ISSUE BRIEF and RECOMMENDATIONS
Crisis Intervention Team Training in Chicago

Key Points

- The CIT program works – it has been proven effective nationally and in Chicago. It reduces the use of force, increases officer safety, reduces number of arrests and improves access to mental healthcare.
- Chicago has been a *nationally recognized CIT leader*. Until recently we had the largest number of trained officers, and we pioneered advanced training with a focus on youth and veterans.
- CIT training is cost effective, yet underfunded and understaffed in Chicago. At a minimum, we should increase the number of staff at the CIT Unit in the CPD (had 10, was reduced to 4), increase its status, and double the number of officers trained ensuring there are at least two CIT officers on every watch and every shift.

Recommendations for Improvement

- At a minimum, double the number of active duty officers who are CIT trained and ensure there are at least two CIT officers on every watch and every shift.
- Add CIT as a permanent code attached to badge numbers to ensure that dispatch knows the CIT officers that are on duty and for better data collection.
- Improve data collection on mental health crisis calls to assess staffing needs and program adjustments.
- Increase the bandwidth of the CIT Unit at the Chicago Police Department. Until recently, CIT had 10 employees; this has been decreased to 4. Elevate the status of this Unit.
- Require Sergeants and Lieutenants and Field Training Officers to have the full 40 hours, ensure Deputy-chiefs, Commanders, and Captains have at least 8-16 hours of training.
- Provide 8-16 hours of mandatory training on mental illness signs and symptoms and de-escalation for all non-CIT trained personnel. This should include information about the CIT program and when and how to request CIT officers on scene.
- Reinvigorate training at OEMC, and improve dispatch preparedness, coding and tracking. Last training was in 2011.
- Improve General Orders.
- Implement a CIT refresher course every two years for CIT officers.
- Implement Mobile Crisis Prevention/follow-up for high risk/high frequency utilizers and/or institute co-responder teams (clinician/CIT officer). Houston, LA and Portland have models.

Contextual Facts

- People with untreated mental illness are 16 times more likely to be killed by a police officer, according to a new report by the Treatment Advocacy Center (TAC).
- Previous research has revealed that 25% of all fatal police interactions involve a victim who is mentally ill.
- Where official government data regarding police shootings and mental illness have been analyzed – in one U.S. city and several other Western countries – the findings indicate that *mental health disorders are a factor in as many as 1 in 2 fatal law enforcement encounters.*

- People with mental illness are far more likely to be the victims of violence than they are to be perpetrators of violence.
- The majority of people who commit violent crimes are not mentally ill and most people who are mentally ill are not violent.
- Recently, the United States Department of Justice has begun filing complaints against cities where encounters with the local police departments have resulted in the deaths of a large number of mental health recipients: Investigation of the Portland Police Bureau by the United States Department of Justice Civil Rights Division
- Following potentially preventable tragedies, the Department of Justice Civil Rights Division has intervened, entering into consent decrees/settlement agreements that include specific requirements for improving mental health crisis response in the following cities: Seattle, Washington; Portland, Oregon; New Orleans, Louisiana; Albuquerque, New Mexico and Cleveland, Ohio. [http://www.justice.gov/crt/special-litigation-section-cases-and-matters0#police] The requirements closely track the recommendations we are making here-increase staffing, better data collection, expanded number of officers trained.
- There has been no formal tracking of police suicides since the 2012 National Surveillance of Police Suicides (NSOPS). For the years in which there is reasonably reliable officer-suicide/officer-line-of-duty-death data (2008, 2009, & 2012), the number of police officer suicides exceeded the number of officers killed by felonious assault or by accident (combined). For most years of at least the past two decades, **suicide has been the number one killer of police officers**. - See more at: http://www.policesuicidestudy.com/index.html

About CIT

Crisis Intervention Team training (CIT) is a *joint program* with the police department and local mental health providers to improve police response to crisis situations involving the mentally ill. The goal is to have response to mental health crises be appropriate, so that persons with mental illness/addictions are not automatically thrown into the criminal justice system, and to reduce possible injury to police and mental health recipients.

