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Illinois Criminal Justice Information Authority

EVALUATION OF CHICAGO POLICE DEPARTMENT'S CRISIS INTERVENTION TEAM FOR YOUTH TRAINING CURRICULUM

Year 2

Evaluation of Chicago Police Department's Crisis Intervention Team for Youth (CIT-Y) training curriculum

Year 2

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Key findings

Beginning in 2010, the Illinois Criminal Justice Information Authority (Authority) awarded several grants to the National Alliance on Mental Illness of Chicago (NAMI-C) to fund Crisis Intervention Training for Youth (CIT-Y) courses to officers at the Chicago Police Department (C. An Edward Byrne Memorial Justice Assistance Grant through the American Recovery and Reinvestment Act in the amount of $249,000 provided resources for 12 Crisis Intervention Training for Youth (CIT-Y) courses - four training sessions per year for three years offered on a volunteer basis. An additional two years of funding in the amount of $97,000 per year was provided through Justice Assistance Grants. The program was the first 40-hour, five-day law enforcement youth crisis intervention training offered in the country. NAMI-C and CPD developed the course to answer requests for additional training from officers responding to calls for service involving youth with mental, emotional, or behavioral disorders.

CIT-Y training objectives were to improve officer awareness of signs and symptoms of youth mental, emotional, and behavioral disorders, increase knowledge of risk levels and corresponding crisis de-escalation techniques, and provide information on CPD's mental health-related directives on youth service call dispositions. Preparing officers to identify youth in crisis, assess their risk of harm, and apply de-escalation techniques may reduce additional trauma to responding officers, youth and their families, as well as criminalization of juvenile offending behavior related to unmet needs (National Federation of Families for Children's Mental Health, 2008).

This study was part of a multi-year evaluation conducted by Authority researchers. It was designed to assess CIT-Y core training components and measure the curriculum's effect on officer knowledge of and attitudes toward appropriate responses to youth crisis calls during the second year of training implementation in 2012. The evaluation also sought to assess progress on recommended diversification of training participation among the various levels of CPD staff, especially those responsible for supervising trained officers. Authority researchers designed evaluation tools to measure training effectiveness, including a pre-/post-curriculum test, 18 training module evaluation surveys, and follow-up focus group questions. Data was collected from 144 officers attending advanced CIT-Y training courses from January 2012 through May 2013 after completing basic adult CIT training, and a comparison group of 137 officers volunteering for adult CIT training classes but not yet trained in crisis intervention techniques.

CIT-Y training participation

Only officers who had completed an adult crisis intervention course (available at CPD since 2004) were eligible for CIT-Y training. Both the adult and youth CIT courses are offered on a voluntary basis. Research suggests that officers often self-select CIT training because they have family members with mental illness or have failed to help individuals in previous crisis situations and want to avoid such failures in the future (Doulas & Lurigio, 2014). However, as documented in the initial CIT-Y evaluation report (Skorek, 2012), the voluntary nature of the program can lead to lack of program awareness and department support for implementation of CIT-Y techniques in the field. It was then recommended that training participation be expanded to more

diverse levels of staff to overcome barriers to training implementation. Findings indicated that Year 2 CIT-Y training participants did not significantly differ in characteristics from those receiving training in Year 1 - the majority were older officers with close to two decades of CPD experience, and there were virtually no participants of higher rank beyond sergeant. Further, training participants did not differ in composition from a comparison group of officers seeking initial CIT training. Since the pool of eligible CIT-Y training participants was not attracting supervisory and command staff, departmental diversity in CIT-Y training was not likely to be achieved.

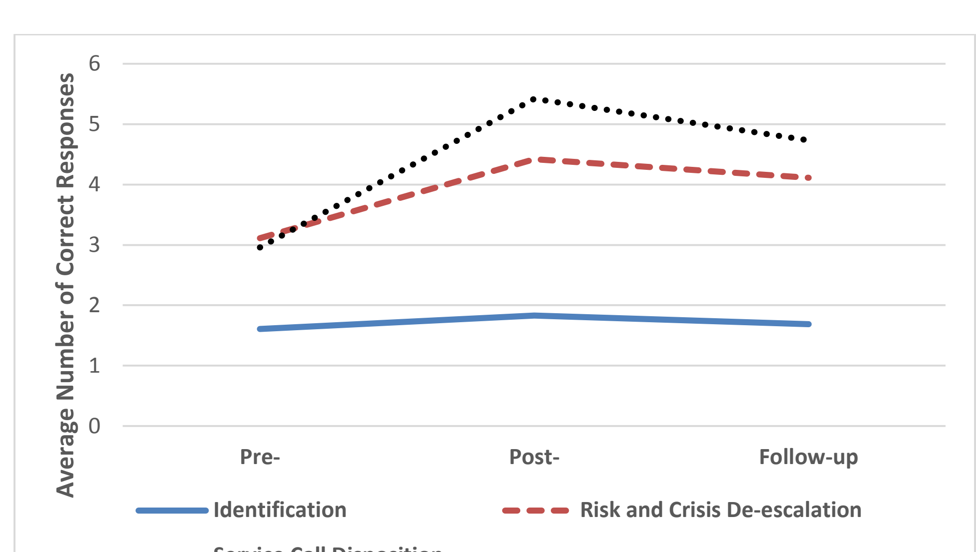
Training effect: Increased knowledge and more favorable attitudes toward handling youth crisis service calls

Some material taught in the basic adult course carried over into the advanced youth course, including how to gauge risk levels of harm during a crisis call, corresponding crisis de-escalation techniques and information on department mental health-related directives (*Appendix A*).

At the start of the CIT-Y training course, participating officers (n=144) averaged 2.55 years of law enforcement experience with CPD as a CIT officer, and had higher baseline knowledge for two of the three training objectives—*Risk & de-escalation* and *Service call disposition*—than untrained officers (n=137). They also differed with respect to their confidence in successfully responding to youth in crisis, their role as first responders, and their opinion of the mental health system as an effective solution to police referrals. These findings indicated that the prerequisite adult course provided a foundation of knowledge for more advanced CIT-Y training. This is consistent with past research (Compton, Bahora, Watson, & Oliva, 2008; Teller, Munetz, Gil, & Ritter, 2006).

Figure 1 shows the changes in knowledge regarding CIT-Y objectives measured in officers at pre-test, after training, and at six months after training. Officers had more correct responses to test questions on two of the three training objectives *Risk & crisis de-escalation* and *Service call disposition* immediately following the week-long training session and six months later than on the pre-test (*Risk & crisis de-escalation* and *Service call disposition).* However, there was no statistically significant training effect for the *Identification* of youth mental health signs and symptoms objective over time. Responses to items measuring attitude change also showed the training positively influenced officers' confidence in their ability to handle youth crisis calls and the mental health system's capacity to provide effective solutions.

Figure 1
Change over time in training participants' knowledge of CIT-Y training objectives (n=26)



Officer satisfaction with training

Participating officers (n=144) were very satisfied with the CIT-Y training curriculum. They found it be relevant to their law enforcement role, engaging, and easy to understand. They were also very satisfied with expert presenters, finding them knowledgeable, professional, and prepared. Presenter satisfaction ratings positively correlated with knowledge of CIT-Y objectives. Thus, as trained officers' satisfaction with presenters increased so did their post-curriculum test scores.

Of 43 officers providing responses about training limitations, the most commonly mentioned was lack of role-playing opportunities. A majority of trained officers (61 percent, n=88) anticipated barriers implementing newly learned techniques in the field; one-third (n=30) stated that the department's culture could present a barrier, and 23 percent (n=20) credited lack of CIT training among supervisors as a potential barrier.

Focus group discussion with CIT-Y officers

A subgroup of trained officers (n=26) attended focus groups six months post-training. Officers in all focus groups reported the CIT-Y training prepared them with appropriate responses to youth crisis calls. Some requested more guidance for handling repeat incidents involving the same youth and their families. Participants reported using crisis de-escalation techniques daily and added that there were safety concerns for officers and youth when they were not applied.

Focus group participants identified barriers to implementing CIT-Y training information on their jobs, including lack of program awareness among the department and public, lack of department support, difficulties with dispatcher linkage to calls, availability of non-emergency community-

based treatment providers besides psychiatric hospital admission, and difficulty in accessing department paperwork to document the event.

Focus group discussion included ways to enhance the application of training information in the field. One suggestion was to improve record sharing across systems, including the police department, detention, courts, hospitals, youth protective agencies, and behavioral health providers. Another recommendation was to offer refresher courses.

Implications for policy and practice

Based on the evaluation findings, the following recommendations are offered.

Improve the CIT-Y training curriculum and departmental reporting processes to help officers better identify youth in crisis.

The CIT-Y training curriculum used in Year 2 was focused on three training objectives – the identification of youth mental illness signs and symptoms, awareness of levels of risk of harm and appropriate de-escalation techniques, and knowledge of CDP protocols for responding to youth crisis calls. For two of the three core CIT objectives—*Risk & crisis de-escalation* and *Service call protocols* trained officers' knowledge was statistically higher at six months post-training than before the course, suggesting that these training objectives were being met in the course. However, there was no statistical evidence of knowledge gains for the *Identification* training objective over time. On the contrary, findings revealed that the training barely caused participants' scores to increase on this domain to the levels of the untrained officers – participants' average knowledge scores after the training was 1.83 correct answers (out of three items), compared to 1.89 average scores for the group of untrained officers. While some research suggests that differentiating between youth crisis calls and other calls involving youth may be difficult simply because they "reflect those of the adolescents living in the community" (Doulas & Lurigio, 2014, p. 121), this is a foundational concept of the youth crisis intervention team program.

The core training component of youth-in-crisis identification can be bolstered in several ways. Future trainings should present real-world youth crisis call data captured by the Mental Health/CIT report in the *Youth mental illness—Signs & symptoms* module for better instruction on recognizing youth in crisis. Training participants may better retain scenario-based information that they have experienced on the job. Curriculum developers can also incorporate this material into such modules as *Q&A with CIT-Y officers*, as well as the *Department Procedures for Mental Health Crisis* module, for further reinforcement of the information. If such changes are made, the curriculum test should be revised to reflect this new material, and the number of questions increased to equal those testing knowledge of the other two core components (which averaged nine questions, not just three).

At the departmental level, problems with this core component of CIT-Y training may be reflective of the fragmented nature of youth crisis call tracking. Training participants identified problems with the reliance on paper-based documents to record information about these calls, which severely limit the ability to track the frequency, characteristics, and outcomes of mental

health calls, as well as dispatcher success in assigning calls to CIT-Y officers. The CIT-Y curriculum cannot be expected to accurately impart information on these calls if the department does not generally know their characteristics. At the very least, this evaluation pointed to a disconnect between course content and officer knowledge, which may improve as departmental record tracking is improved and the resulting knowledge about youth crisis calls is incorporated into the training curriculum.

Expand CIT-Y training to more officers and partnering agencies and develop refresher courses.

Recommendations made by training participants in both Year 1 and this Year 2 evaluation stressed the importance of wider adoption of CIT-Y training within the department for greater impact in the field. This evaluation found that there was little or no change in the composition of training participants between the first and second year, and the predominance of patrol officers with many years of service was evident even in the untrained group of officers volunteering for basic CIT training. Reliance on this volunteer pool of CIT trained officers as a departmental training policy for further CIT-Y training will not achieve more diversity in trained staff, particularly in reaching supervisory-level staff that can reinforce the use of CIT-Y training techniques in the field. This evaluation found that prior knowledge of core CIT-Y concepts was higher than for untrained officers, but that even the most informed participants (who were already trained as adult CIT officers) started out with low pre-test scores (an average of 8 out of 21 questions correctly answered). Therefore, the departmental policy of requiring adult CIT training as a prerequisite for CIT-Y training should be re-evaluated as to its effect on reaching a wider training audience.

Expansion of CIT-Y training should be considered in two other aspects. Participants in this evaluation commented that it could be difficult to apply CIT-Y techniques in tandem with untrained officers who may misinterpret de-escalation techniques as outside of normal protocols. It was recommended that CIT-Y training video presentations be made available to untrained officers through roll-call presentations or on CPD’s website. Increased awareness of CIT-Y training concepts will promote more coordinated responses by all officers responding to youth crisis calls and dispel misconceptions. Training participants also recommended expansion of CIT-Y training to partnering entities, particularly school personnel and youth probation officers. While this may be beyond the scope of departmental training capacity, making the training video material available to other entities could fill this perceived training need. Exposure to CIT-Y training concepts developed from a law enforcement perspective can also inform partnering entities of that perspective, which may differ from the viewpoint of their profession.

Finally, CIT-Y training is limited to the one 5-day course. Participants in this evaluation recommended the opportunity for yearly refresher courses to support CIT-Y officer knowledge of training information and address implementation barriers and any questions/concerns.

Develop protocols and training to help officers more effectively deal with repeat youth crisis calls.

Partnerships with mental health service providers are fundamental to successful law enforcement responses to youth crisis calls. The CIT-Y program model calls for diversion from the juvenile justice system and linkage to appropriate treatment services to reduce subsequent law enforcement contact, arrests, and jail and hospital admissions (National Alliance for the Mentally Ill, 2009). This model assumes that diverted youth do not re-enter the juvenile justice system because of successful treatment of their underlying mental health issues. However, training participants identified that one barrier to successful CIT-Y training implementation is the lack of information on how to deal with other agencies when dealing with repeat crisis calls involving the same youth and their families. They identified the lack of non-emergency, but urgent, linkage options as one barrier to successful youth diversion. In particular, they expressed a need for more cross-system information sharing and streamlined follow-up processes with child protective services, especially when dealing with service calls involving child abuse and neglect. It is recommended that department CIT-Y directives be enhanced to address these inter-agency collaborations.

Conduct additional evaluations of the impact of CIT-Y training.

Future evaluation efforts should explore implementation and impact of CIT-Y training in the field. There are many avenues for future investigation: the outcomes for youth handled by CIT-Y officers, an assessment of adherence to CIT department directives and cross-system collaborations, and the diffusion of CIT-Y concepts and techniques through informal peer training on the job. The key to future evaluation efforts is better data collection on mental health calls within the department. Toward that end, researchers developed a proposed information system map to assist in data exchange development (see Appendix F). The recommended automation of the Mental Health/CIT form and record linkage among collaborating partners will allow for more research on the prevalence, characteristics, and dispositions of youth crisis calls which will result in a better understanding crisis call characteristics, officer responses, and the progression of violence.

Introduction

Nationally, it is estimated that as many as 70 percent of the 2 million youth and young adults arrested each year suffer from mental health disorders which the justice system is not equipped to handle (Hammond, 2007). These youth could be diverted to community-based treatment services rather than the juvenile justice system. Law enforcement, under the doctrine of *parens patriae*, have the authority to intervene in mental health-related incidents and determine the juvenile's trajectory - resolution on scene, arrest, or psychiatric hospitalization transport. However, law enforcement officers called to intervene in crisis situations may not have the skills to safely interact with youth in crisis. Too often, officers resort to excess or even deadly force (Wexler, 2016), although many individuals with mental disorders pose little risk of harm to others and are much more likely to harm themselves or be victims of violence (Teplin, McClelland, Abram, & Weiner, 2005).

The Crisis Intervention Team (CIT) model was developed in response to the need for alternative law enforcement response to crisis calls. The team is designed to be a collaboration between police and appropriate community service systems to ensure that individuals with mental health needs are referred for services rather than brought into the criminal justice system (National Alliance for the Mentally Ill, 2009). Extending this model to youth crisis calls requires additional training to prepare officers to identify youth in crisis, assess their risk of harm, and apply de-escalation techniques to reduce trauma to themselves, youth and their families and avoid criminalization of juvenile behaviors related to unmet needs (National Federation of Families for Children's Mental Health, 2008).

