MIDD ES Briefing Paper

ES 10a Crisis Intervention Training – First Responders

Existing MIDD Program/Strategy Review √ MIDD I Strategy Number 10a (Attach MIDD I pages)
New Concept □ (Attach New Concept Form)
Type of category: Existing Program/Strategy NO CHANGE

SUMMARY: Crisis Intervention Training (CIT) is a model of police-based crisis intervention with community behavioral health care and advocacy partnerships. CIT provides intensive training to law enforcement and other first responders that teaches them to effectively assist and respond to individuals with mental illness or substance use disorders, and better equips them to help individuals access the most appropriate and least restrictive services while preserving public safety.

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Name	Role	Organization
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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

Crisis Intervention Training (CIT) is a model of police-based crisis intervention with community behavioral health care and advocacy partnerships. CIT provides intensive training to law enforcement and other first responders that teaches them to effectively assist and respond to individuals with mental illness or substance use disorders, and better equips them to help individuals access the most appropriate and least restrictive services while preserving public safety. The goals for CIT are to increase safety for first responders, individuals, and the community; increase options and tools when responding

to individuals in crisis; and encourage and increase the use of community resources resulting in decreased jail bookings and hospital emergency department admissions.

The nature of the interactions between first responders and people with mental illnesses is varied. While responses to some calls for service (i.e., those requiring medical assistance or involving criminal activity) are well-defined, others are less clear and may require the application of problem-solving skills to handle the immediate situation or assist the individual and his or her family in identifying and obtaining solutions and appropriate support services.

The King County CIT model, provided under contract with the Washington State Criminal Justice Training Commission (WSCJTC), addresses the complexity of mental health and substance use issues, and the critical nature of the first responder role in assisting individuals with behavioral health disorders (which includes mental illness, substance abuse, etc.). No single model or procedure can address all the situations in which law enforcement and other first responders may be required to provide assistance to a person who has a behavioral health disorder and his or her family. Criminal justice or first responder personnel are provided with a basic overview of mental health and substance use disorders, as well as tools for more effectively managing the most common types of interactions they encounter with people who are affected by these disorders.

Variability in populations, resources, and staffing are additional considerations that need to be taken into account when developing training programs. Providing opportunities for specialized trainings that meet these varying needs of the multiple agencies working with King County is a component of the King County CIT program that continues to expand and grow. CIT trained first responders in King County understand that they must assume different roles in their encounters with those who have a behavioral health disorder. As first responders, CIT police officers may provide immediate aid. As law enforcers, these officers encounter suspects, victims, or witnesses who may have behavioral health problems. As service personnel, they may assist people in obtaining appropriate medical attention or other needed services. Helping people with behavioral health disorders and their families to obtain the services of other appropriate agencies, organizations, hospitals, clinics, and shelter care facilities is an important component of the CIT mission.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☐ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

This primarily fits under the Crisis Diversion strategy area, as it is an intervention primarily focused on increasing the understanding and use of community-based resources to help reduce the reliance on and use of jail and hospitals. The initial strategy goals were to increase diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement, and to reduce the number of people with mental health and substance use disorders using costly interventions such as jail, emergency rooms, and hospitals. It also fits under System Improvements, as it provides law enforcement and other first responders with increased opportunities, resources, and skills to intervene with individuals living with behavioral health disorders in ways that promote access to services and supports. It is also arguable that CIT Training is also an Early Intervention Program. Often law enforcement officers are the first to know that an individual's mental status is deteriorating and are able

to engage in early intervention to forestall or reduce further complications and/or the need for further crisis response.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

In police departments of cities in the United States (U.S.) with populations greater than 100,000, approximately seven percent of all police contacts, both investigations and complaints, involve a person believed to have a mental illness.[1] It is a major challenge for police and other first responders to maintain the safety of everyone involved in these situations while also resolving the situation so they can move on to other calls and duties. CIT equips law enforcement and other first responders with the training needed to enable them to respond effectively to individuals in crisis and to help these individuals access the most appropriate and least restrictive services while preserving public safety.

