Crisis Intervention Team (CIT)

Methods for Using Data to Inform Practice: A Step-by-Step Guide

SAMHSA
Substance Abuse and Mental Health Services Administration

Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under SAMHSA IDIQ Prime Contract #HHSS283200700029I/Task Order HHSS2834002T with SAMHSA, U.S. Department of Health and Human Services (HHS). Stacey Lee served as the Government Contracting Officer Representative.

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Recommended Citation

Substance Abuse and Mental Health Services Administration, Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide. HHS Pub. No. SMA-18-5065. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2018.

Electronic Access and Copies of Publication

This publication may be downloaded at http://store.samhsa.gov/ or by calling SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Originating Office

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, HHS Publication No. SMA-18-5065. Printed in 2018.

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I. Introduction

Background

The Crisis Intervention Team (CIT) program has become a globally recognized model for safely and effectively assisting people with mental and substance use disorders who experience crises in the community. The CIT Model promotes strong community partnerships among law enforcement, behavioral health providers, people with mental and substance use disorders, along with their families and others. While law enforcement agencies have a central role in program development and ongoing operations, a continuum of crisis services available to citizens prior to police involvement is part of the model. These other community services (e.g., mobile crisis teams, crisis phone lines) are essential for avoiding criminal justice system involvement for those with behavioral health challenges – a goal of CIT programs (Steadman & Morrissette, 2016). CIT is just one part of a robust continuum of behavioral health services for the whole community.

CIT Core Elements

Ongoing Elements

1. Partnerships
2. Community Ownership
3. Policies & Procedures

Operational Elements

1. CIT: Officer, Dispatcher, Coordinator
2. Curriculum: CIT Training
3. Mental Health Receiving Facility

Sustaining Elements

1. Evaluation & Research
2. In-Service Training
3. Recognition & Honors
4. Outreach

Figure 1. CIT Core Elements

The need for CIT programs is urgent and ever apparent, as communities are challenged with insufficient mental health funding and services, years after the de-institutionalization of people from state psychiatric hospitals. These communities now rely heavily on law enforcement officers to provide assistance to people in crisis. As a result, people with mental illnesses are more likely than the general public to experience arrest and to be injured or killed during encounters with law enforcement. The arrest rate for recipients of public mental health services is estimated to be 4.5 times that of the general public (Fisher et al., 2011). While national data on police involved shootings is not systematically tracked, recent reports by the Washington Post (Lowery et al., 2015) and the Treatment Advocacy Center (Fuller et al., 2015) estimate that at least one in four people fatally shot by police in the United States had a serious mental illness.

The first CIT program was established in Memphis, Tenn., in 1988. The model created there has proven to be replicable across jurisdictions and there is growing research evidence supporting its effectiveness (Compton et al., 2014a; Compton et al., 2014b; Watson & Fulambarker, 2012; Watson, Morabito, Draine, & Ottati, 2008.). The "Memphis Model," as it is often referred to, is considered the "gold standard" for effective CIT programming and can be considered evidence-based for improving several important outcomes (Watson, Compton & Draine, 2017). Based on

this model, the *Crisis Intervention Team Core Elements* report was created as a guiding document for programs in setting up and sustaining effective programming (Dupont, Cochran, & Pillsbury, 2007). The recommended processes for data collection and analysis provided in the following sections are intended to complement the *CIT Core Elements* and provide support as programs strive to develop the CIT program that works best for their community.[1]

The *CIT Core Elements* are divided into three sections: Ongoing Elements, Operational Elements, and Sustaining Elements (see Figure 1). "Evaluation and Research" is listed as a Sustaining Element and is a foundational component of an effective CIT program. Data collection and analysis can be challenging due to constraints with technology, personnel, time, and other issues. However, these challenges are surmountable, and when armed with the right data, many programs are better able to show their impact and solidify the role of CIT in supporting law enforcement and improving responses to people with mental and substance use disorders. The Ongoing, Operational, and Sustaining Elements of the CIT Model all offer meaningful data points and measures for CIT programs to consider tracking to help them meet their short- and long-term outcomes goals.

Data Collection and Program Measurement: Making the Most of Your Program Investment

While the Core Element of Evaluation and Research is often challenging for local CIT programs, it provides tremendous support to the other Core Elements of effective CIT programming:

- *Document program activities:* Collecting data to document program activities is important to understanding if the CIT program is being implemented as planned and can help identify gaps and problems with implementation. Additionally, as CIT program leaders examine outcomes data, having good documentation of the program will assist in understanding desired as well as unexpected outcomes and, where indicated, making program improvements. Finally, good data on program activities is necessary to accurately calculate costs of existing programs and estimating costs of program modifications or expansions.
- *Design program improvements:* Data can help program stakeholders identify and target improvements to the program design and structure to achieve better outcomes. For example, findings may highlight or emphasize areas for improvement with the Curriculum or CIT Training (Operational Element 2), within the process of identifying CIT calls and assigning them to CIT officers (Ongoing Element 3 and Operational Element 1), or in the handoff policies and procedures at local designated mental health receiving facilities (Ongoing Element 3 and Operational Element 3).

[1] The *Crisis Intervention Team Core Elements* can be accessed through the University of Memphis CIT Center at http://cit.memphis.edu/pdf/CoreElements.pdf and CIT International at www.citinternational.org.

- *Demonstrate program effectiveness:* Through meaningful data collection and analysis, CIT program leaders may better understand the program's results and outcomes. Data collected from officers participating in CIT training can demonstrate the impact on officers' knowledge, attitudes, skills, and satisfaction. Call data can be used to examine the impact of CIT on safety outcomes, such as use of force and injuries, as well as diversion and mental health service linkage outcomes. Over time, data from partner agencies can be used to examine changes in criminal justice system involvement of people with serious mental illnesses and use of non-law enforcement crisis mental health services (e.g., crisis and warm lines, mobile crisis teams, triage centers).
- *Ensure program sustainability:* Data can help build a program's identity and internal support from both executive and rank-and-file law enforcement officers by validating the program's value and successes. Data collection and analysis can help persuade existing Partnerships (Ongoing Element 1) to continue supporting CIT and increase the resources allocated to sustain the program by producing numbers and findings that underscore the collective impact of their efforts. Community Ownership (Ongoing Element 2) can also be fostered as people with mental illness, their families, and advocates better understand their role in helping achieve optimal outcomes for people with mental and substance use disorder.
- *Maximize utilization of scarce resources:* Data can help ensure that CIT programs focus their time and money on efforts that are most relevant to their communities. Anecdotal information, media hype, and other factors may draw attention to the many issues that law enforcement and partners need to address; however, once informed by data, CIT stakeholders can gain the confidence of community leadership that scarce fiscal resources and the time of CIT officers is properly invested. Data collection can also confirm to leaders that mental health is a critical issue impacting the local criminal justice system.
- *Enhance officer and other frontline partners' morale:* When CIT programs provide officers and frontline partners with information about the outcomes of CIT cases, they may have a greater sense of empowerment helping people they believe need services. Sharing the information with officers and program partners may also build support for the program.
- *Support the development of other community-based resources:* As CIT programs gather data around the interactions between people with mental and substance use disorders and CIT partners, findings can be generated to support development of other needed community-based behavioral health treatment programs and services. This will help communities develop programs or expand services that assist citizens in distress avoid contact with law enforcement and strengthen the overall continuum of behavioral health services. It also helps answer the question of what types of services are most appropriate to divert a person to.

Getting Started and Using this Report

It is important for CIT partnerships to start to expand their data collection efforts in a way that makes sense for their local program. The *CIT Core Elements* report provides an ideal starting place to identify what data to collect and analyze. Programs will first need to consider if they are currently collecting data that can be used to evaluate their program or if they will need to design new strategies to capture the data needed. The step-by-step guide in *Section II* of this report will help programs create a system to ensure they have the necessary components in place for an effective data collection and review process. Steps one through seven will walk programs through the foundational activities for identifying needed data and strategies to capture that data. These steps are based on the input, lessons learned, and successes of CIT programs across the United States.

Section III of this report provides a breakdown of recommended data points, measurements, and metrics for CIT programs to collect, broken out by three tiers:

- *Tier One*: Mission Critical Data
- *Tier Two*: Intermediate Data
- *Tier Three*: Advanced Data

This section aims to provide CIT programs across the nation with a consistent set of data descriptions and definitions to standardize the way CIT programs gather, analyze, and talk about data. By providing a uniform set of data descriptions and definitions, CIT programs may better compare their data and progress against that of other programs. The tiered approach helps organize and prioritize data collection efforts for programs that may otherwise be overwhelmed with the volume and variety of potentially useful data to collect. *Section III* should be helpful as CIT partnerships work through the step-by-step guide, particularly at Step 3: Identify Key Metrics and Step 7: Expand Program Data Collection.

II. Step-by-Step Guide: Creating a Local CIT Program Data Collection and Review Process

Step 1. Ensure the Right Partnerships are in Place

The CIT Model considers partnerships to be a Core Element in effective CIT programming. Partnership is also a critical aspect of data collection. Through these partnerships, the CIT program should articulate the features of their program and establish goals or describe the anticipated result of implementing a CIT program in their community. (See Figure 2 for potential partners.)

Foster alignment around agreed upon goals

There should be alignment among partners so data gathered and analyzed are parallel with the goals and outcomes sought by the CIT partnership. It is particularly critical within law enforcement agencies to have top leadership in agreement with the program goals and the corresponding data collection and analysis efforts. The established partnership should work to develop a vision for data collection, but as different parties involved may have different priorities and interests, compromise and planning will be necessary.

Increase data analysis in accordance with capacity

Program partners should work together to establish agreement to ensure plans for data collection are feasible and produce good quality data. As program capacity grows, data collection and analysis activities can expand.

Research Partner Opportunities

Local universities can often provide a wealth of information and resources for developing or expanding local CIT data collection.

Criminal justice, public health, social work, engineering, and information technology departments can potentially provide staffing through student and professorial support and expertise to help with:

- Developing logic models.
- Generating process flow charts.
- Creating electronic data collection templates and databases.
- Providing data analytics support.
- Supporting dissemination of CIT program information and successes.

Figure 2. Research Partners

Programs having multiple partners with the capacity to perform data-related activities are encouraged to leverage this capacity and collect and analyze data across partners. Step 7 will provide more guidance around this.

Step 2. Document Your Local CIT Program

Outline the CIT program using maps, charts, or models

Sometimes, CIT programs will begin data collection before establishing a clear connection between the data and the program's goals, objectives, or activities. In these situations, they may find they are missing important data elements and the data they have collected is not as useful as they had hoped. To avoid this, it can be extremely useful to gather partners to map out and document the program's processes. This can be done by creating process maps, flow charts, or logic models that connect the CIT activities to the eventual outcomes and goals of the CIT partnership. By writing and mapping the program processes, the data points and data sources that are most needed for collection will begin to emerge. This process will help identify data points that are necessary for documenting implementation activities as well as outcomes. Including stakeholders and partners in this process will ensure important data points and sources are not overlooked and create buy-in for the data collection process itself. This improves the likelihood that partners will work to collect and share the data needed to evaluate the program.

Figure 3 provides one example of a CIT program logic model. A logic model is a useful tool for conceptualizing a CIT program and its specific resources (inputs), activities and participants (outputs) and intended results (outcomes). Many of the items listed as inputs and outputs map onto the *CIT Core Elements*. Not only does the logic model provide a roadmap of the program components and how they are believed to work, it also identifies important elements to track and measure. While programs may not have the initial capacity to measure all elements, the logic model provides a guide to begin identifying data points that can be collected and analyzed.

INPUTS	OUTPUTS		HYPOTHESIZED OUTCOMES*		
			Short-term	Intermediate-term	Long-term
Partners: - Systems - Community - CIT coordinator - Police/agency trainers - Evaluator **Training items:** -Training space - Materials/ curricula - Backfill: Resources to cover the shifts of officers/others while they attend training **Having designated drop-off site(s) identified**	**Collaboration:** - Partner/ stakeholder meetings - Policy & procedure review - Recognition and awards - Outreach to other communities **Training:** - 40-hour CIT training - Advanced & refresher training - Partner training **CIT response**	**Participation:** - CIT coordinator - Law enforcement personnel - Emergency communications personnel - Mental health providers - System partners - Community partners - People in crisis - Families	↑: - Relationships - Knowledge, attitudes, skills - Linkage - Diversion ↓: - Use of force - Injuries - Arrests	↑: - Problem solving - Continuity of care - Engagement in services - Non-emergency mental health service utilization ↓: - Repeat calls for service	↑: - Mental health crisis response system change ↓: - Jail population - Costs for law enforcement, jails, healthcare system
Assumption: Implementing a CIT program will lead to better immediate response to mental health crisis calls (safety, linkage, diversion) and better service coordination and outcomes over time.* ***Outcomes are hypothesized until measured**. Arrows indicate the hypothesized direction of change.*					

Figure 3. Example CIT Program Logic Model

Process maps can also be useful. Figure 4 provides a process map of a CIT call process. This example is intended to inspire ideas of how process mapping could be helpful to CIT programs just starting or seeking to expand their data collection process. For example, Figure 4 makes clear the various dispositions (key outcome data points to gather) that may result from a CIT program, as well as the partners involved with each disposition (who may need to provide that data).

