficulties in the future.

Resources & Tools

- History of CIT
- *Meeting the Needs of Partners*
- *Contact list of existing CIT programs in Tennessee*
- Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask (Stepping Up Initiative)
- University of Memphis CIT Center database of CIT programs
- NAMI CIT Advocacy Toolkit
- Building bridges: 10 Essential Elements for Effective Community Partnerships between Law Enforcement and Mental Health
- TDMHSAS Crisis Services Statewide map
- TDMHSAS Planning & Policy Council

Know your community: The first step in launching a CIT program is to bring key partners together in your community. *Who are the people, organizations, and systems that respond to behavioral health crises in your community? Who are the people whose lives are most affected by police responses to mental illness and substance misuse?*

Identifying Potential Partners:
Brainstorm the best representative you need from each core CIT group—law enforcement, behavioral health providers, and advocacy organizations and individuals and families with lived experience.

- Individuals and families affected by mental health conditions, substance use disorders, and developmental disabilities, especially those with history of criminal justice involvement
- Law enforcement and other first responders, including: agency leadership, dispatchers, patrol officers, nearby agencies, and Tennessee Department of Correction staff and community corrections
- Behavioral health agencies, including crisis walk-in centers, mobile crisis teams, and criminal justice behavioral health liaisons. Consider partnering with your regional Planning & Policy Council committee
- Local hospital systems and emergency departments are often the only drop-off location for law enforcement in places where community behavioral health and crisis services are insufficient. Having strong partnerships with stakeholders in local health systems where there are no dedicated drop-off options will be particularly important.
- University/academic institutions can support data collection and program evaluation activities. Partnerships should work to develop a vision for data collection at this stage.
- NAMI Affiliates and State Organizations have a long commitment to CIT and have helped expand CIT programs across the country. Local NAMIs serve a key role in bringing together partners, advocating for needed services, cheering on progress and ensuring the inclusion of people living with mental illness and their families. Learn more about the work of your local NAMI Affiliate.
- Other participating groups/organizations: Housing Authority, Veterans services and programs, homeless services and shelters.

Strategies for Effectively Building Partnerships:

- Offer to be a resource to potential partners. Spell out how you can be of use to each other
- Take time to educate and provide resources about mental health issues
- Begin by holding 1-on-1 conversations with key stakeholders about the goals of CIT and your common challenges and concerns
- Include people with lived experience in every step of the planning process
- Identify allies and enlist bridge builders that work at the intersection of health and justice systems
- Invite NAMI TN and/or CIT program coordinators from neighboring programs to lead a discussion about the benefits of CIT
- Reach out to the CIT in TN Task Force for support

Ensure police buy-in: Law enforcement are central to CIT. As the primary first responders to people in behavioral health crisis and the focus of CIT training, law enforcement are essential partners and when police take a leadership role in CIT development activities, programs are more likely to succeed.

Strategies for Engaging Law Enforcement:

- Connect with a police champion who is CIT-trained, familiar with the model, or is passionate about working with the community
- Ask to participate in a “ride-along” with police officers
- Consider partnering with other municipal police departments in your area and the County Sheriff’s office
- Nearby agencies that have already adopted CIT may be helpful partners.
- Connect with law enforcement agency leadership early in the planning process
- Has your county passed a resolution in support of the Stepping Up Initiative? If not, consider introducing to your county leadership. See Shelby County’s resolution: https://explorer.naco.org/profiles/SteppingUp/ShelbyCountyTN.pdf

Resources & Tools

Identifying Potential Partners
Tool for identifying CIT partners and other stakeholders

Meeting the Needs of Partners worksheet
Outlines talking points to plan discussion with core CIT partners

CIT in TN Contact List
List of all existing CIT programs in TN and contact information

Additional Resources

- NAMI's CIT Advocacy Toolkit (2010) www.namiorangenc.org/wp-content/uploads/sites/62/2014/07/CIT-Advocacy-Toolkit.pdf
- Contact list of NAMI TN affiliates www.namitn.org/findsupport/
- History of CIT www.nami.org/Blogs/NAMI-Blog/October-2013/Saving-Lives,-Changing-Communities
- University of Memphis CIT Center database of CIT programs www.cit.memphis.edu/citmap/tennessee.php
- Stepping Up Initiative stepuptogether.org
- CIT in TN Core Components document (See CIT in TN Report)

Identifying Potential Partners

Instruction: The categories below represent possible agencies, organizations, or local groups within your community that should be considered as you form/strengthen your Crisis Intervention Team program. First, decide what role they may play in advancing your cause (check all the green columns that apply) and then fill in additional information about the organizations/groups that may be invited to partner (blue columns that apply).

Potential Cross-Sector Partner	Potential steering committee member	Other potential stakeholder	Solicit input	Dissemination partner	Organization/ group name	Known expertise? What perspective do they bring?	Contact name & info	Comments
911 dispatch								
Local police department								
County Sheriff's office								
EMS								
Mobile crisis								
Criminal justice behavioral health liaisons								
Peer support								

NAMI Affiliate								
Other community advocacy								
Community-based behavioral health providers								
Hospital or health care institution								
Universities or colleges								
Representatives from local and/or county government								
Faith organizations								
Housing/ homelessness services								

Meeting the Needs of CIT Partners Worksheet*

Meeting the Needs of Law Enforcement Officers

Challenges	CIT program benefits	Potential objections	Responses
The lack of crises care services in the community poses a problem for law enforcement in identifying an alternative to arrest or to hospital emergency departments While CIT programs support law enforcement officers act as liaisons to the behavioral health system, police have competing priorities. Law enforcement repeatedly come into contact for "high utilizers"	CIT training teaches law enforcement officers and other first responders to effectively prevent or de-escalate a crisis situation, communicate with individuals and families with lived experience, and educate them about the available behavioral health services Reduces the need for use of force in crises and reduces the trauma experienced by police. Improves the safety of police and others. Expands options for law enforcement through the establishment/ strengthening of treatment-based alternative responses to arrest for people experiencing behavioral health crises	We have no time or funding to train officers in CIT We are police officers, not social workers We already have a process for addressing these issues	CIT is cost-effective and saves law enforcement officers time by providing a proactive approach to reducing and preventing crises. The CIT in TN Task Force can help facilitate local training opportunities It also can reduce the number of "super utilizers" by ensuring they receive the behavioral health services and supports they need instead of relying on existing protocols that lead to unnecessary arrest or overuse of emergency room visits CIT reduces officer injury. After the introduction of CIT in Memphis, officer injuries sustained during responses to "mental disturbance" call dropped 80 percent.

Adapted from NAMI's *Responding to Youth with Mental Health Needs (2011)

Meeting the Needs of Individuals and Families

Challenges	CIT program benefits	Potential objections	Responses
Community members are often forced to involve police because other alternatives do not exist. Police are available and obligated to respond 24/7 while behavioral health services and supports are sometimes not as readily available. Obtaining mental health services in the community can often be challenging. Locating behavioral health providers, long waits for appointments and high out-of-pocket costs are frequent barriers.	CIT links individuals in crisis with behavioral health services Usually, services and supports are integrated into CIT program so more options exist (e.g. mobile crisis, criminal justice behavioral health liaisons, drop-off centers) Increases the likelihood that individuals will stay out of the criminal justice system and remain in the community Ensures the safety of everyone involved in a crisis.	Police officers are not social workers. I do not trust police	CIT programs reduce repeated interactions with law enforcement officers and helps officers to understand effective and humane ways to respond to a behavioral health crisis. It also helps divert individuals to community-based services and way from the criminal justice system

Meeting the Needs of Behavioral Health Providers

Challenges	CIT program benefits	Potential objections	Responses
Community members are often forced to involve police because other alternatives do not exist. Police are available and obligated to respond 24/7 while behavioral health services and supports are sometimes not as readily available. Obtaining mental health services in the community can often be challenging. Locating behavioral health providers, long waits for appointments and high out-of-pocket costs are frequent barriers.	CIT links individuals in crisis with behavioral health services Usually, services and supports are integrated into CIT program so more options exist (e.g. mobile crisis, criminal justice behavioral health liaisons, drop-off centers) Increases the likelihood that individuals will stay out of the criminal justice system and remain in the community Ensures the safety of everyone involved in a crisis.	Police officers are not social workers. I do not trust police	CIT programs reduce repeated interactions with law enforcement officers and helps officers to understand effective and humane ways to respond to a behavioral health crisis. It also helps divert individuals to community-based services and way from the criminal justice system

CIT program (Status)	Program Type	Localities Served	Contact (s) (Partner type)	Phone	Email
Rutherford CIT (Operational)	Multi-jurisdiction	Rutherford County, Murfreesboro, Smyrna	Kimberly Rush (Behavioral health)	(615) 542-2364	krush@vbhcs.org
Collierville CIT (Operational)	Local	Collierville	Lt. Chris Rossie (Law enforcement)	(901) 457- 2853	crossie@ci.collierville.tn.us
Oak Ridge CIT (Operational)	Multi-jurisdiction	Oak Ridge, Anderson County	Jan Cagle (Behavioral health)	(865) 481-6170 x1223	caglejg@ridgeview.com
Memphis CIT (Operational)	Multi-jurisdiction	Shelby County, Memphis, University of Memphis, Christian Brothers University, Memphis Airport PD	Lt. Col. Vincent Beasley (Law enforcement)	(901) 357-1701	vincent.beasley@memphistn.gov
Germantown CIT (Operational)	Local	Germantown	Lt. Joshua Schultz (Law enforcement)	(901) 569 – 3337	schultz@germantowntn.gov
Memphis Veterans Affairs CIT (Operational)	Local	Memphis VA	Chief Terrell Owens (Law enforcement)		Terrell.owens@va.og
Madison County CIT (Operational)	Multi-jurisdiction	Madison County, Jackson	Vicki Lake (Behavioral health) Leslie Hallenback, Jackson PD (Law enforcement) Karen Pomeroy; Bryan Rushing, Madison County Sherriff's Office (Law enforcement)	(731) 984-2160	vicki.lake@WTH.org

Knoxville CIT (Operational)	Multi-jurisdiction	Knoxville, Knox County, Knox County Schools Security Division, UT-Knoxville, Blount County, Alcoa	Candace Allen (Behavioral health)	(865) 329-9141	candace.allen@mcnabb.org
Hamilton County CIT (Operational)	Multi-jurisdiction	Hamilton County, Signal Mountain, Soddy-Daisy, UT Chattanooga. Chattanooga	Lt. Eliott Mahaffey, Hamilton County Sheriff's Office (Law enforcement) Tim Tomisek, Chattanooga PD (Law enforcement)	(423) 893-3503	esmahaffey@hcsheriff.gov
Greene County CIT (Developing)	Multi-jurisdiction	Greene County, Greene			
Washington CIT (Developing)	Multi-jurisdiction	Johnson City, Washington County, East Tennessee State University, Erwin			
Sullivan County (Operational)	Multi-jurisdiction	Sullivan County, Bristol, Northeast State Community College	Chief of Police John Eden, Northeast State Community College		
Putnam CIT (Developing)	Multi-jurisdiction	Putnam County, Cookeville			
Brentwood CIT **(Developing)**	Local	Brentwood	Kimberly Rush (Behavioral health)	(615) 542-2364	krush@vbhcs.org
Franklin (In Planning)	Local	Franklin	Kimberly Rush (Behavioral health)	(615) 542-2364	krush@vbhcs.org

Dyer CIT (Lapsed, In Planning)	Multi-jurisdiction	Dyer County, Dyersburg	
Estill Springs CIT (In Planning)	Local	Estill Springs	
McMinnville CIT (In Planning)	Local	McMinnville	Chief Bryan Denton, McMinnville PD
Obion CIT (Lapsed)	Local	Union City	
Weakley CIT (Lapsed)	Local	Martin	
LaFollette (Developing)	Local	Lafollette (Campbell County)	Chief Bill Roehl, LaFollette Police Department

Establishing a Steering Committee

Step 2

Take steps to formalize the partnership by establishing an advisory group or steering committee. Ask leaders from mental health organizations, law enforcement agencies, your local NAMI and other important community leaders to join an advisory group or steering committee for implementing a CIT program.

Forming a local advisory group or steering committee: Invite the key community stakeholders and partners you've been engaging to a meeting where everyone can meet each other and discuss the role of the steering committee.

The *Core Components for Tennessee's CIT Programs* guidance document encourages CIT programs to establish a local steering committee or advisory group that meets on a regular basis in order to:

- Identifying crisis services & resource opportunities and gaps in the community (***See Step 3 for more details***)
- Provide ongoing guidance and oversight of the program's implementation, including review of crisis incidents, funding support, and outreach and education activities; ***(See Step 4***)
- Develop oversight and review plan; and
- Planning/ Coordinating CIT trainings (***See Step 5***)
- Review and support the data collection process. (***See Step 6***)

Resources & Tools

- *Sample CIT program mission statements*
- *Working Agreement templates*
- *Model Commitment Form*
- *Sample CIT coordinator duties*

Strategies for Establishing an Advisory Group or Steering Committee:

- Develop an agenda and set a meeting(s) for all community partners that might serve on the committee. Consider inviting representatives from an established CIT program.
- Review the benefits of CIT programs and discuss potential roles & responsibilities of the steering committee
- Have community partners brainstorm goals for the steering committee. Each community has a unique set of needs and strengths and for a CIT partnership to be successful it is important that the goals of the CIT program are understood and shared by participating groups.
- It is strongly recommended that a working agreement is established and partner responsibilities

  See the *Sample CIT program mission statement*, *Working Agreement*, and *Model Commitment form* and adapt to meet the needs of your community
- Healthy, open, and respectful communication can strengthen your partnership. It is particularly important to discuss the communication style of the steering committee's meetings in order to ensure that all voices have equal time and weight.
- Establish regular, continuous meetings. A general way to start might be to schedule a monthly steering committee meeting.

Establishing CIT coordinator(s)

Having a coordinator whose responsibility is to ensure that CIT efforts move forward will be critical to the program's success. Funding a full or part-time position requires substantial investment that may be challenging to provide. Absent a paid-coordinator position, identifying an individual who can streamline communication and take the lead in helping to move the CIT partnership forward will be important.

Identifying a coordinator or point-person within the local law enforcement agency is strongly encouraged. Many CIT programs have designated law enforcement coordinators, behavioral health coordinators, and advocacy coordinators to ensure participation from the core CIT partner groups.

The *Core Components for Tennessee's CIT Programs* guidance document encourages CIT programs to have an appointed individual or individuals to serve as CIT Coordinator(s) whose role may include:

- Managing and scheduling training facilitation and logistics
- Managing day-to-day program elements, such as inter-departmental communication, scheduling and leading local steering committee/task force meetings
- Overseeing the development of local policies and procedures
- Regularly convening steering committee/community stakeholder group per oversight plan
- Supporting data collection efforts

See *Sample CIT Coordinator duties*

Resources & Tools

Sample CIT program mission statements
CCIT program Taunton, MA
CIT program in St. Louis County, MO

Template Working Agreement
Complete with your CIT steering committee to set guidelines and responsibilities

Template Model Commitment Form
Commit partners to the steering committee responsibilities

Sample CIT Coordinator duties
Virginia CIT Coordinator duties
Memphis Model CIT Coordinator description

Additional Resources

- National Association of Counties Case Studies https://www.naco.org/resources/index/stepping-up?field_type_document_tid=240
- Judges' and Psychiatrists' Leadership Initiative https://csgjusticecenter.org/courts/judges-leadership-initiative/
- Police-Mental Health Collaboration Toolkit https://pmhctoolkit.bja.gov/

Sample CIT program mission statements

Community Crisis Intervention Team (CCIT) Taunton, Massachusetts Mission Statement
For more information: https://ccittauntonma.weebly.com/

A genuine community partnership, the mission of the Community Crisis Intervention Team is two-fold. Principally it exists to promote communication and enhance the response of public and private agencies when summoned to intervene with individuals who are mentally ill, developmentally disabled or experiencing trauma in their lives. Secondly, team members are specifically trained and equipped to assist other communities in their quest of identifying the components and collaboration necessary to replicate a similar Community Crisis Intervention Team initiative of their own.

St. Louis County, Missouri Crisis Intervention Team Mission Statement
For more information: https://www.stlouisco.com/Law-and-Public-Safety/Crisis-Intervention-Team

The mission of the St. Louis Area Crisis Intervention Team (CIT Coordinating Council) is to deliver positive law enforcement crisis intervention service to people with mental illness in the St. Louis area by:

1. Providing cooperative community partnerships of law enforcement, mental health service providers, consumers, families, and advocates.
2. Coordinating and enhancing services to people with mental illness and/or substance abuse problems through law enforcement-based Crisis Intervention Teams.
3. Providing leadership to facilitate CIT programs and playing an integral role in the design of training for the CIT officers, and
4. Supporting success and continuing improvement of CIT.

The Crisis Intervention Team Model- St. Louis Area

The St. Louis Area CIT Program is based on the Memphis Model, but has gone through extensive evaluation and revision to make the training program relevant to the needs of the St. Louis County and Municipal area.

CIT Coordinating Council Mission Statement

The mission of the St. Louis Area Crisis Intervention Team (CIT Coordinating Council) is to deliver positive law enforcement crisis intervention service to people with mental illness in the St. Louis area by:

1. Providing cooperative community partnerships of law enforcement, mental health service providers, consumers, families, and advocates.
2. Coordinating and enhancing services to people with mental illness and/or substance abuse problems through law enforcement based Crisis Intervention Teams.
3. Providing leadership to facilitate CIT programs and playing an integral role in the design of training for the CIT officers, and
4. Supporting success and continuing improvement of CIT.

CIT Program Structure

Coordinating Council; Director, Major Bob Trittler

- **Membership**
  - Open to police officers, mental health community, families, and consumers.
- **Commitment to the Council's mission statement**
- **Functions**
  - To develop and implement CIT Training, Debriefing, and In-service Training
  - To identify and resolve any problems that arise along the flow from immediate response crisis intervention to delivery of care
  - To partner with Mental Health Court, Jail Diversion, and Family Crime programs
  - To offer assistance in the expansion of CIT training to other area police departments
- **Council Committees/Functions**
  - ***Executive Committee***
    - Core group representing the collaborative effort to coordinate and set agenda for the Coordinating Council
    - Representatives include director of the council, a police officer, BHR representative, NAMI representative and a CIT trainer.
  - ***Provider Relations Committee***
    - Works to identify and encourage those hospitals with a psych unit in key geographical areas of the County to partner with the CIT Program.
    - Encourages hospitals to work toward efficient hospital triage and directing individuals in crisis to mental health care.
  - ***Training/Curriculum Committees***
    - Develops and implements a highly relevant and effective 40 hour post-certified training for the St. Louis area in which CIT officers are trained to more knowledgably and safely intervene with individuals who are in mental illness crisis, de-escalate the crisis situation and direct individuals to appropriate care.
    - Develops and implements ongoing training evaluation, and updating of the CIT training
    - Develops and implements debriefing meetings and in-service training.
  - ***Evaluation***
    - Working to obtain grant funding to identify and define the data needed to determine if the program is accomplishing the Model's proposed benefits of (a) immediate crisis response; (b) decrease in arrests and use of force; (c) underserved consumers identified and diverted to care; (d) reduction in patient violence and use of restraints in the ER; (e) better officer training in de-escalation techniques; (f) reduction in officer injuries; (g) reduction in recidivism; (h) increase in officer recognition and appreciation by the community; (i) decrease in "victimless" crime arrests; (j) decrease in litigation; (k) cost savings
  - ***Mental Health Court/Jail Diversion***
    - Working to partner with the CIT Program to more effectively access Mental Health Court and Jail Diversion Programs.

CIT Program--More than Training

The CIT program is more than just training, it involves a whole process of:

- Three to four trainings a year to maintain CIT officer availability 24 hours a day -7 days a week
- Immediate response crisis intervention from specialized police officers
- 24-7 access to BHR's crisis counselors and mobile outreach
- Efficient triage and admission to the hospital for individuals in crisis
- Referral to community care
- Four police debriefings a year to track progress and provide support
- Accountability through monthly Coordinating Council meetings to identify and resolve problems
- Ongoing collaboration and dialogue among police, mental health providers, agencies, families, and consumers
- Ongoing police in-service trainings to maintain officer skills and provide advance training
- Research programs to measure program effectiveness and benefits.

Template Working Agreement*

Name of Committee
Overarching Goal **What is the primary overarching goal of the committee?**
Value of the Committee **What unique value does the committee bring to the stated goal?**
Key Priorities **What are the committee's key priorities for achieving the stated goal?**
Guiding Principles **What principles or values related to the goal will guide committee priorities and activities? (*e.g.*, we focus on priorities that meet the shared interests of our members or we seek new solu- tions to challenging issues).**
Members **What other individuals/groups would be valuable to include as additional members?**

Adapted from NAMI's *Responding to Youth with Mental Health Needs (2011)

Processes
What type of decision-making process will be used for important decisions ? (*e.g.*, will decisions require all members to participate, those present at a meeting, a simple majority, etc.?).
Who will draft agendas? Who will draft minutes?
How will communications within the group be handled? How will communications with the public, elected officials and other stakeholders be handled?
How and how often will the group assess progress toward its priorities?
Roles and Functions **What responsibilities will be expected of each steering committee member?**
Authority **Which members will be authorized to speak on behalf of the group?**

Operations	
Meeting dates and times:	
Meeting Location:	
Copies:	
Conference Calls:	
Facilitative materials (flip charts, markers, sticky dots, etc.):	
Formal printed materials from group:	

Other Agreements

Template: Model CommitmentForm*

Name of Steering Committee: [From Working Agreement]

Overarching Goal: [From Working Agreement]

Key Priorities
1.

2.

3.

Guiding Principles: [From Working Agreement]

Responsibilities: [From Working Agreement]

Organizational Statement of Commitment:

Our organization is committed to be an active member of the CIT steering committee. As a member, we attest that the goal, key priorities, responsibilities and guiding principles of the steering committee are in alignment with our organizational goals and policies. We agree to abide by agreed-upon decision-making processes and to support steering committee decisions. We agree to notify the steering committee, in writing, in the event our organization experiences a conflict of interest or is no longer able to support steering committee goals and priorities.

Adapted from NAMI's *Responding to Youth with Mental Health Needs (2011)

As evidence of our commitment to the steering committee, our organization agrees to do the following:

□ **Appoint** a designated representative and a backup person to attend steering committee meetings and conference calls.

Name of Representative:

Name of Backup Representative:

Authorize our representative to make decisions on issues or actions as follows:
- □ After obtaining formal organizational approval
- □ Without formal organizational approval (has decision-making authority)

Authorize our representative to make decisions regarding financial contributions as follows:
- □ After obtaining formal organizational approval
- □ Without formal organizational approval (has decision-making authority)

□ **Actively assist** with steering committee activities.
□ **Supply** the steering committee with our organizational name and/or logo.
□ **Disseminate** steering committee materials to our members or other stakeholders

Our organization further agrees to commit the following resources to the steering committee:
□ **Financial contribution** of $_____per year/month/one-time
□ In-kind donation (s) of:
□ **Volunteers** for steering committee responsibilities of:

_____

Signature and Title Date

_____

Organization

Sample CIT Coordinator duties

Virginia CIT Coordinator Job Duties

APPENDIX A:

CIT Coordinator Job Duties

The Crisis Intervention Team (CIT) Coordinator is responsible for organizing and standardizing CIT trainings within the Program. This position can be under either a behavioral health agency or a law enforcement agency or both. Building on the CIT Training model, the CIT Coordinator is responsible for the following duties:

1. managing the logistics and coordination of training presenters and activities;
2. developing and producing a training manual for participants;
3. overseeing course evaluations and enhancing the quality of the training;
4. gathering and analyzing data;
5. working with the planning committee to develop smaller, more focused trainings for other criminal justice players such as probation/parole officers, dispatchers, and EMS;
6. educating the community about the goals and purpose of the program.;
7. enhancing community awareness as well as following state mandates and protocols;
8. interfacing with the criminal justice system, county and private social services, mental health services, state and other systems.;
9. maintaining and completing all appropriate records related to logistics and planning, preparing written reports, entering statistical data;
10. conducting program evaluation and monitoring.

The Coordinator will develop close working relationships with various agencies including (but not limited to) the Police Department, Magistrates, Sheriff's Office, Probation and Parole, Commonwealth's Attorney and Public Defender's Office. The Coordinator must be able to communicate and understand the many complexities that arise from interaction with different systems.

QUALIFICATION REQUIREMENTS

Minimum: Bachelor's degree in Criminal Justice, Sociology, Psychology, Social Work, Communications, Business Administration or related field plus one year's experience working with criminal justice system and or mental health.

Substitution: Additional qualifying experience may substitute for educational requirement on a year for year basis. Directly-related higher level criminal justice degrees may substitute for the Bachelor's degree, education requirement and one year of experience.

Desirables:
a) experience with law enforcement, criminal justice system and logistics;
b) experience in developing and training professionals;
c) experience in general knowledge regarding mental health and community based mental health programs.

Crisis Intervention Team (CIT)
Law Enforcement Coordinator

A Crisis Intervention Team (CIT) Coordinator is a law enforcement supervisor appointed by the Sheriff or Chief to participate in efforts of assisting, implementing and sustaining CIT as a community program. The CIT Coordinator serves as a community liaison representing both law enforcement and other community partnerships to the citizens. The appointment of the CIT Coordinator should be made at the early stages of planning for a CIT program. Tasks and assignments may vary depending on specific needs of both law enforcement and the community as a whole. Leadership, planning and problem-solving skills are essential attributes for a CIT Coordinator. A CIT Coordinator will serve many roles with an emphasis on examining, reviewing, and making recommendations to ensure departmental and community needs are met. The following is a list of duties requiring the attention of the CIT Coordinator:

a. Maintain continuous working relationships with all community partners, with specific emphasis on mental health and advocacy partnerships.
b. Meet regularly with a CIT community steering committee
   -develop an agenda for the CIT Community Steering Committee and Subcommittees
   -address the issues raised by the community concerning the CIT program
c. Work with Community Partners to promote and sustain the CIT program.
d. Meet with law enforcement leadership
e. Review and develop CIT departmental policy and procedures.
f. Meet and with Uniform Patrol Supervisors
g. Provide leadership for CIT Patrol officers
   -address operational issues raised by CIT Patrol Officers, and interface with patrol supervisors in problem-solving such issues.
   -address community issues raised by CIT Patrol Officers and interface with the Community Steering Committee in problem-solving such issues.
h. Working closely with 911 local communication systems (call-taking and dispatch).
i. Take primary responsibility for CIT 40 Hour Training and on-going CIT In-Service
j. Review and monitor state commitment laws and transportation policies.
k. Monitor state, county and local issues that may affect community crisis services.
l. Maintain familiarity with federal, state, and county CIT grant requirements.
m. Develop a systematic approach to collecting program output and event outcome measures.
   -Take responsibility for organizing and presenting CIT program output and outcome data to police leadership and the community steering committee.
n. Produce or oversee a departmental CIT newsletter, CIT webpage or other methods of internal or external communication.

The CIT Coordinator position is vital to the day-to-day operations of the law enforcement agency. In addition to representing department internal interests, the CIT Coordinator represents the community partnerships as a primary contact person for the CIT program. Thus, the CIT Coordinator is a leader to ensure goals of the CIT program are beyond those of training. The CIT Coordinator ensures that the broader goals of enhancing service and safety are met.

Assess Your Community's Crisis Care Continuum

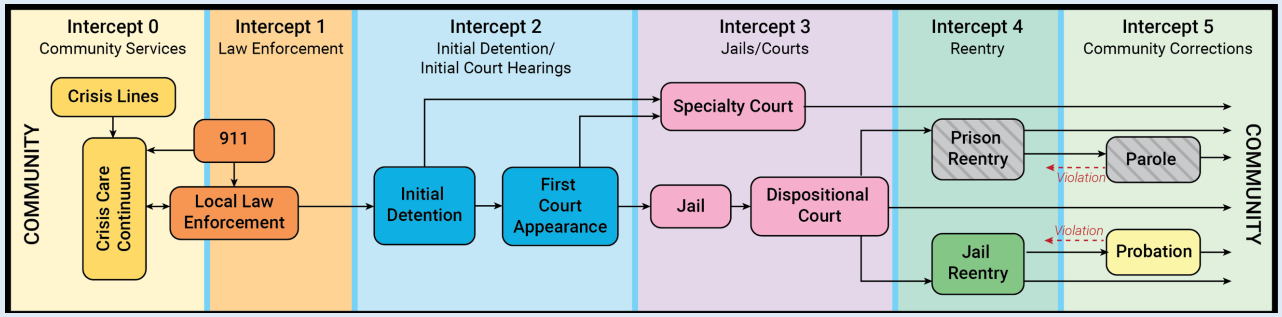
Step 3

Asset Mapping is a collaborative exercise that helps you create a "map" of the resources available in your community. It focuses on creating comprehensive picture of a community's strengths and needs when it comes to serving those with behavioral health needs or in crisis.

Asset mapping provides a structure to engage your core community partners and broad stakeholder group in planning for an effective CIT program. The mapping session can allow you to get to know the resources that exist in your community, identify areas for collaboration and coordination and set the stage for your CIT program.

Many communities have moved forward with CIT without completing a formal asset mapping. There are many ways to accomplish your goals, but you should strive to develop a good sense of the needs and resources in your community and engage a broad stakeholder group in doing this.

You can use the Sequential Intercept Model to identify points where people with behavioral health needs come in contact with and flow through the justice system. ***If your steering committee is interested in completing a formal asset mapping exercise, connect with the CIT in TN Task Force for resources and support***



The Sequential Intercept Model *has been used as a focal point for states and communities to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others. A Sequential Intercept Model mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention of further penetration into the justice system.*

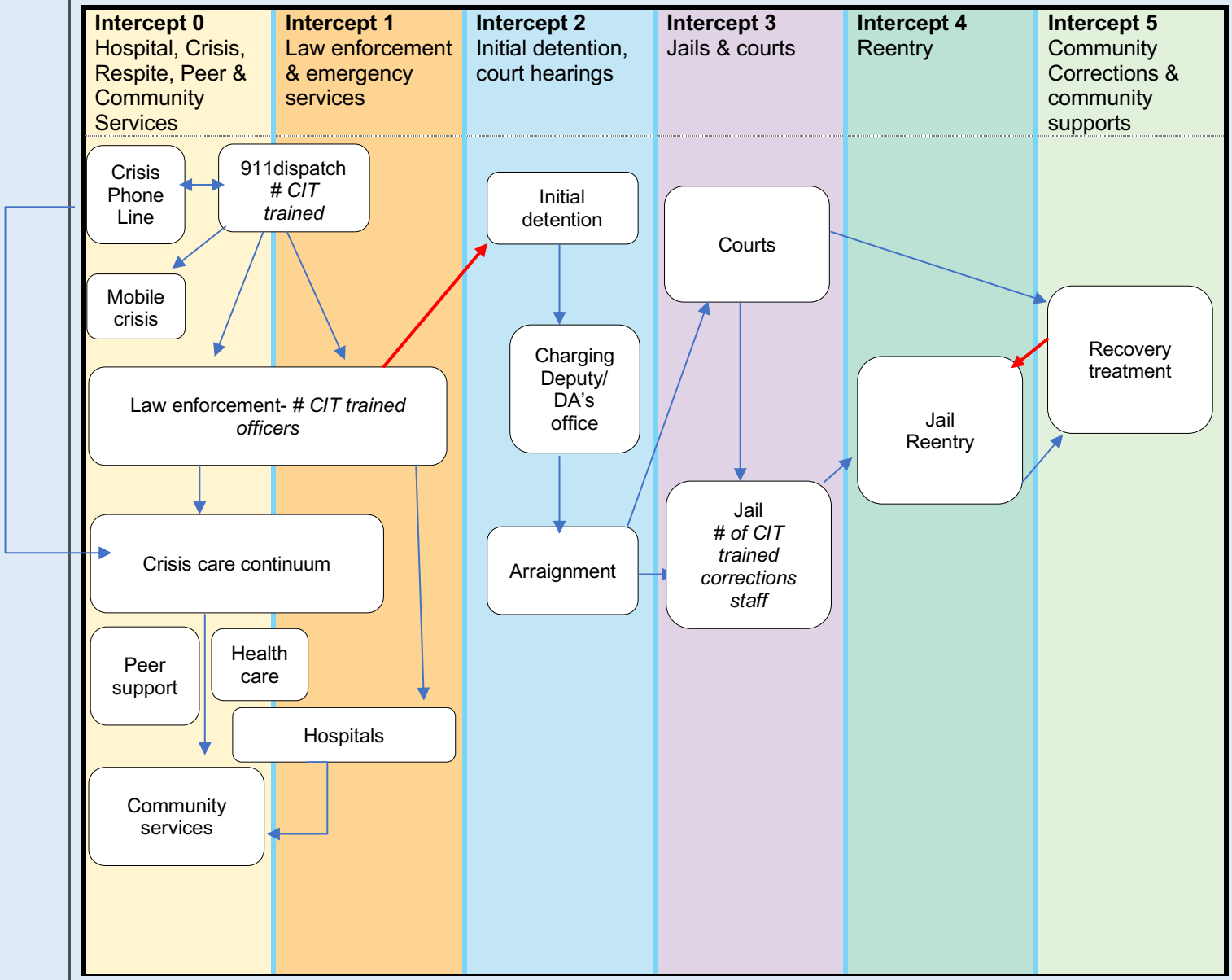
- The Sequential Intercept Model for Developing CJ-BH Partnerships
- *Using the Sequential Intercept Model to Guide Local Reform* (Urban Institute, October 2018)
- The Asset-Based Community Development Institute, Asset mapping tools
- National Neighborhood Indicators Partnership
- U.S. Census Fact Finder
- www.wonder.cdc.gov
- County Health Rankings
- TN Department of Mental Health and Substance Abuse Services:

  Crisis Services Fast Facts

  Crisis Services Statewide Map

  Planning & Policy Council details

Template CIT mapping



The CIT program and steering committee will be primarily interested in Intercept 0 and Intercept 1:

- *Intercept 0:* Community services is considered a gate-keeper to formal interaction with the criminal justice system. It encompasses the early intervention points for people with mental health issues before they are arrested and involves entities outside the criminal justice, such as crisis hotlines and community dispatchers coordinating with law enforcement; a continuum of crisis care options ranging from 23-hour stabilization or observation beds to short-term crisis residential stabilization services, mobile crisis services, peer crisis services, and specialized protocols for collaboration between law enforcement and behavioral health service providers are also common approaches.

