Crisis Intervention Training

Current Practices and Recommendations for California

CALIFORNIA INSTITUTE FOR BEHAVIORAL HEALTH SOLUTIONS

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INTRODUCTION

BACKGROUND

In 2013, California lawmakers legislated Senate Bill 82 Investment in Mental Health Wellness Act to improve the crisis response infrastructure in the State of California. The Mental Health Services Oversight and Accountability Commission (MHSOAC) was given authority to administer a portion of those funds, including funding for surveying practices in Crisis Intervention Team (CIT) training and implementation in California. In February 2014, with funding from the MHSOAC, the California Institute for Behavioral Health Solutions (CIBHS) began a series of activities toward collecting information about CIT best practices and practice gaps in California. These activities included: convening an Expert Panel; interviewing persons with lived experience and family members, including persons from diverse ethnic and cultural backgrounds and transition-age youth (TAY); conducting a survey of all 58 counties in the state; and researching CIT best practices in other parts of the country. For the purpose of this report the acronym CIT must be clarified. In this report, we use "CIT" for Crisis Intervention Teams, which refers to the Memphis Model, a 40-hour comprehensive training. We refer to all other crisis Intervention trainings as "behavioral health crisis intervention trainings." It is our hope that this report will contribute to the development of consistent guidelines across the State of California for CIT training to law enforcement and other first responders that will improve outcomes for persons experiencing a mental health challenge and in crisis.

WHAT IS CIT?

CIT is a first responder model designed to "improve officer and consumer safety, and to redirect individuals [living] with mental illness from the judicial system to the health care system" (Dupont, Cochran, & Pillsbury, 2007). The first CIT was established in Memphis in 1988 after the tragic shooting by a police officer of a man with a serious mental illness. This tragedy stimulated collaboration between the police, the Memphis chapter of the National Alliance on Mental Illness, the University of Tennessee Medical School and the University of Memphis to improve police training and procedures for responding to persons with mental illness. Today, the "Memphis Model," which refers to the 40 hour training has been adopted by more than 2000 communities in more than 40 states, is being implemented statewide in several states including Maine, Connecticut, Ohio, Georgia, Florida, Utah, and Kentucky (NAMI, National Alliance on Mental Illness).

A growing California trend is the identification of CIT as a model for behavioral health crisis intervention training for law enforcement. Foundational to the CIT Model are community partnerships between law enforcement, community mental health, community based organizations, and individuals and families with lived experience working together to improve outcomes of police interactions with people with mental illness. CIT involves bringing these key partners together to collaboratively plan and implement training and protocols that will result in reducing the risk of injury to police officers and mentally ill persons, and diverting persons to mental health treatment instead of jail, when appropriate. The 40-hour CIT comprehensive training emphasizes mental health conditions, crisis resolution and de-escalation skills, community resources, and consumer and family member perspectives. The training includes didactics, on-site visits, and scenario-based skills practice. Continuing education or in-service training modules to regularly provide officers with advanced knowledge and skills is another essential component of the CIT Model. Program evaluation is critical for monitoring how well the program is achieving its outcomes. Some of the recommended data collection/reporting include crisis response times, injury rates to officers and citizens, health care referrals, arrest rates, community perception of law enforcement, and law enforcement perceptions of

individuals with mental illness. Finally, the Memphis Model recommends recognizing and honoring CIT officers to provide an incentive to perform this specialized work. Examples of incentives are service awards at annual banquets and/or through local media outlets, certificates of recognition, departmental commendations, and salary bonuses.

BENEFITS OF CIT

Oftentimes, peace officers are the first to respond to persons experiencing a mental health crisis. CIT equips peace officers with the knowledge and skills to effectively interact with and de-escalate individuals experiencing a mental health crisis. Peace officers are also trained in techniques to appropriately engage family members and loved ones who may be present during the crisis. Some of the reported benefits of CIT training include: reduction in use of force and injury to both officers and citizens; reduction in arrests/jail time; and increased diversions to treatment or other services (NAMI, National Alliance on Mental Illness).

PROCESS OF DEVELOPING RECOMMENDATIONS

CIBHS gathered information from several sources. In May 2014, CIBHS convened an Expert Panel for a facilitated strategic planning session. The Expert Panel comprised representatives from national, state and local affiliates of NAMI, California Crisis Intervention Training Association Board of Directors, law enforcement, and county behavioral health providers. The Panel members contributed a wealth of expertise related to training and implementing CIT and other behavioral health crisis intervention trainings in California. The Expert Panel served as a "think tank" to examine the high priority areas, needs, and best practices; to determine the leverage points; and to define how best to utilize limited resources to achieve the greatest impact for CIT training and implementation.

CIBHS conducted key informant interviews with individuals and families living with mental illness, including persons from diverse ethnic and cultural backgrounds and transition-

age youth (TAY). Five key informants were recruited through consumer advocacy organizations. The purpose of the key informant interviews was to enhance the information gathered via the Expert Panel by including perspectives of persons of color, non-English speakers, transition-age youth, and family members.

CIBHS then researched national and international CIT practices. Information was gathered through web research and conference presentations, reports that were available online, and from conference presentations from the 2014 International Crisis Intervention Teams (CIT) Conference held in Monterey, California. Nationally researched programs included Albuquerque, NM; Chicago, IL; Madison, WI; Connecticut; Memphis, TN; San Antonio, TX; St. Louis, MO; Virginia Beach, VA; and Toronto, Canada. The purpose of the research was to identify best practices and implementation formats including number of training hours, curriculum outline, training target audiences, percentage of officers trained, funding sources, state certification, and outcomes measures.

Finally, CIBHS surveyed training coordinators throughout California counties responsible for the implementation of behavioral health crisis intervention training, including CIT for law enforcement and other first responders. There are 58 counties and two city-operated public mental health programs in California. The survey was distributed to all mental health directors through the County Behavioral Health Directors Association of California (CBHDA). An initial email announcing the survey and inviting all counties to participate in the survey was sent followed by multiple reminder emails. Additionally, the survey was announced at the in-person All Director's Meeting and an in-person reminder was done at a subsequent All Director's Meeting encouraging non-responders to complete to the survey. CIBHS project staff also reached out individually via telephone calls and emails to mental health directors and designated CIT coordinators of non-responsive counties. The findings from this survey, presented later in this report, are based on the results received from 33 counties, one city, and

the BART[1] Police Department. The majority of the data was received between August and November 2014. A few survey responses were received later, between July and August 2015, and added to the report. While the findings are not truly representative of the entire state due to non-participation of some counties, it does represent more than half of the state.

[1] BART stands for Bay Area Rapid Transit and covers multiple cities and counties in the Greater San Francisco Bay Area.