I. Chicago Police Department's Crisis Intervention Team for Youth

The Chicago Police Department (CPD) established its adult CIT training in 2004 as a pilot in two districts and expanded the program to the entire department in 2006 on a voluntary basis. Research suggests that officers are drawn to CIT training because they have family members with mental illness or that they had failed to help individuals in previous crisis situations and wanted to avoid such failures in the future (Doulas & Lurigio, 2014). The CIT course teaches officers how to recognize signs and symptoms of adult mental illness and exercise skills to defuse crisis situations and reach service calls dispositions based on department mental health-related directives. The program has been found to reduce use of force in encounters with persons with mental illness and increase linkage to services (Watson, 2010).

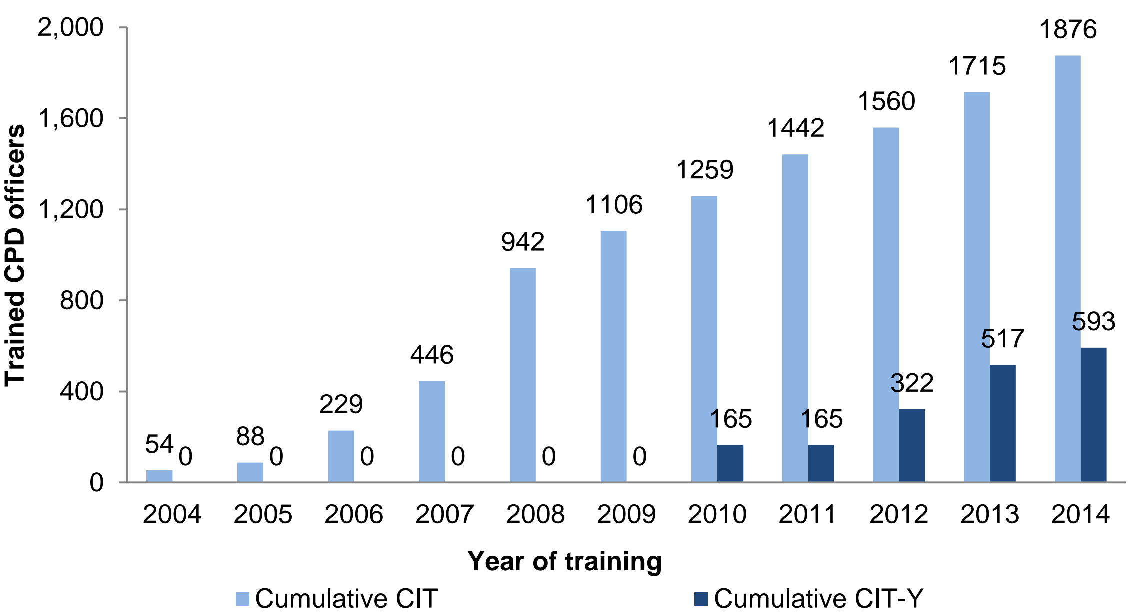
Research on adult crisis intervention team training in other jurisdictions found trained officers used low-lethality methods when responding to events with individuals who posed serious to extreme risk of violence, and were very likely to resolve events by means of psychiatric hospitalizations rather than ending in an arrest (Skeen & Bibeau, 2008; Steadman, Borum, & Morrissey, 2000). In 2011, CPD made 3,166 non-criminal, psychiatric hospital transports (Research and Development Division, personal communication, January 2013).

In response to officers' requests for additional training, CPD was the first police department in the country to develop a 40-hour, five-day training on best practices for responding to service

calls involving youth in crisis. CPD and the National Alliance on Mental Illness of Chicago (NAMI-Chicago) collaborated in 2009 to develop the Crisis Intervention Team for Youth (CIT-Y) course, with additional input from local mental health professionals including school crisis workers, hospital administration, counselors, and psychologists. CIT-Y was designed to be an advanced training for CPD officers who already completed the basic, adult, 40-hour, five-day, CIT training.

Figure 2 outlines annual cumulative numbers of CPD CIT and CIT-Y trained officers. As of October 1, 2014, a total of 91 adult CIT basic trainings were held with 1,876 sworn officers trained (per communication with CPD CIT Training Lead Instructor). CPD held a total of 18 CIT-Y trainings between June 2010 and August 2014 and 593 sworn CPD CIT officers attended, which is about one-third of CPD's CIT officers.

Figure 2
Cumulative number of CPD officers CIT and CIT-Y trained by year



CPD's adult and youth CIT trainings and application of course techniques are upheld through two department directives (*Appendix A*), which are policies that recognize the need for mental health training and provide procedures for operation. Although CIT trainings are voluntary, these directives define how the department as a whole will operate to ensure that law enforcement respond appropriately when called to situations involving an individual with mental illness or serious emotional disturbance. The mechanics for operation include: a) creating a cadre of trained officers, b) providing dispatch with a list of trained officers, c) screening 9-1-1 calls to determine if an incident involves a mental health component, d) assigning trained officers to pre-identified mental health calls, and d) requiring officers to document incidents that had a mental health component, but were not pre-identified by 9-1-1 dispatch.

II. Authority funding and research support

In 2010, the Illinois Criminal Justice Information Authority awarded the National Alliance on Mental Illness of Chicago (NAMI-C) an Edward Byrne Memorial Justice Assistance Grant through the American Recovery and Reinvestment Act in the amount of $249,000 to fund 12 Crisis Intervention Training for Youth (CIT-Y) training sessions for officers at the Chicago Police Department. The grant provided resources to NAMI-C to conduct 12 CIT-Y sessions—four per year for three years – in which officers were instructed on signs and symptoms of youth mental, emotional, and behavioral disorders, risk levels and corresponding de-escalation techniques, and service call dispositions based on department mental health-related directives. Funding was continued under the Justice Assistance Grants program for two additional years, in the amount of $94,000 each year.

Authority researchers completed an evaluation of Year 1 of the training program in 2012, and recommended curriculum enhancements such as the incorporation of videos and other more relevant examples to explain technical/clinical content, more diversity in the types of staff trained, including more supervisors and dispatch officers, and revisions to evaluation tools used to assess how course components influence officer knowledge and attitudes towards crisis intervention and youth in crisis. The final report is available on the Authority's website: http://www.icjia.state.il.us/assets/pdf/ResearchReports/CIT_Year1_July_2012.pdf.

III. Year 2 CIT-Y training goals and objectives

CPD's Year 2 CIT-Y training curriculum consisted of 18 sessions presented over 5 days in a classroom setting at the training academy or headquarters. Presenters included CIT-Y trained officers, psychiatrists, psychologists, counselors, school crisis workers, NAMI-C staff, and youth with mental, emotional, and behavioral disorders and their families. Instructional techniques included PowerPoint slides, video, and group discussion. ICJIA's funding was used for expert presenters and course material—trained officers were given a course binder that had all 18 module PowerPoint presentations with copies of the department's mental health-related directives, Illinois' Mental Health Code, paperwork for emergency psychiatric hospitalization, and a list of community-based mental health services available to youth in Chicago.

CIT-Y training goals were:

- diversion of youth in crisis from the juvenile justice system to community-based mental health treatment, and:
- safe interactions when encountering youth with mental, emotional, or behavioral disorders.

CIT-Y training objectives to achieve training goals included:

- increasing law enforcement officer knowledge of signs and symptoms of youth mental, emotional, and behavioral disorders;
- enhancing officers' ability to assess youth risk of harm to self or others and apply corresponding crisis de-escalation techniques; and,
- improving awareness of existing department directives to achieve and document appropriate dispositions to crisis calls.

A. Year 2 CIT-Y curriculum enhancements

In light of Year 1 evaluation findings, CIT-Y training staff made several revisions to the curriculum. These enhancements included:

- Creation of two field reference guides to illustrate CIT-Y objectives (*Appendix B*) and service call dispositions available for the range of a youth's involvement with justice and mental health treatment systems (*Appendix C*). These field reference guides were added to the *Department procedures for mental health crises* module, as requested by Year 1 CIT-Y training participants.
- A *Q & A with CIT-Y Officers* module replaced the *Juvenile Intervention Support Center (JISC)* module. Year 1 training participants recommended this change, as they saw a need for time when participants can ask CIT-Y officers questions about their experiences of applying course information in the field.
- Technical/scientific material within the *Child & Adolescent Brain Development* module was replaced with a short documentary that showed police responding to a school-based service calls due to a disruptive student.
- Added an *Adolescents & Gangs* module that presents information about why youth join gangs.

B. Year 2 CIT-Y training modules and learning objectives

The 18 CIT-Y training modules and their associated learning objectives included:

1. *Introduction, Child & Adolescent Overview*
   - Definitions of mental illness and serious emotional disturbance.
   - Prevalence of youth mental illness.
   - Examples of how untreated youth mental disorders affect school performance and increase risk of juvenile justice system involvement.
   - Role of law enforcement as first responders to youth mental health-related incidents.

2. *Child & Adolescent Brain Development*
   - Brain maturity and how it relates to youth impulsivity, planning, and judgment.
   - How genetics and environmental factors affect brain development.

3. *Signs & Symptoms of Youth Mental Illness*
   - Origins of youth mental illness and signs and symptoms of youth mental disorders.
   - Questions to ask youth/parents/guardians to recognize signs and symptoms of mental illness.

4. *Medical & Development Disabilities*
   - Definitions of developmental disability and dual-diagnosis.
   - Types of developmental disabilities and laws protecting the civil rights of individuals with disabilities.

5. *Violence & Urban Trauma*
    - Definition of trauma and types of traumatic events.
    - Bridge between violence and traumatic stress response.
    - Strategies to adopt when CIT officers respond to trauma calls.

6. *Adolescents & Gangs*
    - Information about why youth join gangs.
    - Effects of adverse childhood experiences, such as post-traumatic stress disorder.

7. *Self-Injurious Behavior*
    - Types and causes of self-injurious behaviors.
    - Risk factors and warning signs of youth self-harm.
    - Distinction between youth self-harm and suicide.

8. *Substance Abuse & Co-Occurring Disorders*
    - Meaning of and facts about substance abuse and co-occurring disorders.
    - Factors that contribute to co-occurring disorders.
    - Signs of adolescent substance abuse and consequences.

9. *Psychotropic Medications*
    - Overview of medications used to treat symptoms associated with youth mental illness.
    - Side effects of psychotropic medications.

10. *Parents & Teachers as Allies*
    - Overview of National Alliance on Mental Illness.
    - Collaborating to address and alleviate shortage of mental health resources for youth.
    - Importance of early intervention and education.

11. *Crisis Intervention Skills & Risk Assessment*
    - Youth risk assessment based on levels of anxiety, anger, hostility, and violence.
    - Crisis de-escalation techniques.

12. *Department Procedures for Mental Health Crisis*
    - Chicago Police Department procedures to follow and paperwork to complete when responding to youth crises.
    - Circumstances requiring youth transport for emergency psychiatric assessment.

13. *Q & A—MH Scenarios*
    - Examples of how CIT-Y officers applied training techniques.
    - Strategies to overcome barriers when applying CIT-Y techniques in the field.

14. *Family Perspectives*
    - Personal experiences of youths with mental illness and their families, including ways officers can assist youth and their families when responding to mental health crises.

15. Seamless Integration with Schools

- Overview of Chicago Public Schools' Crisis Management Unit and its reliance on Chicago Police Department officers.
- Utilizing the Crisis Management Unit to assist youth with mental health needs.

16. Department Procedures for Special Circumstances

- Chicago Police Department procedures for processing juveniles and minors.
- Definitions of legal terms, including mandated reporter, abused minor, dependent minor, and family member.

17. FBI—School Violence & School Shooters

- Overview of school shooting incidents across the country.
- Assessing school violence.
- Signs that school violence may occur.

18. Community Resource Panel

- Overview of local community-based mental health services for youth.
- Utilizing resources when responding to calls involving youth with mental health needs.

See Appendix D for the CIT-Y daily training schedule and order of module instruction.

While all material presented during the 5-day course were designed with these training goals and objectives in mind, certain aspects of the curriculum were identified as key learning objectives and were the focus of this evaluation. These included: identification of signs and symptoms of youth mental illness (Module 3), risk of harm & crisis de-escalation techniques (Modules 11 and 14), and service call dispositions (Modules 12, 15, and 18).

Literature review

Youth mental health and disorders

Youth who are mentally healthy meet developmental and emotional milestones including social and coping skills that lead one to have a sense of identity and worth and connection to the community. These youth function well at home, school, and in the community; they are able to learn, be productive, and have a positive outlook regarding their quality of life (Hoagwood, Jensen, Petti, & Burns, 1996; Lippman, Moore, & McIntosh, 2011; World Health Organization, 2005). "Good mental health in childhood is a prerequisite for optimal psychological development, productive social relationships, effective learning, an ability to care for self, good physical health, and effective economic participation as adults" (World Health Organization, p. 7).

It is estimated that one in five children in the U.S. has a mental disorder (U.S. Department of Health and Human Services, 1999) indicated by a pattern of thoughts, emotions, or behaviors that cause distress or impair functioning in such a way that it disrupts home, school, or social environments. Researchers have found that 13 percent of youth aged eight to 15 years have symptoms so severe that their daily lives are affected, such as the inability to achieve academically (Merikangas, He, Brody, Fisher, Bourdonj, & Koretz, 2010). This figure increases to 21 percent in youth aged 13 to 18 years (Merikangas, He, Burstein, Swanson, Avenevoli, Cui, Behet, Georgiades, & Swendsen, 2010). In addition, half of all lifetime cases of mental disorders begin by age 14 and three-quarters by age 24 (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005).

Failure and delay in initial treatment contact

On average, youth suffer from signs and symptoms of mental, emotional, and behavioral disorders for eight to 10 years before they are treated for those disorders (Wang, Berglund, Olfson, Pincus, Wells, & Kessler, 2005). Delaying access to needed mental health services can adversely impact major, developmental years in a youth's life and "interventions to speed initial treatment contact are likely to reduce the burdens and hazards of untreated mental disorders" including school failure and justice system-involvement (Wang et al., 2005, p. 603). One study found that linkage to treatment varies by race—White youth are linked to treatment twice as often as non-White youth (24 and 12 percent respectively) (Kataoka, Zhang, & Wells, 2002). Non-White youth are more likely to be referred to mental health services by teachers, probation officers, or child welfare representatives, whereas White youth are more likely to self-refer or receive a referral from healthcare providers (Daryanani, Hindley, Evans, Fahy, & Turk, 2001). Factors that contribute to treatment disparities include stigma, poverty, absence of culturally appropriate services, and variation in problem identification (Daryanani, et al.).

Youth with mental health needs who are not in school are at great risk for justice system involvement. It is estimated that 50 percent of youth who have unaddressed mental, emotional, and behavioral disorders fail to graduate from high school (U.S. Department of Education, 2001), with nearly 75 percent arrested within five years of dropping out (Wagner, 1995). The

failure of school administrators, mental health providers, and justice system professionals to address youth mental health needs in a coordinated and comprehensive manner has increased the likelihood that they will encounter the police and further penetrate the juvenile and adult criminal justice systems (Doulas & Lurigio, 2014). Without efficient access to effective, community-based treatment, many with serious mental disorders will continue to end up in the justice system, often for minor quality-of-life offenses and other non-violent crimes, helping to perpetuate the mistaken impression that mental illness, criminality, and violence are inextricably linked.

Law enforcement responses to youth crisis calls

Much of youth delinquent behavior can be attributed to unaddressed mental, emotional, and behavioral disorders (Howell, 2003). It is estimated that nationally only 20 percent of youth in need of mental health services receive care (U.S. Department of Health and Human Services, 1999). A survey conducted by the National Alliance on Mental Illness (2001) found that one-third of parents who had a child placed in a temporary detention center reported it happened solely so that they would receive otherwise non-accessible mental health treatment. Law enforcement officers across the county have self-reported a phenomenon of mercy booking, which occurs when an arrest is made to ensure an individual's safety (Wells, & Schafer, 2006). More research is needed to better understand the occurrence of mercy booking, especially among the youth population as an estimated 25 percent of detained youth have histories of victimization including physical and sexual abuse (Skorek, 2014).

