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# EVALUATION OF ALLEGHENY COUNTY'S CRISIS INTERVENTION TEAM TRAINING PROGRAM

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## Allegheny County Department of Human Services

The Allegheny County Department of Human Services (DHS) is dedicated to meeting the human services needs of county residents, particularly the county's most vulnerable populations, through an extensive range of prevention, early intervention, crisis management and after-care services.

This report was prepared by the Office of Data Analysis, Research and Evaluation (DARE), an office within DHS. DARE supports and publishes research related to the activities of DHS offices, including: Aging; Behavioral Health; Children, Youth and Families; Community Services and Intellectual Disability.

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## Acronyms

AJC – Allegheny County Jail

CIT – Crisis Intervention Team

CRC – Central Recovery Center

DAS – Diversion and Acute Stabilization Unit

DHS – Department of Human Services

NAMI – National Alliance on Mental Illness

OBH – Office of Behavioral Health

PBP – Pittsburgh Bureau of Police

PTSD – Post Traumatic Stress Disorder

**Acknowledgements & Contributors**

## Acknowledgements

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## Contributors

We would like to thank the following individuals for contributing to the completion of this report:

- Sue Martone, Assistant Deputy Director, DHS Office of Behavioral Health
- Officer Patricia Menendez, CIT Coordinator, Pittsburgh Bureau of Police
- Stephanie Moravec, Reviewer
- Emily Sturman, Writer and Editor
- Evelyn Whitehill, Research Products Coordinator
- Lindsay Williams, Graphic Designer

Research Brief

## RESEARCH BRIEF

In 2007, a high number of persons with a mental health diagnosis were incarcerated in the Allegheny County Jail (ACJ). While only 2.7 percent of the general population in Allegheny County was persons with a mental illness, 28 percent of inmates had a diagnosed mental illness (Ridgely, Engberg, Greenberg, Turner, DeMartini, & Dembosky, 2007[1]). Jails and prisons are typically ill-equipped to provide the necessary level of mental health care to inmates (Sniffen, 2006[2]), and Allegheny County was no exception.

Trained police-based Crisis Intervention Teams (CIT) are charged with de-escalating, assessing and referring individuals with mental illnesses, who are exhibiting non-violent behaviors and may be in a behavioral health crisis, to the appropriate treatment services; by design, they are be less likely to be detained and treated within the penal system. In addition to preventing the arrests of individuals with mental illness, police officers with effective training in mental health crisis intervention may also be more likely to prevent injury to themselves and to the public. Expertise in de-escalation can result in more effective mental health referral, an increase in appropriate diversion and enhanced public safety.

The CIT-specific training curriculum enables officers to better respond to mental health emergencies. The trainings were all hosted by Mercy Behavioral Health in Pittsburgh's Southside neighborhood.

### CIT Program Purpose

The CIT model was developed to train police officers with a specially developed curriculum designed to help them better respond to mental health emergencies. In addition to this training, the Allegheny County project established a triage site to which police could divert individuals with mental illnesses and co-occurring substance use disorders deemed in crisis and in need of immediate mental health care. The triage site, operated by a contracted behavioral health provider, offers mental health and substance abuse services and is staffed by crisis intervention professionals and a psychiatric nurse.

1 Ridgely, S., Engberg, J., Greenberg, M.D., Turner, S., DeMartini, C., Dembosky, J. W. (2007). Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court. RAND Technical Report. Retrieved April 2, 2007 from http://www.rand.org/pubs/technical_reports/TR439/.

2 Sniffen, M. J. (Sept 6, 2006). Prisons Lacking Mental Health Treatment. Washington Post. Retrieved April 2, 2007 from www.washingtonpost.com/wp-dyn/content/article/2006/09/06/AR2006090601629.html

Diverted individuals can access intake, screening, assessment, crisis intervention, overnight care/treatment, and coordination with family and community-based treatment providers 24 hours per day, seven days a week. The triage site provides an alternative to emergency treatment centers for mental health crisis intervention, thus facilitating access to care.[3]
The site opened on August 6, 2007 as the Mercy Behavioral Health Central Recovery Center (CRC).

The goals of the CIT program are:

1. Train police officers to better respond to individuals experiencing behavioral health crises;

2. Reduce the rate of arrest of youth and adults in the target group (individuals with mental illness and co-occurring disorders) in Allegheny County; and

3. Decrease the number of incidents in which police or the public are injured.

The CIT program recognizes the needs of those with mental illness and the different response required from police officers in addressing those special needs when intervening in crisis situations.

### CIT Program Evaluation Purpose

This report provides preliminarily feedback about the CIT training course to its sponsor and the PBP.

In order to gather participant feedback from the trainings, the authors performed a series of assessments during the creation and execution of the training class, including class evaluations and pre- and post-tests on officers' attitudes toward mental illness.

3 For more on this issue, see Working Group for Mental Health Care in Emergency Departments: Final Report and Recommendations. (1998). Centre for Mental Health, New South Wales. Retrieved April 2, 2007, from http://www.health.nsw.gov.au/pubs/w/pdf/working980083.pdf.

Research Brief

## Training Program Strengths and Achievements

Program Strength 1: Existing relationships can be utilized to explore options for increased referral to treatment. Individuals on the police force are now more familiar with resources available to them and with the services they can contact to provide consistent, reliable assistance when dealing with individuals exhibiting behavioral health issues.

Program Strength 2: A culture of change has been established that promotes continued excellence in the CIT training program.

Participants' completion of feedback forms and the CIT staff's willingness to address areas of need identified in those forms, including seeking out the most appropriate instructors, have created a culture in which the CIT leadership is comfortable making necessary changes to improve elements of the CIT program.

## Training Program Recommendations

Recommendation 1: Continue to increase enrollment

In order to better utilize the resources and opportunities made available through the intensive week-long course, the CIT committee should consider exploring multiple avenues of recruiting and enrolling officers for the CIT class; the committee should also work to eliminate possible barriers to enrollment.

Recommendation 2: Continue to support the evolving collaboration

CIT is a continuously evolving collaboration. As an ongoing effort, the individuals who initiated this collaboration should "keep in touch" and continue mutual efforts to maintain and update program materials on a regular basis.

Introduction & Background

# INTRODUCTION AND BACKGROUND

This report provides DHS and the PBP valuable feedback about the CIT training course. The training ran for one week (Monday through Friday) each quarter between June 2007 and January 2009 and was hosted by Mercy Behavioral Health in Pittsburgh's Southside neighborhood. It was hypothesized that police officers with effective training in mental health crisis intervention would be more likely to prevent the arrest of nonviolent individuals with mental illnesses (who would be better served by treatment than by incarceration); it was also believed that such training would limit injury to officers and the public via de-escalation, thus enhancing both effective mental health referral and public safety. Seven CIT classes were held during the grant period, during which time 67 officers from the PBP were certified along with 28 officers from other municipalities and eight non-police participants. This report will examine participant feedback from all seven training sessions.

The evaluation process included the following steps:

- Tracking the number of police officers CIT certified;
- Tracking the number of other, non-police participants trained through the CIT;
- Conducting traditional class evaluations;
- Assessing participants' attitudes toward mental illness via pre-test/post-test questionnaires; and
- Detailing the strengths of the class and the opportunities for program enhancement.

Dr. Beth Nolan of the University of Pittsburgh's Institute for Evaluation Science in Community Health performed a series of assessments during the training classes. First, participating officers completed class evaluations. Second, surveys that assessed participating officers' attitudes toward mental illness were conducted pre- and post-class.

Background

## BACKGROUND

In 2007, a high number of people with mental illnesses were incarcerated in AJC; while 2.7 percent of Allegheny County's general population was mentally ill, 28 percent of inmates at the ACJ had a diagnosed mental illness (Ridgely, Engberg, Greenberg, Turner, DeMartini & Dembosky, 2007). Jails and prisons are typically ill-equipped to provide mental health care to inmates (Sniffen, 2006[4]). In an effort to address the unique needs of criminals with mental illness, ACJ partnered with DHS, the courts system and other government entities to identify those individuals with mental illness who had been arrested for minor crimes, and divert them to appropriate health care services instead of jail time. However, despite successes with programs like the Mental Health Court (established in 2001), it became clear that earlier identification of and intervention with those individuals were needed before arrest.

Partnerships formed between the Allegheny County Court system, the Office of the District Attorney, the Office of the Public Defender, the PBP, the ACJ, DHS's Office of Behavioral Health (OBH), service providers, consumers and families to decriminalize individuals with mental illness who may encounter the criminal justice system and to seek solutions through diversion programs. The Bureau of Justice Assistance, an agency of the U.S. Department of Justice's Office of Justice Programs, issued a 30-month, $250,000 grant to DHS (October 2006 – February 2009) to fund the planning, implementation and short-term program evaluation of a police-based CIT certification training program that would prevent arrests of non-violent individuals with mental illness.

Police-based CITs are charged with de-escalating, assessing and referring non-violent individuals with mental illnesses to the appropriate treatment services, so that these individuals will be less likely to be detained and treated within the penal system. A CIT program is designed as a pre-arrest jail diversion for individuals in a behavioral health crisis. In addition to preventing the arrests of individuals with mental illness, police officers with effective training in mental health crisis intervention may also be more likely to prevent injury to officers and the public and to refer individuals to appropriate mental health treatment.

4 Sniffen, M. J. (Sept 6, 2006). Prisons Lacking Mental Health Treatment. Washington Post. Retrieved April 2, 2007 from www.washingtonpost.com/wp-dyn/content/article/2006/09/06/AR2006090601629.html

Background

## CIT Program Purpose

The goals of the CIT program are:

1. Train police officers to better respond to individuals experiencing a behavioral health crisis;

2. Reduce the rate of arrest of youth and adults in the target group in the City of Pittsburgh and Allegheny County; and

3. Decrease the number of incidents in which police or the public are injured.

The CIT program recognizes that a different response is required from police officers when addressing the needs of those with mental illness during a crisis situation. As such, the program trained police officers with a specially developed curriculum to help them better respond to mental health emergencies. In October 2006, a six-month planning period commenced, led by a steering committee comprised of individuals representing the institutions listed above. This steering committee broke into two other committees: the Protocol Committee and the Curriculum Committee.

The Protocol Committee was charged with developing the flow and procedures associated with the diversion of individuals in crisis, from police custody to the behavioral health system. The process had to comply with the needs and protocols of the PBP, OBH, and all contracted behavioral health providers in the county. The committee developed a detailed process flow (Figure 1) to depict the CIT process from beginning to end. This process flow enabled committee members to address each corresponding agency's protocols and procedures and to better facilitate the movement of an individual through the system. The methods that were eventually adopted for the program's evaluation and data collection measures were identified using this same protocol.