- *Intercept 1:* Law enforcement recognizes that law enforcement officers and/or emergency services are the first responders for people experiencing a mental health crisis or emergency, which can be an intervention point to avoid formal entry to the criminal justice system. *Intercept 1* includes all prearrest diversion options and concludes when someone is arrested. Crisis intervention training (CIT), mobile crisis outreach teams staffed by law enforcement agencies and mental health providers, training 911 dispatchers to identify a mental health crisis, and crisis stabilization units are popular tactics.

Benefits of Asset Mapping include:

- Assisting in defining goals and objectives
- Identifying both gaps and overlapping services with community needs and challenges for future CIT planning and implementation
- Highlighting current successes; and
- Undertaking the data collection process necessary for evaluation

Key Actions:

Determine Logistics

- Decide what type of asset mapping (e.g. Sequential Intercept Model) you will conduct and who will lead and coordinate the activity.
- What steering committee members have the resource or expertise to oversee an asset mapping activity? Should we consult with the CIT in TN Task Force?
- What other stakeholders should be involved?
- How will you identify and keep track of the data?

Define boundaries—these questions will also help you define your goal and actions

- What physical areas are you including as part of the CIT program? Are you looking at one municipality, a campus, the county, or a larger region?

Determine Data and Identify Sources

- What relevant behavioral health and criminal justice data is available?
- Is the information publicly available and accessible?
- What organizations or agencies 'own' that information?
- What state-level agencies or initiatives might be gathering related or helpful data
- Identify local and state, school and community coalitions, partnerships and any coordinating entities that are already trying to link region's efforts.

- Revisit your asset mapping periodically and be prepared to revise and update as develop and implement the CIT program. Remember, this is a cyclical process and asset mapping will help you plan as well as assess your initiatives. **See Step 6 for detail about data collection**

Resources & Tools

Organizational Profile
Form to collect information from mapping session participants before mapping exercise

Template Asset Mapping worksheets
Use these templates to guide your asset mapping activities

Template Strengths and Needs Analysis
Use this template to guide discussion and planning based on asset mapping

Additional Resources

- **Data sources for individual and community health by state, county or zip code:**
    - National Neighborhood Indicators Partnership www.neighborhoodindicators.org
    - http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
    - TDMHSAS Crisis Services Statewide Map, Crisis Services Fast Facts & Planning & Policy Council details www.tn.gov/content/tn/behavioral-health.html
    - www.wonder.cdc.gov
    - www.countyhealthrankings.org

- The Sequential Intercept Model for Developing CJ-BH Partnerships www.prainc.com/sim
- Using the Sequential Intercept Model to Guide Local Reform (Urban Institute, October 2018) www.urban.org/sites/default/files/publication/99169/using_the_sim_to_guide_local_reform_1.pdf
- The Asset-Based Community Development Institute, Asset mapping tools www.resources.depaul.edu/abcd-institute/resources/Pages/tool-kit.aspx

Template Organizational Profile*

Organization name: _____

Contact person: _____

Contact information: _____

Mission or purpose: _____

Geographic area served: _____

Population served: _____

Programs, services and activities offered: _____

_____

- In what setting(s) do you serve individuals with behavioral health needs? What types of services and supports do you provide (e.g. mental health treatment, promotion and education, crisis intervention services)?

- What outcomes would you like to see as a result of implementing or strengthening a CIT program?

Adapted from NAMI's *Responding to Youth with Mental Health Needs (2011)

- What opportunities for collaboration should the CIT steering committee focus on?

- What do others need to know about your organization's values and priorities?

- What are the unmet behavioral health needs in your community?

- What do you think your organization does best? What are your greatest strengths and your greatest challenges?

Template Asset Mapping Worksheets

Use these templates to guide your asset mapping

Potential Cross-Sector Partner	**Intercept 0** Hospital, Crisis, Respite, Peer & Community Services		**Intercept 1** Law enforcement & emergency services		**Intercept 2** Initial detention, court hearings		**Intercept 3** Jails & courts		**Intercept 4** Reentry		**Intercept 5** Community Corrections & community supports	
	Services	Challenges	Services	Challenges	Services	Challenges	Services	Challenges	Services	Challenges	Services	Challenges
911 dispatch												
Local police department												
County Sheriff's office												

BH care services												
Mobile crisis												
Criminal justice behavioral health liaisons												
Peer support												
NAMI Affiliate												

Crisis stabilization												
Housing and homeless services												
Health care/ hospitals												

Template Asset Mapping Worksheets (continued)

Assessment of Local Response to Behavioral health Crises				
Community Strengths	**Community challenges**	**Gaps between strengths and challenges**	**Resources**	**How developing or strengthening CIT will address gap**

Template Asset Mapping Worksheets (continued)

Assessment of Local Response to Behavioral health Crises: Goals				
Goal	**Measure**	**Current baseline**	**Short objective**	**Timeline**
1. Improved officer safety				
2. Improved individual and community safety				
3. Reduced behavioral health crises sent to justice system				
4. Reduced stigma associated with mental illness and substance use disorders				
5. Improved collaboration between criminal justice and health systems				
6. Improved community appreciated for first responders				

Sample Strengths and Needs Analysis

- What is the biggest strength you see in the local response to addressing mental health needs and behavioral health crises?

- What is the biggest opportunity you see for collaboration and change to respond to behavioral health crises?

- What themes do you see in the asset map? (e.g., there are plenty of crisis intervention services but no follow-up care)

Adapted from NAMI's *Responding to Youth with Mental Health Needs (2011)

Template Strengths and Needs Analysis (continued)

- What are the points of intersection between organizations?

- Where do you see gaps in services? Overlaps? Bottlenecks? Hidden resources? Barriers?

- What is the best way to address these concerns?

- How can we use our strengths and resources to intervene earlier to prevent a crisis?

Planning and Coordination

Step 4

After taking the time to build partnerships and collect information about the available community behavioral health and crisis services, your CIT steering committee is now equipped with the knowledge and tools needed to begin planning and coordinating the CIT program.

It is important that regularly scheduled steering committee meetings are held to discuss ongoing systems issues, review incidents, coordinate training, and support the implementation of all CIT program activities.

Outlined below are the day-to-day issues and questions you may need to address during the planning and coordinating of the CIT program.

○ Roles and responsibilities

It's strongly encouraged that you get in writing the roles and responsibilities of each community partner and agency when it comes to addressing behavioral health crises events in the community. Oftentimes, a Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU) is put in place so that all of the collaborative partners are clear on roles, responsibilities, and procedural issues.

Elements to consider including in a collaborative agreement: Mission/principles/vision; goals and desired outcomes; name of the program; target population and scope; start date; roles; responsibilities/procedures related to referral or transfer of clients; information sharing procedures; training requirements; communication expectations; terms for amending or cancelling agreement

See the *Example Memoranda of Agreement* in the resources section

Questions to consider:

- What will the roles and responsibilities of the core steering committee partners be when the CIT program is implemented? What does each partner need to commit in order for the CIT program to be successful?
- How will partners coordinate with each other to ensure individuals receive the services and supports they need? How will they work together to follow up with individuals and their families?

- *Example Memoranda of Agreement*
- *Sample CIT policies & procedures*

Policies & Procedures

There may be policies and procedures that impact the implementation of the CIT program. Policies and procedures are an important component of CIT. They can provide a set of local guidelines that direct the actions of law enforcement, dispatch and providers.

Partners need to be aware of these issues and discuss ways to adapt policies and procedures that create barriers to success. All agencies and stakeholders in a CIT program should have the opportunity to participate in the development of these guidelines.

Each CIT program or law enforcement agency will develop their own policies that might include:

- The size of their CIT-trained patrol division: There are differences that exist between large urban communities and small rural communities. Smaller agencies may need to train a higher percentage of officers. The ultimate goal is to have an adequate number of patrol officers trained in order to ensure that CIT-trained officers are available 24/7
- Officer selection: self-selected, supervisor approved, and experienced
- How to safely and effectively respond in the field to a behavioral health crisis in a trauma-informed manner
- How to safely and respectfully transport people experiencing a behavioral health crisis in a trauma-informed manner
- Procedures that expedite the transfer of custody so that officers' wait times are reduced might support the success of the CIT program.
- How to develop supportive program infrastructure
- The role of dispatchers in the CIT program

CIT partners within the behavioral health community should develop policies and procedures that:

- Accommodate individuals in the least restrictive setting and allow for a wide range of inpatient and outpatient referral sources

- Address barriers that might potentially prevent officers from accessing immediate care for an individual
- Encourage data sharing and program evaluation

See the *Sample CIT policies & procedures* in the resources section

Questions to consider:

- Are there a sufficient percentage of CIT trained officers with the local police department or across the county or region?
- Are there any law enforcement or behavioral health policies and procedures that may hinder or impact the implementation of the CIT program?
- Is there a designated place or places in the community where officers can go and that are set-up to handle the receipt of individuals in crisis 24/7 for assessment and/or treatment?
- How will privacy and confidentiality concerns be addressed?

Behavioral health and crisis care services

The asset mapping exercise will generate information about the availability of mental health services and supports and the capacity of the steering committee partners and other stakeholders to fulfill the goals of the CIT program. This information will guide the implementation of the CIT program and inform policies and procedures, including those that address diversion and referral processes.

Questions to consider:

- What are the existing mental health and crisis care services available to individuals in crisis in your community or region?
- How will the CIT program utilize or integrate with these services and programs?
- What additional services or programs are required in order to successfully implement the CIT program model?

Therapeutic Drop-off Site and Referrals

Each community must assess their available resources, context, and the practicality or reality of operating a fully functioning, non-criminal justice, therapeutic receiving facility. Each CIT program should at a minimum develop a diversion mechanism or protocol to divert individual into community care and treatment while also reducing officer involved time. This may consist of a non-criminal justice facility where individuals experiencing a behavioral health crisis may be taken for emergency treatment or stabilization or some set of alternative means for responding to individuals in crisis.

The ideal components necessary to achieve the most successful type of assessment/triage would include, for example:

- 24/7 availability of the assessment site for law enforcement to use as an access point for services which is an alternative to incarceration
- 24/7 availability at that site of emergency services/clinical personnel who can determine clinical status and assess treatment needs for the individual
- 24/7 availability of security to support the site/program in accepting transfer of the individual and to provide for the safety of all persons involved
- 24/7 ready availability of medical screening
- 24/7 ready access to dispositional options including beds, crisis stabilization, detox, and other community-based service
- 24/7 availability of Certified Peer Recovery Specialists

Questions to consider:

- Is there a therapeutic drop-off site available in the community or region?
- Is there a process in place for law enforcement to refer individuals to the drop-off site?
- What additional services or programs are required in order to successfully implement the CIT program model?

- ## Advocacy

  It will most likely be necessary to advocate for additional behavioral health and crisis services to meet the needs of your community.

  Questions to consider:

  - What advocacy efforts will be needed to make these behavioral health services accessible to your community or region?
  - What advocacy efforts will be needed to successfully develop or strengthen the CIT program?
  - What is currently being done in this area? Where are the gaps?
  - How can you coordinate with local or state advocacy groups for a more effective, broader array of behavioral health and crisis services?
  - Is this feasible given the political environment? Does it fit officials' priorities? Is there a way to link it to a priority?
  - What is the timeline for policy development? Can you deliver the resources and/or get involved within their time frame?

- ## Using data

  You will want to develop a data collection plan to monitor program effectiveness and progress. **This will be discussed in more detail in Step 6**.

  Questions to consider:

  - How will feedback from community partners be gathered? Who will gather it?
  - How will baseline data be collected?
  - How will program success be measured?

Resources & Tools

Example Memoranda of Agreement
BJA Police-Mental Health Collaboration Toolkit Example Memorandum of Agreement
Madison County, TN Justice- Mental Health Collaborative Memorandum of Understanding

Sample CIT Policies & Procedures
Memphis Policy Department Policy and Procedures: Dealing with Mental Illness/ Crisis Intervention Teams
Virginia Crisis Intervention Team Programs: Sample Law Enforcement CIT Policy
Kansas City, MO Procedural instructions for Persons with Mental and/or Substance Abuse Disorders
CIT Policy from Hartford, CT Police Department
New York City PD Patrol Guide: Mentally Ill or Emotionally Disturbed Persons
Murfreesboro, TN Police Department CIT General Order
Murfreesboro, TN Police Department Emergency Committal General Order
Montana State Hospital CIT Policy and Procedures

Additional Crisis Intervention Policies

- Chicago, IL Summary of Proposed Revisions to the Crisis Intervention Section of the Chicago Police Department Draft Consent Decree
- Cleveland, OH CIT Policies: CIT Definition, CIT Program, CIT Response
- Akron, OH Emergency Mental Illness Procedures & Proposed Emergency Mental Illness Procedures
- Albermarie County, VA General Order & Special Order
- Albuquerque, NM Response to Mentally Ill/Suspected Mentally Ill and People in Crisis
- Anne Arundel County, MD Responding to Persons with Mental Illness, Emotional Crisis or Physical Disabilities
- Charlotte-Mecklenburg Standard Operating Procedure Crisis Intervention Team
- Collier County, FL Law Enforcement Response to Person with Mental Illness and other Mental Development Disabilities
- Milwaukee, WI Standard Operating Procedure—Persons with Metal Illness
- West Palm Beach Police Department CIT General Order

Example Memoranda of Agreement

BJA Police-Mental Health Collaboration Toolkit Example Memorandum of Agreement

MEMORANDUM OF AGREEMENT
BETWEEN THE
[Name of LE Agency]
AND
[Name of BH Agency]
FOR
PARTNERSHIP IN CONTINUING THE
[Name of Program of Operation]

This Memorandum of Agreement (MOA) is entered into by the [Name of LE Agency] and the [Name of BH Agency] for the purpose of continuing the [Program Name], which consists of the [Detailed description of Program Initiatives]

I. LIFE OF THIS AGREEMENT

This agreement is effective on the first day of [Include date], and terminates upon mutual agreement between the [Name of LE Agency] and [Name of BH Agency]. The life of this agreement is also subject to Section IX of this MOA.

II. AUTHORITY

The foundation of this agreement is established pursuant to the written communication between [Name of LE Agency] and the [Name of BH Agency] on [Date of initial communication].

III. PURPOSE OF THIS AGREEMENT

[Include purpose of agreement here]

IV. NAME OF JOINT OPERATION

[If applicable, include name of joint Operation with brief description]

V. MISSION OF THE OPERATION

[Include Mission of Operation here]

VI. MANAGEMENT OF OPERATION

Executive [Name of LE Agency] management responsibility over the [Name of Operation] shall remain with the Program Coordinator assigned to [Name of Division/ Unit]. Functional [Name of LE Agency] management responsibility shall remain with the Captain assigned to [Name of Unit / Division]. Line management responsibility over the [Name of Operation] shall remain with the [Name of LE Agency] Mental Illness Project Coordinator assigned to the [Name of Operation/Division/Unit].

Executive [Name of BH Agency] management responsibility over the [Name of BH Agency] personnel assigned to the [Name of Operation] shall remain with the [Title of BH Agency Personnel] in the [Name of BH Agency]. Functional [Name of BH Agency] management responsibility shall remain with the [Title of BH Agency Personnel] at the [Name of BH Agency]. Line management responsibility over [Name of BH Agency] personnel assigned to [Name of Operation] shall remain with the [Name of BH Agency] [Title of BH Agency Personnel], assigned to the [Name of Operation].

The [Name of LE Agency] shall recognize the [Title of BH Agency Personnel] from the [Name of BH Agency] and the [Title of LE Agency Personnel] of [Name of Agency] staff officer equivalents. The [Name of LE Agency] shall recognize the Title of LE Agency Personnel] as [Name of Agency] as a LAPD command officer equivalent.

VII. CONDITIONS AND PROCEDURES

A. DEPLOYMENT OF PERSONNEL BY [Name of LE Agency]

[Insert detailed information on deployment of personnel from LE Agency]

B. DEPLOYMENT OF PERSONNEL BY [Name of BH Agency]

[Insert detailed information on deployment of personnel from BH Agency]

C. OFFICE SPACE, TRANSPORTATION, EQUIPMENT AND SUPPLIES

[If Applicable, insert information regarding [Name of LE Agency] provision of office space, transportation, equipment use, and supplies for [Name of BH Agency] personnel.

D. ACCESS TO POLICE FACILITIES

[If Applicable, insert information on access to [Name of Agency] facilities by [Name of BH Agency] personnel.

E. CONFIDENTIALITY AND SHARING OF INFORMATION

All personnel assigned to the [Name of Operation] shall be knowledgeable and abide with the provisions of the law pertaining to confidentiality of information related to a client's mental history and other medical records, and shall be in HIPPA (Health Information Privacy Protection Act) compliance both in areas of privacy and security of protected health information.

The mental health history of a client is accessed only by [Name of BH Agency] clinicians and is made available to police only during critical indents. The clinicians may disclose appropriate and relevant information and any other protected mental health information to other specialized units within [Name of LE Agency] in the following circumstances:

- In response to a court order, warrant, subpoena, summons or process issued by a court.
- If the clinician believes that the client presents a serious present or imminent danger of violence to self or another person.

F. RESPONSIBILITY FOR DISPATCHING SMART OR CAMP

The [Name of LE Agency] [Name of Program] management will serve as the primary authority for generating work, and in dispatching program team when requests are made for their services. The [Name of Agency] management will prioritize all calls for service and dispatch accordingly. The [Name of BH Agency] agrees not to direct or re- direct [Name of BH Agency] personnel to perform duties not identified by the [Name of LE Agency] management. The [Name of BH Agency] will permit the [Name of Operation] to function within the confines of the [Name of LE Agency] structure and mission.

G. OFF-HOUR MANAGEMENT OF MENTAL ILLNESS RESPONSE CALLS

[If applicable, insert information regarding off-hour management of mental illness response calls]

H. UNUSUAL OCCURRENCES AND TACTICAL MOBILIZATIONS

[If applicable, insert information regarding unusual occurrences and tactical mobilizations

I. TRAINING

The [Name of LE Agency] will provide [Name of BH Agency] personnel with Mental Health Intervention Team training, and Crisis Negotiation Team training. The [Name of BH Agency] shall provide sworn [Name of Program] personnel mental illness field and investigative training relative to the [Name of Program] missions. The [Name of BH Agency] shall provide intellectual and personnel support to the [Name of LE Agency] for its mental illness training conferences and classroom training sessions as requested by the [Name of LE Agency].

VIII. PROGRAM AUDIT

This MOA and its obligations are subject to audit by both the [Name of LE Agency] and [Name of BH Agency]. Audits can occur as each department deems appropriate to assesses compliance with the terms of this MOA. The [Name of Agency] agrees to maintain all records relating to [Program Name] operations consistent with [Name of LE Agency] procedures governing records retention. The [Name of BH Agency] client records shall be housed for a period of seven years after contact with the client is terminated in compliance with the Welfare and Institutions Code. The [Name of BH Agency] will similarly retain its operations documents consistent with [Name of BH Agency] procedure governing records retentions.

IX. REVISIONS AND CANCELLATIONS

The terms of this agreement may be amended upon written approval by both original parties, and their designated representatives. The MOA becomes effective upon the date of approval. Either party can cancel this agreement upon 60 days written notice to the other party.

X. NO PRIVATE RIGHT CREATED

This is an internal Government MOA between [Name of Agency] and [Name of Agency] and is not intended to confer any right or benefit to a private person or party.

NAME
Chief of Police/ Sheriff
LE Agency Name
City, State
Date:_____

NAME
Director
BH Agency Name
City, State
Date: _____

Madison County Justice- Mental Health Collaborative Memorandum of Understanding

May 21, 2018

MEMORANDUM OF UNDERSTANDING

The Madison County Justice-Mental Health Collaborative is a Coalition of local agencies that meet on a monthly basis and work together to make the community a better place to live. The focus of the Collaborative is on adults with serious mental illness, substance abuse issues, or co-occurring disorders who come in contact with the Justice System (the "target population"). The Collaborative has the following responsibilities.

- Conduct community planning to determine interactions that the target population has with the Justice System.
- Identify the current programs and services available for the target population in Madison County, especially in relation to interaction with the justice system.
- Identify the gaps in services, programming, policies and procedures for the target population and the local justice system.
- Develop strategies, programs, and services to address the identified gaps in services.
- Develop policies and procedures that ensures the justice system interaction with the target population balances their needs and meets legal requirements.
- Oversees and promotes crisis intervention team training (CIT), train-the-trainer classes, other classes on autism, veterans, post traumatic stress disorders and others for first responders
- Promotes the Law Enforcement Mental Health National Learning Center through organizing trainings and hosting conferences
- Conducts case review by identifying members of the target population with multiple arrests in prior three months to develop plans of care and wraparound services to limit their future interaction with the justice system
- Participate fully in the Justice Mental Health Collaborative Grant Program
- Oversees the collection, review, analysis of data on the interaction of the target population with the justice system.
    - Number of the target population diverted from Jail by local programs
    - Number of mental health/CIT calls from Jackson Police Department and Madison county Sheriff's Office
    - Number of the target population that received services from the local crisis stabilization unit or Crisis Detox; number going to the acute care hospital emergency room
    - Number of target population placed under observation at the local Crisis Walk In Center
    - Number of the target population receiving early release from jail and referred into treatment services by type of treatment service
    - Number of target population completing recovery court programs
    - Estimated monthly cost savings to local criminal justice system based on total number diverted each month
    - Local monthly jail census and recidivism
    - Number of target population transported using alternate transportation
    - Number of local meetings each month of key partners
    - Number of times Narcan administered
    - Number of first responders trained each month
    - Number of behavioral health professionals trained each month

Memphis Policy Department Policy and Procedures: Dealing with Mental Illness/ Crisis Intervention Teams

Dealing With Mentally Ill / Crisis Intervention Team

I. Recognition of Mental Illness

Signs or symptom which may indicate the presence of Mental Illnesses:

- Loss of memory/disorientation
- Delusions - These are false beliefs that are not based in reality. The individual will often focus on persecution or grandeur (he/she is God)
- Depression
- Hallucinations - hear voices, or see, smell, taste or feel things
- Manic behavior - accelerated thinking and speaking or hyperactivity with no or little need for sleep - may also be delusional
- Anxiety - feelings are intense, state of panic or fright
- Incoherence - difficulty expressing themselves, disconnected ideas and/or thoughts
- Response - may process information more slowly

When an officer recognizes that they are potentially dealing with a mental consumer, they should consider applying some of the following de-escalation techniques. If the person is actively violent the officer may request assistance from a CIT Officer.

The officer should:

- Assess safety issues
- Introduce yourself and attempt to obtain the person's name.
- Remain calm and avoid overreacting
- Be helpful
- Present a genuine willingness to understand and help
- Speak slowly, low tone -- using short sentences – repeating
- Move slowly
- Remove distractions or disruptive people from the area
- Demonstrate "active listening skills" – i.e., summary of verbal communications.

The officer should NOT:

- Engage in behaviors that can be interpreted as aggressive.
- Allow others to interact simultaneously while you are attempting to talk to the person and to stabilize the situation.
- Corner, or be cornered: (Give the person expanded space and ensure that you, the officer, has expanded space and a safe exit, if it should become necessary).
- Raise your voice, use a sharp edge in your speaking, or use threats to gain compliance.
- Attempt to gain compliance based on the assumption that the person is as reasonable about things as you are.
- Argue

Officers will receive entry level training regarding recognition and interaction with mentally ill persons. Refresher training will be given a minimum of every three years, and will be given at in-service training, or in the form of a training alert tape. (41.2.8 a, c, d, e)

II. Crisis Intervention Team

The Crisis Intervention Team is made up of volunteer officers from each Uniform Patrol Precinct. C.I.T. Officers have received specialized training with regard to mental disturbance type events.

C.I.T. Officers currently respond to regular police service calls, in addition to mental disturbance crisis events.

On all police service calls involving mentally ill individuals in a disturbance/crisis event, the dispatcher will dispatch the nearest available precinct (city wide) C.I.T. car(s), along with necessary police patrol cars.

The C.I.T. Officer(s) on the scene of a mental crisis call has the duty and responsibility of that scene event and, if necessary, should advise other officers of request(s) that supports a team effort for a safe and appropriate disposition. The C.I.T. Officer(s) will maintain scene responsibility unless otherwise directed by a Supervisor. C.I.T. Officers also have the responsibility of completing a "C.I.T. STAT SHEET" Form.

If a C.I.T. car (city wide) is not available for a crisis call, the dispatcher will send the appropriate patrol cars. In this event, the dispatcher is to advise the patrol cars that "no" C.I.T. unit is available. The first officer(s) on the scene of a mental disturbance where a C.I.T. Officer(s) is not available for that response will weigh the situation based on the information and circumstances as presented and/or known. If in a situation that the scene officer reasonably concludes that a C.I.T. Officer(s) is necessary the scene officer(s) will request the dispatcher to "clear" a C.I.T. car(s). The dispatcher, in accordance with the officer's request, will contact the closest C.I.T. car that is available to "clear", and dispatch the C.I.T. car to the requested scene.

III. Handling Calls to Mental Health Facilities

A. If a treating facility feels that a person is of sufficient mental stability to be allowed a pass or furlough from the institution and that individual does not return, the person is probably not a candidate for police action. However;

B. If a person has escaped from an institution and constitutes a danger to himself/herself or others, officers of this department shall cooperate in the apprehension of the person, which includes taking a missing person report and, subsequently, if apprehended, returning him or her to the reporting facility.

C. If the mental patient has pending criminal charges, officers of this department will take all appropriate action to apprehend the individual and, likewise, return the party to the reporting facility until such time he or she is released for the purpose of criminal prosecution.

D. If the patient, while away from the institution, commits a criminal offense or sustains injury during the course of the apprehension, the officer should initially transport the patient to the Regional Medical Center and the County will make arrangements to deliver the individual to the reporting facility.

IV. Non-Emergency Civil Commitment

When an officer receives a request for information as to a Non-Emergency Civil Commitment, the officer may advise the citizen as follows:

A petition may be filed by a family member in Probate Court seeking to have the individual examined by doctors. This procedure, under T.C.A 33-6-504, allows treatment to be ordered for persons who are suspected to be mentally ill, but does not fit the guidelines for a TCA 33-6-401 emergency commitment.

In the event an officer is ever involved in any type of dispute with a citizen regarding this policy a Commanding Officer will be called to the scene.

V. Taking Mentally Ill Persons Into Custody:

The State Mental Health law has defined and established the right of law enforcement officers to take alleged mentally ill people into custody for evaluation.

The only time a mentally ill person can be taken into custody solely for being mentally ill is in an "Emergency Commitment" situation. (With one exception: Non-Emergency Civil Commitment through Probate Court TCA 33-6-504).

Officers can and should take a person into custody who appears to be mentally ill AND poses an immediate substantial likelihood of serious harm because of the mental illness. A "substantial likelihood of serious harm" is defined as:

IF AND ONLY IF:

A person has threatened or attempted suicide or to inflict serious bodily harm on himself, OR

The person has threatened or attempted homicide or other violent behavior, OR

The person has placed others in reasonable fear of violent behavior and serious physical harm to them, OR

The person is unable to avoid severe impairment or injury from specific risks, AND

There is a substantial likelihood that such harm will occur unless the person is placed under involuntary treatment.

Authorization to take a person into TCA 33-6-401 custody may be given by: a licensed physician/ health care psychologist or mobile crisis team social worker.

It is important to note that the emergency commitment law is intended to allow a police officer to act in order to prevent a person from harming himself/herself or others. The person does not have to be violent at the time the officer arrives on the scene. The person may be taken into custody when the officer arrives, and there is sufficient information available to lead the officer to a reasonable belief that the person is dangerous. This belief can be based on statement of the person, witnesses, family members, and on the physical scene itself (broken dishes, windows, furniture, torn clothing, weapons, etc.)

This determination is basically the same as any other probable cause determination. It can consist of minor facts or consist entirely of one fact (ex: the person is wandering around in traffic talking to himself/herself). The officer must simply be able to decide the issue of: "If I don't do something, this person is going to hurt himself/herself or someone else."

The intent of the law is that the officer will be able to take a person into 33-6-103 custody if he/she feels that the failure to do so will probably result in physical harm to the person or others.

When an officer takes a mentally ill person into custody through this process, the officer should transport the individual according to procedures outlined in Section VI below.

VI. Transporting of Emergency Commitment Persons (TCA 33-6-401)

A. Transporting to the Crisis Assessment Center:

1. When transporting becomes necessary regarding a TCA 33-6-401 call, then such transporting will be to the Crisis Assessment Center. An officer is authorized to take a person into custody if a licensed physician / health care psychologist or a mobile crisis team social worker advises the officer the person is subject to custody under TCA 33-6-401. An officer may also transport based on information and/or personal observations that can substantiate a T.C.A. 33-6-401 custody arrest. Call locations may include: Street, Private Residence, Public Locations, Non-Hospital Facilities - I.E. Mental Health Center, Doctor's Office, Crisis Stabilization Unit, et cetera.

2. 33-6-401 Arrest Tickets: The original and one copy are to be left at the Crisis Assessment Center. Officers will follow the procedures below, when transporting individuals to the Crisis Assessment Center for treatment:

   a. Officers may park in the curved lane next to the south side main entrance to the building. Officers should not block the access ramp under the canopy.

   b. Officers will enter the building through the front door and take the elevator to the second floor. Between the hours of 11 PM and 7 AM, the doors could be locked if the front desk security guard is making rounds. If this occurs, officers should have the dispatcher call the CAC, 577-9400, for entry.

   c. Officers will use the lock boxes located outside of the elevators on the second floor to secure their weapons before entering the facility.

   d. Officers will be directed to take the individual into the assessment rooms or holding tank before turning in the paperwork and briefing CAC personnel about the individual at the front desk.

   * The holding tank is provided for individuals who display violent behavior. If the holding tank and all rooms are occupied, and officers may be asked to wait with an individual until space becomes available.

3. In the event that the Crisis Assessment center refuses to accept a person due to their medical needs, an officer will be directed to transport the person to the Med. Upon arrival at the Med, the officer should check the person in and notify Med Securityfor

release of custody. Med personnel will contact the Crisis Assessment Center (577-9400) about assessing the person.

4. If the situation warrants, and the person is violating a criminal statute, then the person may be charged with a criminal offense. The CAC will not accept persons with a warrant(s) or criminal charges. Persons with warrant(s) or criminal charges should be taken to the Med ER. If a patient (TCA 33-6-401) is brought to the MED ER then the following procedures should be completed by the arresting officer:
   a. Arresting Officer completes Hold Ticket (leave Hold Ticket with MED Officers.)
   b. Arresting Officer completes original Arrest Ticket and leaves it at the MED Holding Station.
   c. Arresting Officer proceeds to the 24 hour Clerk's Office and submits an Affidavit of Arrest (misdemeanor or straight charge felony) regarding above mentioned arrested subject. 24 Hour Clerk maintains holding of signed Affidavit. Arresting Officer does NOT submit an arrest ticket to the Clerk nor to the CDO.
5. Patient/Prisoner with pending criminal charges who is subsequently referred to MMHI from the Med will be transported by a Med Officer when sufficient staff is available and delivered to MMHI with the following documents:
   a. Copy of the Arrest Ticket
   b. Certificate of Need
   c. The original and copy of Hold Ticket. The transporting officer will return a signed copy (by MMHI Personnel) of the Hold Ticket back to MPD MED Holding Station.
6. After Patient/Prisoner has been delivered to MMHI the transporting officer will proceed immediately to the CJC Sally Port and submit the Original Arrest Ticket of the Patient/Prisoner. Note: Emergency Commitment Charge is to be marked out - only criminal charges will be accepted. Detention Officer will confirm by phone the Patient/Prisoner is in fact detained at MMHI. On confirmation of this detention a booking number will be placed on the submitted arrest ticket.
7. After transporting officer receives the arrest ticket with a booking number the officer will proceed to 24 Hour Clerk's Office and then to the CDO Office. The officer will advise the 24 Hour Clerk an Affidavit is held on file. (Arresting officer has submitted an Affidavit after the Patient/Prisoner had been taken to the Med for Emergency Commitment Evaluation.)
8. If the Patient/Prisoner is <u>NOT</u> referred to MMHI for further TCA 33-6-401 proceedings then the patient will be transferred to the CJC Sally Port by a transporting officer following normal arrest booking procedures. Transporting Officer will continue booking procedures as outlined in number 7 above.
9. If the Patient/Prisoner is taken into custody for TCA 33-6-401: No new criminal charges, **but** a warrant check has indicated an <u>outstanding criminal warrant</u> then:

a. Warrant is to be verified and a Warrant Number is to be obtained from Fugitive Squad.

b. Patient/Prisoner is transported to Med Holding.

c. Arresting Officer completes MED Hold Ticket. (Hold Ticket is left with MED Officers.)

d. Arresting Officer completes original Arrest Ticket noting facts pertaining to TCA 33-6-401 custody, also including information regarding verified warrant (Warrant Number). After completing tasks (a) - (d) the arresting officer may return to service.

e. Patient/Prisoner with outstanding warrant who is subsequently referred to MMHI from the Med will be transported by a Med Officer when sufficient staff is available and delivered to MMHI with the following documents:

1) Copy of the Arrest Ticket
2) Certificate of Need
3) The original and copy of Hold Ticket. The transporting officer will return a signed copy (by MMHI Personnel) of the Hold Ticket back to MPD MED Holding Station.

f. After Patient/Prisoner has been delivered to MMHI the transporting officer will proceed immediately to the Fugitive Squad and submit the Original Arrest Ticket of the Patient/Prisoner. Note: Emergency Commitment Charge is to be marked out. Notation of an Outstanding Warrant and Warrant Number should be noted in the Arrest Ticket Narrative. Fugitive Squad Personnel are to be advised Patient/Prisoner is being held at MMHI. After completion of this task the transporting officer may return to service.

g. If the Patient/Prisoner is NOT referred to MMHI for further TCA 33-6-401 proceedings then the Patient/Prisoner and the original Arrest Ticket will be transported to the Shelby County Fugitive Squad at 201 Poplar following normal procedures.