On May 15, 2015 the Seattle Police Department (SPD) implemented a data collection template, called the crisis template, to gather information about interactions between officers and subjects in crisis. The goals of the crisis template were to: 1) help the department better understand the nature of the crisis events that officers respond to; 2) help assess deployment levels; 3) ascertain the proportion of incidents involving the use of force during crisis events, and; 4) document the community resources officers are utilizing to match persons in crisis with needed behavioral health resources. During the initial three months after the crisis template was launched, officers responded to 2,464 crisis calls – a rate trending towards 10,000 crisis calls annually.[2] The numbers for SPD alone indicate a need for this specialized training and – taking the 38 other municipalities and additional law enforcement agencies (King County Sheriff's Office, U.S. Marshall Service, Washington State Department of Corrections, Washington State Patrol, etc.) operating within King County into consideration – increases the expectations regarding anticipated crisis response by law enforcement.

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

This Existing MIDD Strategy addresses the need outlined above by providing access to training and resources for law enforcement and other first responders on recognizing signs and symptoms related to mental health and substance use disorders and responding with appropriate de-escalation tactics that keep officers and individuals safe, as well as community-based resources that can help the individual obtain the services and supports they need to remain in the community.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide**

[1] Deane, Martha; Steadman, Henry J; Borum, Randy; Veysey, Bonita; Morrissey, Joseph P. "Emerging Partnerships Between Mental Health and Law Enforcement." *Psychiatric Services* Vol. 50, No. 1 January 1999: pp.99-101

[2] Seattle Police Department Crisis Intervention Program Quarterly Update; May 15, 2015 – August 15, 2015

evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

Research has shown CIT to be effective in improving community response to individuals with mental health and/or substance use disorders, increasing the use of jail diversion options and reducing the number of individuals with mental illness going to jail, and reducing police officer injury rates.[3] Studies have also shown that partnerships between law enforcement, mental health providers, and individuals with behavioral health disorders and their family members, can help those experiencing a behavioral health crisis gain access to treatment services.[4] Another study has shown that CIT training has increased police officers' knowledge about mental illness, and improved perception and attitudes towards individuals with mental health disorders.[5] There have been many studies on the impact of CIT training, detailing impacts and evidence of addressing the following:

- Officers are more confident of their de-escalation skills as a result of CIT Training.[6]
- CIT Training changes officers' attitudes – attitudes that reflect decreased stigma towards individuals with serious mental illness such as schizophrenia.[7]
- CIT Programs increase department's involvement in responding to behavioral crisis events.[8]
- CIT Programs improve law enforcement response times to crisis events.[9]
- CIT may decrease the need for higher level interventions such as that of the SWAT team.[10]
- CIT officers have lower arrest rates of individuals with mental illness than non-CIT Officers[11]
- CIT Training appears to have a positive impact on the use of force. While lower levels of use of force are similar to non-CIT officers, the use of higher levels of force is less prevalent among CIT officers.[12]
- CIT Programs report very low arrest rates of individuals with mental illness, generally around two to four percent. Estimates of national arrest rates are in the range of 20 percent.[13]
- CIT programs increase the rate of referrals to health and social service care, with increases ranging from 20 percent to 90 percent. Analysis of the characteristics and dispositions of individuals referred by CIT officers indicate a strong similarity to groups referred to health and social services by other referral sources including mental health professionals. These studies

[3] Reuland, Melissa and Cheney, Jason. Enhancing Success of Police-Based Diversion Programs for People with Mental Illness. Police Executive Research Forum. May 2005

[4] Jennifer L. S. Teller, Ph.D., Mark R. Munetz, M.D., Karen M. Gil, Ph.D., Christian Ritter, Ph.D. Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls. Psychiatric Services Volume 57, Issue 2, February 2006, pp. 232-237.

[5] Ellis, Horace A. Effects of a Crisis Intervention Team (CIT) Training Program Upon Police Officers Before and After Crisis Intervention Team Training. Archives of Psychiatric Nursing Volume 28, Issue 1, February 2014, Pages 10-16.