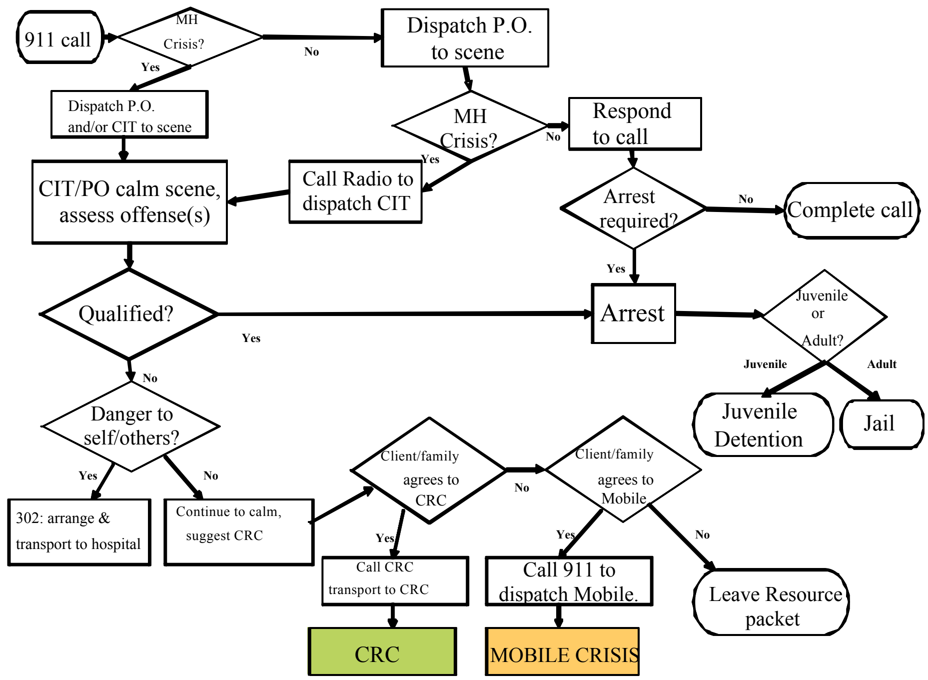



*Figure 1: CIT Process Flow*

In addition to specialized training for CIT officers, the program established a triage site to which police may divert individuals with mental illnesses or co-occurring disorders who are deemed in crisis and in need of immediate mental health care. The triage site opened on August 6, 2007 as the CRC, one month after the first CIT training class was held. The CRC offers mental health and substance abuse services and is staffed by crisis intervention professionals and a psychiatric nurse. Diverted individuals can access intake, screening, assessment, crisis intervention, overnight care/treatment, and coordination with family and community-based treatment providers 24 hours per day, seven days a week. The CRC provides an alternative to emergency treatment centers for mental health crisis intervention, allowing for appropriate access to care at the time an officer presents on site.

The Curriculum Committee was charged with creating the content for the CIT training course. This committee was chaired by the then–CIT Coordinator Detective Karen McClellan, and included representatives from OBH (multiple units, including Justice-related Services), the PBP, each of the county's contracted behavioral health providers, consumers, family members and other key stakeholders (e.g., National Alliance on Mental Illness [NAMI][5]). The Curriculum Committee developed

5 NAMI Southwestern Pennsylvania is a non-profit organization dedicated to helping families and individuals affected by mental illness by providing education and advocacy that supports recovery.

a CIT curriculum to fit the unique needs of the region, borrowing from curricula developed by several existing CIT programs in comparable regions, including Montgomery County, MD, and Akron, OH. The CIT curriculum was presented in a classroom format over a 40-hour work week, and consisted of interactive and instructional modules presented by a variety of behavioral health service providers, psychiatrists, program administrators, police officers, mobile behavioral health professionals, families and consumers. The curriculum consisted of 24 separate modules, described below.

### CIT Module Synopses

1. Registration/Introduction to CIT

A brief overview of the history of CIT and expectations for the week ahead.

2. Overview of Mental Illness

Introduce officers to the framework used by mental health professionals to identify mental illnesses, acquaint officers with the terms used by the mental health community, outline symptoms and characteristics of the most common mental illnesses, and introduce a general response to maladaptive behavioral symptoms.

3. Mood Disorders

Familiarize the officers with the organic/physical basis of the disorders, symptoms, and types/classifications of the disorders. This class will also suggest intervention techniques to use when responding to an individual who may have a mood disorder and/or may already be a consumer of services.

4. Thought Disorders

Familiarize the officers with the organic/physical basis of the disorders, the symptoms and types/classifications of the disorders. This class will also suggest intervention techniques to use when responding to an individual.

5. Personality Disorders

Familiarize the officers with the organic/physical basis of the disorders, the symptoms and types/classifications of the disorders. This class will also suggest intervention techniques to use when responding to an individual who may or may not already be a consumer of services.

6. Hearing Distressing Voices

This exercise is designed to give the officers a first-hand sense of living with a mental illness. Hearing Distressing Voices is a curriculum developed by Dr. Patricia

Background

Deegan in which officers wear headphones for a simulated experience of hearing voices (a symptom manifested in disorders like schizophrenia). The officers wear the headsets while they attempt to perform daily tasks, to help them understand the daily experiences of people who hear voices. The curriculum also contains an instructional video.

7. Suicide and Violence Prevention

The instructor will provide a basic overview of population demographics and current trends. Officers will gain an understanding of how traditional police intervention can fail to prevent suicide or lead to a "suicide by cop[6]" situation. The officers will be given alternative techniques to handle suicide or "suicide by cop" situations.

8. Substance Abuse and Co-occurring Disorders

The officers will gain skills to better identify and respond to situations in which the individual is dealing with a disability or substance-abuse problem that impacts his mental state. The officer will also be given an overview of the phenomenon referred to as "Sudden Unexpected Death.[7]"

9. Assessing Dangerousness and De-escalation

Officers will learn how traditional police interventions can be misinterpreted, and will develop techniques that are effective in helping individuals/families in crisis. They will learn about the predictors of violence and gain understanding of how delusions can escalate. This class will include an overview of CIT's four-step process, to be examined more fully in Module 19.

10. Tactical Communications

This class will consist of training in verbal and nonverbal communications, active listening and negotiation techniques. It is designed to enhance officers' communication skills.

11. Post-Traumatic Stress Disorder (PTSD): Risk Factors and Peer Support

Officers will learn to recognize symptoms of PTSD and the effect that trauma can have on individuals and families. Officers will learn techniques to avoid exacerbat-

6 Suicide by cop is a method of suicide by which an individual deliberately acts in a threatening manner with the intent of provoking a law enforcement officer to shoot. For more information: http://www.policeone.com/suicide-by-cop/

7 Sudden Unexpected Death is a phenomenon whereby an individual dies after being restrained by police, preceded by extreme agitation, respiratory arrest, subsequent restraint, and then death. The suspected cause is unknown. Sztajnkrycer, M. D, & Baez, A. A., (2010). Excited Delirium and Sudden Unexpected Death. American College of Emergency Physicians, Retrieved on 12-28-10 from http://www.acep.org/content.aspx?id=31850.

ing trauma. The officers will also learn about peer support techniques that they can use when they witness signs of PTSD in themselves or their co-workers.

12. Intellectual Disability/Brain Disorders

The officers will learn to more quickly and effectively interpret the behaviors of a person with a brain disorder or intellectual disability. Officers will also learn about the medical conditions that can impact behavior.

13. Community Resources

This module will present an overview of the mental health care system and the range of services available in the region for the treatment and support of individuals with mental illnesses. CIT officers will learn to better collaborate with consumers, families and the mental health system.

14. Site Visits

Officers will visit several drop-in facilities so that they have a better understanding of where the consumers/families go. Participants will also tour CRC and the Diversion and Acute Stabilization (DAS) unit.

15. Diversity and Mental Illness

Officers will learn about the impact that culture has on how individuals perceive mental health treatment; officers will also learn to adjust their actions and communication tactics so that they are more effective. This session will explore the experiences of individuals, considering various factors (e.g., racial, ethnic, spiritual) and circumstances (e.g., aging, homelessness).

16. Children and Adolescents

The instructor will provide information about the special needs of children and adolescents with mental illnesses. Practical aspects will be covered in the context of possible police involvement and the unique characteristics of this population.

17. Liability, Legality and Ethics

Officers will learn the underlying legal reasons for respecting consumer rights and will be able to avoid risking liability.

18. Psychotropic Medications

The instructor will discuss factors that contribute to lack of adherence to a treatment program (e.g. lack of insight, medication costs and side effects) as well as strategies for encouraging individuals to take their medications. The major classes

## Background

of medications will be reviewed and a medication chart will be distributed to officers.

19. CIT: Four-Step Process

This class is designed to provide CIT officers with a four-step process that combines standard police tactics and crisis intervention techniques in managing the dynamics of family, friends, bystanders and the individual when responding to CIT calls.

20. NAMI: Consumer and Family Perspective

This class will introduce officers to the personal impact of mental illness on family members, consumers and lifestyle. As part of this class, representatives will share their stories and experiences as family members and consumers.

21. Scenarios and Role-Play

Officers will practice their new skills through role-play scenarios taken from real-life situations. Officers will de-brief each scenario to discuss the good responses and opportunities for improvement.

22. Homeless Services

Officers will receive an overview of regional services and supports available to homeless individuals.

23. re:solve Crisis Network

Participants will tour the facilities of Allegheny County's behavioral health crisis response network.

24. Developmental Disability and Brain Disorder

The officers will learn to more quickly and effectively interpret the behaviors of a person with a brain disorder or developmental disability. Officers will also learn about the medical conditions that can impact behavior.

Methodology

## METHODOLOGY

### Participants

Over the course of seven CIT trainings, 104 individuals completed the five-day course. Sixty-seven officers from the PBP were certified. Twenty-eight officers from other regional police departments were also certified, including Mt Lebanon (13 officers); Port Authority (four officers); Pittsburgh School Safety Officers-Board of Education (three officers); Ross Township (three officers); Monroeville Police; Northern Regional Police; Shaler Police; Slippery Rock University Police; and Whitehall Police (one officer each). Eight non-police participants graduated from the course, including a police chaplain, mental health providers, assistant district attorneys from the Allegheny County Mental Health Court, and researchers. Seven additional participants observed at least one full day of training. Table 1 lists the number of individuals certified or provided certificates of graduation by the CIT training program.

| CIT Session | Gender (Certified) | Supervisors | Total Others Trained | Total PBP* Officers | Total Certified |
|---|---|---|---|---|---|
| June 2007 | 4 F, 7 M | 1 | 0 | 11 | 11 |
| Sept. 2007 | 6 F, 13 M | 8 | 4 non-PBP officers<br>1 courts (½ week) | 15 | 19 |
| Oct. 2007 | 2 F, 16 M | 5 | 3 non-PBP officers | 15 | 18 |
| Jan. 2008 | 3 F, 14 M | 2<br>(Mt. Lebanon) | 4 non-PBP officers<br>2 Mental Health professionals<br>1 Police Chaplin (only ½) | 8 | 12<br>(2 ½ week) |
| Apr. 2008 | 1 F, 10 M | 0 | 5 non-PBP officers<br>1 Police Chaplin (completed) | 5 | 11<br>(including Chaplin) |
| Sept. 2008 | 4 F, 5 M | 3 | 2 non-PBP officers<br>2 Mental Health professionals | 7 | 9 |
| Jan. 2009 | 9 F, 7 M | 2<br>(EMS, Slippery Rock) | 10 non-PBP officers<br>5 Mental Health professionals<br>1 researcher<br>2 courts (completed) | 6 | 16 |
| **Total** | **29 F, 72 M** | **21** | **29 officers certified including Chaplin (12 others)** | **67 PBP certified** | **96 certified officers** |

*Table 1: Individuals participating and/or graduating from the CIT program; June 2007 – January 2009*

### Class Evaluations

Class evaluation forms (see Appendix A) were included in the CIT Manual given to each participating officer at the beginning of the training week so they could provide feedback on presenters as they viewed them. Participants were given two opportunities during the week (at the opening “Welcome” module and the closing “CIT Process” module) to provide constructive feedback to improve the classes, materials and instructor selection. Officers were prompted several times throughout the week to fill out their evaluations and provide specific feedback on each individual instructor and module. Completed class evaluations were collected from participants at the end of the week.