B. Transporting by Ambulance (Med or Private Hospital):

1. In the event of an attempt suicide, injury or illness, paramedics will address the patient's (33-6-401) need for medical and transportation services. In addition to TCA 33-6-401 facts, if ANY of the following circumstances exists then the patient should be transported to the MED:
   a. Patient is out of control (acting out) and presents the likelihood of a continued confrontational encounter.
   b. No private hospital is willing or has agreed to accept the patient.
   c. Possibility of criminal charges.
2. The patient may be transported to a private hospital under each of the following procedures (non-custody):

a. The patient (33-6-401) is in need of medical attention as a result of an attempt suicide.

b. The patient is cooperating with paramedics and there is no evidence or information that would support further violence.

c. A private hospital has agreed to accept the patient.

Note: The receiving hospital has the responsibility to treat the patient for medical and psychological concerns (first signature evaluation if necessary). Officers are not required to accompany paramedics or maintain a presence at a receiving hospital. The patient is not under TCA 33-6-401 "arrest". Officers will take an Attempt Suicide Report.

3. If a 33-6-401 patient is in need of medical care and the paramedics request police assistance or intervention regarding transporting, officers will charge the patient with TCA 33-6-401 (Emergency Commitment). The patient is to be transported to the MED, and an arrest ticket is to be submitted. If requested, an officer will accompany paramedics during transport. The Crisis Center will be contacted by MED personnel.

4. If paramedics advise that a patient is medically stable and does not require ambulance service, and the officer can substantiate the charge of TCA 33-6-401, then the officer should transport patient to the Crisis Assessment Center.

5. If criminal and emergency commitment charges are placed on a patient in need of medical care then the patient is to be transported to the MED. See also Section A. 3. above.

C. <u>Transporting Juveniles:</u>

1. All Juveniles that are taken into TCA 33-6-401 custody who do not require serious medical attention will be transported to Lakeside Intensive Care Assessment Center (ICAC) located at 2911 Brunswick Rd **or** St. Francis Hospital East ER (on Park Ave.). **Officers should "hand write" the arrest ticket for these individuals as there is no way to print the arrest ticket at the facilities.** A copy of the arrest ticket should be forwarded to the C.I.T. Coordinator's Office.

   a. The following procedures should be followed when transporting an individual to the Lakeside Intensive Care Assessment Center:

      1) Officers should park in the circle drive in front of the building.

      2) Officers should use the phone in the grey box on the wall by the door to call the office. Officers do not have to dial a number; the phone will immediately ring the office. A staff member will meet officers and take them to the reception area.

      * Officers may call ahead to the office at 901-377-4729. If there is no answer at this line, officers may call 901-377-4733. This line will always be answered. This is not required.

      3) Once inside, the staff member will take responsibility for the consumer and escort them to the patient waiting room.

4) The staff member will then receive a verbal report from the officer, and make a copy of the arrest ticket.
5) The officer will then be able to return to service.

b. The following procedures should be followed when transporting a juvenile to St. Francis Hospital East ER:
1) Officers should enter the Emergency Room with the juvenile and advise the ER staff that they have a juvenile transported for Emergency Commitment who needs to go to the Clinical Assessment Center.
2) Officers will be directed to the secured area where they will be met by a staff member.
3) Officers will submit the arrest ticket, explain any details to the staff for the juvenile to be accepted, and get a copy of the arrest ticket.
4) The officer may return to service once the juvenile is secured.

2. Juveniles under the age of fourteen (14) who require serious medical attention will be transported to LeBonheur. Juveniles fourteen (14) year of age or older who require serious medical attention will be transported to the MED.

D. <u>Transporting Patients (TCA 33-6-401) From A Private Hospital to another Facility:</u>

1. Private hospitals that request transportation to other hospitals or facilities, are to be advised to contact the Shelby County Jail Transport Team or a private ambulance service.
2. If a private hospital is unable to obtain the above mentioned transport service then MPD will accommodate a transport to MMHI (ONLY) per the procedures outlined in Section E below.
3. Hospital Disturbance Call - See Section F below.

E. <u>Transporting To M.M.H.I.</u> (State Hospital):

1. CERTIFICATE OF NEED is required.
2. Medical Clearance is required. (Medical Clearance Defined: Given by a medical doctor stating that the patient (33-6-401) has no immediate medical problems that require medical intervention.)
3. M.M.H.I. approval is required. Hospital should obtain M.M.H.I. staff approval before a patient is transferred. If the patient is not committable to M.M.H.I. then the patient would not be an appropriate 33-6-401 transport.

NOTE: Transporting to M.M.H.I. the officer will: complete an arrest ticket noting the EMERGENCY COMMITMENT and the transport disposition; transport to 951 Court (Admissions); deliver CERTIFICATE OF NEED and Medical clearance documentation and a copy of the arrest ticket. Original arrest ticket (no criminal charges) is to be taken to Med Holding.

F. <u>Transporting From Private Hospital Regarding 33-6-401 Disturbance Calls</u>: (Disturbance on the Scene)

1. A mentally ill person walks in a hospital E.R. and causes a disturbance which jeopardizes the safety of hospital personnel and the public. If the person is exhibiting behavior consistent with TCA 33-6-401 and is not a patient to that hospital and police action is the most prudent response, then officers should affect an emergency custody arrest (TCA 33-6-401). The officer should transport the patient to the Crisis Assessment Center. If medical attention is required then this should be addressed before the officer assumes a transporting role.

2. It is the intent of the Department to cooperate with private hospitals as has been previously outlined in this section (F) and Section (D) above.

3. If a First Signature evaluation has not been completed by hospital personnel then the officer should request that the hospital comply with Section E above. In the event that these procedures are not complied with and the patient is in need of TCA 33-6-401 proceedings then the officer should affect an emergency commitment charge. The patient would be transported to the Crisis Assessment Center documenting the TCA statue and the transporting circumstances including the name(s) of hospital personnel who conversed with the officer. A copy of this arrest ticket should be forwarded to the CIT Coordinator in an effort to ensure cooperation between the Department, area hospitals and mental health advocates (National Alliance on Mental Illness).

G. <u>Transporting Request: Physician / Health Care Psychologist or Moble Crisis Team Social Worker</u>: (Non-Hospital Event)

1. TCA 33-6-401 allows a licensed physician / health care psychologist or mobile crisis team social worker to authorize custody (TCA 33-6-401) of a patient. The ideal situation would be to have the physician/clinical psychologist meet the officers on the scene and to articulate the facts which substantiates TCA 33-6-401. However, this is not always feasible in every circumstance. If the physician is not present on the scene then the most practical response would be to have the physician communicate with the officer by phone. After conferring with the physician and receiving facts supporting TCA 33-6-401, the officer should transport to the Crisis Assessment Center and note the appropriate details.

2. Officers that are requested to take involuntary custody action should consider how reasonable the request for officers to take action is. Most requests will involve "attempt suicide calls". Example: A physician advises officers that he/she has reason to believe that a patient is going to commit suicide, however, the patient does not open his/her door and refuses to talk with officers. Officers should confer with their supervisor. The question is how reasonable would it be to force entry or set up for a barricade? The totality of the facts and circumstances must be considered in order to determine what is a reasonable response and the immediacy to act accordingly.

3. There are occasions when a physician / health care psychologist or mobile crisis team social worker will meet an officer on the scene (non-hospital) with a signed Certificate of Need. In this situation the officer would receive facts that support TCA 33-6-401 custody and transport the patient to the Crisis Assessment Center. Transporting the patient to the Crisis Assessment Center completes the requirement of obtaining medical clearance for M.M.H.I. Transporting responsibility ends at the Crisis Assessment Center.

H. In the event a dispute arises regarding the Police Department's Emergency Commitment Transport Policy, a Supervisor will be called to the scene.

VII. Mental Health - Community Resources

In the event that an individual does not meet the criteria set forth above, the following community resources are available to the individual:

Calvary Street Ministry	543-0372
Catholic Charities	722-4700
Case Management INC.	821-5600
Crisis Center	274-7477
Genesis House	726-9786
Homeless Detox	Regional Medical Center
Mobile Crisis Team (Mental Health)	577-9400
National Alliance on Mental Illness (NAMI)	725-0305

SAMPLE LAW ENFORCEMENT CIT POLICY

This policy is for Department use only and shall not apply in any criminal or civil proceedings. The Department policy should not be construed as a creation of a higher legal standard of safety or care in an evidentiary sense with respect to third party claims. Violations of this directive will be basis for Department administrative sanctions. Violations of law will form the basis for civil and criminal sanctions in a recognized judicial setting.

I. PURPOSE

The Department will exercise leadership in the community in responding to incidents involving persons with a mental illness who are in crisis. An immediate and well-executed response can make a major difference in the proper disposition of the case and enhance the quality of life of all concerned.

II. POLICY

It is the policy of the Department to promptly respond to and seek to resolve calls where a citizen with a mental illness is in need of services. It is the duty of police officers responding to a mental illness call to provide for the safety of all persons, and attempt to assist the individual through the immediate crisis. When the person remains in crisis and exhibits signs that they are a danger to themselves or others, officers shall take the person into emergency custody and transport them to a health care professional. In cases that do not warrant an emergency custody detention, officers will endeavor to assist the individual by providing reference materials related to mental health care providers for their continued well being beyond the immediate call for assistance.

III. PROCEDURE

A. Definitions

1. Crisis Intervention Team Officer (CIT): An officer who has received specialized training in recognizing symptoms of mental illness, identifying persons who are in crisis, and communication skills to assist in de-escalating potentially dangerous situations.

2. Crisis: A person is in crisis when they are unable to cope with internal or external stimuli creating an inability to function at a reasonable level, thus creating a risk of harm to themselves or others.

3. Mental Illness: A condition described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) in which a person may experience random or disorganized thought patterns, or demonstrate bizarre or unusual behavior.

4. Emergency Custody Order (see General Order titled Legal Process and COV § 37.1-67.01).(VA Code 37.2-808 for adults and 16.1-340 for juveniles)

5. Temporary Detention Order (see General Order titled Legal Process and COV § 37.1-67.1).(VA Code 37.2-809 for adults and 16.1-340.1 for juveniles)

B. Communication Center Responsibilities

1. Because the Communication Officer is likely to be the first person to receive a call, the Communication Officer becomes a vital link in recognizing calls where CIT officers should be dispatched. These calls include suspected mental illness, ECO service, and persons with prior Department contact who officers suspect or have reason to believe have issues related to their mental health.

2. When a Communication Officer receives a CIT call they shall advise the Uniform Division supervisor on duty and dispatch any available on duty CIT officer. A list of CIT officers is maintained in the Communication Center.

3. The Communication Officer is responsible for dispatching a call's priority which is assigned by CAD. The Communication Officer will, when possible, gather the following information to aid in determining the appropriate call type:

    a. type of incident reported,

    b. location of incident,

    c. name of assailant,

    d. if a weapon is involved,

    e. have any persons at the address been injured,

    f. if any protective orders, injunctions, ECO or TDO's are in effect, and

    g. call history including previous CIT officer involvement.

4. If there is evidence of an injury, the presence of a weapon, or a crime is in progress, the call will be assigned as a Priority I. The Communication Officer will keep the complainant on the phone if possible and obtain additional information, such as:

    a. the assailant's whereabouts, (if not known, obtain direction of travel and elapsed time), and

    b. are alcohol, drugs, or medications involved.

5. The Communication Officer will attempt to maintain telephone contact until the officers arrive in order to advise the victim of the Department's response and to monitor the incident and provide support to the victim.

C. Sworn Officer's Responsibilities

1. CIT Officers should respond and should be the primary officers on all calls for service which pertain to subjects with a suspected mental illness. These include but are not limited to ECO service.

2. The shift supervisor will monitor dispatched calls involving suspected mental illness and ECO service. Supervisors should assign a CIT Officer in place of, or in addition to, the CAD assigned officer.

3. All officers who respond to calls involving a subject with a suspected mental illness will complete a CIT Report form. The primary officer who is not CIT trained, but is required to handle a call due to unavailability of CIT personnel, will complete the form as accurately as possible for potential follow-up by CIT.

D. Supervisor's Responsibilities

1. A copy of all CIT reports will be forwarded to the CIT program supervisor for review and possible follow-up.

2. The CIT program supervisor will maintain a log of CIT contacts with subjects and any assigned follow-up. The logbook will be maintained by the CIT program supervisor in a locked file cabinet. The CIT supervisor will submit a yearly evaluation of the CIT program to the Chief no later than the end of January for each preceding calendar year. This report will include, at a minimum:

   a) the number of CIT calls to which officers responded,

   b) the number and percentage of these calls in which, CIT officers were assigned as primary responders,

   c) the number of CIT officers that conducted call follow-ups,

   d) any other information relative to the evaluation of the CIT function, and an assessment of the effectiveness of the CIT program.

3. The CIT program supervisor will be responsible for updating the CAD premise hazard log in the Communication Center using the information obtained from the CIT contact logbook.

4. The CIT program supervisor will normally be available by pager for CIT officers to consult on appropriate courses of action.

E. ECO DECISION

1. Once officers have assessed the situation, they must make a determination whether or not to take the person into emergency custody. The decision is made based on the belief that the individual is a danger to themselves or others.

2. Even when the officer is able to assist the individual through a crisis, the individual will be encouraged to seek additional professional assistance. This should be accomplished by having a family member or friend take them to a health care provider for a voluntary committal, or referral back to their counselor the next day.

3. The CIT program supervisor may assign a Team member for follow-up when it is deemed that it could be beneficial. While not qualified to provide treatment or make a diagnosis, the CIT Officer's goal will be to serve as a resource to the individual when possible.

END OF GENERAL ORDER 10.9.1
4th Edition CALEA References 55.1.3 (a, d)

Kansas City, MO Procedural instructions for Persons with Mental and/or Substance Abuse Disorders

KANSAS CITY, MO. POLICE PARTMENT **PROCEDURAL INSTRUCTION**	DATE OF ISSUE 06-23-09	EFFECTIVE DATE 07-07-09	NO. 09-4

Subject	AMENDS
Persons with Mental and/or Substance Abuse Disorders	

REFERENCE	RESCINDS
RSMo 631.120 & 632.305.3 P.I. Arrest Guidelines; Patrol Procedures; Operation 100	Procedural Instruction 07-3 Department Memorandums 90-3, 03-6

I. PURPOSE

To present guidelines for dealing with persons exhibiting a mental and/or substance abuse disorder, including persons that have displayed an imminent likelihood of serious physical harm to themselves or others.

II. PROCEDURE

This directive is divided into the following annexes:

Annex A- Persons Exhibiting a Mental or Substance Abuse Disorder, Including Intoxicated Persons
Annex B- Crisis Intervention Team
Annex C- Negotiator Response
Annex D- Mental Health Facility Walkaways
Anenx E- Mental Health Pick-Up Orders

James D. Corwin
Chief of Police

Adopted by the Board of Police Commissioners this this_____day of_____2009.

Mark C. Thompson
President

DISTRIBUTION: All Department Personnel
Post on all bulletin boards for two weeks Public
View Master Index – Internet Department
Master Index – Intranet

ANNEX A

PERSONS EXHIBITING A MENTAL OR SUBSTANCE ABUSE DISORDER, INCLUDING INTOXICATED PERSONS

A. General Information

1. Officers responding to incidents involving a person suffering from a mental or substance abuse disorder must be aware that the individual may exhibit signs of agitated/excited delirium. Agitated/excited delirium is defined as a state of extreme mental and physiological excitement, characterized by extreme agitation, hyperthermia, extreme tearing of the eyes, hostility, exceptional strength, and endurance without fatigue. Other signs or symptoms may include but are not limited to profuse sweating, foaming at the mouth, hallucinations, and exhibiting signs of a high body temperature.

2. If a subject appears to be exhibiting signs of agitated/excited delirium, members will request Emergency Medical Services (EMS) personnel to respond to the scene. The member will also request a field supervisor and commander respond to the scene.

3. When an officer believes that, unless a person is taken into custody, there exists the likelihood that the person will cause serious physical harm to themselves or others as the result of alcohol and/or drug abuse, the officer may take the individual into custody and transport them to a mental health/drug-alcohol abuse facility. Persons primarily exhibiting symptoms of intoxication may be taken to a detoxification center as an initial option.

4. Officers may take a person into custody for evaluation and treatment when there are reasonable grounds to believe the person is suffering from a mental disorder, or alcohol and/or drug abuse, and presents an imminent likelihood of serious physical harm to themselves or others.

B. An officer may be dispatched to meet a mental health provider for purposes of taking a person into custody for involuntary detention and transportation to an appropriate mental health facility. On such occasions, the mental health provider must present a completed Department of Mental Health “Application for 96 Hour Imminent Admission to a Mental

Health or Alcohol and Drug Abuse Facility" (DMH Form 132) for the person prior to an officer taking the person into custody or transporting them to a facility. The officer must conduct his or her own investigation, regarding the individual in question. The officer must have independent reasonable cause (in this context reasonable cause is equivalent to reasonable suspicion) to believe that such person is suffering from a mental disorder and that the likelihood of serious harm to themselves or others is imminent unless such person is immediately taken into custody. If the officer does take the person into custody the officer must complete another "Application for 96 Hour Imminent Admission to a Mental Health or Alcohol and Drug Abuse Facility" (DMH Form 132) based on their own personal observations or investigation. Officers may also be required to complete the "List of Witnesses" (DMH Form 137) and "Affidavit" (DMH Form 142). Officers may refuse to seize an individual when it appears forcible entry will be required and the officer has legitimate reason to believe:

1. That the person in question does not pose an imminent risk of serious physical harm to themselves or others, or;

2. The mental health provider does not possess the appropriate application for admission form requesting officers to take custody of the individual for transportation to an appropriate facility.

*C. Offenses Committed by Mental Health Patients

1. If an officer is dispatched to a mental health facility regarding an offense committed by a patient, the officer will:

   a. Complete the appropriate report.

   b. For city cases, issue a General Ordinance Summons (GOS). Contact the appropriate investigative element on state cases.

   c. Use discretion in making a custodial arrest based on the overall condition of the suspect and the recommendations of the treating caregivers.

   d. When the offense is an assault, the Assault Squad will be notified by phone. In the event the Assault Squad is not available, the Homicide Unit is to be notified.

2. The reporting officer shall record all notifications made by phone or in person by documenting the time notification was made and the identity of the person notified.

D. Persons Suffering from a Mental Disorder and Alcohol and/or Drug Abuse

1. Persons suffering from a mental disorder, alcohol and/or drug abuse, and persons taken into custody for mental health evaluation and treatment shall be taken directly to one of the below listed facilities, except when there are complaints or visible signs of physical injury. Officers should use their best judgment in the event that the person is uncooperative. Officers shall not place a police hold on the person unless warrants are existing. The following are available mental health center locations:

   a. Western Missouri Mental Health Center (W.M.M.H.C.), 1000 East 22nd Street, Kansas City, Missouri.

      Individuals who have a police hold placed on them will be taken to W.M.M.H.C. Involuntary admissions will be accepted at W.M.M.H.C. for persons who are mentally disturbed persons and who display an imminent likelihood of serious physical harm to themselves or others. The reporting officer, when not CIT certified, will provide a detailed explanation for the police hold on the Mental Health Center Report, Form 208 P.D.

   b. Truman Medical Center-Lakewood, 7900 Lee's Summit Road, Kansas City, Missouri.

      T.M.C.-Lakewood shall not be used if the mentally disturbed person exhibits violent/aggressive behavior or if an imminent likelihood of serious physical harm to themselves or others exists. Prior to transportation, T.M.C.-Lakewood should be contacted to determine if adequate staffing is available.

2. For officer safety purposes officer(s) may request additional assistance upon their arrival at the receiving facility to assist in handling an uncooperative person.

E. The officer having the most knowledge of the circumstances shall:

1. Respond to the receiving facility.

2. Complete and submit a copy of the Mental Health Center Report, Form 208 P.D., and any other required state reports to the admitting staff.

3. Answer additional questions from the admitting staff.

4. Complete all other necessary reports. When an Incident Report is required in regard to the incident, officers may use the narrative from the Mental Health Center Report, Form 208 P.D., or the state forms entitled, “Affidavit in Support of Application for Detention, Evaluation and Treatment/Rehabilitation – Admission for 96 Hours” (DMH 132), the "List of Witnesses" (DMH Form 137) and "Affidavit" (DMH Form 142). In the narrative portion of the Incident Report the officer will write, "see attached report(s)." The attached report will have the case report number printed in the designated area or at the top right corner of the page, when an area is not assigned. Additionally, the report will be given a page number and have the current date on it. These reports will be scanned into Intellivue.

F. Admitting personnel may request an officer accompany a mentally disturbed person who exhibits violent tendencies to another location within the facility. The officer(s) may request additional officers if necessary.

G. Requests for a police response to transport an individual from a mental health facility to their home or other location should only be honored if the initial referral was generated by the police department.

H. Intoxicated Persons

1. Officers may release an intoxicated person to a responsible friend or relative at the scene, arrange for a taxi if a person is agreeable, transport the person to the person’s residence or transport the person to a patrol division if arrangements have been made for a friend or relative to pick up the person. Officers will use good judgment and discretion in choosing any of these options. Additional options available to officers include the use of the following alcohol detoxification services which accept indigent and drug abuse referrals for voluntary admission:

   a. Kansas City Community Center, Inc. (KCCC), 1514 S. Campbell Street, Kansas City, Missouri. (816) 421-6670

   b. Missouri Shield of Service (MOSOS) (Salvation Army), 5100 E. 24th Street, Kansas City, Missouri. (816) 483- 2281

   c. ReStart 918 E. 9th Street, Kansas City, Missouri. (816) 472-5664

2. All three facilities provide detoxification services for both male and female clients. The procedure for admission requires telephoning the facility **prior to** transporting to ensure accommodations and to answer basic questions regarding the individual's condition.

3. If the individual is too incapacitated to stand/walk unsupported or respond to the officer's requests, the Metropolitan Ambulance Service Trust (MAST) should be notified to transport the individual for medical attention. The determination as to the appropriate hospital will be left to the discretion of the MAST paramedics.

4. Persons that appear to be under the influence of drugs or extremely intoxicated, and persons complaining of, or having visible signs of physical injury, will be transported to a hospital emergency room for treatment prior to being transferred to an alcohol/drug abuse facility.

5. The officer's Daily Activity Log, Form 112 P.D., should reflect the date, time, and location of any contact with intoxicated parties and if applicable, the location where the individual is transported.

ANNEX B

CRISIS INTERVENTION TEAM (C.I.T.) OFFICERS

A. General Information

1. The C.I.T. program provides a specialized approach when police intervention may be required during events that involve an individual with a mental illness, who is in crisis. This program utilizes uniformed patrol officers and supervisors who have been specifically trained for response to these calls.

2. C.I.T. officers will utilize their training to assess the situation and use their best efforts to determine the least confrontational approach in resolving the incident. If the situation dictates, the request for an "Operation 100" and/or a Negotiator response may become a consideration.

B. Crisis Intervention Team Officers

1. The Daily Assignment/Exception Entry Sheet, Form 469A P.D., will alert the respective zone dispatcher of C.I.T. certified officers who are on-duty and will be faxed to the Communications Unit prior to the beginning of each shift.

2. When available, priority will be given by the dispatcher in dispatching a C.I.T. officer(s) to incidents involving a party experiencing a mental illness crisis.

3. Any officer, department-wide, may request a C.I.T. officer to assist in crisis intervention.

4. C.I.T. officers will be available to handle all other calls when not responding to calls involving mental illness.

C. Reporting Responsibilities of C.I.T. Officers

1. The primary officer on the call will be responsible for the completion of all other reports unless relieved by the C.I.T. officer.

2. C.I.T. officers will obtain an original Case Report Number (CRN) and complete a Crisis Intervention Team Report, Form 459 P.D., on all incidents involving an individual with a mental illness.

3. Any other reports taken as a result of the incident will require a separate Case Report Number.

4. Only officers who have received certified C.I.T. training will complete the Crisis Intervention Team Report, Form 459 P.D. All other officers will continue to use the Mental Health Center Report, Form 208 P.D., when transporting a party to a mental health facility.

ANNEX C

NEGOTIATOR RESPONSE

A. General Information

1. This annex is not to be construed as superseding or modifying Operation 100 procedures. If a person is threatening to harm themselves and also has the capacity of harming others (i.e., armed with a firearm), the appropriate response is an Operation 100.

2. The dispatcher will notify an available sergeant on all suicidal parties.

B. Officers having contact with a person threatening suicide, who is believed to have the means available, shall take appropriate action to minimize the danger to themselves and others. Police response will be directed toward successful negotiation with suicidal subjects when it can be done within a reasonable margin of safety.

C. The sergeant shall evaluate the incident and make a decision regarding a negotiator response. If necessary, the sergeant may:

1. Designate an assembly area.

2. Request a "Negotiator response."

3. Request a Tactical Response Team be dispatched to the assembly area.

D. The Communications Unit supervisor will notify the negotiator supervisor, a negotiator, the affected Tactical Response Team commander, and the Media Relations Unit.

E. The responding negotiators will work under the supervision of the Tactical Response Team commander.

F. The Tactical Response Team supervisor will have overall authority until the arrival of the Tactical Response Team commander, who will then assume overall command of the "negotiator response."

G. After Tactical Response Team personnel have taken responsibility for the scene, all officers and the sector sergeant may return to normal duties at the discretion of the Tactical Response Team commander.

H. Officers must exercise their best judgment, based on their own training, experience, and knowledge of department policies and procedures, when faced with unique and difficult situations.

ANNEX D

MENTAL HEALTH FACILITY WALKAWAYS

A. When an individual walks away from any mental health facility and it has been determined by mental health officials that the individual poses an imminent danger to themselves or others:

1. Officials from the mental health facility will notify the Communications Unit.

2. Communications Unit personnel will issue a broadcast for the return of the individual to the mental health facility.

B. An individual needing mental health care who also has a “Police Hold,” for a warrant(s), should be taken to W.M.M.H.C. When an individual with a police hold walks away from a W.M.M.H.C. facility:

1. Officials at W.M.M.H.C. will notify the Communications Unit.

2. The Communications Unit staff will contact the Detention Unit to verify the police hold and then issue a broadcast for the return of the walkaway to W.M.M.H.C.

C. Walkaways who have been committed to a mental health facility by court action will be entered into the Alert System by the appropriate court, county, or state law enforcement agency. Generally, no action should be taken unless a pick-up is entered into the Alert System and is verified through the appropriate mental health facility. This does not prevent department members from providing assistance if the walkaway has just occurred and the subject has been determined to pose an imminent danger to themselves or others.

ANNEX E

MENTAL HEALTH PICK-UP ORDERS

A. General Information

1. When an individual has been incarcerated in a mental health facility following acquittal of a criminal charge on the grounds of mental disease or defect and that individual completes treatment, a trial or conditional release may be granted by the facility.

2. Facility personnel can revoke this release and verbally request law enforcement personnel apprehend and return the individual to the facility. This is accomplished through the completion of a Notice of Revocation of Conditional Release. The Notice of Revocation of Conditional Release is not issued by a court of law and should be treated as a warrantless arrest. A Mental Health Pick-up Order may also be issued.

B. Mental Health Pick-up Orders, whether issued locally or through an outside agency, should be verified by the Fugitive and Arraignment Section from 0700 through 1500 hours, Monday-Friday and by the Warrant Desk at other times. If the officer is unable to make the contact, the dispatcher can be requested to verify the order.

1. Following verification of the pick-up order, the officer will transport the individual directly to Western Missouri Mental Health Center (W.M.M.H.C.).

   a. If during the apprehension process the individual commits a criminal act, the individual will be transported directly to W.M.M.H.C.

   b. The officer will contact the appropriate mental health official to inform them that there is probable cause to believe the person in-custody has committed a crime and request a Police Hold be placed on the person. An arrest number is not issued until the party is actually in custody at a department detention facility.

2. The officer will complete a Mental Health Center Report, Form 208 P.D., noting in the comment section that the person was apprehended on a Mental Health Pick-up Order.

3. The Warrant Desk will be contacted for cancellation of the Pick-up Order.

C. If an individual wanted on a Mental Health Pick-up Order voluntarily returns to W.M.M.H.C., an official from W.M.M.H.C. will notify Warrant Desk staff and request the Pick-up Order be canceled.

CIT Policy from Hartford, CT Police Department

I. PURPOSE:

This order establishes guidelines and procedures under which the Crisis Intervention Team (CIT) shall operate to ensure a coordinated response in providing services to persons involved in a crisis.

II. DEFINITIONS:

1. **Crisis Intervention Team (CIT):**

   A partnership between the police, telecommunicators, mental health professionals, and the community that seeks to achieve the common goals of safety, understanding, and service to persons in crisis, the mentally ill, and their families.

2. **CIT Officer:**

   A police officer trained and certified in first response crisis intervention. The CIT Officer works in partnership with the CIT Clinician to respond to incidents of persons in crisis.

3. **CIT Clinician:**

   A mental health professional who is trained in mobile outreach crisis intervention and works in partnership with CIT trained police officers to effectively respond to incidents of persons in crisis.

4. **Crisis Incident:**

   Any call in which an individual would benefit from the specialized training and knowledge of the CIT member. Crisis incidents include but are not limited to calls involving persons known to have mental illness who are experiencing a crisis; persons displaying behavior indicative of mental illness [with] attempted or threatened suicides; calls involving gravely disabled individuals; or calls in which individuals may be experiencing emotional trauma.

5. **Mentally Ill:**

   A person who has a mental or emotional condition, which has substantial adverse effects on their ability to function, and who requires care and treatment. Persons who are alcohol or drug dependent are excluded from this category because they would unlikely be receptive to intervention efforts.

6. **Gravely Disabled:**

   A condition in which a person, as a result of mental or physical impairment, is in danger of serious harm as a result of an inability or failure to [care for their own] human needs, and such person is mentally incapable of determining whether or not to accept such treatment.

7. **Incapacitated Person:**

   A condition in which a person, as a result of alcohol or drug use, has their judgment

impaired, so that they are incapable of realizing and making a rational decision regarding the need for medical treatment.

III. POLICY:

It is the policy of the Hartford Police Department to respond to incidents involving individuals with mental or behavioral health problems with professionalism, compassion, and concern for the safety of all involved. During these incidents officers shall use the CIT as a resource for identifying and providing services for the individual in crisis.

In the absence of a supervisor during the initial patrol response to a crisis incident as defined in Section II.4. of this general order, the senior CIT officer on scene has the authority to direct police activities. The CIT officer shall relinquish such authority when relieved by or at the direction of a supervisor. Non-CIT trained supervisors shall confer when possible with CIT officers in a unified effort to obtain a positive outcome in a crisis incident.

IV. PROCEDURE:

A. Identifying CIT Calls for Service

1. Public Safety Dispatch Center (PSDC) Radio-Telephone Operators (RTO) are the primary sources for identifying CIT calls. However, officers investigating an incident may classify it as a CIT situation.

2. Types of calls that may require a CIT officer response include, but are not limited to:

    a. Mental Health Disorders
    b. Traumatic Incidents
    c. Sudden Deaths
    d. Attempted Suicides
    e. Medical Assists/Well-Being Checks
    f. Breach of Peace/Disorderly Conduct
    g. Trespassing/Refusing To Leave Property

B. Public Safety Dispatch Center Responsibilities

1. RTOs shall attempt to compile the necessary information at the time of call intake and record the information in the comments section of the CAD screen. RTOs will identify calls needing a CIT Officer by typing CIT in the comments section.

2. Dispatchers shall alert the CIT Clinician over the police radio and advise them of the CIT call. Every effort shall be made to provide the clinician with as much
information as possible such as the subject/client's name, address, and activities.

3. Dispatchers shall refer to the list of CIT Officers on duty and attempt to dispatch a CIT Officer to CIT calls as the Primary Responder. If a CIT Officer is not available at the time of dispatch then they will respond as a secondary unit when they become available if needed.

4. The dispatcher shall alert the District/Zone supervisor to the dispatch of a CIT call for service.

5. The dispatcher shall amend the dispatch information based on initial information received from the officer on scene.

6. The dispatcher shall refer calls for service addresses to the PSDC Supervisor for review and entry into the Responder Alert System.

7. The PSDC shall maintain contact numbers for the CIT Clinician and other supporting agencies.

C. Responsibilities of the Patrol Officer (CIT and Non-CIT)

1. CIT Officers shall sign-in at the beginning of their shift with the PSDC Supervisor and ensure that the PSDC is aware that they are CIT certified.

2. Officers upon arriving at the incident and identifying it as a CIT call shall request that the clinician respond to the scene. Clinicians may be able to identify whether the subject is an existing client and can help with the disposition of the case. CIT
Officers should confer with the Clinician for advice. The final decision as to the outcome or arrest of t

3. Officers shall complete a CIR and any necessary documentation using the standards in section G. "Reporting and Documenting CIT calls" of this order. They shall refer the CIR to the clinician by checking the "other" box on the CIR and writing CIT. CIT shall be noted on the upper right hand corner adjacent to the case number.

4. **In arrest cases officers shall notify any transporting officer(s) and the Booking Supervisor that the prisoner is the subject of a CIT call so the necessary precautions can be taken.** Booking personnel will enter all arrest information per procedure.