The Crisis Intervention Team model has been extensively implemented and evaluated over the country. Currently, there are over 2,700 CIT Programs nationally, according to the University of Memphis. There are standard best practice components for CIT programs, including:

1. Partnerships: Law Enforcement, Advocacy, and Mental Health: bringing together a wide array of stakeholders in the community and professionally to identify core needs of the community.
2. Community Ownership: Planning, Implementation & Networking: Ensuring the partnership group is included in key decisions.
3. Policies and Procedures: Standardization of procedures for responding to a mental health crisis.
4. CIT: Officer, Dispatcher, Coordinator: A senior-level law enforcement official stewarding the development, implementation, and sustainability of the CIT program.
5. Curriculum: CIT training: Standardized, with a core curriculum and expert presenters and teachers.
6. Mental Health Receiving Facility, Emergency Services: Identified partners who operate under shared principles and procedures.
7. Evaluation and Research: An external evaluator who can legitimize the training product and establish fidelity to the principles of the CIT model.

8. In-Service Training: Continuing education credits for officers who become certified.
9. Recognition and Honors: Commendation for officers who become certified and effectively implement CIT principles and techniques in a crisis situation. 10) Outreach: Developing CIT in Other Communities: Promoting the CIT principles and techniques in bordering cities/counties to build momentum for the project and to promote safe and healthy communities.

CIT has been proven effective. CIT started in Memphis in 1988 and has become the most widely recognized and adopted best practice model of specialized police response (Compton et al 2011). The CIT model is evidence-informed. Research on CIT demonstrates CIT trained officers:

- Are less likely to endorse use of force as effective response (Compton, et al 2011)
- Use less force as resistant demeanor increases (Morabito, Kerr & Watson, 2012)
- Are more likely to transport or refer to mental health services (Watson et al 2011, Compton et al 2014b) Are less likely to arrest subjects with mental illnesses (Compton et al 2014b)

CIT implementation associated with:

- **Lower arrests rates** than in jurisdictions with other models (Steadman, et al 2000)
- Greater confidence in department's response (Borum, et al 1998)
- A study funded by the National Institute of Mental Health and conducted by investigators from the University of Illinois at Chicago (UIC) found that compared to their non-CIT-trained peers, **CIT-trained Chicago Police Officers directed people to mental health services 18% more often, reported feeling better prepared to respond without needing to resort to use of force, and used less force when subject agitation/resistance increases**.[1]
- Other studies have concluded that CIT **improves safety and reduces injuries to officers** and to persons experiencing a mental health crisis, reduces arrests, diverts more subjects from the criminal justice system, increases linkage to psychiatric services, and improves the knowledge, attitudes, and confidence of officers. Skeem & Bibeau (2008) found that CIT officers used force in only 15% of encounters rated as high violence risk and that when they did use force, they generally relied on low-lethality methods.

CIT training is cost effective. A study examining cost effectiveness of diversion programs compared the cost of jail alone to the cost of CIT intervention and subsequent treatment. No significant difference in cost was found between the two options—CIT intervention is not more expensive than jail alone (Crowell, Broner, & Dupont, 2004).

CIT training is time efficient. A 40-hour comprehensive training that emphasizes mental health-related topics, crisis resolution skills and de-escalation training, and access to community-based services, CIT is not labor or time intensive. The format of a 40-hour course consists of didactics/lectures, on-site visitation, exposure to several mental health facilities, intensive interaction with individuals with a mental illness, and scenario based de-escalation skill training.

CIT training combats stigma. Studies have shown CIT training may reduce stigmatizing attitudes toward persons with schizophrenia, (Compton et al, 2006) and improve officers' interactions with people with mental illnesses and substance use disorders. (Bahora et al 2008)

[1] Canada, K. Angell, B & Watson, AC (2010). Crisis Intervention Teams in Chicago: Success on the ground. Journal of Police Crisis Negotiations. 10 (1-2) 86-100.