The National Center for Mental Health and Juvenile Justice (NCMHJJ) identified the event of police responding to youth crisis calls as a critical intervention point and "police response at this initial contact has significant implications in determining what happens next" (Skowyra & Cocozza, 2007, p. 7). Under the doctrine of parens patriae, law enforcement are given the power to intervene in a mental health-related incident, determining the juvenile's trajectory (e.g., arrest, psychiatric hospitalization transport, or resolution on scene). Mental health training for law enforcement has shown to increase linkage to mental health services and improve officer and public safety when servicing calls particularly those involving aggressive or potentially aggressive youth (Herz, 2001).

Although, Howell (2003) agrees that an opportunity for intervention exists at the point in time when law enforcement respond to service calls involving a youth appearing to have unmet mental health needs, he suggests a number of factors must be in place to prevent youth with mental disorders from further penetrating the juvenile justice system by diverting them at their earliest state of justice contact into community-based mental health care including:

1) A cadre of law enforcement officers properly trained to identify the signs and symptoms of mental disorders among the youth population with whom they are interacting, or mental health professionals readily available to assist the police in responding to incidents involving youth in crisis.

2) Law enforcement has a designated emergency psychiatric facility where youth requiring immediate care can be transported.

Transporting an individual in psychiatric crisis to an emergency department is often frustrating for both law enforcement and mental health professionals (Steadman, Stainbrook, Griffin, Draine, Dupont, & Horey, 2001). Some jurisdictions have created triage centers to augment crisis intervention team training, allowing officers to divert call subjects to community-based treatment including a psychiatric assessment and psychotropic medications. Texas operates such programming and since its inception in 2003, more than $50 million in taxpayer costs have been saved by diverting more than 17,000 people from jails and emergency rooms while reducing overcrowding in Bexar County Jail from over-capacity to 500 empty beds (Jail Diversion Program, n.d.). Collaboration between the justice and mental health systems may increase officer and public safety while reducing costs associated with unaddressed mental disorders and violence.

Methodology

This evaluation was conducted from January 2012 to May 2013 and utilized a baseline pre-test completed by training participants and a group of untrained officers, a post-curriculum test, course evaluation surveys, and focus groups of trained officers to obtain:

- Comparisons between training participants and untrained officers on key personal and organizational characteristics.
- Comparisons between training participants and untrained officers on prior knowledge of key training objectives (identification of signs and symptoms; risk of harm and de-escalation techniques; departmental protocols for handling incidents).
- Participants' self-reported understanding of course information and satisfaction with content and delivery.
- Immediate, short-term, and long-term changes in the participants' knowledge of training objectives.
- Comparisons between training participants and untrained officers on baseline attitudes toward youth crisis calls, and the local mental health system.
- Immediate, short-term, and long-term changes in participants' attitudes toward youth crisis calls and the local mental health system.
- Feedback on the training, training implementation successes and barriers,

Approval to conduct this research was granted by the Authority's Institutional Review Board.

I. Evaluation tools

A. Year 2 pre-post curriculum test

The Year 2 curriculum test was substantially revised from the one used in the Year 1 evaluation, which had been developed by CIT-Y training staff from material other than course content and therefore poorly measured officer knowledge of actual training objectives. Some questions were derived from previous studies (Clayfield, Fletcher, & Grudzinskas, 2011; Finn & Stalans, 2002; Wells & Schafer, 2006). Unlike the evaluation instrument used previously, participants' responses could be linked at all measurement points for more robust analysis of training effects.

The test was administered before training began and again at the conclusion of the 5-day course. Baseline knowledge and attitude scores were obtained from a group of officers not yet exposed to any CIT training (untrained officers) and from the officers about to receive the CIT-Y training. Post-test knowledge and attitude scores were obtained solely from trained officers completing the 5-day course. The curriculum test was also used to gauge knowledge and attitude retention six months after training.

Authority researchers designed the pre-post curriculum test to answer the following research questions:

- To what extent did participants volunteering for CIT-Y training in Year 2 reflect more diversity in CPD job titles and demographics than Year 1 participants, as recommended in the Year 1 evaluation?
- To what extent did training participants (who had prior CIT training as a course prerequisite) differ from untrained officers in their knowledge and attitudes towards youth crisis calls prior to CIT-Y training course participation?
- To what extent did training improve participant knowledge of training objectives and attitude towards youth crisis calls and the local mental health system?
- To what extent did participants retain knowledge gains and attitudinal changes in the months after training?

B. Officer characteristics questions

Eight questions on officer characteristics were included to allow researchers to compare Year 1 and Year 2 training participants' demographics and law enforcement experience. Further, researchers examined whether these officer characteristics were related to knowledge of training objectives and attitudes toward youth crisis calls.

The curriculum test included 47 questions designed to assess officer knowledge of, and attitudes towards, CIT-Y training objectives. These included: 21 multiple-choice questions that reflected knowledge of the CIT-Y decision tree (*Appendix C*); 18 agreement statements that assessed attitudes towards responding to youth crisis calls; and eight questions that measured participant characteristics and job experience

C. Knowledge questions

The curriculum test included 21 multiple-choice knowledge questions tied specifically to the CIT-Y decision tree (*Appendix C*). This was information delivered in seven core training modules designed to increase officer knowledge of the three training domains of identification of signs and symptoms of youth mental illness, assessment of risk of harm and corresponding de-escalation techniques, and department service call completion options. The questions were derived as follows:

- **Identification of signs and symptoms**– Three questions were derived from the three-hour *Signs & Symptoms of Youth Mental Illness* module, which covered signs and symptoms of youth mental, behavioral, and emotional disorders.

- **Risk of harm & de-escalation techniques**– Ten questions were derived from the two-hour *Family Perspective* module and the two-hour *Crisis Intervention Skills & Risk Assessment module,* which covered assessing risk levels of harm and corresponding de-escalation techniques.

- **Service call disposition** – Eight questions regarding CPD protocols for responding to youth mental health-related incidents were derived from the one-hour *Seamless Integration with Schools* module; the two-hour *Department Procedures for Mental Health Crisis* module; and one-hour *Community Resource Panel* module.

D. Attitude questions

Researchers developed 18 items to determine whether officers' attitudes toward youth crisis calls changed over the 5-day training course, and further, whether those changes were related to changes in knowledge scores. Baseline attitude scores were obtained from both the officers about to receive CIT-Y training, and the group not yet trained in the CIT model. Answers were given as 1=strongly disagree, 2=moderately disagree, 3=slightly disagree, 4=slightly agree, 5=moderately agree, and 6=strongly agree.

Once the data were collected, a factor analysis was conducted to identify any underlying themes measured by the attitude questions. Using the principal components method, four factors (themes) were found, accounting for 62 percent of the variance within officers' responses. These themes included: 1) attitudes towards CIT-Y training objectives, (2) attitudes towards the mental health system, (3) attitudes towards handling crisis calls, and (4) attitudes toward youth in crisis.

The five items found to measure **attitudes towards core CIT-Y training objectives** were:

1. I feel confident in my ability to recognize youth mental disorders.
2. I am adequately trained to handle situations/calls involving mentally ill/emotionally disturbed youth.
3. I feel confident in my ability to handle situations involving mentally ill/emotionally disturbed youth.
4. I know when to implement an application for emergency psychiatric commitment of a youth.
5. I feel comfortable accessing the MHS to resolve calls involving youth with mental illness.

Together, these items created a scale (estimate of internal reliability (Cronbach's alpha) of 0.87) where higher combined scores represented more positive attitudes toward identifying and safely resolving youth crisis service calls.

The six items found to measure **attitudes toward the local mental health system (MHS)** were:

1. The MHS in my area provides effective solutions for managing mental health-related calls.
2. The MHS in my area appropriately processes police referrals.
3. The MHS in my area is cooperative with law enforcement.
4. The MHS in my area has adequate resources to respond to youth who do not meet emergency criteria, but need mental health services.
5. The MHS in my area efficiently processes police referrals.
6. The MHS in my area is willing to accept violent youth.

These six items also created a scale (Cronbach's alpha of 0.88) where higher combined scores represented more positive attitudes toward diverting service calls involving youth with mental health needs from the juvenile justice system to community-based treatment providers.

The three items found to measure attitudes towards **Chicago Police Department (CPD) departmental support** were:

1. I feel pressured by CPD to arrest mentally ill/emotionally disturbed youth, so I can quickly move on to the next call.
2. I feel pressured by CPD to solve problems associated with mentally ill/emotionally disturbed youth on an informal basis.
3. Responding to calls involving mentally ill/emotionally disturbed youth is not really part of a police officer's role.

These three items could not be combined into a scale due to insufficient internal reliability (Chronbach's alpha of 0.64). Consequently, each statement was treated individually instead of as a combined score. Lower ratings on these items represented more positive attitudes towards time spent on de-escalation of crisis situations and the appropriateness of law enforcement's role in stemming criminalization of youth mental illness.

The four items found to measure attitudes towards **youth in crisis** were:

1. Mentally ill/emotionally disturbed youth need control and discipline.
2. Calls to handle mentally ill/emotionally-disturbed youth take up more than their share of police time.
3. There is something about mentally ill/emotionally-disturbed youth that make it easy to tell them from normal youth.
4. The MHS is hostile towards police referrals.

These four statements could not be combined into a scale due to low internal reliability (Chronbach's alpha of 0.45) and were treated individually rather than as a combined score. Lower ratings on these statements represented more supportive attitudes toward youth in crisis.

E. Training module evaluation surveys

Authority researchers developed 18 individually tailored training module evaluation surveys, which were administered at the start and conclusion of each module. Training module evaluation surveys included three sections, designed to assess participants' prior familiarity with the module's topic, understanding of course information and satisfaction with course content and delivery. These surveys were designed to answer the following research questions:

- To what extent were training participants familiar with the module's content prior to the session?
- To what extent did self-reported prior familiarity with individual module content correlate with participants' correct answers on corresponding curriculum pre-test questions?
- To what extent did participants report gaining knowledge of the module's content?
- To what extent did participants report satisfaction with the presentation of module content?

- To what extent did participants' self-reported satisfaction with module content and presentation relate to increased knowledge of module content?

F. Ratings of prior familiarity with module content

Before each module presentation, CIT-Y training participants completed the first section on the module evaluation survey, which asked the extent to which they were already familiar with specific module topics. Familiarity ratings were made on a scale of 0=not at all familiar, 1=slightly familiar, 2=somewhat familiar, 3=moderately familiar, and 4=very familiar.

G. Ratings of information gained through module presentations

After each module presentation, CIT-Y training participants were asked to rate how well the presentation informed them of each module topic, using a scale of 0=not at all informed, 1=slightly informed, 2=somewhat informed, 3=moderately informed, to 4=very informed.

H. Ratings of satisfaction with module presentations

For each training module, CIT-Y training participants responded to 12 statements about their satisfaction with course information and delivery, using a scale of 0=strongly disagree, 1=disagree, 2=uncertain, 3=agree, and 4=strongly agree.

These statements were:

1. The presentation related to my law enforcement role.
2. I was engaged in the presentation.
3. Information presented was easy to understand.
1. The presentation was dry/boring.
2. The presentation was too technical.
3. The presentation lacked examples.
4. The presentation lacked role-play.
5. The presentation was repetitive.
6. PowerPoint slides were read word-for-word.
1. Presenter was prepared.
2. Presenter acted in a professional manner.
3. Presenter was knowledgeable of subject matter.

II. Data collection

Data collection for this Year 2 evaluation began in January 2012 with the start of the Year 2 CIT-Y training sessions and ended in May 2013 when a comparison group of CPD officers not yet trained on the CIT model was obtained.

A. CIT-Y training participant acquisition

Officers volunteered for CIT-Y training though CPD's Special Functions Group under the Bureau of Patrol. Four 5-day CIT-Y training courses were held between January and March 2012, with a total of 157 CPD officers trained. All officers had previously completed the 40-hour, five-day, adult CIT training, a prerequisite for the CIT-Y course.

Ninety-two percent of training participants (n= 144) completing all evaluation instruments, including the curriculum test before and after training, and 18 module evaluation surveys. These participants comprised the trained officer evaluation sample.

B. Recruitment of comparison group

CPD officers volunteering for adult CIT training but not yet trained on the CIT model were recruited by CIT staff to serve as a comparison group (untrained officers) for this evaluation. Comparison group officers (n=137) were invited to complete the curriculum test online at their own convenience between October 2012 and May 2013. Their scores served as a baseline against which CIT-Y training participants' pre/post curriculum test scores were compared.

C. Focus group recruitment

CPD officers who attended Year 2 CIT-Y trainings were informed of a follow-up focus group to be held six months after the course ended, and a sign-up sheet was made available on the last day of training. Of the 144 training participants completing all evaluation instruments, 121 participants completed the focus group sign-up sheet. All were contacted via email and phone six months post-training and invited to participate in a focus group held in October 2012 at CPD headquarters. A total of 26 CIT-Y training participants attended one of six focus group sessions, with an average of five officers per session.

D. Pre-post-curriculum test administration

The curriculum tests took about 30 minutes to complete and were administered at three points in time:

- Pre-test - before the training (training participants and untrained officer comparison, (n=281).
- Post-test - immediately following the five-day training course, for training participants only (n=144).
- Six months after the training, for focus group participants only (n=26).

The comparison group of untrained officers accessed the instrument once via an on-line survey during the period October 2012 to May 2013.

CIT-Y training participants (n=144) were asked to complete the curriculum tests on the first day of the course and just after it ended on the fifth day. Those who consented were assigned a unique numeric code so that researchers could match their pre- and post- tests without additional personal identifiers.

Curriculum test data was entered into an Access database and analyzed in Predictive Analytics Software.

E. Training module evaluation survey administration

Researchers distributed a packet of 18 one-page evaluation surveys to CIT-Y participants on the first day of training. Participants were instructed to complete sections of the corresponding evaluation survey immediately before and after each module presentation. The evaluation surveys were numerically coded so that training participants could be linked to their responses on all 18 modules.

F. Focus group administration

A focus group is an open-ended discussion between participants on a particular topic, guided by a moderator. Focus groups were held to collect feedback from trained officers on the CIT-Y training. Participants were also asked to complete the curriculum test, to assess retention of training objectives six months after training.

Focus group discussions lasted about 60 minutes, with an additional 30 minutes for completion of the curriculum test. Questions discussed by the groups included:

- To what degree did you use what you learned in the CIT-Y training?
- What were the *most helpful* and *least helpful* parts of the CIT-Y training?
- To what extent were you prepared to implement the CIT-Y training objectives?
- To what extent did you face barriers when implementing the CIT-Y training objectives?
- What information, if any, was not addressed in the CIT-Y training that would have been beneficial?

Six focus group sessions were held in a private conference room at CPD headquarters during October 2012, with an average of five officers per session.

III. Research limitations

Three research limitations should be considered when interpreting the findings.

First, the sample is affected by selection bias. Officers volunteered for CIT-Y training and were not selected randomly from all officers already trained in the adult CIT model. Further, the comparison group (untrained officers) was comprised of volunteers as well, and not selected to match training participant characteristics and job experience. Future evaluations should seek to use randomization of participants where feasible to produce results more reflective of the entire CPD organization.

Second, the replicability of any findings of long-term effects of the CIT-Y training is unknown, due to the small number of officers in the follow-up group (n=26). Future evaluations should seek to re-test all trained participants in the follow-up to more systematically assess long-term retention of training information and attitudinal changes.

Finally, this evaluation was not designed to correlate findings of CIT-Y knowledge gains with participants' actual behavior in handling youth crisis calls. Future evaluations should seek to determine the actual outcomes of youth crisis calls handled by trained officers compared to untrained officers to determine if training goals and objectives are achieved in practice and not just in a classroom setting.