5. When possible CIT Officers shall volunteer for CIT calls as primary or secondary responders if they are available. Non-CIT Officers may request assistance from CIT officers when necessary.

D. Responsibilities of the District/Zone Patrol Supervisor

1. Supervisors shall monitor the dispatching of CIT officers to the appropriate calls and ensure that the clinicians are called by officers to the incident scene as soon as practical for consultation and follow-up.

2. Supervisors shall ensure that a CIR is properly completed and that the report is referred to the CIT Clinician by being properly checked off and denoted CIT.

3. Supervisors shall ensure that the clinician is called to critical incidents involving individuals that have been exposed to traumatic situations.

E. Responsibilities of the CIT Clinicians

1. CIT Clinicians may attend roll calls.

2. CIT Clinicians with the approval of the HQ Shift Lieutenant ride with CIT and non- CIT officers and supervisors.

3. CIT Clinicians may be escorted across police barriers after showing proper ID and the notification of an on-scene supervisor.

4. CIT Clinicians shall retrieve and review CIT reports at the Crime Analysis Unit. Information in the police report will be considered confidential and may be used for clinical purposes only.

5. CIT Clinicians shall monitor the police radio frequencies and respond to calls as needed. They may be contacted and advised of the CIT call by:

    a. The CIT Officer on scene.
    b. The Supervisors at the scene or at any Critical Incident.
    c. The dispatcher or PSDC Supervisor requesting response to a scene or hospital.
    d. The HQ Shift Lieutenant requesting response to Headquarters or the Hospital.
    e. The Non-CIT Officers on scene.

6. CIT Clinicians will be assigned a work area in Headquarters, an access device to the building, a portable police radio, battery charger, and police department ID card.

7. CIT Clinicians may interview prisoners identified as CIT Clients in the Booking facility Interview Room, Hospital Emergency Room or other locations upon the request of a police supervisor or officer.

8. CIT Clinicians shall contact the CIT Coordinator regarding any problems or concerns. If the CIT Coordinator is not on duty and the issue is urgent the clinician may contact the HQ Shift Lieutenant or any other supervisor who is on duty to assist them.

F. Responsibilities of the CIT Program Coordinator

1. The Chief of Police shall designate a CIT Coordinator. The CIT Coordinator will serve as a liaison between the Police Department and the Department of Mental Health. The coordinator will handle issues arising from the implementation of the CIT Program.

2. The CIT Coordinator shall provide the Department of Mental Health with the necessary reports to meet grant criteria.

3. The CIT Coordinator shall review reports, evaluate outcomes, prepare, and forward a monthly report to the Chief of Police outlining the status of the team, response to calls for CIT service statistics, and issues/recommendations.

4. The Chief of Police or designee shall select the officers for CIT certification. Candidates shall attend a 40 hour certification program and receive in-service training as needed.

5. The CIT Coordinator shall coordinate with the Police Academy Commander to ensure that all CIT officers complete the basic 40 hour certification program and attend ongoing training sessions conducted by the Department of Mental Health and Addiction Services (DMHAS).

G. Reporting and Documenting CIT calls

1. A CIR shall be completed for incidents involving mentally ill or gravely disabled individuals whether handled by a CIT Officer or a Non-CIT Officer in compliance with HPD General

2. The CIR shall be properly completed and should also include the following information:

   a. CIT Subject/Client personal identification information.
   b. Who, what, where, when etc. (Narrative Section).
   c. Any visible injury to the subject or others.
   d. Location of treatment of the subject.
   e. Name, address, and phone number of any responsible family member on scene.
   f. Any appearance of alcohol or drug use shall be documented.
   g. The name of the CIT clinician that responded.
   h. Action taken/Referrals made.
   i. Name of the HPD supervisor who was notified of the CIT situation.

H. Crime Analysis Unit and Records Unit Responsibilities

1. The Crime Analysis/Report Review Unit will compile all CIRs documenting CIT incidents for the CIT clinician who will retrieve them daily from the unit.

2. The Crime Analysis/Report Review Unit will forward copies of all CIRs documenting CIT incidents for to the CIT Coordinator on a daily basis.

••• 216-05 •••

MENTALLY ILL OR EMOTIONALLY DISTURBED PERSONS

DATE EFFECTIVE: 09-28-07

PURPOSE

To safeguard a mentally ill or emotionally disturbed person who does not voluntarily seek medical assistance.

SCOPE

The primary duty of all members of the service is to preserve human life. The safety of ALL persons involved is paramount in cases involving emotionally disturbed persons. If such person is dangerous to himself or others, necessary force may be used to prevent serious physical injury or death. Physical force will be used ONLY to the extent necessary to restrain the subject until delivered to a hospital or detention facility. Deadly physical force will be used ONLY as a last resort to protect the life of the uniformed member of the service assigned or any other person present. If the emotionally disturbed person is armed or violent, no attempt will be made to take the EDP into custody without the specific direction of a supervisor unless there is an immediate threat of physical harm to the EDP or others are present. If an EDP is not immediately dangerous, the person should be contained until assistance arrives. If the EDP is unarmed, not violent and willing to leave voluntarily, a uniformed member of the service may take such person into custody. When there is time to negotiate, all the time necessary to ensure the safety of all individuals will be used.

DEFINITIONS

EMOTIONALLY DISTURBED PERSON (EDP) - A person who appears to be mentally ill or temporarily deranged and is conducting himself in a manner which a police officer reasonably believes is likely to result in serious injury to himself or others.

ZONE OF SAFETY - The distance to be maintained between the EDP and the responding member(s) of the service. This distance should be greater than the effective range of the weapon (other than a firearm), and it may vary with each situation (e.g., type of weapon possessed, condition of EDP, surrounding area, etc.). A minimum distance of twenty (20) feet is recommended. An attempt will be made to maintain the "zone of safety" if the EDP does not remain stationary.

PROCEDURE

When a uniformed member of the service reasonably believes that a person who is apparently mentally ill or emotionally disturbed, must be taken into protective custody because the person is conducting himself in a manner likely to result in a serious injury to himself or others:

1. Upon arrival at scene, assess situation as to threat of immediate serious physical injury to EDP, other persons present, or members of the service. Take cover, utilize protective shield if available and request additional personnel, if necessary.

a. If emotionally disturbed person's actions constitute immediate threat of serious physical injury or death to himself or others:

(1) Take reasonable measures to terminate or prevent such behavior. Deadly physical force will be used only as a last resort to protect the life of persons or officers present.

NOTE: Damaging of property would not necessarily constitute an immediate threat of serious physical injury or death.

b. If EDP is unarmed, not violent and is willing to leave voluntarily:

(1) EDP may be taken into custody without the specific direction of a supervisor.

c. In all other cases, if EDP's actions do not constitute an immediate threat of serious physical injury or death to himself or others:

(1) Attempt to isolate and contain the EDP while maintaining a zone of safety until arrival of patrol supervisor and Emergency Service Unit personnel.

(2) Do not attempt to take EDP into custody without the specific direction of a supervisor.

2. Request ambulance, if one has not already been dispatched.

a. Ascertain if patrol supervisor is responding, and, if not, request response.

NOTE: Communications Section will automatically direct the patrol supervisor and Emergency Service Unit to respond to scene in such cases. Patrol supervisors' vehicles are equipped with non-lethal devices to assist in the containment and control of EDP's, and will be used at the supervisor's direction, if necessary.

3. Establish police lines.

4. Take EDP into custody if EDP is unarmed, not violent and willing to leave voluntarily.

PATROL SUPERVISOR

5. Verify that Emergency Service Unit is responding, if required.

a. Cancel response of Emergency Service Unit if services not required.

6. Direct uniformed members of the service to take EDP into custody if unarmed, not violent, and willing to leave voluntarily.

NOTE: When aided is safeguarded and restrained comply with steps 25 to 32 inclusive.
BUT WILL NOT LEAVE VOLUNTARILY:

PATROL SUPERVISOR

7. Establish firearms control.

a. Direct members concerned not to use their firearms or use any other deadly physical force unless their lives or the life of another is in imminent danger.

8. Deploy protective devices (shields, etc.).

a. Employ non-lethal devices to ensure the safety of all present (see "ADDITIONAL DATA" statement).

9. Comply with provisions of PG 212-38, "Hostage/Barricaded Person(s)," where appropriate.

10. Establish police lines if not already done.

11. Request response of hostage negotiation team and coordinator through Communications Section.

12. Notify desk officer that hostage negotiation team and coordinator have been notified and request response of precinct commander/duty captain.

13. Request Emergency Service Unit on scene to have supervisor respond.

14. If necessary, request assistance of:

a. Interpreter, if language barrier

b. Subject's family or friends

c. Local clergyman

d. Prominent local citizen

e. Any public or private agency deemed appropriate for possible assistance.

NOTE: The highest ranking uniformed police supervisor at the scene is in command and will coordinate police operations. If the mentally ill or EDP is contained and is believed to be armed or violent but due to containment poses no immediate threat of danger to any person, no additional action will be taken without the authorization of the commanding officer or duty captain at the scene.

EMERGENCY SERVICE UNIT SUPERVISOR

15. Report to and confer with ranking patrol supervisor on scene.

a. If there is no patrol supervisor present, request response forthwith, and perform duties of patrol supervisor pending his/her arrival.

NOTE: The presence of a supervisor from any other police agency does not preclude the required response of the patrol supervisor

16. Evaluate the need and ensure that sufficient Emergency Service Unit personnel and equipment are present at the scene to deal with the situation.

17. Verify that hostage negotiation team and coordinator are responding, when necessary.

18. Devise plans and tactics to deal with the situation, after conferral with ranking patrol supervisor on scene.

DESK OFFICER

19. Verify that precinct commander/duty captain has been notified and is responding.

20. Notify Operations Unit and patrol borough command of facts.

COMMANDING OFFICER/DUTY CAPTAIN

21. Assume command, including firearms control.

22. Confer with ranking Emergency Service Unit supervisor on scene and develop plans and tactics to be utilized.

23. Direct whatever further action is necessary, including use of negotiators.

[IO 20/08] 24. Direct use of alternate means of restraint, if appropriate, according to circumstances.

WHEN PERSON HAS BEEN RESTRAINED:

UNIFORMED MEMBER OF THE SERVICE

25. Remove property that is dangerous to life or will aid escape.

26. Have person removed to hospital in ambulance.

a. Restraining equipment including handcuffs may be used if patient is violent, resists, or upon direction of a physician examiner.

b. If unable to transport with reasonable restraint, ambulance attendant or doctor will request special ambulance.

c. When possible, a female patient being transported should be accompanied by another female or by an adult member of her immediate family.

27. Ride in body of ambulance with patient.

a. At least two (2) uniformed members of the service will safeguard if more than one (1) patient is being transported.

NOTE: If an ambulance is NOT available and the situation warrants, transport the EDP to the hospital by RMP if able to do so with reasonable restraint, at the direction of a supervisor.

28. Inform examining physician, upon arrival at hospital, of use of non-lethal restraining devices, if applicable.

29. Safeguard patient at hospital until examined by psychiatrist.

a. When entering psychiatric ward of hospital, unload revolver at Firearm Safety Station, if available (see PG 216-07, "Firearms Safety Stations At Psychiatric Wards And Admitting Areas").

30. Inform psychiatrist of circumstances which brought patient into police custody:

a. Inform relieving uniformed member of circumstances if safeguarding extends beyond expiration of tour.

b. Relieving uniformed member will inform psychiatrist of details.

31. Enter details in ACTIVITY LOG (PD112-145) and prepare AIDED REPORT WORKSHEET (PD304-152b).

a. Indicate on AIDED REPORT WORKSHEET, name of psychiatrist.

32. Deliver AIDED REPORT WORKSHEET to desk officer.

ADDITIONAL DATA

Refer persons who voluntarily seek psychiatric treatment to proper facility.

Prior to interviewing a patient confined to a facility of the NYC Health and Hospitals Corporation, a uniformed member of the service must obtain permission from the hospital administrator who will ascertain if the patient is mentally competent to give a statement.

Upon receipt of a request from a qualified psychiatrist, or from a director of a general hospital or his/her designee, uniformed members of the service shall take into custody and transport an apparently mentally ill or emotionally disturbed person from a facility licensed or operated by the NYS Office of Mental Health which does not have an inpatient psychiatric service, or from a general hospital which does not have an inpatient psychiatric service, to a hospital approved under Section 9.39 of the Mental Hygiene Law.

Uniformed members of the service will also comply with this procedure upon direction of the Commissioner of Mental Health, Mental Retardation and Alcoholism Services or his/her designee.

[IO 20/08] USE OF NON-LETHAL DEVICES TO ASSIST IN RESTRAINING EMOTIONALLY DISTURBED PERSONS

Authorized uniformed members of the service may use a conducted energy device (CED) to assist in restraining emotionally disturbed persons, if necessary.

Emergency Service Unit personnel will obtain the permission of the Emergency Service Unit supervisor prior to utilizing a CED, except in emergencies.

Authorized members of the service will be guided by Interim Order 20, series 2008, "Use of

Conducted Energy Devices (CED)", when a CED has been utilized.

LESS LETHAL/RESCUE EQUIPMENT USE REPORT (PD 320-151) will be prepared whenever a less lethal restraining device or rescue equipment is used by a uniformed member of the service in the performance of duty.

The Commanding Officer, Investigation Review Section, will collate statistical information recorded on the REPORTS, and will forward a monthly report to the Office of the Chief of Department by the seventh (7th) business day of each month.

RELATED PROCEDURES

Aided Cases - General Procedure

(PG 216-01) Mental Health

Removal Orders (PG 216-06)

Unusual Occurrence Reports (PG

212-09) Investigation Of

Carjackings (PG 207-32)

Unlawful Evictions (PG 214-12)

Hostage/Barricaded Person(s)

(PG 212-38)

FORMS AND REPORTS

ACTIVITY LOG (PD112-145)

AIDED REPORT WORKSHEET (PD304-152b)

NON-LETHAL RESTRAINING DEVICE/RESCUE EQUIPMENT REPORT (PD320-

150) TASER/STUN DEVICE REPORT (PD304-150)

UNUSUAL OCCURRENCE REPORT (PD370-152)

CRISIS INTERVENTION TEAM (CIT)

General Order No. 379
Page 1 of 3
Effective Date 06JAN14

I. POLICY:

It is the policy of the Murfreesboro Police Department to have a Crisis Intervention Team (CIT) composed of police officers who have received specialized training in the area of mental health. CIT officers will respond to calls involving an individual who appears to be mentally ill.

II. CRISIS INTERVENTION TEAM.

A. Members of the Crisis Intervention Team will be selected according to the Specialized Assignments General Order.

B. CIT officers must successfully complete a CIT specialized training class prior to serving in a CIT capacity. Once officers have successfully completed CIT training, they are eligible to wear the CIT Pin on the police uniform above their nameplate as long as they serve on the CIT Team.

C. The CIT Coordinator will be appointed by the Chief of Police or designee. The CIT Coordinator will be responsible for maintaining statistical information about the Unit's response to calls as well as coordinating training for the unit.

III. PROCEDURES.

A. CIT officers respond to regular police service calls, in addition to mental disturbance crisis events. On all police service calls involving individuals who appear to be mentally ill and may be in a disturbance/crisis event, the dispatcher will dispatch the nearest available CIT officer, along with necessary police zone officers.

B. If a CIT officer (city wide) is not available for a crisis call, the dispatcher should advise the responding officers that no CIT officer is available. The first officer(s) on the scene of a mental disturbance where a CIT officer(s) is not available will weigh the situation based on the information and circumstances as presented and/or known. If the on-scene officer requests that a CIT officer(s) respond, the on-scene officer(s) will advise their supervisor of the current situation and explain why a CIT officer is needed. It will be the discretion of the supervisor whether to clear a CIT

car(s) from another call. If directed, the dispatcher, in accordance with the supervisor's instruction, will dispatch the CIT car to the requested scene.

C. CIT officer(s) on the scene of a mental crisis call have control of that scene event, and will maintain scene responsibility unless otherwise directed by a supervisor.

D. After responding to any CIT call, CIT officers should complete a "Crisis Intervention Team Incident Report" (see Appendix A) and submit it to the Records Section. This report is in addition to a basic Incident Report.

E. When an officer recognizes that they are potentially dealing with a mentally ill person, they should consider applying some of the following de-escalation techniques.

1. The officer should:

   a. Assess safety issues;

   b. Introduce themselves and attempt to obtain the person's name;

   c. Remain calm and avoid overreacting;

   d. Be helpful;

   e. Present a genuine willingness to understand and help;

   f. Speak slowly, in a low tone, using short sentences, repeating, if necessary;

   g. Move slowly;

   h. Remove distractions or disruptive people from the area; and

   i. Demonstrate "active listening skills" – e.g., summarize verbal communications.

2. The officer should NOT:

   a. Engage in behaviors that can be interpreted as aggressive;

   b. Allow others to interact simultaneously while the officer is attempting to talk to the person and to stabilize the situation;

c. Corner, or be cornered: (Give the person expanded space and ensure that the officer has expanded space and a safe exit, if it should become necessary);

d. Raise their voice, use a sharp edge in speaking, or use threats to gain compliance;

e. Attempt to gain compliance based on the assumption that the person is as reasonable about things as the officer is; and/or

f. Argue with the person.

Although the goal is to gain voluntary compliance, officer safety tactics should not be compromised.

F. When taking a determining whether to take a mentally ill person into custody for mental evaluation, see General Order #452 Emergency Committal.

EMERGENCY COMMITTAL

General Order No. 452

Effective Date 06JAN14

I. POLICY:

It shall be the policy of the Murfreesboro Police Department when dealing with an adult person who appears to be mentally ill to evaluate the needs of such person based on personal observations and other available information and to take such measures as may be available to obtain proper care to meet the person's needs.

II. PROCEDURES:

A. Obtaining Information.

When an officer authorized to make arrests in Tennessee encounters a person who appears to be mentally ill, the officer shall attempt to determine if the person needs care and treatment because of such mental illness by:

1. Attempting to collect credible and pertinent information from family members and other witnesses;

2. Observing the person; and

3. Talking with the person, if possible.

An officer may request a CIT trained officer to respond to assist.

B. Basis for Taking Person into Custody for Evaluation.

If the person poses an immediate substantial likelihood of serious harm, the officer shall take the person into custody to obtain an immediate medical examination to determine whether the person should be hospitalized for care and treatment in accordance with T.C.A. §33-6-401. The person may be taken into custody if and only if the officer reasonably believes that:

1. A person has a mental illness or serious emotional disturbance, AND

2. The person poses an immediate substantial likelihood of serious harm as defined under T.C.A. §33-6-501 because of the mental illness or serious emotional disturbance. "Substantial likelihood of serious harm" is defined as:

   a. A person has threatened or attempted suicide or to inflict serious bodily harm on the person; or

   b. The person has threatened or attempted homicide or other violent behavior; or

   c. The person has placed others in reasonable fear of violent behavior and serious physical harm to them; or

   d. The person is unable to avoid severe impairment or injury from specific risks; and

   e. There is a substantial likelihood that such harm will occur unless the person is placed under involuntary treatment.

   AND

3. The person needs care, training, or treatment because of mental illness.

   AND

4. All available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person.

C. Location of Evaluation.

If an officer takes such a person into custody, the officer shall immediately transport the person to the Saint Thomas Rutherford Hospital Emergency Room for observation, examination and certification by a licensed physician or by a qualified psychologist. Restraints may be used in transporting the person if necessary to prevent the person from harming self or others. Depending upon the person's behavior, the officer may be required to remain until released by the physician or psychologist.

If the person is eligible, family members may be informed that subsequent treatment, if necessary, may be provided at the Veterans Administration Hospital but that initial examinations pursuant to T.C.A. §33-6-103

instigated by officers are to be conducted at Saint Thomas Rutherford Hospital.

D. Request for Examination.

1. The officer shall complete a Request for Immediate Examination under T.C.A. §33-6-402 form, attached as Appendix A, requesting immediate examination of the person by a licensed physician or by a qualified psychologist which form shall be submitted to the medical staff at the time of the person's presentation.

2. The form shall include:

   a. The person's name;

   b. The officer's name and signature;

   c. The time and date of observation;

   d. The Department's event number;

   e. The name of any witness to the person's behavior; and

   f. Reasons for the officer's request.

3. If the examining medical personnel determine that the person should be admitted to a facility for further care and treatment, said medical personnel shall make the arrangements for transportation and/or admission.

4. An officer shall file an appropriate report concerning the officer's involvement and actions in any such process.

E. Criminal Activity.

1. If the person commits or has committed a criminal act, the officer may arrest the person for that act.

2. If the criminal act was a misdemeanor committed in the officer's presence or a felony, an arrest may be made whether or not the officer seeks to have the person examined under T.C.A. §33-6-103.

REQUEST FOR IMMEDIATE EXAMINATION UNDER T.C.A. §33-6-103 FOR CERTIFICATION OF NEED FOR CARE AND TREATMENT

On_____, at approximately_____A.M./P.M., I, _____, observed _____. At this time, I have reason to believe that he/she poses an immediate and substantial likelihood of serious harm. For purposes of this Request, "substantial likelihood of serious harm" means that a person has threatened or attempted suicide or to inflict serious bodily harm on the person; or the person has threatened or attempted homicide or other violent behavior; or the person has placed others in reasonable fear of violent behavior and serious physical harm to them; or the person is unable to avoid severe impairment or injury from specific risks; and there is a substantial likelihood that such harm will occur unless the person is placed under involuntary treatment; AND the person needs care, training, or treatment because of mental illness; AND all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person; AND, that there is a substantial likelihood that such harm will occur unless the person is placed under involuntary treatment. Therefore, I have reason to believe that this person is subject to detention without a civil order or warrant for immediate examination for certification of need for care and treatment.

I believe the person is mentally ill, that this person poses an immediate substantial likelihood of serious harm because of such mental illness, and that this person needs care, training, or treatment because of the mental illness, and that all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person. I therefore seek to have the person immediately examined by a licensed physician, or an actively practicing clinical psychologist with competency in clinical psychology under the laws of Tennessee and at least three years of experience, for certification of need for care and treatment at a hospital or treatment resource.

_____	_____
Event No.	Officer
_____	_____
Witness (name, address, relationship)	Witness (name, address, relationship)
_____	_____

Reasons: _____

_____

_____

MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

CRISIS INTERVENTION TEAM

Effective Date: May 24, 2018 **Policy:** TX-18

I. PURPOSE:

A. To ensure that patient and staff safety is maintained to the greatest extent possible when intervening with a patient who is demonstrating physical aggression or threatening physical aggression.

B. To provide guidelines for utilizing a team approach to crisis intervention that will provide protection for both patients and staff and maintain therapeutic relationships to the greatest extent possible.

II. POLICY:

A. Montana State Hospital (MSH) utilizes a model of intervention that treats people with dignity and respect and uses a system of gradual and graded alternatives for de-escalating and supporting people in behavioral crisis.

B. MSH will provide training to staff in crisis intervention processes that use a combination of interpersonal communication skills and physical interaction techniques designed to support the patient's involvement in therapy and reduce the risk of physical and emotional injury to all parties to the greatest extent possible.

C. Whenever a physical hold, restraint or seclusion is initiated, the documentation and process outlines in the MSH policy "Use of Seclusion and Restraint, TX-16" must be followed.

III. DEFINITIONS:

A. **Crisis Intervention Team**: Shall consist of members of individual treatment units who are trained in de-escalation. MSH Security Officers are considered permanent members of the Hospital's Crisis Intervention team.

B. **Crisis Response Coordinators**: Trained Registered Nurses or Licensed Independent Practitioners of individual treatment units.

C. **Verbal Intervention Techniques**: May include active listening, setting limits, support techniques and problem solving.

D. **Physical Intervention Techniques**: May include supportive holds and/or restraint techniques to manage dangerous behavior.

E. **Show of Support**: A summons of Crisis Intervention Team members, Security Officers and supervisors to a planned patient intervention by use of telephone and paging system.

F. **Code Green**: An audible summons of Crisis Intervention Team members via the public-address system when patient behavior is violent toward staff or hospital property.

IV. RESPONSIBILITIES:

A. Unit staff: Request assistance from the Crisis Intervention Team as needed.

B. Hospital Operations Specialist (HOS): Activate the public-address system for code green situations and/or dialing units to request a show of support.

C. Professional staff: Respond to emergencies or requests for assistance on their primary unit unless directly involved with other patients at the time.

D. Nursing supervisors: Ensure unit assignments are written and responders clearly identified on each unit.

E. Unit Registered Nurse: Manage the crisis by delegating and directing staff not directly involved in the intervention.

F. Security Officers: All security officers will respond to all calls for code green situations as well as calls for a show of support unless involved with a similar crisis or other emergency.

V. PROCEDURE:

A. GUIDELINES:

1. All interventions shall promote keeping people safe and treating people with dignity and respect.

2. All treatment staff will be trained in crisis response principles and techniques at new staff orientation and annual de-escalation training.

3. In all situations, staff members will work to use verbal/non-physical interventions before attempting to use physical interventions. Physical techniques shall be used only as a last resort, and only after non-physical interventions have proven to be insufficient to ensure the safety of everyone.

4. Staff members shall work as a de-escalating team to bring about a reduction in tension in the patient who is demonstrating physical aggression or threatening physical aggression.

5. Treatment unit staff maintains responsibility for care of the patient during behavioral crisis.

B. PROCEDURES:

1. At the start of each 8-hour shift, the unit Registered Nurse will designate 2 trained psychiatric technician/mental health technician from each unit to respond to a code green or show of support.

2. All planned interventions during a behavioral crisis will be implemented by Unit Staff led by a Crisis Response Coordinator.

3. Unit staff will attempt to secure the safety of the patient through use of verbal techniques and then physical interventions if needed.

4. The trained RN or Licensed Independent Practitioner will assume Crisis Response Coordinator role for all behavioral crisis responses with leadership changed only by clear transfer to another professional responder.
    a. The Crisis Response Coordinator will assess the situation, nature of the problem, and identify resources needed.
    b. The Crisis Response Coordinator will communicate with the person in crisis or designate another team member with the best rapport with the patient to do so.
    c. The Crisis Response Coordinator will direct other crisis intervention team members or cue their action.
    d. When assessed to be needed by the Crisis Response Coordinator, the call for the Crisis Intervention Team will be made by unit staff by dialing 7440, the emergency number and either declaring a code green or requesting a show of support through the Hospital Operations Specialist. The Hospital Operations Specialist will summon the Crisis Intervention Team members to a code green via the public-address system. Security will also be notified via radio. If a show of support is needed, the Hospital Operations Specialist will notify security and dial the treatment units individually to summon help. In both situations during regular business hours, the Hospital Operations Specialist will notify the Director of Nursing, Assistant Director of Nursing, Program Managers and Nurse Supervisors via the paging system. During weekends, holidays, afternoon and night shifts the House Supervisor will be notified of all interventions as soon as possible.
    e. The Crisis Response Coordinator will assign a unit staff member to meet the Crisis Intervention Team as they arrive on the unit. At the main hospital this will be at the outside of the double doors and at the Spratt building the unit staff member will be at the south end nurses' station. The staff member will let team members know who is involved and where the intervention is taking place. Unit staff will brief and direct the Crisis Intervention Team. If not needed, Crisis

Intervention Team members will depart from the area. Unit staff may also be directed to issue gloves and other Personal Protective Equipment. Crisis Intervention Team members on the unit where the intervention is taking place will prepare the transport blanket and/or seclusion room if needed.

f. Crisis Intervention Team members will assist the unit staff in caring for an aggressive patient.

5. Training during orientation and annually will be conducted by designated staff on seclusion room use and restraint equipment as needed. The Staff Development Department will coordinate this training.

6. Designated Treatment Team members will complete the Event Review, as appropriate. Crisis Intervention Team responders from other units whenever possible will participate in the Initial Review part I as outlined in MSH policy "Event Review, TX-25."

VI. REFERENCES: MSH Seclusion & Restraint Policy, The MANDT Systems Manual and Training.

VII. COLLABORATED WITH: Director of Nursing, Director of Clinical Services; Nurse Supervisors; Program Managers, Medical Director, Hospital Administrator, Director of Quality Improvement and Public Relations, Safety Officer; Director of Health Information.

VIII. RESCISSIONS: TX-18, *Crisis Intervention Team* dated July 21, 2014; TX-18, Crisis Intervention Team dated May 27, 2009; TX-18, *Crisis Intervention Team* dated May 9, 2008; TX-18, *Crisis Intervention Team* dated November 17, 2004; TX-18, *Crisis Intervention Team* dated April 24, 2001.

IX. DISTRIBUTION: All hospital policy manuals.

X. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XI. FOLLOW-UP RESPONSIBILITY: Director of Nursing

CIT Training

Step 5

Planning & Coordinating CIT Training: After you've coordinated efforts with your partners and have a plan in place for program implementation, the next step is to plan a CIT training. You may identify training opportunities in the state to send officers to or you may want to develop a local training that meets the needs of your community. However, there is no need to re-invent the wheel when it comes to developing a training curriculum. The many training programs conducted across the state have developed curricula and you may consider adapting their training curricula to fit your community's needs. **See and review the *CIT in TN training guidelines***

Determine Training Roles & Responsibilities

The steering committee should take the lead in choosing/adapting the curriculum and organizing and providing the training. The core members of the steering committee should contribute instructors for the training including peers.

Curriculum Development

While all CIT curricula have the same 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 to two-hour blocks, while others use shorter, hourlong blocks.

The CIT in TN training guidelines encourage programs to follow the five consecutive eight hour day (40 hours) schedule.

Checklist:

- ☐ Adapt curricula/training to meet local needs—content & time slots, field visits, resource book
- ☐ Review learning objectives and content outline for each module, set up training schedule
- ☐ Identify instructors, including individuals and families with lived experience
- ☐ Identify scenarios and role players. Scenarios are a way to let participants practice what they have learned and are frequently cited as the best part of the training.
- ☐ Review instructors' materials
- ☐ Investigate whether the training can provide continuing education until for participants

– List of CIT training & train-the-trainer dates in TN (2019-20)

– *CIT Training Budget Planning Worksheet*

– *Example Pre/Post training assessment*

– *CIT training for dispatchers and ED personnel*

- ☐ Determine whether you want the training to be certified and approved by POST
- ☐ Develop pre/post training assessment for officers to complete before and after the training
- ☐ Practice the training with instructors and finalize

Coordination

Checklist:

Trainers

- ☐ Local behavioral health professionals and agencies are encouraged to provide instruction as a service to the community. This practice is strongly suggested in an effort to minimize training costs for local law enforcement agencies and increase ownership of the CIT program.
- ☐ Create instructor training schedule
- ☐ If necessary, complete contractual agreements for instructions
- ☐ Collect training materials, learning objectives, training segment overviews, PPT handout if you're relying on outside trainers for curriculum
- ☐ Inform trainers of arrival times, IT and equipment needs

Law enforcement officers and other first responders

- ☐ Determine how to identify first group of officers for training, method to register, and minimum and maximum number of participants. Generally, the maximum number is 30 and many programs set their minimum attendance at 8 participants.
- ☐ Hold general orientation for law enforcement agencies
- ☐ Invite leadership from behavioral health and law enforcement to open and close the training.

Logistics

- ☐ Estimate the costs and funding (administrative, marketing, food/beverages, instructors per diem/mileage, facilities)
- ☐ Create training schedule, frequency of training/ year

- ☐ Secure venue
- ☐ Assemble training packets
- ☐ Prepare rosters and nametags, on-site sign in sheets
- ☐ Arrange for Field Visits
- ☐ Order pins and diplomas
- ☐ Plan for graduation – Meal? Press? Dignitaries? Guests? Speakers?

Training day

- ☐ Collect evaluations
  - Pre/post assessment
  - Participant evaluations
- ☐ Provide pins & diplomas/ certificates of completion

CIT training for other first responders: There are other first responders for whom CIT may be beneficial. Some examples are 911/emergency dispatchers and ED personnel.

In some localities, 911/emergency dispatchers participate in behavioral health crisis intervention training. Virginia Beach, Virginia provides a good example where as of January 2016, 1,625 dispatchers had either participated in the core 40-hour CIT training or completed a specialized CIT dispatcher course (Virginia Department of Behavioral Health and Developmental Services, Office of Forensic Services, 2016)

There is great value in 911/emergency dispatchers trained to acquire the necessary info for officers arriving on the scene for a behavioral health call, and even assist in de-escalation during a call. Hamilton County, TN other jurisdictions in the state have developed abbreviated courses especially for dispatchers to provide training in the skills they are likely to need when handling a behavioral health crisis call. See **CIT in TN Core Components document for dispatcher training guidelines**

CIT Training for Emergency Department Personnel:

- ☐ Emergency Rooms frequently receive persons experiencing a behavioral health crisis. CIT programs and protocols from Emergency Department personnel can reduce risk of injury to ED personnel and person in crisis from over-reliance on restraints to de-escalate individuals, reduce officer wait times, and support care coordination efforts with behavioral health providers.

- ☐ The following are examples of Emergency Department protocols for behavioral health crisis intervention currently being practiced.
    - An established crisis intervention team within the unit comprised of doctors, nurses, social workers, clinicians, etc.
    - Protocols and guidelines for handling mental health crisis.
    - Training opportunities for ED personnel on behavioral health crisis intervention.
    - A Mental Status Examination form to assist with assessing patients.
    - A brief form to assist first responders with communicating essential information to ED personnel.
    - A directory of behavioral health professionals, treatment centers, and other resources.
    - Continuous quality improvement practices such as regularly updating directory of local resources, and regularly assessing crisis event processes.

