

# BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING AND PROGRAMS FOR LAW ENFORCEMENT AND OTHER FIRST RESPONDERS:

## A TOOLKIT FOR GETTING STARTED

May 2017



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# MESSAGE FROM CIBHS

This project was funded by the Mental Health Services Oversight and Accountability Commission (MHSOAC) with funds legislated by Senate Bill 82 Investment in Mental Health Wellness Act that aimed to improve the crisis response infrastructure in the State of California. It is our hope that this Toolkit will lead to furthering the use of best practices in the field of behavioral crisis intervention training programs for law enforcement and other first responders, and ultimately to improving outcomes and reducing risk of injury to both officers/first responders and persons experiencing a mental health challenge and in crisis.

The California Institute for Behavioral Health Solutions (CIBHS) is a statewide leader in mental health and substance use disorders, and in whole person integrated care. CIBHS provides training and technical assistance in the areas of health equity, evidence-based practices, whole person integrated care, quality improvement practices, evaluation, and workforce development. For over 20 years, CIBHS has been dedicated to improving the lives of people living with mental health and substance use challenges.

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# OUR PURPOSE

## WHY CIT?

Oftentimes, peace officers and other first responders are the first contact for persons experiencing a mental health crisis. Behavioral health crisis intervention training equips these first responders with the knowledge and skills to effectively interact with and de-escalate individuals experiencing a mental health crisis, and with techniques to appropriately engage family members and loved ones who may be present during the crisis. Behavioral health crisis intervention training has been demonstrated to reduce risk of injury to both officers/first responders and individuals in crisis.

## WHY THE TOOLKIT?

The purpose of this Toolkit is to fill an important gap in the field of behavioral health crisis intervention training of practical strategies covering the “A to Zs” of planning, designing, implementing and evaluating training programs. Currently, for those interested in getting started with a behavioral health crisis intervention training program, there is no resource that brings together in one document the “how to’s” of what to train, who and when to train, how to bring key partners together for planning, and how to approach evaluating program success. Our Toolkit addresses these areas and also provides specific strategies for two important areas that leadership often face. Those are: how to address diversity and be responsive to community members with lived experience, and how to implement meaningful training with limited resources.

## WHO IS THE TOOLKIT FOR?

This Toolkit is intended to provide those in the position of planning and implementing behavioral health crisis intervention programs with specific strategies based on best practices for developing a successful program. Our goal in compiling this Toolkit is to further the use of best practices across the State of California for behavioral health crisis intervention programs for law enforcement and other first responders that will improve the outcomes for persons experiencing a mental health challenge and in crisis, and reduce risk of injury to both officers/first responders and persons in crisis.

# OUR METHOD

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 that included funding for a report on practices in behavioral crisis intervention training and implementation in California, and for writing this Toolkit. In February 2014, the MHSOAC contracted with the California Institute for Behavioral Health Solutions (CIBHS) to conduct a statewide survey, literature review and key informant interviews toward the writing of the aforementioned report, which was completed in September 2015. While many aspects of the report were used to inform the writing of this Toolkit, our efforts on developing the content for and writing of the Toolkit began in earnest in March of 2016. CIBHS convened an Expert Panel and subcommittees comprised of law enforcement, mental health clinicians, persons with lived experience, representatives from POST, and experienced trainers, to thoroughly vet the Toolkit's development at various stages.

The design of this Toolkit evolved out of a need that we identified from our involvement in this work for the past several years, for greater consistency in the implementation of behavioral health crisis intervention trainings and programs. CIBHS's recent survey of communities across California highlighted considerable variability in how behavioral health crisis intervention training is being implemented across the State, and shed light on the need for more deliberate thought around training content and also the need for entire programs as opposed to isolated trainings. (CIBHS, 2015).

The development of this Toolkit was also influenced by our observation that community partnerships were important to the success and sustainability of behavioral health crisis intervention programs. Strong community partnerships between law enforcement, community mental health, community-based organizations, and individuals and families with lived experience are critical to building successful behavioral health crisis intervention programs. It is our desire to share and promote these and other strategies for success from our own learnings.

This Toolkit has been written with primarily three audiences in mind: law enforcement leadership (e.g., Sheriff, Police Chief), behavioral health leadership (e.g., directors, managers), and training coordinators in both law enforcement and behavioral health. Our aim is to provide these three target audiences with information to support their understanding of the basics of behavioral health crisis intervention trainings and programs, the benefits, and how they can be designed, implemented and evaluated. It is our hope that this information will help inform better policies and decision making at the executive level related to designing trainings, developing programs, and establishing community partnerships.

While there are many different types of first responders, the sections within this Toolkit that address training are geared for the training of law enforcement and other first responder professionals generally (e.g., dispatchers, street officers, highway patrol officers, correctional officers). As such, the Toolkit covers knowledge and skills useful in all of those various settings (e.g., de-escalation, communication, understanding of mental illness and substance use disorders) with examples for how it can be applied to each of their unique settings.

The Toolkit covers the history and evolution of behavioral health crisis intervention programs, the benefits, guidelines for a tiered approach to implementing training, strategies for building effective community partnerships, perspectives of persons with lived experience and family members, and best practices around transferring custody, developing interagency agreements, sharing information, and evaluating program outcomes. Featured in this Toolkit is a **Tiered Approach to Behavioral Health Crisis Intervention Training** a new innovation and one that we are confident will contribute to both the expansion and quality of behavioral health crisis intervention training programs. Those familiar with advocating for, planning or implementing behavioral health crisis intervention training programs know how oftentimes resources do not lend themselves to full-scale implementation (defined here as 40 hours of comprehensive training) out the gate. Smaller counties with fewer resources rarely achieve full-scale implementation. Adding a few more hours of training when resources become available or sending officers out-of-county to be trained when the opportunity arises, can result in a haphazard approach rather than a more favorable, strategic approach to training law enforcement. A Tiered Approach to Behavioral Health Crisis Intervention Training addresses these realities and offers a more strategic framework for training that builds upon officers' competencies in a planned and incremental manner.

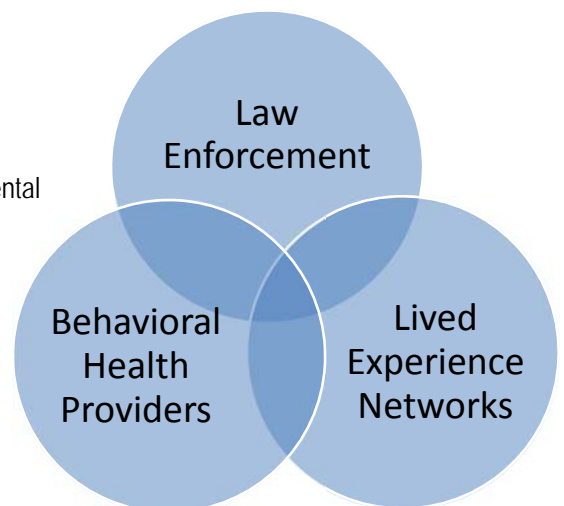
# WHAT ARE BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING PROGRAMS?

## MEMPHIS MODEL

- Behavioral health crisis intervention programs are fairly recent developments. Today there are many different approaches being implemented that grew and evolved from the original Crisis Intervention Team (CIT) Model. CIT is the earliest first responder model and is 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, PhD, Cochran, MS, & Pillsbury, MA, 2007). The first CIT was established in Memphis in 1988 after the tragic shooting by a peace officer of a man with 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 and teams, is considered by many as the gold standard for behavioral health crisis intervention and has been adopted by more than 2000 communities in more than 40 states (NAMI, 2016).

## KEY PARTNERS IN THE MEMPHIS MODEL

- Foundational to the Memphis 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 law enforcement interactions with people living with mental illness and in crisis. The Memphis Model 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 behavioral health treatment instead of jail, when appropriate.





## KEY COMPONENTS OF THE MEMPHIS MODEL.

- The 40-hour comprehensive training, per the Memphis Model, emphasizes behavioral 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 Memphis 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 living with mental illness. Finally, the Memphis Model advocates for recognizing and honoring CIT officers to provide an incentive to perform this specialized work. Examples of incentives are services awards at annual banquets and/or through local media outlets, certificates of recognition, departmental commendations, and salary bonuses.
- The Memphis Model identifies 10 Core Elements for Crisis Intervention Teams that cover Core, Operational and Sustaining Elements, as follows: (Dupont, Cochran, & Pillsbury, 2007)

### **Core (Ongoing) Elements**

1. Partnerships: Law Enforcement, Advocacy, Mental Health
2. Community Ownership: Planning, Implementation and Networking
3. Policies and Procedures

### **Operational Elements**

4. CIT: Officer, Dispatcher, Coordinator
5. Curriculum: CIT Training
6. Mental Health Receiving Facility: Emergency Services

### **Sustaining Elements**

7. Evaluation and Research
8. In-Service Training
9. Recognition and Honors
10. Outreach: Developing CIT in Other Communities

## TRENDS IN CALIFORNIA

- In California, while several counties implement the authentic Memphis Model, there are multiple other approaches to behavioral health crisis intervention that have evolved. One departure from the Memphis Model to note is that oftentimes, the “T” in “CIT” represents “training” rather than “teams” in places in California. This is an important distinction to note, as most California communities doing some form of “CIT” are providing trainings but not necessarily implementing teams. (CIBHS, 2015). Mostly, local adaptation to both training content and length are likely due to how diverse California counties are in population, geography and economics. In addition, the lack of state regulations and funding has contributed to the vast inconsistency in training implementation. Local budgetary and personnel constraints often prompt local adaptations to both training content and length that result in behavioral health crisis intervention training and programs that are actually quite different from the Memphis Model.
- At CIBHS, we have adopted the term “behavioral health crisis intervention training,” or **BHCIT**, to distinguish what is happening in California from the Memphis Model of CIT, in which the “T” stand for “Teams.”
- BHCIT is a term we use to describe an approach that allows organizations to design the level and quality of training that works best for their communities and funding resources. BHCIT is a concept that in its implementation includes meaningful planning and community collaboration to establish sustainable crisis intervention programs.
- In the BHCIT Model, the leadership team, law enforcement and first responders, and community partners have clear roles and responsibilities.