EXPERT PANEL

The Expert Panel identified the high priority areas and the best practices that should be promoted within each of the following key areas community partnerships, training length, who should be trained, when to train, trainers, distinction between training and a program, state certification, and funding.

COMMUNITY PARTNERSHIPS

- Expert Panel members insisted that fidelity to the CIT model relies on strong community partnerships among the following entities NAMI or another local community-based organization that serves in an advocacy role for persons with lived experience, the mental health/behavioral health provider system, and law enforcement.

TRAINING HOURS

- The Expert Panel members promoted the 40-hour Memphis Model as the gold standard for CIT training. They felt strongly that any reduction in the training hours would significantly alter and compromise the content and quality of the training. That said, the Panel acknowledged the extensive variation in training hours and curriculum throughout California and therefore proposed a tiered training approach.

WHO SHOULD BE TRAINED?

- The Expert Panel members stressed the value of expanding training beyond peace officers to include other community crisis first responders. This includes fire fighters, emergency medical services, border patrol, public transit officers, campus police and security officers. At a minimum, the Expert Panel recommended that a designated CIT team should be fully trained (40 hours) and, optimally, that law enforcement

organizations and other first responder agencies should endeavor to provide a minimum of eight hours of CIT training to their entire workforce.

WHEN TO TRAIN?

- The Expert Panel discussed various pros and cons to when officers should be offered CIT training. One of the pros to offering CIT training during academy was to establish a culture that values CIT as a core skill. One of the con arguments to offering CIT training during academy was that there was already so much material in academy that very little of the CIT training would be absorbed. One of the pros to offering CIT training after having several months of patrol experience was that they would better understand the relevance and utility of the CIT training. One of the con arguments to offering CIT training after several months of patrol experience was that officers would already have developed a bias against persons with mental illness.

TRAINERS

- The training team should include a combination of POST certified law enforcement and mental health trainers.
- The Expert Panel members agreed that training should always include persons with lived experience as trainers.

DISTINCTION BETWEEN TRAINING AND A PROGRAM

- Expert Panel members agreed that implementing a CIT program approach was an important standard and that simply offering training was not sufficient. Programmatic components should include engagement of community partners to plan and develop

protocols, continuous training opportunities, a coordinated team, and data collection for continuous quality improvement.

STATE CERTIFICATION

- The Expert Panel felt that CIT training should be part of a state certification requirement.

FUNDING

- Expert Panel members agreed that adequate funding from the State would be necessary in order to implement CIT with consistency across the State.
    - To establish a framework for training, programs, protocols and outcomes measures.
    - To fortify standardized training and consistent outcomes statewide.

KEY INFORMANT INTERVIEWS

Key areas identified by the key informants focused on training and the knowledge and skills that officers, in particular (because of officers' access to lethal means), should possess for responding most effectively to a person experiencing a mental health crisis. These areas included understanding of mental health conditions, understanding of officers' responsibility to ensure safety and link to resources, de-escalation tactics; addressing stigma and bias, establishing trust and positive rapport, cultural competency, understanding family member needs, and how to appropriately involve family members.

UNDERSTANDING OF MENTAL HEALTH CONDITIONS

- Key informants expressed the importance of officers gaining knowledge and understanding of mental illness and other health conditions, understanding the symptoms associated with mental health disorders, and how individuals may present in a mental health crisis situation. This understanding can greatly assist officers to identify a mental health crisis situation that may otherwise appear to be strictly criminal in nature. Officers should be aware that a person's presentation when in crisis can appear fluid and erratic – e.g., "She might be psychotic and dangerous one moment, a charming and adorable human being the next, then in another moment something else." It is important for officers to understand that the individual is going to change and cycle around, so that they are better equipped to handle the situation effectively. Key informants suggested officers develop the skills to "be patient and calm," "talk her down," "let them burn off sometimes," and "give it a minute or five or ten or an hour," rather than reactively resorting to the use of force. Key informants also suggested officers have an understanding of drug and alcohol symptoms to differentiate between someone who is experiencing a mental health crisis versus an individual with a drug or alcohol induced condition.

UNDERSTANDING OF PEACE OFFICERS' RESPONSIBILITY TO ENSURE SAFETY AND LINK TO SERVICES

- Key informants expressed that training should emphasize that the primary goal is to ensure a safe outcome for all involved. Toward that goal, officers should receive sufficient training in de-escalation techniques and trainers should emphasize the use of these skills before the use of lethal means to gain control of the situation.
- Peace officers have a key role in the expedite linkage with appropriate interventions for individuals experiencing a mental health crisis. Training should aim to increase officers' awareness of mental health programs and facilities, resources for veterans and their family members, and youth services for transition-age youth. Resource lists should be made available to officers that include local community providers, their locations, and the types of services that are available.

DE-ESCALATION TACTICS

- Key informants offered numerous suggestions for increasing officers' effectiveness in de-escalating an individual experiencing a mental health crisis. These are listed below. The first list pertains to reducing stigma and bias against persons living with mental illness and persons who are both homeless and mentally ill. The second list contains suggestions related to establishing rapport with the individual experiencing a crisis.

Address law enforcement stigma and bias against persons with mental illness and persons who are homeless mentally ill:

1. Promote the understanding that mental illness is a neurological disease that the individual needs exceptional help to control.
2. Promote the understanding that persons with mental illness are human beings, that they are sick, and that they can't help it.
3. Promote the awareness that persons with mental illness are intelligent and should be spoken to respectfully.

Train officers in the importance of and skills for establishing communication with the individual:

1. Gain trust through demonstrating compassion and reassurance.
2. Be empathic and listen – e.g., "By listening they may find out that they just forgot to take their medications."

3. Engage with a calm, moderate voice and a non-threatening dialogue.
4. Avoid the use of physical or verbal threats.
5. Avoid the use of barking orders and loud demanding tones.
6. Avoid the use of defensive and threatening posturing.
7. Avoid approaching with guns drawn.
8. Use non-uniformed officers, trained negotiators and/or mental health workers known to the individual.
9. Encourage bystanders to move away, disengage and stop participating in the event, in a way that doesn't appear to be defensive – e.g., "If they are trained to handle it effectively then they shouldn't be threatened by recording on cell phones."