- ☐ The following are examples of topics from CIT training for ED personnel:
    - **Safety First:** procedures and protocols for assessing a crisis situation to ensure health and safety for all.
    - **Role of Mental Health Crisis First Responders:** responsibilities of a Mental Health Crisis First Responder.
    - **Effective Communication Skills:** how to consistently communicate with diplomacy, tact and credibility related to difficult circumstances.
    - **De-escalation:** techniques for staying calm, managing responses, handling challenging questions and preventing physical confrontation during a mental health crisis.
    - **Self-Care/Stress Management:** tools for managing stress for crisis response professionals.
    - **Debriefing Skills:** the value of reflection and process for recognizing and naming the skills and strengths used in an experience.
    - **Understanding Mental Illness:** understanding of mental illness, signs and symptoms, and metal health challenges during a crisis and recovery.
    - **Partnerships between Law Enforcement and Community:** the importance of strategies building positive working relationships between law enforcement and community members.

Resources & Tools

CIT Training Budget Planning Worksheet

Sample Training Curriculum Worksheet

Sample CIT Topics & Content

Sample CIT Training Materials
Role Play Scenarios
Role Play Groups
Role Play Evaluations

CIT Training Evaluation Forms
Virginia CIT Pre/Post Training Assessment
Mississippi CIT Training Pre/Post Questions
Sample CIT Survey Form
Sample Future Involvement Form

Sample Training Videos

Additional Resources

- *National Curriculum Model*, University of Memphis CIT Center (2006) http://cit.memphis.edu/curriculuma.php?id=0
- *CIT Suggested Course Materials Facilitator's Guide*, Washington State Criminal Justice Training Commission (2008) https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/CITResourceManual.pdf
- Missouri Crisis Intervention Team Council Resources www.missouricit.org/mo-cit-toolkit
- *HBHS CIT 40-Hour Law Enforcement Training*, Hinds Behavioral Health Services, Mississippi (2018) www.namims.org/wp-content/uploads/sites/176/2017/11/2018-HBHS-CIT-Program-1.pdf
- Utah CIT Program Curriculum Overview https://pmhctoolkit.bja.gov/ojpasset/Documents/CIT%20Utah%20Training%20Curriculum.pdf
- *Crisis Intervention Teams: A Frontline Response to Mental Illness in Corrections*, National Institute of Corrections (2010) https://nicic.gov/crisis-intervention-teams-frontline-response-mental-illness-corrections-lesson-plans-and

CIT Training Budget Planning Worksheet

CIT Training Budget Planning Worksheet								
Expense Category	Cost Estimate	Payment Method			Donor / Payer	MOU/MOA Completed	Deposit	Date Paid
		In Kind	Donation	Cash				
Trainer Expenses								
Fees								
Advertising & Marketing								
Save the Date								
Registration								
Social Media								
TDMHSAS Website								
Newspaper								
Radio								
Email Notice								
Radio Programs								
Additional Expenses								

Sample Training Curriculum Worksheet

Sample CIT Training Curriculum Worksheet					
Training Category	**Who can teach this?**	**Who will contact presenter?**	**Presenter Confirmed**	**Biography Received**	**PowerPoint Received**
Core Topics					
Advocacy/Perspectives					
Child, Youth, & Adolescence (including trauma informed care and ACEs)					
Community Resources					
De-Escalation Role Plays					
De-Escalation Strategies/ Crisis					
Graduation – Entry/Exit Evaluations					
Legal issues (e.g. liability, CIT code provisions, etc.) & Civil Commitment					
Medications and side effects					
Networking Lunch – Local Sponsor					
Officer Wellness					
Overview of CIT					
CIT Policies & Procedures					
Overview of Mental Illness					
Site Visits					
Special Focus – Populations disproportionately impacted by criminal justice system (poor, low-income, minority communities)					
Special Focus – Overview of intellectual and developmental disabilities					
Special Focus – Suicide Intervention					
Special Focus – Veterans' Topics					
Substance Use / Co-Occurring (including information about opioid use disorder, overdose awareness and MAT options)					

Sample Training Curriculum Worksheet (continued)

Sample CIT Training Curriculum Worksheet					
Training Category	**Who can teach this?**	**Who will contact presenter?**	**Presenter Confirmed**	**Biography Received**	**PowerPoint Received**
Elective courses					
Autism Spectrum Disorders					
Bipolar Disorder					
CIT from an Officer's Viewpoint					
CIT Reports/Supervision					
Eating Disorders					
Jail Diversion					
Excited Delirium					
Guardianship and Power of Attorney					
Hoarding Disorder					
Homelessness					
Inpatient Hospital Assessment					
Law Enforcement Suicide					
Ongoing In-service					
Advanced Mental Health Training					
Advanced De-escalation					
Suicide-Homicide					
Advanced Suicide Crisis					
Developments in Psychiatric Medication					

Sample CIT Topics & Content (this is not a comprehensive listing)

Topic	Content
Overview of CIT	Review the history of CIT the Memphis Model.
Overview of Mental Health Disorders	Review basic information for a law enforcement/ first responder audience on schizophrenia, major depression and bipolar disorder. Focus presentation on the behavioral indicators; it is good to provide information on how illness develops and effective treatments. How will law enforcement recognize it when they respond to a disturbance call? Feel free to utilize video clips or other media to help illustrate signs and symptoms that officers may see (or can infer based on behavior). Spend about 1/3 of your time presenting intervention tips and de- escalation techniques for managing this mental health crisis by law enforcement.
Substance Use/Co-Occurring Disorders	This disorder is one of the most challenging areas that law enforcement officers/deputies encounter. Provide basic information on substance use disorders suitable for law enforcement audience. For example, you may explore the brain chemistry involved in addiction and how treatment works, the cyclical nature of relapse, and what works in substance use treatment. Discuss what it looks like to have substance abuse and a mental health disorder (co-occurring disorders). Discuss information about opioid use disorder, overdose awareness and Medication Assisted Treatment (MAT) options
Medication	Provide an overview of common medications prescribed for psychiatric problems to a law enforcement audience. Discuss direct effects and side effects of medications. Provide basic information on how medicines work and the challenges of psychiatric medications, medication continuity, possible side effects and ongoing care. Provide local resources for psychiatric medications (prescribers, case managers, etc.)
Community Resources	Provide the officers with a comprehensive list of the local resources, including behavioral health clinics, day treatment programs, food banks, emergency shelters. Review local mental health and substance abuse resources.
De-escalation Strategies / Techniques / Crisis Cycle	Provide examples on how to verbally de-escalate a situation. The course will discuss how when an individual becomes highly stressed, non- verbal communication becomes dominant. Feel free to utilize video clips or other media to help illustrate strategies and techniques. These skills will be practiced during the role play portion of the training.
Suicide Intervention	Provide facts about suicide in Tennessee and the USA. Teach de-escalation techniques with acute suicidality. Emphasize what works long-term.
Site Visits	Depending on local resources — psychiatric hospital, veteran's centers, day treatment programs, homeless programs, outpatient treatment programs, treatment foster homes. (This can also be presented as a panel presentation, with each program described, if distance is a concern.)
Legal issues	Provide basic information for law enforcement audience on case law and litigation results for cases where officers have resulted in the use of force with mentally ill individuals and the results of some of those cases. Review current procedures for both emergency detention and involuntary hospitalization. Allow time for questions and answers.
Graduation Entry/Exit Evaluations	Provide the officers with evaluation forms, graduation certificates and CIT Pins. Some programs have a cake for after the graduation ceremony
Networking Lunch	Commonly provided by NAMI or other Advocacy Partners on one day of the training to show support.

Sample CIT Training Materials

Sample Scenario Evaluator's Training Guide (Adapted from Oregon CIT program)

Scenario Evaluator Guidelines (Sample 1)

Goal: Facilitate scenarios to maximize learning process

1. Fill in participant's name, scenario number, date, evaluator on evaluation form
2. Allow participant to engage with role player until he/she seems stuck or asks for time-out
3. If they get stuck, you may want to ask what they were trying to accomplish, offer a suggestion, and invite suggestions from others in the group
4. Re-start scenario-watch for attempt to utilize feedback
5. End of scenario-together with role player provide skill-based feedback, invite feedback from group
6. Escort learning group to new scenario location

Feedback:

1. Observe scenario and provide feedback on demonstration of skills
2. Scenario specific objectives-Diversion? Safety plan? Transport?

Scenario Learning Objectives Evaluation (Sample 2)

Question: What the 6 Baseline Objectives are and how they are met during role plays:

1. **Introduction –** Introduces self and agency, provides reason they are there, and asks name of person in crisis.
2. **Rapport –** Builds slowly, LISTENS to the person, reflects statements, asks pertinent questions, shows interest, is patient, respectful, and demonstrates active listening skills.
3. **Tone –** Calm, patient tone and pace, maintains throughout interaction, able to apologize if rushing or sounds frustrated.
4. **Non-verbal (demeanor/movement) –** Safe, yet engaged distance. Hands are calm/non-threatening, eye contact if appropriate for the interaction.
5. **Problem Solving –** Begins this area after establishing rapport and gathering information that accurately reflects problem based on person's description and response in scenario. Action plan needs to fit the problem, involve the person's action/skill when applicable, and uses resources identified by person and those known to participant, when applicable.
6. **Tactics/Safety –** Set up and maintain safe distance, simulated search method, bladed stance, hands ready but relaxed, asks about objects, uses partner when appropriate.

SCENARIO # 1

Title: The Bottle

Personnel: 1 role player, 1 student, 1 coach

Props: Table, chair, whiskey bottle

Information: An anonymous call is received about a subject being suicidal. No other details are received. Arriving law enforcement finds the screen door closed and the inside door open. A subject is seen sitting at a dining room table.

Variation 1: The subject is compliant with the student, says student can come in when requested. Subject is talking quietly and looking down, appears depressed. The role player keeps staring at the bottle and trying to control themselves from taking a drink. Role player will fluctuate from being anxious to calming down. The subject is a recovering alcoholic and the roommate has moved out causing a possible relapse to drinking again.

Subject is not taking prescribed meds.

Variation 2: Subject appears intoxicated and is talking to themselves. They are not responsive to law enforcement except to tell them to go away. Subject lives alone and their dog was just put to sleep the day before after being injured by a car. Subject keeps blaming themselves for the dog's death. Subject is suicidal and has no friends because they just moved to the area.

Variation 3: Subject is agitated and slamming the bottle on the table. Keeps yelling for everything to stop, starts muttering about the government spying on them and trying to take their money and their life. Acts Paranoid.

Variation 4: (mania) Subject is sitting at table, bottle in reach. Talking in accelerated speech, is hyper and finally explains they have no friends. Subject is not taking meds, and making inappropriate sexual comments or behaviors (if Role Player is comfortable with this action). Along with these actions, subject is very intent on listening and watching the student, to a point of violating the personal space of the student, but not in threatening or angry manner.

Variation 5: (developmentally disabled) Subject has been left alone, and found the liquor. Very friendly, wants to know about being a "cop" but doesn't understand why the student would be there to talk.

SCENARIO #2

INSTRUCTIONS TO ROLE PLAYERS:

1. Follow the scenario. You may add supporting details, but stick to the main ideas.
2. Present and maintain a challenge to successful resolution, but remember to allow for a successful resolution if the officer's response indicates that it might work.
3. Do not do anything that might warrant Use of Force by the officers.
4. Do not reach to put your hands in your pockets.
5. Do not charge the officer.
6. Do not lunge at the officer. Do not grab at the officer.
7. Do not throw items at the officer.
8. If at any point you need to stop the role play, say the word ORANGE. This is the safe word. This word can be used by any party involved (the observers and those involved in the role play).

INSTRUCTIONS FOR OBSERVERS:

1. Do not let the scenario get out of hand to where the Officer is in a position that would warrant Use of Force. Say the word ORANGE and all parties involved will stop the role play.
2. Ask the role player what they experienced or felt when the Officer talked with them.
3. Ask the Officer what he thought? Was it difficult/easy? Do they have questions?
4. Ask any other observers what thoughts they had while watching.
5. Give feedback about non-verbal skills you saw (good or bad).
6. Give feedback about the skills you saw the officer use (i.e. empathetic, allowed client to vent).
7. Give feedback on what the Officers could have done better or might have tried?

Sample CIT Training Materials (continued)

Role Play

SETTING: In a local Primary Care Doctor's waiting area

SCENARIO: Officer is called to a local Primary Care Doctor's office because there is a patient in the waiting area who says she has an appointment but is not on the schedule. She is speaking loudly and in a manner that does not seem to make any sense to anyone around her. She is talking about someone murdering her children and scaring other patients in the lobby.

ROLE PLAYER ACTIONS: Appear frightened and confused. Jump back and forth between talking about your murdered children and other unrelated topics. Continue to look around as if worried and paranoid. Do not respond well if the officer attempts to tell you that your belief about your children murdered is not true. Respond if the officer attempts to ask you about your emotions regarding the issue, validates emotions, and attempts to help you feel safe.

LEARNING OBJECTIVE: Focus should be on reducing emotions and/or refocusing on reality based information. Help the woman to a safe location to keep others safe.

* Adapted from the Umatilla County, Oregon CIT Program

SCENARIO #3

Title: Jail

Personnel: 1–2 student(s), 2 evaluators (1 LEO & 1 MH if possible)

Props: A door between student and Role Player

Read this information to the student/participant: Radio traffic reports that a subject on the cell block is stating that he is suicidal. You know that this offender was recently told that he was going to be served with a restraining order due to the domestic violence charge that he is currently in jail for. You have heard from inmates that he has not been eating and appears depressed.

Information (ROLE PLAYER ONLY):

You are angry and upset that you have been arrested on a domestic violence charge. It is not fair that the officers always pick on the man, when you believe the “bitch” started it and hit you. Now you found out that she is trying to get a restraining order, so you will not be able to see your kids. You are depressed; not eating and fear that you have probably lost your job because people will believe her story and not believe your side of the story. You are not getting along with your cell mate, who has stinky feet, won’t shower and won’t shut up. You tell him that you want to die! He has told the guards that you are feeling suicidal.

* Adapted from the Deschutes County, Oregon CIT Program

SCENARIO #4

Title: Meth Induced Psychosis

Personnel: 1 student, 2 evaluators (1 LEA & 1 MH if possible)

Props: backpack

Read this information to the student/participant: Dispatch note for meth induced psychosis: A Concerned community business employee in downtown Bend called dispatch to report that there was a “homeless” person scaring away customers and wanted the police to come and take them to jail. The reporter is adamant that they want the person trespassed from downtown and that they do not want that type of person at their business. Reporter states that the subject is yelling and waving their arms and is believed to be high or intoxicated. Subject has just left the store and is on the sidewalk outside.

Information (ROLE PLAYER ONLY): You are walking through a yard, talking loudly to yourself. You are looking in the windows of vehicles you are walking by. You are yelling, waving your arms and appear to be angry. You are looking over your shoulder, afraid someone may be following you (paranoid). You are “twitching”, unable to remain still, scratching and picking at your arms. You appear dirty, disheveled, and seem to be experiencing auditory, visual, and tactile hallucinations.

You are not suicidal.

Scenario # 5

Title: Jesus

Personnel: 2 students, 2 evaluators (1 LEO & 1 MH if possible)

Props: Robe, medication bottles

Read this information to the student/participant: A female caller on 911 is reporting that her son is going crazy and needs to go to the Emergency Room. She reports that he has not been eating the last couple of days. He yells at her when she does not address him as Jesus, and just got really mad because the water that she brought him did not turn into wine when he commanded it to. The female states that her son has a mental health diagnosis and was working with Sara at the local mental health agency, but that he has not seen her in at least a month. She states that he is prescribed medication but she does not think that he has been taking it.

Information (ROLE PLAYER ONLY):

Role Player 1:

You are the subject's mother. You are very concerned about your son who is refusing to come out of the basement. You will tell the police when they arrive that your son has been seen at Deschutes County Behavioral Health, at the downtown Annex on Harriman, in the past, but that he stopped going about a month ago. Your son has been prescribed medication-Seroquel, Lamictal and Ativan, but you are pretty sure that he has stopped taking the medication due to his recent behaviors. You report that your son appears to be angry because he tried to turn water into wine and when that did not work he started throwing things around. He has not come up to eat and when you go downstairs to get his dishes, they still had food on them. It appears that it has been a few days since he has eaten anything.

Role Player 2:

You are the adult son of the reporting party. You have been staying in your mother's basement even though you have a bedroom in the main part of the house. When the officer's call you by the name given by your mother, or when they ask your name, you will tell them that you are Jesus. You will appear disorganized, have rapid, pressured speech and will appear dirty. You are angry that the devil will not allow you to turn water into wine and that Satan must be vanquished from the world. While disorganized and believing that you are Jesus, be semi-cooperative and attempt to interact with the officers.

Desired Officer Response:

- Assess for safety.
- Identify yourself.
- Have one officer stay with the mother.
- Other officer will attempt to build rapport and trust through calm, clear communication.
- Officer should not buy into the delusion of subject being Jesus.
- Officer should attempt to contact local mobile crisis team (if that is an option) or local mental health agency to work on an assessment in the house and come up with a safety plan (crisis walk-in may also be an option).
- Divert from the hospital if appropriate.

SCENARIO # 6

Title: The Vet

Personnel: 1 role player, 1 student, 1 evaluator

Props: Table, chairs, whiskey bottles, simulated apartment, camo military jacket

Read this information to the student/participant: A call of a domestic is received from neighbors to the apartment in question. The calls report someone leaving the apartment, but can still hear loud noises inside the apartment. The neighbor calls can give no other information about the people who live in the apartment.

ROLE PLAYER ONLY information:

Variation 1 (Mania): Student goes to upstairs of home and can hear a voice talking, as well as the television on. Student knocks on door and gets response from subject, in very fast tone, "wait, I'm busy with someone."

Variation 2 (Schizophrenia): Student goes to upstairs of home and can hear a voice. Student knocks on door and gets response from subject of "I'm busy I have visitors." Role Player can use television, radio or other items for hallucinations.

Variation 3 (Depression as a result of sexual abuse as young child by a parent): Student goes to upstairs of home and can hear crying. Student knocks on door and gets response from subject of "leave me alone."

Variation 4 (Suicidal): Subject is former vet. Drinking but not intoxicated. Very depressed due to receiving information about serious cancer found, and wants to be with spouse who passed five years ago. Subject does not want to have doctors attempt to stop the health risks.

Variation 5 (PTSD): Subject is medically retired Police Officer who was shot, during the bank robbery in Los Angeles where the suspects were heavily armed. Subject also lost his partner of six years to the gunmen. The sight of uniforms causes flashbacks, which in turn causes great anger because subject feels the need to return to law enforcement but angered because the former department will not take subject back and now does not trust the tactics of the student because subject feels threatened by the government.

Sample CIT Training Materials (continued)

Role Play Groups

Training Date: _____

Group	Officers' Names	Agency	Evaluator(s) (1 LEO / 1 MH)
1			
2			
3			
4			

Sample CIT Training Materials (continued)

Role Player Evaluations

Student Name:				Agency:	
Date:				Day:	
The four role plays	Introduce self	Y N	Other	Ask about MH treatment	Y N
	Name of citizen	Y N		Ask about medications	Y N
	Reflect feeling	Y N		Ask about substance abuse	Y N
	Summarize	Y N		Ask about a crisis plan	Y N

Comments:
Verbal (include quotes of greeting, de-escalation, connecting, explanation, "I" statements, offer options & resources, response to others in scenario)

Non-verbal (tone of voice, eye contact, stance, approach)

Responder Safety (for **LEA** only to evaluate)

What one thing could the responder have done differently to improve?

Date:				Day:	
The four role play	Introduce self	Y N	Other	Ask about MH treatment	Y N
	Name of citizen	Y N		Ask about medications	Y N
	Reflect feeling	Y N		Ask about substance abuse	Y N
	Summarize	Y N		Ask about a WRAP/crisis plan	Y N

Comments:
Verbal (include quotes of greeting, de-escalation, connecting, explanation, "I" statements, offer options & resources, response to others in scenario)

Non-verbal (tone of voice, eye contact, stance, approach)

Responder Safety (for **LEA** only to evaluate)

What one thing could the responder have done differently to improve?

CIT Training Evaluation Forms

Virginia CIT Pre-Training Assessment

Form ID # _____

Charlottesville CIT Training: Pre-Training Evaluation

The following survey is for research purposes only. Your responses will remain anonymous and no identifiable information will be provided to your supervisor/head of department.

Please indicate your position:

☐ Consumer Advocate ☐ Law Enforcement

☐ Communications ☐ Mental Health Professional

To answer each question, please **circle** a number:

1. How comfortable are you with your current knowledge of mental illness?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

2. How aware are you of community resources available to people with mental illness?

1	2	3	4	5
Not at all		Moderately		Very Aware

3. How would you rate your knowledge of civil commitment laws?

1	2	3	4	5
Poor		Moderate		Excellent

4. How would you rate your knowledge of the professional liability that can arise when dealing with people with mental illness who are in crisis?

1	2	3	4	5
Poor		Moderate		Excellent

5. How familiar are you with the roles of various actors in the mental health system (e.g., Region Ten, the hospitals, the courts)?

1	2	3	4	5
Not at all		Moderately		Very Aware

6. Do you believe the average person with a mental illness is more or less aggressive (such as temper outbursts and verbal threats) than an individual not suffering from mental illness?

1	2	3	4	5
More Aggressive		The Same		Less Aggressive

7. Do you believe the average person with mental illness is more or less likely to commit a violent crime than an individual not suffering from mental illness?

1	2	3	4	5
More Likely		The Same		Less Likely

8. How well prepared do you feel when handling people with mental illness in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

9. Overall, how well prepared do you think other law enforcement officers are to handle people with mental illness in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

10. How would you rate your comfort level dealing with people with mental illness in crisis?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

Please answer the following questions only if you are a law enforcement officer:

Considering the last year, on average, how many arrests per month do you think you have made involving a person with mental illness? _____

Form ID # _____
Charlottesville CIT Training: Post-Training Evaluation

To answer each question, please circle a number:

1. How comfortable are you with your current knowledge of mental illness?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

2. How aware are you of community resources available to people with mental illness?

1	2	3	4	5
Not at all		Moderately		Very Aware

3. How would you rate your knowledge of civil commitment laws?

1	2	3	4	5
Poor		Moderate		Excellent

4. How would you rate your knowledge of the professional liability that can arise when dealing with people with mental illness who are in crisis?

1	2	3	4	5
Poor		Moderate		Excellent

5. How familiar are you with the roles of various actors in the mental health system (e.g., Region Ten, the hospitals, the courts)?

1	2	3	4	5
Not at all		Moderately		Very Familiar

6. Do you believe the average person with a mental illness is more or less aggressive (such as temper outbursts and verbal threats) than an individual not suffering from mental illness?

1	2	3	4	5
More Aggressive		The Same		Less Aggressive

7. Do you believe the average person with mental illness is more or less likely to commit a violent crime than an individual not suffering from mental illness?

1	2	3	4	5
More Likely		The Same		Less Likely

8. How well prepared do you feel when handling people with mental illness who are in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

9. Overall, how well prepared do you think the other CIT-trained officers will be in handling people with mental illness in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

10. How would you rate your comfort level in dealing with people with mental illness in crisis?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

********** What was your overall impression of CIT training?

1	2	3	4	5
Poor		Moderate		Excellent

How well do you feel the training was organized?

1	2	3	4	5
Poor		Moderate		Excellent

Please comment on the aspects of CIT training that you found **most effective**:

_____

_____

_____

Please comment on the aspects of CIT training that you found **least effective**:

_____

_____

_____

What recommendations do you have to improve CIT training?

_____

_____

HINDS BEHAVIORAL HEALTH CIT TRAINING PRE-TRAINING EVALUATION

The following survey is for research purposes only. Your responses will remain anonymous and no identifiable information will be provided to your supervisor / head of department.

*To answer each question, please **circle** a number:*

1. How comfortable are you with your current knowledge of mental illness?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

2. How aware are you of community resources available to people with mental illness?

1	2	3	4	5
Not at all		Moderately		Very Aware

3. How would you rate your knowledge of civil commitment laws?

1	2	3	4	5
Poor		Moderate		Excellent

4. How would you rate your knowledge of the professional liability that can arise when dealing with people with mental illness who are in crisis?

1	2	3	4	5
Poor		Moderate		Excellent

5. How familiar are you with the roles of various actors in the mental health system (e.g. Region Ten, the hospitals, the courts)?

1	2	3	4	5
Not at all		Moderately		Very Aware

6. Do you believe the average person with a mental illness is more or less aggressive (such as temper outbursts and verbal threats) than an individual not suffering from mental illness?

1	2	3	4	5
More Aggressive		The Same		Less Aggressive

7. Do you believe the average person with mental illness is more or less likely to commit a violent crime than an individual not suffering from mental illness?

1	2	3	4	5
More Likely		The Same		Less Likely

8. How well prepared do you feel when handling people with mental illness in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

9. How would you rate your comfort level in dealing with people with mental illness in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

Considering the last year, on average, how many arrests per month do you think you have involving a person with mental illness? _____

HINDS BEHAVIORAL HEALTH CITTRAINING

POST-TRAINING EVALUATION

To answer each question, please circle a number:

1. How comfortable are you with your current knowledge of mental illness?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

2. How aware are you of community resources available to people with mental illness?

1	2	3	4	5
Not at all		Moderately		Very Aware

3. How would you rate your knowledge of civil commitment laws?

1	2	3	4	5
Poor		Moderate		Excellent

4. How would you rate your knowledge of the professional liability that can arise when dealing with people with mental illness who are in crisis?

1	2	3	4	5
Poor		Moderate		Excellent

5. How familiar are you with the roles of various components of the mental health system (e.g. community mental health center, hospitals, courts)

1	2	3	4	5
Not at all		Moderately		Very Familiar

6. Do you believe the average person with a mental illness is more or less aggressive (such as temper outbursts and verbal threats) than an individual not suffering from mental illness?

1	2	3	4	5
More Aggressive		The Same		Less Aggressive

7. Do you believe the average person with mental illness is more or less likely to commit a violent crime than an individual not suffering from mental illness?

1	2	3	4	5
More Likely		The Same		Less Likely

8. How well prepared do you feel when handling people with mental illness who are in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

9. How would you rate your comfort level in dealing with people with mental illness in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

****

9. What was your overall impression of CIT training?

1	2	3	4	5
Poor		Moderate		Excellent

How well do you feel the training was organized?

1	2	3	4	5
Poor		Moderate		Excellent

Please comment on the aspects of CIT training that you found **most effective**:

_____

_____

_____

Please comment on the aspects of CIT training that you found **least effective**:

_____

_____

_____

What recommendations do you have to **improve** CIT training?

_____

_____

_____

Sample CIT Survey

DATE: _____ RANK:_____ AGENCY: _____

In collaboration with the CIT in TN Task Force and local CIT partners, we are conducting an evaluation of the CIT training program. Your participation is voluntary and your responses will be kept confidential. Accurate and complete information is necessary to determine the impact of the program. For all questions, please choose only one response. We would like to thank you for your cooperation and participation.

Please rate how helpful the following tracks were for you:

	Not Helpful				Very Helpful		Not Helpful				Very Helpful
Overview	1	2	3	4	5	**De-Escalation Techniques**	1	2	3	4	5
Medication Time	1	2	3	4	5	**Suicide/Self Harm**	1	2	3	4	5
Mental Health 101	1	2	3	4	5	**Developmental Disabilities**	1	2	3	4	5
Crisis Cycle	1	2	3	4	5	**In Our Own Voice**	1	2	3	4	5
Jail Panel	1	2	3	4	5	**NAMI**	1	2	3	4	5
Legal Panel	1	2	3	4	5	**Family Perspectives**	1	2	3	4	5
Suicide by Cop and Self Care	1	2	3	4	5	**Site Presentation**	1	2	3	4	5
PTSD/VA	1	2	3	4	5	**Child and Adolescent Crisis**	1	2	3	4	5
Veterans	1	2	3	4	5	**Treatment of Psychiatric Illness**	1	2	3	4	5
Liability and Use of Force	1	2	3	4	5	**Mental Illness in the Elderly**	1	2	3	4	5
Personality and Mood Disorders	1	2	3	4	5	**Seniors Presentation**	1	2	3	4	5
Addictive Diseases	1	2	3	4	5	**Scenario Based Trainings**	1	2	3	4	5
Excited Delirium	1	2	3	4	5	**Over All**	1	2	3	4	5
Synthetic Drugs	1	2	3	4	5						

For the following statements, please rate your level of preparation:	**Very Satisfied**	**Somewhat Satisfied**	**Somewhat Dissatisfied**	**Very Dissatisfied**
How well prepared do you feel when handling people in a behavioral health crisis?				
Overall, how well prepared do you think the other officers in your department are to handle people in a behavioral health crisis?				
To what extent do you feel you are prepared to address a person who is threatening suicide?				
Overall, how effective is your department's response to handling people with behavioral health issues in a crisis?				

For the following statements, please rate your local resources:	**Excellent**	**Good**	**Fair**	**Poor**
How would you rate your department's ability to implement a new program for improving the response to a behavioral health crisis?				
How would you rate the level of administrative support for the CIT program in your agency?				
How helpful are your community's mental health resources in providing assistance to you when you are handling people experiencing a behavioral health crisis?				
How helpful is the emergency room/hospital system in providing assistance to you when you are handling a person experiencing a behavioral health crisis?				

Please rate your impressions of CIT	Very satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
How satisfied are you with the CIT training you received?				
How satisfied are you with the way the CIT training has prepared you to respond to handling people in a MH crisis?				
How satisfied are you with the way CIT has been implemented in your agency?				

Gender: **Age:** **Years in current position?**

Please describe types of additional training or support that could have improved your use of CIT.

How could CIT be implemented in your agency?

To what extent do you think this workshop shared information, tools and resources designed to enhance first responder response and reduce the overall risk of injury or life? Not at all 1 2 3 4 5 Very much

Would you recommend this training to one of your co-workers? Why? Not at all 1 2 3 4 5 Very much

In your opinion, what didn't work during this workshop? What suggestions do you have for improving it?

What was the highlight of the workshop? When was it, and what did you learn?

What will you take away with you from this workshop? How will it transfer to your everyday life?

What suggestions would you give to the facilitator/s for their professional development?

Please make any additional comments you have with regard to the CIT training, the local CIT program or suggestions.

Sample – Future Involvement Form

Name_____ Phone_____

Agency_____ Email_____

1. I would like to get involved in future CIT trainings in Tennessee. Please check below what areas you are interested in.

   □ Present on topics
   □ Co-Present on topics
   □ Present on lived experience (tell my story or a family member's story)
   □ Role-Play/Role Player
   □ Evaluator/Coach
   □ Work with the local community to "start-up" or "support an existing" CIT program.
   □ I am willing to travel outside of my community to help
   □ Sponsor a meal or break snack

2. I would like information on local coalitions in my community:

   □ Drug and Alcohol

   □ Suicide Prevention

   □ NAMI

3. I would like to be information regarding attending the CIT in TN Task Force meetings Y/N

4. I would like to be informed about future CIT trainings in Tennessee to share with my colleagues: Y/N

Comments:_____

SAMPLE TRAINING VIDEOS

Murder of Fouad Kaady - 11 minutes https://www.youtube.com/watch?v=ZWEpawB-Dfo

Centre County CIT training video- 7 minutes https://www.youtube.com/watch?v=4SbVP-JvxPk

Emergency First Responders: Treating Mental Health Issues in a Culture of Mental Toughness- 1hr 4o minutes https://www.youtube.com/watch?v=P5F9cEOaCV8

Deaf sensitivity training video for police officers https://www.youtube.com/watch?v=l9aNpMRHH2c

Saint Leo University CIT module- 6 minutes https://www.youtube.com/watch?v=ryD8AUq4K5E

Addiction - 5 minutes https://www.askmen.com/recess/trending/drug-addiction-cartoon.html

The Arc: CIT Lesson Learned- 60 minutes https://www.youtube.com/watch?v=o4MQeylXUxA

Bergen County New Jersey Community Health Project, Responding to a mental health emergency https://www.youtube.com/watch?v=ffIQf-T155o

Charlotte CIT: MHFA vs. CIT- 11 minutes https://www.youtube.com/watch?v=nGkgGZFb7nA

Austin Police Officer - 3 minutes https://www.youtube.com/watch?v=23lKBSX0P9I

San Antonio CIT Role Play Training 15 minutes https://www.youtube.com/watch?v=Srg3Isr3jlA

Crisis Intervention Training - 3 minutes https://www.youtube.com/watch?v=kdLh8FtN404

De-escalation techniques, St. Louis County PD 60 minutes https://vimeo.com/274704642

De-escalation Techniques - 6 minutes https://www.youtube.com/watch?v=pBe4A32fpyI

Dissociative Identity Disorder - 5 minutes https://www.youtube.com/watch?v=0tITzDjPf4g

Empathy vs Sympathy - 3 minutes https://www.youtube.com/watch?v=1Evwgu369Jw

Vicarious Trauma Toolkit, SAMHSA 60 minutes www.youtube.com/watch?v=aaJt23KmQ5Q

Wrong Side of Heaven - 7 minutes https://www.youtube.com/watch?v=o_l4Ab5FRwM

HPD mental health cops - 5 minutes https://www.youtube.com/watch?v=EAR8S-MspHI

It's not about the nail – 2 minutes https://www.youtube.com/watch?v=-4EDhdAHrOg

Jon Ronson - Psychopath -18 minutes https://www.youtube.com/watch?v=xYemnKEKx0c

Kevin Hines Story -14 minutes https://www.youtube.com/watch?v=loiGNZTfu6g

Mental Health Response - 8 minutes https://www.youtube.com/watch?v=Nr83X66I3sE

Seeing the Need – 4 minutes https://www.youtube.com/watch?v=7mm0b1VTtZU

My Pill Journey – 4 minutes https://www.youtube.com/watch?v=0eV1o86_DB8

Skill Overview - 7 minutes https://www.youtube.com/watch?v=-IYCwQ88-LE

PPB Incident Debrief - 6 minutes https://www.youtube.com/watch?v=LJ0eoJiqHL8

Seattle Police - 2 minutes https://www.youtube.com/watch?v=R-MmPVSGcnM

San Francisco PD CIT Working Group- 4 minutes https://vimeo.com/276174398

Shawnee CIT - 19 minutes https://www.youtube.com/watch?v=yF7vBDHJFhc

Toronto Police Mobile CIT- 4 minutes https://www.youtube.com/watch?v=r9elvdBlheA
And https://www.youtube.com/watch?v=jr7akYxEApo

Comm. w/ angry patient - 4 minutes https://www.youtube.com/watch?v=tyUl3kqmeLo

Comm. w/ schizophrenic patient - 4 minutes
https://www.youtube.com/watch?v=HBAeWH_WHR0

What's so funny about MI - 9 minutes https://www.youtube.com/watch?v=mbbMLOZjUYI

TN Department of Correction-CIT Overview- 8 minutes www.youtube.com/watch?v=0nfq0Oo8Dlw

TDMHSAS Mental Health in the Jail https://www.youtube.com/watch?v=uoAqyCcK06s

TDMHSAS Firsthand Perspectives https://www.youtube.com/watch?v=aJ5cU_4bovw

TDMHSAS Mental Health Collaborative https://www.youtube.com/watch?v=KYkMrchefpg

TDMHSAS Clayton's Encounter with CIT https://www.youtube.com/watch?v=ZWVpYcNFWis

NAMI- CIT Overview- 1 minute https://www.youtube.com/watch?v=-net9xEotXc

Mental Health Channel - http://www.mentalhealthchannel.tv/

Step 6

Using data to inform practice

Data collection is critically important and can be used to document CIT program activities, inform program improvements, demonstrate program effectiveness, help ensure program sustainability, maximize utilization of scarce resources, and support the development of other community-based resources.