[6] Borum R, Deane M, Steadman H, *et al*: Police perspectives on responding to mentally ill people in crisis: perceptions of program effectiveness. Behav Sci Law 16:393-405, 1998

[7] Compton MT, Esterberg ML, McGee R, *et al* : Crisis Intervention Team training : changes in knowledge, attitudes, and stigma related to schizophrenia. Psychiatr Serv 57:1199-1201, 2006

[8] Dupont RT, Cochran CS: Police response to mental health emergencies – barriers to change. J Am Acad Psychiatry Law 28:228-44, 2000 Teller JL, Munetz MR, Gil KM, *et al*: Crisis Intervention Team training for police officers responding to mental disturbance calls. Psychiatr Serv 57:232-7, 2006

[9] Steadman JH, Dean MW, Borum R, *et al*: Comparing outcomes for major models of police responses to mental health emergencies. Psychiatr Serv 51:645-9, 2000

[10] Dupont RT, Cochran CS: Police response to mental health emergencies – barriers to change. J Am Acad Psychiatry Law 28:228-44, 2000. Bower, DL, Pettit WG: The Albuquerque Police Department's Crisis Intervention Team report card, FBI Law Enforcement Bulletin 70:1-9, 2001

[11] Compton MT, Bakeman R, Broussard B, Hankerson-Dyson D, Husbands L, Krishan S, et al. (2014). The police-based crisis intervention team (CIT) model: II. effects on level of force and resolution, referral, and arrest. Psychiatric Services 523-529.

[12] Compton MT, Bakeman R, Broussard B, Hankerson-Dyson D, Husbands L, Krishan S, et al. (2014) The police-based crisis intervention team (CIT) model: I. effects on officers' knowledge attitudes and skills. Psychiatric Services 517-522.

[13] Steadman JH, Dean MW, Borum R, *et al*: Comparing outcomes for major models of police responses to mental health emergencies. Psychiatr Serv 51:645-9, 2000. Straus G, Glenn, M, Reddi P, *et al*: Psychiatric disposition of patients brought in by Crisis Intervention Team officers. Community Mental Health Journal 41:223-8, 2005. Teller JL, Munetz MR, Gil KM, *et al*: Crisis Intervention Team training for police officers responding to mental disturbance calls. Psychiatr Serv 57:232-7, 2006. Sheridan E, Teplin L: Police-referred psychiatric emergencies: advantages of community treatment. J Community Psychol 9:140-7, 1981. Borum R, Swanson J, Swartz M, *et al*: Substance abuse, violent behavior and police encounters among people with severe mental disorders. J Comtemp Crim Just 12:236-50, 1998.

suggest CIT officers are making greater use of referrals to healthcare and social service resources while making appropriate decisions about the need for psychiatric care.[14]

- Individuals with serious mental illness diverted by CIT Officers to healthcare have improved continuity of care, improved mental status, and lower rates of re-arrest than a similar group of individuals booked into jail by non-CIT officers.[15]

SPD representatives recently presented data obtained from the newly instituted crisis template (described in B1) to track interventions between SPD officers and individuals in crisis, after all department personnel attended at least one CIT training or internal forum during the 2014 calendar year. A preliminary analysis of the 2,464 crisis contacts from the first three months of data collection (May 15, 2015 to August 15, 2015) shows that SPD officers used force minimally, with less than one half of one percent of crisis contacts resulting in an intermediate use of force. Fewer than two percent of crisis contacts resulted in any use of force at all, with the most common use of force being a control hold. No comparison data are available. CIT certified officers (who undergo 40 hours of crisis intervention training) responded to 82 percent of these crisis calls. An additional 14 percent of crisis contacts were effectively handled by non-CIT certified officers (all of whom receive a day of basic crisis intervention training annually) in the field without need of more specialized certified officers. Finally, in the first three months since deployment of the crisis template, officers made 1,594 referrals to community services, such as the Geriatric Regional Assessment Team (GRAT), shelter facilities, case managers and/or treatment services, the Crisis Clinic, and the Mobile Crisis Team (MCT), as well as referrals for voluntary or involuntary hospital commitments (1,044). These data indicate attempts to address the needs of individuals in crisis outside of the criminal justice and hospital systems.[16]