### LEADERSHIP

Making funds available and establishing collaborative relationships.

### LAW ENFORCEMENT AND FIRST RESPONDERS

Ensuring safety and access to appropriate resources and interventions.

### COMMUNITY PARTNERS

Educating others on the role of law enforcement, behavioral health conditions and resources.

- Regardless of the number of training hours, the goals of BHCIT are to:
  - Foster relationships between behavioral health and law enforcement;
  - Establish a foundation of learning and experience about behavioral health conditions;
  - Provide appropriate intervention strategies and available resources for managing a behavioral health crisis.
  
- Based on the CIBHS statewide survey, there are many different types of first responders receiving CIT training. Below is a list of the wide range of occupations and personnel participating in BHCIT in different regions in the state, (CIBHS, 2015):
 

<ul style="list-style-type: none"> <li>▪ Behavioral Health Providers</li> <li>▪ Border Patrol Officers</li> <li>▪ California Highway Patrol</li> <li>▪ Campus Police</li> <li>▪ Correctional Officers</li> <li>▪ District Attorney Investigators</li> <li>▪ Emergency Dispatchers</li> <li>▪ Emergency Room Providers</li> <li>▪ Emergency Room Security</li> <li>▪ EMT</li> <li>▪ Federal Marshals</li> <li>▪ Fire Fighters</li> </ul>	<ul style="list-style-type: none"> <li>▪ Jail Personnel</li> <li>▪ Mobile Crisis Team Providers</li> <li>▪ Paramedics</li> <li>▪ Parks and Recreation Officers</li> <li>▪ Partner Agencies – e.g., social services, public health, consumer and family members</li> <li>▪ Peace Officers</li> <li>▪ Probation Officers</li> <li>▪ Rangers</li> <li>▪ Sheriff Deputies</li> <li>▪ Transit Police</li> </ul>
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- At the time of the CIBHS statewide survey, we observed differing opinions on when it is best to train peace officers in BHCIT. While some thought new recruits should have exposure during the academy training, others felt that officers with some patrol experience were better positioned to understand the relevance and utility of BHCIT. We acknowledge the merits to both ways of thinking. There is no data to support one way over the other. Legislation passed just one month after the release of our statewide survey now mandates that all new recruits receive some behavioral health crisis intervention training as part of their academy training.

- Two recent pieces of legislation, Senate Bills 11 and 29—both passed on October 3, 2015—clarify when training should be offered and the minimum hours of training.

<b>NEW RECRUITS ACADEMY TRAINING</b>	Fifteen (15) hours of BHCIT will be provided to new recruits in the training academy. (SB11)
<b>FIELD TRAINING INSTRUCTORS (FTOs)</b>	Eight (8) hours of BHCIT training. (SB29)
<b>PEACE OFFICERS</b>	Minimum of four (4) hours of BHCIT training. (SB29)
<b>ADVANCED LEVEL TRAINING</b>	Completion of a thirty-six (36) to forty (40) hour curriculum (that follows the Memphis Model) is highly recommended when funding resources are available.

**Senate Bill 11** requires a minimum of fifteen hours of training for new cadets attending the academy. *The training should address issues relating to stigma, be culturally relevant and appropriate, including training scenarios and facilitated learning activities and be included in the current hour requirement of the regular basic course.* The regular basic course should relate to persons with mental illness, intellectual disability or substance use disorder, include skill development for effective conflict resolution, communication and de-escalation techniques; use of force options and alternatives, and should address the perspective of individuals with lived experience with mental illness, intellectual disability and substance use disorders. The course should also include mental/behavioral health resources (California SB11, Beall, 2015).

**Senate Bill 29** directs Police Officer Standards and Training (POST) to require field training officers (FTOs), who are instructors for the field training programs, to have at least eight hours of BHCIT training. At least four hours should be dedicated to how to interact with persons with mental illness or intellectual disabilities. The POST commission is also required to establish and update four hours of police training for active peace officers that addresses how to interact with persons living with a mental illness or intellectual disability. The training course should be scenario-based, culturally relevant and appropriate, and should address issues related to stigma. This training is for peace officers who work in the field. The course topics should be consistently updated and ongoing:

- Identify indicators of mental illness, intellectual disability substance use disorders, neurological disorders, traumatic brain injury posttraumatic stress disorders and dementia
- Autism spectrum disorder
- Genetic disorders, including but not limited to Down Syndrome
- Conflict resolution and de-escalation techniques for potentially dangerous situations
- Alternatives to the use of force when interacting with potentially dangerous persons with mental illness or intellectual disabilities
- The perspective of individuals or families who have experiences with persons with mental illness, intellectual disabilities and substance use disorders.
- Involuntary Holds
- Community and state resources available to serve persons with mental illness or intellectual disability and how these resources can be best utilized by law enforcement.

(California SB 29, Beall, 2015)

- In California, the Police Officer Standards and Training (POST) Commission reviews and certifies all training curriculum for peace officers, including BHCIT. With POST-approved training, peace officers can receive training credits for completion of training. While BHCIT can be offered without POST certification, this is not preferable. Current POST certified BHCIT courses reflect the changes mandated by SB11 and SB29. These are the essential steps for training coordinators to obtain curriculum POST approval.
  - POST certification applications are completed and submitted by a law enforcement training coordinator. Typically, the coordinator is a member of a “training planning team” who participates in the curriculum development and selects course instructors.
  - All instructors are required to submit a POST resume. BHCIT trainers are also usually POST certified.
  - Standard Training Credits (STCs) can also be provided for parole, probation and other correctional officers. The application for these units is usually completed by the law enforcement training coordinator.

# WHY START BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING PROGRAMS?

- ❑ Training in behavioral health crisis intervention equips peace officers and other first responders with the knowledge and skills to effectively interact with and de-escalate individuals experiencing a behavioral health crisis. These trainings offer techniques to appropriately engage family members and loved ones who are present at the scene during the crisis.
- ❑ California police chiefs, sheriff's deputies, county behavioral health personal, and individuals with mental health disabilities endorsed BHCIT as a best practice for training officers in interacting with individuals in crisis (Disability Rights California, 2014).
- ❑ Reported benefits of behavioral health crisis intervention training programs include (NAMI, 2016):
  - Reduced use of force
  - Reduced injury to officer
  - Reduced injury to citizens
  - Reduced arrests/jail time
  - Increased diversion/referral to treatment or other services
  - Improved partnership among mental health, law enforcement and persons with lived experience
  - Saves public money

# A TIERED APPROACH TO BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING (BHCIT)

- The Tiered Approach to develop and administer BHCIT is in sync with the reality that limited resources oftentimes restrict full scale, 40-hour training in five consecutive days. Rather than accepting resource limitations as a hindrance to implementation, we provide the Tiered Approach as a framework for BHCIT that builds upon officers' competencies in a planned and incremental manner.
- The development of the Tiers involved a comprehensive review of existing BHCIT course agendas and multiple consultations with BHCIT POST-certified California instructors. The table below represents a snapshot of the five Tiers, including the number of training hours, course concepts and intended training audiences. The Memphis Model course, which is nationally regarded as the required training for a CIT certified officer, is considered advanced level training, and is reflected as Tiers 4 and 5.

SNAPSHOT OF THE FIVE TIERS					
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Number of Hours	6-8 hours	16 hours	24 hours	40	Ongoing
Audience	General, all officers	General, all officers	General, all officers	Select number of uniformed patrol officers	Community Partnership
Description	Overview and introduction to BHCIT	Core topics	Core topics, plus panel presentations and limited role play	Advanced level training (Memphis Model)	Forensic team, mobile crisis, inter-disciplinary, forums, training and advisory teams



- CIT International purports that the five core topics listed below are essential to all BHCIT training. As such, these core topics are incorporated into all five Tiers.
  - Understanding Behavioral Health
  - Developing Empathy
  - Navigating Community Resources
  - De-escalation Skills
  - Practical Application
  
- Teaching modalities amenable to each Tier are as follows:
  - Didactic- content expertise
  - Small group exercise and discussion
  - Panels
  - Role Plays
  - Site Visits

BHCIT training is developed in accordance with the needs and priorities of each community. While there is no standardized format or agenda, it is recommended that the set of BHCIT core topics and the 10 Core Elements establish the foundation for all training. The training collaborative representing law enforcement, behavioral health providers, and mental health lived experience networks and communities, jointly determines the number of hours and curriculum topics. In the *Matrix for a Tiered Approach to Behavioral Health Crisis Intervention Training*, we have integrated the diverse training models currently being implemented in California. The Matrix presents recommended course topics, corresponding learning concepts for each course topic, and a general idea for how much time is needed to effectively cover each topic. The time allotments should be thought of as minimum time requirements.