### Pre- and Post-Test Attitudes toward Mental Illness Scale

During the introduction segment on the first day of training, participants were given one of four vignettes that involved either a male or female suffering typical symptoms associated with either a major depressive episode or schizophrenia. Participants were asked three questions regarding these scenarios to assess their pre-class attitudes toward mental illness (see Appendix D for full pre- and post-test surveys). The pre-test vignettes were distributed systematically so that at least two participants received each of the four possible tests. The likelihood of receiving a particular disorder or gender was dependent only on where the pages fell after shuffling.

Post-tests were also systematically distributed. In order to ensure anonymity, however, no names were recorded, and it is thus unknown how many participants received the same vignette for both the pre-test and post-test. All participants completed pre- and post-tests. The vignettes and questions were adapted from the Australian version of the Pre- and Post-Test Attitudes toward Mental Illness Scale by Jorm et al. (1999) and Hugo (2004). In those versions, the scale was used to compare mental health practitioners’ attitudes to those of a community sample. The scale was adapted for the CIT training to adjust the original’s Australian English phrases for an American audience.

Methodology

## Instructor Feedback

### Feedback Meetings

In order to solicit feedback and collectively determine the changes that needed to be incorporated into the next class, the CIT Coordinator met with a core group of individuals from OBH after each class to review participants' written feedback and adjust the instructor line-up.

### Targeted Telephone Interviews

In addition to the feedback meetings described above, instructors who were not directly involved in ongoing feedback meetings were interviewed in a series of telephone interviews early in the grant period. These interviews covered feedback on the development, organization and execution of the classes, utilizing a semi-structured interview schedule. Cooperation from instructors was excellent: none refused to participate in an interview and, in fact, all interview requests were met with enthusiasm. Interviewed instructors were asked for feedback because they served as key organizers of the training classes and/or they provided instruction/organization for class components that were deemed particularly informative by participants.

The three individuals interviewed were:

- A Unit Director from Mercy Behavioral Health who served as an instructor, site-visit coordinator and pre-planning team member;
- A Clinical Director, Critical Incident Stress Management Team Leader and Component Services Director from Mercy Behavioral Health who served as an instructor, site-visit coordinator and pre-planning team member; and
- An Assistant Center Coordinator and Advocate at New Horizons Drop-In Center, who served as a site-visit coordinator.

## Interview Questions

A semi-structured interview was conducted over the telephone. An interview guide was prepared to ensure that consistent information was obtained from each person, and to minimize bias. Probe questions were eliminated if the interviewee provided unfettered responses to primary questions. The interview included the following open-ended questions and probes:

- Could you start by telling me how you became involved with the CIT program?
- Could you give me some idea of how your module(s) went from your perspective?
- Are there any areas that went particularly well?
- Do you have any thoughts as to how to improve your segment of the program?
- Is there anything that you would have liked to know beforehand?
- Are you planning on being involved in the future? (If appropriate for interviewee).
- Any thoughts on other modules you attended?

Several strengths and recommendations from these interviewees are highlighted in detail in the "Telephone Interviews" section beginning on page 33.

# DATA ANALYSIS

## Course Evaluations

### Course Ratings: All CIT Courses

Each participant filled out a course evaluation in which he or she rated every module using a Likert scale[8] between 1 and 4 (1 was poor, 4 was excellent). The average ratings were then converted to percentages, as representing the ratings on a zero to 100 scale was more easily understood by the instructors than a one to four scale. The overall course ratings were fairly high and stable across all seven CIT sessions, ranging from 83 percent to 91 percent (Figure 2).

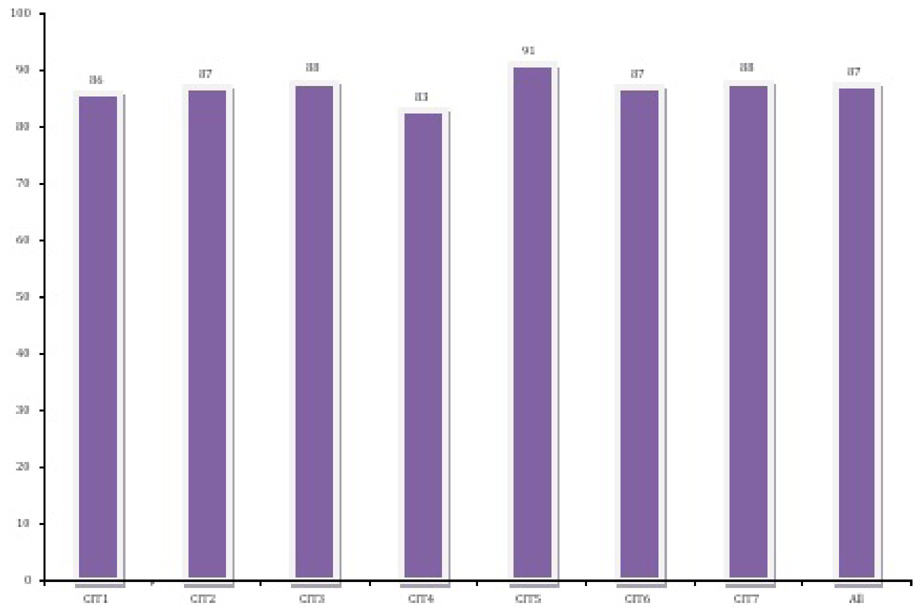



*Figure 2: Overall module ratings across CIT sessions*

8 A scale, usually of approval or agreement, used in questionnaires. The respondent is asked to say whether, for example, they 'Strongly agree', 'Agree', 'Disagree', or 'Strongly disagree' with some statement.

## Data Analysis

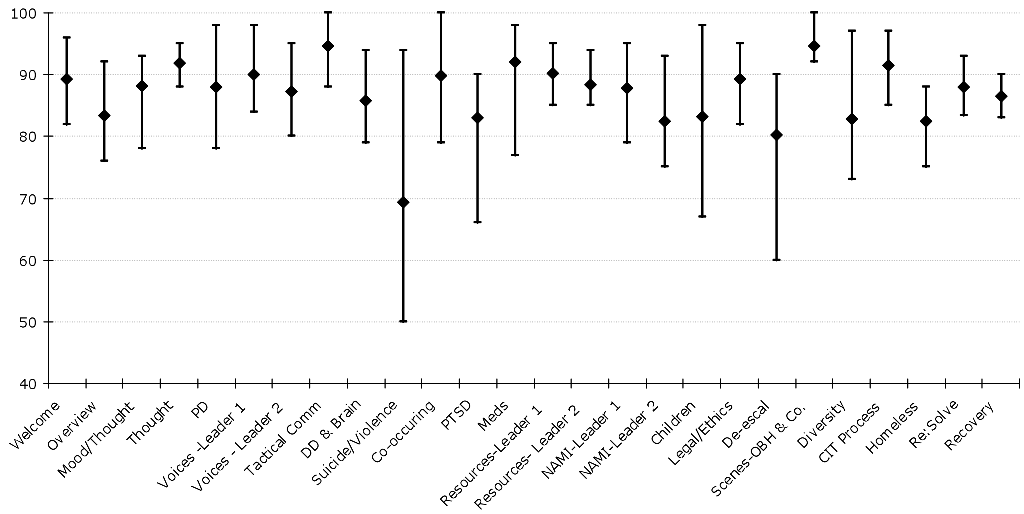
### Module Ratings

By the final course of the grant period, the 40-hour training week included the following 24 modules, described more fully beginning on page 15.

1. Registration/Introduction and Overview of CIT
2. Overview of Mental Illness
3. Mood Disorders
4. Thought Disorders
5. Personality Disorders
6. Hearing Distressing Voices Exercise (with audio component)
7. Suicide and Violence Prevention
8. Substance Abuse and Co-occurring Disorders
9. Assessing Dangerousness and De-escalation
10. Tactical Communication/Negotiation Techniques
11. PTSD
12. Intellectual Disability/Brain Disorders
13. Community Resources
14. Site Visits
15. Diversity and Mental Illness
16. Children/Adolescents
17. Liability/Legality and Ethics
18. Psychotropic Medications
19. CIT: Four-Step Process
20. NAMI: Consumer and Family Perspective
21. Scenarios and Role-Play
22. Homeless Services
23. re:solve Crisis Network
24. Developmental Disability/Brain Disorder

## Data Analysis

Figure 3 demonstrates the participant ratings of each module across the seven CIT trainings, with the mean rating illustrated by the central point and the maximum and minimum ratings designated by the range bars. The participant ratings tended to be based largely on the perceived quality of the instructor, as participants rarely




had any negative comments on the information provided. For a full, tabulated list of module ratings from each CIT training, please see Appendix B.

*Figure 3: Mean module ratings for all CIT courses, with maximum and minimum rating ranges*

Module Ratings - Analysis

## MODULE RATINGS – ANALYSIS

The tactical communications module consistently received high performance ratings. Based on participants' comments, officers appreciated the real-world examples, practical information and informal format of the presentation.

The suicide prevention module (see Figure 3) consistently scored lower than most other content modules. When the information was presented by a temporary yet exceptional speaker, however, there was a notable exception (it received a 94% rating). Participants indicated that much of the information presented during the suicide prevention section was repetitive, and the CIT coordination team may wish to seek an alternative to this important module. In the context of behavioral health, appropriate suicide response is critical to saving lives. As such, this training module may be improved by adapting the curriculum to include real case scenarios and interactive opportunities for officers to explore possible responses. A team teaching approach, where the class is taught jointly by an experienced CIT officer and a behavioral health professional specializing in suicide response, may also improve the response of participants in the future.

While the modules on diversity and on children/adolescents initially received among the lowest ratings, these modules' ratings steadily improved over the seven courses. The improvement in these ratings is most likely attributable to instructor changes as well as modifications to the content of the modules, in response to early feedback.