CULTURAL COMPETENCY

- Key informants who are Latino said that officers should avoid labeling them as criminals and avoid responding differently. One bilingual Spanish-speaking key informant said that the police station is located on the same street as her house yet it took one and a half hours for the police to respond. When officers arrived, they shoved her against the wall, smashed her face, and punched her belly although she was visibly pregnant and in the presence of her other children. Her husband had shot himself in the head with a gun but the officers failed to attend to his medical needs. Rather, the officers took her and her teenage daughter into custody and left the younger children in the home unattended. This key informant felt very strongly that officers must be trained to address their biases and assumptions that Latinos are gang-involved, drug dealers and criminals. Officers need to understand that family members are expecting the responding officers to help them, not beat and arrest them. Officers need to address the needs of the children present and not further traumatize them. Regardless of race or ethnicity, officers need to show compassion and respect.
- An African American, male key informant cautioned against the assumption that it is only the White officers that need cultural competency training. Although he did point out that White officers tended to mistakenly assume he was not educated, in his experience, he had more problems with African American than White officers treating

him in a rough manner, such as putting him in “a stretch position during pat down” and being overly judgmental.

- TAY key informants said that youth in crisis needed help de-escalating their feelings. Officers should be empathic and listen. Officers should acknowledge the youth’s feelings (whether they agree or believe them) because what they are feeling is very real to the youth. Officers should not be judgmental and say things like “they are crazy” or “I hope you learned your lesson.” Law enforcement needs to be aware of cultural barriers for them to be more successful in establishing a relationship with a youth of color. In particular, according to one key informant, “youth of color will have the mindset that law enforcement is not there to help.” The officer will be more successful in engaging the youth if they act less in the role of the police officer or probation officer. Officers should be encouraged to recognize their own biases and to not make the assumption that all youth of color are gang-involved or drug dealers. For instance, one foster youth with depression who was living in a car would have benefited more from being connected to services rather than arrested and given a criminal record. Officers need to be sensitized to how detrimental it is to a youth’s entire future when, as a consequence of experiencing a crisis, the youth gets a criminal record. One key informant suggested a mobile response team that travels with law enforcement on mental health calls and helps connect youth with services. Another suggestion was to create an advocate position to conduct follow-up with the youth to make sure she or he is linked to services and benefits. Many youth are not connected to Medi-Cal and it is devastating and unrecoverable when the TAY is charged for the ambulance and stay, and sent to collections. Still another suggestion was for a multi-service place for youth to go and receive immediate help and linkage to benefits and services.

UNDERSTANDING FAMILY MEMBER NEEDS

- Family member key informants recommended dispatchers be trained to know when to send out a CIT trained officer. Dispatchers should dispatch a CIT trained officer when the caller/family member requests. Dispatchers should be trained to ask the right questions because the caller, oftentimes a family member who is experiencing this for the first time, will likely not know what to do or say. According to one family member key informant, “The dispatcher needs to be smarter than the parent.” Family members need

dispatchers to demonstrate confidence to reassure the family member – e.g., “It’s going to be okay. Just hang in there. Hold on. We’re going to send the right person out.”

- Family member key informants expressed the importance for officers to understand the despair of the family member. One family member key informant stated that officers need to understand “the terror of the family member and all the emotions the family member is experiencing and to calm the family member.”

HOW TO APPROPRIATELY INVOLVE FAMILY MEMBERS

- Officers should engage with the family member and have the necessary skills to appropriately involve the family member. For instance, an officer may talk to the family member to obtain information about the individual’s mental health history, drug or alcohol-use history, health issues requiring prior law enforcement intervention, history of suicidal tendencies, if the individual is taking medications, and what recent event may have brought on the break.
- If the individual is taken into custody, family members want officers to ask if they have medications so that they are not taken to jail without them.
- The officer needs to know “exactly what to do so the parent can move aside and let the officer help the sick person.” The officer should demonstrate by demeanor and actions that she or he has the knowledge and skills to handle the situation without additional violence. Officers should have the skills to calm the person and should not reactively shoot their gun when a person experiencing a mental health crisis is coming at them with a knife.

BEST PRACTICES BEYOND CALIFORNIA

Nationwide, 3000 law enforcement agencies have adopted CIT training since the late 1980s (Bouscaren, 2014). The agencies using CIT training cover more than 2000 communities and 40 states (NAMI, National Alliance on Mental Illness). We highlight here the best practices from several of the programs that are generally acknowledged among CIT experts as model programs. In this section, we organized our findings under the following broad areas partnerships and protocols, various aspects related to trainings, recognition; programmatic approach, and funding.

PARTNERSHIPS AND PROTOCOLS

Successful CIT programs are those that are built upon strong relationships among several key partners. Partnership between law enforcement, mental health system and hospitals, and consumer and family member advocacy groups from early planning is fundamental to developing the training curriculum and processes – such as for sharing information, properly transporting consumers, and drop-off/receiving at mental health receiving facilities or emergency departments. Strong relationships are essential for establishing trust among partners and for ongoing feedback on operations to ensure quality services. In Chicago, Illinois, for example, officers are encouraged to go to local group homes to introduce themselves to staff and residents. Group home staff let the officers stop there to do paperwork and have a cup of coffee. This helps workers, residents and officers get familiar with each other in a positive, non-crisis context (Watson, 2014). Collaboration among partners in Chicago around creating hospital admission procedures (i.e., “police drop”) resulted in developing a form that the officer completes at drop-off that has reduced the drop-off time from eight hours to only fifteen minutes (Watson, 2014).

WHAT PERCENTAGE OF AN AGENCY'S WORKFORCE SHOULD RECEIVE CIT TRAINING?

In several of the programs we researched – including the State of Connecticut; San Antonio, Texas; and Madison, Wisconsin – all of the officers are CIT trained. In other programs, such as Chicago, the goal is to have enough CIT trained officers to have at least one per shift (Andriukaitis, 2014). An article published by the University of Memphis, *Crisis Intervention Team Core Elements*, recommends that 20-25% of an agency's patrol division should be CIT trained for that program to be most successful. The article acknowledges that there may be reasons for some agencies to train a higher percentage of officers to meet the demand in their particular community. For instance, some rural communities may need to have a higher percentage of CIT trained officers because of the geographic distance between the communities they serve. Ideally, the number of designated CIT officers per shift should be sufficient to meet the demand of that given local mental health consumer community (Dupont, Cochran, & Pillsbury, 2007). A strategy that has been implemented in several places is for all officers to receive some basic level of CIT training (briefer than the 40 hours) with a smaller set of officers designated as CIT officers who undergo the more comprehensive, 40-hour training. This strategy, which has been practiced in places like Chicago and Toronto, Canada, has helped with the challenging balance between keeping enough patrol officers on the street while also ensuring enough officers are adequately exposed to CIT training (Niedra, 2014).

WHICH SPECIALTY AREAS SHOULD RECEIVE CIT TRAINING?