The Matrix is intended to be used as a guide for training coordinators and other staff responsible for developing BHCIT curriculum and agendas. The information included in the Matrix provides recommendation and therefore allows room for additional priority topics, flexibility with timeframes and customized training. Tactical communication and de-escalation strategies and skills are key concepts and should be taught at all levels of training. Role plays, scenarios, demonstrations and small group discussions are recommended to be utilized throughout training to address these key concepts.

The **Matrix for a Tiered Approach to BHCIT** contributes added value to the BHCIT field by:

- Providing a comprehensive menu of BHCIT training topics and corresponding learning concepts;
- Providing a critical tool to assist the curriculum development team with planning and prioritization of curriculum topics and use of training time; and
- Identifying areas of subject matter expertise that will be needed for delivering effective trainings.

In the Matrix, the breadth of training topics is organized under five learning domains. These learning domains are:

- General Behavioral Health
- Mental Health Disorders
- Law Enforcement and First Responders
- Panel Presentations
- Electives

Tier 5 does not contain specific course content, but is included in the Matrix to represent the highest level of implementation – that is, a team approach to behavioral health crisis intervention and ongoing collaboration and community partnership.

#### HOW TO READ THE MATRIX

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**TOPICS** – These are training topics.

**CONCEPTS** – These are general descriptions of the principles, models, issues and strategies to be covered under each training topic. These concepts can be expanded upon and customized by the training planning team.

**CORE/ELECTIVE** – Classification of the training topics as either **core** (essential for training) or **elective** (to be included at the discretion of the training planning team). Electives can be based on the specific priority needs of each community.

**HOURS** – These are the minimum recommended time to be allotted in order for each training topic to be covered effectively. The timeframes are flexible.

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MATRIX FOR A TIERED APPROACH TO BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING (BHCIT)

TOPICS	CONCEPTS	CORE / ELECTIVE	TIER 1 HOURS	TIER 2 HOURS	TIER 3 HOURS	TIER 4 HOURS	TIER 5
<b>GENERAL BEHAVIORAL HEALTH</b>							
<b>Substance Use Disorder</b>	Understanding signs and symptoms for substance use, clarifying protocols for 5150, understanding services and resources for substance use disorders.	C	.25	.5	1	1	
<b>Medications</b>	An understanding of psychotropic medications to recognize key symptoms and side effects, and learn techniques on inquiring about the use of medication during a crisis.	C	.25	.5	1	1	
<b>Involuntary Hold, County Policies and Protocols</b>	Present information on the W & I Code 5150 including the application for writing 5150s. The facilities for evaluation and holds, county protocols and policies for admittance and discharge.	C	1	1	1	1	
<b>Multi-cultural Issues</b>	Provide a training on cultural identity, professional law enforcement and behavioral health. To help law enforcement understand the ethnic and cultural specific attitudes and stigma towards mental illness and intervention (factors include gender, identity, age, socio-economic and high risk communities).	C/E	.25	.5	1	1	
<b>Local Resources for Crisis Intervention</b>	Presented by BH staff acute care, crisis stabilization units, hotlines, and other resources available in the community	C	.5	.5	1	1	
<b>Site Visits and Local Mental Health Resources</b>	Participants tour local key resources such as acute care and crisis stabilization units.	E			4	4	
<b>Implicit Bias</b>	Develop understanding about associations, often unconscious, between groups of people and stereotypes about those people.	C	.25	.25	2	4	

MATRIX FOR A TIERED APPROACH TO BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING (BHCIT)

TOPICS	CONCEPTS	CORE / ELECTIVE	TIER 1 HOURS	TIER 2 HOURS	TIER 3 HOURS	TIER 4 HOURS	TIER 5
<b>MENTAL HEALTH DISORDERS</b>							
Anxiety Disorder	Characteristics related to anxiety disorder including panic attacks	E	.25	.25	.5	.5	
Excited Delirium	Understand the characteristics of excited delirium that include anxiety, hallucinations, violent and bizarre behavior, elevated body temperature and extraordinary strength. Strategies for de-escalation and safety.	C		.75	1.5	1.5	
Mood Disorders	Major depression, dysthymic, bipolar disorder, and cyclothymic disorder.	C	1	1	2	2	
Personality Disorders	Understand the characteristics of personality disorders and strategies for tactical communication and safety. (Odd, bizarre, eccentric; dramatic, erratic; anxious and fearful).	E	0	.25	.25	.25	
PTSD - On-Going Trauma Disorders.	Presentation on diagnostic criteria, the impact of community violence and other traumatic events such as loss, abuse, incarceration, and human trafficking.	C	.25	.5	1	1	
Thought Disorders	Understanding thought disorder as disorganized thinking and disorganize speech.	E			.25	.25	
Traumatic Brain Injury	Understanding the symptoms and triggers of traumatic brain injury common in returning military veterans. Can appear like a person under the influence of drug or alcohol.	C	.25	.25	.5	1	

MATRIX FOR A TIERED APPROACH TO BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING (BHCIT)

TOPICS	CONCEPTS	CORE / ELECTIVE	TIER 1 HOURS	TIER 2 HOURS	TIER 3 HOURS	TIER 4 HOURS	TIER 5
<b>LAW ENFORCEMENT AND FIRST RESPONDERS</b>							
<b>Critical Incident Stress Management</b>	Exercising de-escalation skills and tactical communication and approach to debriefing the situation for peace officers and other first responders.	C	0	0	2	4	
<b>Tactical Communication And De-Escalation Skills</b>	Help officers communicate with an individual in crisis and reduce the amount of force that they use. Teaches the officers that time is on their side so they can slow down, decrease the individuals level of excitement and anxiety, and attempt to establish rapport and to gain better understanding what's happening.	C	.5	1	4	4	
<b>Officer Self Care</b>	Self-help tips, when to seek professional help	C	.25	.25	.5	1	
<b>Officer Safety</b>	Discussion of Peace officer exposure to traumatic events-officer resiliency.	C	.25	.5	2	4	
<b>Border Patrol &amp; Mental Health</b>	For counties bordering Mexico, helps officers understand potential disposition of individuals, families and youth exposed to trauma, abuse, deprivation during their journey. Resources for individuals experiencing mental health crisis while attempting to cross the border. Protocols for limited treatment and interventions.	E	0	1	1	1	
<b>Writing better 5150s</b>	Introduction to writing 5150 applications: Documentation, word use (descriptions); weapons in the home (search and seizure); understanding signs for gravely disabled; local protocols; where to take individuals; mental health procedures and protocols; group discussion to resolve differences.	C	.25	.5	1	1	

MATRIX FOR A TIERED APPROACH TO BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING (BHCIT)

TOPICS	CONCEPTS	CORE / ELECTIVE	TIER 1 HOURS	TIER 2 HOURS	TIER 3 HOURS	TIER 4 HOURS	TIER 5
Case Law - Legal Issues	Primarily related to 5150 holds/applications. Understand the criteria, danger to self, danger to others, gravely disabled. Tarrasoff	C	.25	.5	3	4	
Scenario Based Training Role Play Demonstration Training	Provides officers an opportunity to practice what they've learned.	C	0	.5	3	4	
Suicide Prevention / Suicide by Cop	Recognize own attitude about suicide. Recognize the general characteristics of signs of suicidality (danger to self): Stress, Depression, Life problems, Health problems, not going back to jail, Loss, Cultural components Assess the degree of risk for suicide Learn how to communicate with a person of risk of suicide Suicide by cop List of resources available to a person at risk of suicide	C	.25	.5	1	1	

MATRIX FOR A TIERED APPROACH TO BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING (BHCIT)

TOPICS	CONCEPTS	CORE / ELECTIVE	TIER 1 HOURS	TIER 2 HOURS	TIER 3 HOURS	TIER 4 HOURS	TIER 5
<b>PANEL PRESENTATIONS</b>							
Lived Experience	"I am not my diagnosis" Develop an appreciation of the impact of mental illness on individuals and families. Increase empathy and understand the hopes and expectation of individuals and families living with mental illness.	C	1	1	1	1	
Veterans Panel/ Presentation	Returning military veterans and family members share their experience with mental illness and strategies to shed stigma and loss.	E	1	1	1	1	
Transitional Age Youth		E	1	1	1	1	

MATRIX FOR A TIERED APPROACH TO BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING (BHCIT)