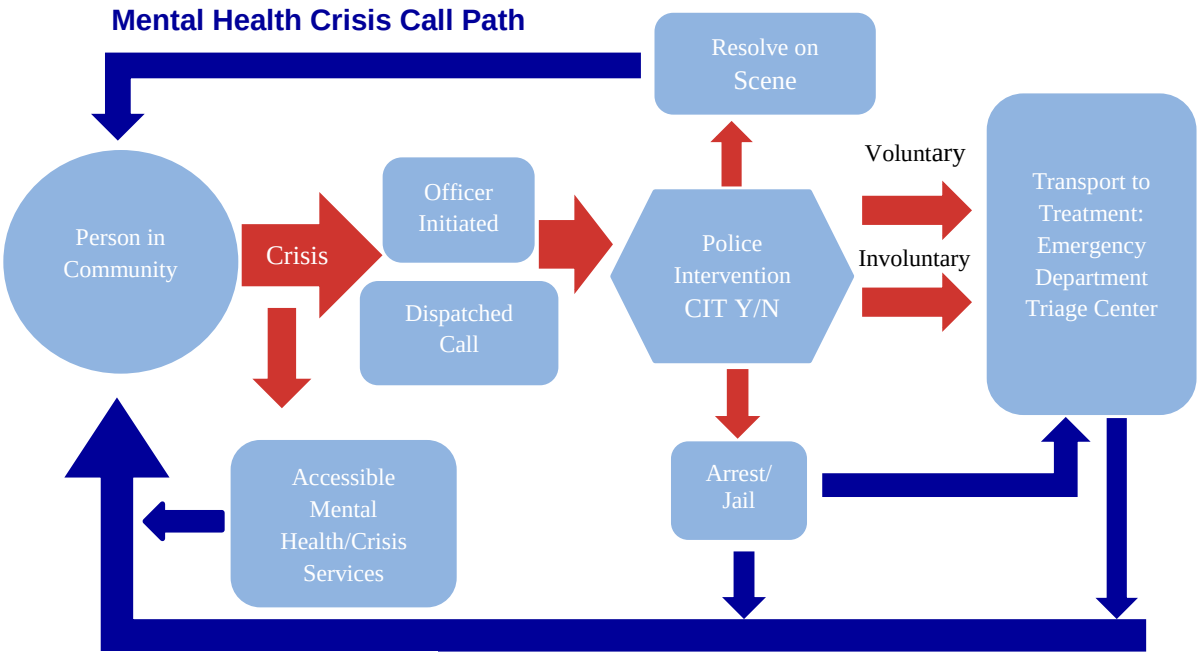

Figure 4. CIT Call Process Map

While some jurisdictions may choose to work with a university partner or consultant to develop logic models and process maps, programs with limited capacity should not be deterred. Simple written descriptions, process maps, decision trees, and basic logic models can be created to clearly show the program components and desired results. Taking this step will help programs avoid overlooking important data elements and data sources and wasting valuable time and resources.[2]

Having clarity about CIT processes is also helpful in continuing conversations among partners as need for changes requiring substantial investments of time and resources emerge, such as updating or replacing electronic databases, implementing more paperwork, or instituting other changes in how staff conduct their day-to-day work. With processes and anticipated results clearly documented, CIT programs can help keep stakeholders focused and support a consistent message about the purpose and function of the CIT program.

[2] Cross et al., 2014, provides a conceptual framework of the CIT Model, which includes many of the outcomes that leaders generally expect from their CIT programs. The basic logic model provided in the article is another example that can be used as a template and modified to reflect local CIT activities, results, and outcomes.

Step 3. Identify Key Metrics

One of the biggest challenges setting up a data collection process is deciding, "What is the data we most need to support our local CIT program?" There are many items that can be tracked and priorities will differ based on who is collecting and looking at the data. A foundational tenet of CIT is the partnership between law enforcement and behavioral health organizations; however, there may be differing purposes for data collection due to the diverse perspectives and organizational goals of the partners. All CIT programs will be in different places in terms of capacity and readiness to gather and analyze data.

Determine what measures and data metrics are related to stated program goals

The key to starting and sustaining an effective data collection process is to clearly understand the reasons for the CIT program, the activities being implemented, and the results sought. The *CIT Core Elements* support programs striving to reach two basic goals:

1. Redirect individuals with mental illness from the judicial system to the healthcare system.
2. Improve officer and consumer safety.

Key stakeholders in CIT programs should work together to determine and articulate the basic goals of the local CIT initiative to ensure that relevant data is collected and used to continually evaluate and improve the program. Additionally, programs should articulate the resources and activities undertaken to reach these goals, as tracking this data is key to understanding program success or lack thereof, and making program improvements.

Track measures and metrics most aligned with the CIT Model

Programs should start gathering and analyzing data that is directly related to their stated goals. Programs could benefit by considering the *CIT Core Elements* to inform their desired measures and metrics. Many components of the Core Elements can be assessed through a simple yes/no response to each item. However, more refined measures of components of the Ongoing, Operational Elements and Sustaining Elements may be necessary to inform program progress and improvements. Figure 5 shows the framework of components that align with the Core Elements and can be measured.

The chosen data elements should have clear descriptions, definitions, and documentation procedures (See *Section III* for further guidance.). CIT programs should also include data points that measure basic demographics of the populations that receive CIT services (e.g., age, race/ethnicity, gender). These should also be clearly defined to ensure consistency of data across agencies. For example, all agencies should determine how race and ethnicity is defined, gathered in the field, and reported through databases, spreadsheets, or forms to ensure that comparison of that data is possible across agencies.

Organize data collection strategies based on community partners' needs

It is critical that behavioral health agencies, university partners, criminal justice, consumers, families and other stakeholders establish processes for identifying and collecting mission critical data. Key measures or metrics requested by CIT stakeholders can be identified during the initial phases and grow as the program collects and analyzes more data. CIT programs with data collection that supports community-driven justice and behavioral health goals are far more likely to be sustained in the long-term. While communities may initially begin with strategies focused on law enforcement data, as capacity increases, it will be important to consider data elements and sources across systems to fully capture and understand the operational challenges and outcomes and to create community-wide solutions.

Law enforcement agencies play a key role in implementing the CIT program, therefore, their needs surrounding data collection related to CIT are important. Some agencies will be understandably resistant to placing additional documentation demands on their personnel. Thus, data collection strategies must be sensitive to agencies' operational demands and officer paperwork burden and align with the objectives of law enforcement leadership. This will increase the likelihood of participation and accountability for robust data collection. Initial program activities and successes demonstrated with data will often lay the foundation for expansion of and willing participation in data collection efforts, as leadership and front-line personnel see the value of good data for supporting safer and more effective mental health crisis response. Additionally, sometimes data from another part of the system (e.g., the number of people with serious mental illness booked into local jails, their status with community behavioral health agencies, the cost of these respective services to the community) can help establish the importance of data collection within the law enforcement agency.

As CIT programs and their capacity to gather information grow through technology, increased staffing, or expanded partnerships, data collection should be expanded. The benefits of CIT extend beyond law enforcement to behavioral health providers, research agencies, families, communities, and other partners. Therefore, it is important that as the program grows, the data collection and review process comprehensively measure outcomes across CIT partners. (See Step 7 for more on expanding data collection.)

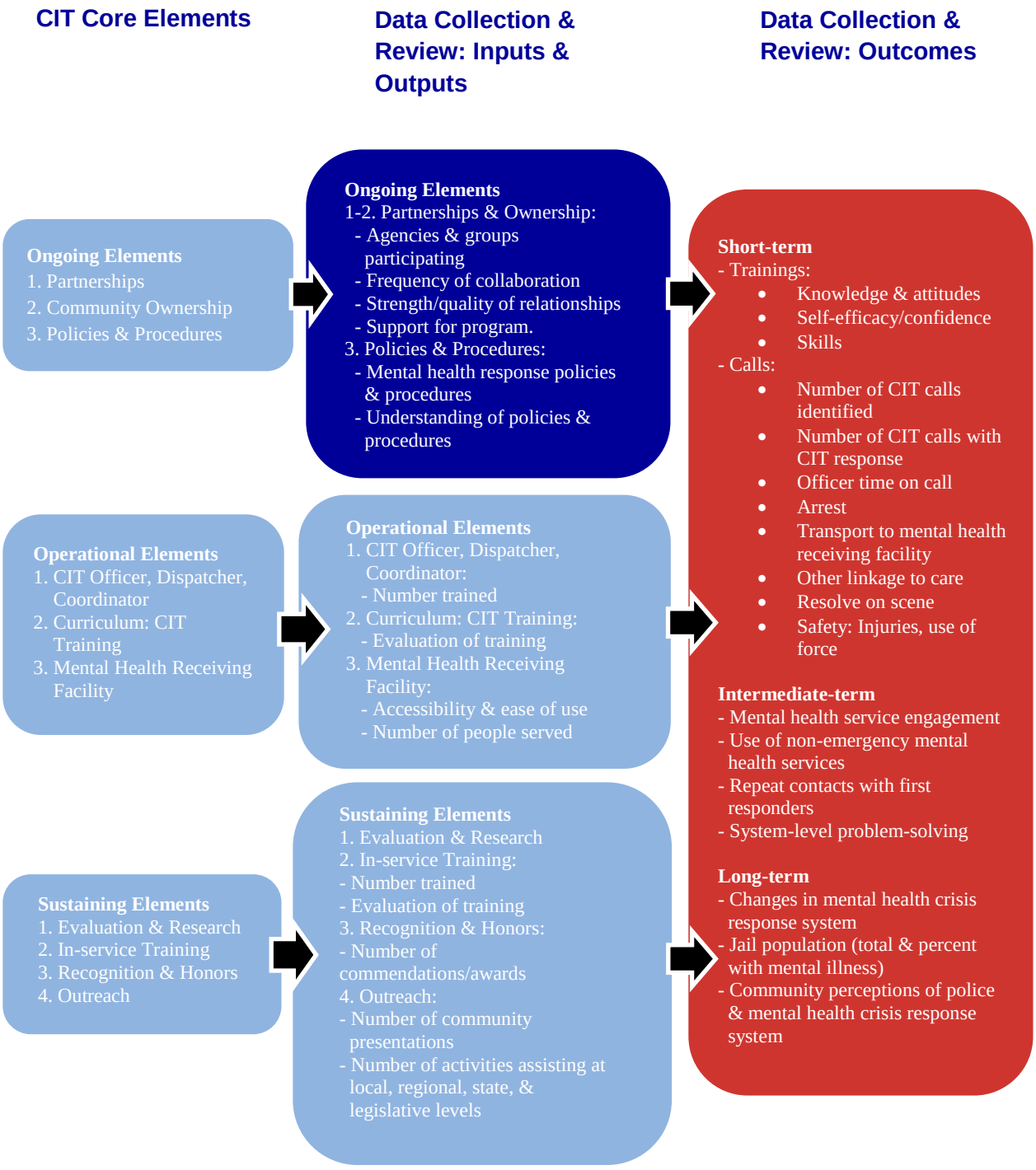

Figure 5. Measurement Framework

Step 4. Establish a Consistent, Routine Data Collection Process

Define a process, roles, and responsibilities for data collection and analysis

It is important to establish a consistent, routine process for collecting and analyzing data. CIT partners should come to agreements on the data to gather and the staff responsible for data entry and analysis. Staff should be clear on the responsibilities and procedures for entering, pulling, reviewing, and disseminating data and findings. Agency leadership across the CIT partnership should endorse the roles and provide oversight to ensure compliance with the agreements. Figure 6 is a sample flow chart that depicts the data collection and sharing process and clarifies each partner's role in data collection and review. The central role of the CIT coordinator is gathering data from each source and ensuring it is analyzed and reported to the community and CIT partners. Communication and reporting are key because the individuals providing data, including front-line staff documenting activities and partner agency data analysts, must be confident that the data is being seen and used, or they may not consistently expend the effort to provide quality data. The CIT coordinator also plays a central role in tracking the data necessary to measure implementation of the CIT program elements (e.g., participation of partners, collaboration, changes to policies and procedures, trainings).