CIT in the Chicago Police Department

- General Orders: http://directives.chicagopolice.org/lt2015/data/a7a57bf0-12d103eb-84112-d103-f262f51c26634e29.html
- Basic CIT began in 2004. Advanced CIT training programs specifically for juvenile and veteran populations began in 2010. These are the first such advanced training programs in the nation. As an evidence-informed practice, CPD CIT has become the most widely recognized and adopted best practice model of specialized police response in the nation.
- Training is conducted in partnership with NAMI Chicago.
- Approximately 15 basic trainings per year and 4 advanced trainings. Cost per training is $8-10K.
- Approximately 35 officers per training.
- About 500 officers will become CIT certified each year, in addition, 150 will get advanced training in youth or veteran populations- approximately 6% of the total force.
- To date, Chicago has trained over 2,200 officers, approximately 1800 of which are active CDP members. This is approximately 15% of officers.
    - Data is not public, attrition and disbursement (district, leadership) is not known
- According to CPD data and Congressional Testimony, Chicago police responded to over 2.2 million calls for service in 2012, and a significant but underreported percentage of those calls for service (CPD CIT staff believe that the below reported "Z-coded" calls for service are but a fraction of the calls for service that should be so coded) are documented as involving individuals with histories of mental illness and/or who are experiencing current mental health or co-occurring mental health or substance abuse symptoms.
    - From 2010-2012, just over 25% of these 911 "Z-coded" calls (those over a three-year period were handled by CIT trained personnel.
    - **Approximately 56.5% (2,992) of the 5,392 CIT-trained responses in 2010 resulted in non-criminal diversions to hospital intake facilities and mental health evaluations**.
- CIT is funded by the State via the Training and Standards Board. $500K per year for the entire state.

Expert Resources

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*The Kennedy Forum developed this brief in partnership with NAMI-Chicago, Amy Watson at UIC, and Thresholds.

CHICAGO POLICE DEPARTMENT
CRISIS INTERVENTION TEAM

BASIC TRAINING MATRIX

<table>
<tr><th></th><th>Monday</th><th>Tuesday</th><th>Wednesday</th><th>Thursday</th><th>Friday</th></tr>
<tr><td>0745 - 0800</td><td>Roll Call</td><td>Roll Call</td><td>Roll Call</td><td>Roll Call</td><td>Roll Call</td></tr>
<tr><td>0800 - 0850</td><td>Introduction, History & Overview</td><td rowspan="4">Risk Assessment & Crisis Intervention Skills</td><td>Geriatric Issues</td><td rowspan="4">Community Resource Panel/ Mental Health Court Project</td><td rowspan="4">Crisis Intervention Role Play & Virtual Hallucinations Machine</td></tr>
<tr><td>0900 – 0950</td><td rowspan="3">Mental Illness: Signs & Symptoms</td><td>Developmental Disabilities</td></tr>
<tr><td>1000 – 1050</td><td rowspan="2">Child & Adolescent Disorders</td></tr>
<tr><td>1100 – 1150</td><td>Luncheon</td></tr>
<tr><td>1200 – 1300</td><td>Lunch</td><td>Lunch</td><td>Lunch</td><td rowspan="4">Crisis Intervention Role Play & Hearing Voices Simulation Exercise</td><td>Lunch</td></tr>
<tr><td>1300 – 1350</td><td>Psychotropic Medications</td><td rowspan="3">Family Perspectives & Consumer Panel</td><td>Department Procedures</td><td>Summary & Evaluation</td></tr>
<tr><td>1400 – 1450</td><td rowspan="2">Substance Abuse & Co-Occurring Disorders</td><td rowspan="2">Legal Issues</td><td>Written Examination</td></tr>
<tr><td>1500 - 1550</td><td>Superintendent’s Ceremony</td></tr>
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