TOPICS	CONCEPTS	CORE / ELECTIVE	TIER 1 HOURS	TIER 2 HOURS	TIER 3 HOURS	TIER 4 HOURS	TIER 5
<b>ELECTIVES</b>							
<b>Intellectual or Developmental Disabilities</b>	<p>General characteristics that might identify a person as having an intellectual/developmental disability</p> <p>Communication and safe strategies relative to persons with intellectual/developmental disabilities.</p> <p>Understanding of people first philosophy and beginner use terminology.</p> <p>Establish a working knowledge of law enforcement issues relative to persons with diminished mental/intellectual capacities, autism, cerebral palsy, and epilepsy.</p>	E	.25	.5	1	1	
<b>Supplemental Activities, Games, Handouts</b>	Activities to provide participants with the opportunity to practice crisis intervention techniques in the form of experiential activities, small group discussions and role plays.	E	.25	.25	1	1	
<b>Child/Youth/ Transitional Age Youth (Tay)</b> <b>LGBTQ</b> <b>Suicide Prevention</b> <b>Bullying</b>	<p>Crisis intervention with youth</p> <p>Risk of suicide</p> <p>Out of control behaviors (risk behaviors)</p> <p>Family conflict</p> <p>Abuse/trauma</p> <p>School conflict/bullying</p> <p>Gender identity race, ethnicity, bullying</p>	E	.25	.25	1	1	
<b>Alzheimer's / Dementia</b>	<p>Recognize the signs, symptoms and effects of the disease (older adults).</p> <p>Identify safe physical approach to persons with dementia or Alzheimer's.</p> <p>Establish strategies for effective communications techniques.</p> <p>Gain skills for de-escalation without force</p> <p>Adult Protective services</p>	E	.25	.25	.5	.5	



MATRIX FOR A TIERED APPROACH TO BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING (BHCIT)

TOPICS	CONCEPTS	CORE / ELECTIVE	TIER 1 HOURS	TIER 2 HOURS	TIER 3 HOURS	TIER 4 HOURS	TIER 5
<b>Coalition Against Sexual Exploitation - Human Trafficking</b>	<p>Increase knowledge of sex and labor trafficking cases likely to be encountered by law enforcement</p> <p>Skills for identification and assessment of a human trafficking situation</p> <p>Local resources, safe houses</p> <p>Understand the business aspect of commercial sexual and labor exploitation.</p>	E	.25	.25	.5	1	
<b>Mental Illness and Returning Military Veterans</b>	<p>PTSD: causes, signs and symptoms. Traumatic Brain injury: Signs and symptoms Impact on families, resources and supports</p>	E	.25	.25	.5	1	
<b>Community Policing</b>	<p>Concept for service</p> <ul style="list-style-type: none"> <li>• Community partnerships</li> <li>• Organizational transformation</li> <li>• Problem solving</li> </ul>	E	.25	.25	.5	1	
<b>Homelessness</b>	<p>Resources available for homeless individuals and families.</p> <p>The culture of homeless.</p> <p>Homelessness and the cause and effect relationship to mental illness, trauma and substance abuse.</p>	E	.25	.25	.5	1	

MATRIX FOR A TIERED APPROACH TO BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING (BHCIT)

TOPICS	CONCEPTS	CORE / ELECTIVE	TIER 1 HOURS	TIER 2 HOURS	TIER 3 HOURS	TIER 4 HOURS	TIER 5
<b>Forensic Teams: Collaboration Between Law Enforcement And Mental Health</b>	The Multi-Disciplinary Forensic team is a voluntary coalition of law enforcement, BH and allied service providers who convene around the purpose of assisting individuals with mental illness, substance abuse and co-occurring disorders who are at high risks for frequent welfare checks, involuntary hospitalization or arrest / incarceration of behavior and activities related to their disabilities. This segment outlines the creation of a coalition and the purpose for ongoing collaboration, evaluation, outcome review and data collection.	E	0	0	.5	.5	
<b>Privacy and confidentiality laws such as HIPAA</b>	Recognize general policy goals of HIPAA and other federal privacy laws  Describe policies and procedures utilized by law enforcement to partner with mental health care providers.	C	.5	.5	.5	.5	
<b>New Legislation: Laura's Law, SB11 and SB29</b>	Laura's Law	E	.25	.25	.25	.5	

# PRACTICAL STRATEGIES FOR GETTING STARTED

The development of BHCIT training requires a thoughtful planning approach and is a process. To aid planners, the chart below summarizes the process for developing BHCIT programs and is followed by a checklist of detailed steps. The timing to complete the process to start training generally takes from 1 – 4 months depending on POST approval for course outline.

## PROCESS FOR DEVELOPING BHCIT PROGRAMS

PLAN	<ul style="list-style-type: none"><li>• Establish leadership and partner commitment to determine needs, training priorities, funding resources and strategic plan.</li></ul>
DEVELOP	<ul style="list-style-type: none"><li>• Develop training curriculum, course outline with POST certification, identify instructor team (local and guest instructors) and panelists.</li></ul>
COORDINATE	<ul style="list-style-type: none"><li>• Organize and manage training schedule, training materials, packet registration, certificates, finalize training team, contracts, per/post test questions.</li></ul>
IMPLEMENT	<ul style="list-style-type: none"><li>• Schedule and convene trainings.</li></ul>
EVALUATE	<ul style="list-style-type: none"><li>• Conduct a debriefing session to examine training feedback, per/post tests, and participant evaluations. Develop revisions and plans for advanced training.</li></ul>
EXPAND/SUSTAIN	<ul style="list-style-type: none"><li>• Community partnerships, resources, extended training, ongoing refresher courses, and ongoing funding.</li></ul>

## CHECKLIST OF STEPS FOR DEVELOPING BHCIT PROGRAMS

### PLAN

- Establish Organizational Commitment and Support
  - The leadership and partnership commitment begins with bringing together leaders and key executive staff from behavioral health, crisis services, law enforcement, advocacy and lived experience networks and key community support organizations to acknowledge the need for BHCIT training.
  - Convene an interdisciplinary leadership meeting to identify and confirm funding sources and potential staff commitments.
  
- Determine Training Goals and Desired Outcomes
  - Explore if any crisis intervention training is currently being offered such as mental health first aid.
  - Outline the various crisis response programs especially for mental illness, intellectual disabilities and substance abuse including mobile crisis units, Psychiatric Health Facility (“PHF Unit”), Emergency Room partnerships and crisis stabilization.
  - Define desired outcomes, including what you hope to accomplish as a result of implementing BHCIT training.
  
- Community Support and Commitment
  - Identify community partners and ascertain willingness to share commitment. This may involve consideration for hosting a separate psycho-social educational workshop for community organizations and members around mental illness, law enforcement role and mental health crisis intervention.
  - Contract agencies
  - Other first responders: EMT, ER staff, acute care, jail staff, juvenile justice staff, mental health courts, schools, property managers, cultural and ethnic community based organizations, homeless programs/ shelters, markets/business, etc.

Do Your Research

- Explore the various training models and programs being offered (the tiered matrix provides an outline of the various curricula being provided in California) to identify the appropriate formant for your county and community.
- Review the Memphis Model curriculum, the core elements, and Senate Bills 11 and 29.
- Review local statistical reports on adverse incidents and legal actions involving law enforcement and individuals experiencing a behavioral health crisis.
- Determine the desired percentage of BHCIT certified officers to establish a behavioral health crisis team approach.

Establish a BHCIT Training Planning Team

- This team can include the original leadership group and other potential representation such as the following:
  - Director of County Mental/Behavioral Health
  - Local College or University,
  - Local NAMI or other Lived Experience Network
  - County Mental/Behavioral Health
  - Crisis intervention partner programs/mobile crisis
  - Crisis stabilization program providers
  - Community resources organizations
  - Veterans programs
  - Shelters
  - ER staff
  - Medical staff (county medical director)
  - Cultural organizations
  - Local law enforcement, Corrections, Courts, Sheriff, City Police, College Police, CHP, and other first responders
  - Individuals with lived experience
  - Community organizations
  - Veterans Services

Determine meeting schedule and member roles and responsibilities.

- The team members agree to work together to identify key community issues and needs related to mental illness, determine priority topics (use the Tiered Approach Matrix), make recommendations for training curriculum, review and provide feedback for training, outline materials, identify potential expert and local instructors (guest presenters and key participants). The team can also assist with identifying potential funding sources and establish the training budget.
- Meetings can occur regularly or only a few times prior to training implementation.
- Assign someone to coordinate meeting notices and reminders, and to keep meeting notes.

## DEVELOP TRAINING

- Determine training hours: based on budget and resources (use the Tiered Approach Matrix).
- Determine training objectives: based on number of training hours, core topics, and priority issues.
- Develop training curriculum.
- Topic selection:
  - Review the Memphis Model as a guide to determine core topics.
  - Trending community issues and concerns can be used to inform topic selection.
  - The Tiered Approach is a great guide for selection of topics. There may be additional topics, not listed in the Matrix, that are relevant to your specific community needs and priority crisis intervention issues. These topics can be added to the curriculum. Be mindful to address topics and considerations outlined in Senate Bill 29.
  - Course should include presentations from legal experts (case law) and lived experience testimonials (panel presentations). Field visits for law enforcement to various mental health and behavioral health facilities, and “ride-alongs” with law enforcement for behavioral health staff are encouraged to foster cross disciplinary understanding of roles, responsibilities and challenges.
  - Submit complete training agenda course outline to law enforcement sponsor to develop the POST course outline and applications. Several documents are required to meet criteria for the credits. We recommend that the planning team work with behavioral health and law enforcement training coordinators for process for application requirements and submission.
- Identify Instructors
  - Instructors can include contracted BHCIT instructor consultants, guest presenters who possess specific subject matter expertise, county clinical/medical and support services providers, local law enforcement trainers, lived experience panelists, resources organizations, POST trained and certified instructors are highly recommended. All instructors (except those on the lived experience panel) must submit a POST resume as a requisite for post course certification
- The training course can qualify for:
  - Standard Training Credits (STC) for probation and corrections staff.
  - Continued Education (CE) for mental health and nursing staff
  - Police Officer Standards and Training (POST) credits for Peace Officers
- Other training tools and formats may include but not limited to:
  - Video, You-Tube, slides, didactic and experiential
  - Scenarios, vignettes, small group discussions, role plays
  - Binders, pre/post-tests, handouts, etc.