Most successful programs train beyond just local law enforcement. For instance, in Virginia Beach, officers, deputies, first responders and emergency dispatchers are all CIT trained (Lee, Boone, St John, & Jones, Developing CIT Programs for 911 Telecommunicators, 2014). In San Antonio, those personnel who are CIT trained include all law enforcement, fire fighters and Emergency Medical Services (EMS) (Paradise, 2010). In Connecticut, the list of personnel who are trained in CIT is much longer than most and includes local and state police departments,

local college and university police, hospital police departments, US Coast Guards, Department of Veterans Affairs police departments, State Capitol police, civilian police volunteers, mental health clinicians, probation and parole officers, judicial marshals and US marshals, EMS, and fire departments (Meckel).

SHOULD THERE BE A SELECTION PROCESS?

Several programs implement an application, screening and selection process for identifying those officers most suited for being a CIT officer. In both Albuquerque and Chicago, officers have to be accepted through an application and screening process (Bower & Pettit, 2001); (Andriukaitis, 2014). In San Antonio, officers must additionally pass an exam and are graded on the role play exercises (Paradise, 2010).

HOW MUCH TRAINING AND WHEN?

This question about the length and timing of CIT training is also very important. The Memphis Model recommends a 40-hour comprehensive training that covers mental health topics, crisis resolution and de-escalation skills, and accessing community-based resources (Dupont, Cochran, & Pillsbury, 2007). Among all of the programs we researched, all used the 40-hour model except for Madison, Wisconsin, which provided 60 hours of training during pre-service academy. In Chicago, this 40-hour training is considered the basic course for their Critical Response Unit officers, and advanced CIT modules on veterans, youth, geriatric issues and suicide crisis, as well as a refresher course, are offered as continuing education (Andriukaitis, 2014). Although not supported by proponents of the Memphis Model, some programs offer a briefer training to all officers and only their designated CIT officers receive the full 40-hour training. In Chicago, this briefer training is provided to all academy recruits (Andriukaitis, 2014). Emergency dispatchers need to know how to recognize when a call involves a behavioral health crisis or event, ask the appropriate questions to obtain critical information that will be helpful to the responding officer, and to appropriately dispatch a CIT

trained officer. In Virginia Beach, dispatchers receive 16 hours of CIT training (Lee, Boone, St John, & Jones, Developing CIT Programs for 911 Telecommunicators, 2014). A course based on CIT and specialized for dispatchers was developed in Virginia Beach and is being replicated in other parts of the country.

CLASS SIZE, CONTENT AND FORMAT

It appears that the better the resources the more frequently classes can be offered making it possible to keep class sizes smaller. For example, in Chicago, they offer training one to two times each month and typically cap the classes to 30 students (Andriukaitis, 2014).

The following is a list of the core elements of the didactics and lectures portion of the 40-hour Memphis Model training, (Dupont, Cochran, & Pillsbury, 2007):

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

The 40-hour comprehensive training also includes on-site visits and practical skills/scenario based components (Dupont, Cochran, & Pillsbury, 2007). In Chicago, role plays are done by consumers themselves rather than by actors. The role play exercises are videotaped and reviewed by the participants. A critical training component is where the consumers give feedback on how it felt (Andriukaitis, 2014).

RECOGNITION

Some programs provide special incentives and recognition to CIT officers for their work in the forms of graduations, awards, certificates of recognition, or salary incentives to provide a sense of pride and ownership toward the program. For example, in Albuquerque, CIT trained officers receive a $50.00 incentive per month in their paycheck (Bower & Pettit, 2001).

PROGRAMMATIC APPROACH

The concept of training versus program is an important distinction. Training alone does not result in a successful implementation of CIT. Trainings are a one-time event, whereas a program will provide on-going training opportunities, activities that promote relationship building between law enforcement and community members experiencing mental illness, and data collection on outcomes of CIT interventions in the community for monitoring and continuous quality improvement purposes. In Virginia Beach, Chicago and other communities, law enforcement agencies partner with local NAMI organizations to educate persons with severe and chronic mental illness and family members on what to communicate to the dispatcher during a 911 call (Lee, Boone, St John, & Jones, Developing CIT Programs for 911 Telecommunicators, 2014); (Andriukaitis, 2014). There are numerous policies and procedures to develop, such as how to properly transport a consumer, and what information and how that information will be shared between the law enforcement community and the mental health provider community. The mental health receiving community is a critical aspect of an effective CIT program. Where consumers will be received, what information is to be exchanged, and how quickly officers are able to turnaround and return to their duties on the street are all part of the processes that must be developed in partnerships for a CIT program to be successful.

There should be a designated “team” consisting of liaisons or coordinators from each of the partner entities – i.e., CIT law enforcement coordinator, CIT mental health coordinator, and CIT advocacy coordinator. Specific persons should be designated in each of these roles and

function as a team. One of these partners, typically law enforcement, is designated as the primary or lead CIT coordinator.

Data collection is an important aspect of a more programmatic implementation of CIT. Data collection on the calls, response and outcomes of the encounter are very important for the purposes of monitoring and continuous quality improvement. For example, in St. Louis, as a result of their data collection they are able to report that individuals are being diverted to treatment in 90% of the crisis response situations, and tasers or restraints are being used in only 4% of those situations (Bouscaren, 2014). Some examples of data being collected and reported to monitor the impact of CIT in a community are:

- Crisis response times
- Rates for taser use
- Rates for use of restraint
- Rates of citizen injury
- Officer injury rates
- Rates of diversion to treatment versus taken into custody
- Mental health consumer perceptions of law enforcement
- Community perceptions of law enforcement

FUNDING

Adequate funding is critical for CIT to be implemented with fidelity and to consistently produce positive outcomes. In Albuquerque, funding for CIT training comes from the New Mexico Department of Health (Bower & Pettit, 2001). In Connecticut, CIT training is state-funded from the Department of Mental Health and Addiction Services (CABLE, 2014). CIT training is also state-funded in Madison by the Department of Health Family Services (Wisconsin State Legislature, 2013-14). In Toronto, funding comes solely from the police department's budget (Niedra, 2014).

CIT PRACTICES IN CALIFORNIA

As we described earlier in the report, we conducted a statewide survey primarily between August and November 2014, and received responses from 33 counties, one city, and BART Police Department for a total of 35 respondents. Respondents included Alameda, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, Humboldt, Inyo, Kern, Kings, Los Angeles, Madera, Marin, Merced, Modoc, Mono, Monterey, Orange, Plumas, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, and Yolo counties, the city of Berkeley, and BART Police Department. We asked if CIT training was being implemented and if not, what other crisis intervention or crisis support services were available. All but nine of the respondents (n=26) (74.3%) reported that they implemented CIT. Among the nine respondents that said they were not implementing CIT, four reported they implemented Assessment and Referral Teams, one reported that they implemented Mobile Crisis Teams, and one reported that they implemented SMART (System-wide Mental Assessment Response Team). See Table 1, page 36.