There was great inconsistency in officers' receptiveness to one presenter in the NAMI family module; however, this same presenter led the co-occurring disorders module to consistently high acclaim. It may be beneficial to adjust the NAMI family module to include as instructors only those family members who are not themselves suffering from addiction or an acute behavioral health issue.

Participants' feedback on quality presentation should be considered when making future selections of module instructors. In order to strengthen the program, it may be necessary to replace ineffective presenters. Further, CIT staff should increase the cadre of individuals who can act as back-up instructors, which may improve the delivery and stability of the CIT course. Given that instructors all have full-time careers, time conflicts and last minute instructor cancellations can and did sometimes arise, albeit rarely. The CIT Coordinator assisted the regular instructor in identifying and recruiting a replacement in as timely a fashion as possible, but having a contingent of trained back-up instructors would improve the consistency of the course.

Methods & Materials Rating

## METHODS AND MATERIALS RATINGS

Participating officers provided feedback on the teaching methods and materials used in the CIT course, including the manual of CIT course material, the audio-visual aspects of the course (e.g., PowerPoint format), and the interactive learning situations (e.g., role-playing opportunities and the "Hearing Distressing Voices" exercise). Overall, these methods received a high score across all classes (83 out of 100). The interactive learning situations were consistently rated in the high 90s in almost all CIT classes. See Figure 4 for the average participant ratings for these methods and materials.

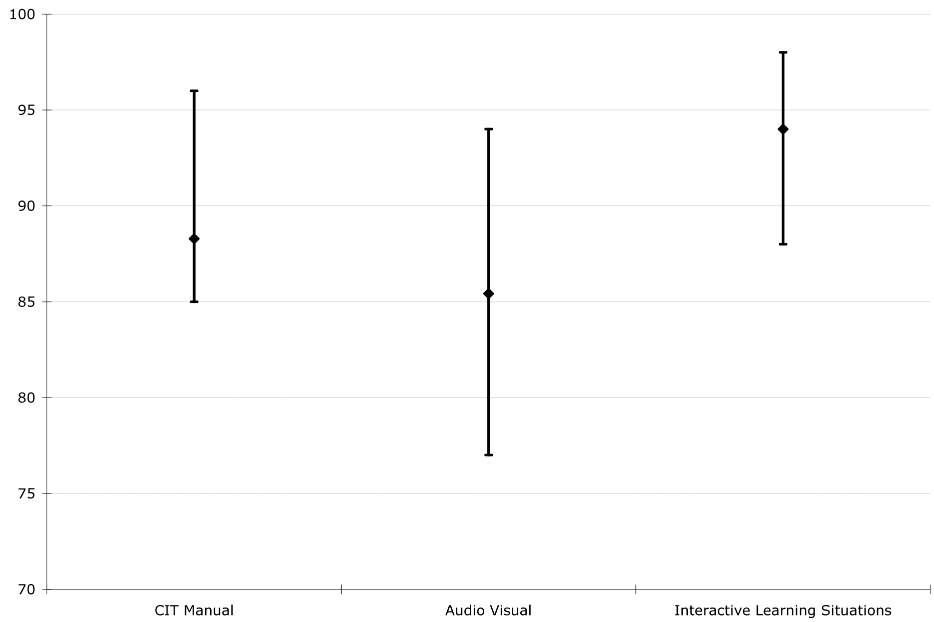
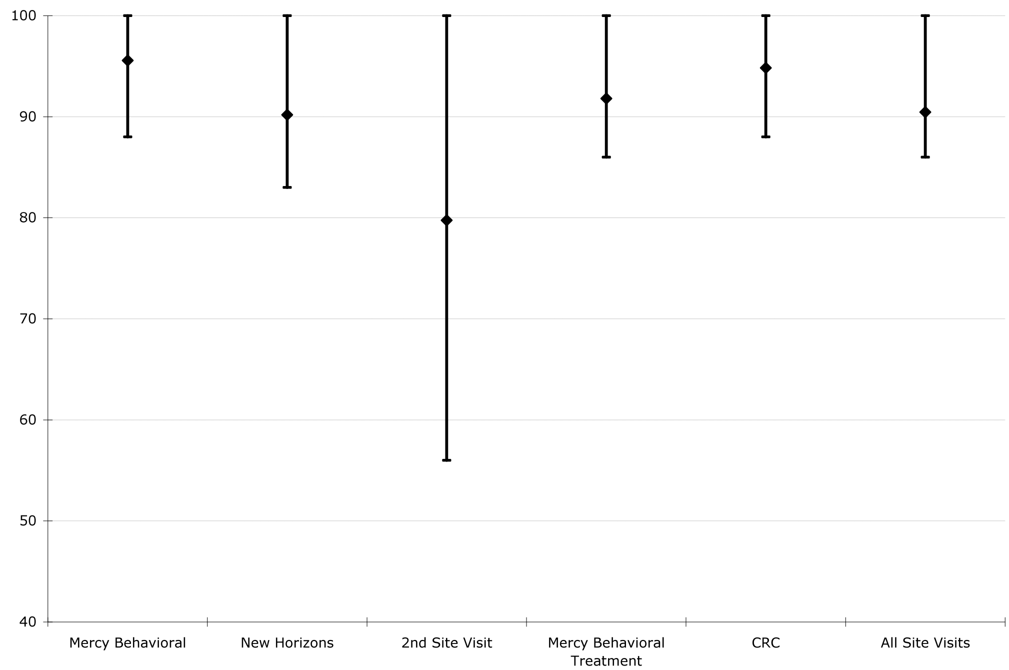



*Figure 4: Mean methods and materials ratings across CIT classes, with maximum and minimum ratings range*

Facilities Ratings

## FACILITIES RATINGS

The training facility (Mercy Behavioral Health) and the CRC site visits consistently rated very highly (see Figure 5). For the second site visit, participants in trainings two, three, four and five visited Wellspring, a local drop-in center or Peoples' Oakland; this module was omitted altogether during course seven due to severe weather. Not only was the visit to Peoples' Oakland rated at 100 out of 100, but the visit included an interactive question-answer session with all individuals—




police and consumers—fully engaged.

*Figure 5: Mean facilities ratings across CIT classes, with maximum and minimum ratings range*

Content Categories

## CONTENT CATEGORIES

The four learning content categories of the CIT training are 1) background information about mental illness and substance abuse, 2) services/resources for referral, 3) legal issues concerning mental illness and treatment and 4) intervention techniques to de-escalate behavioral health-related situations. Participants were asked to rate whether they felt the content and related learning objectives had been met, and the overall rating across all seven trainings was 92 percent (see Figure 6). Comments added to the evaluation form included:

- Excellent Training!!
- It raised my awareness levels of mental health services and resources.
- Resource information and having real clients give their life story about illness, role play made it real to life.

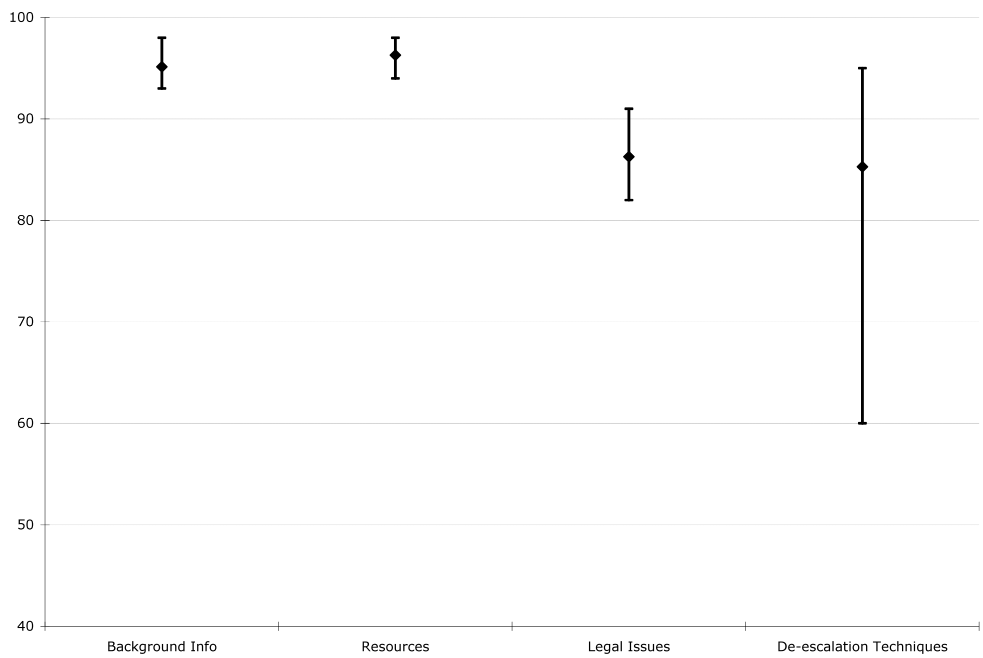



*Figure 6: Mean module ratings across CIT training classes, with maximum and minimum rating range*

Additional Individual Comments

## ADDITIONAL INDIVIDUAL COMMENTS

The evaluation form provided three specific sections for officers to write comments and suggestions regarding the CIT training. Those comments can be found in full in Appendix C.

## PRE- AND POST-TESTS ON ATTITUDES TOWARD MENTAL ILLNESS

During the course's introduction module, participants were given one of four vignettes and asked to answer three questions regarding its content (see Appendix D). The vignettes involved either a male or female who suffered typical symptoms associated with either a major depressive episode or schizophrenia. The pre-test and post-test vignettes were distributed systematically so that at least two participants received each of the four possible tests. The likelihood of receiving a particular disorder or gender was dependent only on where the pages fell after shuffling. To ensure anonymity, no names were recorded. All participants completed a pre- and post-test.

### Likely Long-Term Outcomes for Individuals with Mental Illness

Following the description of symptoms experienced by a person suffering from a mental illness, the participants were asked, "How likely do you think the following long-term outcomes are for the person described above, compared to the general population?" Participants were then presented with a list of behaviors and asked whether they believed the person described in the vignette was more or less likely than the general population to engage in each of those behaviors (participants used a five-point Likert-like scale, with one being less likely than the general population and five being more likely than the general population to engage in those behaviors). The behaviors included: be violent; drink too much; understand others' feelings; take illegal drugs; have a good marriage; be a productive worker; be creative or artistic; be a caring parent; and attempt suicide. The mid-point in the scale represents the attitude that an individual with a mental illness would be "as likely" as the general population to engage in a particular behavior.

The aim of this exercise was to assess participants' perception of long-term care outcomes for individuals with mental illness compared to the general population, and to gauge the course's success in shifting those perceptions. Figures 8 and 9 depict pre- and post-test differences in these perceptions.

Figure 7 illustrates the responses from participants in the seventh training (held January 2009) who received a vignette about individuals suffering a major depressive episode.