Research from the Seattle University Department of Criminal Justice focused on evaluating the impact of curriculum changes at the WSCJTC (including the CIT program), and officer attitudes and knowledge on two separate groups: Basic Law Enforcement Academy (BLEA) cadets and CIT trained officers, as compared to a comparison group. According to the study, findings show clear training effects upon completion of both BLEA and CIT with respect to support for CIT, identification of the condition of individuals in behavioral health crisis, interactions, and case disposition involving individuals in behavioral crisis.[17]

Since program inception in 2010, the CIT program in King County has trained personnel from all law enforcement agencies operating in King County, with the exception of the Washington Department of Fish & Wildlife that has yet to send their officers to CIT training. Participants have also included mental health practitioners, Community Service Officers, corrections staff, paramedics and other fire department staff, university/college students and security officers, private security companies, telecommunication staff, prosecutors, court staff, advocacy groups, parks and recreation staff, and many other organizations from within King County and across the U.S.

[14] Straus G, Glenn, M, Reddi P, *et al* (2005) Psychiatric disposition of patients brought in by Crisis Intervention Team officers; Community Mental Health Journal 41:223-8. Teller JL, Munetz MR, Gil KM, *et al* (2006) Crisis Intervention Team training for police officers responding to mental disturbance calls; Psychiatr Serv 57:232-7. Dupont RT, Cochran CS (2000) Police response to mental health emergencies – barriers to change; J Am Acad Psychiatry Law 28:228-44.

[15] Dupont RT: (2002) Final Report: Criminal Justice Diversion Project. Rockwell, Md, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[16] Seattle Police Department Crisis Intervention Program Quarterly Update May 15, 2015 – August 15, 2015; Prepared by the Data Driven Policing Unit / Compliance Section

[17] Evaluation of the Washington State Criminal Justice Training Commission's "Warriors to Guardians" Cultural Shift and Crisis Intervention Team (CIT) Training, Final Report June 30, 2015; Seattle University Department of Criminal Justice

Agency/City/ Division	40-HR Basic Attendees	8-HR In-Service Attendees	Other CIT Attendees*	Attendance Total
Number of Total Participants Trained October 2010-June 2015	**1171**	**1980**	**215**	**4131**
King County Sheriff's Office Total Count October 2010-June 2015	270	231	218	719
Seattle Police Department Total Count October 2010-June 2015	356	841	1260	1260

*Other CIT Course offerings include CIT-Force Options, CIT-Youth, Mental Health First Aid, Justice-Based Policing, Blue Courage, CIT-Train the Trainer courses (Dispatch, Youth, MH First Aid, and Corrections), and CIT Executive Roundtables (2010-2012).

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Best Practice . Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

CIT programs were described at the first White House Conference on Mental Health in 1999 as a best practice. Additionally, CIT was featured in the SAMHSA News and the BJA Practitioner Newsletter in 2000, as well as many other publications including:

- American Association of Suicidology (1997)
- National Association of People of Color Against Suicide (1999)
- Amnesty International (1999) Race, Rights and Police Brutality
- White House Conference on Mental Health (1999)
- Department of Justice (2000)
- Department of Health and Human Service SAMHSA (2000)
- CUNY, John Jay College of Criminal Justice Law Enforcement News (2000)

Often the term "Best Practice" was used in those articles. The outcome research for CIT is among the best for a nationwide applied program. However, one new standard that is being used is an outcome experiment with true double blind random assignment. This would be impossible under any applied program. Even the FBI negotiator training is not subject to such a standard.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

The Existing MIDD Strategy outcomes expected are:

- Reduced emergency department utilization
- Reduced incarcerations
- Improved linkages to treatment
- Increased skills related to crisis de-escalation/intervention
- Increased knowledge of, and improved perceptions regarding individuals with, behavioral health disorders

The King County CIT program at the WSCJTC utilizes pre- and post-tests to identify skills learned, as well as post-program evaluations to assess participant's perceptions of, and information gained during, the training. Data sources include: SPD's crisis template data on crisis contacts and outcomes/dispositions; internal data that MCHADSD collects on treatment admissions; booking and length of stay data already available to MHCADSD from municipal and county jails within King County, and state prisons; and data available through negotiated agreement with the state Emergency Department Information Exchange.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☐ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☐	☐ **First Nations/American Indian/Native American**
☐ **Adults**	☐ **Immigrant/Refugee**
☐ **Older Adults**	☐ **Veteran/US Military**
☐ **Families**	☐ **Homeless**
☒ **Anyone**	☐ **GLBT**
☐ **Offenders/Ex-offenders/Justice-involved**	☐ **Women**

☒ **Other – Please Specify:** Individuals in behavioral health crisis coming to the attention of first responders.