Findings

I. Characteristics of Year 2 CIT-Y training participants

As a means of addressing barriers to training implementation within CPD, officers receiving Year 1 CIT-Y training recommended increased departmental diversity of training participants, particularly of supervisory staff who could reinforce training objectives in the field. Characteristics of officers who volunteered for Year 2 CIT-Y training were examined to determine the extent to which this recommendation was implemented. Analysis revealed that training participant characteristics did not vary between Year 1 (n=118) and Year 2 (n=144) (*Table 1*). The majority of participants were older officers with close to two decades of CPD experience and close to three years of experience as a CIT officer. There were slightly more women than men trained, and very few (6 percent) participants of higher rank beyond sergeant.

A. Characteristics of comparison group (untrained officers)

A comparison group of officers with no prior CIT training was obtained by soliciting volunteers from the list of officers seeking to take the prerequisite adult CIT training course. A total of 137 officers completed the curriculum test on-line; their scores served as a baseline of general knowledge about the CIT model.

CIT-Y training participants and the comparison group (untrained officers) did not differ by age, years of CPD experience, or rank (*Table 2*). Variation between the two groups was found with regard to race and assigned area command.

II. Gauging baseline knowledge of CIT-Y training objectives

To assess the training's impact on officer knowledge of training content, two baseline measures were obtained. The first measure was the curriculum test, administered as a pre-test to training participants on the first day of the course, and to the comparison group of officers via an on-line survey. The second measure was the ratings of prior familiarity with course content provided by training participants on each module evaluation survey.

Table 1
Characteristics of Year 1 and Year 2 CIT-Y training participants (n=262)

Officer characteristics	Year 1		Year 2	
	n	percent	n	percent
Age				
30 years or younger	11	9%	5	4%
between 31 and 40 years	32	27%	49	34%
between 41 and 50 years	55	47%	63	44%
51 and older	20	17%	27	19%
Years CPD experience				
Five years or less	13	11%	10	7%
between 6 and 10	27	23%	35	24%
between 11 and 16	36	31%	47	33%
17 years or more	42	36%	51	35%
Missing data	0	0%	1	1%
Sex				
Male	58	49%	67	47%
Female	60	51%	77	53%
Race				
White	55	47%	62	43%
Non-white	58	49%	70	49%
Missing data	5	4%	12	8%
Command area				
North	40	34%	39	27%
Central	45	38%	67	47%
South	27	23%	30	21%
Other	6	5%	8	6%
Rank				
Police	102	86%	123	85%
Sergeant	10	9%	12	8%
Detective	2	2%	2	1%
Lieutenant	2	2%	0	0%
Other	2	2%	7	5%

Table 2
Characteristics of CIT-Y training participants (n=144) and untrained officer comparison group (n=137)

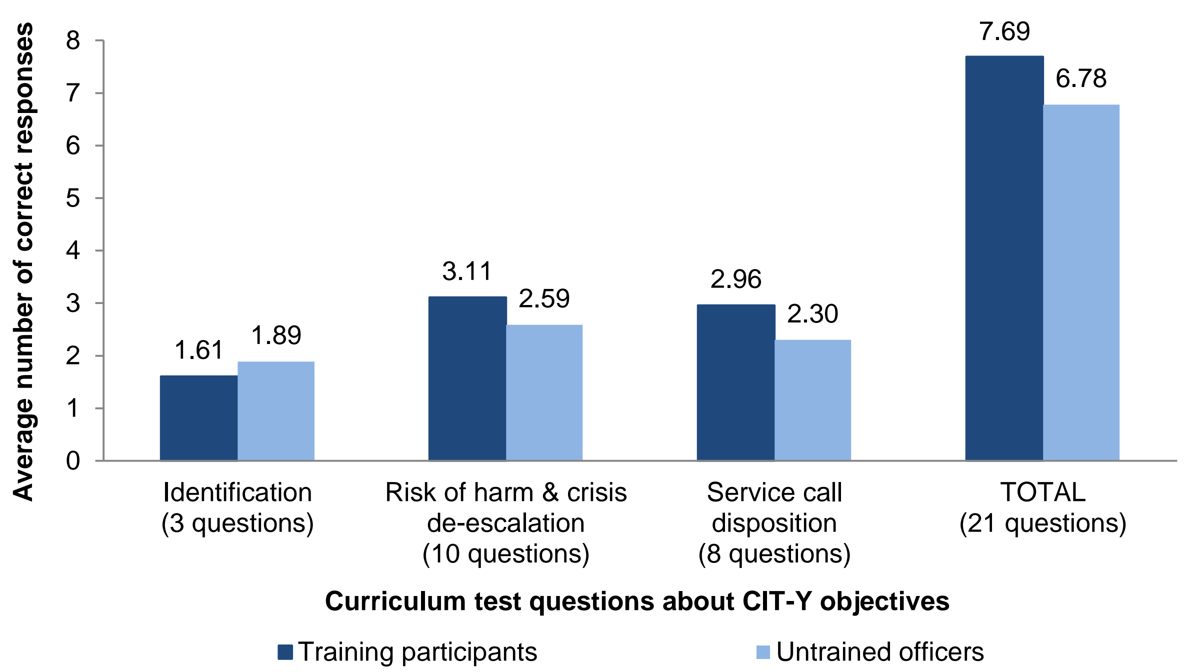
Officer characteristics	Training participants		Untrained officers	
	n	percent	n	percent
Age				
30 years or younger	5	4%	11	8%
between 31 and 40 years	49	34%	40	29%
between 41 and 50 years	63	44%	65	47%
51 and older	27	19%	21	15%
Years CPD experience				
Less than 5 years	10	7%	13	10%
between 6 and 10	35	24%	28	20%
between 11 and 16	47	33%	42	31%
17 years or more	51	35%	54	39%
Missing data	1	1%	0	0%
Experience as a CIT officer (years)	M =2.55, SD = 1.90		n/a	
Sex				
Male	67	47%	78	57%
Female	77	53%	59	43%
Race				
White	47	33%	82	60%
Black	62	43%	30	22%
Hispanic	31	22%	23	17%
Missing data	4	3%	2	2%
Command area				
North	39	27%	39	29%
Central	67	47%	46	34%
South	30	21%	34	25%
Other	8	6%	18	13%
Rank				
Police	123	85%	109	80%
Sergeant	12	8%	13	10%
Detective	2	1%	8	6%
Lieutenant	0	0%	6	4%
Other	7	5%	1	1%

A. Curriculum pre-test scores

At the start of their CIT-Y course, trained officers (n=144) correctly answered 37 percent of the pre-curriculum test questions (average of 7.69 out of 21.00), whereas untrained officers (n=137) correctly answered 32 percent (average of 6.78 out of 21.00). This overall difference in baseline knowledge of CIT-Y objectives was significant ($t = 3.42$, $df = 279$, $p = .001$, two tailed). The higher baseline knowledge scores for course participants were expected, due to their exposure to the prerequisite adult CIT course.

Further analysis revealed that trained officers had significantly more correct responses to *Risk of harm & crisis de-escalation* and *Service call disposition* domain questions than untrained officers; untrained officers had more correct answers to the *Identification of signs and symptoms* domain questions (*Figure 3*).

Figure 3
Baseline knowledge of CIT-Y training objectives, training participants (n=144) and untrained officers (n=137)



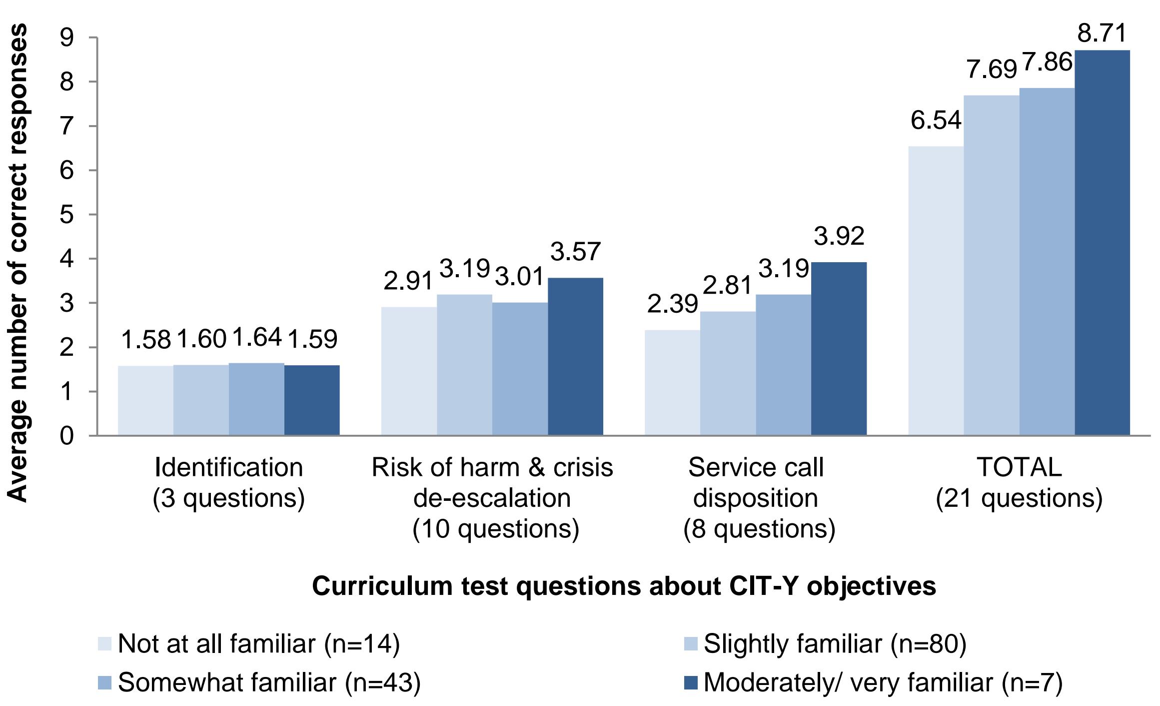
B. Ratings of prior familiarity with module content

Training participants were asked to rate the extent to which they were already familiar with course content before each of the 18 CIT-Y module presentations. Participants reported less familiarity with the core training modules (identification, risk & de-escalation, and service call disposition), on average, than the group of other 15 modules (1.80 average rating compared to 2.09, on a 4-point scale)

Even with their prior adult CIT training, participants' overall baseline familiarity with training content was rated as only slightly or somewhat familiar. Therefore, the CIT-Y training course was being offered to a target audience that could improve its knowledge, as opposed to an audience that was already fully informed about specific course content.

Participants' ratings of baseline familiarity with the content of the three core modules were compared to their scores on the curriculum pre-test (*Figure 4*). Participants who rated themselves as moderately or very familiar with core module content did score higher on corresponding curriculum test questions than participants rating themselves as not at all familiar with module content. While this correlation was in the right direction, the difference in scores was not statistically different (F [3, 140] = 1.19, p = .299). In general, participants were not highly informed of course content prior to training, even with their work experience as CIT officers.

Figure 4
Training participants' pre-test curriculum scores and ratings of module familiarity (n=144)



III. Training effect on knowledge

Four types of effects were measured to assess changes in trained officer knowledge of CIT-Y objectives after completion of the training:

1) Immediate change: Before and after each training module presentation
2) Short-term change: Pre-course test and post-course test
3) Long-term change: Post-course test and six-month follow-up test

4) Overall change: Differences between pre-test, post-test, and follow-up.

A. Immediate change

Immediately following each module's presentation, trained officers rated the degree to which they were informed of course information on a scale of 0-4 (0=*not at all informed*, 1=*slightly informed*, 2=*somewhat informed*, 3=*moderately informed*, and 4=*very informed)*. Their self-reported ratings of knowledge gain were relatively high (3.46 out of 4.00), and higher than their ratings of familiarity before the module presentation. *Table 3* presents participant's ratings of being informed of course content.

Table 3
Participants' ratings of module information prior to and after presentation (n=144)

Course information	Prior (0 - 4 scale)		After (0 – 4 scale)		Change	t
	Mean	Mean	Mean	SD		
Core training objectives modules	**1.80**	**0.67**	**3.46**	**0.54**	**1.66**	27.08***
Identification	1.84	0.85	3.33	0.70	1.49	18.63***
Risk of harm & crisis de-escalation	1.75	0.75	3.49	0.55	1.73	24.74***
Service call disposition	1.81	0.80	3.46	0.63	1.65	22.73***
Other modules	**2.09**	**0.66**	**3.46**	**0.50**	**1.37**	23.43***
Dept. procedures for special circumstances	2.56	0.91	3.65	0.62	1.10	13.85***
Adolescents & gangs	2.89	0.94	3.65	0.61	0.75	9.17***
Q&A w/ CIT-Y officers	2.39	0.85	3.59	0.61	1.20	15.23***
Violent & urban trauma	2.20	0.98	3.52	0.66	1.32	15.60***
FBI—School violence & school shooters	1.00	0.97	3.50	0.69	2.51	28.20***
Substance abuse & co-occurring disorders	2.04	1.09	3.44	0.74	1.40	14.19***
Psychotropic medications	1.76	1.05	3.43	0.67	1.66	18.33***
Introduction	2.55	0.77	3.41	0.69	0.87	11.20***
Self-injurious behavior	1.69	1.13	3.34	0.86	1.65	15.67***
Brain development	1.95	0.96	3.26	0.85	1.31	12.95***
Medical & developmental disabilities	1.95	0.99	3.26	0.84	1.31	14.54***
Overall	**1.97**	**0.64**	**3.46**	**0.50**	**1.48**	23.43***

*** Significant at $p < .001$

1. Pre-post module presentation ratings

In order to identify which training modules had the most immediate impact on officer knowledge gains, differences between prior familiarity and informed ratings were calculated (*Table 3*). Significant increases were seen for each module. Of particular interest were ratings from the three core modules that corresponded to the key CIT-Y training objectives (identification of signs and symptoms, risk of harm & crisis de-escalation, and service call disposition).

Differences between pre-and-post module presentation ratings were significantly higher (increase in rating of 1.66) for the group of key training modules compared to the other modules (increase in rating of 1.37) (t= 8.22, df= 143, $p < .001$, two tailed), indicating immediate gains in knowledge of the core training objectives.

In terms of participants' ratings of the new or revised modules added to the Year 2 CIT-Y training course, the *Adolescents and gangs* and *Q&A w/ CIT-Y officers* modules had the among highest ratings for prior familiarity. However, they were also highly rated for the degree to which they provided information. Therefore, they added value to the CIT-Y curriculum. While participants indicated they were moderately informed after viewing the newly added documentary in the *Child & Adolescent Brain Development* module, the difference in pre-post module rating scores was only average (at the median of all difference scores), indicating the material was not as compelling to participants as the other revised modules.

While not new for Year 2 curriculum, the greatest change in ratings was observed for the *FBI—School violence & school shooters* module. Participants rated themselves as least familiar with that topic before the presentation (1.0 average rating on the 4-point scale), and moderate to highly informed afterwards (3.5 average rating on the 4-point scale). The 2.51 difference in ratings was the largest observed for any module.

2. Participant satisfaction ratings

Training participants were asked to rate each module presentation on relevance, ease of comprehension, and presenter qualities by answering 12 agreement statements on a 0-4 scale (0=*strongly disagree*, 1=*disagree*, 2=*uncertain*, 3=*agree*, and 4=*strongly agree*). The rating statements were grouped into presentation scores (positive and negative) and presenter scores. *Table 4* presents satisfaction ratings by module.

Overall, training participants *agreed* to *strongly agreed* that module content was relevant to their law enforcement role and easy to understanding (3.54 out of 4.00). Core training modules (identification, risk of harm & de-escalation techniques and service call dispositions) were rated more positively (3.60 out of 4.00) than other modules (3.51 out of 4.00).This mean difference was significant ($t = 5.81$, $df = 143$, $p < .001$, two tailed).