## COORDINATION

- Trainers
  - Create instructor training schedule
  - Complete contractual agreements for instructors includes resumes and bios
  - Collect training materials, learning objectives, training segment overviews, PowerPoint handouts
  - Inform trainers of arrival times, IT and equipment needs (thumb drives, speakers, wifi, etc.)
  - Training reminders and evaluation
  
- Logistics
  - Create training series schedule (number of rounds of training), frequency of training per year
  - Secure venue
  - Coordinate IT equipment, speakers, flip charts, laptop projector tables chair set up
  - Recruit individuals and families with lived experience to share their experiences
  - Coordinate registration
  - Assemble training packets
  - Provide hospitality
  
- Develop a promotional/marketing strategy
  - Market to law enforcement officers and other first responders
  - Commanders meetings
  - Community outreach
  - Promote training to the community, local board of supervisors, Local Mental Health Boards/Commissions, and city officials for support
  - Market to partner agencies to join in the efforts

- Participants
  - Participants- determine number of peace officers, and other disciplines to attend per training session.
  - Invite leadership from behavioral health and law enforcement to open and close the training session. Other key leadership can also be invited and may attend the part or all of the training as desired.
  - Determine how participants will be assigned, recruited and managed per training session

## IMPLEMENT

- Convene training series
- Follow debriefing meeting with planning team

## EVALUATE

- Develop outcome measures to determine implementation success and challenges.
  - Pre/post test
  - Participant evaluations
  - Provide certificates of completion to participants that includes number of hours trained.
  - Officers who complete the comprehensive course of 36 to 40 hours can receive CIT pins or coins

## EXPAND/SUSTAIN

- This is about TIER V action to support ongoing training implementation, data collection, community engagement and reports of success.
- Funding resources, commitment for law enforcement to attend advance level and refresher training
- Establish a forensic committee or case review committee to monitor the process of training, and rate of improvement in the field with behavioral health crisis interventions.



# BUILDING SUSTAINABLE COMMUNITY PARTNERSHIPS

Foundational to successful behavioral health crisis intervention programming are strong partnerships between law enforcement, the mental health provider system (including community based organizations), and persons with lived experience. Establishing a successful behavioral health crisis intervention program in the community involves bringing these key partners together to begin building relationships, collaboratively plan and implement training and protocols. Working collaboratively from the start will improve the likelihood of achieving improved outcomes of police interactions with people with mental illness, including desired results such as reducing the risk of injury to police officers and mentally ill persons, and diverting persons to mental health treatment instead of jail, when appropriate.

Each community is unique and there is not a one-size-fits-all approach for getting started on building sustainable community partnerships. We offer here several examples from other communities with demonstrated success.

## EXAMPLES FOR BUILDING SUSTAINABLE COMMUNITY PARTNERSHIPS

- Build relationships in a non-crisis context
  - In Chicago, Illinois, 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 is a unique approach and has helped workers, residents and officers get familiar with each other in a positive, non-crisis context (Watson, Swartz, Bohman, Kriegl, & Draine, 2014).
- Have a designated team and a lead coordinator
  - Having a designated “team” consisting of liaisons or coordinators from each of the partner entities – i.e., law enforcement coordinator, mental health coordinator, and advocacy coordinator – is critical to sustaining community partnerships. 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 coordinator.

## EXAMPLES FOR BUILDING SUSTAINABLE COMMUNITY PARTNERSHIPS *(continued)*

- Jointly develop procedures around transfer of custody
  - Procedures that expedite the transfer of custody so that officers' wait times are reduced are critical for increasing law enforcement's enthusiasm and commitment to the partnership. It is helpful to have a designated place or places in the community where officers can go and that are set-up to handle the receipt of persons in crisis 24/7 for mental health assessment and/or treatment. Furthermore, jointly developing procedures for transferring custody can greatly reduce the time that officers are off of patrol. Collaboration among partners in Chicago around creating hospital admission procedures (known as "police drop") resulted in developing a form that the officer completes at the drop-off that has reduced the drop-off time from eight hours to only fifteen minutes (Watson, Swartz, Bohrman, Kriegl, & Draine, 2014).
  
- Have an officer serve as lead trainer.
  - With an officer in the role as the lead trainer, the officers participating in the training will feel more comfortable to ask questions and express their concerns, and be more open to learning from one of their own. The officer/lead trainer will be able to more naturally draw upon her/his own firsthand experiences when providing scenarios and examples to enhance the learning and buy-in of the participating officers.
  
- Include mental health advocacy organizations as key partners from the beginning.
  - It is important to recognize the value that persons with lived experience bring to the partnership. These partners should be included in a meaningful way at the inception of planning. Involving mental health advocacy organizations such as National Alliance on Mental Illness (NAMI) and Mental Health America (MHA) in the early planning, training of officers, and ongoing monitoring and quality improvement of the program contributes to greater officer awareness of the perspectives and experiences of persons with lived experience and their family members, including awareness of cultural issues and issues across the age span.

# GUIDANCE FROM PERSONS WITH LIVED EXPERIENCE

The perspectives of persons with lived experience and their family members are a critical component of developing a successful behavioral health crisis intervention program. The following is a list of recommendations based on key informant interviews conducted with persons with lived experience and family members.

## PROMOTING AWARENESS OF MENTAL HEALTH CONDITIONS

- ❑ Train officers to understand mental health conditions, the symptoms associated with each condition, and how individuals may present in a crisis situation. It is helpful for officer training to include differentiating behavior that may look like a criminal act.
- ❑ Train officers to be aware of how a person's presentation when in crisis can be very fluid and erratic. It is important for officers to be aware that the individual is going to change and cycle around, so that they are better equipped to handle the situation effectively.
- ❑ Patience, calmness, letting the person "burn off" for a few minutes or an hour, rather than reactively resorting to the use of force, are all valuable skills for officers to use in these situations.
- ❑ Train officers to recognize drug and alcohol symptoms and to differentiate between someone who is experiencing a mental health crisis versus an individual with a drug or alcohol induced condition.

## PROMOTING SAFETY AND SERVICE LINKAGE AS GOALS

- ❑ Develop trainings that emphasize ensuring a safe outcome for all involved as the primary goal. It is ideal for officers to have the opportunity to receive sufficient training in de-escalation techniques and for trainers to emphasize the use of these skills before the use of lethal means to gain control of the situation.
- ❑ Develop trainings that emphasize law enforcement's role in linking individuals with mental health needs to services. Training can 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 can be made available to officers that include local community providers, their locations, and the types of services that are available.

## PROMOTING THE USE OF DE-ESCALATION TACTICS

- Training can address law enforcement stigma and bias against persons with mental illness and persons who are homeless mentally ill. For example:
  - Promote the understanding that mental illness is a neurological disease that the individual needs exceptional help to control.
  - Promote the understanding that persons with mental illness are human beings, that they are sick, and that they can't help it.
  - Promote the awareness that persons with mental illness are intelligent and should be spoken to respectfully.
  
- Training can emphasize the importance of and skills for establishing communication and rapport with the individual in crisis. For example:
  - Gain trust through demonstrating compassion and reassurance.
  - Be empathic and listen – e.g., “By listening they may find out that they just forgot to take their medications.”
  - Engage with a calm, moderate voice and a non-threatening dialogue.
  - Avoid the use of physical or verbal threats.
  - Avoid the use of barking orders and loud demanding tones.
  - Avoid the use of defensive and threatening posturing.
  - Avoid approaching with guns drawn.
  - Use non-uniformed officers, trained negotiators and/or mental health workers known to the individual.
  - 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.”

## PROMOTING CULTURAL COMPETENCE

- Training can help officers be aware of any biases and assumptions that they may hold about certain racial or ethnic groups, such as the assumption of persons of color as gang-involved, drug dealers and criminals. Officers can be trained to avoid labeling entire groups of people as criminals and to avoid responding differently.
- Training can address that family members are expecting the responding officers to provide help rather than harm.
- Officers can be trained to address the needs of the children present and not further traumatize them.
- Regardless of race or ethnicity, officers' training can address the value of showing compassion and respect.
- It is important for trainers to be aware that it is not only the white officers who can benefit from cultural competency trainings.
- Officers can be trained to understand that youth in crisis need help de-escalating their feelings. Officers can be empathic and listen. Officers can acknowledge the youth's feelings (whether they agree or believe them) because what the youth is feeling is very real to the youth. Officers can avoid judgmental comments like "they are crazy" or "I hope you learned your lesson".
- Training can help officers be aware that oftentimes youth of color have the mindset that law enforcement is not there to help. An awareness of this cultural barrier may help officers to be more successful in establishing a relationship with a youth of color. Officers may be more successful in engaging the youth if they act less in the role of the police officer or probation officer.
- Officers can be encouraged to recognize their own biases and to not make the assumption that all youth of color are gang-involved or drug dealers.
- Officers can benefit from sensitivity training to understand that a youth of color living in a car may be a foster youth with depression, rather than engaged in criminal behavior. Officers' training can emphasize helping link youth to services. Officers can be sensitized to understand how detrimental it is to a youth's entire future when, as a consequence of experiencing a crisis, the youth gets a criminal record.