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

Law enforcement and other first responder agencies are the front line response for individuals of all ages, genders, racial backgrounds, and sexual identity regardless of housing status, criminal justice history, military involvement, and citizenship status. Individuals with behavioral health disorders are not limited by any of these circumstances or demographics. As such, this strategy has the ability to impact individuals across all populations.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

As noted above, the CIT program in King County has trained personnel from all law enforcement agencies in King County as well as mental health practitioners, Community Service Officers, corrections staff, fire departments, university/college students and security officers, private security companies, telecommunication staff, prosecutors, court staff, advocacy groups, parks and recreation staff, and many other organizations from within King County, the state of Washington, and across the U.S.

The WSCJTC primarily conducts training at their facility in Burien, WA; however, they have also provided off-site training upon request at locations more accessible to local agencies within King County. In addition, the King County Sheriff's Office (KCSO) Sergeant, funded by the MIDD, participates in local community meetings and trainings, and provides trainings relevant to the CIT program and law enforcement as requested by associated stakeholders, to assist with relationship and collaboration building efforts across multiple systems and community partners.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities,**

law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.

Collaborations are essential to the King County CIT program. The WSCJTC coordinates and contracts with many local resources to provide trainings on specific programs and services accessible to law enforcement and other first responders. Local trainers come from a variety of agencies including: the Washington State Department of Veteran's Affairs, Sound Mental Health, Seattle YMCA, the National Alliance on Mental Illness (NAMI) Eastside and Greater Seattle chapters, local law enforcement agencies, King County MHCADSD, King County Regional Mental Health Court, Downtown Emergency Services Center (DESC), Evergreen Healthcare, the Arc of Washington, Edgeworks: Crisis Intervention Resources, the Crisis Clinic, Rainier School, and other divisions of the WSCJTC Academy. The continuation of partnership with the KCSO that allows for an assigned KCSO Sergeant to oversee the law enforcement focus of the King County CIT program is necessary to ensure that common law enforcement interactions and available techniques for responding are built into, and maintained throughout, the curriculum. Partners needed for an ongoing, successful training program include the King County NAMI affiliates, all law enforcement agencies in King County, the SPD Crisis Intervention Committee, tribal police, service providers, jails, and other first responder agencies.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

In April, 2015, the State Legislature passed SSB 5311, known as the Douglas M. Ostling Act, establishing requirements for Crisis Intervention Training for all peace officers in Washington State. The legislation funded an eight-hour in-service training for all law enforcement officers in the State, which increases access to basic information on behavioral health, but not the full range of resources and skills available through the 40-hour class. Staffing ratios for law enforcement agencies may impact their ability to send individuals to the training while maintaining minimum staffing levels. In addition, the bill requires two hours of refresher training each year beginning in 2017.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

There are limited barriers to implementation, as this program has been operational for the past five years. Ongoing relationships with local presenters is crucial to maintain an effective program, however, there is also the need to have back-up trainer options to address availability and scheduling conflicts that may arise. The WSCJTC CIT coordinator and KCSO Sergeant will need to provide for ongoing instructor development and feedback opportunities to ensure that the right message is getting to the trainees; and, if needed, to find alternative trainers who are able to provide the level of training necessary to meet the audience's needs and respond to individuals in the community with mental health and/or substance use disorders.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

The program is already implemented; however, if CIT trained police officers respond and subsequently refer individuals to social service/health care services, then these receiving facilities may have an increase in referrals. Wait times could potentially increase if there is inadequate capacity for the existing need for care.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

Individuals with behavioral health disorders will continue to utilize costly resources such as emergency departments and jails due to the symptoms of their disorder(s). Law enforcement and other first responders would have limited access to more intensive and focused training regarding this population, resources to assist in the field, and skills to continue to reduce instances of use of force and utilization of jail and hospital settings. An important benefit of the King County CIT program is its flexibility to add course options that address specific needs noted by local first responders in their communities, and help focus training topics related to those needs. Other areas that can support some of the basic CIT course offerings do not provide support for these more specialized courses and, as such, would limit ongoing training and advanced training opportunities to support the officers on the street. Additionally, statewide funding only exists for the basic de-escalation components of the training, and does not address local resources or focus on collaboration with consumers, advocates, and providers.