The average rating for the negative statements was 0.93 out of 4.00. In other words, trained officers *disagreed* to *strongly disagreed* that presentations were dry/boring, too technical, lacked examples or role-play, was repetitive or read word-for-word from a PowerPoint. Again, the core training modules were rated less negatively (0.98 out of 4.00) than the other modules (0.85 out of 4.00).This mean difference was significant ($t = 6.67$, $df = 143$, $p < .001$, two tailed).

For the statements regarding course presenters, the average rating was 3.70 out of 4.00, indicating participants perceived presenters to be prepared, knowledgeable, and professional. Presenters of the three core training modules were rated more positively (3.74 out of 4.00) than presenters of other modules (3.68 out of 4.00). This mean difference was significant ($t = 3.99$, $df = 143$, $p < .001$, two tailed).

Table 4
Participants' ratings of satisfaction with training modules (n=144)

Course information	Presentation Positive (0-4 scale)		Presentation Negative (0-4 scale)		Presenter Positive (0-4 scale)	
	Mean	SD	Mean	SD	Mean	SD
Core training objectives modules	**3.60**	**0.36**	**0.85**	**0.42**	**3.74**	**0.32**
Identification	3.52	0.52	0.96	0.60	3.75	0.46
Risk of harm & crisis de-escalation	3.65	0.37	0.75	0.45	3.74	0.34
Service call disposition	3.57	0.42	0.92	0.48	3.73	0.37
Other modules	**3.51**	**0.35**	**0.98**	**0.39**	**3.68**	**0.31**
Medical & developmental disabilities	3.11	0.75	1.42	0.83	3.59	0.53
Introduction	3.38	0.56	1.25	0.68	3.57	0.62
Brain development	3.23	0.62	1.12	0.57	3.47	0.62
Self-injurious behavior	3.42	0.55	1.11	0.66	3.69	0.43
Substance abuse & co-occurring disorders	3.46	0.60	1.09	0.69	3.59	0.54
Psychotropic medications	3.49	0.51	0.95	0.54	3.76	0.45
Violent & urban trauma	3.57	0.54	0.92	0.57	3.72	0.45
Q&A w/ CIT-Y officers	3.69	0.40	0.77	0.54	3.75	0.47
Dept. proc. for special circumstances	3.77	0.34	0.71	0.54	3.82	0.37
FBI—School violence & school shooters	3.74	0.39	0.69	0.55	3.79	0.37
Adolescents & gangs	3.72	0.39	0.68	0.56	3.78	0.39
Overall	**3.54**	**0.34**	**0.93**	**0.38**	**3.70**	**0.30**

Participants' module satisfaction ratings were correlated with their ratings of being informed by module content (*Figure 5*). That is, the perceived quality of the presentation and course content was significantly related knowledge gains of training objectives. For the core training modules, the *Identification of signs and symptoms of youth mental illness* module received the lowest ratings for both providing information and satisfactory content and presentation. For the other modules, the *Medical & developmental disabilities* module received the lowest ratings on both scales.

B. Short-term change in knowledge of core CIT-Y objectives

Participants completed the curriculum test again at the conclusion of the 5-day training course. The number of correct responses increased significantly from the pre-tests to the post-curriculum tests, from 7.69 at the start of the course to 11.66 at the end (out of 21 possible correct answers) (t = 15.57, df = 143, p < .001, two-tailed). Knowledge of all three core objectives increased significantly, with the biggest gain in correct answers to *Service call disposition* questions. Further, satisfaction with course content and presenters were significantly correlated with increased post-curriculum test scores and presenter satisfaction ratings (r = 0.214, n = 144, p= .010, two-tailed) (*Table 5*).

Figure 5
Self-reported informed ratings by satisfaction ratings (n=144)

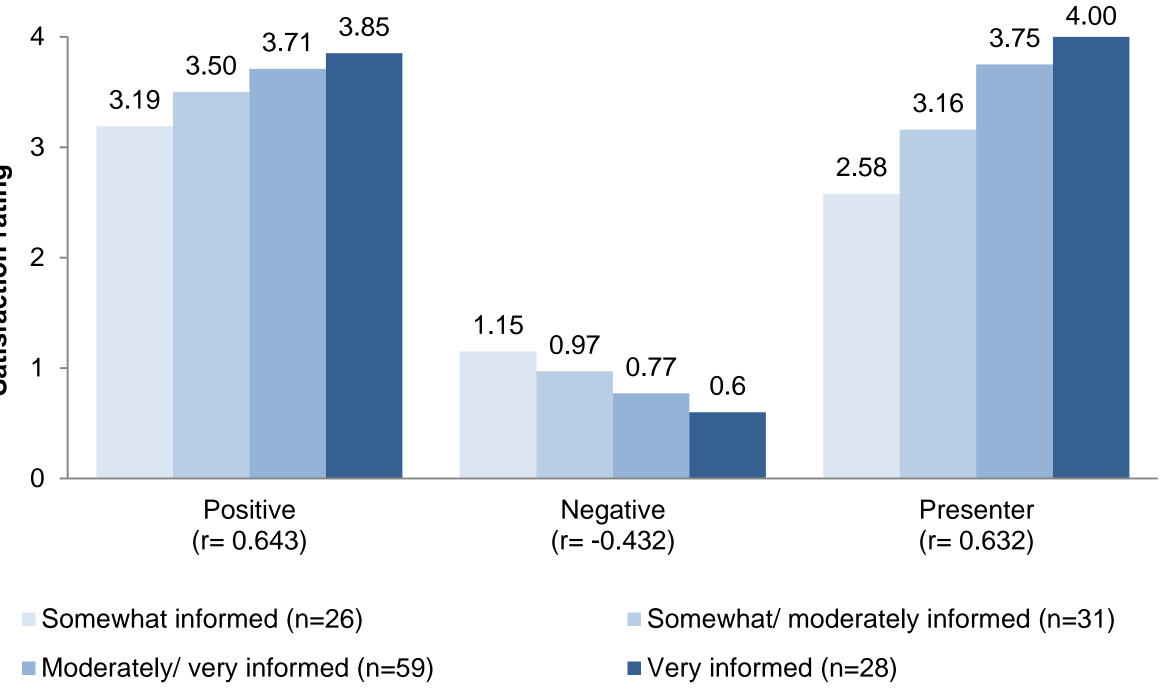


Table 5
Short-term change in knowledge of core CIT-Y objectives (n=144)

Training objectives	Pre-test			Post-test			Change	t
	Mean correct	SD	%	Mean correct	SD	%		
Identification (3 questions)	1.61	0.74	54%	1.83	0.74	61%	0.21	2.71**
Risk & crisis de-escalation (10 questions)	3.11	1.45	31%	4.42	1.64	44%	1.30	7.93***
Service call disposition (8 questions)	2.96	1.44	37%	5.42	1.27	68%	2.45	16.81***
Total (21 questions)	**7.69**	**2.20**	**37%**	**11.66**	**2.48**	**56%**	**3.97**	**15.57*** **

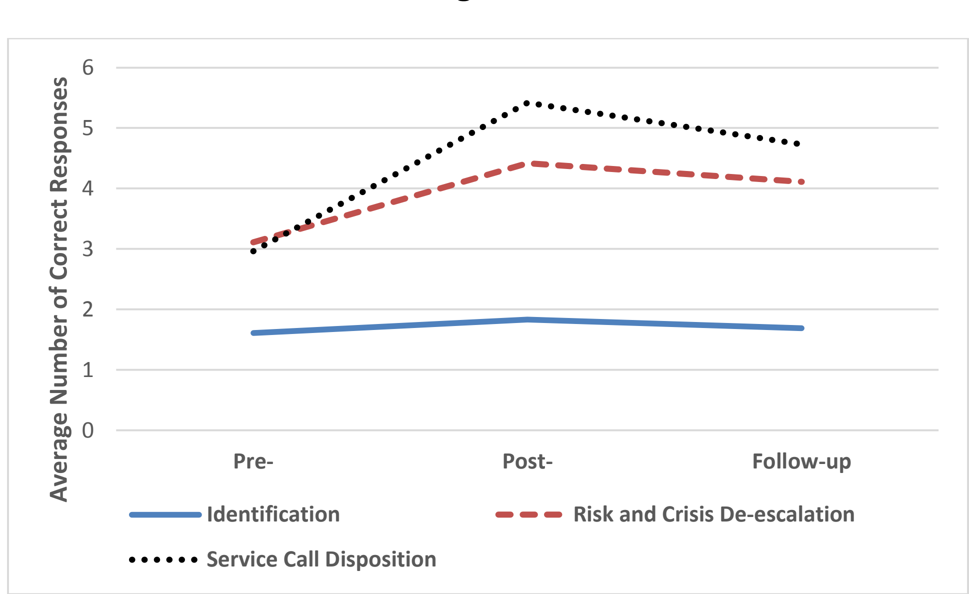
Significant at $p < .05$, * Significant at $p < .001$

C. Long-term change in knowledge of core CIT-Y objectives

A subgroup of trained officers (n=26) completed the curriculum test six months post-training. Results revealed no significant change in the low rate of correct responses to the three *identification* questions, a retention of correct responses to the 10 *risk of harm & de-escalation questions* from six-months previous, and a statistically significant decrease in correct responses to the eight *service call disposition* questions from six months previous (Figure 6). However, the six-month follow-up scores for the *Risk & crisis de-escalation* and *Service call disposition* questions were still statistically significantly higher than base-line pre-test scores, indicating long-term retention of training information.

Changes in knowledge of CIT-Y objectives over time (n=26)

Figure 6



IV. Gauging baseline attitudes toward youth crisis calls

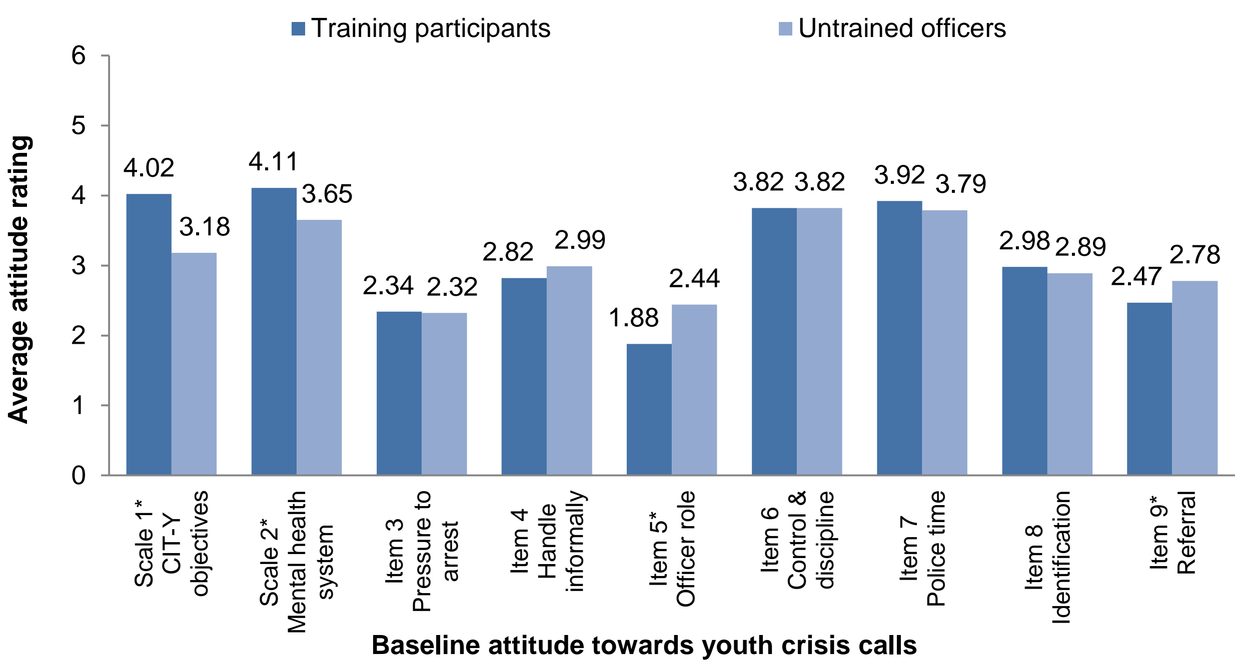
Baseline scores regarding attitudes toward CIT-Y training, the local mental health system, and youth crisis calls were established for both training participants and the comparison group of untrained officers, to detect changes in participants' attitudes as a result of the training. Each of the eighteen attitude statements were rated on a scale of 1-6 (were grouped into nine scales of 1-6 (1=strongly disagree, 2=moderately disagree, 3=slightly disagree, 4=slightly agree, 5=moderately agree, and 6=strongly agree).

Some of the responses could be grouped into two attitude scales - **attitudes toward core CIT-Y training objectives** and **attitudes toward the local mental health system.** The other seven attitude statements were analyzed as independent items. These were:

Item 3 - I feel pressured by CPD to arrest mentally ill/emotionally disturbed youth, so I can quickly move on to the next call.
Item 4 - I feel pressured by CPD to solve problems associated with mentally ill/emotionally disturbed youth on an informal basis.
Item 5 - Responding to calls involving mentally ill/emotionally disturbed youth is not really part of a police officer's role.
Item 6 - Mentally ill/emotionally disturbed youth need control and discipline.
Item 7 - Calls to handle mentally ill/emotionally-disturbed youth take up more than their share of police time.
Item 8 - There is something about mentally ill/emotionally-disturbed youth that make it easy to tell them from normal youth.
Item 9 - The local mental health system is hostile towards police referrals.

Figure 7 provides baseline scores for attitudes toward CIT-Y training, youth crisis calls, and the local mental health system for training participants and untrained officers, as measured prior to the training course.

Figure 7
Baseline attitude scores, training participants (n=144) compared to untrained officers (n=137)



Baseline attitude ratings differed significantly between training participants and untrained officers on both attitude scales, and on two additional attitude items:

- **Scale 1 (attitude toward core training objectives):** Training participants had more confidence in their ability to handle youth crisis calls than untrained officers ($t = 6.76$, $df = 278$, $p < .001$, two-tailed).

- **Scale 2 (attitude toward the mental health system):** Training participants were more likely to agree that the mental health system provides solutions for managing mental health service calls than were untrained officers ($t = 3.64$, $df = 278$, $p < .001$, two-tailed).

- **Item 5 (officer role):** Training participants were more likely to agree that responding to calls involving mentally ill/emotionally disturbed youth was a part of a police officer's role than were untrained officers ($t = 3.48$, $df = 277$, $p < .001$, two-tailed).

- **Item 9 (police referrals):** Training participants were more likely to agree that the mental health system was not hostile toward police referrals than were untrained officers ($t = 3.64$, $df = 272$, $p < .001$, two-tailed).

Some attitudinal difference were expected between the two groups prior to the CIT-Y training, as the training participants had already taken the adult CIT course and were volunteering to learn to apply CIT principles to youth populations. However, prior to the CIT-Y course, both groups had similar attitudes toward youth in crisis.

A. Training effect on attitudes

Three measures were used to assess changes in officer attitudes toward CIT-Y training, the local mental health system, and youth crisis calls as a result of CIT-Y training:

1) Short-term change: Pre-course attitude ratings compared to post-course attitude ratings;
2) Long-term change: Post-course attitude ratings compared to those at the six-month follow-up;
3) Overall change: Difference between pre-course attitude ratings and the six-month follow-up.

1. Short-term change in attitudes

Short-term changes in training participants' attitudes toward youth crisis calls were measured by comparing their pre- and post-course attitude item ratings. Changes in ratings are displayed in *Table 6*.

After the CIT-Y training, participants' attitude ratings became significantly more positive toward their ability to handle youth crisis calls (*Scale 1*), and towards the local mental health system (*Scale 2*) compared to their baseline scores, which were already significantly higher than the untrained officers' baseline attitude scores.