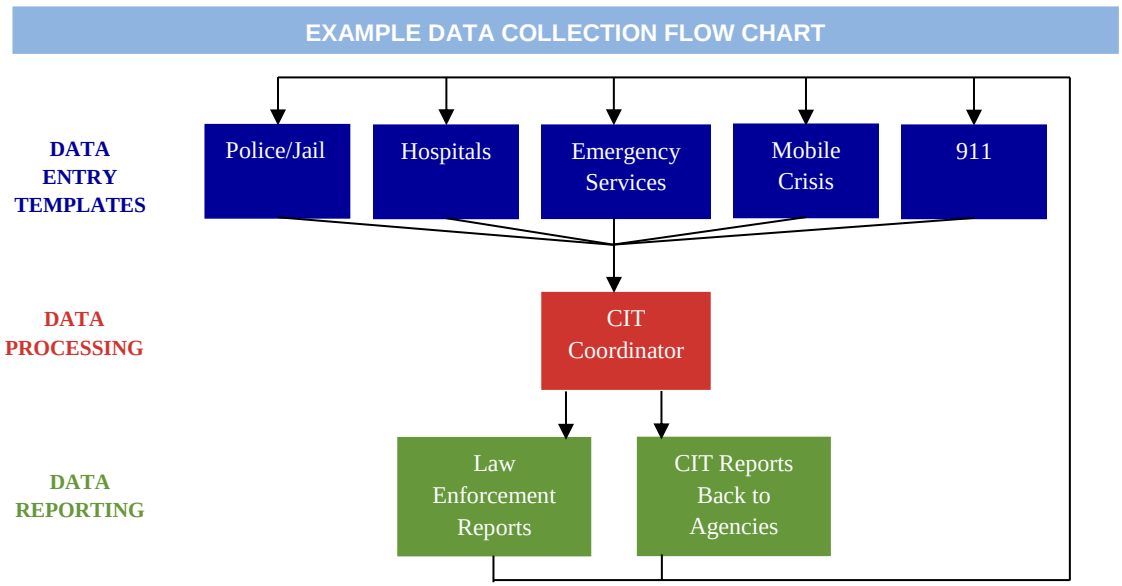

Figure 6. Flow Chart

Each CIT program must develop its own approach to data collection in consideration of agency staffing levels, the partners included within the CIT partnership, and other factors. Special consideration should be given to staffing allocations and research partners:

- *Staffing allocations:* Data collection and analysis requires staffing allocations. Some programs assign staff within the law enforcement agencies with data responsibilities; other programs fund a central position, such as a CIT coordinator, to coordinate the data gathering and analysis work. Some programs utilize the dispatch system to capture and pull data and/or have the behavioral health partner agency enter and track data.
- *Research partners:* Some CIT programs have established effective partnerships with a local university or government agency (such as the health department) to assist with data collection and analysis. These research entities can also assist with identifying and applying for grant opportunities that might support this and other aspects of the CIT program.

Successful University Partnership

The Thomas Jefferson Area CIT (Charlottesville and Albemarle County, VA) and the University of Virginia's Department of Systems and Information Engineering have had a longstanding research partnership that has directly benefited the local CIT program. Through this partnership they have developed system maps, identified key metrics, created an Excel-based CIT evaluation tool, designed an integrated database to support reducing jail overcrowding, and conducted an analysis of individuals with mental illnesses in the criminal justice system to establish baseline data on referred individuals over a six-month period.

More detail regarding the partnership and research conducted can be found in Evidence-based Decision Support for Managing the Mentally Ill Inmate Population, a paper presented at the Systems and Information Engineering Design Symposium in 2017: http://ieeexplore.ieee.org/Xplore/home.jsp

Figure 7. University Partnership

Figure 7 shows the projects that have resulted from a long-standing research partnership between the Thomas Jefferson Area (Charlottesville/Albemarle County, Va.) CIT program and the University of Virginia's Department of Systems and Information Engineering, many of which have directly benefitted the local CIT program.[3] This list provides ideas and examples of joint projects that could be undertaken, and consequently, produce rich information for the CIT partnership without placing a tremendous burden on CIT officers or behavioral health agencies.

Measure CIT program implementation

Building on the documentation of the local program described in Step 2, local CIT programs should measure the extent to which the components of their program are being implemented. For many programs, the CIT coordinator is responsible for tracking the participation of partners, the frequency of collaboration, the number of personnel from various agencies trained, and other

[3] More detail regarding the partnership and research conducted can be found in *Evidence-based Decision Support for Managing the Mentally Ill Inmate Population*, a paper presented at the Systems and Information Engineering Design Symposium in 2017. The paper can be accessed at: http://ieeexplore.ieee.org/document/7937706/.

important components of the program. While these may be documented initially in the mapping and logic model process, they should also be measured over time. This information is critical to understanding outcomes and determining where program improvements are most needed. *Section III* provides more detailed guidance on implementation metrics.

Support regular, accurate data entry

Quick, concise data entry is key to obtaining critical CIT information. CIT programs are not the only programs requesting special codes and data entry from law enforcement and other partners. Agencies often face a long list of wishes and demands for data from many programs (e.g. domestic violence programs, homelessness programs). Therefore, it is important that upper management be knowledgeable and in full support of CIT data collection efforts. If new codes or other requirements for data entry are added, training and accountability mechanisms that support consistent and accurate data reporting should also be implemented. Simply adding new data requirements will not produce good data unless personnel understand the reason for the new requirements, what they are required to document, and are held accountable.

Most law enforcement agencies use two systems, a computer-aided dispatch (CAD) system and a records management system (RMS), which may or may not be connected and able to communicate. Both systems track critical information related to calls for service and responses to those calls. CIT programs often have data needs that apply to both systems, making requests for entering and tracking data more difficult to fulfill. Often, these systems are not designed to capture the data CIT stakeholders are interested in. All CIT stakeholders should understand the local paper-based or electronic systems used by law enforcement and dispatch personnel to track the demand for services and the responses provided. In some cases, data already captured by these systems will be useful for a basic analysis of CIT calls for service. However, in many cases, CIT programs will need to devise new data collection strategies to supplement the available CAD and RMS data to analyze CIT call volume and outcomes:

- *Paper or electronic supplemental forms*: Some CIT programs provide paper or electronic document templates for CIT officers to complete a supplemental CIT report and attach it to the main police report. However, many jurisdictions using these forms have found that they are not consistently completed. Additionally, using this approach requires personnel hours to go through the reports and retrieve the relevant data items for analysis. Appendix A provides several examples of reports used in the field.
- *Separate reporting spreadsheets*: Some CIT programs have electronic databases ranging from spreadsheets for law enforcement and other program partners to fields embedded in regular police report interface systems.
    - The Thomas Jefferson Area CIT (Charlottesville and Albemarle County, Va.) uses an Excel spreadsheet to collate data from both CIT officers and local

mental health assessment centers. Appendix B shows both the spreadsheet and the definitions created for each data element collected.

- *Embedded fields and templates in existing report systems*: Some CIT programs embed fields or templates in regular police report interface systems that transfer data directly into analyzable databases. Officers are more likely to complete these fields consistently if data already existing in the CAD/RMS system prefills in the CIT report to avoid data re-entry, if they understand the value of the data, and if they are held accountable for completing the reports.
    - The San Marcos Police Department (San Marcos, Texas) has incorporated a custom tab into the computer information system (CIS) that houses the CAD system and their RMS, which are connected and able to communicate. The custom tab enables officers to quickly and easily click a few boxes so information related to mental health issues during calls/encounters is tracked. Appendix D shows a screenshot of the custom tab.
- Shared data collection:
    - *Call-in systems*: CIT officers may call a CIT coordinator to provide the needed information by phone, which is entered into a spreadsheet or database.
    - *Behavioral health agency role*: Some CIT programs depend heavily on a local mental health crisis assessment center or other similar "drop-off" program to provide substantial data entry around mental health calls/encounters. This requires close collaboration with law enforcement so that calls/encounters with a disposition that do not result in a referral are included in the data.
    - *Jurisdiction-wide CIT data entry portals:* Rather than changing the CAD and/or RMS of each police department, it may be beneficial to provide a separate data management system for CIT programs, through which all partners can enter or import pertinent data. Some stakeholders prefer this approach because one jurisdiction might have several law enforcement agencies participating in their CIT program.

Develop useful dispatch and disposition codes

A common challenge for CIT programs is that law enforcement and dispatch agencies may not have codes specific to mental health calls/encounters, CIT responses, or related dispositions in their dispatch or RMS. This makes it difficult to pull data on mental health calls/encounters to document their frequency and assess capacity to get CIT officers to these calls and the outcomes of CIT response.

Some codes, such as identifiers of mental health related calls, are critical to collect even if a CIT program does not exist. All jurisdictions should strive to create reliable mechanisms to measure the impact of behavioral health needs on their systems, particularly the emergency, law

enforcement, and jail systems. Ideally, systems will include codes for mental health-related calls identified at the point of dispatch, whether a CIT officer responded, and how the calls were resolved (closeout code). Since the mental health component of a call may not be recognized until the officer arrives on scene, call closeout codes allow officers to capture of more complete data on mental health response.

Capture data about mental health calls in the dispatch system

Dispatch codes for encounters involving people with a mental illness enable data collection on call volume and allow searching, tracking, and analyzing of data on officer encounters with people experiencing mental health crises. A few local jurisdictions provide examples for how to capture this data:

- The Memphis Police Department (Memphis, Tenn.) established a specific dispatch code for mental health-related calls (referred to as "mental disturbance" calls). They also established a separate code for mental disturbance calls that involved weapons. Those calls would otherwise be coded with a higher classification due to the presence of weapons and the disposition data from those calls would be missed.
- The Thomas Jefferson Area CIT (Charlottesville/Albemarle County, Va.) uses a specific dispatch code for calls that involve a person with mental illness, as well as a disposition code that indicates one of four potential resolutions:
    - 931-3: Mental Health Crisis Call – Resolved at location
    - 931-7: Mental Health Crisis Call – Voluntary committal transport (to hospital)
    - 931-1: Mental Health Crisis Call – Emergency custody order (involuntary transport)
    - 931 + Arrest Code: Mental Health Crisis Call – Resolved with an arrest

When establishing codes, consider the existing systems and whether hardware or software changes will be required. Dispatch and 911 systems purchased from private vendors may incur costs for modifications. In addition, consider the impact that adding new codes will have on existing processes, such as whether officers will need to close out calls through the dispatch system or in some other way, and whether there is a feedback loop for correcting disparities between officer and dispatcher coding.

Codify program processes into policy

By codifying agreed upon procedures into policy, CIT programs provide clear guidelines on what data collection is required and needed of partners and they are better able to hold the partnership accountable. In many cases, local agencies have begun to partner with technology firms to develop IT solutions to data collection (see Figure 8). If a CIT program policy already exists, ensure that it contains a section regarding data collection expectations, training, and procedures.

Leveraging the Interest of Technology Firms

Many information technology, coding, and data science programs have begun partnering with local agencies to develop private or open source technology solutions for local community or government needs. Partnerships could be explored to develop and test innovative data gathering systems.

Technological support may also be found at:

- Local university information technology, engineering, or public health departments or programs.
- Local governments with strong IT departments.

Figure 8. Leveraging Technology Firms

Provide training on data collection procedures

To ensure accurate tracking, provide training to dispatchers, law enforcement, and other involved parties on the methods for collecting and entering data into relevant databases, forms, or spreadsheets. When data is self-reported by people in crisis, CIT partner agency staff should be trained in how to ask for that information to ensure consistency in the data across agencies. Additionally, dispatchers need clear guidance on how to identify and code calls that involve a person in a mental health crisis. CIT officers need to be educated on where and how to enter relevant information into the forms, databases, or fields created to capture CIT data. Other partners, such as mental health crisis assessment centers, arrest processing or jail intake centers, and others will need clear instructions on how to report and provide the data desired by the CIT program.

Step 5. Establish Regular Data Analysis and Reporting to the Field

Reports, including data, findings, and where appropriate, recommendations should be generated and circulated among all leadership of the CIT partnership. Information should also be pushed down to the frontline about the CIT's work and impact. This should serve to increase familiarity with and buy-in of CIT among both leadership and frontline staff.

Regularly scheduled CIT councils, collaboratives, or CIT case staffing meetings are useful ways to foster collaboration and disseminate data and findings. Some CIT programs share data reports with their partners at these meetings, who then are responsible for ensuring the information is shared broadly within their respective organizations.

Jurisdictions with a Criminal Justice Coordinating Council could invite the local CIT coordinator to be a member, thus ensuring that CIT data will be accessible and shared with all key criminal justice stakeholders in the area. This could also increase buy-in for tracking mental health data within other areas of the justice system.

By partnering with a university or other research partner, CIT programs could consider sharing their data through journal articles, conference presentations, or other publications as students and professors may be interested in sharing new data and information with their fields of study.

Step 6. Incorporate What is Learned into Program Improvements

Identify areas for improvement

Using the logic model or process maps created for the local CIT program, identify areas where the data indicate room for improvement or needed changes. Data and analyses should be considered when determining new directions or changes in processes to increase progress toward the CIT program's goals. While this process will look very different for each program, there are many established methods around evidence-based decision-making and data-driven justice within the criminal justice system. The following are examples of ways CIT programs have applied data to their programming:

- One CIT program set a goal to reduce the number of arrests of people with mental illness. Once baseline data and program data were collected, the jurisdiction recognized that arrest rates were already very low. Consequently, the CIT partnership changed the focus of the program goals to areas that truly merited attention.
- Another CIT program's local mental health partner used data to track and develop patterns around law enforcement activities during busy and slow times. The agency, which only had onsite clinical staff during regular business hours, adjusted staff schedules based on this information so that clinical staff were on duty during periods when law enforcement would be most likely to need them.
- CIT programs can use dispatch code data to spot trends that are costly and time consuming. For example, if calls are properly coded in the dispatch system, law enforcement agencies may be able to track patterns of repeat calls from specific locations and address the service needs of these callers. This can benefit consumers by connecting them with appropriate resources and benefit officers by reducing time spent on repeat calls.
- In Bexar County, Texas, the case was built for their local mental and substance use disorder crisis-based screening, assessment, and treatment facility, called the Restoration Center, based on data gathered from law enforcement, which identified gaps and critical needs within the local behavioral health services continuum. Data collection began first as information on mental health needs, then was expanded to include medical clearance needs, substance use disorders, etc.