There continues to be focus every day in local and national news on the number of individuals in jails and prisons with mental health and/or substance use disorders, and how law enforcement is engaging with these individuals, especially surrounding use of force. Without training that provides the knowledge and skills necessary to change the way in which they have learned to respond when dealing with individuals with behavioral health disorders, or that enhances officers' alternative options for addressing these needs appropriately, there will continue to be an over-reliance on jails to manage this population and more use-of-force scenarios when responding to them.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

The new SSB 5311 requires an eight hour in-service across all law enforcement agencies in Washington state, a two hour refresher training annually (the refresher trainings are online courses), and encourages 40 hours of training and certification for 25 percent of all patrol officers. However, the bill did not provide funding for the 40 hour class, or any additional or advanced trainings. The King County CIT program does provide funding to support these additional and advanced trainings, including backfill and overtime, for law enforcement. In addition, the King County CIT program also provides backfill and overtime for all CIT classes for fire department/Emergency Medical Services (EMS) and corrections/jail staff. Stakeholders and providers are also welcome to attend these classes as space is available. The state funding will coordinate with the current King County CIT program, and will take some of the financial responsibility for the blocks that match the training requirements from SSB 5311; however, with the addition in 2015 of backfill and overtime reimbursement for Fire/EMS and corrections/jail staff, the funding to support these costs, as well as instructors, facility, and programmatic support, is still needed.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

When the King County CIT program was initially identified as a strategy under the MIDD, it was done in line with the Sequential Intercept Model, understanding that the earlier individuals can be intervened with in their own communities, the more likely they are to stay out of the criminal justice system and get the on-going help they need. This is an initial step in the continuum of care, intended to support and promote access to services, with appropriate knowledge regarding resources in place to facilitate this access. An understanding that recovery can take time and that continued efforts on the part of first responders and service providers is needed to support the recovery process.

The program was intended to specifically link with other Council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan, and the Recovery Plan for Mental Health Services. Additionally, Behavioral Health Integration will link to this effort, especially given the high levels of co-occurring disorders in the population served, which will allow for more integrated and, hopefully, streamlined access to services.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

The de-escalation presentations are expanding to include interactive discussions with first responders that determine their main concerns of difficulties regarding specific populations to discuss appropriate and available intervention techniques. Ensuring a focus on the types of day-to-day interactions that law enforcement attends to during their shift allows opportunities to strategize, discuss and role play interventions. Additionally, these trainings reinforce experience and relationships; the first responder, mental health provider, and the individual in crisis are viewed as partners in de-escalating the crisis. The focus is on identifying how to determine the best way to collaborate when approaching individuals in crisis when both first responders and mental health workers are present. The training consists of peer facilitated presentations and small group discussions to help officers understand the perspective of individuals they engage in the community who have behavioral health needs, and show officers that individuals have much to offer and are so much more than their crises. This type of approach is more trauma-informed than historical approaches to law enforcement and behavioral health crisis management.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

CIT is focused on reducing the criminalization of behavioral health disorders. The King County CIT program incorporates peers, consumers and community advocates/service providers in the implementation of training. CIT training often has a strong diversity component with critical concepts of diversity embedded in the ongoing training. That is one reason why the National Association of People of Color Against Suicide gave CIT training their national award in 1999.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

All the resources to provide the training are currently available. Ongoing funding is needed to support technology and evaluation activities, as well as curriculum development for advanced CIT course offerings and quality improvement activities of current programs.

2. **Estimated ANNUAL COST: $501,000-$1.5 million. Provide unit or other specific costs if known.**

Costs include: backfill and overtime reimbursement for law enforcement, Fire/EMS, and jail/corrections staff; WSCJTC staff/program support salaries; instructor training opportunities; facility costs; and additional miscellaneous training administration costs.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

SSB 5311 may cover a small portion of the work of the King County CIT program, but will not cover all aspects of the program.