Additionally, participants' attitudes became significantly more positive toward five of the seven other attitude items. After receiving training, they were more likely to disagree that they felt pressured by CPD to solve youth crisis calls informally (without the assistance of mental health

service providers) (item 4), to disagree that responding to youth crisis calls was not part of their role as police officers (item 5), to disagree that youth in crisis need control and discipline (item 6), to disagree that youth crisis calls take too much time from other policing (item 7), and to disagree that there is something about mentally ill/disturbed youth that make it easy to tell them from normal youth (item 8).

Before the course, participants had not differed from untrained officers on any individual items except item 5 (that a police role was appropriate in youth crisis calls) and item 9 (hostility to police referrals). The training did not change participants' attitude on that last item – they maintained their moderate disagreement with the statement that the mental health system was hostile toward police referrals.

Table 6
Short-term change in attitudes toward CIT-Y training, youth crisis calls and the local mental health system (n=144)

Attitude towards youth crisis calls	Pre-test		Post-test		Change	t
	Mean	SD	Mean	SD		
Scale 1: Knowledge of CIT-Y training objectives	4.04	0.96	5.24	0.65	1.21	13.98***
Scale 2: Mental health system	4.13	1.01	4.41	0.99	0.27	3.42***
Item 3: CPD support: Pressure to arrest	2.35	1.52	2.50	1.61	0.14	1.21
Item 4: CPD support: Handle informally w/o assistance	2.82	1.53	2.35	1.40	-0.46	-3.81***
Item 5: CPD support: Officer role	1.88	1.22	1.36	0.85	-0.53	-4.71***
Item 6: Youth in crisis: Control & discipline	3.86	1.45	3.01	1.48	-0.85	-6.40***
Item 7: Youth in crisis: Police time	3.93	1.55	3.56	1.74	-0.37	-2.40**
Item 8: Youth in crisis: Identification	2.98	1.41	2.57	1.43	-0.42	-3.60***
Item 9: Youth in crisis: Referrals	2.46	1.27	2.54	1.31	0.08	0.67

** Significant at $p < .05$, *** Significant at $p < .001$

2. Long-term change in attitudes

A subgroup of trained officers (n=26) provided attitude item ratings six months post-training. These scores were used to assess changes in attitudes toward youth crisis calls across three time periods—immediately before the training (pre-course), at the conclusion of the five-day course (post-course), and six months post-training.

While short-term positive changes were found for most attitude items, few of these attitude changes were sustained long-term above baseline ratings. Findings revealed that trained officers retained confidence in their ability to handle youth crisis calls (*Scale 1*) and the mental health system's capability to provide effective solutions (*Scale 2*) six months following the training, and were less likely to feel pressure by CPD to solve youth crisis calls on an informal basis without formal service provider assistance (*Item 4*). While trained officers significantly disagreed with

the statement “There is something about mentally ill/emotionally disturbed youth that make it easy to tell them from normal youth” (*Item 8*) at the end of the course, their ratings at the six-month follow-up reverted to baseline levels (pre-course ratings).

Figure 8 shows the changes over time in attitudes toward CIT-Y training objectives (Scale 1). The slight decrease in attitude scores at the six-month follow-up (mean=4.78, SD=0.91) compared to immediately after the course (mean=5.01, SD=0.82) was not statistically significant.

Figure 8
Overall change in attitudes toward CIT-Y training objectives (*Scale 1*) (n=26)

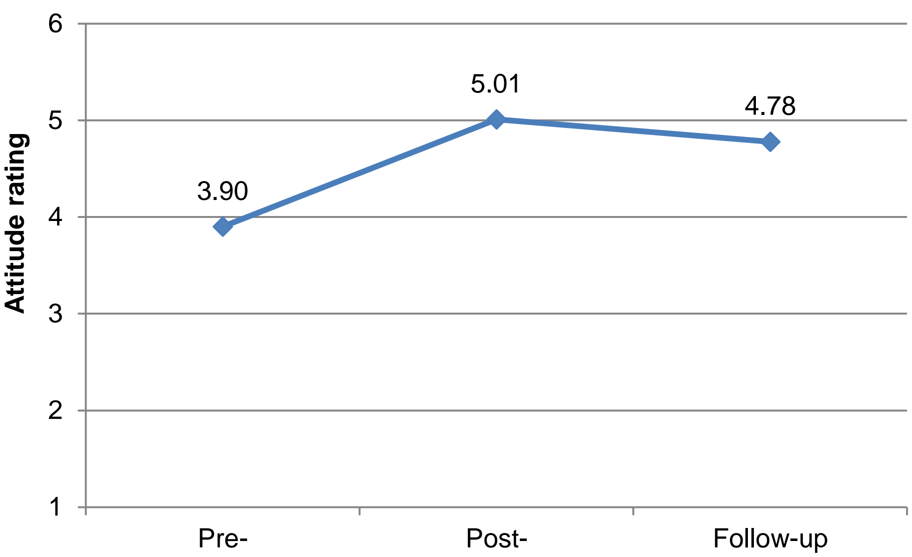


Figure 9 shows the changes over time in attitudes toward the local mental health system (Scale 2). A statistically significant main effect for time was found (F [2, 46] = 6.69, p = .003). Trained officers’ attitudes toward the local mental health system remained as positive six month later as immediately after the training course. Post hoc analyses revealed a statistically significant increase from the pre-test (Mean = 3.78, SD = 1.08) to the post-test (Mean = 4.34, SD = 1.09) followed by a non-significant increase between the post-test and follow-up (Mean = 4.48, SD = 1.03).

Figure 9
Overall change in attitudes toward the local mental health system (*Scale 2*) (n=26)

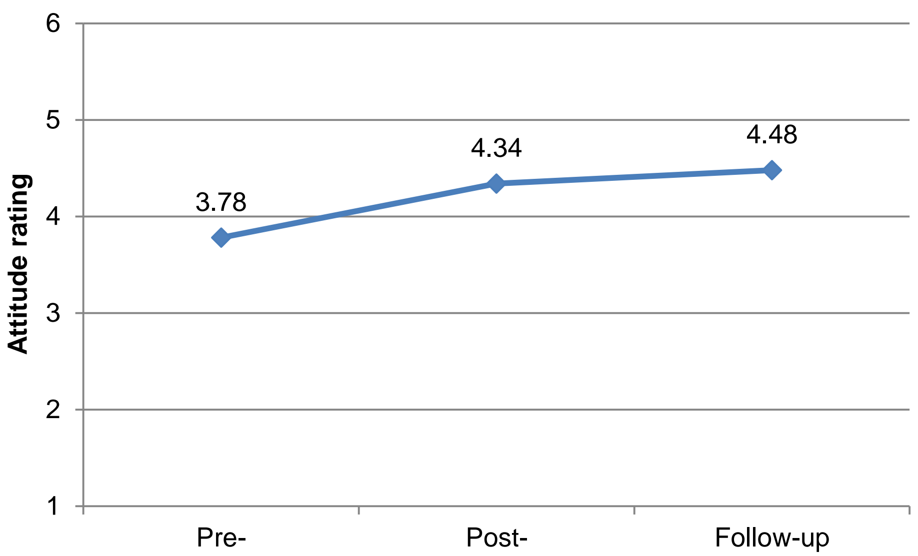
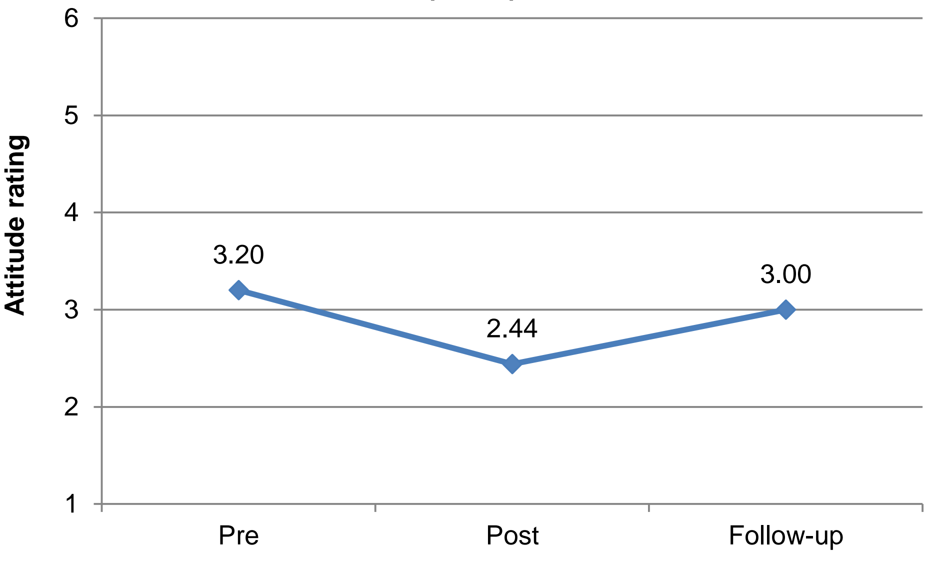


Figure 10 shows the changes over time in attitude item 8: *"There is something about mentally ill/emotionally disturbed youth that make it easy to tell them from normal youth".* A significant main effect was found (F [2, 48] = 3.39, p = .042) from before to after the course. Trained officers rating of disagreement with the statement changed significantly from before to after the course. However, the effect dissipated over time; officers reverted to their baseline attitude on this item over time, which was not significantly different from untrained officers before the course. Post hoc analyses revealed no statistical difference between pre-test (Mean = 3.20, SD = 1.53) and follow-up (Mean = 3.00, SD = 1.44) agreement scores.

Figure 10
Overall change in attitude towards ease of identification of mental illness in youth (n=26)



V. Officer feedback on training experience

A. Comments on training curriculum

Training participants were asked to provide feedback on the course's strengths and weaknesses in the post-course evaluation survey. Of the 144 officers trained in Year 2, 40 percent reported that the course had no weaknesses and offered generally positive comments, and another 30 percent responded with training limitations and recommendations. The remaining 30 percent did not offer comments.

The following are examples of positive survey comments:

> *I wish I had received this training 20+ years ago in the academy. Training will definitely assist me dealing with juveniles having a crisis. This training helps with most disturbances involving homeless, domestic, and other disturbance calls. It helps to calm people down.*

> *I [am leaving] this class prepared to deal with supervisors, schools, and parents better when it comes to all legal aspects when rendering aid to children in crisis. For that I am grateful.*

> *I really enjoyed all the speakers, the insight [of CIT staff and their] incredible passion, and above and beyond hard work. Just awesome. I really was changed and my empathy and compassion more zeroed in—not everyone has to go to jail.*

> *I have been a school officer dealing with juveniles in crisis for the past seven years and I think this training is going to be a real asset when I return there next week.*

Of the 43 participants who responded with training limitations and recommendations, 11 provided comments on lack of role-play during instruction on how to recognize and defuse youth crises. Survey responses included:

> *I would have liked to do role play like the first class. I think it helped a lot to understand the material we had learned by actually putting it to use. I learned a lot from doing the role-playing from the first class. I know there are complications using juveniles. Perhaps we can use late teens who have mental illness since childhood. It would be similar.*

> *Additional training on recognizing and diffusing youths in crisis {including scripts and body language]. Effective communication skills with various partners including school and hospital staffs [would be helpful and practical].*

> *CIT officers need more training and support; perhaps an entire block on educating non-CIT officers, sergeants, and watch commanders on the importance of CIT when we address an individual in crisis.*

B. Potential barriers to implementation of training techniques

Participants were asked if they anticipated any barriers from CPD or school personnel when implementing CIT-Y course material. A majority of officers (61 percent) responded that they expected barriers implementing course information. The other 39 percent either did not comment or responded they did not anticipate problems.

Of the 88 participants who believed potential barriers existed, 34 percent attributed them to the culture within CPD. The following is an example of a survey comment regarding CDP culture:

> *The department has consistently shown little interest or support for training for people in crisis. Leadership often has little regard for the mental health of members [officers]. They talk a good game, but their actions say different.*

Another 23 percent anticipated barriers as a result of their supervisors lacking CIT training. Survey comments included:

> *Supervisors at my worksite are not familiar with the critical impact of CIT measures. They need the training to ensure awareness and strategies of CIT are welcomed, used more and more to prevent crisis in the community and educate the community in concerns related to mental health challenges. With the increase in mental illness across [Chicago], the department barriers need to be removed faster through education, community practice, and community awareness.*

> *I do anticipate barriers. I've already experienced them. These barriers include sergeants who do not understand the time spent, beginning with the initial engagement with the individual to the final resolution of the incident. Also, the lack of cooperation, patience, and understanding of fellow officers [is a barrier]. I also feel that the dispatchers should not be asking what our status is when they can clearly see on a GPS that we are still on scene.*

> *The only barrier from the department is members [officers] becoming familiar with CIT procedures and training. School personnel also need training because sometimes they try to tell CPD officers how to do their jobs; they need to know our CIT training.*

The following are examples of survey responses from the 42 trained officers who did not expect any barriers to implementation.

> *The training has given me additional resources to remove any barriers that may arise. The knowledge of what rights a responding officer has, in regards to information concerning the individual in crisis is an asset for reducing obstacles.*

> *No [barriers expected]. Anytime a police officer can interact with the community in a more professional manner and can provide quality service that can actually solve problems there should not be any push back by other department personnel.*

My district and supervisors are very supportive and relieved when we effectively transport [an individual to a hospital for a psychiatric assessment] and/or [deescalate] the job [involving an individual in crisis].

The administrators at [my assigned high school] are excellent and work well with the police.

C. General comments

The evaluation survey provided space for any other additional comments. More than one-third of officers (35 percent) responded with general positive comments about the course, and 44 percent offered recommendations to enhance programming. Four officers (3 percent) provided negative comments about course information and programming, while nineteen percent did not offer additional comments.

The following are examples of recommendations offered to enhance programming:

There should be a meeting every quarter to talk, train, and adopt new information and technology which may aid crisis intervention. How are we preparing for the future? Supervisors need to know the CIT program. There needs to be a more aggressive marketing plan for CIT, as well, through any means necessary.

What I suggest is to start sending a supervisor along with the officers from each district. Usually, information is disseminated quicker when a boss can convey the needs to another boss before a patrol officer will be able to do.

I think it would be interesting to have juveniles turned adults come in, who have committed crimes and been through the juvenile system and believe their mental illness aided them in the commission of the crime because they were undiagnosed.

Negative comments included:

Still much confusion over what facilities provide what services, and what steps to take in certain situations under certain conditions.

CIT needs to understand that patrol has a limited time to resolve a crisis situation. There needs to be specialized [CIT] unit or identified CIT officers who are given an adequate amount of time to handle these jobs. Supervisors need to have better understanding of CIT.

Could use less clinical information at beginning; a little repetitive as far as drugs and such.

Some of [the] instructors were not receptive to officer comments and appeared offended when officers did not agree with them or their views.

VI. Focus group follow-up discussions

Six months following the CIT-Y training, 26 of the 121 trained officers that provided follow-up contact information (21 percent) attended one of six focus group sessions. During the sessions, they shared what they retained from the training and how they applied what they learned on the job. They were also asked to re-take the curriculum test to assess retention of knowledge and attitude changes.

As a whole, focus group participants were fairly reflective of the larger participant group trained during Year 2. This follow-up group had an equivalent median age (43 years old), years of CPD experience (14 years) and years of experience as a CIT officer (3 years). However, focus group participants were more likely to be higher-ranking CPD staff than the larger group of Year 2 CIT-Y trained officers (15 percent vs. 6 percent, respectively).

A. Application of CIT-Y training information

Officers reported that they had applied learned crisis de-escalation techniques after the course when working in the field. Crisis de-escalation techniques were described as "a little more time talking [with youth] trying to get them to calm down."