CIT partnerships' data collection efforts should be an integral part of CIT program development and implementation. Partners should ask themselves "what is the data we most need to support our local CIT program?" Program partners will need to consider if they are currently collecting data that can be used to evaluate their program or if they will need to design new strategies to capture the data needed.

As the Core Components of CIT in TN document outlines, the mission critical data elements that all CIT programs should collect include:

Community Partnerships:

- Number of formal (MOU) and informal partnerships.
- Number of participants from different stakeholder groups participating in different program activities.
- Number of community stakeholder meetings
- Number of CIT programs in planning/development stage

CIT Training Participation:

- Number/percent of law enforcement rank and file personnel and command staff completing the 40hour CIT training.
- Number/percent of dispatch personnel completing CIT for telecommunications training.
- Number of specialized trainings, as provided.
- CIT training outcomes (pre/post)

Counts of Mental Health Calls for Service/Encounters:

- Number of calls for mental health reasons.
- Number of calls for other reasons that result in a "mental health" encounter that ends up addressing a mental health need.
- Number of mental health encounters, with no preceding call from dispatch, that address a mental health need.
- Number of CIT calls leading to arrests
- Number resolved on scene
- Voluntary transport to treatment

CIT Methods for using data to inform practice: a step by step guide (SAMSHA, 2018)

CIT reporting forms

- *Memphis CIT Center Statistics Sheet*
- *Arlington County Police Department CIT Supplement Form*
- *Central Florida Tracking Form*
- *Laurel Highlands Region CIT Data Sheet*
- *Virginia Crisis Assessment Center Data Form*

Data Entry Spreadsheet

- *Virginia Data Entry Spreadsheet and Data Definitions*

- Involuntary transport to treatment

Counts of Mental Health Calls Responded to by CIT Officers:

- Number of mental health calls and encounters responded to by CIT-trained officers.
- Number of mental health calls and encounters responded to by non-CIT-trained officers.

We strongly encourage you to use SAMHSAS's *CIT Methods for Using Data to Inform Practice: A Step By Step Guide* (2018) as you develop and strengthen the CIT program.

Document Your Local CIT Program: As you begin developing or strengthening a CIT program, it can be useful to document planning and implementation processes through the development of flow charts or logic models that connect the CIT activities to the short- and long-term goals.

INPUTS	OUTPUTS		HYPOTHESIZED OUTCOMES*		
			Short-term	Intermediate-term	Long-term
Partners: - Systems - Community - CIT coordinator - Police/agency Trainers - Evaluator **Training items:** -Training space - Materials/ Curricula - Backfill: Resources to cover the shifts of officers/others while they attend training **designated drop-off site(s) identified**	**Collaboration:** - Partner/ stakeholder meetings - Policy & procedure review - Recognition and Awards - Outreach to other communities **Training:** - 40-hour CIT Training - Advanced & refresher training - Partner training **CIT response**	**Participation:** - CIT coordinator - Law enforcement Personnel - Emergency communications personnel - Mental health Providers - System partners - Community Partners - People in crisis - Families	↑: - Relationships - Knowledge, attitudes, skills - - Linkage - Diversion ↓: - Use of force - Injuries - Arrests	↑: -Problem solving - Continuity of care - - Engagement in services - - Non-emergency mental health service utilization ↓: - Repeat calls for service	↑: -Mental health crisis response system change ↓: - Jail population - Costs for law enforcement, jails, healthcare system
Assumption: Implementing a CIT program will lead to better immediate response to mental health crisis calls (safety, linkage, diversion) and better service coordination and outcomes over time. **Outcomes are hypothesized until measured. Arrows indicate the hypothesized direction of change.*					

***Example CIT Program Logic Model* (CIT Methods for Using Data to Inform Practice, SAMHSA, 2018)**

Identify Key Metrics

Questions to consider:

- Are officers already collecting data that can be reviewed in a new way (e.g. outcome or disposition of calls for service, use of force during calls for service)? Do officers report on the outcomes of calls through a computer system or on paper?
- Can data that is already being collected be used as a baseline? Can you collect some baseline data for a few months while the training is in the planning stages?
- Is there data available from other community partners that can help establish program effectiveness (e.g., does provider data show that individuals are being linked to community behavioral health services?)
- Is the data easy to collect? Are officers or others responsible for collecting data going to find it too time-consuming?
- Who will help develop the data collection methods, if necessary? Who will be responsible for regular data collection and analysis?

Establish a Consistent, Routine Data Collection Process

Your steering committee and a broader stakeholder group, including research experts from local colleges or universities, can help with measuring program effectiveness. Partners should be clear on the responsibilities and procedures for data entry and analysis. Here, the role of the CIT coordinator will be important to the data collection effort and reporting the findings to the community and CIT partners.

Most law enforcement agencies use two systems, a computer-aided dispatch (CAD) system and a records management system (RMS), which may or may not be connected and able to communicate. Both systems track critical information related to calls for service and responses to those calls. CIT programs often have data needs that apply to both systems, making requests for entering and tracking data more difficult to fulfill.

Questions to consider:

- What partners will you be requesting data from (police/jail, hospitals, emergency services, mobile crisis, 911?) How will the data be collected? How will it be reported?
- Are there research partners (local universities, colleges) willing to assist with data collection and analysis?

- Will you be using paper or electronic forms? Will the CIT program have a separate reporting database from the regular police report interface system?
- Does your law enforcement agency and dispatch agency share codes for mental health calls/encounters, CIT responses, or related dispositions in their dispatch or RMS?

Establish Regular Data Analysis and Reporting to the Field

Incorporate What is Learned into Program Improvements

Expand Program Data Collection as Capacity and Skills Grow

Resources & Tools

Sample CIT Logic Model

Crisis Call Process Map

CIT Reporting Forms
Arlington County
Central Florida
Virginia CIT Coordinator duties
Memphis Model CIT Coordinator description
Laurel Highlands Region
Memphis
Virginia
Bowling Green University
Thomas Jefferson Area Health Data Form

Data Entry Spreadsheet
Virginia Data Entry Spreadsheet and Data Definitions

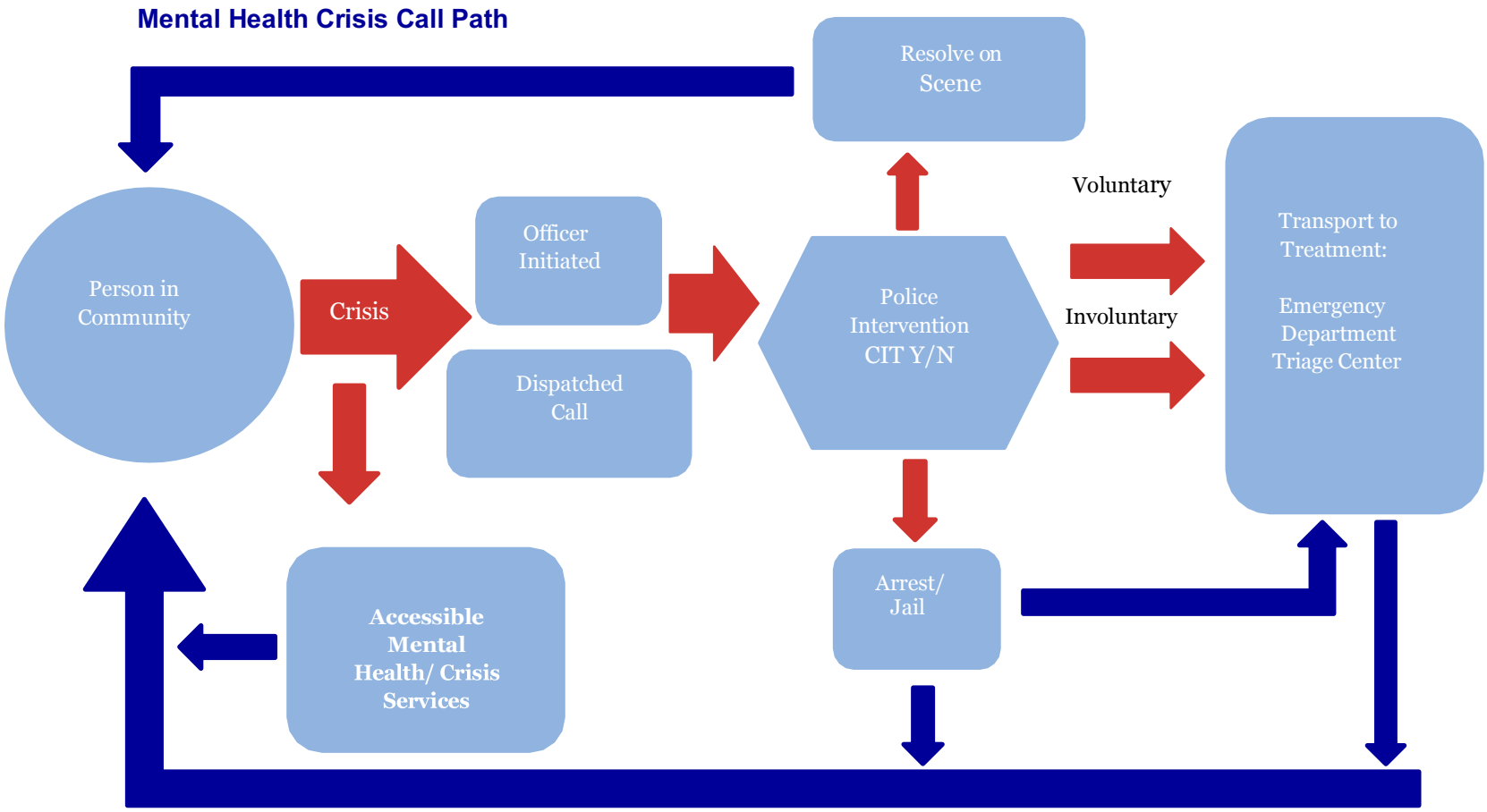
Additional Resources

- *CIT Methods for using data to inform practice: a step by step guide* (SAMSHA, 2018*)* https://store.samhsa.gov/product/Crisis-Intervention-Team-CIT-Methods-for-Using-Data-to-Inform-Practice-/sma18-5065

Sample CIT Logic Model

INPUTS	OUTPUTS		HYPOTHESIZED OUTCOMES*		
			Short-term	Intermediate- term	Long-term
Partners: **Training items:** **designated drop-off site(s)** **Y/N**	**Collaboration:** **Training:** **CIT response**	**Participation:**			

Crisis Call Process Map*



***Adapted from SAMHSA's *CIT Methods for Using Data to Inform Practice* (2018)**

CIT Reporting Forms

Arlington County Police Department CIT Supplement Form

ACPD CIT Supplement

Incident Number:

Was there a CIT-trained officer on the original scene? Yes No Unk

If yes, select one: ☐ CIT dispatched ☐ CIT responded voluntarily

☐ CIT self-initiated encounter ☐ CIT called to scene by non-CIT officer

Was the incident resolved without the EDP being transported from the scene? Yes No

If yes, check any that apply: ☐ DHS contacted via phone only ☐ DHS already on scene

☐ DHS responded to scene ☐ DHS contact info given

Was video conferencing used on scene? Yes No

Was the subject transported to the Crisis Intervention Center or to VHC voluntarily? Yes No

Did you involuntarily detain the subject? Yes No **If no, skip the rest of this section.**

What type of ECO was used? ☐ ECO Issued by a Magistrate ☐ Ofc. Initiated Paperless ECO

What time was the subject detained? _____

Where was the subject transported to? ☐ Crisis Intervention Center ☐ Virginia Hospital Center

What time did the subject arrive at the destination? _____

What time did you contact DHS regarding the detention (N/A if DHS initiated the call)? _____

Which DHS representative did you speak with? _____

What time was the subject evaluated by DHS (if known)? _____

Did you transfer custody of the subject to VHC Security? Yes No

If yes, list the following: _____ _____

Security Officer Name/DID Date/Time

If known, list the following: _____ _____

Doctor Who Gave Medical Clearance Date/Time

If a TDO was issued, list the following: _____ _____

Source: http://cit.memphis.edu/policies.php?page=3

Crisis Intervention Tracking Form

Agency Case #: _____

Subject:	Date of Birth:	Race:	Sex:
Home Address:		Times: / / /	
City:	State:	Zip:	Phone:
Enrolled in Medical Security Program (MSP)? Yes ☐ No ☐ Unk ☐			
Diagnosis (if known):			

Call Dispatched ☐ Referred By: _____ Self-Initiated ☐ Other: _____

Nature of Incident *(check all that apply)*

- ☐ Disorderly/disruptive behavior
- ☐ Neglect of self-care
- ☐ Public Intoxication
- ☐ Nuisance (loitering, panhandling, trespassing)
- ☐ Theft/other property crime
- ☐ Drug-related offenses
- ☐ Suicide threat or attempt
- ☐ Threats or violence to others
- ☐ Other / specify:
- ☐ No Information

Threats/Violence/Weapons

Did subject use/brandish a weapon?
☐ Yes ☐ No ☐ Don't Know
If YES –
Type of weapon *(check all that apply)*:
☐ Knife ☐ Gun
☐ Other / specify:

Did subject threaten violence toward another person?
☐ Yes ☐ No ☐ Don't Know
If so, to whom? *(Partner, Law Enforcement, Stranger, Etc)* _____

Did subject engage in violent behavior toward another person?
☐ Yes ☐ No ☐ Don't Know
If so, to whom? *(Partner, Law Enforcement, Stranger, Etc)* _____

Did subject injure or attempt to injure self?
☐ Yes ☐ No

Prior Contacts *(check all that apply)*

Known person (from prior police contacts)
☐ Yes ☐ No ☐ Don't Know
Repeat call (within 24 hours)
☐ Yes ☐ No ☐ Don't Know

Drug/Alcohol Involvement

Evidence of drug/alcohol intoxication
☐ Yes ☐ No ☐ Don't Know
If YES –
☐ Alcohol
☐ Other Drug / specify:
☐ Don't Know

Medication Compliance
☐ Yes ☐ No ☐ Don't Know

Specify if known:

Complainant Relationship *(check one)*

- ☐ Partner/spouse
- ☐ Boyfriend/girlfriend
- ☐ Parent
- ☐ Sibling
- ☐ Friend/acquaintance
- ☐ Business owner
- ☐ Other family member
- ☐ Police Observation
- ☐ Other Stranger
- ☐ Don't Know

Behaviors Evident at Time of Incident *(check all that apply)*

- ☐ Disorientation/confusion
- ☐ Delusions – *specify if known*:
- ☐ Hallucinations – *specify if known*:
- ☐ Disorganized speech (freq. derailment, incoherence)
- ☐ Manic (elevated/expansive mood, inflated self-esteem, pressured speech, flight of ideas, distractible)
- ☐ Depressed (sadness, loss of interest in activities, loss of energy, feelings of worthlessness)
- ☐ Unusually scared of frightened
- ☐ Belligerent or uncooperative (angry or hostile)
- ☐ No information

Incident Injuries

Were there any injuries during incident?
☐ Yes ☐ No ☐ Don't Know

If so, to whom? *(Partner, Law Enforcement, Stranger, Etc)* _____

Disposition *(check all that apply)*

- ☐ No action/resolved on scene
- ☐ On-scene crisis intervention
- ☐ Police notified case manager or mental health center
- ☐ Outpatient/case management referral
- ☐ Transported to treatment facility

Facility Name: ☐ ☐
☐ Baker Act ☐ Marchman Act

☐ Arrested
If YES, most serious charges: ☐ ☐

Mental health referral ☐ Yes ☐ No

☐ Other – *specify*:

Prior to CIT, would you have taken this individual to jail? ☐ Yes ☐ No

What would the charges have been? _____

_____

Signature of Officer: _____

Printed Officer Name: _____

Badge/ID #: _____

Agency: _____

Date: _____

10-1563 Word Version (1/03)

Laurel Highlands Region CIT Data Sheet

Source: http://cit.memphis.edu/policies.php?page=3

CIT DATA SHEET

Laurel Highlands Region
Crisis Intervention Team

Date of Incident_____ **20**____ **Day of week** Su Mo Tu We Th Fr Sa **Time** _____ **AM / PM**

Location of incident_____ **Incident #**_____

Police Dept. _____ **Officer on scene/Badge #** _____

CIT officer present Y / N **Was a CIT officer called if not present** Y / N

Consumer Name _____ **Age:** _____ **Gender M / F**

Race: Caucasian / African American / Hispanic/ Native American / Other

Address: _____

_____

Nature of call: _____

_____

_____

Was Crisis Called? Y / N

Was the consumer under the influence? Drugs / Alcohol

List any reported mental illness _____

_____ **No mental illness reported**

Medications prescribed? Y / N **Compliance?** Y / N

Threat assessment: ____ NONE

_____ suicide attempt: method_____ _____ Attempt to harm others: method _____

_____ suicide threat _____ Threat to others

Weapons present: None / Firearm / Edged Weapon / Other _____

Injuries to Consumer? Y / N **to Officer?** Y / N

Was the consumer injured prior to police contact? Y / N

Force used: None / physical / taser / baton / spray / firearm / other

Method of transportation: Police / EMS / other Private Vehicle

Outcome of Incident: Hospitalization / Arrest / No action / Other _____

SERT called Y / N

Send completed form to :
Laurel Highlands CIT
401 Washington St.
Johnstown, PA 15901
FAX 814-535-6842

jcc 3/21/2008

Memphis CIT Center Statistics Sheet

Source: http://cit.memphis.edu/policies.php?page=3

CRISIS INTERVENTION TEAM STAT SHEET

(To be completed on crisis calls involving mental illnesses)

Date: _____ Time: _____ Scene Time: _____

Location: _____ Ward: _____

Consumer Name: _____ Sex/Race: _____ Age: _____

Address: _____

Complainant: Name & Address – If complainant is unknown, list how call was reported:

_____

Supervisor (Commanding Officer) on scene: ( ) yes ( ) no

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

EQUIPMENT / TECHNIQUE:

( ) Verbalization
( ) Handcuffs
( ) Ripp Hobble
( ) Chemical Agent(s) - Report Required
( ) Less-Lethal Equipment - Report Required: (specify) _____
( ) Other (specify) _____

CONSUMER and/or OFFICER INJURY:

( ) Prior to Police arrival - Consumer (Explain in Arrest Ticket narrative or on back of this document)
( ) During Police presence - Consumer (Explain in Arrest Ticket narrative or on back of this document)
( ) None/Unknown - Consumer
( ) Officer(s) (Total number of officer(s) injured # _____)

DISPOSITION OF PERSON TAKEN INTO CUSTODY: See *

* A summary of the arrest event is **not** required on this document if a copy of the arrest ticket is attached and submitted to the officer's workstation.

( ) TCA 33-6-401 Emergency Commitment **with** pending criminal charges
( ) TCA 33-6-401 Emergency Commitment **without** pending criminal charges

DISPOSITION OF PERSON NOT TAKEN INTO CUSTODY: See *

(*) A brief Summary is required on the back of this document.

( ) Complaint unfounded, requiring no police action. (*)
( ) Consumer stabilized requiring no further police intervention. (*)
( ) Other (*)
( ) Complainant and/or Consumer not located

OTHER INFORMATION:

Armed - Yes ( ) No ( ) Weapon: _____
Veteran - Yes ( ) No ( )

TRANSPORTING:

( ) Consumer transported by MPD car _____ to_____

( ) Consumer transported by MFD unit _____ to _____

NARRATIVE

Routing Procedures:

- Precinct
- CIT Coordinator's Office

Effective Date: February 2009

Virginia Crisis Assessment Data Form

CRISIS ASSESSMENT CENTER (CAC) DATA SHEET

(updated: July 01, 2015)

IMPORTANT: **ALL FIELDS MUST BE COMPLETELY FILLED BEFORE SUBMITTING REPORT.**

Patient Name: _____ **Date of ECO:** / /

ORIGINATING OFFICER

Originating Case # _____

Who called for the ECO: (check one)

- ☐ Patient
- ☐ Family/Other Civilian
- ☐ CIT Officer
- ☐ Non CIT Officer
- ☐ CIT First Responder
- ☐ Non CIT First Responder
- ☐ CIT Jail/Corrections
- ☐ Non CIT Jail / Corrections
- ☐ ED / Medical Refferal

Which Law Enforcement agency transported ECO Patient: (check one)

- **UPD** ☐ **CPD** ☐ **Nelson** ☐
- **APD** ☐ **Greene** ☐ **Fluvanna** ☐
- **Louisa** ☐ **Wintergreen** ☐
- **Town of Louisa** ☐ **Lake Monticello** ☐

ECO Documentation: Paper ☐ Paperless ☐

CIT Certified Officer: Yes ☐ No ☐

Time when dispatched: __:__

On Location Time: __:__

Time of custody: __:__

Time officer notified dispatch to call Region Ten: __:__

Time officer arrived at UVA Hospital (Crisis Assessment Center) __:__

ECO Call Type:

- Dispatched MH Call ☐
- Dispatched ECO ☐
- Dispatched Wellness Check ☐
- Officer Initiated Call ☐
- Dispatched Other ☐

Injuries:

- **None** ☐
- Officer ☐
- Individuals ☐
- Both ☐

Arrest:

Would criteria have been met for Discretionary Arrest? Yes ☐ No ☐

UVA OFFICER

UVA POLICE Officer taking custody info:

Name \ Badge # _____

UVA SECURITY Officer taking custody info:

Name \ Badge # _____

Time of custody: __:__

ECO searched? Yes ☐ No ☐

Hospital Room # _____

ORIGINATING OFFICER SUMMARY OF INCIDENT

_____

_____

_____

_____

_____

Officer Name: _____

Officer Cell # ___-___-____

So if needed medical or MH provider can review incident

_____ _____

Originating Officer Signature Badge #

Bowling Green State University Police Department
Crisis Intervention Response Stat Sheet

Date: _____ Time of Call: _____ Incident Number: _____

Location: _____ Shift Responding: _____

Subject: Last Name _____ First Name _____

Subject Type: Student ☐ Staff ☐ Faculty ☐ On-Campus ☐ Off-Campus ☐ Juvenile ☐ Homeless ☐

Subject Gender: Male ☐ Female ☐ ☐ Residence Hall ☐ Nonresidential

Involvement of Drugs/Alcohol: Drugs ☐ Alcohol ☐ Unknown ☐

County of Residence: _____

Subject Crisis:

General Depression ☐ Anxiety/Panic Attack ☐ Cutting ☐

Suicidal Thoughts ☐ Suicidal Threat ☐ Suicidal Attempt ☐ Delusions ☐ Unable to care for self ☐

Involving Violence to Others: Yes ☐ No ☐ Involving Weapons: Yes ☐ No: ☐

Additional Information: _____

Disposition:

Link ☐ Counseling Center: ☐ Rescue Crisis: ☐ Jail: ☐ No Action Necessary ☐

Hospital: _____ Other: _____

Emergency Hospitalization: Voluntary (sought treatment) ☐ Involuntary (did not seek treatment) ☐

Completed by: _____ Title: _____

Department: _____ Phone No.: _____

Other Officers on Scene (Unit#) _____ _____ _____ _____

Thomas Jefferson Area CIT Health Data Form

Thomas Jefferson Area CIT - Crisis Assessment Center (CAC)
CAC MENTAL HEALTH DATA FORM

This page to be completed by Region Ten Mental Health Staff @ CAC

ECO CONSUMER INFORMATION	
FIRST NAME	**LAST NAME**
REGION TEN CONSUMER ID #	**SOCIAL SECURITY #**

CONSUMER PRIMARY RESIDENCE: (check one)

☐ Charlottesville ☐ Albemarle ☐ Nelson ☐ Other- Name City or County: _____

CLINICAL DISPOSITION: (check one)

- ☐ No further treatment required
- ☐ Individual declined referral and no involuntary action taken
- ☐ Referred to ambulatory crisis stabilization
- ☐ Referred to voluntary outpatient or community treatment other than crisis stabilization& treatment
- ☐ Referred to voluntary inpatient admission
- ☐ Involuntary patient admission and treatment
- ☐ Medical admission

NAME OF FACILITY (if hospitalized):

PEER SUPPORT:

On-Site Peer Support? ☐YES ☐NO

Referred Peer Support? ☐YES ☐NO

VIDEO CONFERENCING: ☐YES ☐NO

ECO NOTIFICATION RECEIVED Date:_/__/__Time:

ARRIVAL TIME @ UVA ER Date:_/__/__Time:__

RESOLUTION OF ECO Date:_/__/__Time:__

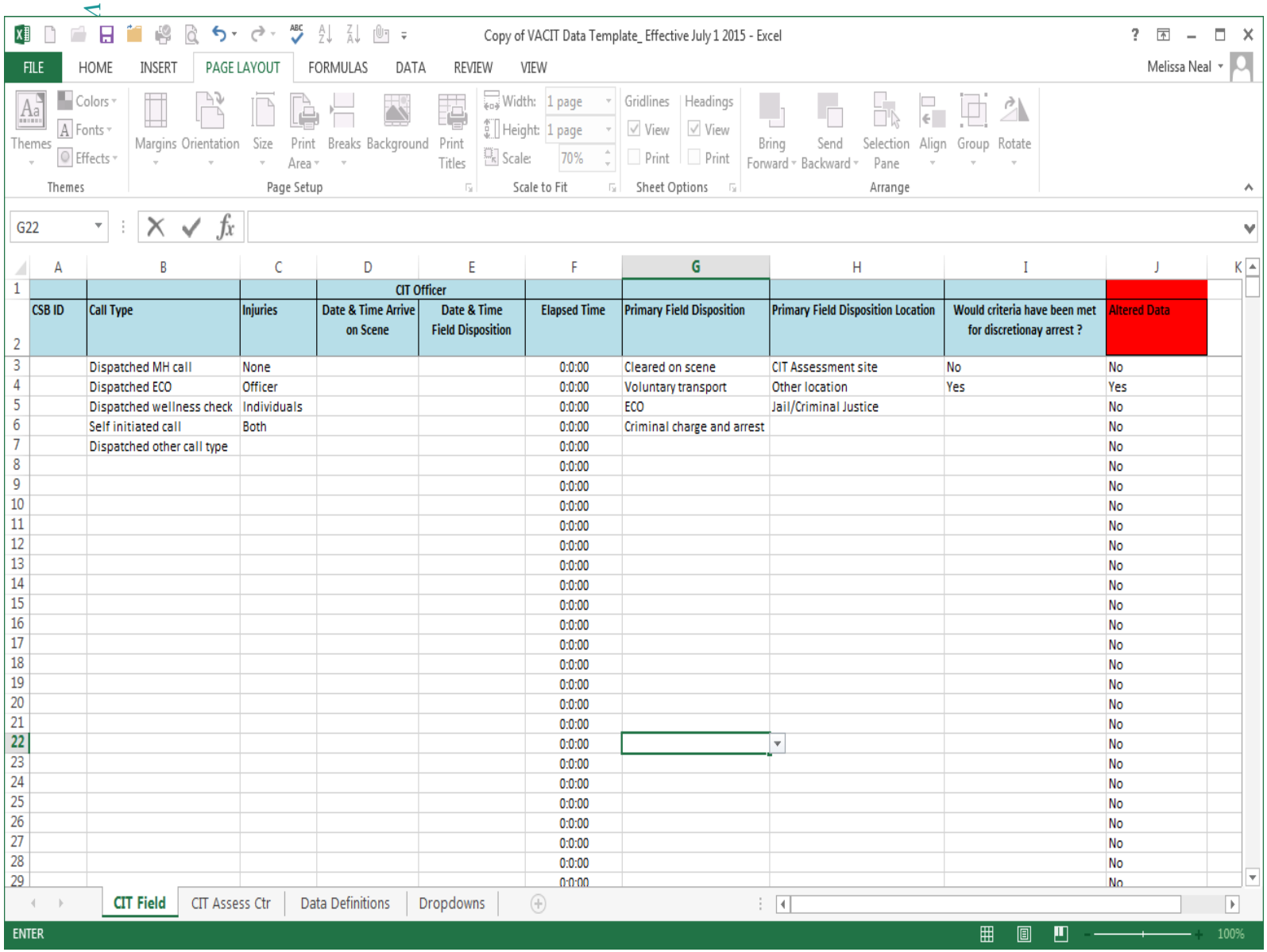
FORM COMPLETED BY:

Print Signature

IMPORTANT: After Region Ten Pre-screener completes this entire data sheet page return form to UVA Office

Data Entry Spreadsheet

Virginia Data Entry Spreadsheet and Data Definitions



Law Enforcement Officer Field Information		
Call Type	**Drop Down Choices**	How the law enforcement officer initially comes in contact with subject.
	Dispatched MH call	Law enforcement officer dispatched to call for assistance with possible mental health involvement
	Dispatched ECO	Law enforcement officer dispatched to serve ECO
	Dispatched wellness check	Law enforcement officer dispatched for wellness check
	Self initiated call	Law enforcement officer self-initiated response on scene for any of the above
	Dispatched Other call type	Law enforcement officer dispatched to any other type of call for service that results in mental health crisis intervention
Arrival Date and Time	Manually Entered Data	The date and time the law enforcement officer arrives and makes contact with the consumer Use the following format = mm/dd/yy hh:mm, 24 hr time
Date and Time of Field Disposition	Manually Entered Data	The date and time the law enforcement officer is released from the call for service. Use the following format = mm/dd/yy hh:mm, 24 hr time
Elapsed Time	This is an automatically calculated number. This number reflects the total number of Hours : Minutes spent handling a call for service involving a Consumer	
Injuries	**Drop Down Choices**	Any reportable injury to an officer, subject or bystander that occurs AFTER the CIT officer has arrived on scene, excluding self
	None	No injuries occurred after the Consumer was initially contacted by law enforcement
	Officer	The only injuries after contact with the consumer were to law enforcment officer(s)
	Individuals	Any subject or bystander
	Both	Any subject or bystander AND any law enforcement or CIT officer
Primary Field Disposition	**Drop Down Choices**	What thelaw enforcement officer does with the subject up to the time of transfer of custody at assessment site or other call
	Cleared on scene	The Consumer was not relocated to the Assessment Site for services (ie: CSB evalution on site, or not eligible)
	Voluntary transport	Law enforcement transport of anyone who is NOT under criminal charge or ECO
	ECO	Subject in custody of a paperless or paper ECO
	Criminal charge and arrest	Services were not appropriate/available and the officer made the decision to seek criminal warrants
Primary Field Disposition Location	**Drop Down Choices**	The location where the officer was able to reach a resolution for the Consumer receiving services.
	CIT Program Assessment site	Non criminal justice, therapeutic location specifically designed to accept transfers for CIT program
	Other location	Any other non criminal justice site
	Jail/Criminal Justice	E.g. magistrates office, sheriffs office, police department
Jail Diversion?	**Drop Down Choices (Yes/No)**	If the Assessment Site were not an option, were criteria met to affect a discretionary arrest?
Other information	**Manually Entered Data**	Any categories that an individual Assessment Site program adds containing information additional to required submissions
Altered Record	**Check or Un-checked**	If the CSB ID, CCS number, or Consumer date and time of arrival have changed since a previous submission for any data you must check the box to indicate a change has occurred

Additional Resources

TN Law Enforcement Training Academy- Basic Mental Health Crisis Response Lesson Plan

TN Law Enforcement Training Academy- Specialized Behavioral Health Crisis Training

CIT in TN Task Force Framework Brief

CIT in TN Program Inventory Survey (20017-18)

CIT in TN Law Enforcement Survey (20017-18)

CIT in TN Program Overview (2017-18)

Lesson Plan Outline | 2019

Tennessee Law Enforcement Training Academy Basic Police School 12/14/18-3/28/19	
Lesson	**Mental Health Crisis Response for Patrol Officers**
Prepared By	Instructor Kat Cooper
Date Prepared	November 15th, 2018
Hours	4

Objective:

To provide students a general basis of knowledge regarding police response to a mental health crisis. Specifically, students will have general knowledge of mental illnesses and its significance; Understand Officer Responsibilities; Have the ability to recognize and respond to signs and symptoms; Have a general knowledge of excited delirium; Have a general knowledge of Autism; Understand current accepted methods and protocols in dealing with persons suffering from mental illness and crisis with positive outcomes; Know how to seek the appropriate assistance and treatment.