## PROMOTING AWARENESS OF FAMILY MEMBER NEEDS

- Train dispatchers to know when to send out a BHCIT trained officer.
- Dispatch a BHCIT trained officer when the caller/family member requests this.
- Train dispatchers 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.
- Train 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.”
- Train officers to understand the despair of the family member. Officers can be made aware of the terror and emotions the family member is experiencing and be trained to help calm the family member.

## PROMOTING APPROPRIATELY INVOLVING FAMILY MEMBERS

- 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 interventions, 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, ask the family member if the individual in crisis has medications so that they are not taken to jail without them.
- Reassure family members (by demeanor and actions) that the officer is knowledgeable and skilled in behavioral health crisis intervention so that the family members feels they can step aside and let the officer take over.
- Reassure family members that the officer has the skills to calm the person and not reactively shoot their gun when a person experiencing a mental health crisis is coming at them with a knife.

# DEVELOPING PROCEDURES AROUND CUSTODIAL TRANSFERS

In the event of a behavioral health crisis response that involves transporting an individual to a local emergency department for professional evaluation and treatment, it is beneficial to have protocols in place to ensure the safe transport of the individual and efficient drop-off so that officers can return to their patrol duties in a timely manner. Long wait times for officers arriving at emergency departments to drop-off an individual experiencing a behavioral health crisis create frustration as well as is a public safety concern. A quick drop-off process can reduce officers' wait times from several hours to only a few minutes so that officers can return to their street patrol duties quickly while also ensuring that professional staff receiving the individual have the information they need to provide the appropriate services. The following list provides some basic guidance for developing procedures around custodial transfer.

## EXAMPLES FOR DEVELOPING EMERGENCY DEPARTMENT DROP-OFF PROTOCOLS

- Develop procedures for custodial transfer through a collaborative process.
- Develop a process for how law enforcement can have expedited access to professional staff during custodial transfer.
- Develop a brief one-page form for officers to communicate the essential information that professional staff receiving the individual need to provide appropriate services and complete the custodial transfer.
- Establish a formal agreement such as a Memorandum of Agreement (MOA) between the hospital and law enforcement agency around these procedures to support their implementation.
- Train both officers and emergency department staff in the agreed upon procedures.
- Revisit the procedures routinely to assess what is working well and what is not, and jointly make modifications to continuously improve the process.

# ESTABLISHING A COLLABORATIVE AGREEMENT

It is beneficial to jointly develop some type of collaborative agreement among all the partnering agencies. 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.

While training is typically the most visible aspect of actualizing a behavioral health crisis intervention program, training itself does not build a collaborative effort. It is through a well-led, joint decision-making process, that appropriate levels of buy-in from all parties can happen to strengthen the effort.

The following list presents the core elements that are helpful for partnering agencies to jointly consider, and to ultimately include in their collaborative agreements. The list covers core areas that, without advanced agreement on how it will be handled, could threaten to destabilize an otherwise successful effort.

## EXAMPLES FOR JOINTLY DEVELOPING A COLLABORATIVE AGREEMENT

- Mission, principles and vision
- Goals and desired outcomes
- Name of the program
- Program's target population and scope
- Effective start date and period that is covered by the agreement
- Purpose and scope of the agreement
- Roles and authority of partnering agencies
- Program management staff
- Personnel to be assigned/deployed, including support staff for administrative functions
- Funding sources for program staff and other program expenses
- Office space, computer equipment and supplies (if co-locating staff)
- Access to police facilities and parking arrangements



## EXAMPLES FOR JOINTLY DEVELOPING A COLLABORATIVE AGREEMENT *(continued)*

- Responsibilities and procedures related to referrals or transfer of clients
- Requirements and procedures related to sharing of information
- Procedures for off-hour management of behavioral health response calls
- Procedures for notification when unusual circumstances disrupt usual personnel assignments/deployment
- Training requirements
- Expectations related to documentation or data collection
- Responsibilities and procedures for maintaining data and conducting program audits
- Productivity markers and performance standards for measuring success
- Communication expectations of all partners
- Procedures for regular and ongoing feedback and reflection on progress
- Process for resolving problems
- Clear terms for amending or cancelling the agreement

## SHARING INFORMATION

As mentioned in the prior section, a clear understanding around information sharing is an important component of a collaborative agreement. It is especially important that all parties have a clear understanding of the laws governing the sharing of Protected Health Information (PHI) and to provide training on them. The exchange of information between law enforcement and a covered entity such as a hospital is likely to occur in the process of determining the disposition of a call, the best strategy for de-escalating a situation, appropriate service linkage or diversion alternative, or during custody transfer. As a general rule, covered entities are held to much stricter limitations around sharing PHI than law enforcement. The clearer all parties are at the outset of a collaborative partnership, the less likely for costly errors or misunderstandings that can erode a successful collaboration

## ADVICE FROM THOSE IN THE FIELD

In this section, we have an opportunity to hear advice from those in the field. This expert advice is provided by individuals who have many years of experience as trainers, training coordinators, administrators, or in other key roles.

Another important lesson learned and strategy for developing a CIT training program is to have the lead instructor be an officer, the mental health/clinician co-instructor be someone with experience working with officers, and the mental health consumer or family member be prepared and from a creditable association. A programs' success depends on the ability of officers to relate to the instructors and be open to receiving the information.

Officer Doria Neff  
Mental Health Liaison, Alameda County C.I.T. Coordinator, Oakland Police Department.

CIT is important because it is more than a training; it is a partnership. The only way we are going to change the criminalization of the mentally ill is through reducing force and partnering together to produce better outcomes.

Law enforcement officers do not take care of themselves. These trainings are helping to open the conversation about mental health care for officers. There are more officer suicide deaths than officer shootings. We need to do more to accommodate officers.

Although there is much hesitation by the officers to do role playing, ultimately they appreciate this part of the training because it provides practice for what they learned.

Debra Buckles, Public Guardian  
Chief, Forensics Services, Stanislaus County, BHRS

Acknowledging a CIT officer with an Officer of the Year award inspires other officers to step up. The recognition is a big deal. It means a lot.

Devon Corpus, LCSW  
Behavioral health Unit Supervisor – AB109 Team  
Monterey County Behavioral Health Probation Department

What makes ours a good program is the partnership between the Sheriff's Department, Behavioral Health and Community Partners, working together for a common goal.

Miriam Clark, MPA  
Department of Behavioral Health Workforce Education & Training Mental Health Education  
Consultant / CIT Training Coordinator

The biggest problem with CIT is the funding. There has to be a funding stream dedicated to CIT. Although new legislation has mandated more hours to CIT training, it's not going to be successful without dedicated funding.

Charles Dempsey, Detective III  
Officer in Charge Mental Evaluation Unit/Admin-Training Unit, Detective Support and Vice Division  
Los Angeles Police Department.

A key element for sustaining a successful program is relationships. Fostering strong relationships is important to partnerships. Keeping everyone informed helps to sustain the partnership.

There is a need for more instruction on PTSD and traumatic brain injury.

James Coffman, Deputy Sheriff  
Sheriff's Office, San Mateo County

One component of the training features a panel presentation by the Field Crisis Consultation Committee (a multi-disciplinary group composed of officers, mental health specialist, public defenders, district attorneys, wrap-around service providers, and NAMI) that provides participants with resources and alternative strategies to incarceration and hospitalization.

James Coffman, Deputy Sheriff  
Sheriff's Office, San Mateo County

CIT builds collaborative efforts between law enforcement and mental health communities to protect the wellness of not only mental health consumers but also officers. It is essential to provide whatever resources necessary to preserve life and wellness, and CIT training is a best practice to do that. The same commitment I have to mental health consumers and their wellbeing, I have to law enforcement for officers' safety and wellbeing. It is our responsibility to make sure law enforcement gets the training needed to deal with what they are facing in the community and are aware of the resources available to help them deal with their own PTSD.

Especially for small counties, it would be helpful to have external trainings available statewide so small counties can send their staff versus having teams trained together. There is value in team training, but it is not always possible due to funding and manpower.

It is important to get CIT training in the police academy, particularly in the small counties. Funding and resources are not available, so the academy is the best chance for officers to get an in-depth training on crisis interventions.

Karen Stockton, Director  
Modoc County Health Services, Behavioral Health

# BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING FOR OTHER FIRST RESPONDERS

In addition to peace officers, there are other professionals and people in our communities for whom behavioral health crisis intervention training can be beneficial. Some examples are 911/emergency dispatchers, family members/caregivers of persons with a mental health condition, Emergency Department personnel, and school personnel. While this Toolkit's focus is on law enforcement, we felt it was important for the Toolkit's user to be aware of BHCIT strategies in existence for other professionals and community members. We encourage those in key leadership positions in their communities to explore these other trainings and to consider implementing a community wide strategy. In this section, we provide examples of strategies being used to train 911/emergency dispatchers, family members/caregivers, Emergency Department personnel and school personnel.

## BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING FOR 911/EMERGENCY DISPATCHERS

- ❑ 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 information for officers arriving on the scene for a behavioral health call, and even assist in de-escalation during a behavioral health crisis call. In Virginia Beach, an abbreviated 8-hour course has been developed especially for dispatchers to provide training in the skills they are likely to need when handling a behavioral health crisis call. The course covers a basic introduction to behavioral health diagnoses/presentations, suicide and PTSD, hearing voices, how to verbally de-escalate a crisis situation, and local community resources.

## PREPARING FAMILY MEMBER AND SUPPORT PERSONS FOR INTERACTING WITH PEACE OFFICERS

- NAMI provides valuable suggestions for family members and caregivers for being prepared for the event that a situation progresses into a crisis in which a 911 call is placed. Acknowledging that it may be uncomfortable for everyone involved to think about the possibility of such as crisis, advanced planning involving the family member or loved one with a mental health condition may be helpful for facilitating a safe outcome from the call.

*The following tip sheets have been taken in their entirety from the NAMI website.*

## Being Prepared for a Crisis

A Wellness Recovery Action Plan can also be very helpful for your loved one to plan his overall care, and how to avoid a crisis. If he will not work with you on a plan, you can make one on your own. Be sure to include the following information:

- Phone numbers for your loved one's therapist, psychiatrist and other healthcare providers
- Family members and friends who would be helpful, and local crisis line number
- Phone numbers of family members or friends who would be helpful in a crisis
- Local crisis line number (you can usually find this by contacting your NAMI Affiliate, or by doing an internet search for "mental health crisis services" and the name of your county)
- Addresses of walk-in crisis centers or emergency rooms
- The National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
- Your address and phone number(s)
- Your loved one's diagnosis and medications
- Previous psychosis or suicide attempts
- History of drug use
- Triggers
- Things that have helped in the past
- Mobile Crisis Unit phone number in the area (if there is one)
- Determine if police officers in the community have Crisis Intervention Training (CIT)

Go over the plan with your loved one, and if he is comfortable doing so, with his doctor. Keep copies in several places. Store a copy in a drawer in your kitchen, your glove compartment, on your smartphone, your bedside table, or in your wallet. Also, keep a copy in a room in your home that has a lock and a phone.

<http://www.nami.org/Find-Support/Family-Members-and-Caregivers/Being-Prepared-for-a-Crisis>

# Calling 911 and Talking with Police

If a situation escalates into a crisis, you may have to call the police. Thankfully, there are a few things you can do to keep the situation as calm as possible.

## *On the Phone*

Share all the information you can with your 911 operator. Tell the dispatcher that your loved one is having a mental health crisis and explain her mental health history and/or diagnosis. If the police who arrive aren't aware that a mental health crisis is occurring, they cannot handle the situation appropriately. Many communities have crisis intervention team (CIT) programs that train police officers to handle and respond safely to psychiatric crisis calls. Not every police officer is trained in a CIT program, but you should ask for a CIT officer if possible.

## *During a Crisis*

Police are trained to maintain control and ensure safety. If you are worried about a police officer overreacting, the best way to ensure a safe outcome is to stay calm. When an officer arrives at your home, say "this is a mental health crisis." Mention you can share any helpful information, then step out of the way. Yelling or getting too close to the officer is likely to make him feel out of control. You want the officer as calm as possible.

Be aware that your loved one may be placed in handcuffs and transported in the back of a police car. This can be extremely upsetting to witness, so be prepared.

## *What Can the Police Do?*

- Transport a person who wants to go to the hospital. A well-trained CIT officer can often talk to a person who is upset, calm him down and convince him to go to the hospital voluntarily.
- Take a person to a hospital for an involuntary evaluation. In certain circumstances, police can force a person in crisis to go to the hospital involuntarily for a mental health evaluation. The laws vary from state to state.
- Check on the welfare of your family member if you are worried about her or can't reach her. Call the non-emergency number for the police department in your community and explain why you are concerned. Ask them to conduct a welfare check.

If you have questions about the laws in your state, talk to your local police department or contact your local NAMI.

<http://www.nami.org/Find-Support/Family-Members-and-Caregivers/Calling-911-and-Talking-with-Police>



## BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING FOR EMERGENCY DEPARTMENT PERSONNEL

- Emergency Rooms frequently receive persons experiencing a behavioral health crisis. BHCIT and protocols from Emergency Department (ED) 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 BHCIT 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 mental 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.

## BEHAVIORAL HEALTH CRISIS INTERVENTION TRAINING FOR SCHOOL PERSONNEL

- Behavioral Health Crisis Intervention training for school personnel is a well-developed field. The following are examples of core elements of most school-based crisis intervention programs.
  - An established crisis response team including, for instance, the principal, vice principals, school nurse, school counselor, teachers, office staff, campus police, hall monitors, and student leaders.
  - Tools to organize the crisis response team such as meeting invitations, a team roster that includes names, contact information, team members' roles and functions, and a crisis response checklist to use in the event of a crisis.
  - A crisis plan that includes general principles for responding to a crisis, and procedures for prevention, emergencies, and the immediate aftermath.
  - Implementation of good practice standards such as: updating team roster regularly; maintaining a directory of local mental health services and professionals; providing team trainings that include scenarios and role playing; conducting regularly scheduled crisis response team meetings; and participating in BHCIT trainings led by mental health professionals.

# EVALUATION AND OUTCOMES

Data collection is an important aspect of a more programmatic implementation of BHCIT. 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).

Examples of data being collected and reported to monitor the impact of BHCIT in a community:

- Number of mental health related calls
- Demographic information
- Symptomology presented by the person in crisis
- Length of time spent on those calls
- 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

# BIBLIOGRAPHY

- Alameda County Behavioral Health Care Services and Oakland Police Department. (2015, June 2). Retrieved from ACHCSACAPE: [https://www.youtube.com/watch?v=32Y-2\\_CIAwA](https://www.youtube.com/watch?v=32Y-2_CIAwA)
- Alameda County Behavioral Health Care Services and Oakland Police Department. (2015, June 18). Retrieved from ACHCSACAPE: <https://www.youtube.com/watch?v=rc8O7-Q7Ufw>
- Alameda County Behavioral Health Care Services and Oakland Police Department. (2015, August 20). Retrieved from ACHCSACAPE: <https://www.youtube.com/watch?v=1tnCHCTSRu8>
- Alameda County CIT, Oakland Police Department. (2011-12). CIT: Cumulative Participation by Agency.
- Alameda County CIT, Oakland Police Department. (2012-13). CIT: Cumulative Participation by Agency.
- Alameda County CIT, Oakland Police Department. (2013-14). CIT: Cumulative Participation by Agency.
- Alameda County CIT, Oakland Police Department. (2015-16). CIT: Cumulative Participation by Agency.
- Alameda County Crisis Intervention Training (CIT), Oakland Police. (2015, November 2-5). CIT Training Schedule. Oakland.
- Bay Area Rapid Transit Police. (2013, January 23). MOU Alameda County Multi-Disciplinary Forensic Team. 1. Oakland, CA, Alameda.
- Bouscaren, D. (2014, September 23). *National Public Radio*. Retrieved from [www.npr.org](http://www.npr.org): <http://www.npr.org/2014/09/23/349098691/as-run-ins-rise-police-take-crash-courses-on-handling-mentally-ill>
- Buckles, D. (2015, November 20). Public Guardian; Chief, Forensics Services; Stanislaus County, Behavioral Health and Recovery Services. (S. Wright, & K. Kurasaki, Interviewers)
- California SB 29, Beall. (2015). *Peace officer training: mental health*.
- California SB 11, Beall. (2015). *Peace officer training: mental health*.
- CIBHS. (2015). *Crisis Intervention Teams: Current CIT Practices and Recommendations in California Counties*. Sacramento.
- Clark, M. (2016, January 13). MPA; San Bernardino Department of BH Workforce Education & Training MH Education Consultant/CIT Training Coordinator. (S. Wright, & K. Kurasaki, Interviewers)
- Clifford, K. (2013). Mental Health Crisis Interventions and the Politics of Police Use of Deadly Force. In D. Chappell (Ed.), *Policing and the Mentally Ill: International Perspectives* (pp. 171-196). CRC Press.
- Coffman, J. (2015, November 20). Deputy Sheriff; Sheriff's Office, San Mateo County. (S. Wright, & K. Kurasaki, Interviewers)
- Corpus, D. (2016, January 13). LCSW, Monterey County Behavioral Health and Probation Departments. (S. Wright, & K. Kurasaki, Interviewers)
- Council of State Governments Justice Center. (2008). *Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training*. New York: Council of State Governments Justice Center.
- Council of State Governments Justice Center. (2008). *Improving Responses to People with mental Illnesses: The Essential Elements of a Specialized Law Enforcement-Based Program*. New York: Council of State Governments Justice Center.
- Council of State Governments Justice Center. (2008). *Mental Health Courts: A Primer for Policymakers and Practitioners*. New York: Council of State Governments Justice Center.