PARTNERSHIPS AND PROTOCOLS

According to the Memphis Model and demonstrated elsewhere in the country, successful CIT programs are built on strong relationships between law enforcement, the mental health provider system, and community-based advocacy organizations representing individuals and families with lived experience. We asked which agencies collaborate to provide CIT training. Of the 26 respondents that reported implementing CIT, the majority (n=22) (84.6%) reported partnerships that included all three of these essential entities – law enforcement, the mental health provider system, and community-based advocacy organizations representing individuals and families with lived experience. The remaining four respondents (15.4%) reported having an existing working relationship between the mental health provider system and law enforcement.

PERCENTAGE OF CIT TRAINED WORKFORCE

Next, we asked what percentage of peace officers are CIT trained. Of the 26 respondents that reported implementing CIT, just under half (n=11) (42.3%) did not know what percentage of peace officers are CIT trained, indicating that this is not being tracked well by much of the state. Two counties – Riverside (reported training 100% of peace officers) and Modoc (reported 90%) – along with BART (reported 95%) stood out as training the highest percentage of peace officers. Several counties – San Diego (30-40%), San Francisco (24%), Monterey (30%), Humboldt (25%), Kern (21%) and San Mateo (20%) – fell within or slightly above the 20-25% range recommended by the Memphis Model. Two respondents – Berkeley (18%) and Butte (10-20%) – were just slightly under that recommended range.

The survey also asked what percentage of other first responders are CIT trained. We received only six responses that ranged from 0% (San Bernardino) at the low end to 50% (Humboldt) at the high end with Butte and San Diego in the middle at 10% and 30-40%, respectively.

Not surprisingly, when we asked if CIT was a requirement for peace officers, the majority (n=18) (69.2%) of the 26 respondents that reported implementing CIT responded "no" that there was not a requirement. The eight respondents that reported there was some requirement for peace officers were: BART, Merced, Monterey, Riverside, Sacramento, San Bernardino, San Diego and San Francisco. Only four respondents – BART, Merced, Sacramento and San Diego – reported that there was a CIT requirement for other first responders.

WHO ATTENDS CIT TRAININGS?

We wanted to know who attends CIT trainings in California, so we asked our respondents to tell us what types of occupations participated in their CIT trainings. All 26 of the respondents that reported implementing CIT said that peace officers were among those who have attended CIT trainings. Twenty-four of the respondents (92.3%) that reported

implementing CIT said that sheriff deputies have attended CIT trainings. Beyond local law enforcement, a wide range of occupations were reported to have attended CIT trainings. Most of these occupations are also in the law enforcement field, but in specialized settings – such as, in emergency rooms, college campuses or correctional facilities – or responsible for wider jurisdictions – such as, border patrol or highway patrol officers. However, the list also includes health professionals such as behavioral health providers, emergency room providers, and other emergency responders. Table 2, on page 37, shows the wide range of occupations that have reportedly attended CIT trainings.

SELECTION PROCESS FOR CIT TRAINING

We asked our respondents to describe any criteria, policy, protocol or procedure for determining which peace officers are CIT trained. Of the 26 respondents that reported implementing CIT, two respondents (7.7%) (Humboldt and Modoc) reported that departments invited volunteers. Kern reported a mixed method of training volunteers along with others who are assigned by a superior deputy or sergeant. Berkeley and Orange described a process that included volunteers with an application and selection process. According to five respondents (19.2%) (Marin, Monterey, San Mateo, Shasta and Yolo), selection is solely determined by the department. Butte reported that participation in training is dependent upon whether the agency can backfill behind an officer or deputy for the week-long training. Sacramento reported that the current Sheriff has mandated that all sergeants and deputies, regardless of job assignment, attend at least the 8-hour "CIT Awareness Course," and deputies who will be part of the upcoming Mobile Crisis Support Teams are required to complete the 24-hour CIT Course. Riverside reported that CIT training is mandated for all officers by the Sheriff's Office and Riverside Police Department however, there are several independent city police agencies within Riverside County that have no mandate. San Bernardino reported that all new sheriff deputy graduates and transfer deputies are required to attend CIT training, but the police departments do not have specific requirements. San Francisco reported that since July 2015, CIT training is required of all new academy classes. Alameda reported that there was not a uniform process

being implemented for determining which officers are CIT trained. The remaining nine (34.6%) respondents did not answer this question.

TRAINING HOURS

Typically, 1-day training is equivalent to eight hours of training, and so five days adheres to the full, 40-hour Memphis Model. We asked our respondents to tell us the length of their CIT trainings in days. We found a considerable variation in the length of CIT trainings across the state. Of the 26 respondents that reported implementing CIT, just above half (n=15) (57.7%) reported providing 4-day (Alameda, BART, Humboldt, San Bernardino, San Francisco, San Mateo, and Shasta) or 5-day (Berkeley, Butte, Contra Costa, Kern, Marin, Monterey, Stanislaus and Yolo) trainings. Alameda County noted that it offers 38 hours of training within those four days. Similarly, San Francisco and San Mateo County explained that it provides 40 hours of training in those four days. Several respondents indicated having trainings of different lengths (n=5) (19.2%). Of these, Amador reported having both a one- and two-day training. Calaveras said it offered both a three-day training and a four-hour "mini CIT" training. Both Sacramento and San Diego counties reported that they offer one- and three-day modules. According to the model used in Sacramento, the one-day training is an awareness course mandated by the Sheriff for all deputies, and the three-day intensive course is required of deputies who are part of the Mobile Crisis Support Teams. As noted by Sacramento, the intensive course was shortened to three days by excluding site visits and role play teaching activities. Shasta County indicated that it also offers both two- and four-day trainings. Modoc alone reported that it provides just the three-day training. Three respondents (11.5%) (Orange, Riverside and Solano) reported providing just two-day trainings, although at the time of the survey, Orange indicated that it was looking to add a 32- or 40-hour training once or twice a year. Two respondents (7.7%) reported just one-day trainings (Merced and San Joaquin). See Table 3, page 38.

WHEN TO TRAIN

There are various times throughout an officer's career when CIT training might be provided. We broke these down into "during academy training," "immediately after academy," and "after spending time in the field," and asked respondents when officers were required to receive CIT training. Once again, we found variation across the state around when officers were CIT trained. Of the 26 respondents that reported implementing CIT, 12 respondents (46.2%) (Alameda, BART, Butte, Contra Costa, Humboldt, Kern, Monterey, San Bernardino, San Diego, San Francisco, Stanislaus and Yolo) reported that CIT training was provided to officers after spending time in the field. Monterey, San Bernardino and San Francisco all reported that CIT training was also provided immediately after academy training. Ten respondents (38.5%) (Amador, Marin, Merced, Modoc, Orange, Riverside, Sacramento, San Joaquin, San Mateo, Shasta) reported that there was no particular set time when CIT trainings were required. Of those ten respondents, Merced, Modoc and Riverside explained that when officers were trained was based upon when trainings were scheduled. Sacramento explained that although CIT training is not built into the academy curriculum, it strives to train officers as early as possible. This respondent further expounded that "CIT has proven very beneficial for the new deputies working within the jails." The remaining four respondents (15.4%) did not provide an answer to this question.