Officers across all the focus groups commented that when de-escalation techniques were not used when responding to crisis calls, there were safety concerns. Examples of such statements were:

> *I found that it's helpful when you take that little extra time. When you don't, the outcome is always bad, always ends violent.*
>
> *I just think that if we have a little bit more time on these calls [such as] an hour to do whatever we need to do so the outcome will be better and there won't be a second call and it won't end violent.*

Some focus group participants reported de-escalation techniques helped them resolve situations and save time. For example:

> *A lot of times the calls are not mental health-related, but just taking the time to assess the situation is important instead of just arresting the kid. Just talk to the kids, talk to the parents, and you find out a lot. It used to be like 'Get the call out, get in and out, do what you have to do, and get out of there,' but it's more like let's take our time, and make sure we get the right answers so we are not back in a half hour.*

Focus group participants said that after the CIT-Y training, they were more empathic and were more apt to use active listening skills. For example:

> *I think the training has made me more in tune with listening to the stress in the voice of the parent.*

> *I would tell my partner just because I'm [being quiet] doesn't mean I'm not doing anything. I think the de-escalation techniques help us not get offended. When you can recognize what it is, you're less likely to take it personal.*

Officers reported frequent sharing of CIT-Y training information with untrained officers. For example:

> *A lot of officers who found out I took the [CIT-Y training], they keep calling me and asking me 'Can we take the youth [for a hospital psychiatric assessment] without their parents' consent?' They ask me that a lot, and I say, 'Yes you can.'*

About the training as a whole, one participant said,

> *The whole training just showed the big picture. It's not one little thing—'Oh, the kid's angry....' Why is [this child] angry? What point is [this child] angry? 'Is [this child] punching, fighting, or is it just anxiety bouts?' [The CIT-Y training] shows you the whole, big picture; instead of walking in and seeing a yelling kid and grabbing him.*

B. Most and least helpful training modules

Focus group participants were asked to identify the most and least helpful of the 18 training modules. Some officers listed more than one module when responding. Six of the seven core training modules were named. The training modules identified as most helpful included:

- *Mental Illness: Signs & Symptoms* (nine officers),
- *Family Perspectives* (eight officers),
- *Children & Adolescent Brian Development* (four officers),
- *Crisis Intervention Skills and Risk Assessment* (four officers),
- *Violence & Urban Trauma* (three officers),
- *FBI: School Shooters* (three officers),
- *Department Procedures for Mental Health Crises* (three officers),
- *Parents & Teachers as Allies* (three officers), and
- *Community Resource Panel* (three officers).

One focus group participant described how the *Child & Adolescent Brain Development* module was helpful:

> *I didn't know how exactly the brain was operating in youth. I think about the brain portion of what the kids are going through and how they cannot get back on target or focus [during a crisis]. I think that part helped a lot because you know that kid is disconnected now. And before you just thought 'oh he's old enough, he should know better,' but when your brain is disconnected or offline, you can't get it back online by yourself. You need a little coaching. And that helped me because a lot of people think that these kids are just being bad.*

Another officer described how the *Family Perspectives* module was helpful:

> *Parents tell you what they went through, in the system, and realizing it...it just upped my empathy.*

Officers said meeting with hospital personnel during the *Community Resource Panel* module helped them develop stronger relationships with service providers. Focus group participants commented:

> *I also thought it was also very helpful that you met with the actual personnel from the hospital [who gave us their contact information] and said, 'here is [where you can find us.]'*
>
> *I don't know if it's since the class or if the hospital just signed-on to helping us out, but I notice a difference in the way they handle the CIT youth as opposed to how it used to be. [Before the class], I felt hostility... but it's easy sailing now. To me it's no difficulty getting that youth in."*

There was not consensus among focus group members regarding the least helpful modules. Recommendations for improvements were made for several, including *Psychotropic Medications*, *FBI school violence*, and *Seamless Integration with Schools*.

Focus group participants believed the *FBI school violence* presentation would be more helpful if it included information about improving school safety in Chicago. Further, they said more clarity was needed regarding CPD and Chicago Public Schools (CPS) policies discussed in the *Seamless Integration with Schools* module. One focus group participant requested stronger and better-informed crisis intervention collaboration between CPD and CPS through awareness and policies, to make that collaboration as strong as the partnership CPD has with the local hospitals.

C. Preparedness for application of CIT-Y training in the field

Focus group participants were asked to describe their ability to apply in the field what they learned in the course. Officers in all the focus groups reported being prepared, but some said more guidance was needed for handling repeat youth crisis calls. One officer commented being prepared means making "a little more effort to resolve the situation, a little more effort to be patient and listen."

Others suggested repeat youth crisis calls should be handled in the same way as other types of repeat call, through deployment of youth detectives or CIT-Y officers for follow-up or well-being checks. One participant stated, "follow-up occurs on other police reports and should be done here."

Another recommendation was to improve record sharing across systems including throughout the police department, the jails, courts, hospitals, youth protective agencies, and behavioral health providers.

Officers gave examples of how the CIT report (*Appendix E*) could be used for early intervention and violence prevention, including informing the Illinois Department of Children and Family Services (DCFS) and treatment providers of youth and families who are repeatedly having police contact. Participants reported that they complete both a CIT report and a DCFS report, but the two documents are never filed together and consequently, the information is not shared. Further, participants indicated they would be more efficient with their paperwork if they knew how to properly documenting case reports for DCFS. One participant stated having a better working relationship with DCFS is important because "a lot of these kids would be better off in homes or group homes, somewhere else outside that parent's [home, which is] probably making their condition 100 times worse."

D. Barriers to implementation of training techniques

Focus group participants were asked to describe barriers they faced when attempting to apply course material in the field. Most barriers identified related to being linked to youth crisis calls by dispatchers, the inability to effectively document crisis events due to lack of integrated reporting mechanisms within CPD, and referring youth with mental health needs to urgent, but non-emergency community-based mental health services.

Some participants reported that inefficient internal processes prevent 9-1-1 dispatchers from linking them to youth crisis calls. The daily officer rosters used by 9-1-1 dispatchers don't always properly indicate which are trained in youth crisis intervention (Z code). They suggested that this status code be added to the automated roster program, so that it populates the list as automatically as the gender code.

One participant requested dispatchers assign them a youth crisis call through 9-1-1 when they hear it over the police radio. The officer stated, "If I deal with [the same youth] lot, I'll have dispatch link me to the call. That helps; I think just building a rapport with the same kid."

Officers recommended more awareness of department documentation protocols related to documenting crisis events. One officer recommended the use of the CPD's Automated Incident Reporting Application (ARIA) system for CIT reporting, which is currently not automated:

> *I can't... [report to] the department that a call is CIT related or that a CIT officer handled it [due to current data reporting deficiencies]. I can [access] the hospitalization report [through ARIA] when on scene for an attempted suicide or something relative to a CIT incident.... I believe that the [paper-based] CIT report has to be implemented in ARIA.*

Officers also requested more information on community-based mental health service providers who can address youth mental health needs. They suggested updates to their mobile devices that would allow them to more easily record crisis events and access list of treatment providers based on location.

E. Other focus group recommendations regarding CIT-Y training

Prior to concluding the focus group sessions, participants were asked for additional CIT-Y training recommendations.

Some officers suggested the training include success stories. Officers said program successes would offer context to officers as they apply CIT-Y concepts in the field. For example one officer asked,

> *[Whether] there [are] success [stories].* [*Those would make me] a lot more aggressive as far as getting the referrals out and making sure that I carry more [community resource] cards [for distribution to youth with mental health needs and their families] and whatever it takes.*

Participants discussed how they respond to repeat 9-1-1 calls involving the same youth in crisis and their families. These officers asked that the CIT-Y training include information about solutions to repeat youth crisis calls, as there is a need for more guidance on how to recognize the point when "untreated mental health needs escalate to [violent] behavior."

In addition, officers requested a stronger partnership DCFS, including more information on the services and interventions it provides and actions police should take in cases of abuse or neglect. As one officer stated, "DCFS would be a huge help. I think just to learn more about what their process is and when you should and shouldn't contact them, and what they are going to do for the police."

Another suggested that CIT-Y training detail the documentation that DCFS needs to intervene. Officers reported filling out multiple forms across different agencies and were unclear on how to document known cases of abuse and neglect.

Lastly, participants requested information on Medicaid, incorporating other juvenile justice system professionals such as juvenile court judges in the training to discuss court processes, and the opportunity for refresher courses.

F. Focus group participant recommendations

The focus groups offered the following programmatic enhancements:

- Incorporate CIT-Y success stories, including examples of law enforcement and service provider collaboration.
- Create and automate a list of CIT-Y officers for 9-1-1 dispatchers.
- Provide a refresher course.
- Increase department awareness of CIT techniques so officers without training know what to expect when on scene with a trained officer, perhaps through a video about CIT techniques that could be viewed during roll calls to close the gap between CIT-trained and non-trained officers.

- Make electronic copies of CIT-Y training video presentations accessible on CPD’s internal website.
- Automate the Mental Health/CIT Report make it accessible to officers via their portable device terminals (*Appendix J*).
- Establish a specialized youth crisis intervention team unit.
- Address repeat youth crisis calls by developing an internal follow-up process that includes youth detectives, who have more authority than first-responding patrol officers.
- Post CIT-Y field reference guides (Appendices B and C) in all district stations to educate untrained officers and remind trained officers of CIT-Y supported techniques and responses.
- Diversify training participants by including CPD squadrol officers, recruits, and supervisors, and expanding training to partnering entities, such as probation officers, principals and teachers, and school safety and security staff.
- Clarify when it would be appropriate to request students’ individual education plans when responding to calls at school, and the process for involving a school’s crisis unit.
- Increase linkages to community-based treatment providers that provide urgent, non-emergency services.
- Offer brochures on CIT-Y at district stations, including the Juvenile Intervention Support Center (JISC) to notify and educate the public about the program.

Conclusion

Illinois Criminal Justice Information Authority (ICJIA) researchers evaluated Chicago Police Department's (CPD) Crisis Intervention Team for Youth (CIT-Y) training curriculum with positive findings of improving officer knowledge of, and attitude towards, appropriate responses to 9-1-1 youth crisis calls.

CPD and the National Alliance on Mental Illness of Chicago (NAMI-Chicago) collaborated in 2009 to develop the CIT-Y training, which has goals of diverting youth from the juvenile justice system to community-based treatment while increasing officer and public safety. Local mental health professionals, including school crisis workers, hospital administrators, counselors, and psychologists also aided in the course development.

In 2010, ICJIA awarded NAMI-Chicago with an Edward Byrne Memorial Justice Assistance Grant through the American Recovery and Reinvestment Act to fund CIT-Y training sessions for CPD officers. Evaluation efforts were also provided to measure the effectiveness of the course and increase program sustainability. Three research methods were used including a pre-/post-curriculum test, evaluation module surveys, and focus groups. Data collection began January 2012 with the start of the Year 2 CIT-Y training sessions and ended May 2013 when a group of untrained officers was obtained.

Prior to the course, training participants, who had previous crisis intervention training as a prerequisite (n = 144) had a higher baseline knowledge of CIT-Y objectives and attitude towards youth crisis calls than untrained officers (n =137). Immediately following the course and six months later at follow-up, trained officers gained and retained even more knowledge of core CIT-Y core concepts, and more positive attitudes toward appropriate responses to service calls involving youth in crisis than before the course.

Results from evaluation module surveys indicated that training participants rated curriculum information as relevant, engaging, and easy-to-understand. They found the presenters to be knowledgeable, professional, and prepared. Officer satisfied with training presentations reported more understanding of core CIT-Y objectives.

In focus groups held six months after the training, CIT-Y officers reported regularly applying crisis de-escalation techniques and stated that they experienced safety concerns when they were not used. They also discussed program barriers such as limited implementation of department protocols to assign CIT-Y trained officers to youth crisis calls and the inability to record data related to the frequency, characteristics, and outcomes of mental health calls.

Some ways in which application of course techniques can be improved are: 1) improving course curriculum material to better reflect CPD's actual youth crisis calls, 2) training supervisors, 3) supporting cross-system collaborations for diversion and service linkage, 4) assessing internal, administrative CIT-related data to inform and improve program operations, and 5) establish non-emergency (but urgent) linkage options, outreach and follow-up services.

Implications for policy and practice

This evaluation revealed that the CIT-Y training curriculum positively impacted law enforcement officer knowledge of and attitudes toward appropriate responses to youth crisis calls, and that long-term (six month post-training) retention of core training concepts was achieved. Further, the evaluation solicited feedback from trained officers on both the training course and their experiences with implementation of training techniques in the field. These findings have several implications for improvement to the CIT-Y training curriculum, for departmental CIT-Y training practices and policies and for improved implementation CIT-Y core concepts within CPD.

Improve the CIT-Y training curriculum and departmental reporting processes to help officers better identify youth in crisis.

The CIT-Y training curriculum used in Year 2 was focused on three training objectives – the identification of youth mental illness signs and symptoms, awareness of levels of risk of harm and appropriate de-escalation techniques, and knowledge of CDP protocols for responding to youth crisis calls. For two of the three core CIT objectives—*Risk & crisis de-escalation* and *Service call protocols* trained officers' knowledge was statistically higher at six months post-training than before the course, suggesting that these training objectives were being met in the course. However, there was no statistical evidence of knowledge gains for the *Identification* training objective over time. On the contrary, findings revealed that the training barely caused participants' scores to increase on this domain to the levels of the untrained officers – participants' average knowledge scores after the training was 1.83 correct answers (out of three items), compared to 1.89 average scores for the group of untrained officers. While some research suggests that differentiating between youth crisis calls and other calls involving youth may be difficult simply because they "reflect those of the adolescents living in the community" (Doulas & Lurigio, 2014, p. 121), this is a foundational concept of the youth crisis intervention team program.

The core training component of youth-in-crisis identification can be bolstered in several ways. Future trainings should present real-world youth crisis call data captured by the Mental Health/CIT report in the *Youth mental illness—Signs & symptoms* module for better instruction on recognizing youth in crisis. Training participants may better retain scenario-based information that they have experienced on the job. Curriculum developers can also incorporate this material into such modules as *Q&A with CIT-Y officers*, as well as the *Department Procedures for Mental Health Crisis* module, for further reinforcement of the information. If such changes are made, the curriculum test should be revised to reflect this new material, and the number of questions increased to equal those testing knowledge of the other two core components (which averaged nine questions, not just three).

At the departmental level, problems with this core component of CIT-Y training may be reflective of the fragmented nature of youth crisis call tracking. Training participants identified problems with the reliance on paper-based documents to record information about these calls, which severely limit the ability to track the frequency, characteristics, and outcomes of mental

health calls, as well as dispatcher success in assigning calls to CIT-Y officers. The CIT-Y curriculum cannot be expected to accurately impart information on these calls if the department does not generally know their characteristics. At the very least, this evaluation pointed to a disconnect between course content and officer knowledge, which may improve as departmental record tracking is improved and the resulting knowledge about youth crisis calls is incorporated into the training curriculum.

Expand CIT-Y training to more officers and partnering agencies and develop refresher courses.

Recommendations made by training participants in both Year 1 and this Year 2 evaluation stressed the importance of wider adoption of CIT-Y training within the department for greater impact in the field. This evaluation found that there was little or no change in the composition of training participants between the first and second year, and the predominance of patrol officers with many years of service was evident even in the untrained group of officers volunteering for basic CIT training. Reliance on this volunteer pool of CIT trained officers as a departmental training policy for further CIT-Y training will not achieve more diversity in trained staff, particularly in reaching supervisory-level staff that can reinforce the use of CIT-Y training techniques in the field. This evaluation found that prior knowledge of core CIT-Y concepts was higher than for untrained officers, but that even the most informed participants (who were already trained as adult CIT officers) started out with low pre-test scores (an average of 8 out of 21 questions correctly answered). Therefore, the departmental policy of requiring adult CIT training as a prerequisite for CIT-Y training should be re-evaluated as to its effect on reaching a wider training audience.