- The Thomas Jefferson Area CIT uses a pre- and post-survey at its CIT trainings. (see Appendix E.) Initially, they noticed anticipated improvements pre-to-post-test on several important items related to knowledge and confidence in responding to mental health crisis calls. However, there was not much movement on violence perceptions. As a result, they adjusted the training and subsequently saw the desired improvements on these items.

Utilize existing resources to support evidence-based program improvements

For CIT partnerships interested in going to the next level in applying data to make program changes, there are numerous resources in the field. Because these resources have been tested and vetted, they come highly recommended for CIT programs that have achieved their data collection and analysis goals and are now ready to put the data to work to create improvements and more effective programming.

The National Institute of Corrections provides information on evidence-based decision-making in local criminal justice systems. They provide an extensive, tested framework along with a web-based starter kit for programs interested in applying data in decision-making and program enhancements.[4]

The National Implementation Research Network provides information about implementing science. This can clarify exactly how data fits into the everyday activities of implementing the local CIT program.[5]

Finally, the Bureau of Justice Assistance's report, *Tailoring Law Enforcement Initiatives to Individual Jurisdictions*, also provides useful guidance in applying data to program improvements (Reuland, Draper, & Norton, 2010) and is particularly focused on law enforcement-driven programming, which can be easily applied to CIT.[6]

[4] A Framework for Evidence-Based Decision Making in Local Criminal Justice Systems can be accessed at https://info.nicic.gov/ebdm/.

[5] The National Implementation Research Network can be accessed at http://nirn.fpg.unc.edu/.

[6] The Bureau of Justice Assistance's report on Tailoring Law Enforcement Initiatives can be accessed at https://www.bja.gov/Publications/CSG_LE_Tailoring.pdf.

Step 7. Expand Program Data Collection as Capacity and Skills Grow

As the capacity of the CIT program expands, programs can increase data collection to include more data points and analyses. As mentioned in the Introduction, it is recommended that programs tackle their data collection planning and implementation in a way that systematically and incrementally builds on the information gathered and produced. Programs may find it useful to organize their efforts by tiers:

- *Tier One:* Mission Critical Data is considered the most basic and essential data for CIT programs to collect to demonstrate productivity and basic impacts on the community.
- *Tier Two:* Intermediate Data builds onto and expands data gathered and analyzed at Tier One, producing a more complete picture of the CIT partnership's results and outcomes.
- *Tier Three:* Advanced Data includes more ambitious data points and metrics, many of which will reflect the comprehensive impact of the entire CIT partnership.

CIT programs will gain clarity on their use and impact by gathering, analyzing, and incorporating findings from the Mission Critical Data and metrics. Once a plan for gathering and analyzing Mission Critical Data is implemented, steps to expand and gather Intermediate and Advanced Data should be initiated.

Some of the Advanced Data may be beyond the scope of most CIT programs initially. Therefore, it is important to develop these processes in conjunction with behavioral health agency partners and research partners to ensure proper agreements and protocols are in place. The Advanced metrics lend themselves to periodic review through a formal evaluation every two to three years. These can be conducted by an external evaluator and produce rich data for CIT partnerships to consider when making program improvements.

It is important that the CIT partnership works together to determine the right course of action for measuring the data points most critical to the CIT program and the various partners involved. *Section III* provides detailed descriptions, definitions, and guidance around the collection of the data recommended at each tier.

III. Recommended Data and Definitions

The following data points, measures, and metrics have been identified, defined, and prioritized based on input from CIT International, Inc., and leading CIT programs across the U.S. These do not capture all the data that are important to many CIT partnerships; however, these are considered priority. The descriptions and definitions provided may serve to standardize data collection across various programs and increase their capacities to compare data and findings with one another. The following sections are broken out by tier, in keeping with the recommendation of an incremental, tiered approach to CIT data collection and analysis. (See Appendix C and Appendix D for data at-a-glance and additional resources.)

Tier One: Mission Critical Data

The following are key data points that programs will ideally start to collect as they build a data collection and review process. Many of these items would be helpful for law enforcement agencies to collect, regardless of whether a CIT program is in place (e.g., tracking the number of "mental health calls for service"). As these data points are considered critical to the mission of CIT programming, they are called the most basic, Mission Critical Data points (see Figure 9).

Tier One: Mission Critical Data

- Community Partnerships and Engagement
- CIT Training Participation
- Number of Mental Health Calls for Service/Encounters
- Number of Mental Health Calls Responded to by CIT Officers

Figure 9. Tier One

Community partnerships and engagement

Local jurisdictions typically focus on community partnerships during the development and mapping phases of CIT programs, but may lose sight of the importance of maintaining these fundamental aspects of programs as they develop and measurement becomes more focused on specific outcomes:

- Number of program partner agencies and stakeholder groups.
- Number of formal and informal partnerships.
- Number of participants in different program activities from different types of partner agencies and stakeholder groups.

While more elaborate measures of community partnerships and engagement may be utilized at Tiers Two and Three, at Tier One the number of partnerships and frequency of participation of

members of partner agencies and stakeholder groups is mission critical data that will help ensure that community collaboration continues to be tracked and its importance emphasized. The CIT coordinator or another designated person can track the number of formal (e.g., memorandums of understanding) and informal partnerships at regular intervals (e.g., quarterly). Additionally, the coordinator can record data on attendance and participation of the different stakeholder groups in regular steering committee and advisory board meetings.

CIT training participation

CIT programs should track the number and percent of personnel completing CIT training. While training typically starts with law enforcement officers, CIT programs should also track delivery of training for dispatchers and other involved personnel when those trainings are made available. The recommended data points are:

- Number and percent of law enforcement officers (e.g., police departments, sheriff's offices):
    - Rank and file staff.
    - Command/Executive staff.
- Number and percent of dispatch personnel.
- Number and percent of emergency medical management system personnel.
- Number and percent of fire department staff.
- Number and percent of community corrections staff.
- Number and percent of mental health provider/hospital staff.
- Number and percent of court personnel.
- Number and percent of "other community partners."

Second, CIT programs that provide specialized trainings beyond the basic 40-hour training are encouraged to capture the number of personnel completing other CIT trainings, by type:[7]

- Youth-specific training.
- Advanced CIT training.
- Veteran-focused training.
- Other (e.g., refresher, train-the-trainer).

Since there is not an empirically-based benchmark for the percentage of personnel that should be CIT trained, programs should identify their own benchmarks and aim to have 24/7 capacity to

[7] Please contact CIT International for more detail regarding different CIT training types. Online resources may be accessed at www.citinternational.org.

dispatch a CIT officer to mental health related calls. The optimal percentage for a program will vary based on many factors, including agency size, call volume, and geographic area, and will likely change over time. However, it is useful for programs to calculate the percentage of law enforcement agency personnel that is CIT-trained in total and by shift. These percentages, along with data on the number of mental health related calls for service can be used to determine if CIT capacity can meet demand.

Number of mental health calls for service/encounters

CIT programs should request data on overall calls for service per month or quarter. Dispatch or law enforcement systems commonly have this data. Knowing the overall calls for service will allow CIT programs to put number of mental health calls into context of the total demand for services from the community.

Mental health calls are calls for service or encounters that result due to a mental health service need. Knowing the number of mental health calls provides insight into the demand for service placed on agencies and allows for monitoring patterns or trends over time. This data point is also needed to calculate other important data points described later in this document. If a jurisdiction does not have dispatch codes that allow for the identification of mental health calls and they are currently unable to add them, the program will want to consider if there are other ways these calls can be flagged in the data system. For example, there may be a code or field in the existing system that is no longer in use that can be repurposed.

This data point should include several metrics that may require further defining (see Figure 10) prior to collection:

- Number of calls for mental health reasons (as coded by dispatch).
- Number of calls for other reasons that result in a mental health encounter that addresses a mental health need (officer often will add information to flag the encounter as being for mental health reasons; this may or may not overwrite dispatch's original coding).
- Number of mental health encounters, with no preceding call from dispatch, that address a mental health need (officers need to ensure the encounter is documented as a mental health call/encounter). Many agencies that do have dispatch codes for mental health calls may not have a mechanism for capturing these on-view or officer-initiated encounters. It is important for data analysis to fully understand what is included in the data, and what may be excluded.

Questions Your Program May Need to Answer

- What is considered a mental health call in your jurisdiction?
- Is a mental health call different than a CIT call? If so, what is the difference?
- Is there a single code or several codes that identify these calls?

Figure 10. Questions to Answer

Number of mental health calls responded to by CIT officers

To track the number of mental health calls responded to by CIT officers, agencies need to be tracking mental health calls (see preceding section). These data should include:

- Number of mental health calls and encounters responded to by CIT-trained officers.
- Number of mental health calls and encounters responded to by non-CIT-trained officers.

As part of the analysis, staff can look at this by shift and precinct so you can determine if calls are being matched as intended, and if CIT capacity is adequate.

Programs may find through data analysis that the proportion of mental health calls responded to by CIT-trained officers is lower than they would like. This information could point to one or a combination of issues: there may not be enough CIT-trained officers to meet demand; there may enough CIT-trained officers, but the distribution across shifts and geographic areas does not match demand; there may be a breakdown in the process of dispatchers identifying mental health calls and dispatching them to available CIT-trained officers. The Mission Critical Data on CIT response provides a starting point for understanding the operation and outcomes of a CIT program.

Tier Two: Intermediate Data

Once programs have mastered the Mission Critical Data, it is recommended that they slowly and thoughtfully expand to include additional data. Once the local CIT partnership is ready, Tier Two: Intermediate Data are recommended to be added to the Mission Critical Data, as these are also tremendously important for demonstrating success of the CIT program (see Figure 11).

Tier Two: Intermediate Data

- CIT Training Outcomes
- Call Disposition: Health Care Referrals/Arrest Rates
- Injury Rate
- Use of Force

Figure 11. Tier Two

CIT training outcomes

CIT programs should track the participant satisfaction, learning, and skill-building outcomes of their trainings to understand the immediate impact on personnel knowledge, perceptions, and skills. At Tier Two, programs can measure changes in several important areas described in the *CIT Core Elements* report:

- *Law enforcement perceptions of individuals with mental illness:* Defined as law enforcement self-reported knowledge and attitudes about people with mental illness or disability.
- *Confidence in interaction:* Defined as law enforcement self-reported confidence in responding to mental health calls/encounters.

While assessing participant satisfaction with training content and delivery can be done with a post-training survey, changes in knowledge, attitudes, and confidence are best measured with pre-training and post-training measures. (See Appendix E for examples.) Regardless of the tool used, the following aspects should be assessed:

- Participant satisfaction with CIT trainings, post-training-only measure.
- Change in participants' knowledge of covered topics, pre- and post-training measure.
- Change in participants' perceptions of people with mental illness or disability, pre- and post-test measure.
- Change in participants' confidence/self-efficacy related to skills to serve people with mental illness or disability, pre- and post-test measure.

Call disposition: healthcare referrals/arrest rates

Two CIT outcomes described under Sustaining Element: Evaluation and Research, improved healthcare referrals, and decreased arrest rates are disposition outcomes. Healthcare referrals are defined as transports or warm hand-offs to appropriate mental health services as an outcome of mental health calls/encounters. If baseline or comparison information such as number/proportion of healthcare referrals prior to CIT implementation or for a group not getting CIT response is available, programs can compare outcomes to determine if the CIT program has produced improvements in this important CIT outcome. Arrest rate is defined as the proportion of people served by CIT officers on mental health calls/encounters having a disposition of "arrest." Again, when baseline or other comparison data is available, programs can determine the effect of the CIT program on arrests of people with mental illnesses. Even if comparison data is not available, programs should track both healthcare referral and arrest rate outcomes to determine if they are within acceptable range and to monitor trends.

When gathering disposition data, CIT programs and law enforcement agencies will not only be informed of referrals to service and arrest dispositions, they can also capture other disposition types, providing clarity around any patterns or changes in disposition trends. Call/encounter dispositions can be assessed by measuring:

- Number of each disposition of mental health calls/encounters out of total mental health call/encounters compared to baseline or a comparable group when possible:
    - Resolved on scene.

- Voluntary transport to treatment (including warm hand-offs to mental health services that arrive on scene).
- Involuntary transport to treatment.
- Arrest.

Injury rate

It is generally anticipated that CIT officers and the people they encounter will sustain fewer injuries during mental health calls/encounters following implementation of a CIT program. Injury rate can be assessed by measuring:

- *Officer injury rate*: Number of mental health calls/encounters where an officer sustained an injury during the call/encounter out of the total number of mental health calls/encounters, compared to baseline or comparable group when possible.
- *Person in crisis injury rate*: Number of mental health calls/encounters where a person in crisis sustained an injury during the call/encounter out of the total number of mental health call/encounters, compared to baseline or comparable group when possible.

CIT programs need to work with their partners to clarify how "injury" is defined and how the number of injuries is measured. Generally, injuries are tracked through mandated paperwork, medical assessment or treatment administered by certified medical providers.