We also asked respondents to tell us, based on their experience, when would be the *ideal* time for officers to receive CIT training. Of the 26 respondents that reported implementing CIT, one respondent (3.8%) (Sacramento) stated that it was "never too early" and again noted how valuable it has been to introduce CIT training early to new deputies working in the jails. Six respondents (23.1%) (Amador, Calaveras, Merced, Modoc, Orange, and Solano) thought CIT training was important at every step beginning with a course "during academy training" and followed by periodic, refresher courses. The rationale offered by one respondent for the early introduction of CIT training starting in academy is to give it equal weight with everything else. Another respondent said that officers should have training to work with individuals with mental illness before they encounter them. Five respondents (19.2%) (BART,

Humboldt, Monterey, San Bernardino and Yolo) selected "during field training" as the ideal time. The rationale offered by one respondent that selected field training as the ideal time, is so that officers begin their careers with good habits of slowing things down and taking time to listen to people. Eight respondents (30.8%)(Alameda, Berkeley, Butte, Contra Costa, Kern, San Diego, San Mateo, and Stanislaus) selected "a year or greater in the field" as the ideal time for CIT training to occur. The most frequently cited rationale that was provided by these respondents was that without community experience to give context to the material, the content of CIT training is too theoretical. San Francisco endorsed both "during field training" and "a year or greater in the field" as ideal times in an officer's career to provide CIT training. Although Riverside did not specify an ideal time, this respondent offered the following insight about the mutual benefit of mixing rookie and seasoned officers in CIT trainings: "Seasoned officers bring experience to the conversation and can set a tone to value the training when we get their buy in. New officers often bring an eagerness to help that has not been jaded by years of managing crime and criminal behavior." We did not receive a response from the remaining four respondents (15.4%).

TRAINING MODEL AND METHODS

We were interested in knowing where in the state the Memphis Model was actually being used as opposed to other behavioral health crisis intervention approaches. So, we asked our survey respondents to tell us if their CIT trainings were modeled after the Memphis Model or not. According to our survey findings, just over half (n=16) (61.5%) of the 26 respondents that reported implementing CIT said they modeled their trainings after the Memphis Model. These respondents included Alameda, BART, Berkeley, Butte, Calaveras, Contra Costa, Kern, Marin, Monterey, Orange, Sacramento, San Bernardino, San Francisco, San Mateo, Stanislaus and Yolo. Seven respondents (26.9%) (Humboldt, Merced, Modoc, Riverside, San Diego, San Joaquin and Solano) reported that their CIT trainings did not follow the Memphis Model, and three (11.5%) did not respond. See Table 3, page 38.

We also asked our survey respondents to tell us what types of teaching methods or modalities they were using. We inquired about the following five teaching modalities: lecture, speaker panels, video clips, role plays, and simulators. Of the 26 respondents that reported implementing CIT, nine (34.6%) (Alameda, Amador, BART, Butte, Contra Costa, Kern, Modoc, San Francisco and San Mateo) reportedly use all five modalities – i.e., lecture, speaker panels, video clips, role playing and simulator. Ten (38.5%) (Calaveras, Humboldt, Marin, Monterey, Orange, Riverside, San Bernardino, Shasta, Stanislaus and Yolo) reportedly use the following four modalities lecture, speaker panels, video clips and role playing, but not simulation. At the time of the survey, two of these 11 respondents (Alameda and San Mateo) indicated that they had each purchased and expected to receive a simulator within the next six months. Therefore, these two respondents were counted as using all five modalities. Four respondents (15.4%) (Sacramento, San Diego, San Joaquin and Solano) reported using only lectures, speaker panels and video clips, with no hands-on learning approaches. One respondent (3.8%) (Merced) reported it uses lectures, video clips and simulation, but not speaker panels or role plays. Two respondents (7.7%) did not respond to this question. See Table 4, page 39.

TRAINING FREQUENCY

In general, smaller class sizes lend themselves to a higher quality learning experience. So on the general assumption that the more frequently trainings are offered the smaller the class sizes would be, we wanted to know how frequently CIT trainings were being offered within a single year. Once again, we found considerable variation in the responses. Of the 26 respondents that reported implementing CIT, just over half (n=15) (57.7%) reported that they provide multiple trainings per year. Among these respondents that reported offering multiple trainings per year, the frequencies ranged from two per year (Contra Costa, Kern, San Mateo and Stanislaus) to 30 per year (Riverside). Those that fell within this range include BART (attends trainings offered throughout the San Francisco Bay Area); Monterey and Solano (3 per year); San Bernardino, San Francisco and Yolo (4-5 per year); Alameda and San Diego (10-12 per year); Orange (15 per year); and Sacramento (28 per year). Three respondents (11.5%) (Butte,

Humboldt and Marin) reported offering one training per year. Four respondents (15.4%) (Amador, Calaveras, Modoc and Shasta) reported that trainings are not offered annually. The remaining four respondents (15.4%) either did not respond or did not provide a numeric response. See Table 5, page 40.

TRAINERS

We asked who are used as CIT trainers. Of the 26 respondents that reported implementing CIT, nearly all included persons with lived experience and/or family members along with behavioral health providers and law enforcement within the roster of trainers (n=22) (84.6%) (Alameda, BART, Butte, Contra Costa, Humboldt, Kern, Marin, Merced, Modoc, Monterey, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Shasta, Solano, Stanislaus and Yolo). Amador and Calaveras (7.7%) reported they do not include behavioral health providers as trainers, and Sonoma and Berkeley (7.7%) did not answer the question.

In addition, eight respondents (30.8%) (Alameda, BART, Butte, Humboldt, Marin, Orange, Sacramento and San Francisco) reported that they included university personnel as trainers, ten respondents (38.5%) (BART, Butte, Humboldt, Kern, Marin, Modoc, San Diego, San Francisco, San Mateo and Yolo) reported Office of the Public Guardian representatives, 15 respondents (57.7%) (Alameda, Butte, Calaveras, Humboldt, Kern, Marin, Monterey, Sacramento, San Diego, San Mateo, Solano, and Stanislaus) reported Veterans Affairs representatives, and ten respondents (38.5%) (Alameda, BART, Butte, Humboldt, Marin, Monterey, San Bernardino, San Diego, San Mateo, and Stanislaus) reported Regional Center representatives. Two respondents (7.7%) (Monterey and San Bernardino) included Alzheimer's Association or Department of Aging and Adult Services representatives as trainers.