- Council of State Governments Justice Center. (2009). *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice*. New York: Council of State Governments Justice Center.
- Council of State Governments Justice Center. (2010). *Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*. Bureau of Justice Assistance, Office of Justice Programs. New York: Council of State Governments Justice Center.
- Council of State Governments Justice Center. (2015). Strategic Information Sharing. *Justice and Mental Health Collaboration Program Training Summit*, (p. 22).
- Council of State Governments Justice Center and the Police Executive Research Forum. (2010). *Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Individual Jurisdictions*. New York: Council of State Governments Justice Center.
- Crisp, A. P. (2015). *Understanding Best Practice: The Emergency Response to Mental Illness - An Exploratory Report*. Office of the Police & Crime Commissioner for Leicestershire. Winston Churchill Memorial Trust.
- DeKruise, LMFT, J. (2016, January 15). Sr Program Manager 24 Hour Services, Dept. of Health and Human Services, Mental Health. (S. Wright, & K. Kurasaki, Interviewers)
- Dempsey, C. (2015, November 6). Detective III, Officer in Charge, Mental Evaluation Unit, Admin Training Unit, Detective Support and Vice Division, LA Police Department. (S. Wright, & K. Kurasaki, Interviewers)
- Disability Rights California. (2014). *An Ounce of Prevention: Law Enforcement Training and Mental Health Crisis Intervention*. Disability Rights California.
- Dupont, PhD, R., Cochran, MS, M., & Pillsbury, MA, S. (2007). *Crisis Intervention Team Core Elements*. The University of Memphis, School of Urban Affairs and Public Policy Department of Criminology and Criminal Justice.
- Giles, G. (2013). Queensland Police Department, Cairns Police Station. Cairns, Queensland, Australia: Winston Churchill Trust.
- Grandrath, B. (2015). *Comments on CIT Tool Kit Outline*. Napa, CA.
- Herrington, V., Clifford, K., Lawrence, P. F., Ryle, S., & Pope, R. (2009). *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report*. Charles Sturt University, Center for Inland Health/Australian Graduate School of Policing, New South Wales.
- Johnson, K. (2000). *School Crisis Management: A hands-on guide to training crisis response teams (2nd ed.)*. Alameda: Hunter House.
- Los Angeles County, District Attorney Office of Jackie Lacey. (2015). *Mental Health Advisory Board Report: A Blueprint for Change*. Los Angeles County, District Attorney, Los Angeles.
- Los Angeles Police Department. (2015). Detective Support and Vice Division: Crisis Response Support Section. 11. Los Angeles, CA.
- Los Angeles Police Department. (2015). Los Angeles Police Department: Mental Evaluation Unit Handout. 13.
- Los Angeles Police Department. (2015, November 17-20). Mental Health Intervention Training Hourly Distribution. *POST No: 1850-20911-15-009*, 4. Los Angeles, CA: Los Angeles Police Department.
- Los Angeles Police Department. (2015, November 9). Mental Health Intervention Training, Training Order. *In-Service Training, Training Division(Training Order 12.1.2)*, 3. Los Angeles, CA.
- Los Angeles Police Department. (2016, January 26). Mental Health Intervention Training. *POST Control No. 1850-20911*, 1. Los Angeles, CA: Los Angeles Police Department.
- Mojica, D. (2016, January 19). East Division, Crisis Intervention Team Coordinator, Critical Incident Negotiations Team, Sacramento County Sheriff's Dept. (S. Wright, & K. Kurasaki, Interviewers)

- Molina, Lt., M. (2016, January 15). OIC/CIT Coordinator, Behavioral Science Unit, SF Police Department. (S. Wright, & K. Kurasaki, Interviewers)
- Moule, Lt., J. (2016, January 13). Chief of Security, Health Services Security Unit, Contra Costa Health Services. (S. Wright, & K. Kurasaki, Interviewers)
- NAMI. (2016). *Being Prepared For A Crisis*. Retrieved from <http://www.nami.org/Find-Support/Family-Members-and-Caregivers/Being-Prepared-for-a-Crisis>
- NAMI. (2016). *Calling 911 And Talking With Police*. Retrieved from NAMI: <http://www.nami.org/Find-Support/Family-Members-and-Caregivers/Calling-911-and-Talking-with-Police>
- NAMI. (2016). *What is CIT*. Retrieved from NAMI.org: <http://www.nami.org/Get-Involved/Law-Enforcement-and-Mental-Health/What-Is-CIT>
- NAMI. (n.d.). CIT Toolkit Frequently Asked Questions. National Alliance on Mental Illness.
- NAMI Wake County. (n.d.). *Self-help Manual: Starting a CIT Program A Step by Step Guide*.
- NASMHPD/CSG Justice Center. (2010). *Responding to a High-Profile Tragic Incident Involving a Person with a Serious Mental Illness: A Toolkit for State Mental Health Commissioners*. National Association of State Mental Health Program Directors/Council of State Governments Justice Center.
- Neff, O. D. (2015, November 25). Mental Health Liaison; Alameda County CIT Coordinator; Oakland Police Department. (S. Wright, & K. Kurasaki, Interviewers)
- Oakland Police Department. (2015). CIT Coordinator Job Description. CA: Alameda County CIT, Oakland Police Department.
- Reuland, M. (2004). *A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness*. Delmar, NY: Technical Assistance and Policy Analysis Center for Jail Diversion.
- Reuland, M., & Cheney, J. (2005). *Enhancing Success of Police-Based Diversion Programs for People with Mental Illness*. Police Executive Research Forum. Delmar, NY: GAINS Technical Assistance and Policy Analysis Center for Jail Diversion.
- Ross, T. (2016, January 14). Mental Health Training Specialist, Workforce Education Training, Riverside University Health Systems Behavioral Health, Riverside County. (S. Wright, & K. Kurasaki, Interviewers)
- Sharps, PhD, M. J. (2012, October). The Mental Edge: Effective Cognitive Processing in Law Enforcement. *The Police Chief*, pp. 100-104.
- Stockton, K. (2015, November 25). Director; Modoc County Health Services, Behavioral Health. (S. Wright, & K. Kurasaki, Interviewers)
- Trump, K. S. (2000). *Classroom killers? Hallway hostages?* Thousand Oaks, CA: Corwin Press.
- Virginia Department of Behavioral Health and Developmental Services, Office of Forensic Services. (2016, January). *Virginia's Crisis Intervention Team Programs 2015 CIT Inventory Survey*. Retrieved from Virginia Department of Behavioral Health and Developmental Services: <http://www.dbhds.virginia.gov/library/forensics/ofo%20-%20cit%20inventory%202015%20final%20report.pdf>
- Virginia Department of Behavioral Health and Developmental Services. (January, 2016). *2015 CIT Inventory Survey Office of Forensic Services*. Retrieved from Virginia's Crisis Intervention Team Programs.
- Watson, A., Swartz, J., Bohrman, C., Kriegl, L., & Draine, J. (2014). *Understanding how police officers think about mental/emotional disturbance calls*. *International Journal of Law & Psychiatry*.

# RESOURCES

## ALAMEDA COUNTY – BERKELEY CIT PROGRAM

This video looks into the Crisis Intervention Training program in Alameda County. It briefly walks you through an officer's experience with encounters, to what a CIT training looks like, and a glimpse into a CIT advisory meeting.

[https://www.youtube.com/watch?v=32Y-2\\_CIAwA](https://www.youtube.com/watch?v=32Y-2_CIAwA)

This video discusses the work and impact of the Alameda County Crisis Intervention training (CIT) Program, a program led by the Oakland Police Department in partnership with Alameda County Behavior Health Care Services and the Family Education Resource Center. Funded by the Alameda County Behavioral Health Care Services through the Mental Health Services Act.

<https://www.youtube.com/watch?v=rc8O7-Q7Ufw>

This video gives you a brief introduction to the Crisis Intervention Training program in Alameda County. It provides an overview of the program components, existing partnerships, and potential impacts of the program.

<https://www.youtube.com/watch?v=1tnCHCTSRu8>

## CALIFORNIA INSTITUTE FOR BEHAVIORAL HEALTH SOLUTIONS

The California Institute for Behavioral Health Solutions (CIBHS) is a non-profit agency that helps health professionals, agencies and funders improve the lives of people with mental health and substance use challenges through policy, training, evaluation, technical assistance, and research.

<http://www.cibhs.org/>

## CIT CENTER - UNIVERSITY OF MEMPHIS

The CIT Center is a resource for CIT Programs across the nation. It provides the history of CIT, how to start a CIT program, national curriculum and policy and procedures.

<http://www.cit.memphis.edu/>

## CIT INTERNATIONAL

CIT International is a non-profit membership organization whose primary purpose is to facilitate understanding, development and implementation of Crisis Intervention Team CIT Programs throughout the U.S. and in other nations worldwide in order to promote and support collaborative efforts to create and sustain more effective interactions among law enforcement, mental health care providers, individuals with mental illness, their families and communities and to reduce the stigma of mental illness.

<http://www.citinternational.org/>

## COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER

The Council of State Governments Justice Center provides practical, nonpartisan, research-driven strategies and tools to increase public safety and strengthen communities.

<https://csgjusticecenter.org/>

## DISABILITY RIGHTS CALIFORNIA

The Disability Rights of California advocates, educates, investigates and litigates to advance and protect the rights of Californians with disabilities. They monitor and champion issues such as: benefits and managed care, discriminations, employment, jails & juvenile facilities advocacy, mental health, regional centers, special educations, and voting.

<http://www.disabilityrightsca.org/>

## NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

The National Alliance on Mental Illness (NAMI), is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

<http://www.nami.org/>