This information should be tracked over time, even if baseline or comparison group data unavailable. Fortunately, injuries in police encounters are relatively rare. However, given their low frequency, it may be difficult to document a statistically significant change in short periods of time. Thus, measuring use of force as described below may be a more effective strategy for documenting a program's impact on safety related outcomes.

Use of force

CIT programs are advised to track lethal and non-lethal use of force in mental health calls. This data point is not listed specifically in the *CIT Core Elements* report; however, it is recommended to be tracked, as the data will help inform an overall shift in approach to use of force and is a good indicator of safety outcomes. The Police Executive Research Forum (PERF), the U.S. Department of Justice, and other leading entities in law enforcement have increased their focus on the collection of data and responses to findings around use of force. Use of force can be assessed by measuring:

- *Rate of use of force during mental health calls*: Number of mental health calls/encounters where use of force is applied out of the total number of mental health calls/encounters. This should be compared to baseline, or comparable group when possible.
- *Rate of use of force during mental health-related calls:* Number compared to rate of use of force in all calls.

CIT programs need to understand how the law enforcement agency(s) defines and documents use of force (referred to in some jurisdictions as "response to resistance"[8]) and work with their partners to develop a consistent and appropriate strategy for gathering this data. The International Association of Chiefs of Police defines use of force as the "amount of effort required by police to compel compliance by an unwilling subject" (International Association of Chiefs of Police, 2001). The definition of "use of force" should encompass several types of responses:

Data Consideration

Use of data on force may show CIT officers using as much or more force than other officers, as they may be dispatched or requested to respond to higher risk calls. Alternatively, some CIT programs will see decreased use of force as CIT officers slow down, take more time to diffuse tense situations, and see positive outcomes due to relationships that have been established with people with mental and substance use disorders in the community.

Given the amount of national attention given to this issue, many agencies are revising or have recently revised their force policies. When looking at use of force over time, it is important to consider if the use of force policy or documentation of use of force has changed during periods examined.

Figure 12. Data Consideration

- Physical
- Chemical
- Electronic
- Firearm
- Other

It is important when analyzing Tier Two data to consider context, such as potential policy changes during the measurement period (see Figure 12).

Tier Three: Advanced Data

After programs successfully incorporate Mission Critical Data and Intermediate Data into their collection process, they should consider adding Tier Three: Advanced Data to their systems (see Figure 13). These are considered the most sophisticated data and are recommended only once programs have mastered the collection and analysis of Mission Critical and Intermediate Data.

[8] "Response to resistance" was initially adopted in Knoxville, Tenn., as a replacement for the phrase "use of force;" further details are provided in the PERF's report, *Re-Engineering Training on Police Use of Force* (Police Executive Research Forum, 2015).

These data, however, are important for the entire CIT partnership, which should include behavioral health agencies and research partners, along with the criminal justice and first responder agencies that receive the CIT trainings.

Figure 13. Tier Three

Collection of Tier Three data may require the engagement of external evaluators and additional resources. It is just as important when analyzing Tier Three data as it is when analyzing Tier Two data to consider context, such as potential policy changes during the measurement period (see Figure 12).

Tier Three data allows for a more comprehensive look at the function, progress, and success of the entire CIT partnership. Many of these data points will not be possible to gather without the agreement and involvement of behavioral health agencies that work with CIT officers to ensure appropriate services and diversions from jail are occurring when needed. While these data are recommended based on the experience of established CIT programs nationally, there are many other behavioral health-related measures that could be tracked in addition to the ones recommended here. It is important that the CIT partnership communicate and work cohesively to ensure data gathering that lends to a comprehensive understanding of the local impact of CIT.

Strength of partnership/ownership

As emphasized in the *CIT Core Elements* report and discussed in Tier One, partnerships and community ownership are vital to successful CIT programs. Thus, as programs expand their capacity to collect and analyze data, they will want to consider assessing this aspect of their program with more advanced measures than simple counts of participation. Programs can utilize both qualitative and quantitative methods to capture the quality and extent of interaction and collaboration among partners. Qualitative approaches may involve convening focus groups to discuss experiences and perceptions. Quantitative strategies could involve surveys of partners about the frequency and nature of their interactions with each other.

It is unclear whether any CIT programs are currently utilizing program-specific validated tools to capture this data, so programs may also consider engaging professional evaluators or academic

partners to supplement in-house expertise and provide assistance developing data collection tools and analyzing the data.

Crisis response times and call duration

Crisis response times may be measured differently across jurisdictions. Some jurisdictions define it as the time between a 911 call for service and an officer's or a CIT-trained officer's arrival on-scene. Others define it as the length of time between arrival on scene and when the mental health call is cleared. While overall response time (the time it takes for an officer to arrive on scene of a 911 call) is regularly tracked by law enforcement, for the purposes of CIT data collection, it is recommended that jurisdictions also track both the amount of time it takes for CIT officers to respond to mental health calls and the total time spent on mental health calls/encounters.

Originally in the *CIT Core Elements*, the goal was to reduce the time spent by officers on mental health calls. While some jurisdictions have found the total time spent on mental health calls can be reduced, perhaps due to improved referral and handoff to care practices including shortened wait times at crisis drop off, many jurisdictions find mental health calls may take longer to resolve as officers employ skills learned in CIT training that emphasize slowing the interaction, giving space to the person in crisis, and taking the time necessary to de-escalate without use of force.

Therefore, this data point should be tailored to allow CIT programs to measure improvements in crisis response times as appropriate for their communities and may include:

- Response time from 911 call to a CIT officer arriving to a mental health call, measured in minutes. In some jurisdictions, the CIT officer would be the first dispatched on mental health calls, in other jurisdictions the CIT officer would be called by the first responding officer.
- Time spent on scene at mental health calls/encounters, measured in minutes.
- Time transporting person to psychiatric drop off or jail and time spent waiting and transferring custody to jail or care, measured in minutes.
- Total time on call from 911 dispatch to transfer of custody or call conclusion, measured in minutes.

These should be monitored over time and where possible, measured against the baseline or a comparison group.

Mental health call descriptors

General descriptors

Descriptive information regarding mental health calls and encounters can provide increased understanding of the needs of people in crisis who use CIT services. Many of these data points will already exist for calls for which officers are required to complete documentation (e.g.,

general offense reports, arrest reports, hospital transport reports, use of force documentation). Metrics for this data point may include:

- *Location of mental health call/encounter:* By tracking the location of mental health calls/encounters, leadership may better identify patterns, develop strategies, and leverage resources to support high volume areas of the community.
- *Type of call:* Call type labels vary based on community, but could include public disturbance, domestic disturbance, suicide threat/attempt, and well-being check.
- *Age*: Tracking age ranges of clients served during mental health calls/encounters may reveal trends related to the involvement of youth, adults, or senior citizens.

Risk and behavior descriptors

As indicated in *Section I*, some agencies have electronic or paper reporting requirements for CIT mental health related calls. These forms can include fields for officers to indicate a variety of risks and behaviors. Providing a mechanism for officers to document risk and behavior information can serve two purposes. First, it can help officers articulate their observations so that information can be passed to healthcare providers. Second, the frequency with which these risks and behaviors are noted can help programs understand patterns in mental health crisis calls and inform training and mental health service system planning.

To collect this data, programs can calculate the proportion of calls with risk or behavioral/mental health calls in which these risks and behaviors are observed by officers. More elaborate analysis of the relationships between these factors and other outcomes may also be informative. For example, programs can examine how different risk factors or behaviors are related to time on call, use of force, injury, and call resolutions. Potential risks and behaviors include:

- *Risks:* Suicide threat, attempt, or harm to self; threat or attempt to harm others; unable to care for self; presence or use of weapon.
- *Behaviors:* Severe, depressed mood; illogical thinking or talking; suicidal talk; abnormal behavior or appearance; suicidal gesture(s); hearing voices or hallucinating; signs of alcohol or illegal drug use; anxious or excited; paranoid or suspicious; aggressive or threatening actions or speech; possible developmental disability.

Though mental health call descriptors provide great data, CIT programs should carefully consider how this information is shared and comply with Health Information Portability and Accountability Act (HIPPA) regulations (see Figure 14).

Health Information Portability and Accountability Act (HIPAA)

HIPAA provides safeguards that ensure data privacy and security for a person's protected health information (PHI). This and state laws may limit sharing of information between CIT partners.

HIPAA allows for PHI to be shared with a law enforcement officer (or correctional facility) to provide health care to the individual, or prevent or lessen a serious or imminent threat to the health or safety of the individual, the public, other inmates, officers, or employees. Additional circumstances in which PHI may be legally shared include responding to a request for PHI to identify or locate a fugitive, suspect, witness, or missing person, or when PHI is believed to be evidence of a crime. While HIPAA permits health and mental health providers to release PHI under these circumstances, it does not compel them to do so. There are, however, circumstances in which mental health providers are compelled to release PHI; for example, to comply with a subpoena or court order.

The U.S. Department of Health and Human Services provides more guidance at: https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf

Figure 14. HIPPA Considerations

Treatment continuity

CIT programs are likely to increase the amount of time that people stay in treatment if those people are referred to services and their case managers instead of being arrested and booked into jail after an encounter. As tracking treatment continuity is beyond the scope of everyday data collection practices, CIT programs are recommended to assess this measure by tracking the rate at which CIT officers, in the case of a known individual, notify a case manager or behavioral health provider regarding the interaction at the mental health call/encounter, or refer the individual to behavioral health services. The data needed to calculate this could be collected as a field on a paper or electronic mental health/CIT call report form. Officers could simply check a field to indicate they notified a provider.

When the CIT program expands its data collection capacity to include data from involved behavioral health agencies, a wealth of information regarding CIT-referred patients' length of time in treatment and sustained medication management, and reduction of acute symptomology can be tracked. This may require data sharing agreements and additional resources.

Impact on jail diversion

Effective CIT programs have strong community partnerships and, therefore, look beyond the initial interaction with law enforcement officers at the pre-arrest/arrest phase to understand the full impact of CIT across all the intercept points. As CIT programs are anticipated to increase the diversion of people with mental illness at arrest, data at the jail intake, booking, and housing should also be reviewed for potential decreases. This can be achieved by implementing a brief mental health screen at jail intake, such as the standardized and validated Brief Jail Mental

Health Screen.[9] If jail mental health screen data is not available, an alternative is to examine the number/proportion of detainees taking psychotropic medications. Tracking this overtime can demonstrate whether the CIT program is having impacts on diversion outcomes and reducing the overrepresentation of people with serious mental illnesses in jails.

Impact on recidivism rate

Evaluations of CIT programs have shown fewer arrests, more transports and linkages to healthcare services, and more voluntary engagement with services when CIT officers are involved (Franz and Borum, 2010; Compton, et al., 2014; Teller, Munetz, Gil, and Ritter, 2006; and Watson, Ottati, Draine, and Morabito, 2011). This measure is intended to assess how CIT may reduce overall justice and emergency response system involvement by people with mental and substance use disorders. This advanced measure may be beyond the scope of a law enforcement agency alone, but would be appropriate for ongoing tracking by a research partner or CIT coordinator. As jurisdictions may measure recidivism differently, the definition for this metric is intentionally broad and may be revised to better fit the data needs of the local CIT partnership. This measure is not intended to replace the previously defined measures for decreased arrests or jail diversion. The measure is defined as:

- Rate at which people with SMI served by CIT officers are charged and re-enter the criminal justice system process compared to people with SMI served by non-CIT officers during the same timeframe.
- Rate at which people with SMI served by CIT officers have subsequent police (or other first responder) contacts, compared to people with SMI served by non-CIT officers (or some other comparison).

If there is an effort to assign mental health calls to CIT officers, then the comparison of CIT officer intervention to non-CIT officer intervention may not be valid because the group of calls assigned to CIT officers may be different than those assigned to non-CIT officers. It is important to engage a knowledgeable research partner to help programs consider appropriate comparisons or ways to control for differences when making comparisons so that conclusions are trustworthy.

Community engagement

With an increasing focus on the relationship between law enforcement and the community, CIT has been recognized widely as a way to enhance the dynamic between officers and the people they serve who are in crisis or have a mental illness. In turn, this can foster improved relationships between police departments and the communities they serve.

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[9] The Brief Jail Mental Health Screen is an eight-question screen that allows clinical or non-clinical jail staff quickly determine if a defendant may need further assessment for mental health services. The tool was developed in 1999 and validated in 2005. A copy of the tool can be accessed at https://www.prainc.com/wp-content/uploads/2015/10/bjmhsform.pdf.

CIT programs that gather data around community engagement are equipped to better understand different groups within the community, the perspectives of those groups, and their needs. Stakeholders should use this information to foster informed conversations with residents. Often, communities may share perspectives about their needs that are shaped by anecdotal information; data collection provides an opportunity for the CIT program to give information back to the community about what issues exist and how CIT may be able to help. Two measures are recommended CIT partnerships starting to assess community engagement:

- *Number of calls requesting a CIT officer tracked over time:* By tracking requests to the dispatch system for a CIT officer, stakeholders may better understand the community's buy-in, awareness of, or demand for CIT services. This is a new recommendation, not included in the *CIT Core Elements.*
- *Community members' perception of CIT-trained law enforcement:* This can be assessed through satisfaction surveys, population surveys, or other mechanisms that generate feedback on how CIT is perceived at the local level. This is a recommendation from the *CIT Core Elements* that remains critically important.