PROGRAMMATIC APPROACH

One of the best practices we identified in other parts of the country is a programmatic implementation of CIT rather than isolated trainings. CIT programs we researched consisted of on-going training opportunities, activities that promote relationship building between law enforcement and community members experiencing mental illness, and data collection on outcomes of CIT interventions in the community for monitoring and continuous quality improvement purposes. We asked our survey respondents whether they implemented CIT trainings in isolation or whether trainings were part of a programmatic approach. According to our survey findings, only eight (30.8%) of the 26 respondents that reported implementing CIT also reported using a programmatic approach. The eight programs are Alameda, BART, Berkeley, Merced, Monterey, Orange, Riverside and Yolo. Almost all of the other respondents (n=17) (65.4%) reported only offering trainings, except for Sonoma, which did not respond to this question.

We also asked about the quality of the data being collected and found that of the 26 respondents that reported they implement CIT, only five (19.2%) (BART, Berkeley, Butte, San Bernardino and San Francisco) reported collecting data to track programmatic data. BART Police Department reported collecting demographic, outcomes, 5150 persistent contact, and "likely to continue" or LTC data. Berkeley reported collecting the number of mental health related calls and how much time is spent on those calls. Butte reported that the sheriff's office tracks responses and dispositions. San Bernardino reported collecting demographic information, dispositions of calls, which crisis service responds to the call, length of time spent on the call, symptomology presented by the person in crisis, and any injuries. San Francisco reported collecting data on calls for service and the outcomes on calls. Eight others (30.8%) (Calaveras, Humboldt, Modoc, Orange, Riverside, Sacramento, San Diego and Yolo) reported that they only collect training related data (e.g., attendance, numbers trained). Four of the respondents (15.4%) (Amador, Kern, San Joaquin, and San Mateo) reported collecting no data at all. One respondent (3.8%) (Monterey) reported it is in the process of developing a data collection strategy. And, the remaining eight (30.8%) did not answer this question.

FUNDING

We asked how CIT trainings were funded and whether any of the CIT Training Coordinator positions were funded. Our findings indicated that CIT trainings and Training Coordinator positions are both poorly resourced. Of the 26 respondents that reported implementing CIT, six different sources of funding were reported for CIT trainings, including MHSA (n=19) (73.1%); POST (n=6) (23.1%); NAMI (n=2) (7.7%); Sheriff's Office budget (n=1) (3.8%); Public Safety Realignment funds (n=2) (7.7%); and grants (n=1) (3.8%). Several respondents checked multiple funding sources and so the percentages presented above add up to more than 100%. See Table 6, page 41.

Of the 26 respondents that reported implementing CIT, only ten (38.5%) (Alameda, BART, Berkeley, Monterey, Orange, Riverside, San Bernardino, San Diego, Sonoma and Yolo) said that the Training Coordinator positions were funded or partially funded. For the other 16 respondents (61.5%) that said the Training Coordinator position was not funded, most explained that the duties were typically added on to the job duties of another position.

SUMMARY AND RECOMMENDATIONS

Our survey findings highlight the variability in how CIT training is being implemented across California and the need for greater consistency and uniformity around what are considered best practices. Other efforts to examine and document California law enforcement and behavioral health crisis intervention collaborations were underway concurrently with the writing of this report, and they too have arrived at a similar conclusion. In August 2014, Disability Rights California and California Mental Health Services Authority (CalMHSA) issued a comprehensive report, *An Ounce of Prevention: Law Enforcement Training and Mental Health Crisis Intervention*. Their report included information gleaned from multiple interviews from law enforcement, county mental health provider agencies, individuals with mental health challenges, family members, and advocates. A repeated theme among those interviewed was that at a time of a crisis, communities have relied heavily on law enforcement primarily due to the lack of appropriate mental health crisis services.

There has been movement toward achieving more standardization in behavioral health crisis intervention training for law enforcement. In November 2014, the California Highway Patrol Mental Illness Response Program (MIRP) hosted *Bridging the Gap,* a statewide invitational summit in Sacramento, California. Summit attendees included statewide representation from law enforcement, the state legislature, POST, behavioral health, lived experience networks, POST certified CIT trainers, and other key stakeholders. The Summit's purpose was to examine current efforts around the state and to generate recommendations for improving behavioral health crisis intervention training for California. Key findings from the Disability Rights California report and preliminary findings from CIBHS' statewide survey were presented at the Summit to inform the thinking and discussion. Summit recommendations have led to the development of legislation for mandating statewide minimum standards in behavioral health training hours for law enforcement and the provision of behavioral health resources for community-based crisis intervention and stabilization. Those legislative efforts are still in process at the time this report is being written.

Another related effort occurring concurrently with this project is an effort to establish more consistency in involuntary detainment protocols and statewide guidelines for clinical assessment, intervention, and discharge for involuntary detainment in a variety of settings. As directed by legislation (SB 82) and through a contract with the MHSOAC, CIBHS is leading the effort that engages counties, providers and key stakeholders to establish consensus on and train to statewide guidelines ultimately to reduce trauma, foster recovery and improve the consumer experience and outcomes. The recommendations from that project are directly relevant to CIT or any kind of behavioral health crisis intervention training for law enforcement.

RECOMMENDATIONS

The following recommendations for strengthening CIT training for law enforcement in California are based on our findings and are in alignment with these other efforts.

1. Continue to assess California counties' needs related to the implementation of effective CIT programs, including: law enforcement training, program development with appropriate community partners, implementation support, outcome measures and advanced level training. Map information gathered by counties to provide the state with an easily accessible snapshot of the California CIT landscape.
2. Continue collaboration with the California CIT Association, the CIT Expert Panel, the MHSOAC and other relevant organizations to promote greater consistency in CIT training statewide, best practices, and quality improvement processes.
3. Support legislative actions and other statewide efforts to establish greater consistency in the implementation of CIT and/or behavioral health crisis intervention training for law enforcement.
4. Develop a statewide approach to evaluating the impact of CIT training on key outcomes (e.g., frequency of adverse incidents).
5. Establish guidelines for instructors, including core competencies by topic or module expertise, and POST certification requirement.
6. Establish a statewide network of POST certified trainers by content expertise.