## Pre- and Post-Tests on Attitudes Towards Mental Illness

**Officers Attitudes toward Depression Pre- and Post CIT (Jan 2009) Training**

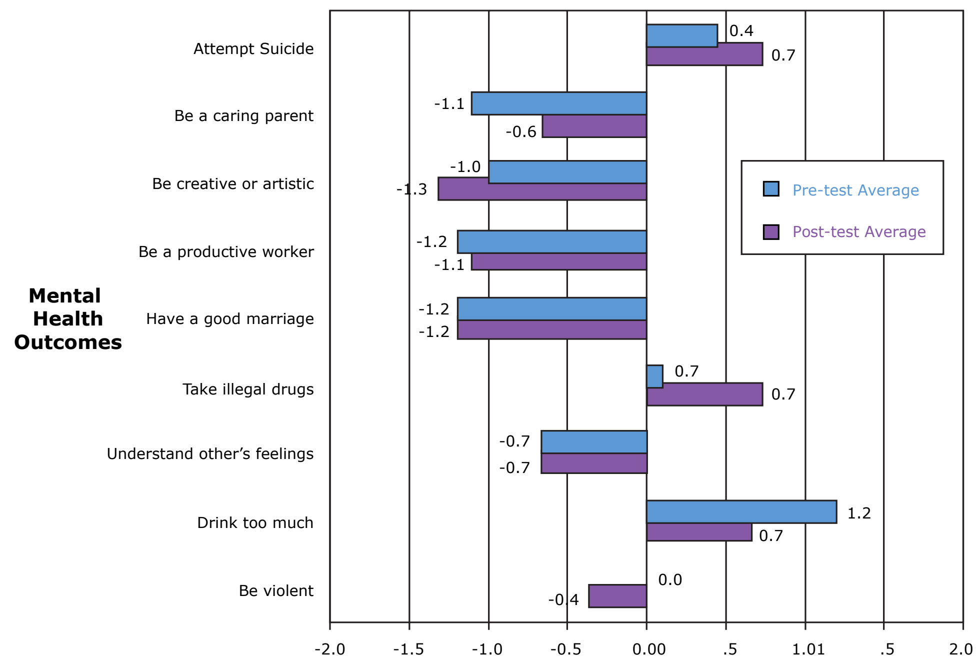



*Figure 7: Officers' perception of deviation from the general population of individual suffering a major depressive episode; Pre- and post-test averages from CIT 7 training (January 2009)*

Figure 8 depicts pre- and post-test differences from the same CIT training course (session 7, January 2009) among participants who received a vignette about individuals with schizophrenia.

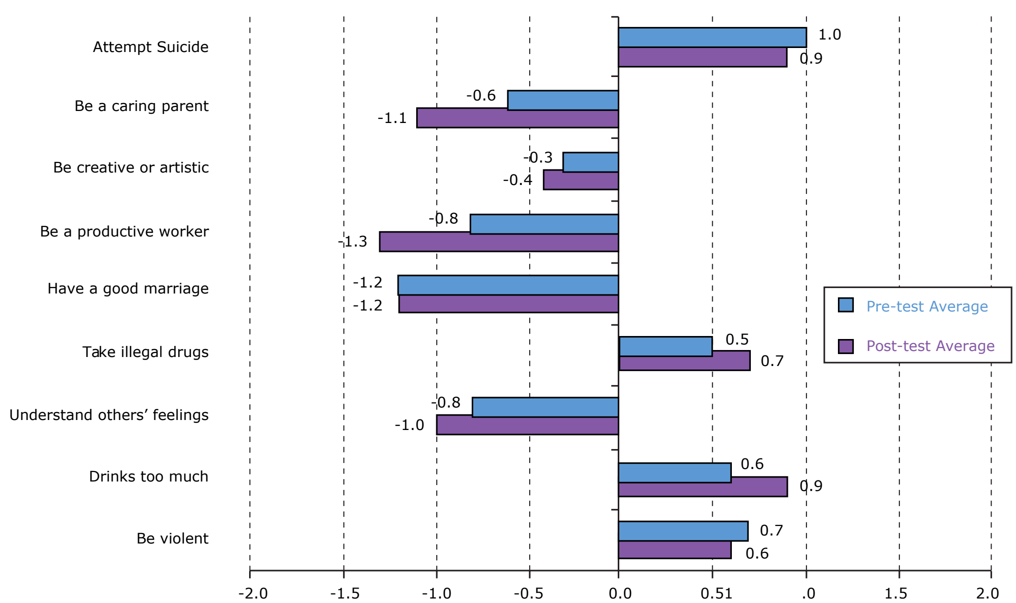



*Figure 8: Officers' perceptions of deviation from the general population of individual suffering from schizophrenia; Pre- and post-test averages from CIT 7 training (January 2009)*

Pre- and Post-Tests on Attitudes Towards Mental Illness

## With and Without Professional Help

Participants were also asked about the role of professional help in an individual's recovery from mental illness. Participants were asked to select the outcome they believed was most likely for the individual described in the vignette, with and without professional help. Outcomes included: get worse; no improvement; partial recovery, but problems will probably recur; partial recovery; full recovery, but problems will probably recur; and full recovery with no further problems. Figures 9 and 10 demonstrate participants' attitudes toward professional help and its role in recovery from mental illness, averaged across all seven CIT courses from pre- to post-CIT course completion (results combine both depression and schizophrenia vignettes, as disorder-specific differences were negligible).

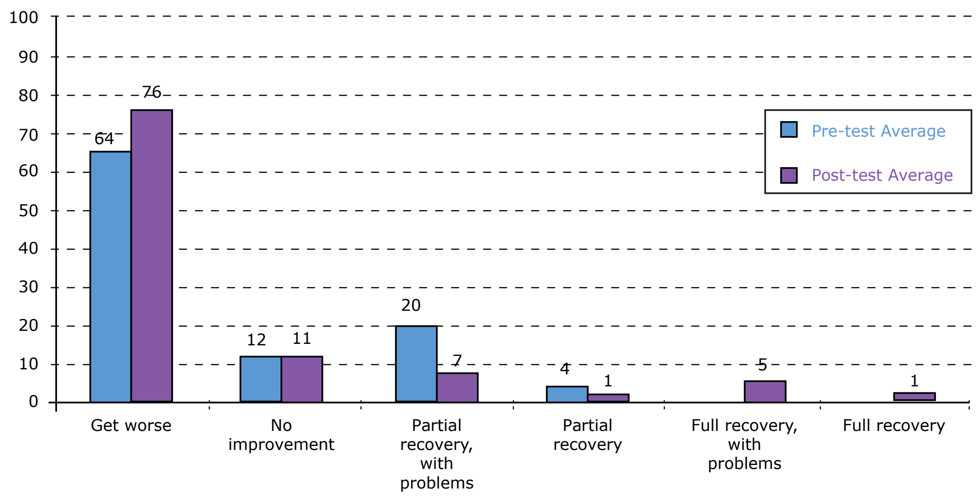



*Figure 9: Pre- and post-course beliefs about outcomes for individuals with mental illness WITHOUT professional intervention*

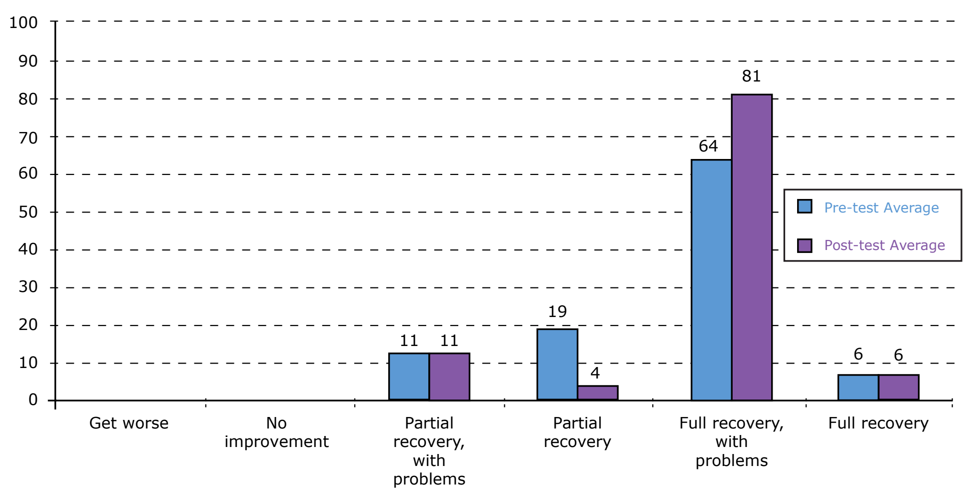



*Figure 10: Pre- and post-course beliefs about outcomes for individuals with mental illness WITH professional intervention*

Telephone Interviews

## TELEPHONE INTERVIEWS

In July 2007, following the first course, telephone interviews were conducted with three key instructors and coordinators to solicit their feedback about the development, organization and execution of the CIT training (see the Methodology section for a list of individuals interviewed). The interviews were partially structured and followed a prepared interview guide to ensure that consistent information was obtained from each person, and to minimize bias. Probe questions were eliminated if an interviewee provided unfettered responses to primary questions. The interview included the following open-ended questions and probes:

- Could you start by telling me how you became involved with the CIT program?
- Could you give me some idea of how your module(s) went from your perspective?
- Are there any areas that went particularly well?
- Do you have any thoughts as to how to improve your segment program?
- Is there anything that you would like to have known beforehand?
- Are you planning on being involved in the future?
(If appropriate for interviewee).
- Any thoughts on other modules you attended?

Respondents' comments were reviewed by the steering committee. Several key strengths and recommendations, gleaned from each interview, are highlighted below, along with corresponding changes made by CIT staff in response to this feedback (note: many of these points mirrored suggestions made by participants in their evaluations, and thus contribute to the overall recommendations for curriculum and presentation improvements):

Involve more CRC staff in the training and reduce the total number of instructors.

- Decreasing the number of instructors and establishing a core group of trainers (including CRC staff) in the course would facilitate networking with the officers and behavioral health staff.
- With some deliberate effort, and some attrition, a core group of quality instructors emerged who were interested in investing their personal time into the program.

Connect officers with mental health service consumers at site visits.

- Having consumers sit down with the officers during site visits would encourage more one-on-one conversation.
- This was instituted and deemed successful, as officers learned of consumers' struggles, and consumers learned that officers were just people trying to keep everyone safe.

Introduce instructors before each module.

- Having introductions by the CIT Coordinator (1-2 sentence about each speaker) would start off the session well, and give the officers context for the module.
- Introductions were instituted and reportedly appreciated by participants.

Include the experiences of seasoned officers in the material.

- If instructors received a clear understanding of what skills police officers already have, they could better tailor the material to enhance existing skills, fill knowledge gaps, and reduce redundancy.
- As the core group of instructors formed, they received specific information about what the officers already knew.

Incorporate local examples into the modules.

- Including real-life, local examples of encounters between law enforcement and individuals with a behavioral health issue, with which officers may already be familiar, could provide excellent training opportunities.
- As instructors learned their roles, they saw the positive effect of incorporating Pittsburgh examples into their training.