Lesson Scope

Topic

First Session	Classroom with PowerPoint, Demonstrations, Visuals

1. **How Serious A Problem Is It?**
   - A. Statistics on Mental Health Crisis and Police Response
   - B. T.C.A. regarding Mental Health Crisis and Law Enforcement Response
   - C. Arrest Considerations when Dealing with a Mental Health Crisis

2. **Defining Mental Health Disorders**
   - A. What is it?
   - B. What are Common Myths about Metal Health
   - C. The 4 Major Mental Health Categories
   - D. Most Common Forms of Mental Illness that Law Enforcement Officers Deal With
     - Major Depression
     - Schizophrenia (CLASS EXERCISE-Hearing Voices)
     - Bipolar Disorder
     - Panic Disorder
     - Post Traumatic Stress Disorder (PTSD)
     - Suicide

3. Signs And Symptoms of Mental Disorders

A. Hallucinations
- Hearing Voices Which Aren't Present
- Seeing Something Not Present

B. Intense Anxiety
- Shaking
- Sweating
- Unable To Speak
- Signs Of Terror Or Panic In Absence Of Danger

C. Unrealistic Physical Complaints
- "Heart Doesn't Work Anymore"
- "Hole In Head And Thoughts Leaking Out"
- "Stomach Rotted Away"

D. Paranoia
- Irrational Distrust Of Others
- "The Presidents Spies Are Trying To Kill Me"
- Irrational Feelings Of Persecution

E. Delusions
- Person Believes They Are Someone Famous
- Person Believes They Are God
- False Belief Having No Basis In Reality

F. Loss Of Memory

G. Talking To Non-Existent Entity

H. Major Changes In Behavior
- Someone Passive Becoming Aggressive
- Someone Talkative/Outgoing Becoming Quiet

I. Dangerous Behavior
- Self-Destructive / Violent Behavior
- Sudden, Unprovoked Attacks on Others

J. Attention / Concentration
- Inability To Stay On Topic
- Difficulty Following Directions

L. Intense Depression
- Feelings of Hopelessness, Loneliness
- Pessimism
- Isolation

4. **The Crisis Response (VIDEO)**

A. **Preliminary Crisis Response**
- Assess safety issues
- Remove distractions or disruptive people
- Be helpful - OIC or support officer
- On-scene emergency aid
- Present a genuine willingness to help
- Speak slowly, -- using short sentences -- repeating
- Move slowly
- Remain calm
- Assess safety issues
- Remove distractions or disruptive people
- Be helpful - OIC or support officer
- On-scene emergency aid
- Present a genuine willingness to help
- Speak slowly, -- using short sentences -- repeating
- Move slowly
- Remain calm

B. **Fundamental Principles of Crisis Intervention Skills**
- Safety and Communication
- Patience and Understanding
- Caring / A Sincere Attitude (Genuine)
- Dignity / Respect
- Honesty
- Offer of Hope
- Leadership

C. **Mental Illness & Effective Communication**
- Things Your Mother Taught You
- Verbal Skills -"Doorway" to Success
- Some Avenues By Which To Open And Maintain Dialog / Communication
- Keys to Unlocking Communication Barriers

D. **Things to Avoid**

- Shouting -- more shouting -- and louder shouting
- Moving suddenly -- giving rapid commands/orders
- Forced discussion
- Maintaining direct, continuous eye contact
- Touching the person (unless necessary)
- Crowding the person
- Body or Verbal Language expressing anger, impatience or irritation
- Assuming that a person who does not respond cannot hear
- Using inflammatory language - "crazy" "psycho" "mental"

- Challenging delusional or hallucinatory statements
- Misleading the person.

E. Helpful Resources and CIT

5. The Play Book Approach to Crisis Response "THE PLAN"

- Introduce yourself
- Obtain the Person's Name... "What's your name?"
- Expressing to the person what you are seeing.
  - Express the emotions you are seeing
  - What do you see?
- Use the I word – "I can see you're angry"
- Summarize... to be an "active listener" you should "summarize"
  - Communicating with the person in crisis
- Summarize the information that you have learned / obtained

6. Excited Delirium

A. Defining Excited Delirium
B. Symptoms (VIDEO)
C. What to Look For (VIDEO)
D. What the Officer Should Do

7. Autism

A. Defining Autism
B. Encounters
C. What Questions to Ask

Second Session	Class Role Play

Role Play Exercises (1500 hours -1700 hours)

Class will be broken into groups and will role play scenarios mimicking a crisis response. Students will demonstrate the following:

- Introduce yourself
- Obtain the Person's Name... "What's your name?"
- Expressing to the person what you are seeing.
  - Express the emotions you are seeing
  - What do you see?
- Use the I word – "I can see you're angry"
- Summarize... to be an "active listener" you should "summarize"
  - Communicating with the person in crisis
- Summarize the information that you have learned / obtained

Note: Crisis Situations Should Mimic Real Life Scenarios and Metal Health Crisis Response Situations

Instructor References:	**Student References**
CIT Training Manual, National Alliance on Mental Illness, Tennessee Code Annotated	Supplied Class Material
Training Aids	**Student Handouts**
Power Point Presentation, Video Aids, Class Exercises and Role Plays	On Classroom Disc

Scenarios

Patrol Response to a Mental Health Crisis with 2 Plays

Instructor Role Player: Male/Female

Scenario: Officer is dispatched to a check the wellbeing on a party seen in dark and empty parking lot acting suspicious. The party is reportedly talking to themselves. The party appears to be in distress and possibly lost.

Play 1: During the officers' encounter the party is verbally non-compliant, ignores the officer's presence, becomes verbally loud, and yells at the officer that they hear voices, passively resists officer's commands. The party appears to me experiencing auditory hallucinations *(Example: I hear them talking to me/// they are telling me to drink your blood/// they won't stop yelling at me).*

The party will become compliant as the Officers demonstrate appropriate measures to deescalate.

Outcome: Officer must display appropriate learned skills to deescalate the situation to gain compliance and open dialogue with the individual.

Play 2: During the officers' encounter the party is very arrogant and antagonistic. The party verbally insults the Officer. The party continues to circle the officer, clinching fist, and talking about having nothing to lose in life. The party continues to make statements about "them" following he/she and trying to kill them. The party makes references to "them" always breaking into their home and taking meds. The party keeps hitting their head while stating "it hurts…it hurts… don't you see them hitting me?" The party is insistent they are being followed and attacked by something with evil powers. The party continuously engages the Officer stating "they are right there (while pointing)….don't you see them?!!!!!" The party appears to me experiencing visual hallucinations, is very agitated, has a loss for life, and is very paranoid acting.

The party will become compliant as the Officers demonstrate appropriate measures to deescalate.

Outcome: Officer must display appropriate learned skills and tactics to gain compliance and open dialogue.

1 **Interactive Engagement with Persons in Behavioral Health Crisis**

Model Curriculum

2 **Critical Behaviors—What to Watch For**

- Guardedness, territorial
  - Resistance to interaction
    - Won't engage in dialogue
    - Avoiding eye contact
    - Increase personal distance
    - Elopement behavior
  - Reluctance to follow commands or instruction
    - Won't answer questions
    - Keep moving despite instructions to stop
    - Won't acknowledge persons of authority
    - Talks over others
    - Argumentative
-

3 **Critical Behaviors—What to Watch For**

- Anxiety, Fear
  - Restlessness
    - Pacing
    - fidgeting
  - Panic symptoms
    - Hyperventilating
    - Sweating
    - Trembling, shaking
  - Pressured speech
    - Rapid, frenzied
    - Difficult to interrupt
    - May be incoherent
-

4 **Critical Behaviors—What to Watch For**

- Anger, irritability, agitation—what might this look like?
  - Intensified speech volume and content
    - Yelling, shouting
    - Profanity, offensive words
  - Short-tempered
    - Volatile mood
  - Intensified gesturing and posturing
    - Forced arm swinging
    - Fist clenching
    - Knocking objects to the floor
    - Hitting a wall
-

5 **Critical Behaviors—What to Watch For**

- Verbal aggression
  - Name calling, insults, character attacks
  - Racial, misogynistic, homophobic or religious epithets
  - Profanity
  - Implicit verbal threats, direct verbal threats
- Nonverbal aggression
  - Rolling the eyes
  - Gritting teeth
  - Scornful looks

6 **Critical Behaviors—What to Watch For**

- Violence, physical aggression*
  - Hitting, shoving
  - Kicking
  - Biting, scratching
  - Head-butting, choking
  - Use of weapons
  - Property destruction
- *It is very important to keep in mind that most people living with mental illness do not present an increased risk of violence
- Only 3%-5% of violent acts are attributed to people with serious mental illness [Criminal and Juvenile Justice (2016, March 7) http:www.samhsa.gov/criminal-juvenile-justice]

7 **Most Frequent Categories of Behavioral Health Crisis**

- Homicidal thoughts or attempts
  - Verbal threats
    - Spoken in person, by phone, televideo
  - Written threats
    - Note, email, text message, social media
  - Nonverbal/Implicit threats
    - Motioning with hands
  - Attempts/Gestures
    - Gestures without contact can be considered attempts
-

8 **Most Frequent Categories of Behavioral Health Crisis**

- Inability to properly care for self due to mental illness
  - Unable to avoid dangerous circumstances
  - Unknowingly place themselves in life threatening situations
  - Poor self care results in imminent deterioration
  - Sustained poor hygiene from being bedridden
  - Matted hair, incontinence
  - Living without electricity or water

9 **Most Frequent Categories of Behavioral Health Crisis**

Acute Psychosis—What You Need to Know Part 1

- Delusional thoughts-various types
  - Paranoid—someone trying to kill them, FBI/CIA/Satellites following them
  - Persecution—someone is trying to ruin them

- Grandiose—they are a prophet or deity who must act or are a bodyguard for a famous person and must protect them
- Love—another person is in love with them and they are supposed to marry

10 **Most Frequent Categories of Behavioral Health Crisis**

Acute Psychosis—What You Need to Know Part 2

- Hallucinations
  - Auditory—voices or sounds, some commanding
    - Self harm; harm to others
  - Visual—people, threatening figures, apparitions, images
- May incite fear or sense of danger, resulting in reactive behavior
  - Flight
  - Barricade
  - Refusal to leave home
  - Attacking behavior to defend self

11 **Most Frequent Categories of Behavioral Health Crisis**

Acute Psychosis—What You Need to Know Part 3

- The person's perceptions (delusions or hallucinations) do not align with reality
- They often do not verbalize or explain their perceptions—search for cues
- Usually cannot convince the person that what they see, hear or believe is not real—it IS real to them
- Hallucinations are as "real" to the person as this slide is to you
- The person often cannot focus on what you are saying—they are significantly distracted by the delusion/hallucination
- This may result in failure to follow your commands and instructions—it may appear as the person is resisting law enforcement, but this is NOT their intent

12 **Interacting with Someone in Crisis**

- Active listening
  - Full attention to the person and their words
  - Repeat back to the person in your own words—affirms you are listening and trying
  - Do not have to agree with them
- Useful tips for keeping them engaged
  - Recall any state reasons to live, people they care about or who support them
  - Recall things they love, trust, enjoy and believe in
  - Speak of hopefulness, supportiveness, care, willingness to help
  - Explain what you are doing and why

13 **Principles for Interaction and Engagement**

- Upon initial encounter, avoid invading personal space unless required for safety
- Use calm, reassuring tone when speaking
- Use their name often
- If the person tells you what they are experiencing, avoid indulging in the delusion—instead say "I don't hear what you are telling me you hear, but I believe you are hearing what you say you hear."

14 **Principles for Interaction and Engagement**

If the person does not verbalize or explain what they are experiencing, search for clues:

- Does it appear they are talking to someone who's not there?

- Do they fix their eyes on a particular space?
- Are their responses relevant to your questions?
- Are they repeating phrases or words?
- Is the content of their speech fixed on one particular subject?

15 **Principles for Interaction and Engagement**

- Throughout your encounter with the person, remember their perceptions are real to them—keeping this in the forefront of your mind will help guide your approach safely
- Continue to engage the person verbally unless that is escalating them—this is attempting to keep them connected to the actual setting
- Try to find out whom the person trusts and engage them when available and appropriate—the person in crisis may be watchful for whom you ally yourself with

16 **Principles for Interaction and Engagement**

- Whenever appropriate, continue to communicate your actions and the reasons for them—this can reduce fear and anxiety and may increase cooperation
- Ask for permission to engage them or to do something—this can provide them a sense of autonomy and participation in a situation very intimidating, traumatizing and controlling for them
- Reassure person that you are there to help and protect them, that you are not there to harm them

17 **Mobile Crisis**

- Mobile Crisis is a 24 hour/day, 365 day/year response service to those experiencing a behavioral health crisis in Tennessee
- Role of Mobile Crisis:
  - Telephonic consultations
  - Face-to-face assessments (live or video)
  - Consult with family or support persons as appropriate
  - Complete and sign Certificate of Need for involuntary treatment
  - Make referrals for placement to appropriate facility
    - Psychiatric hospitalization
    - Crisis Stabilization Unit
    - Same-day medication management
  - Request involuntary transport as needed
  - Crisis management follow-up

18 **Mobile Crisis**

- When do you call Mobile Crisis?
  - Threats of self harm or self harm behavior
  - Threats of harm to others or threatening behavior
  - Behavior that places person in imminent danger
  - Behavior that demonstrates inability to properly card for self
  - If uncertain, call for consultation
  - Dispatch or 855-CRISIS-1 (855-274-7471)
  - Mobile Crisis can't appropriately asses a person severely under the influence of mind-altering substances, so consider consultation to determine whether to take them to a crisis center or emergency room

19 **Mobile Crisis**

- When might Mobile Crisis call Law Enforcement?

- For coordinated response to scene to assure safety
- After receiving a request to respond to a potentially dangerous situation
- To request secure transport for involuntary psychiatric hospitalization or the like
- Wellness checks

20 **Detention of Person in Crisis**

- A person whom a law enforcement officer has reason to believe fulfills both of the following criteria:
  - Has a mental illness or serious emotional disturbance, and
  - Poses an immediate substantial likelihood of serious harm *because* of the mental illness
- Examples:
  - A youth standing on the outside railing of a bridge
  - A man barricading himself in house due to paranoia
  - A woman hearing a voice telling her to stab her neighbor
  - A man running naked in the middle of the street with traffic
  - An intoxicated woman threatening to cut her wrists
  -

21 **Detaining: When?**

- Mobile Crisis is needed to respond to scene
- Person needs to be transported to a safe location for examination/assessment
- While Mobile Crisis is conducting an assessment to determine whether involuntary psychiatric admission is necessary
- When Certificate of Need is signed and Mobile Crisis has determined a risk for danger or elopement until inpatient placement is secured
- When the person needs secure transportation to a psychiatric inpatient facility

22 **Detaining: How?**

- TN law permits law enforcement to detain someone *without* a signed Certificate of Need for involuntary psychiatric admission (TCA §§33-6-401, 33-6-402) for the following:
  - For the purpose of obtaining examination for Certification of Need
  - To get Mobile Crisis to respond for assessment
  - Can transport to a safe location during detainment period
  - Legal document not required
  - Documentation in case record recommended
  - Person needs to be transported to a safe location for examination/assessment
- Law enforcement can also detain someone with a signed Certificate of Need

Crisis Intervention Team (CIT) Task Force Framework Brief

In our state there is growing public support and bipartisan action focused on reducing the number of people with unmet mental health needs who enter Tennessee's criminal justice system and on improving access to community and hospital based behavioral health services. Investing in police-mental health collaboration (PMHC) models should be a component of the broader strategy to reduce the incarceration of people with mental health needs and increase access to community-based treatment alternatives. The Crisis Intervention Team (CIT) program is a nationally recognized, best practice PMHC model that has been shown to improve officer and community safety, and appropriately redirect individuals with mental illness, co-occurring disorders, substance abuse, developmental disorders or other brain disorders who are in crisis from the criminal justice system to the health care system.

The goal of the CIT Task Force is to gain an understanding of CIT best practices and statewide CIT coordination efforts; support a comprehensive statewide assessment of the current usage, policy, and practice of the CIT model; identify system gaps; and develop recommendations to expand and sustain CIT programs and infrastructure in alignment with ongoing criminal justice and behavioral health reform efforts.

Context

- Previous research has estimated that over 1 in 4 people who die in officer-involved shootings are in a mental health crisis
- Mental illness is not directly related to criminal involvement or violence yet individuals with mental health conditions are disproportionately represented in prisons and jails.
- Jails and prisons throughout the United States currently function as de facto mental health facilities. Approximately 56% of state prisoners, 45% of federal prisons and 64% of jail inmates have been diagnosed with a mental illness. Approximately 17% of U.S. jail inmates have serious mental illnesses.
- In Tennessee, 33% of all TDOC inmates are flagged as having mental health issues needing attention.
- Sheriff Daron Hall of Davidson County, Tennessee, reports a similar figure – approximately 25 people with mental illness are jailed in Nashville each day, 30 percent of all new admissions
- The cost of health care for those incarcerated with mental illness is 2-3 times greater than for people without mental illness.
- The CIT model is the most recognized and considered a "Best Practice" PMHC model, and other promising, complimentary models have emerged in recent years. That said, the disproportionate presence of mentally ill individuals in jails and prisons won't be ameliorated by new programs alone. CIT and CIT-related programs need to be part of a broader shift away from punitive approaches to behavioral health, toward increased collaboration across mental health and criminal justice systems, and systemic criminal justice reforms.

What is CIT and what is needed?

CIT are programs that bring together local stakeholders, including law enforcement officers, mental health treatment providers, community advocates, consumers of mental health and substance use services and others (non-law enforcement first responders such as emergency dispatchers, hospitals, and emergency medical care facilities). The goal is to improve multi-systems' response to persons experiencing behavioral health crises who come into contact with law enforcement first responders. Effective CIT programs enhance community collaboration, develop a stable infrastructure and provide training to improve criminal justice and mental health system response to individuals with mental health issues. CIT has been shown to keep people with mental health issues out of jail, get them into treatment, and reduce the incidents of arrests (Steadman). Pre-arrest diversion, including CIT, has been shown to reduce the number of re-arrests by 58 percent (Gains). CIT-trained officers are better able to identify people who need psychiatric care and they are 25% more likely to transport those people to a psychiatric facility than non-CIT trained officers (Strauss; Teller). CIT training is cost effective (Crowell, Broner, & Dupont, 2004), time efficient, and may combat stigma towards persons with mental illnesses (Compton et al, 2006) and substance use disorders (Bahora et al 2008). The CIT model was originally developed through a collaboration between the Memphis, Tennessee Police Department, NAMI Memphis and mental health providers, and has subsequently spread throughout the country.

Essential elements for the development and implementation of effective CIT programs include:

- *Law enforcement/ advocacy / mental health partnerships:* bringing together a wide array of stakeholders in the community and professionally to identify core needs of the community.
- *Community Ownership:* Planning implementation & networking. Ensuring the partnership group is included in key decisions.
- *Policies and Procedures:* Standardization of procedures for responding to behavioral health crises.
- *CIT Officer, Dispatcher, Coordinator:* Senior-level law enforcement official stewarding the development, implementation, and sustainability of the CIT program.
- *Intensive 40-hour training:* Standardized training, with a core curriculum and expert trainers and inclusion of individuals with lived experience and caregivers
- *Additional training support:* Train-the-trainer classes for CIT program sustainability. Training for other first responders (i.e. dispatchers, etc.) & additional content modules as needed (I/DD; Trauma & PTSD; substance abuse and addiction disorders; etc.)
- *Mental Health Receiving Facility/ Crisis stabilization/respite location* (not law enforcement or jail facility)*:* Identified partners who operate under shared principles and procedures.
- *Evaluation and Research:* collection of data to monitor program fidelity and outcome measures

In addition to these core elements, some jurisdictions have implemented further program enhancements such as information sharing tools or applications, hiring full-time clinicians into the law enforcement agency, conducting more preventive outreach with vulnerable individuals, and using secure communication apps or a "warm line" (as opposed to a hotline) to contact clinicians in the field.

Common Myths about CIT

- **CIT is a police intervention**. Though officers are often the first responders, partnership and coordination with health services is integral to the CIT model and essential for success.

- **CIT is just training.** CIT requires sustained partnership across agencies and should be embedded in law enforcement and health operations to be successful. Training without drop-off locations or clinician support leaves officers without the tools to successfully resolve situations.

- **CIT is expensive.** Law enforcement agencies often think they can't afford CIT at all. However, the national curriculum is freely available for local adoption; thus, the main costs of starting a CIT program are time or in-kind contributions (e.g., printing materials) for training and coordination meetings. Higher costs come through enhancements such as crisis triage centers.

- **CIT is only for crisis situations.** CIT officers are trained to be mental health specialists in the department and are best equipped to respond to any calls involving a person showing symptoms of mental health conditions, even if they are not currently in crisis. Bringing in a CIT officer who knows how to handle the situation appropriately can also prevent a situation from escalating to a crisis.

- "**Crisis" always means mental illness**. Very often, mental health and substance use disorders are co-occurring. CIT trains officers to recognize a potential behavioral health crisis, but not to diagnose. The skills taught in CIT, including de-escalation, apply to a variety of crisis situations.

- **Arrest is always the wrong answer**. The ultimate goal of CIT is to ensure the safety of people in crisis, people around them, the responding officer, and the public. Though CIT generally promotes responses other than arrest, there may be some instances where arrest becomes necessary to ensure public safety.

- **Departments should always aim to train 20 percent of officers in CIT.** Customary practice among law enforcement agencies is to seek to train 20 percent of patrol officers. However, there is little evidence to support this threshold for all agencies in all cases; instead, it is essential to ensure that all shifts and patrol districts have at least one CIT-trained officer available. Ultimately, the percentage of trained CIT officers should take into account a variety of factors, including call volume, the makeup of the department and local context.

- **CIT training should be mandatory for law enforcement officers.** Though some departments have made CIT mandatory, this approach can be detrimental. Mandating CIT can undercut officer buy-in and place officers who are neither interested nor appropriate to become CIT officers in the position of responding to sensitive crisis situations. Instead, there should be emphasis on the value of CIT to officers as a tool to protect officer safety and liability and employing credible messengers (i.e., well-respected and experienced officers) to deliver this message. Outside of CIT, all officers should be equipped with baseline mental health training.

CIT Task Force Objective

A robust statewide task force of law enforcement leaders; behavioral health providers; individuals with lived experience of behavioral health disorders; community advocates and other stakeholders will explore CIT best practices, policies and protocols, gaps, and statewide police-mental health collaboration strategies to expand and sustain CIT programs and infrastructure in alignment with ongoing criminal justice and behavioral health reform efforts.

The Task Force's objectives include:

- Review existing CIT programs in the state and identify gaps
- Review CIT best practices and consider CIT enhancements, including improved data integration, greater involvement and/or direct hiring of clinicians, more proactive outreach to people who frequently encounter CIT officers as well as CIT facilitators such as the establishment of crisis triage centers, respite beds and co-responder linkage teams.
- Define the goals and essential elements for local and regional CIT programs
- Establish criteria for the development of CIT programs that include assessment of effectiveness of an area's plan for community involvement, training, crisis response alternatives and policies, protocols and agreements between law enforcement and mental health care providers and other community stakeholders
- Recommend specific policy proposals and actions that can be taken by the executive and legislative branches of state government, local government, and behavioral health and law enforcement agencies to expand and sustain CIT programs and infrastructure.

Task Force Composition

The objectives of the task force necessitated bringing together members with diverse perspectives, including: professional experience (law enforcement, behavioral health providers, community advocates); geography in state (rural, suburban and urban areas in west, middle and east Tennessee); and people overrepresented in behavioral health crisis encounters with police (individuals with lived experience, d substance use disorders, people with I/DD, and racial and ethnic minorities).

The Task Force will be co-led by the Tennessee Department of Mental Health & Substance Abuse Services and Tennessee Department of Corrections in partnership with the NAMI Tennessee.

See attached table for the list of Task Force members.

Timeline

During the first year, the Task Force will meet seven times between April and October of 2018 and a expansion strategy will be issued no later than January 2019.

In addition to regular meetings, the Task Force will use a variety of forums to gather information and develop recommendations:

- Work Groups will serve as the Task Force's working meetings and will be focused on specific topics. The following 4 work groups have been proposed but are open to revision:

    - Mental Health/criminal justice system coordination: Will focus on developing model guidelines, protocols and collaborative agreements between law enforcement, behavioral health provider agencies and community system partners

    - Data and assessment: Will focus on Identifying what data is available and effective assessment measures of crisis intervention team programs (e.g. the number of crisis incidents, rates of diversion to treatment versus taken into custody, mental health consumer perceptions of law enforcement)

    - Training: Will focus on reviewing national curricula and CIT training best practices, recommending any needed adaptations (e.g. training modalities, instructors, target audience, percent of law enforcement personnel trained, funding sources, certification, outcome measures)

    - Community engagement: Will focus on ensuring that a broad range of perspectives and experiences are shared, including people with lived experience from communities of color and LGBTQ communities, and members of communities disproportionately represented in jails

- The Task Force will aid in the development, distribution and evaluation of the findings of a state survey of existing CIT programs and resources.

- A Task Force website will provide ongoing and changing opportunities for input and feedback related to the work of the Task Force and its work groups and will serve as a repository for agendas, schedules of Task Force meetings and CIT resources.

Task Force Members List. *This is not a definitive list of task force members and is subject to change.*

Field	Name	Title	Organization
County Government	David Connor	Executive Director	1. Tennessee County Services Association
Behavioral health	Mary Linden Salter	Executive Director	2. TAADAS (TN Association of Alcohol, Drug & other Addiction Services)
Behavioral health	Morenike Murphy	Director	3. Office of Crisis Services and Suicide Prevention, Tennessee Department of Mental Health and Substance Abuse Services
Law enforcement	Marie Crosson	Executive Director	4. Tennessee Association of Recovery Court Professionals
Behavioral health	Victoria Lake	Director	5. West Tennessee Healthcare
Behavioral health	Ellen Abbott	Director	6. Office of Criminal Justice Services, Tennessee Department of Mental Health and Substance Abuse Services
Behavioral health	Pam Womack	CEO	7. Mental Health Cooperative
Law enforcement	John R. Mehr	Sheriff	8. Madison County Sheriff's Office
Behavioral health	Justine Bass	Director of Operations for Division of Mental Health Services	9. Tennessee Department of Mental Health and Substance Abuse Services
Law enforcement	Daina Moran	Deputy Director	10. TN Office of Criminal Justice Programs, Department of Finance & Administration
Behavioral health	Jerry Vagnier; Candace Allen	CEO; CIT programs	11. Helen Ross McNabb Center
Law enforcement	Wanda Mays	Crisis Intervention Team manager	12. Hamilton County Sheriff's Office
Behavioral health	Jan Cagle	Criminal Justice Liaison	13. Ridgeview Behavioral Health
Healthcare	Rebecca Jolley	Executive Director	14. Rural Health Assoc of TN
Behavioral health	Kim Rush	Regional Vice President	15. Volunteer Behavioral Health Care System
Law enforcement	Lt. Colonel Vincent E. Beasley	Lieutenant; CIT coordinator	16. Memphis Police Department
Healthcare	Mike Dietrich	Vice President, Member Services	17. Tennessee Hospital Association
Behavioral health; Community/ Advocacy	Jack Stewart	Member	18. NAMI TN
Community/ Advocacy	Liz Logsdon	Intake Director	19. Disability Rights Tennessee
Community/ Advocacy	Judge Dan Eisenstein	Retiree	20. Former drug court judge
Behavioral health; Community/ Advocacy	Tom Starling	CEO	21. Mental Health America of Middle TN
Disability	Carol Westlake	Executive Director	22. TN Disability Coalition
Behavioral health	Ellyn Wilbur	Executive Director	23. TN Association of Mental Health Organizations
Law enforcement	Terry Smith	CIT Officer	24. Colliersville Police Department
Law enforcement	James Lash	CIT Officer	25. Memphis Police Department- Crisis Intervention Team
Behavioral health	Anthony Fox	Executive Director	26. TN Mental Health Consumers' Association
Law enforcement	Amber McDonald; Jamison Peevyhouse	Director; Training Director	27. Tennessee Emergency Communications Board
Health / behavioral health	Mary Shelton; Shawn Smith	Director, Behavioral Health Operations	28. Division of TennCare

		Deputy Director	
Law enforcement	Xyzeidria Ensley	Director, Behavioral Health	29. Davidson County Sheriff's Office
Healthcare	Cindy Manginelli	TennCare Shelter Enrollment Project Coordinator	30. National Health Care for the Homeless Council
Behavioral health	Lisa Ragan	Director	31. Office of Consumer Affairs and Peer Recovery Services, TN Department of Mental Health & Substance Abuse Services
Law enforcement	Sherlean Lybolt	Mental Health Programs Coordinator	32. TN Department of Correction
Law enforcement	Sam Cochran	Consultant	33. CIT International
Behavioral health; Community/ Advocacy	Jeff Fladen	Executive Director	34. NAMI TN

CIT Inventory Survey

1. **Name:**

2. **Contact Information:**

3. **Date:**

   Example: December 15, 2012

Background

4. **Name of the agency where the program is based:**

5. **Program type that best describes your CIT program:**
   Mark only one oval.

   - ◯ Local Police
   - ◯ County Sheriff's
   - ◯ Housing Authority
   - ◯ Park Service
   - ◯ College/University
   - ◯ Corrections
   - ◯ Airport
   - ◯ Multi-jurisdiction
   - ◯ Other: _____

6. **What jurisdiction does your program serve?**

7. **CIT Program Name:**

_____

8. **CIT Coordinator:**

_____

9. **CIT Contact Phone:**

_____

10. **CIT Contact Email:**

_____

11. **Date Established:**

_____

12. **Please indicate the status of the CIT coordinator for your program:**
Mark only one oval.

- ◯ Full-time
- ◯ Part-time
- ◯ Volunteer
- ◯ Other: _____

Training

13. **Does your CIT program deliver its own training?**
Mark only one oval.

- ◯ Yes
- ◯ No

14. **If no, where were your local law enforcement trained?**

_____

15. **If no, how many local program personnel participated in CIT core training at any location between July 1, 2016 and June 30, 2017**

_____

16. **If yes, how many of the local personnel were trained through your CIT training program between July 1, 2016 and June 30, 2017**

_____

17. **If yes, how many personnel outside of the CIT program jurisdiction participated in your CIT training between July 1, 2016 and June 30, 2017**

_____

18. **What outside jurisdictions sent their local personnel to your CIT training between July 1, 2016 and June 30, 2017**

_____

_____

_____

_____

_____

19. **How many CIT program personnel trained between July 1, 2016 and June 30, 2017 have First Responder duties?**

_____

20. **Please indicate all of the type of personnel trained through your local CIT program between July 1, 2016 and June 30, 2017 (if applicable)**

Check all that apply.

- [ ] Law Enforcement Field Personnel
- [ ] Law Enforcement Jail/ Detention Personnel
- [ ] Law Enforcement Services Personnel (court services, transportation)
- [ ] Fire Department
- [ ] Emergency Medical Services (Paramedics, EMTs)
- [ ] Behavioral Health, Emergency Services
- [ ] Behavioral Health, other than ES Clinicians
- [ ] Medical Staff (M.D., Nurses, etc.)
- [ ] Judicial Employees (Judges, etc.)
- [ ] Probation (federal, state, juvenile)
- [ ] Peers
- [ ] Advocates
- [ ] Corrections (DOC)
- [ ] Emergency Communications (911 dispatchers)
- [ ] Other: _____

21. **Who delivers the CIT training? (Please select all that apply)**
Check all that apply.

- [ ] Law enforcement personnel
- [ ] Mental health personnel
- [ ] People who have mental illnesses
- [ ] Advocates
- [ ] Family members of people who have mental illnesses
- [ ] Other: _____

22. **What instructional methods are used?**
Check all that apply.

- [ ] Lecture
- [ ] Simulations and/or virtual training
- [ ] Ride-alongs
- [ ] Site visits to facilities
- [ ] Presentations by advocates
- [ ] Role play
- [ ] Other: _____

23. **Does the CIT training include any of the following additional topics?**
Check all that apply.

- [ ] Cultural competence
- [ ] Implicit bias
- [ ] Trauma-informed policing
- [ ] Other: _____

24. **How many Train the Trainer sessions were hosted by your CIT program between July 1, 2016 and June 30, 2017?**

_____

25. **Does your CIT program have a specialized Emergency Communications/ Dispatcher CIT curriculum?**
Mark only one oval.

- ◯ Yes
- ◯ No

26. **Describe the specialized Dispatcher curriculum**

27. **How many emergency communications personnel were trained specifically through this curriculum between July 1, 2016 and June 30, 2017?**

28. **Is the training program offered include 40 consecutive hours of training delivered over five days?**
Mark only one oval.

- Yes
- No

29. **If you responded NO to the previous question, please describe the training hour requirements**

30. **Is the training post-certified?**
Mark only one oval.

- Yes
- No

31. **Do participants evaluate the training they receive?**
Mark only one oval.

- Yes
- No

32. **Comments:**

33. **Are you willing to share your training curriculum and trainer contact details?**
Mark only one oval.

- ◯ Yes
- ◯ No

Community Stakeholder Collaboration

34. **Please indicate the behavioral health service provider(s) participating in your CIT program**

35. **Please indicate other healthcare agencies, institutions or organizations participating in your CIT program**

36. **Please indicate the advocacy or peer organizations participating in your CIT program**

37. **Please list any other participating agencies or organizations**

38. **What best describes the frequency that your CIT program meet with its community partners?**
Mark only one oval.

- Weekly
- Monthly
- Quarterly
- Annually
- As Needed
- Other: _____

39. **Please describe other community engagement or outreach activities that your CIT program has led or continues to participate in**

_____

_____

_____

_____

_____

Policies and Procedures

40. **Does your CIT program or law enforcement agency have policies in place regarding the size of its CIT-trained patrol division?**
Mark only one oval.

- Yes
- No

41. **If YES, please describe the policy**

_____

_____

_____

_____

_____

42. **What percentage oft the patrol division would you estimate have been CIT trained?**

_____

43. **Do you have 24/7 CIT officer coverage?**
Mark only one oval.