CIT partnerships may want to invest in an independently conducted public perceptions study to assess a representative sample of the population regarding their awareness of CIT, use of CIT, perceptions of the various CIT partners, and more. Many government agencies (e.g., law enforcement, public health) are already implementing community surveys to assess community needs and satisfaction with services. CIT programs may want to consider partnering with these existing efforts to include some items related to the CIT program. Assessing community perceptions every two to three years can provide valuable data on the progress the CIT partnership is making to positively impact families and communities.

Changes in service utilization patterns across system partners

An overarching goal of CIT programs is to reduce the involvement of law enforcement in the lives of people with mental illnesses by developing a responsive and comprehensive community mental health system. Thus, CIT programs should consider collaborating across partners to collect data on service usage patterns (e.g., crisis lines, triage centers, peer crisis services, emergency departments, traditional outpatient community mental health services) to examine whether the program has shifted patterns away from police/first responder and emergency department services to more appropriate ongoing mental health services in the community. Data elements that can be tracked over time include 911 mental health crisis calls for service, police and Emergency Medical Services (EMS) response, emergency department visits for psychiatric reasons, calls to crisis lines, crisis triage center visits, and peer crisis service contacts.

Additionally, programs can track people who frequently utilize emergency services (police/EMS/emergency department) and examine the changes in service usage patterns for these individuals as well as changes in the number of people meeting the criteria for people who frequently utilize emergency services, as determined by the local program.

While tracking data across systems may seem daunting for many reasons, including privacy regulations, there are a number of resources available to assist programs in integrating data for service provision and program evaluation purposes.

IV. Conclusion

Collecting data to demonstrate a program's impact is challenging, particularly because it involves different systems, databases, and partners. It may place a substantial burden on the CIT partnership during the initial phases. However, the benefits far outweigh the challenges. Data collection is an invaluable tool to demonstrate the positive impact CIT programs have on the community.

Local jurisdictions should not be deterred by limited capacity to collect data when creating or sustaining their CIT program. It is critical that CIT programs start where is most appropriate for their partnership, considering the capacity of each stakeholder to provide data collection or analysis services.

Statistics about the level of mental health needs and the positive impact of a local CIT program can go far to increase buy-in and partnership. CIT programming can be a key component of efforts to reduce use of force and improve relationships between law enforcement and the community, so it is critical to have the data to substantiate the tremendous work being accomplished.

It is also clear that no single agency involved in a CIT program should be solely responsible for data collection efforts. The *CIT Core Element* of partnerships is critical so agencies that expend time and personnel resources to implement CIT are supported in gathering and analyzing the data. The CIT partnership, with support for data collection across the executive leaders of all involved agencies, should be the driving and sustaining force for data gathering, reporting, and implementing subsequent program improvements.

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VI. Appendices

Appendix A. CIT Reporting Forms

Arlington County Police Department CIT Supplement Form

ACPD CIT Supplement

Incident Number:

Was there a CIT-trained officer on the original scene? Yes No Unk

If yes, select one: ☐ CIT dispatched ☐ CIT responded voluntarily

☐ CIT self-initiated encounter ☐ CIT called to scene by non-CIT officer

Was the incident resolved without the EDP being transported from the scene? Yes No

If yes, check any that apply: ☐ DHS contacted via phone only ☐ DHS already on scene

☐ DHS responded to scene ☐ DHS contact info given

Was video conferencing used on scene? Yes No

Was the subject transported to the Crisis Intervention Center or to VHC voluntarily? Yes No

Did you involuntarily detain the subject? Yes No **If no, skip the rest of this section.**

What type of ECO was used? ☐ ECO Issued by a Magistrate ☐ Ofc. Initiated Paperless ECO

What time was the subject detained? _____

Where was the subject transported to? ☐ Crisis Intervention Center ☐ Virginia Hospital Center

What time did the subject arrive at the destination? _____

What time did you contact DHS regarding the detention (N/A if DHS initiated the call)? _____

Which DHS representative did you speak with? _____

What time was the subject evaluated by DHS (if known)? _____

Did you transfer custody of the subject to VHC Security? Yes No

If yes, list the following: _____ _____

Security Officer Name/DID Date/Time

If known, list the following: _____ _____

Doctor Who Gave Medical Clearance Date/Time

If a TDO was issued, list the following: _____ _____

Executing Officer Name/DID | Date/Time

_____ _____ _____ _____

Facility Subject Delivered To | Transporting Officer Name/DID | Start Date/Time | End Date/Time

---

Was the subject released from custody with no TDO issued? Yes No

If yes, select one:

- ☐ DHS determined subject did not meet TDO criteria
- ☐ Subject was voluntarily admitted to psychiatric hospital
- ☐ Subject admitted to the hospital for medical reasons
- ☐ Other (explain) _____

The following questions apply to the period when officers were on scene with the subject:

Was the subject armed? Yes No **If yes, list weapon:** _____

Were any officers injured? Yes No

Was the subject injured? Yes No **If yes, was the injury self-inflicted?** Yes No

Was some other party injured? Yes No

Pre or post officer involvement, could the subject have been charged with any crime? Yes No

Was the subject arrested? Yes No

If yes, did you designate on the Booking Sheet that the subject suffers from mental illness? Yes No

---

What time did you arrive on scene? _____

What time did you clear from the incident? _____

Total elapsed time you spent on this incident: _____

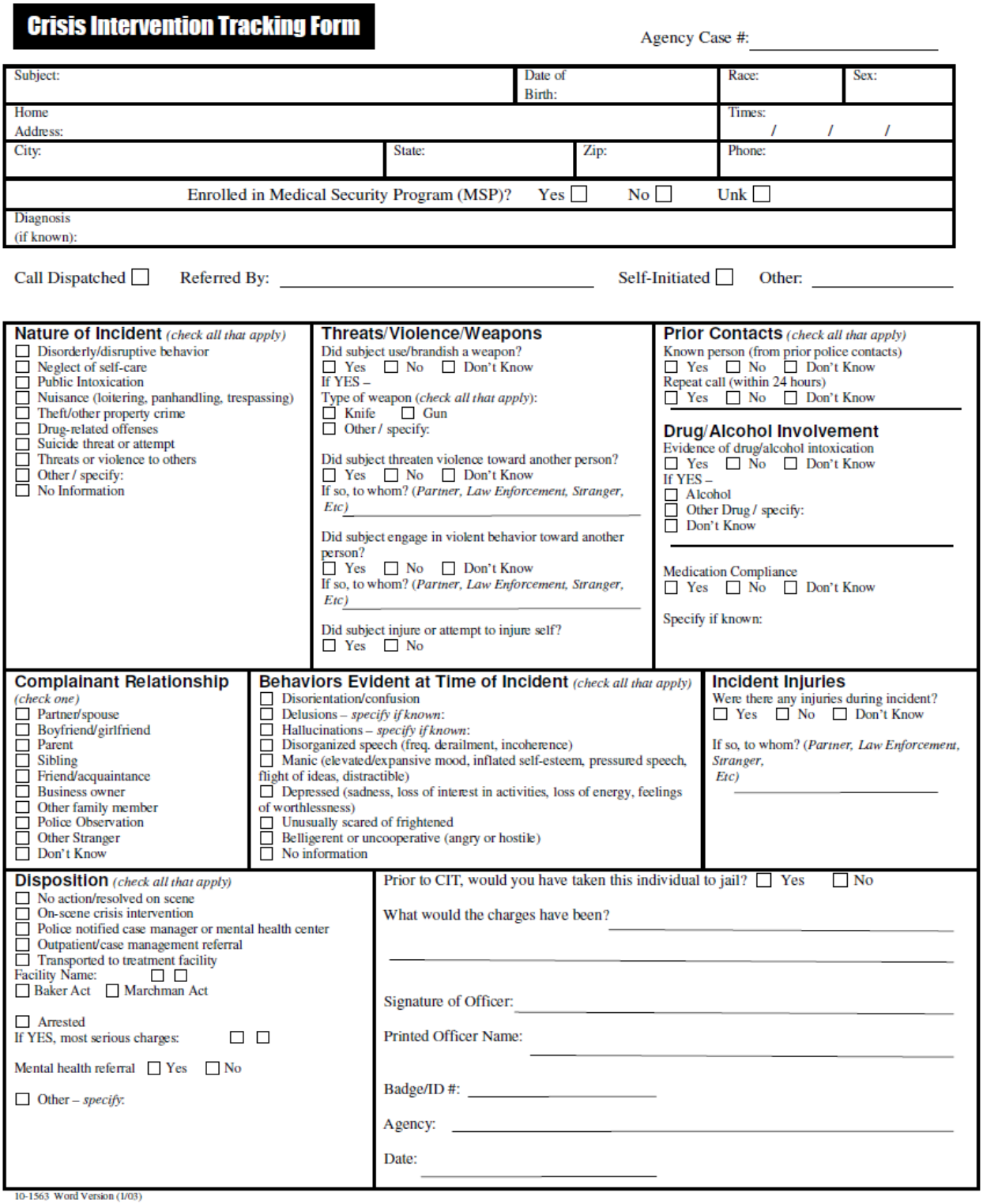
Officer: _____ **DID:** _____ **Date:** _____ **Supervisor Approval:** _____

(Officers should complete sections that apply to their involvement but yellow sections are required at all times.)

Revised 8/15

Central Florida CIT Tracking Form

Source: http://cit.memphis.edu/policies.php?page=3



Crisis Intervention Tracking Form

Agency Case #: _____

Subject:	Date of Birth:	Race:	Sex:
Home Address:		Times: / / /	
City:	State:	Zip:	Phone:
Enrolled in Medical Security Program (MSP)? Yes ☐ No ☐ Unk ☐			
Diagnosis (if known):			

Call Dispatched ☐ Referred By: _____ Self-Initiated ☐ Other: _____

Nature of Incident *(check all that apply)*
- ☐ Disorderly/disruptive behavior
- ☐ Neglect of self-care
- ☐ Public Intoxication
- ☐ Nuisance (loitering, panhandling, trespassing)
- ☐ Theft/other property crime
- ☐ Drug-related offenses
- ☐ Suicide threat or attempt
- ☐ Threats or violence to others
- ☐ Other / specify:
- ☐ No Information

Threats/Violence/Weapons

Did subject use/brandish a weapon?
☐ Yes ☐ No ☐ Don't Know
If YES –
Type of weapon *(check all that apply)*:
☐ Knife ☐ Gun
☐ Other / specify:

Did subject threaten violence toward another person?
☐ Yes ☐ No ☐ Don't Know
If so, to whom? *(Partner, Law Enforcement, Stranger, Etc)* _____

Did subject engage in violent behavior toward another person?
☐ Yes ☐ No ☐ Don't Know
If so, to whom? *(Partner, Law Enforcement, Stranger, Etc)* _____

Did subject injure or attempt to injure self?
☐ Yes ☐ No

Prior Contacts *(check all that apply)*

Known person (from prior police contacts)
☐ Yes ☐ No ☐ Don't Know
Repeat call (within 24 hours)
☐ Yes ☐ No ☐ Don't Know

Drug/Alcohol Involvement

Evidence of drug/alcohol intoxication
☐ Yes ☐ No ☐ Don't Know
If YES –
☐ Alcohol
☐ Other Drug / specify:
☐ Don't Know

Medication Compliance
☐ Yes ☐ No ☐ Don't Know

Specify if known:

Complainant Relationship *(check one)*
- ☐ Partner/spouse
- ☐ Boyfriend/girlfriend
- ☐ Parent
- ☐ Sibling
- ☐ Friend/acquaintance
- ☐ Business owner
- ☐ Other family member
- ☐ Police Observation
- ☐ Other Stranger
- ☐ Don't Know

Behaviors Evident at Time of Incident *(check all that apply)*
- ☐ Disorientation/confusion
- ☐ Delusions – *specify if known*:
- ☐ Hallucinations – *specify if known*:
- ☐ Disorganized speech (freq. derailment, incoherence)
- ☐ Manic (elevated/expansive mood, inflated self-esteem, pressured speech, flight of ideas, distractible)
- ☐ Depressed (sadness, loss of interest in activities, loss of energy, feelings of worthlessness)
- ☐ Unusually scared of frightened
- ☐ Belligerent or uncooperative (angry or hostile)
- ☐ No information

Incident Injuries

Were there any injuries during incident?
☐ Yes ☐ No ☐ Don't Know

If so, to whom? *(Partner, Law Enforcement, Stranger, Etc)* _____

Disposition *(check all that apply)*
- ☐ No action/resolved on scene
- ☐ On-scene crisis intervention
- ☐ Police notified case manager or mental health center
- ☐ Outpatient/case management referral
- ☐ Transported to treatment facility

Facility Name: ☐ ☐
☐ Baker Act ☐ Marchman Act

☐ Arrested
If YES, most serious charges: ☐ ☐

Mental health referral ☐ Yes ☐ No

☐ Other – *specify*:

Prior to CIT, would you have taken this individual to jail? ☐ Yes ☐ No

What would the charges have been? _____

_____

Signature of Officer: _____

Printed Officer Name: _____

Badge/ID #: _____

Agency: _____

Date: _____

10-1563 Word Version (1/03)