# CONCLUSIONS AND RECOMMENDATIONS

## CIT Training Program Strengths and Recommendations

### Program Strengths

Program Strength 1: Existing relationships can be utilized to explore options for a greater referral to treatment.

Individuals on the police force are now more familiar with resources available to them and with individuals upon whom they can call to provide consistent, reliable assistance when dealing with individuals exhibiting behavioral health issues.

Program Strength 2: Culture of change has been established to promote continued excellence in the CIT training program.

Participants' completion of feedback forms and the CIT staff's willingness to seek the best individuals for training participation have fueled a culture in the program in which CIT leadership is comfortable making regular and on-going improvements when necessary.

### Program Recommendations

Recommendation 1: Continue to increase enrollment

As the CIT program continues to grow, there is a risk that the program may lose its novelty and be perceived as "just another training." To combat these misperceptions, and to continue garnering interest in and excitement about the program, the CIT committee should consider exploring multiple avenues for recruiting and enrolling officers for the CIT class (e.g., engage trained CIT officers to recruit their peers). The committee should also work to eliminate possible barriers to enrollment, such as difficulty getting time off.

Recommendation 2: Continue to support the evolving collaboration

CIT is a continuously evolving collaboration between the PBP and OBH. Since the grant supporting the initial development and implementation of the CIT training course ended in February 2009, it is important to ensure that administrators of the two collaborating agencies explicitly define ways to continue the natural relationships that have grown out of the program (e.g., regular communication, meetings, and written documentation of decision making).

Resources

# RESOURCES

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Appendix A

## APPENDIX A: CIT COURSE EVALUATION FORM

This form was used for the seventh CIT course, which took place in January 2009. Note: The actual form for each class included the instructor's name.

# Crisis Intervention Team

## Course Evaluation

**Please rate each of the individual presentations and presenters:**

| Presenter | Poor | Fair | Good | Excellent | No Response |
|---|---|---|---|---|---|
| **Welcome**<br>CIT Coordinator | | | | | |
| **Overview of Mental Illness** | | | | | |
| **Mood Disorder** | | | | | |
| **Thought Disorder** | | | | | |
| **Personality Disorders** | | | | | |
| **Hearing Distressing Voices Exercise**<br>Leader 1 | | | | | |
| Leader 2 | | | | | |
| **Tactical Communications** | | | | | |
| **Resources – Homeless Engagement** | | | | | |
| **Recovery** | | | | | |
| **Suicide and Violence Prevention** | | | | | |
| **Substance Abuse/Co-occurring**<br>Panel | | | | | |
| **Risk Factors for PTSD & Peer Support (CISM)** | | | | | |
| **Psychotropic Medications and Non-compliance** | | | | | |
| **Allegheny Community Resources**<br>JRS Staffer 1 | | | | | |
| JRS Staffer 2 | | | | | |
| **Re:Solve** | | | | | |
| **NAMI- Consumer and Family Perspective**<br>Family Leader 1 | | | | | |
| Family Leader 2 | | | | | |
| **Intervention of Children and Adolescences** | | | | | |
| **Developmental Disability/Brain Disorder** | | | | | |
| **Liability, Legality and Ethics**<br>CIT Coordinator | | | | | |
| **Assessing Dangerousness and De-escalation** | | | | | |
| **Scenarios and Critiques**<br>The Behavioral Health Provider Players | | | | | |
| **Diversity and Mental Illness** | | | | | |
| **CIT 4 Step & How it works**<br>CIT Coordinator | | | | | |

## Appendix A

Please complete the following before leaving the training session.

| Title of Training | Location | Title of Training |
|---|---|---|
| CIT Training | Mercy Behavioral Health South | January 26-30, 2009 |

Rate the following

| Methods: | Poor | Fair | Good | Excellent | No Response |
|---|---|---|---|---|---|
| CIT Manual | | | | | |
| Audio Visual | | | | | |
| Interactive Learning Situations | | | | | |
| **Facilities:** | **Poor** | **Fair** | **Good** | **Excellent** | **No Response** |
| Mercy Behavioral | | | | | |
| Site Visits: 1. New Horizons Drop-In Center | | | | | |
| 2. People's Oakland | | | | | |
| 3. Mercy Behavioral Health (DAS) | | | | | |
| 4. Crisis Center/CRC | | | | | |
| **Met Learning Objectives:** | **Poor** | **Fair** | **Good** | **Excellent** | **No Response** |
| 1. Background information about mental illness and substance abuse | | | | | |
| 2. Services/Resources for referral | | | | | |
| 3. Legal issues concerning mental illness and treatment | | | | | |
| 4. Intervention techniques to de-escalate mental illness and substance abuse situations | | | | | |

| What did you consider most effective about this program? |
|---|
| |
| |
| |
| |

| What did you consider least effective about this program? |
|---|
| |
| |
| |
| |
| |

| Comments and suggestions are welcome. |
|---|
| |
| |
| |
| |

Appendix B

## APPENDIX B: AVERAGED PARTICIPANT PERCENTAGE RATINGS OF EACH MODULE, ACROSS ALL CIT COURSES

| Modules | CIT1 June 2007 | CIT2 Sept. 2007 | CIT3 Oct. 2007 | CIT4 Jan. 2008 | CIT5 Apr. 2008 | CIT6 Sept. 2008 | CIT7 Jan. 2009 | Me-dian | Mean |
|---|---|---|---|---|---|---|---|---|---|
| Welcome | 82 | 92 | 89 | 96 | 83 | 94 | 89 | 89.0 | 89.29 |
| Overview | 90 | 92 | 83 | 79 | 81 | 83 | 76 | 83.0 | 83.43 |
| Mood/Thought | 91 | 93 | 90 | 78 | 86 | 90 | 89 | 90.0 | 88.14 |
| Thought | 89 | 95 | 94 | 88 | 92 | 92 | 93 | 92.0 | 91.86 |
| Personality Disorders | 98 | 90 | 88 | 88 | 88 | 86 | 78 | 88.0 | 88.00 |
| Hearing Voices -Leader 1 | 90 | 98 | 84 | 95 | 89 | 88 | 86 | 89.0 | 90.00 |
| Hearing Voices - Leader 2 | 90 | 91 | 84 | 95 | 89 | 80 | 82 | 89.0 | 87.29 |
| Tactical Communications | 98 | 91 | 99 | 93 | 100 | 88 | 94 | 94.0 | 94.7 |
| Develop. Disabilities & Brain | 82 | 90 | 79 | 79 | 94 | 88 | 88 | 88.0 | 85.71 |
| Suicide/Violence | 71 | 68 | 72 | 55 | 94 | 50 | 75 | 71.0 | 69.29 |
| Co-occurring | 90 | 79 | 93 | 83 | 100 | 98 | 86 | 90.0 | 89.86 |
| PTSD | 84 | 90 | 89 | 66 | 83 | 85 | 84 | 84.0 | 83.00 |
| Meds | 93 | 94 | 94 | 77 | 93 | 98 | 96 | 94.0 | 92.14 |
| Resources-Leader 1 | 85 | 88 | 88 | 92 | 93 | 90 | 95 | 90.0 | 90.14 |
| Resources- Leader 2 | 85 | 85 | 88 | 85 | 94 | 92 | 89 | 88.0 | 88.29 |
| NAMI-Leader 1 | 83 | 79 | 89 | 87 | 94 | 95 | 88 | 88.0 | 87.86 |
| NAMI-Leader 2 | 83 | 79 | | 75 | 93 | 90 | 75 | 81.0 | 82.50 |
| Children | 77 | 86 | 67 | 77 | 88 | 98 | 89 | 86.0 | 83.14 |
| Legal/Ethics | 82 | 88 | 94 | 84 | 95 | 93 | 89 | 89.0 | 89.29 |
| De-escalation | 82 | 72 | 90 | 81 | 89 | 60 | 88 | 82.0 | 80.29 |
| Scenes-OBH & Co. | 93 | 93 | 92 | 94 | 100 | 92 | 98 | 93.0 | 94.57 |
| Diversity | 77 | 89 | 79 | 79 | 73 | 86 | 97 | 79.0 | 82.86 |
| CIT Process | 85 | 91 | 91 | 90 | 95 | 91 | 97 | 91.0 | 91.43 |
| Homeless | | | 81 | | 86 | 75 | 88 | 83.5 | 82.50 |
| Re:Solve | | 88 | 87 | 83 | | 93 | 89 | 87.5 | 87.93 |
| Recovery | | | | | | 83 | 90 | 86.5 | 86.50 |

Appendix C

# APPENDIX C: INDIVIDUAL COMMENTS

## "Most Effective" Components of the CIT Training Course

These comments reflect responses to the question:
"What did you consider most effective about this program?"

### June 2007

- Learning about the different mental disorders
- Distressing voices exercise, talking/hearing from people with mental illness and their stories was excellent
- Talking to mental health patients and site visits
- Awareness
- The scenarios and schizophrenia training
- A lot of information about referral services
- The most effective is the facilities themselves, we need[s] to be more involved in the process maybe work with the phone team and the mobile team. Hands on!
- That there is help for people that have issues other than jail
- Learning about the resources available for individuals with mental illness
- Interactions in situations
- It's nice to get the perspective of people with mental illness
- Getting information about alternative facilities and programs
- Doctor's lectures, expert presentations
- Role playing/site visits
- [A specific presenter]
- The resources and scenarios. Also, talking to individuals with mental illness

### September 2007

- Each presenter 'put a face' to aspect of issue. Some presenters – very dynamic and able to make connections previously unexpected
- All lecturers seemed genuinely committed to subject matter
- Pertinent information; a thorough overview. Not tedious.

- Information on current trends in medical/psychological/pharmacology (was) hands-on
- Was based in reality, ex. officer safety – subject safety first
- Getting the consumers point of view. Talking to groups and just throwing around ideas, concerns, etc
- Very knowledgeable instructors
- Psychotropic meds & non-compliance by [an instructor]
- Handouts are excellent, especially the 'where to call directory' & med list
- Tactical communications good

**October 2007**

- I liked the first-person testimonials from addicts and the mentally ill
- All the options we now have to assist people
- Provided the proper direction for my LEO to follow concerning people suffering from mental disabilities
- Approaching the mentally ill in a police response situation
- Panel discussion
- We deal a lot with people who have mental problems and need to know how to better talk to them and why they act the way they do
- Expand if possible
- The instructors (were the most effective part of the program)
- Learning more about possible resources that are available for MH patients rather than our typical 201 or 302
- Excellent overview for MH/MR
- Info from doctors and consumers and law enforcement personnel (were the most effective part of the program)
- Exposure to the wide range of mental illnesses
- The company of good instructors!