- Yes
- No

44. **Do you currently have any of the following documents to define responsibilities among CIT partners?**
Check all that apply.

- [ ] MOUs
- [ ] Other interagency agreements
- [ ] Joint or collaborative policies and procedures

45. **Comments:**

46. **Are policies and procedures in place to guide call-taker and dispatcher activity with regard to behavioral health calls for service?**
Mark only one oval.

- ◯ Yes
- ◯ No

47. **Comments:**

48. **Do 911 staff use specific screening questions to determine whether a call appears to involve a person who has a behavioral health issue?**
Mark only one oval.

- ◯ Yes
- ◯ No

49. **Comments:**

50. **Are call-takers and dispatchers informed of law enforcement and behavioral health agency staffing patterns so that they can properly route behavioral health calls for services**
Mark only one oval.

- Yes
- No

51. **Do "on-scene" protocols guide collaborative responses to calls for service involving people experiencing a behavioral health crisis (Examples of on-scene protocols include use of verbal de-escalation vs use of force, arrest vs. diversion, transfer of custody, determining final disposition, etc.)**
Mark only one oval.

- Yes
- No

52. **Comments:**

53. **Does your CIT program or law enforcement agency have policies in place to provide guidelines regarding how to safely and respectfully transport individuals?**
Mark only one oval.

- Yes
- No

54. **Comments:**

55. **Are there policies and procedures in place to guide mental health personnel on how to respond to people who are experiencing a behavioral health crisis and are diverted from the criminal legal system and referred to services by officers? (Examples of these policies and procedures include transfer of custody, protocols for emergency evaluations, referral options, follow-up with law enforcement, etc.)**
Mark only one oval.

- Yes
- No

56. **Comments:**

Information Sharing

57. **Are there written policies, MOUs, or other interagency agreements to facilitate and formalize the sharing of information between law enforcement and behavioral health agencies?**
Mark only one oval.

- Yes
- No

58. **Comments:**

Behavioral Health Care Resources

Please assess the behavioral health resources available to your CIT program

59. **Hotline/Warmline: Staffed by clinicians, hotlines can provide support to people in times of crisis. Warmlines are usually run by peers and offer support in times of distress in an effort to prevent mental health crises.**
Mark only one oval.

- Hotline only
- Warmline only
- Both
- Neither

60. **Hours of operation:**

61. **Mobile Outreach: Mobile outreach services are similar to the non-crisis version of a mobile crisis team. Mobile outreach staff attempt to contact people who are at risk of having a mental health crisis. (e.g., those who have dropped out of treatment)**
Mark only one oval.

- ◯ Yes
- ◯ No

62. **Hours of operation:**

_____

63. **Emergency room: An emergency room can serve as a viable alternative to arrest for people who have mental health crises and come into contact with law enforcement. On average how far is the nearest emergency room for people in your jurisdiction?**

_____

64. **Is there a psychiatric emergency room available in your jurisdiction?**
Mark only one oval.

- ◯ Yes
- ◯ No

65. **Hours of operation:**

_____

66. **Emergency/Crisis/Diversion facilities have an array of crisis programming and are easily accessible to law enforcement. Many of these facilities operate 24/7, 365 days a year. Available in your jurisdiction?**
Mark only one oval.

- ◯ Yes
- ◯ No

67. **Hours of operation:**

_____

68. **A Single Point of Access for law enforcement is a place in the community--other than the emergency room--where officers can take a person who is suspected to have behavioral health needs and have that person evaluated by a clinician. Available in your jurisdiction?**
Mark only one oval.

- ◯ Yes
- ◯ No

69. **Which crisis services are available as either a part of the engagement/crisis/diversion facility or independently? (Please select all that apply)**
Check all that apply.

- [ ] Domestic violence and abuse shelter
- [ ] Speciality suicide counseling hotline
- [ ] Intensive outpatient program
- [ ] Short-term crisis residential/respite center
- [ ] Partial hospitalization program/ unit
- [ ] Mobil crisis unit
- [ ] Detox
- [ ] Rehabilitation
- [ ] Sobering unit

70. **Which long- and short-term behavioral health services are available in your jurisdiction (Please select all that apply)**
Check all that apply.

- [ ] Assisted Outpatient Treatment (AOT)
- [ ] Assertive Community Treatment (ACT)
- [ ] Day treatment
- [ ] Counseling services/medication management
- [ ] Employment/vocational services
- [ ] Housing for people who have behavioral health needs
- [ ] Walk-in clinics

Data Collection

71. **Please identify performance measures of your CIT program or law enforcement agency currently utilizes**

Mark only one oval per row.

	Yes	No
Number of trained officers		
Training effectiveness		
Number of officers selected as CIT specialists		
Number and type of CIT policies or protocols developed		
Number and type of MOUs developed		
The number of calls for services involving people with mental illness		
Duration of calls for CIT service		
Percentage of calls that CIT officers handle		
Repeat calls for the same people		
Frequency of disposition decisions CIT officers resolved at scene with no formal action taken		
Frequency CIT officer provided a referral to behavioral health resources		
Frequency CIT officer transported person for voluntary treatment		
Frequency CIT officer detained person for an involuntary examination		
Frequency CIT officer arrested the person		
Frequency of use of force during behavioral health calls		
Number of injuries or fatalities to officers, individuals, in crisis, and third parties		

72. **Who is collecting the data? (Title of position/agency)**

73. **What is the data source? (E.g., incident report or other form, database, survey, etc.)**

74. **Is your agency able to analyze data on behavioral health calls for service in the community?**
Mark only one oval.

- Yes
- No

75. **Comments:**

76. **Have you been able to identify people who have multiple contacts with law enforcement alongside other emergency services? (i.e., high utilizers)?**
Mark only one oval.

- Yes
- No

77. **Comments:**

78. **Is your agency able to track final dispositions for behavioral health calls for service?**
Mark only one oval.

- Yes
- No

79. **Comments:**

80. **Please list the available final disposition options for behavioral health calls for service**

Program Support & Improvements

81. **Has your jurisdiction ever conducted a strategic mapping exercise, gap analysis, process flow analysis, or other needs assessment about the service available in your community?**
Mark only one oval.

- Yes
- No

82. **If YES, how is it being used to guide your program?**

83. **Do you have an award ceremony or formal recognition for CIT trained officers?**
Mark only one oval.

- Yes
- No

84. **Comments:**

85. **Please list funding sources you've relied on to sustain the CIT program**

86. **How satisfied are you with your CIT program?**
Mark only one oval.

- ◯ Very satisfied
- ◯ Somewhat satisfied
- ◯ Somewhat dissatisfied
- ◯ Very dissatisfied

87. **What are the most significant barriers the CIT program faces?**

_____

_____

_____

_____

_____

88. **What suggestions do you have for improvements to your CIT program?**

_____

_____

_____

_____

_____

89. **Do you have a CIT response story or other positive outcome that you would like to share. Please describe below:**

_____

_____

_____

_____

_____

90. **How supportive would you be of greater coordination and networking between CIT programs across the state?**
Mark only one oval.

- ◯ Very supportive
- ◯ Somewhat supportive
- ◯ Somewhat opposed
- ◯ Very opposed

91. **What kinds of technical assistance would your CIT program benefit from? (select all that apply)**
Check all that apply.

- [ ] Identifying funding opportunities
- [ ] Establishing and sustaining community partnerships
- [ ] Building relationships with behavioral health care resources
- [ ] Developing policies/protocols or interagency agreements to guide CIT program responsibilities
- [ ] Support with core or in-service CIT training (trainers, curricula, instructional methods)
- [ ] Facilitating and formalizing the sharing of information between law enforcement and behavioral health agencies
- [ ] Data collection
- [ ] Program evaluation
- [ ] Other: _____

92. **Please provide any additional comments here:**

_____

_____

_____

_____

_____

Crisis Intervention Team (CIT) Program Survey

The CIT in Tennessee strategic planning initiative, co-led by the Tennessee Department of Mental Health & Substance Abuse Services and the Tennessee Department of Corrections in partnership with NAMI Tennessee, is developing a plan to expand and sustain Crisis Intervention Team programs across the state. As part of this initiative, we're surveying local police departments across the state about their interest, capacity or readiness for CIT.

Here's a link to more information about the benefits of CIT and how to build a program: https://www.nami.org/Get-Involved/Law-Enforcement-and-Mental-Health

For more information contact Jake Coffey, Director of Advocacy (NAMI TN); jcoffey@namitn.org; (615) 361-6608 ext. 315

1. **Please identify the name of your police department/ local jurisdiction**

2. **Please list the name and title of the person completing the survey**

3. **How important is it that law enforcement officers be trained on how to safely interact with people experiencing a mental health or addiction crisis?**
   Mark only one oval.
   - ◯ Very important
   - ◯ Important
   - ◯ Moderately important
   - ◯ Slightly important
   - ◯ Not important

4. **What is the level of support in your Department for enhanced mental health training for law enforcement professionals?**
   Mark only one oval.
   - ◯ Strongly favor
   - ◯ Somewhat favor
   - ◯ Neutral
   - ◯ Somewhat oppose
   - ◯ Strongly oppose

5. **Are you familiar with the CIT program model?**
   Mark only one oval.
   - ◯ Yes
   - ◯ No

6. **Do you currently have a CIT program in your jurisdiction?**
   Mark only one oval.

   ◯ Yes
   ◯ No

7. **How many CIT-trained officers do you have in your department?**

   _____

8. **If you do not currently have a CIT program in your jurisdiction, would you be interested in establishing one?**
   Mark only one oval.

   ◯ Yes
   ◯ No

9. **Would your Department be interested in receiving technical assistance towards developing or enhancing a CIT program?**
   Mark only one oval.

   ◯ Yes
   ◯ No

10. **What kinds of technical assistance would your Department benefit from? (Select all that apply)**
    Check all that apply.

    ☐ Identifying funding opportunities for police-mental health collaboration
    ☐ Establishing and sustaining community partnerships
    ☐ Building relationships with behavioral health care resources
    ☐ Developing policies/protocols or interagency agreements to guide CIT program responsibilities
    ☐ Support with core or in-service CIT training (trainers, curricula, instructional methods)
    ☐ Facilitating and formalizing the sharing of information between law enforcement and behavioral health agencies
    ☐ Data collection
    ☐ Program evaluation
    ☐ Other: _____

11. **From your department's perspective, what do you see as the greatest barriers to establishing or enhancing a CIT program**

    _____
    _____
    _____
    _____
    _____

12. **From the below list, select the top 3 barriers to establishing or enhancing a CIT program in your jurisdiction**
Check all that apply.

- [ ] Lack of trainers and training resources
- [ ] Cost of training
- [ ] Attitudinal barriers within law enforcement to persons with serious mental illness
- [ ] Insufficient training and policies for dispatchers
- [ ] Inadequate community mental health services
- [ ] Issues related to transportation between law enforcement and health facilities
- [ ] Command-and-control model and use of force policies within the department

13. **Please provide any additional information or commentary that you think might be relevant**

CIT Program Overview (2017-18)

	Rutherford County 	
Contact Details	Kimberly Rush, LPC, MHSP Regional Vice President, Volunteer Behavioral Health Care System	Phone: (615) 542-2364 Email: krush@vbhcs.org
Governance	– Established 2009-10 – Multi-jurisdiction, County-wide CIT program – 1 volunteer CIT coordinator (Kim Rush) & law enforcement coordination support in Murfreesboro Police Department (Sgt. Joshua Meredith); – Murfreesboro is the lead participating law enforcement agency	
Training	– Delivers own post-certified 40-hr CIT training 2x/year; 25-person cap for Murfreesboro PD, Rutherford County Sheriff's Office, and neighboring counties, including: Williamson (Brentwood & Franklin); Warren, Bledsoe, Murray, Columbia, Coffee and Putnam – Currently no training evaluation component – Murfreesboro sends 4 law enforcement personnel per training – Participating personnel: LE field personnel; Jail/Detention personnel; SWAT and other LE services personnel; Behavioral health clinicians; MPD 911 dispatchers; University campus police – Train-the-trainer sessions planned for later this year	
Stakeholder Collaboration	– No longer facilitating regular County-wide meetings with CIT stakeholders; considering re-establishing regular meetings	
Policies/ Protocols	– 20% of Murfreesboro PD patrol division is CIT-certified; Committed to 30% goal; 24/7 CIT officer coverage – Murfreesboro PD General Order- outlining roles, responsibilities, reporting for Crisis Intervention Team; CIT Incident Report – Murfreesboro PD developed General Order- Emergency Committal (effective January, 2014) *"An officer may request a CIT trained officer to respond to assist"* – Volunteer Behavioral Health Care- Murfreesboro PD MOU	
Data Collection	Murfreesboro PD- To be determined	

Barriers/ Improvements	– High turnover of law enforcement makes continued law enforcement and other stakeholder buy-in challenging; "easy to become complacent" – More CIT coordinators are needed and regional CIT coordination model (east, middle, west TN) was suggested as a solution to support technical assistance and support continued stakeholder buy-in – Requested a CIT toolkit to support program development and implementation
Unique Features/ Updates	– VA participation in training, delivers training on PTSD and Traumatic Brain Injury – Kim Rush is facilitating monthly meeting with McMinnville PD (Warren County) to establish CIT program and train the trainer session; Supporting Brentwood and Franklin (Williamson County) in developing CIT program – All trained personnel participate in a graduation ceremony and receive the Rutherford County CIT pin

	Hamilton County 	
Contact Details	Lt. Eliott Mahaffey Hamilton County Sheriff's Office	Phone: (423) 893-3503 Email: esmahaffey@hcsheriff.gov
Governance	– Established 2009, through a DOJ grant; supported through County budget until 2018 – Multi-jurisdiction, Hamilton County Sheriff's Office/ Chattanooga PD jointly coordinated – 1 Crisis Intervention Team Manager (Eliot Mahaffey) coordinates County (Deputy Jeremy Durham-full-time coordinator) and Chattanooga (Tim Tomisek part-time co-coordinator) programs	
Training	– Delivers own post-certified 40-hr CIT training; In 2017 conducted 1 training (Oct 24-28), graduating 20 CIT law enforcement field personnel from Hamilton County Sheriff's Office, Chattanooga PD, Veterans Affairs, East Ridge PD, Catoosa County Sheriff's Office, Collegedale PD, Signal Mountain PD o 2 Hamilton County 911 dispatchers trained (Not separate training but offers modified role plays and content tracks) – Training evaluations score module 1-10; evaluations used by CIT advisory committee to identify improvements – 2 hours of mental health training provided by CIT program to all law enforcement personnel and civilians of Hamilton County Sheriff's Office and all law enforcement within Chattanooga PD as part of annual in-service. – All cadets in Hamilton County Corrections Academy receive 4 hours of mental health training – Since 2009 over 380 participants have been trained in the program, representing 22 law enforcement agencies from 8 counties and 4 states	

Stakeholder Collaboration	– CIT Advisory Committee meets monthly to discuss CIT objectives and activities. The committee is composed of law enforcement, consumers, advocates, mental health agencies and hospitals – Promotes CIT program through community outreach activities with neighborhood watch and community organizations
Policies/ Protocols	– At least 20% of Hamilton County Sheriff's Office and Chattanooga PD patrol divisions are CIT-certified; 24/7 CIT officer coverage – CIT program has MOU with every participating municipality in Hamilton County and community mental health agency – There are policies in place to guide dispatcher activity; 911 use specific screening questions; call-takers are informed of law enforcement and behavioral health staffing patterns; "on-scene" protocols guide responses to calls for service; there are policies in place to provide guidelines regarding transport; and procedures to guide mental health personnel on how to respond
Data Collection	Chattanooga and Hamilton County have a centralized data management system (TriTech) and the CIT program encourages other local municipalities to file CIT reports Total # of CIT incident reports documented in 2017 by Hamilton County Sheriff's Office and County Corrections: 143 Of the 143 CIT calls reported: – 2 encounters resulted in arrests – 131 individuals transported for mental health evaluation – 7 stabilized by CIT officers with no further action taken – Other dispositions included current jail inmate placed on suicide watch, call determined unfounded, or individual not located – 2 injuries associated with CIT calls, 1 injury occurring before officers arrived, the other sustained when individual jumped and not as a result of hands-on encounter with police Performance measures currently utilized include: – # of trained officers; training effectiveness; # and type of CIT policies developed; # of MOUs; # of calls involving people experiencing mental health crisis; Duration of CIT call; # of calls that CIT officers handle; repeat calls for same people; Frequency of disposition decisions CIT officers resolved at scene with no formal action taken; Frequency CIT officer provided referral to behavioral health resources; Frequency CIT officer transported person to voluntary treatment; Frequency CIT officer detained person for involuntary examination; Frequency CIT officer arrested person; Frequency of use of force during behavioral health calls; # of injuries or fatalities to officers, individuals, third parties Hamilton County/ Chattanooga law enforcement agencies are able to analyze data on behavioral health calls for service in the community. They have been able to identify people who have multiple contacts with law enforcement alongside other emergency services. Not currently able to track final dispositions for behavioral health calls for service, but through the pre-arrest diversion infrastructure grant may have the capacity to do this soon…

Barriers/ Improvements	– Greatest barrier is the lack of community behavioral health services, particularly preventive services so that crisis situations are averted – There is a need for more CIT trainings and training hours dedicated to CIT – Additional barrier is the lack of expertise in using data and program evaluation ("We are not statisticians!") – Recommended regular (quarterly) meetings with all CIT programs to network and share resources/best practices – Any state coordinated CIT effort needs to outline criteria and standards for program fidelity to guide success (at minimum the 40 hr training requirement)
Unique Features/ Updates	– There is an annual award ceremony for CIT trained officers – Publishes an annual report of CIT program activities/achievements – Will be including a module to address opioid epidemic in next CIT training

	Knox County 	
Contact Details	Candace Allen, Senior Director of Adult Intensive Mental Health Services & Elaine Blanton, Criminal Justice Services Coordinator at Helen Ross McNabb Center	Phone: (865) 329-9141 Email: candace.allen@mcnabb.org
Governance	– Established 2012 through a grant collaboration between Hellen Ross McNabb and Knoxville PD – Multi-jurisdiction, County-wide CIT program – 1 volunteer CIT coordinator (Candace Allen) & law enforcement coordination with Knoxville Police Department (primary), and participation with Knox County PD and University of Tennessee PD ; Blount County has participated deputies as well	
Training	– Delivers own post-certified (with Knoxville PD) 40-hr CIT training; 2 in the last fiscal year, but usually provide 3yr – 25 person maximum training – Since 2015 all incoming Knoxville PD recruits have taken 40-hr CIT training (only a fraction of whom become certified CIT officers). Of all sworn officers, 140 (36%) have received the 40 hour class; 244 (64%) have received the 24-hour class – No policies regarding size of CIT training patrol division; 50% of officers are trained – Law enforcement, medical staff, judicial employees and corrections participate in the 40 hour training – Hospital security and EMS complete a modified training – Train the trainer sessions have happened in the past, but none in the last fiscal year	

	– Additional training topics beyond core curriculum include: Information on Tennessee Code Title 33, developmental and intellectual disabilities Disorder, and "Elephant in the Room" (developed by law enforcement personnel to address mental health needs of law enforcement officers)
Stakeholder Collaboration	– Knoxville PD, Covenant Health, Helen Ross McNabb Center, Knox Area Rescue Ministries, UT Medical Center are among the lead agency stakeholders – CIT Program has monthly stakeholder meetings, include but not limited to representatives from the 3 local law enforcement agencies, HRM Center, KARM, and Covenant Health
Policies/ Protocols	*Knoxville PD:* – 24/7 coverage – Currently no policies in place regarding the size of its CIT-trained patrol division, but does have on-scene policies on use of the CIT officer in the field when responding to crisis events and in regard to transportation – Does not have any MOUS, other interagency agreements or joint or collaborative policies specific to CIT beyond the existing MOU with the Behavioral Health Urgent Care Center (BHUCC) – There are specific policies in place to guide call-taker and dispatch activity with regard to behavioral health calls and CIT officer involvement
Data Collection	– *Knoxville PD:* – # of trained officers (collected by CIT coordinator through class roster) – # of calls for services involving people with mental illness (Collected by CIT coordinator) (E-911 Calls for Service database – in the process of trying to come up with a new disposition code that will more accurately reflect the number of calls involving mental illness) – Duration of calls for CIT service is partially collected by CIT coordinator through a tracking/ CIT stats form – Repeat calls for the same offenders is collected by the CIT coordinator through tracking/CIT stats form
Behavioral Health Care Resources	– Received funding for pre-arrest diversion infrastructure – Opened the Behavioral Health Urgent Care Center on March 16, 2018 – List of available final disposition options for behavioral health calls include: Emergency Room, Arrest, BHUCC, Provide Referral Information, CSU (voluntary), Mobile Crisis (involuntary)
Barriers/ Improvements	– Knoxville PD, Knox County PD and University of Tennessee PD do not have a uniform collaborative effort – CIT program would be stronger with more buy-in from leadership in these departments (especially lacking from Sheriff's Office and UTPD) – Perpetual problem of police turn over/staffing – Information tracking and program improvement/evaluation is a challenge – Designate a full-time law enforcement-based CIT coordinator

Unique Features/ Updates	– 40-hour CIT training for all new recruits to the KPD – Law Enforcement self-motivated to develop "Elephant in the Room" component – Formal graduation for CIT officers – Knox County Mayor (described as being a big advocate), Lt Gov, guest speakers attend. Pins are presented.

	Madison County 	
Contact Details	Vicki Lake, Director of Market Research and Community Development & Kim Parker, Director of Inpatient Services at West Tennessee Healthcare Leslee Hallenback, Jackson Police Department; Karen Pomeroy and Bryan Rushing, Madison County Sheriff's Office	Phone: (731) 984-2160 Email: vicki.lake@WTH.org
Governance	– CIT program established 2009; merged into and has become integral component of the Madison County Justice-Mental Health Collaborative Coalition – Multi-jurisdiction, Madison County Sheriff's Office/ Jackson PD – West Tennessee Healthcare is the lead coordinating agency for the CIT program (Kim Parker and Vicki Lake collaborate as part-time CIT coordinators)	
Training	– Delivers 3 post-certified 40-hr trainings/year and expanding. In last fiscal yr. graduated 80 CIT law enforcement personnel. Additionally, in the last fiscal year: o Delivered 2 tailored 2-day trainings for forty (40) 911 dispatchers (Madison County & Jackson 911 personnel) o Post-certified Enhanced training 2 Veterans classes, 2 Autism classes & 2 Law Enforcement Suicide Prevention classes; o 2 Train-the-Trainer classes; 20/class – Since 2010, 2-3 CIT training classes have been held on an annual basis; over 460 first responders trained – Participating personnel in CIT training : LE field personnel; Jail/Detention personnel; LE services personnel; Fire Dept; EMS; Behavioral Health; Judicial Employees; (juvenile) Probation; security staff of West TN Healthcare – Offer training to neighboring law enforcement personnel in Hardeman County, Trenton (Gibson County), Dyersburg (Dyer County), Shelby County, Weakley County, Tipton County	
Stakeholder Collaboration	– Madison County Justice-Mental Health Collaborative coalition of local agencies meets on a monthly basis. Among their responsibilities, it oversees and promotes CIT program and collection, review and analysis of CIT data	

	– Participating agencies include: o West Tenn Healthcare, Aspell Recovery Center, Pathways Behavioral Health, The Grove Primary Care Clinic, Jackson Area Council on Alcoholism and Drug Dependency, Madison County Sheriff's Office, Jackson Police Dept., Tennessee Correctional Services West, Madison County Corrections, City of Jackson Recovery Court, Jackson State Community College – NAMI is an active partner in CIT; Melinda Harden (NAMI regional coordinator) is hosting a CIT awards banquet at upcoming fall conference to raise awareness for CIT program work – CIT trained officers have a group that meet regularly with peer recovery center

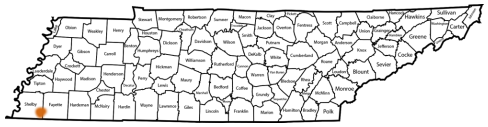
Policies/ Protocols	– Sheriff's Office / Jackson PD % CIT trained >20% ; 24/7 CIT officer coverage
	– Jackson and Madison county have embedded least restrictive responses, use of force policies, and jail diversion protocols into General Orders
	– Madison County Justice-Mental Health Collaborative (MCJ-MHC) MOU outlining agency responsibilities focuses on adults with SMI, SUDs, and co-occurring disorders who come in contact with the justice system
	– MOU regarding transfer of medical information
	  o Better response to frequent fliers
	  o Improved speed and communication during warm handoffs
	– LE personnel and dispatchers in Jackson and Madison County have specific CIT protocols

Data Collection	– Jackson and Madison County use the same CIT data tracking software & CIT screening tool used by all CIT trained officers Performance measures of MCH-MHC relevant to CIT include: – # of target population diverted from jail by local programs; # of mental health/CIT calls form Jackson PD and Madison County Sheriff's office; # of target population that received services form local crisis stabilization unit or Crisis Detox; # of target population placed under observation at the local Crisis Walk In Center; # of target population received early release from jail and referred into treatment services; Estimated monthly cost savings to local criminal justice system based on total # diverted each month; # of target population transported using alternate transportation; # of local meetings each month of stakeholder partners; # of first responders and behavioral health professionals trained each month Madison County and Jackson PD collect frequency of use of force during behavioral health calls/ which the collaborative can pull when needed

Behavioral Health Care Resources	– Received funding for pre-arrest diversion infrastructure
	  o Alternative Transportation Pilot Project Grant
	  o Madison County Jail Expansion Project

	– Federal/State Grants ○ Criminal Justice Liaison Grant; DOJ; Bureau Justice Assistance Grant (pending)
Barriers/ Improvements	– Would benefit from a full-time coordinator for the collaborative and full-time CIT coordinator. Whether these persons should sit within law enforcement or West TN Healthcare still in discussion – Greater capacity for their regional training center operated by the Sherriff's Office to be a truly regional center for CIT and other training opportunities for all of west TN; currently Jackson and Madison County have priority
Unique Features/ Updates	– Developing a 24/7 care unit of CIT first responders with master's level clinician – Order to Disclose Protected Health Information assures communication on team and speed of service – District Attorney buy-in, who has outlined specific classes of misdemeanors for individuals applicable for jail diversion and early release

	Oak Ridge, Anderson/Roane CIT 	
Contact Details	Jan Cagle Criminal Justice Program Manager, Ridgeview Behavioral Health Services	Phone: (865) 481-6170 x1223 Email: caglejg@ridgeview.com
Governance	– Established 2010 – Multi-jurisdiction, County-wide CIT program – 1 volunteer CIT coordinator (Jan Cagle) & law enforcement coordination support in Oak Ridge Police Department – Oak Ridge is the lead participating law enforcement agency	
Training	– Delivers own post-certified 40-hr CIT training X/year; 25-person cap – Between July 1, 2016-June 30, 2017, trained 20 officers (outside the jurisdiction; 0 with first-responder duties) – Currently no training evaluation component –	
Stakeholder Collaboration	– Monthly County-wide meetings with CIT stakeholders	
Barriers/ Improvements	– High turnover of law enforcement makes continued law enforcement and other stakeholder buy-in challenging; – There is need for stipends for law enforcement departments to send participating law enforcement to training – More CIT coordinators are needed and regional CIT coordination model (east, middle, west TN) was suggested as a solution to support technical assistance and support continued stakeholder buy-in – Requested a CIT toolkit to support program development and implementation	

	Collierville 	
Contact Details	Lt. Chris Rossie Collierville Police Department	Phone: (901) 457 – 2853 Email: crossie@ci.collierville.tn.us
Governance	– Established 1999 – Local police-based program; 1 part-time CIT coordinator (Lt. Chris Rossie) – Receives training and support from Memphis CIT	
Training	– Training delivered through the Memphis CIT program – CIT trained officers participate in annual CIT refresher course	
Stakeholder Collaboration	– No formal, independent CIT stakeholder meeting convened on a regular basis; meetings as needed – CIT and CIT adjacent law enforcement personnel participate in monthly TDMHSA Regional Council 7 meetings – Many 911 dispatchers receive mental health first aid training, but it is not a requirement	
Policies/ Protocols	– No % coverage policy, but 26% of Collierville PD patrol division is CIT-certified (18 of 66; by October will be 24); 24/7 CIT officer coverage o Additionally, there are 7 school resource officers (SRO's) in the Community Services Division that are CIT certified – The department has a standard operating procedure (SOP) that addresses protocol for admission to mental health or hospital facilities and emergency detentions under the state law, TCA 33-6-401. – Collierville has an MOU with Shelby County and the CIT Crisis Assessment Center (See Appendix) – CPD also has its own MOU with Lakeside Behavioral Health and Crestwyn Behavioral Health – Collierville PD does not have specific guidance or on-scene protocols related to CIT in its General Order or standards of practice – T911 Computer Aided Dispatch (CAD) System, operated through the CPD Dispatch Center, codes for mental health calls and call-takers and dispatchers are informed of CIT-trained law enforcement personnel and behavioral health staffing patterns so that calls can be routed properly	
Data Collection	– All CIT-trained officers complete and report CIT stat sheet – With Rossie's appointment as new CIT coordinator this year, program has re-committed to collecting CIT data systematically	

	Performance measures that will be utilized include: – # of trained officers; # of calls involving people experiencing mental health crisis; Duration of CIT call; # of calls that CIT officers handle; repeat calls for same people; Frequency of disposition decisions CIT officers resolved at scene with no formal action taken; Frequency CIT officer provided referral to behavioral health resources; Frequency CIT officer transported person to voluntary treatment; Frequency CIT officer detained person for involuntary examination; Frequency CIT officer arrested person; Frequency of use of force during behavioral health calls; # of injuries or fatalities to officers, individuals, third parties
Barriers/ Improvements	– The only constraints CPD faces in regard to sending officers to CIT training are the # of slots allotted by Memphis CIT training program. – There are a lack of community mental health resources – There can be a culture among officers that "we're not social workers" and CIT training requires a culture shift among officers that must be cultivated beyond simply providing training – Consider a regional training arrangement so there's more equitable distribution of training across the region instead of prioritizing Memphis PD – Supportive of the establishment of a statewide conference –
Unique Features/ Updates	– They participate in annual NAMI Memphis CIT awards banquet – They have developed their own unique CIT pins for CIT-certified Collierville personnel – They seem NAMI as a critical resource

	Shelby County 	
Contact Details	– Lt. Col. Vincent Beasley - Memphis Police Department ○ Lt. Joshua Schultz - Germantown Police Department ○ Chief of Police Terrell Owens - Memphis Veterans Affairs	Phone: Lt. Col. Beasley - (901) 357-1701 Email: vincent.beasley@memphistn.gov Phone: Lt. Schultz - (901) 569 – 3337 Email: jschultz@germantowntn.gov Phone: Chief of Police Terrell Owens-terrell.owens@va.gov
Governance	– Established 1988 – Memphis PD is lead agency of Multi-jurisdiction county-wide CIT program	

	– 1 CIT coordinator (Beasley) & an assistant CIT coordinator (James Lash) o There are multiple CIT programs under the umbrella of Memphis CIT that include: Germantown PD and Memphis VA among others, all with their own coordinators – County-wide MOU establishes contractual agreement for participating Law Enforcement/Mental Health providers

Training	– 4 post-certified, 40 hour CIT trainings per year at the Memphis Police Department Training Academy. Within each class:
	  o 10 slots for Memphis PD
	  o 10 slots for all other Shelby County Police Departments (and neighboring counties)
	  o Approximately 8 slots for all others
	  ▪ 2 Dispatchers/class
	  ▪ 2 Federal Agents (FBI) and 2 Field Marshalls attended trainings in last fiscal year
	– 4 train-the-trainer sessions are also facilitated on annual basis
	– Full spectrum of CIT trainer/trainee personnel
	– Corrections provides its own, tailored CIT training
	– 8 hour in service training updates
	  o Previous topics - Autism, Sign Language, Opioids
	–

Stakeholder Collaboration	– CIT stakeholder meetings are organized on an as-needed bassis – CIT program stakeholders are integrated into TDMHSAS Regional Council 7 meetings and use this forum for program updates – An exhaustive list of stakeholders cannot be included here but lead agencies include: CAC, Lakeside Behavioral Health System, LeBonheur Children's Hospital, Regional Medical Center at Memphis, St Francis Hospital Behavioral Health Center, Crestwyn Behavioral Health Center, Alliance Healthcare Services – The CIT program also leads a speaking engagement series (roughly 30/year) with community partners and partners with the Lowenstein House for outreach activities
Policies/ Protocols	– Memphis PD General Order- outlining roles, responsibilities, reporting for Crisis Intervention Team; CIT Incident Report – CAC and Regional One Health have MOUs in place (Appendix) – 911 Personnel follow specific screening questions and utilize a CAD system – Law Enforcement/Mental Health Personnel have policies in place regarding alternative transportation (Appendix)

Data Collection	– CIT State Sheet is completed on all crisis calls involving mental illness and includes (See Appendix);
	  o Equipment/Technique used (Verbalization, handcuffs, chemical agent etc)
	  o Consumer and/or Officer injury
	  o Disposition of person taken into custody
	  o Disposition of person not taken into custody
	  o Other Information (Armed, Veteran, Known Previous Diagnosis)
	  o Transporting

	○ Officer's written summary of interaction and actions taken – Developing processes to use data to prove cost effectiveness of CIT
Barriers/ Improvements	– Demand exceeds supply of CIT training slots for Police Departments other than Memphis PD – Warm handoffs could be more time efficient – Inadequate community mental health resources
Unique Features/ Updates	– Developing Care Unit of CIT first responders with masters level clinician ○ Paramedic, EMT, Behavioral Analyst, CIT officer ○ Reduce time spent on frequent fliers – "Peer Counsels" program focuses on mental health education for LE personnel

Endnotes

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IMAGE CREDITS

Smoky Mountains: Jake Blucker

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