4. **TIME to implementation: Currently underway**
   a. **What are the factors in the time to implementation assessment?** No factors in implementation as this is an ongoing strategy and can continue without interruption.

   b. **What are the steps needed for implementation?** No steps needed for implementation, only continued quality improvement activities to support the training needs of first responders and ensure collaboration with community partners, consumers, and advocates.

   c. **Does this need an RFP?** No.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

King County

Mental Illness and Drug Dependency Action Plan

MIDD Implementation Plan REVISED – January 28, 2010

Title: Pre-Booking Diversion Programs

Strategy No: 10a – Crisis Intervention Training Program for King County Sheriff, Police, Jail Staff and Other First Responders

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

In the police departments of cities in the United States with populations greater than 100,000, approximately 7% of all police contacts, both investigations and complaints, involve a person believed to have a mental illness.[18] It is a major challenge for police and other first responders to maintain the safety of everyone involved in these situations while also resolving the situation so they can move on to other calls and duties. Crisis Intervention Training (CIT) equips police and other first responders with the training needed to enable them to respond most effectively to individuals in crisis and to help these individuals access the most appropriate and least restrictive services while preserving public safety. The Seattle Police Department has had a successful, nationally recognized CIT program for a number of years, but this training has not been readily available to the other 25 police jurisdictions or to other first responders in King County.

◊ *B. Reason for Inclusion of the Strategy*

Research has shown CIT to be effective in improving community response to individuals with mental illness and chemical dependency, increasing the use of jail diversion options and reducing the number of people with mental illness going to jail, and reducing police officer injury rates.[19]

◊ *C. Service Components/Design*

Provide 40-hour CIT training to police officers in any jurisdiction in King County who request full training. Provide one-day training for other officers and to other first responders.

◊ *D. Target Population*

Police officers (including officers working in public schools), firefighters, emergency medical technicians, ambulance drivers, and jail staff throughout King County. When space is available, other interested stakeholders who would benefit from the training, such as prosecuting attorneys and public defenders, may also be invited to participate.

◊ *E. Program Goal*

Increase the knowledge base and skill set of police and other emergency workers in responding to calls involving individuals who may be affected by mental illness and/or chemical dependency.

◊ *F. Outputs/Outcomes*

[18] Deane, Martha; Steadman, Henry J; Borum, Randy; Veysey, Bonita; Morrissey, Joseph P. "Emerging Partnerships Between Mental Health and Law Enforcement." *Psychiatric Services* Vol. 50, No. 1 January 1999: pp.99-101

[19] Reuland. Melissa and Cheney, Jason. Enhancing Success of Police-Based Diversion Programs for People with Mental Illness. Police Executive Research Forum. May 2005

Provide full CIT to 480 police and other first responders per year and a brief, one day training to another 1,200 first responders per year.

Training will result in increased safety for first responders and individuals in crisis and also increase the use of community resources resulting in decreased jail bookings and hospital emergency department admissions.

2. Funding Resources Needed and Spending Plan

The project needs $1.5 million per year to implement CIT throughout King County.

The spending plan is as follows:

Dates	Activity	Funding
January 2010	Contract with the WSCJTC for 2.0 FTE and CIT 40 hour and 8 hour trainings	**$948,000**
February 2010 April 2010	Finalize training plan and schedule CIT begin	
	Total Funds 2010	**$948,000***
	*2010 and beyond funding reduced due to supplantation	
Ongoing Annual	**Total Funds**	**$1,500,000**

CIT costs are estimated at $60,000 for per 40-hour training and $12,000 per 8-hour training.

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and Type of Providers (and where possible FTE capacity added via this strategy)*

~~This strategy involves a single provider, the KSCO who will hire a 1.0 FTE Educator/Consultant II or III who will manage the program and a 1.0 FTE Administrative Specialist II who will provide administrative support. The KCSO will secure specialized training instructors as needed on a fee-for-service basis.~~
KCSO in partnership with KC MHCADSD will contract with the Washington State Criminal Justice Training Commission (WSCJTC) to implement the CIT, hire the 1.0 FTE Police Educator (hired through a local law enforcement agency at police sergeant level) and a 1.0 FTE Administrative/Fiscal Specialist will provide administrative and fiscal support.