**January 2008**

- De-escalation and active listening skills

- The scenarios and interactive opportunities, audio hallucination exercise
- Formative info to enhance experience/knowledge of the mentally ill consumer. Techniques/tools to use when they are going through a break down. Symptoms to look for in the different types.
- I learned a lot of about the availability and services offered
- In-depth information on mental health and available programs
- This is an excellent training for everyone to learn. There should be an in-service class on dealing with individuals with disorders
- Learning a different perspective in dealing with people
- Wide variety of information on mental illness and resources available to police officers for addressing crisis incidents
- [An instructor] and her panel really put a touch on this situation. Not to put a focus on day one thing but more time would be informative. [An instructor] was very smooth and got everyone thinking one way or the other he addressed the subject
- Interviewing techniques to de-escalate mental illness consumers and learning about the options other than jail or do nothing when confronted with certain issues
- Interaction with those with mental illnesses and brain injuries

**April 2008**

- The vast knowledge of the instructors, scenarios were good
- Actual firsthand knowledge and experience by certain instructor and consumer
- Excellent scenario based training
- Material
- Seeing the different agencies working together
- [Several instructors]
- Hands on roll play
- Making known the resources available for MH consumers and their families
- Interaction with MH/MR consumers
- Information on resources

- [Several instructors]-were all good speakers
- Role playing was great
- The overall understanding of mental illness and substance abuse
- The knowledge and references provided within which may be used in real life scenarios

**September 2008**

- Learning about the various signs and symptoms of mental illness and disorders and all the resources available; feel better equipped as an officer to handle mental illness calls
- Presentations by consumers and family members; role playing exercises and condition simulations; I liked the enthusiasm of all the presenters.
- Site visits; hearing from consumers/family members
- A/V smart board; background and family information from real people
- Prescription drug introduction; job related/affected paperwork/protocol
- Resource information; better understanding of MH issues
- Info from consumers and families of consumers; psychiatrists info/ presenters were excellent
- Resources, materials and role playing
- All good
- The set up for the training was excellent
- Very useful information presented in a simplistic way
- Good information made available-a binder could be sent to each zone to assist the city with contact numbers

**January 2009**

- I would have liked to see more de-escalation techniques and more political scenarios. The CIT process information from start to finish was very good.
- Diversity of instructors and topic related to law enforcement and its relation to mental illness
- Program gives a bridge to law enforcement in dealing with the mentally ill person

**Appendix C**

- Coming together, sharing information, excellent presenters
- Being explained how to deal better with mental disability person
- Listening to people that suffer from a mental illness. Hearing what they go through every day and their advice to us, as police officers, on how to cope/deal with them. Scenarios and critique were helpful.
- Tactical communications, Diversity was great, Intervention of Children and Adolescents was also very good. Diversity hour was the most effective for understanding the frustration with hearing voices – should have a longer time scheduled. Active listening skills, good.
- Explanation of schizophrenia-symptoms, communication between patient & police. Reasons for their problems in communication. Excellent
- The use of experienced professionals to present information. The use of different speakers to reduce boredom. The use of persons with problems instead of standard training such as being presented with information.
- Interactive training methods. Consumers' perspectives and background. Resources was absolutely informative and helpful.
- Being able to meet and see people with mental illness, and how well they were doing
- Exposed to topics and individuals that work daily on this topic. Working/blending/cross training of departments
- Hearing voices exercise; Diversity was fabulous – open with that module? Extend her session? Family session was wonderful – to hear from 2 different perspectives; the "practice" session were well done – beneficial
- The response from other officers
- Hearing disturbing voices exercise – really increased my perspective-taking. Thank you and loved the diversity exercise, great – really down to earth: helpful information. Mental health court information interesting

Appendix C

## “Least Effective” Components of the CIT Training Course

These comments reflect responses to the question,
“What did you consider least effective about this program?”

### June 2007

- The drug portion
- Some topics too in depth
- Not enough interaction
- Too much info about what the illnesses are instead of how to de-escalate mental health issues
- Need to cover more about how to talk and de-escalate people with mental illnesses
- Too much class time, not enough about the facilities
- N/A
- [A site visit]
- The lectures at [a site visit]. I liked the one on the meds; it will be helpful in the field. I liked [an instructor] however, have 4-5 lectures in a row, lectures that are unilateral and not interactive, were not conducive to maximizing the training potential.
- Medication and diagnosis information is beyond what we require for the street—we could use more practical application training.
- Track ground history of mental illness. Repeating models we already learned
- Some sessions are repetitive and presenters seem to want to try and teach us everything instead of giving a detailed presentation on the subject at hand
- Site visits needed to be more in depth to show what is actually done there. [Site] visit was not beneficial at all, the discussion was not structured, after visit, still didn’t understand what they offered.
- The trip to [a site visit]
- Medication and diagnosis information since it overlapped and was a repeat of what we had in the academy

Appendix C

## September 2007

- Segments need to be longer, time does not seem to permit full explanation
- Some information was at too basic of a level. Street officers have this knowledge through experience.
- I would like to see/hear more real world experiences. The longer, more academic lectures were a bit boring.
- The first day was an information overload. A lot to try and remember
- site visits
- ALL parts were effective/relevant!
- Some instructors did not know focus of training or openly skipped material or said 'this will be boring' – this takes away from the presentation. (As this was the first class, this could be expected.)
- Of all the areas covered, some speakers not prepared to present (diversity & mental illness)
- Dry section where the instructors just go through a presentation with no stories, no personal experiences, no visual aids other than a PowerPoint; those can be very hard to focus on for any length of time. Spice it up!

## October 2007

- Not enough time for the information!
- I did not care for the hearing distressing voices exercise/ The hearing distressing voices intro tape was too long; hard to pay attention
- Some subjects were covered multiple times/ There seemed to be a lot of repeated topics
- The section on intervention of children & adolescence was too rushed – no handouts
- Had to cover personality disorders too quickly
- Diversity in MH seemed to lean more toward race and mental health
- The suicide violence prevention class presentation needed more info
- Diversity and mental illness—I believe there was more focus on race other than diversity with mental illness

- Least effective for myself was brain & developmental disorder. I understood what was taught, however I believe a bit more depth could be taught.
- Info from counselors – too much opinion

## January 2008

- Poor presentation by [an instructor]and [an agency]
- [An instructor]-unstructured presentations and rants about issues and misconceptions of law enforcement, lack of credibility
- Suicide/sudden death
- N/A
- Homeless shelter intervention not very organized or presented well
- Some of the therapists and MH workers tried to over sell the idea that MH/ MR individuals are victims and not criminals. The woman from [an agency] was terrible
- N/A all areas will be used at one time or another
- Possibly address suicide utilizing staff from Contact Pittsburgh. They are very knowledgeable on the topic, as well as very effective in explaining active listening concepts.
- It's hard to present this type of training but could it relate with more experienced officers who already know the skills
- Redundant information

## April 2008

- I personally felt that many of the guest speakers and the subject matter that was covered was redundant. The general understanding of mental illness and substance abuse was habitually covered and at points repeated verbatim
- Nothing really, overall it was an excellent class. I appreciate all of the hard work the volunteers did to make this class successful. Great job.
- The folder given to us is really good and I understand if everything was in it, it would be huge however, I like to write notes/highlight handout, and in general follow along. This is not meant to be a negative comment; it's just the only negative thing I could think of.

Appendix C

- Need more advance training, I feel like officers are getting some of this information prior to this
- Some segments could have been trimmed down like homeless-PTSD, brain disorders, assessing de-escalation
- Nothing, all parts of the program will prove beneficial in daily patrol responsibilities

**September 2008**

- Assessing dangerousness should be taught by a trained police officer; The [specific presenter] presentation was negatively affected by his severe tactical mistakes conducted in his stories; needs to be more focused on the announced curriculum; I would like more videos showing consumers symptoms
- Suicide prevention piece too long
- Redundancy of some issues
- Diversity – need more Spanish, Middle Eastern cultures
- Need additional information on communicable illness – CDIFF, HIV, HEP C
- Suicide prevention and violence, the presenter did the active listening communication after tactical communication – seemed redundant, looking for more suicide prevention specifically
- Perhaps the individuals that have some mental issues could be trained in what to do when they encounter the police

**January 2009**

- I had concerns during the first panel with the interaction between the younger girl and the peer coordinator. The level of confrontation was uncomfortable for me – perhaps better for that conversation to occur in private with a therapist. The interaction felt painful for me to witness – "bullying."
- Involvements of patients that might not be ready for full discussion
- Really getting based [sic] with the power points and certain presenters that just made time drag. Could be condensed in a bit of areas and expanded in others such as tactical communication (really good speaker). We listen better with another officer speaking (jargon / know where he's coming from

**Appendix C**

- Snow – bad roads
- All seemed helpful
- Nothing – well done for law enforcement
- Nothing
- Biased of course, I feel that the program could use a law enforcement officer with a personal family experience so that law enforcement can see in a real way that it affects all of us – thank you!
- Did not really note any poor portions of this program

Appendix C

## Comments and Suggestions

These comments were submitted in the "comments and suggestions" section of the evaluation form.

### June 2007

- Tad too long
- Facilities and technology were superb
- Good for older officers
- Thank you! [An organizer] did a great job!
- I felt that the training was very well organized as well as informative
- More hands on at [a site visit] in the call center and with mobile teams
- Good training- too long however

### September 2007

- Course material deserves more than 40 hours
- Some segments, like Tactical Communications, could be expanded in order to expressly address communicating with MH individuals in high-stress situations
- Weed out some of the information that was not necessary – not relevant to MH
- A booklet stating specifics about what the CRC can be used for
- It would be nice to have all power points printed out
- Great Idea!
- All the staff are excellent
- More info on Mental Health Court
- Need some more on Jail/Court related part of whole case – Mental Health Court
- Judge/case manager from Mental Health Court – someone who went through process – firsthand experience

- Give a preview of training segment so "student" can know what is expected (e.g. [telling them that] "an opportunity to speak with a panel of consumers sets a different tone than a fact based lecture (you can get more out of it.))
- Need more time spent on learning of or being alert to your individual mind set/bias/fear when engaged in situation – 'self awareness is power.'
- More interactive exercises would add more practice opportunities to apply our new-found skills
- Ride along opportunities with the Mobile Team to get to watch actual crisis interventions
- This was a terrific training – I learned a lot about de-escalation not just how to techniques, but why they work
- In general, a very good class – a condensed version would be beneficial bureau wide!