Laurel Highlands Region CIT Data Sheet

Source: http://cit.memphis.edu/policies.php?page=3

CIT DATA SHEET

Laurel Highlands Region
Crisis Intervention Team

Date of Incident_____ 20____ **Day of week** Su Mo Tu We Th Fr Sa **Time** _____ **AM / PM**

Location of incident_____ **Incident #**_____

Police Dept. _____ **Officer on scene/Badge #** _____

CIT officer present Y / N **Was a CIT officer called if not present** Y / N

Consumer Name _____ **Age:** _____ **Gender M / F**

Race: Caucasian / African American / Hispanic/ Native American / Other

Address: _____

_____

Nature of call: _____

_____

_____

Was Crisis Called? Y / N

Was the consumer under the influence? Drugs / Alcohol

List any reported mental illness _____

_____ **No mental illness reported**

Medications prescribed? Y / N **Compliance?** Y / N

Threat assessment: ____ NONE

_____ suicide attempt: method_____ _____ Attempt to harm others: method _____

_____ suicide threat _____ Threat to others

Weapons present: None / Firearm / Edged Weapon / Other _____

Injuries to Consumer? Y / N **to Officer?** Y / N

Was the consumer injured prior to police contact? Y / N

Force used: None / physical / taser / baton / spray / firearm / other

Method of transportation: Police / EMS / other Private Vehicle

Outcome of Incident: Hospitalization / Arrest / No action / Other _____

SERT called Y / N

Send completed form to :
Laurel Highlands CIT
401 Washington St.
Johnstown, PA 15901
FAX 814-535-6842

jcc 3/21/2008

Memphis CIT Center Statistics Sheet

Source: http://cit.memphis.edu/policies.php?page=3

CRISIS INTERVENTION TEAM STAT SHEET

(To be completed on crisis calls involving mental illnesses)

Date: _____ Time: _____ Scene Time: _____

Location: _____ Ward: _____

Consumer Name: _____ Sex/Race: _____ Age: _____

Address: _____

Complainant: Name & Address – If complainant is unknown, list how call was reported:

_____

Supervisor (Commanding Officer) on scene: ( ) yes ( ) no

CIT Officer(s): 1. _____ 2. _____

EQUIPMENT / TECHNIQUE:

( ) Verbalization
( ) Handcuffs
( ) Ripp Hobble
( ) Chemical Agent(s) - Report Required
( ) Less-Lethal Equipment - Report Required: (specify) _____
( ) Other (specify) _____

CONSUMER and/or OFFICER INJURY:

( ) Prior to Police arrival - Consumer (Explain in Arrest Ticket narrative or on back of this document)
( ) During Police presence - Consumer (Explain in Arrest Ticket narrative or on back of this document)
( ) None/Unknown - Consumer
( ) Officer(s) (Total number of officer(s) injured # _____)

DISPOSITION OF PERSON TAKEN INTO CUSTODY: See *

* A summary of the arrest event is **not** required on this document if a copy of the arrest ticket is attached and submitted to the officer's workstation.

( ) TCA 33-6-401 Emergency Commitment **with** pending criminal charges
( ) TCA 33-6-401 Emergency Commitment **without** pending criminal charges

DISPOSITION OF PERSON NOT TAKEN INTO CUSTODY: See *

(*) A brief Summary is required on the back of this document.

( ) Complaint unfounded, requiring no police action. (*)
( ) Consumer stabilized requiring no further police intervention. (*)
( ) Other (*)
( ) Complainant and/or Consumer not located

OTHER INFORMATION:

Armed - Yes ( ) No ( ) Weapon: _____
Veteran - Yes ( ) No ( )

TRANSPORTING:

( ) Consumer transported by MPD car _____ to _____

( ) Consumer transported by MFD unit _____ to _____

Page 1 of 2

NARRATIVE

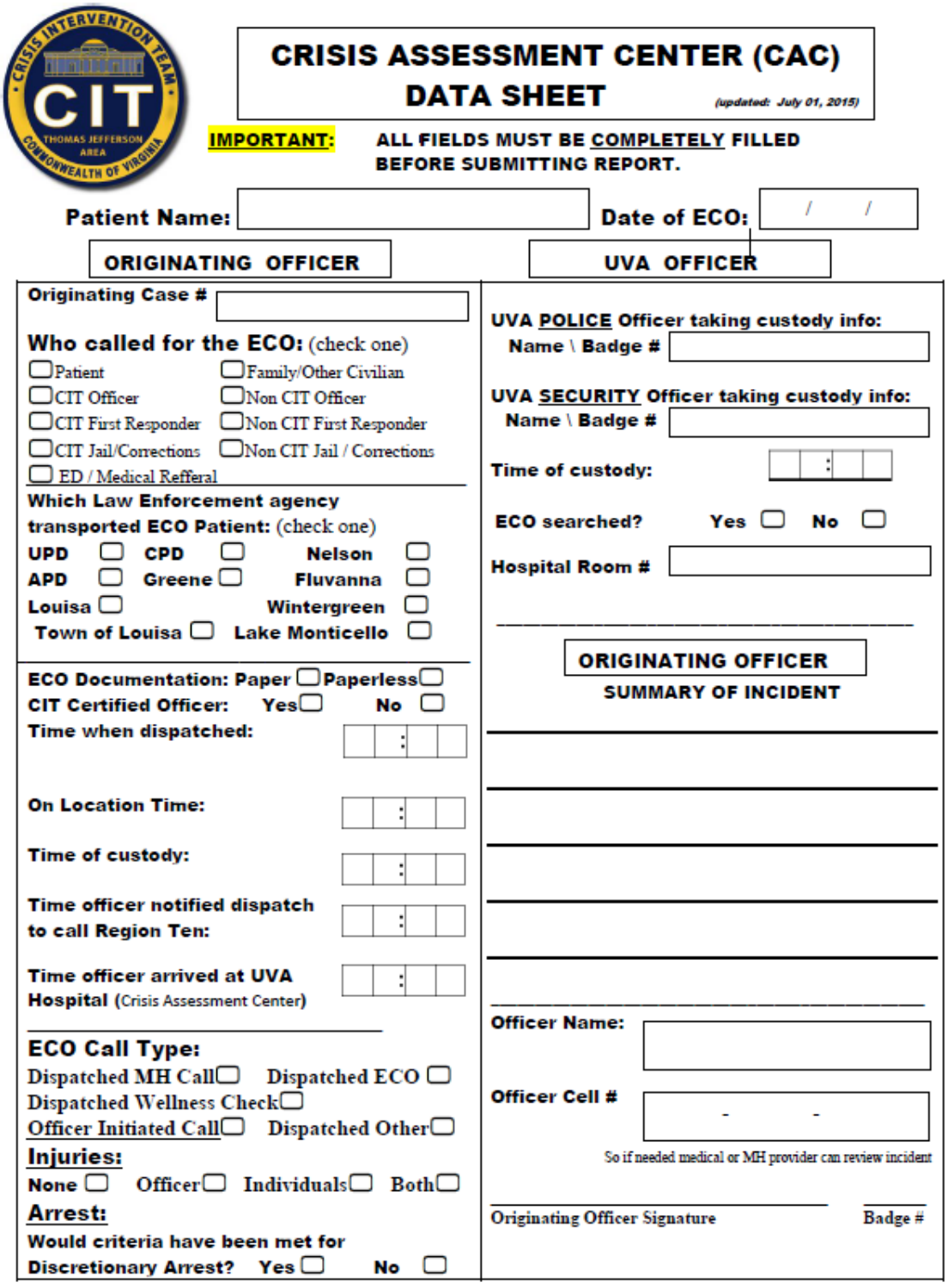
Routing Procedures:

- Precinct
- CIT Coordinator's Office

Effective Date: February 2009

Page 2 of 2

Virginia Crisis Assessment Center Data Form



CRISIS ASSESSMENT CENTER (CAC) DATA SHEET *(updated: July 01, 2015)*

IMPORTANT: ALL FIELDS MUST BE COMPLETELY FILLED BEFORE SUBMITTING REPORT.

Patient Name: _____ **Date of ECO:** / /

ORIGINATING OFFICER

Originating Case # _____

Who called for the ECO: (check one)

- ☐ Patient
- ☐ Family/Other Civilian
- ☐ CIT Officer
- ☐ Non CIT Officer
- ☐ CIT First Responder
- ☐ Non CIT First Responder
- ☐ CIT Jail/Corrections
- ☐ Non CIT Jail / Corrections
- ☐ ED / Medical Refferal

Which Law Enforcement agency transported ECO Patient: (check one)

UPD ☐ CPD ☐ Nelson ☐
APD ☐ Greene ☐ Fluvanna ☐
Louisa ☐ Wintergreen ☐
Town of Louisa ☐ Lake Monticello ☐

ECO Documentation: Paper ☐ Paperless ☐
CIT Certified Officer: Yes ☐ No ☐
Time when dispatched: __:__
On Location Time: __:__
Time of custody: __:__
Time officer notified dispatch to call Region Ten: __:__
Time officer arrived at UVA Hospital (Crisis Assessment Center) __:__

ECO Call Type:

Dispatched MH Call ☐ Dispatched ECO ☐
Dispatched Wellness Check ☐
Officer Initiated Call ☐ Dispatched Other ☐

Injuries:

None ☐ Officer ☐ Individuals ☐ Both ☐

Arrest:

Would criteria have been met for Discretionary Arrest? Yes ☐ No ☐

UVA OFFICER

UVA POLICE Officer taking custody info:
Name \ Badge # _____

UVA SECURITY Officer taking custody info:
Name \ Badge # _____

Time of custody: __:__

ECO searched? Yes ☐ No ☐

Hospital Room # _____

ORIGINATING OFFICER
SUMMARY OF INCIDENT

Officer Name: _____

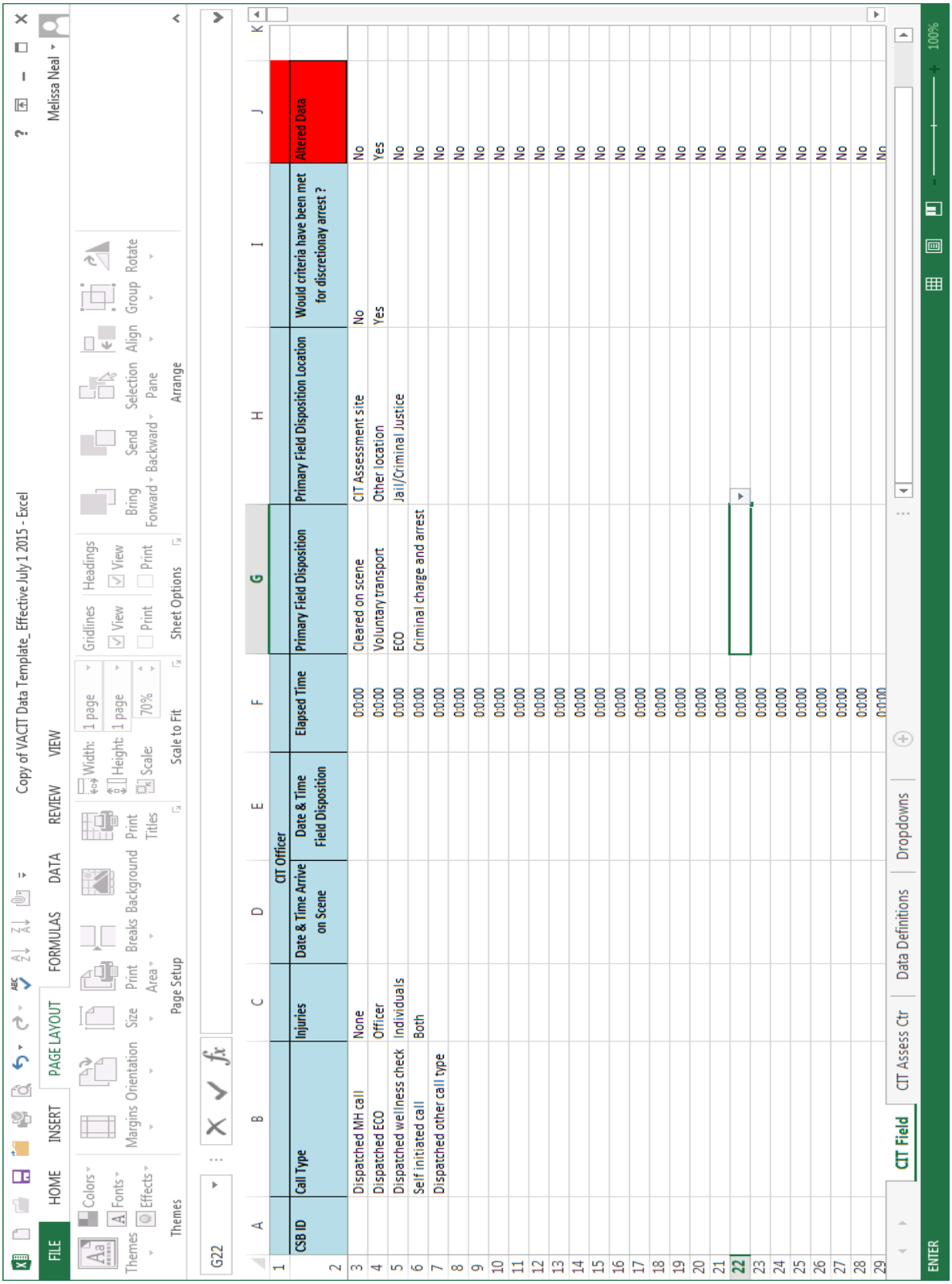
Officer Cell # - -

So if needed medical or MH provider can review incident

Originating Officer Signature _____ Badge # _____

Appendix B. Data Entry Spreadsheet

Virginia Data Entry Spreadsheet and Data Definitions



Law Enforcement Officer Field Information		
Call Type	**Drop Down Choices**	How the law enforcement officer initially comes in contact with subject.
	Dispatched MH call	Law enforcement officer dispatched to call for assistance with possible mental health involvement
	Dispatched ECO	Law enforcement officer dispatched to serve ECO
	Dispatched wellness check	Law enforcement officer dispatched for wellness check
	Self initiated call	Law enforcement officer self-initiated response on scene for any of the above
	Dispatched Other call type	Law enforcement officer dispatched to any other type of call for service that results in mental health crisis intervention
Arrival Date and Time	Manually Entered Data	The date and time the law enforcement officer arrives and makes contact with the consumer Use the following format = mm/dd/yy hh:mm, 24 hr time
Date and Time of Field Disposition	Manually Entered Data	The date and time the law enforcement officer is released from the call for service. Use the following format = mm/dd/yy hh:mm, 24 hr time
Elapsed Time	This is an automatically calculated number. This number reflects the total number of Hours : Minutes spent handling a call for service involving a Consumer	
Injuries	**Drop Down Choices**	Any reportable injury to an officer, subject or bystander that occurs AFTER the CIT officer has arrived on scene, excluding self
	None	No injuries occurred after the Consumer was initially contacted by law enforcement
	Officer	The only injuries after contact with the consumer were to law enforcment officer(s)
	Individuals	Any subject or bystander
	Both	Any subject or bystander AND any law enforcement or CIT officer
Primary Field Disposition	**Drop Down Choices**	What thelaw enforcement officer does with the subject up to the time of transfer of custody at assessment site or other call
	Cleared on scene	The Consumer was not relocated to the Assessment Site for services (ie: CSB evalution on site, or not eligible)
	Voluntary transport	Law enforcement transport of anyone who is NOT under criminal charge or ECO
	ECO	Subject in custody of a paperless or paper ECO
	Criminal charge and arrest	Services were not appropriate/available and the officer made the decision to seek criminal warrants
Primary Field Disposition Location	**Drop Down Choices**	The location where the officer was able to reach a resolution for the Consumer receiving services.
	CIT Program Assessment site	Non criminal justice, therapeutic location specifically designed to accept transfers for CIT program
	Other location	Any other non criminal justice site
	Jail/Criminal Justice	E.g. magistrates office, sheriffs office, police department
Jail Diversion?	**Drop Down Choices (Yes/No)**	If the Assessment Site were not an option, were criteria met to affect a discretionary arrest?
Other information	**Manually Entered Data**	Any categories that an individual Assessment Site program adds containing information additional to required submissions
Altered Record	**Check or Un-checked**	If the CSB ID, CCS number, or Consumer date and time of arrival have changed since a previous submission for any data you must check the box to indicate a change has occurred

Appendix C. Recommended Data At-a-Glance

Tier One: Mission Critical Data

Start with basic measures that provide critical support to the mission and work of the local CIT program.

- Community Partnerships:
    - Number of formal (MOU) and informal partnerships.
    - Number of participants from different stakeholder groups participating in different program activities.
- CIT Training Participation:
    - Number/percent of law enforcement rank and file personnel and command staff completing the 40-hour CIT training.
    - Number/percent of dispatch personnel completing CIT for telecommunications training.
    - Number of specialized trainings, as provided.
- Counts of Mental Health Calls for Service/Encounters:
    - Number of calls for mental health reasons.
    - Number of calls for other reasons that result in a "mental health" encounter that ends up addressing a mental health need.
    - Number of mental health encounters, with no preceding call from dispatch, that address a mental health need.
- Counts of Mental Health Calls Responded to by CIT Officers:
    - Number of mental health calls and encounters responded to by CIT-trained officers.
    - Number of mental health calls and encounters responded to by non-CIT-trained officers.

Tier Two: Intermediate Data

Expand existing measures and add additional data points as the program grows its capacity.

- CIT Training Outcomes (Measured pre- and post-training)
    - Law enforcement perceptions of individuals with mental illness.
    - Confidence in interaction:
        - Participant satisfaction with CIT trainings (post training only).

        - Participants' knowledge of covered topics.
        - Participants' perceptions of people with mental illness or disability.
        - Participants' confidence in their skills to serve people with mental illness or disability.
- Dispositions Health Care Referrals/ Arrest Rates:
    - Number of dispositions of mental health calls/encounters, by type:
        - Resolved on scene.
        - Voluntary transport to treatment.
        - Involuntary transport to treatment.
        - Arrest.
- Injury Rate:
    - Number of officer injuries in mental health calls/encounters out of all mental health calls/encounters.
    - Number of injuries to people with mental illnesses/in crisis in mental health calls/encounters out of all mental health calls/encounters.
- Use of Force:
    - Number of mental health calls/encounters in which force is used out of all mental health calls/encounters.

Tier Three: Advanced Data

At the Advanced tier, CIT program partners should be involved in gathering and analyzing different data components as related to their agencies' work.

- Strength of Partnership/Ownership:
    - Frequency and quality of partner interaction.
- Crisis Response Times:
    - Overall response time from 911 call to a CIT officer arriving on-scene to a mental health call.
    - Time spent on mental health calls/encounters:
        - From arrival to close of call, including transport and custody exchanges, breakout by CIT-trained officer and by non-CIT officer.
- Mental Health Call Descriptors:
    - Location of mental health call/encounter.

    - Type of call.
    - Age of client.
    - Risks and behaviors noted.
- Treatment Continuity:
    - Rate at which CIT officers notify a case manager or behavioral health provider regarding the interaction at the mental health call/encounter.
- Jail Diversion Impact:
    - Number and proportion of people with a mental illness booked into the local jail:
        - Based on brief screen.
        - Based on receipt of psychotropic medication.
- Recidivism Rate:
    - Rate at which people served by CIT officers are charged and re-entering the criminal justice.
    - Rate of repeat contacts with police and other emergency responders.
- Community Engagement:
    - Number of calls requesting a CIT Officer.
    - Proportion of community members surveyed with knowledge of or positive perceptions of CIT program.

Appendix D. Resources

Crisis Intervention Team (CIT) International – www.citinternational.org

CIT International is a non-profit organization supporting law enforcement, behavioral health, and consumer/advocate partnerships in their efforts to support individuals and their families/advocates who suffer from mental illness, and to re-direct people in behavioral health crisis away from the criminal justice system and into treatment. CIT International is dedicated to starting, strengthening, and growing CIT programs.

University of Memphis CIT Center – www.cit.memphis.edu

The Memphis Crisis Intervention Team (CIT) is an innovative police-based first responder program that has become nationally known as the "Memphis Model" of pre-arrest jail diversion for those in a mental illness crisis. The website's resource section (http://www.cit.memphis.edu/resources.php) provides a range of helpful information for CIT programs. The site provides sample CIT policies and procedures that describe standard operating procedures, law enforcement CIT coordinator duties, and CIT patrol division reporting forms.

Virginia Crisis Intervention Team Coalition – **http://www.vacitcoalition.org**

The Virginia Crisis Intervention Team (VACIT) Coalition is a collaborative membership group with a mission to promote and support the effective development and implementation of CIT programs in Virginia to improve the criminal justice and mental health systems and help prevent inappropriate incarceration of individuals with mental illness. The site includes FAQs, resources, and a link to a guidance document, Essential Elements for the Commonwealth of Virginia's CIT Programs, developed by the Virginia Department of Behavioral Health and Developmental Services (DBHDS), Department of Criminal Justice Services (DCJS), and the VACIT leadership and coalition members. This document establishes elements that are central to the success and achievement of CIT program goals.

Ohio Criminal Justice Coordinating Center of Ohio Criminal Justice Coordinating Center for Excellence – **https://www.neomed.edu/cjccoe/**

The Ohio Criminal Justice Coordinating Center of Excellence (CJ CCoE) was established to promote jail diversion alternatives for people with mental illness throughout Ohio and to reverse the trend in what has become known as "criminalization of the mentally ill." The website (https://www.neomed.edu/cjccoe/cit/) provides CIT policies and procedures, training resources, advanced online training, and other technical assistance resources for CIT programs. This includes a CIT Documentation Issues and Goals document that outlines reasons to document CIT encounters and collect data on those encounters. There is also a Sample Crisis Intervention Team Reporting (Stat) Sheet used in the field. This includes a CIT Documentation Issues and Goals document that outlines reasons to document CIT Encounters and collect data on those encounters. There is also a Sample Crisis Intervention Team Reporting Sheet that is used in the field.

Other papers and reports supporting data collection and program improvements:

Reuland, M. M. (2004). A guide to implementing police-based diversion programs for people with mental illness. Delmar, NY: *Technical Assistance and Policy Analysis Center for Jail Diversion.*

Reuland, M., & Cheney, J. (2005). Enhancing success of police-based diversion programs for people with mental illness. Delmar, NY: GAINS *Technical Assistance and Policy Analysis Center for Jail Diversion.*

Appendix E. CIT Training Evaluation Forms

Virginia CIT Pre-Training Assessment

Form ID # _____

Charlottesville CIT Training: Pre-Training Evaluation

The following survey is for research purposes only. Your responses will remain anonymous and no identifiable information will be provided to your supervisor/head of department.

Please indicate your position:

☐ Consumer Advocate ☐ Law Enforcement

☐ Communications ☐ Mental Health Professional

To answer each question, please **circle** a number:

1. How comfortable are you with your current knowledge of mental illness?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

2. How aware are you of community resources available to people with mental illness?

1	2	3	4	5
Not at all		Moderately		Very Aware

3. How would you rate your knowledge of civil commitment laws?

1	2	3	4	5
Poor		Moderate		Excellent

4. How would you rate your knowledge of the professional liability that can arise when dealing with people with mental illness who are in crisis?

1	2	3	4	5
Poor		Moderate		Excellent

5. How familiar are you with the roles of various actors in the mental health system (e.g., Region Ten, the hospitals, the courts)?

1	2	3	4	5
Not at all		Moderately		Very Aware

6. Do you believe the average person with a mental illness is more or less aggressive (such as temper outbursts and verbal threats) than an individual not suffering from mental illness?

1	2	3	4	5
More Aggressive		The Same		Less Aggressive

7. Do you believe the average person with mental illness is more or less likely to commit a violent crime than an individual not suffering from mental illness?

1	2	3	4	5
More Likely		The Same		Less Likely

8. How well prepared do you feel when handling people with mental illness in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

9. Overall, how well prepared do you think other law enforcement officers are to handle people with mental illness in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

10. How would you rate your comfort level dealing with people with mental illness in crisis?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

Please answer the following questions only if you are a law enforcement officer:

Considering the last year, on average, how many arrests per month do you think you have made involving a person with mental illness? _____

Virginia CIT Post-Training Assessment

Form ID # _____
Charlottesville CIT Training: Post-Training Evaluation

To answer each question, please circle a number:

1. How comfortable are you with your current knowledge of mental illness?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

2. How aware are you of community resources available to people with mental illness?

1	2	3	4	5
Not at all		Moderately		Very Aware

3. How would you rate your knowledge of civil commitment laws?

1	2	3	4	5
Poor		Moderate		Excellent

4. How would you rate your knowledge of the professional liability that can arise when dealing with people with mental illness who are in crisis?

1	2	3	4	5
Poor		Moderate		Excellent

5. How familiar are you with the roles of various actors in the mental health system (e.g., Region Ten, the hospitals, the courts)?

1	2	3	4	5
Not at all		Moderately		Very Familiar

6. Do you believe the average person with a mental illness is more or less aggressive (such as temper outbursts and verbal threats) than an individual not suffering from mental illness?

1	2	3	4	5
More Aggressive		The Same		Less Aggressive

7. Do you believe the average person with mental illness is more or less likely to commit a violent crime than an individual not suffering from mental illness?

1	2	3	4	5
More Likely		The Same		Less Likely

8. How well prepared do you feel when handling people with mental illness who are in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

9. Overall, how well prepared do you think the other CIT-trained officers will be in handling people with mental illness in crisis?

1	2	3	4	5
Not at all		Moderately		Very Prepared

10. How would you rate your comfort level in dealing with people with mental illness in crisis?

1	2	3	4	5
Not Comfortable		Moderately		Very Comfortable

****

What was your overall impression of CIT training?

1	2	3	4	5
Poor		Moderate		Excellent

How well do you feel the training was organized?

1	2	3	4	5
Poor		Moderate		Excellent

Please comment on the aspects of CIT training that you found **most effective**:

_____

_____

_____

Please comment on the aspects of CIT training that you found **least effective**:

_____
_____
_____

What recommendations do you have to improve CIT training?

_____
_____

VII. Contributors

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HHS Publication No. SMA-18-5065
Printed 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

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