WSCJTC is uniquely qualified for these contracted services due to their extensive experience in providing CIT for law enforcement agencies in King County and throughout the State of Washington. Every law enforcement agency in the State of Washington works with the WSCJTC for basic training of their recruits. In addition, law enforcement, corrections, probation, community corrections, and other agencies send staff to the WSCJTC for other mandatory and voluntary training as needed. The primary WSCJTC staff persons to be

involved in this project, are Steve Lettic, Division Manager, Development, Training, and Standards Division, and Bob Graham, Regional Training Manager, Central Sound Region (King and Kitsap Counties).

◊ *B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)*

~~The KCSO has identified appropriate job classifications and can begin the hiring process as soon as funding is allocated.~~

~~Sept – Dec 2008 – KCSO hires trained Educator/Consultant and Administrative Specialist staff. Specialized instructors are identified and secured as needed.~~
KCSO in partnership with KC MHCADSD and WSCJTC will develop a staff development plan, training plan and timeline during the first quarter of 2010.

◊ *C. Partnership/Linkages*

King County MHCADSD will need to continue to maintain a significant partnership with the KCSO, which will be responsible for managing the crisis intervention training program for police officers and other first responders in King County. Other partners needed for a successful training program include the King County NAMI affiliates, all 26 law enforcement agencies in King County, tribal police, service providers, jails, and other first responder agencies.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

~~KCSO staff persons recruited and hired by November 1, 2008.~~

~~Program design and training curriculum will be substantially completed by December 1, 2008.~~

~~Specialized instructors and classroom space will be secured by December 31, 2008.~~

~~First trainings will be offered in January 2009.~~
WSCJTC contract will be finalize in February 2010. Project related staff will be hired/identified in March 2010.

Program design and training curriculum will be updated by WSCJTC specific to King County.

First trainings will be offered in April 2010.

◊ *B. Procurement of Providers*

Not applicable.

◊ *C. Contracting of Services*

~~Not applicable.~~
KCSO in partnership with KC MHCADSD will contract with the Washington State Criminal Justice Training Commission (WSCJTC) to implement the CIT.

◊ *D. Services Start Date(s)*

Begin trainings in April 2010.~~January 2009~~ .

MIDD Strategy 10a – Summary of the Revisions/Update to the Strategy
January 28, 2010

The purpose of this document is to provide an update to the oversight committee on the implementation of MIDD Strategy 10a – Crisis Intervention Training Program for King County Sheriff, Police, Jail Staff and Other First Responders. This strategy was included as a means provide divert adults with mental illness and chemical dependency from initial or further involvement with justice system, emergency rooms and hospitals.

The King County Sheriff's Office (KCSO) in partnership with the Mental Health Chemical Abuse and Dependency Services Division (MHCADSD) will contract with the Washington State Criminal Justice Training Commission (WSCJTC) to implement the Crisis Intervention Training program, which includes hiring the 1.0 FTE Police Educator (hired through a local law enforcement agency at police sergeant level) and a 1.0 FTE Administrative/Fiscal Specialist who will provide administrative and fiscal support.

WSCJTC is uniquely qualified for these contracted services due to their extensive experience in providing CIT for law enforcement agencies in King County and throughout the State of Washington. Every law enforcement agency in the State of Washington works with the WSCJTC for basic training of their recruits. In addition, law enforcement, corrections, probation, community corrections, and other agencies send staff to the WSCJTC for other mandatory and voluntary training as needed. The primary WSCJTC staff persons to be involved in this project, are Steve Lettic, Division Manager, Development, Training, and Standards Division, and Bob Graham, Regional Training Manager, Central Sound Region (King and Kitsap Counties).

KCSO in partnership with MHCADSD and WSCJTC will develop a staff development plan, training plan and timeline during the first quarter of 2010. The contract with WSCJTC will be finalize in February 2010. Project related staff will be hired/identified in March 2010.

Program design and training curriculum will be updated by WSCJTC specific to King County.

CIT costs are estimated at $60,000 for per 40-hour training and $12,000 per 8-hour training.

First trainings will be offered in April 2010.