**October 2007**

- I'm glad I took this training – I strongly believe it will help
- Have some presenters include some type of handout
- More info on dealing with juveniles
- Partial PowerPoint highlights
- Could use more info on interventions with children & adolescences
- More diverse panel discussions with more illnesses discussed
- Try to bring in more people into the classroom. Thought the table discussion of co-occurring with [an instructor] was EXCELLENT. One person speaking to the group is better than 1 on 1 in site visits. Bring in more consumers to talk to us not us talking to them.
- Instructor [specific presenter] told too many stories, talked too much about being an EMT.
- More visuals aids during lectures, movies, etc. Only 5 minutes is great each segment
- Having officers admit someone into the CRC to see how it would actually occur—possibly as part of the scenarios segment
- Suicide by cop could be rolled into assessing dangerousness

- Let officers visit places like Mayview & group homes
- I would recommend this course to any police officer. Organized very well
- [A site visit]was very long and did not seem very helpful. It could be a little shorter
- [An agency]visit –good to talk with the people but I fail to see how to use it as a resource
- Speaking with the individuals at [a site visit] was a great idea but just a little long
- Site visits and talking with consumers. We have all talked to people with mental illness and I don't think we received any new info about them
- We talk with people with mental illness on the job quite often, and talk with them was a bit of overkill
- Perhaps on visitations – [specific agency] – we rotate among the consumer to have an opportunity to speak with more people
- The visit to the drop in center was good. Need to rotate every 15 minutes

### January 2008

- Need for dedicated proactive CIT teams for Downtown Central Business district. desired-with transportation.
- Great while, an honor to be apart
- This training should be a (80 hr.), lots of info received in a short time frame (40 hr.)
- Suggest that invitation be extended to Contact Pittsburgh to conduct training on active listening and assessing suicidality
- The PTSD presentation was an extremely important part of this program, and the presentation style made it almost impossible to follow
- [Presenter] was an excellent presenter! [Presenter] was a great presenter! [A presenter]-you can do much better than him as an instructor
- Excellent training-long overdue. Thanks.
- [Presenter] was a fabulous presenter-answered questions out of order and very good at bringing it back, then covering it later. Would help if [Presenter] could share protocol req. suicide etc. and RELAX!

- More officer safety (control continuum), emphasize tools and techniques over how we feel about those who are addicted

**April 2008**

- Illustrations (pictures) of psychotropic medication to assist in identification
- ACES training
- Provide a more energetic instructor regarding "brain injuries"
- Excellent training
- A day at WPIC
- More observations-interaction with people who have various conditions
- I found the diversity and mental illness within [an instructor] to be out dated, offensive, one sided, and absurd. To believe that minorities, most talked about African Americans, are unable to be intelligent, successful, etc. is absolutely ridiculous in this day and age. Mostly, we didn't ever discuss how it was related to MH/MR, more that African Americans are still discriminated against and thought of on a lesser plane. The material was irrelevant to our topic, these generalized statements and views should be recently investigated to have current information instead of the 1890's!
- Statistics were outdated on some presentations, i.e. 1994 for suicides-[presenter]
- [Instructor] was very informative, a lot of information about schizophrenia that could be covered in a longer class, more than one hour.
  Very good speaker.
- [Presenter] great speaker, very knowledgeable, role playing very effective
- [Presenter], great speaker, very informative
- [Instructor] didn't cover much on mental illness. Seemed a little pompous and somethings were one-sided and controversial. Felt uncomfortable being a white male in class, stereotyped whites and gave her views on race issues, may not be true as a whole.

**September 2008**

- Longer breaks – at least 10 minutes – difficult to sit for that long of time period

- Outstanding course; this training needs to be introduced into the training academy
- One of the best training programs I've attended; I feel that I can immediately begin to use this information and these skills
- A list of all acronyms with their meanings would have been helpful
- Make days 7am-2pm, course needs to be opened up, 8-4pm is too much, 6 or 7 days for course; 8-4pm traffic horrible in and out! Rush hour!; site-Mercy BH why not HQ or Academy? Hard to get in and out during rush hour; Presenters-too many Drs./professional presentations inappropriate to police matters, taught as a Dr. not Law Enforcement.; patient/consumer presenters? Some of the consumer presenters were "iffy" – not appropriate? Not comfortable with them in classroom setting; tech issues – issues with presenters not knowing how to use smartboard/TV, don't know it/don't use it; loud static on overhead speakers constantly very distracting; non-students in class working/typing on laptops – rude and distracting, no computers/no cell phones in class; visits to sites – should have transportation vans or bus – not personal vehicles, do visits in morning vs. afternoon; class times? 50 min-10 min or fewer breaks? Collegiate research 20 min, you lose focus, 30 min. 5 min break, 45 min 15 min break; should have an area to leave books rather than taking them home every day; Thursday – should have had tours last; rather than waiting 45 minute for a presenter to show up and then keep us until 4:05; finally get rid of Suicide/Violence module – redundant.
- Excited Delirium; consumer education on what to do when you encounter police (be respectful, comply, be honest, articulate your illness, keep hands visible, realize why you are handcuffed, drop weapon); have short resume/preface of speakers/presenters
- Handout of mental health commitments: explanations; video of mild to acute mental health; yearly update; make the training mandatory for all city supervisors, start with the next recruit class
- It should be mandatory training
- Copy of all presentations slides, besides CDs, be provided; have samples of common psych drugs available for recognition and generics

### January 2009

- Thought disorders block should be longer. The information was valuable. Bring in a uniformed police officer to explain his/her personal experience using the program (small block)

Appendix C

- Great job, will pass on to supervisor how great and informative the information is
- Perhaps a little more sharing of experiences. Graduation luncheon? $$
- Would be an asset to Academy classes
- Maybe talking to more consumers that have had an involvement with the law
- This training was great. The room could have been bigger. I would also suggest a comment at the beginning of class on respect and making negative comments about other officers and why they are in class. [One individual] was out of line a couple of times with his fellow officers. This training was very helpful and I learned many things. Thank you
- Nice job the class [is] relaxed and fun learning
- Thank you, the training was very useful!
- Change around Thursday morning. Assessing dangerousness was not good as a first a.m. class. Started to get repetitive, and a little boring. Need something more interesting to get you motivated as a first class that day
- The role play was extremely important. I think more of that mixed through the week. Great program! Thank you!
- You may enjoy work by John Byrkes and the aggression institute. Excellent resources and tools. His books are reality-based and applicable to all lines of work. Referred to me by an officer-officer safety issues-practice approach
- I think training should include Mental Health Act-302 procedures, etc.
- Good information
- The pre-test and post-test was confusing
- Thank you!
- Very much appreciated. Include more role plays to put theory to practice. Excellent program: great resources – thank you!
- On one of the last slides for overview of mental illness change, mental illness not mental health
- Diversity, liked the experiential exercises
- Emergency Medical Response as presenter – lots of information – thanks!

Appendix D

## APPENDIX D: CIT PRE- AND POST-TEST FORMS

Pre- and post-test surveys were conducted with participants to assess their attitudes toward mental illness. Participants were presented with one of four vignettes about individuals with a mental illness: one male with depression, one female with depression, one male with schizophrenia, and one female with schizophrenia. Vignettes for each illness were identical except for the name of the individual (male or female); as such, only one example for each illness is included in this appendix. The vignettes presented here were used with participants in the fifth CIT session, held in April 2008. [Source: Hugo (2004) and Jorm et al. (1999)]

# Crisis Intervention Team

## Pre-Test

John is 30 years old. He has been feeling unusually sad and miserable for the past few weeks. Even though he is tired all the time, he has trouble sleeping. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of John's boss, who is concerned about his lowered productivity.

1. Check the box ☑ for the most likely outcome for the person described above, ***without*** professional help.

- ❑ Full recovery with no further problems
- ❑ Full recovery, but problems will probably recur
- ❑ Partial recovery
- ❑ Partial recovery, but problems would probably recur
- ❑ No improvement
- ❑ Get worse

2. Check the box ☑ for the most likely outcome for the person described above, ***with*** professional help.

- ❑ Full recovery with no further problems
- ❑ Full recovery, but problems will probably recur
- ❑ Partial recovery
- ❑ Partial recovery, but problems would probably recur
- ❑ No improvement
- ❑ Get worse

3. How likely do you think the following long-term outcomes are for the person described above compared to the general population?

| How likely do you think the person will : | Less likely | | | | More likely |
|---|---|---|---|---|---|
| a. Be violent | 1 | 2 | 3 | 4 | 5 |
| b. Drink too much | 1 | 2 | 3 | 4 | 5 |
| c. Understand other's feelings | 1 | 2 | 3 | 4 | 5 |
| d. Take illegal drugs | 1 | 2 | 3 | 4 | 5 |
| e. Have a good marriage | 1 | 2 | 3 | 4 | 5 |
| f. Be a productive worker | 1 | 2 | 3 | 4 | 5 |
| g. Be creative or artistic | 1 | 2 | 3 | 4 | 5 |
| h. Be a caring parent | 1 | 2 | 3 | 4 | 5 |
| i. Attempt suicide | 1 | 2 | 3 | 4 | 5 |

**Appendix D**

# Crisis Intervention Team

## Pre-Test

Mary is 24 and lives with her parents. She has had a few jobs since finishing school, but is now unemployed. Over the past 6 months, she has stopped seeing her friends, has locked herself in her bedroom, and refused to eat with the family or take a bath. Her parents hear her walking around her room at night. Even though they know she is alone, they have heard her shouting and arguing as if someone else is in there. When they try to encourage her to do more things, she whispers that she won't leave home because she is being spied on. They know she is not taking drugs because she never goes anywhere or sees anyone.

1. Check the box ☑ for the most likely outcome for the person described above, ***without*** professional help.

- ❑ Full recovery with no further problems
- ❑ Full recovery, but problems will probably recur
- ❑ Partial recovery
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| f. Be a productive worker | 1 | 2 | 3 | 4 | 5 |
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| h. Be a caring parent | 1 | 2 | 3 | 4 | 5 |
| i. Attempt suicide | 1 | 2 | 3 | 4 | 5 |

**Appendix D**

# Crisis Intervention Team
## Post-Test

Mary is 30 years old. She has been feeling unusually sad and miserable for the past few weeks. Even though she is tired all the time, she has trouble sleeping. Mary doesn't feel like eating and has lost weight. She can't keep her mind on her work and puts off making decisions. Even day-to-day tasks seem too much for her. This has come to the attention of Mary's boss, who is concerned about her lowered productivity.

1. Check the box ☑ for the most likely outcome for the person described above, ***without*** professional help.

- ❑ Full recovery with no further problems
- ❑ Full recovery, but problems will probably recur
- ❑ Partial recovery
- ❑ Partial recovery, but problems would probably recur
- ❑ No improvement
- ❑ Get worse

2. Check the box ☑ for the most likely outcome for the person described above, ***with*** professional help.

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- ❑ Partial recovery
- ❑ Partial recovery, but problems would probably recur
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| d. Take illegal drugs | 1 | 2 | 3 | 4 | 5 |
| e. Have a good marriage | 1 | 2 | 3 | 4 | 5 |
| f. Be a productive worker | 1 | 2 | 3 | 4 | 5 |
| g. Be creative or artistic | 1 | 2 | 3 | 4 | 5 |
| h. Be a caring parent | 1 | 2 | 3 | 4 | 5 |
| i. Attempt suicide | 1 | 2 | 3 | 4 | 5 |

Appendix D

# Crisis Intervention Team

## Post-Test

John is 24 and lives with his parents. He has had a few jobs since finishing school, but is now unemployed. Over the past 6 months, he has stopped seeing his friends, has locked himself in his bedroom, and has refused to eat with the family or take a bath. His parents hear him walking around his room at night. Even though they know he is alone, they have heard him shouting and arguing as if someone else is in there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied on. They know he is not taking drugs because he never goes anywhere or sees anyone.

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