7. Incorporate best practice recommendations for involuntary psychiatric holds into current CIT training curriculum.

TABLES

Table 1. CIT Implementation in California.*

NAME OF COUNTY/CITY	CURRENTLY IMPLEMENTING CIT (n=26)	IMPLEMENTING OTHER CRISIS SERVICES
Alameda	X	
Amador	X	
BART	X	
Berkeley	X	
Butte	X	
Calaveras	X	
Colusa		Assessment & Referral Teams
Contra Costa	X	
Del Norte		Mobile Crisis Teams
Humboldt	X	
Inyo		Assessment & Referral Teams
Kern	X	
Kings		Assessment & Referral Teams
Los Angeles		SMART
Madera		
Marin	X	
Merced	X	
Modoc	X	
Mono		Assessment & Referral Teams
Monterey	X	
Orange	X	
Plumas		
Riverside	X	
Sacramento	X	
San Bernardino	X	
San Diego	X	
San Francisco	X	
San Joaquin	X	
San Mateo	X	
Shasta	X	
Siskiyou		
Solano	X	
Sonoma	X	
Stanislaus	X	
Yolo	X	

** The table lists only the 35 responding counties/city and BART.*

Table 2. Types of Occupations that have Attended CIT Training in California.*

TYPES OF OCCUPATIONS	NUMBER (PERCENTAGE) OF RESPONDENTS (OUT OF 26) THAT REPORTED EACH TYPE OF OCCUPATION
Behavioral Health Providers	11 (42.3%)
Mobile Crisis Team Providers	7 (26.9%)
Emergency Room Providers	3 (11.5%)
Partner Agencies – e.g., social services, public health, consumer and family members	1 (3.8%)
Fire Fighters	5 (19.2%)
Paramedics	6 (23%)
EMT	4 (15.4%)
Emergency Dispatchers	16 (61.5%)
Peace Officers	26 (100%)
Sheriff Deputies	24 (92.3%)
California Highway Patrol	14 (53.8%)
Federal Marshals	2 (7.7%)
Border Patrol Officers	2 (7.7%)
Parks and Recreation Officers	4 (15.4%)
Rangers	4 (15.4%)
Transit Police	9 (34.6%)
Campus Police	12 (46.2%)
Emergency Room Security	4 (15.4%)
Probation Officers	16 (61.5%)
Jail Personnel	15 (57.7%)
Correctional Officers	9 (34.6%)
District Attorney Investigators	1 (3.8%)

** Data reported is based on the 26 respondents that reported implementing CIT.*

Table 3. CIT Training Model and Hours in California.*

NAME OF COUNTY/CITY	TRAINING IS MODELED AFTER MEMPHIS MODEL (N=16)	1-DAY (n=6)	2-DAY (n=5)	3-DAY (n=4)	4-DAY (n=7)	5-DAY (n=8)
Alameda	X				X (38 hrs.)	
Amador		X	X			
BART	X				X	
Berkeley	X					X
Butte	X					X
Calaveras	X	X (4 hrs.)		X		
Contra Costa	X					X
Humboldt					X	
Kern	X					X
Marin	X					X
Merced		X				
Modoc				X		
Monterey	X					X
Orange	X		X		Planning	
Riverside			X			
Sacramento	X	X		X		
San Bernardino	X				X	
San Diego		X		X		
San Francisco	X				X (40 hrs.)	
San Joaquin		X				
San Mateo	X				X (40 hrs.)	
Shasta			X		X	
Solano			X			
Sonoma						
Stanislaus	X					X
Yolo	X					X

** Data reported is based on the 26 respondents that reported implementing CIT.*

Table 4. CIT Training Modalities across California.*

NAME OF COUNTY/CITY	LECTURE (n=24)	PANELS (n=23)	VIDEO CLIPS (n=24)	ROLE PLAYS (n=19)	SIMULATOR (n=10)
Alameda	✓	✓	✓	✓	Purchased
Amador	✓	✓	✓	✓	✓
BART	✓	✓	✓	✓	✓
Berkeley					
Butte	✓	✓	✓	✓	✓
Calaveras	✓	✓	✓	✓	
Contra Costa	✓	✓	✓	✓	✓
Humboldt	✓	✓	✓	✓	
Kern	✓	✓	✓	✓	✓
Marin	✓	✓	✓	✓	
Merced	✓		✓		✓
Modoc	✓	✓	✓	✓	✓
Monterey	✓	✓	✓	✓	
Orange	✓	✓	✓	✓	
Riverside	✓	✓	✓	✓	
Sacramento	✓	✓	✓		
San Bernardino	✓	✓	✓	✓	
San Diego	✓	✓	✓		
San Francisco	✓	✓	✓	✓	✓
San Joaquin	✓	✓	✓		
San Mateo	✓	✓	✓	✓	Purchased
Shasta	✓	✓	✓	✓	
Solano	✓	✓	✓		
Sonoma					
Stanislaus	✓	✓	✓	✓	
Yolo	✓	✓	✓	✓	

** Data reported here is based on the 26 survey respondents that reported implementing CIT.*

Table 5. Frequency of CIT Trainings Annually across California.*

NAME OF COUNTY/CITY	MULTIPLE PER YEAR (n=15)	ONE PER YEAR (n=3)	NOT EVERY YEAR (n=4)	NO RESPONSE (n=4)
Alameda	✓			
Amador			✓	
BART	✓			
Berkeley				✓
Butte		✓		
Calaveras			✓	
Contra Costa	✓			
Humboldt		✓		
Kern	✓			
Marin		✓		
Merced				✓
Modoc			✓	
Monterey	✓			
Orange	✓			
Riverside	✓			
Sacramento	✓			
San Bernardino	✓			
San Diego	✓			
San Francisco	✓			
San Joaquin				✓
San Mateo	✓			
Shasta				
Solano	✓			
Sonoma				✓
Stanislaus	✓			
Yolo	✓			

** Data reported here is based on the 26 survey respondents that reported implementing CIT.*

Table 6. Funding for CIT Trainings across California.*

NAME OF COUNTY/CITY	POST (n=6)	PSR (n=2)	SHERIFF (n=1)	MHSA (n=19)	NAMI (n=2)	GRANTS (n=1)
Alameda				✓		
Amador	✓			✓		
BART						
Berkeley						
Butte	✓			✓		
Calaveras				✓		
Contra Costa	✓					
Humboldt				✓		
Kern						
Marin	✓			✓		
Merced		✓		✓	✓	
Modoc				✓		
Monterey	✓			✓		
Orange				✓		
Riverside				✓		
Sacramento						✓
San Bernardino				✓		
San Diego				✓		
San Francisco		✓				
San Joaquin				✓		
San Mateo			✓			
Shasta				✓	✓	
Solano				✓		
Sonoma	✓			✓		
Stanislaus				✓		
Yolo				✓		

** Data reported here is based on the 26 survey respondents that reported implementing CIT.*

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