Expansion of CIT-Y training should be considered in two other aspects. Participants in this evaluation commented that it could be difficult to apply CIT-Y techniques in tandem with untrained officers who may misinterpret de-escalation techniques as outside of normal protocols. It was recommended that CIT-Y training video presentations be made available to untrained officers through roll-call presentations or on CPD’s website. Increased awareness of CIT-Y training concepts will promote more coordinated responses by all officers responding to youth crisis calls and dispel misconceptions. Training participants also recommended expansion of CIT-Y training to partnering entities, particularly school personnel and youth probation officers. While this may be beyond the scope of departmental training capacity, making the training video material available to other entities could fill this perceived training need. Exposure to CIT-Y training concepts developed from a law enforcement perspective can also inform partnering entities of that perspective, which may differ from the viewpoint of their profession.

Finally, CIT-Y training is limited to the one 5-day course. Participants in this evaluation recommended the opportunity for yearly refresher courses to support CIT-Y officer knowledge of training information and address implementation barriers and any questions/concerns.

Develop protocols and training to help officers more effectively deal with repeat youth crisis calls.

Partnerships with mental health service providers are fundamental to successful law enforcement responses to youth crisis calls. The CIT-Y program model calls for diversion from the juvenile justice system and linkage to appropriate treatment services to reduce subsequent law enforcement contact, arrests, and jail and hospital admissions (National Alliance for the Mentally Ill, 2009). However, this model has a latent assumption that diverted youth do not re-enter the juvenile justice system because of successful treatment of their underlying mental health issues. However, training participants identified that one barrier to successful CIT-Y training implementation is the lack of information on how to deal with other agencies when dealing with repeat crisis calls involving the same youth and their families. They identified the lack of non-emergency, but urgent, linkage options as one barrier to successful youth diversion. In particular, they expressed a need for more cross-system information sharing and streamlined follow-up processes with child protective services, especially when dealing with service calls involving child abuse and neglect. It is recommended that department CIT-Y directives be enhanced to address these inter-agency collaborations.

Conduct additional evaluations of the impact of CIT-Y training.

Future evaluation efforts should explore implementation and impact of CIT-Y training in the field. There are many avenues for future investigation: the outcomes for youth handled by CIT-Y officers, an assessment of adherence to CIT department directives and cross-system collaborations, and the diffusion of CIT-Y concepts and techniques through informal peer training on the job. The key to future evaluation efforts is better data collection on mental health calls within the department. Toward that end, researchers developed a proposed information system map to assist in data exchange development (Appendix The recommended automation of the Mental Health/CIT form and record linkage among collaborating partners will allow for more research on the prevalence, characteristics, and dispositions of youth crisis calls which will result in a better understanding crisis call characteristics, officer responses, and the progression of violence.

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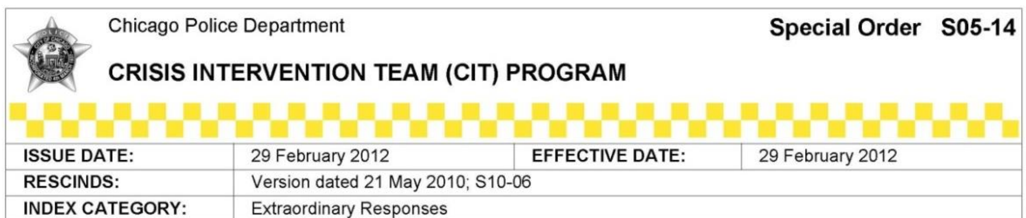
Appendix A: CIT department directives



Chicago Police Department

Special Order S05-14

CRISIS INTERVENTION TEAM (CIT) PROGRAM

ISSUE DATE:	29 February 2012	**EFFECTIVE DATE:**	29 February 2012
RESCINDS:	Version dated 21 May 2010; S10-06		
INDEX CATEGORY:	Extraordinary Responses		

I. PURPOSE

This directive establishes the Crisis Intervention Team (CIT) Program.

II. POLICY

The Chicago Police Department recognizes the correlation between mental health and crime and is committed to the dignified treatment and safety of arrestees and other persons requiring assistance from the Department to obtain mental health evaluation, treatment, or hospitalization.

III. GENERAL INFORMATION

A. Mental illness is a mental or emotional disorder that substantially impairs a person's thought, perception of reality, emotional process, judgment, behavior, or ability to cope with the ordinary demands of life, but does not include a developmental disability, dementia, or Alzheimer's disease absent psychosis, a substance abuse disorder, or an abnormality manifested only by repeated criminal or otherwise antisocial conduct (405 ILCS 5/1 -129).

B. The Chicago Police Department seeks to reduce the incidence and severity of mental-health-related crime in our communities through a coordinated partnership involving law enforcement, mental health service providers, prosecutors, courts, and the community. The Chicago Police Department advocates early intervention for individuals at risk.

C. Department members will treat mental health incidents in the same professional manner as all other requests for police service and will provide immediate, effective assistance and protection.

D. The CIT Program will operate citywide and on all watches based on the availability of on-duty CIT trained members.

IV. RESPONSIBILITIES

A. The CIT Program will be commanded by a coordinator who is responsible for the overall management of the program and will:

1. ensure the submitted Mental Health - Crisis Intervention Reports are compiled and retained, and the appropriate data is collected and maintained to support and memorialize the effectiveness of the program.

2. collaborate in the development of CIT training curricula on mental health issues and district-level response to mental health-related incidents.

3. develop and manage the response protocol for the Critical Response Unit (CRU).

B. The CIT Program is charged with improving the Department's response to mental-health-related incidents and facilitating and coordinating law-enforcement services provided to the mental health community by:

1. developing a comprehensive, uniform intervention strategy and maintaining coordination with other City, criminal justice, and community-based agencies, advocacy groups, educational and research institutions, and members of the community coping with mental health issues.

2. collaborating in the development of the CIT training curricula and materials, both within the Department and for other City agencies or service providers, and participating as instructors

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Appendix A continued

for Department training of in-service and recruit members on mental health issues and district-level response to mental-health-related incidents.

3. engaging as a Critical Response Unit (CRU), for identified mental health emergencies requiring a high level of law-enforcement-related mental health intervention expertise and competence. This engagement is specifically intended to provide CIT-trained Department personnel to assist with mental-health-related incidents:

   a. as determined by a Department *exempt commanding officer*,

   b. as determined by the Incident Commander at the scene of an incident (e.g., *SWAT*) with a mental health factor, or

   c. at the request of district personnel, community-based service providers, or other governmental agencies.

   NOTE: If an identified mental health emergency requires response from the CRU, OEMC will notify the CIT Program Coordinator and/or Operational Manager via the *Crime Prevention and Information Center* (CPIC). The CIT Program Coordinator and/or Operational Manager will determine the degree of response and subsequent resources provided by the CRU to assist with the incident.

4. providing streaming videos and periodic roll call training for district personnel on Department policy and other matters relating to mental heath issues.
5. disseminating information about available mental-heath-related resources and services to officers and the community to facilitate problem solving for mental health issues and to assist in making appropriate referrals for members of the community.
6. informing and, when necessary, consulting with CIT-trained members on recurring mental health issues or problems at the district level.
7. supporting *Bureau of Detectives* area follow-up investigations involving individuals in need of mental health treatment.
8. attending periodic training to remain informed of changes in criminal statutes, Department policy, and other mental health-related issues.
9. coordinating forensic mental health crisis response and emergency intervention service between service providers and district CIT-trained members.
10. other duties as identified by the *exempt commanding officer* responsible for the program.

(Items indicated by *italics/double underline* were revised or added.)

Authenticated by: JKH

Garry F. McCarthy
Superintendent of Police

09-134/12-003 EGV/mwk/TRH

ADDENDA:

1. S05-14-01 - Crisis Intervention Team (CIT) Response

Appendix A continued

Chicago Police Department

Special Order S05-14-01

CRISIS INTERVENTION TEAM (CIT) RESPONSE

ISSUE DATE:	29 February 2012	EFFECTIVE DATE:	29 February 2012
RESCINDS:	Version dated 21 May 2010; S10-06-01		
INDEX CATEGORY:	Extraordinary Responses		

I. **PURPOSE**

This directive:

A. outlines procedures for CIT response to mental-health-related incidents.

B. continues the Mental Health - Crisis Intervention Report (CPD-15.520)

II. **GENERAL INFORMATION**

A. CIT members are Department members who have voluntarily attended and successfully completed the 40-hour Basic CIT Training and have been certified by the Illinois Law Enforcement Training and Standards Board (ILETSB) as CIT officers. The Basic CIT Training is an in-depth specialized training course that provides officers with education about mental illness signs and symptoms and de-escalation techniques.

B. CIT members may field test equipment related to CIT responses, as determined by the Superintendent of Police.

C. Any sworn member assigned to a mental-health-related assignment may complete and submit a Mental Health - Crisis Intervention Report, in addition to any other required reports.

D. CIT members are authorized to wear the Chicago Police Department CIT pin on the right pocket flap of their outer uniform garment, aligned under the name plate.

E. The CIT Program will maintain an updated listing of CIT members and their unit of assignment via the eLearning application.

F. No officer will continue under the provisions of this directive when the circumstances clearly indicate that an Active Shooter, *Special Weapons and Tactics (SWAT) Incidents*, or School Violent Incident Plan (SVIP) situation exists. Members will follow the procedures as delineated in the appropriate Department directive.

III. **PROCEDURES**

A. Office of Emergency Management and Communications (OEMC)

1. When dispatching calls for service, OEMC will be responsible for assigning identified mental-health-related calls for service to:

    a. a CIT member, when available.

    b. non-CIT trained members, if no CIT members are available.

    NOTE: The lack of a CIT member will not delay dispatching of a mental health-related assignment. Dispatchers will not hold assignments pending the availability of a CIT member.

2. Non-CIT members encountering a situation with a mental health component may request the assistance of a CIT member.

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Appendix A continued

3. OEMC dispatchers may deviate from the dispatch protocol outlined in Department directive entitled "**Radio Communications**" when dispatching identified mental-health-related calls for service.

B. District Supervisors

1. *Station supervisors* will:

   a. ensure that the daily assignment roster sent to OEMC and entered in the PCAD reflects CIT members by placing the letter "Z" next to the members' names.

   NOTE: A roster of CIT members is available via the eLearning application.

   b. forward all submitted Mental Health - Crisis Intervention Reports to the CIT Program.

2. CIT sergeants will:

   a. when feasible, respond and provide supervisory guidance on mental-health-related assignments.

   b. ensure that a Mental Health - Crisis Intervention Report is completed on mental-health-related assignments identified in Item III-C-4 of this directive.

   c. be responsible for the collection, review, and approval of the Mental Health - Crisis Intervention Reports and the submission of the approved reports to the *station supervisor*.

   NOTE: When there are no CIT sergeants available, a non-CIT sergeant will fulfill the duties of a CIT sergeant.

C. CIT Police Officers:

1. will receive assignments that have been designated by OEMC as having a mental health component.
2. will provide assistance, when requested, to other members.
3. may assume responsibility, with supervisory approval, of an assignment that they were not originally assigned.
4. when assigned an incident with a mental health component, will complete the Mental Health - Crisis Intervention Report, in addition to any other reports, **only when**:

   a. the original dispatch assignment from OEMC was not identified as mental health related,

   b. no other report has been completed to document the incident, or

   c. unusual circumstances exist (e.g., repeated calls at the same location, subject has a history of violence).

5. when appropriate, will use the proper number-letter code from the Miscellaneous Incident Reporting Table at the conclusion of the incident. When using Police Action "Z" – Zebra "Mental Health Related," "Z" - Zebra will be the first alpha code given.

NOTE: When there are no CIT-trained officers available, a non-CIT-trained officer will fulfill the duties of a CIT officer. Non-CIT-trained officers may request the assistance of a CIT officer(s) for assignments that have a mental health component. CIT officers will be assigned as available; however, the responsibility of the assignment will remain with the assigned non-CIT officer.

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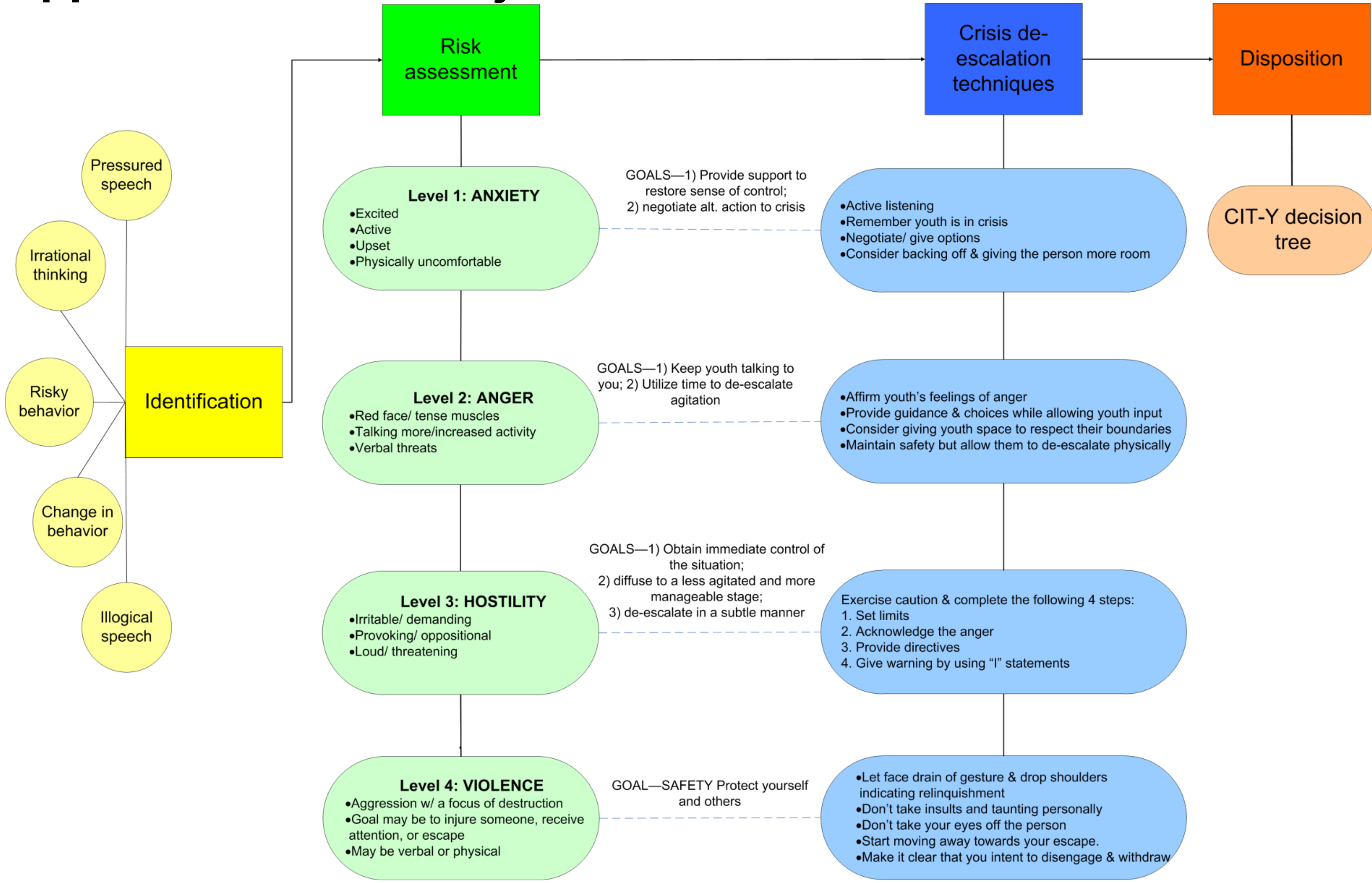
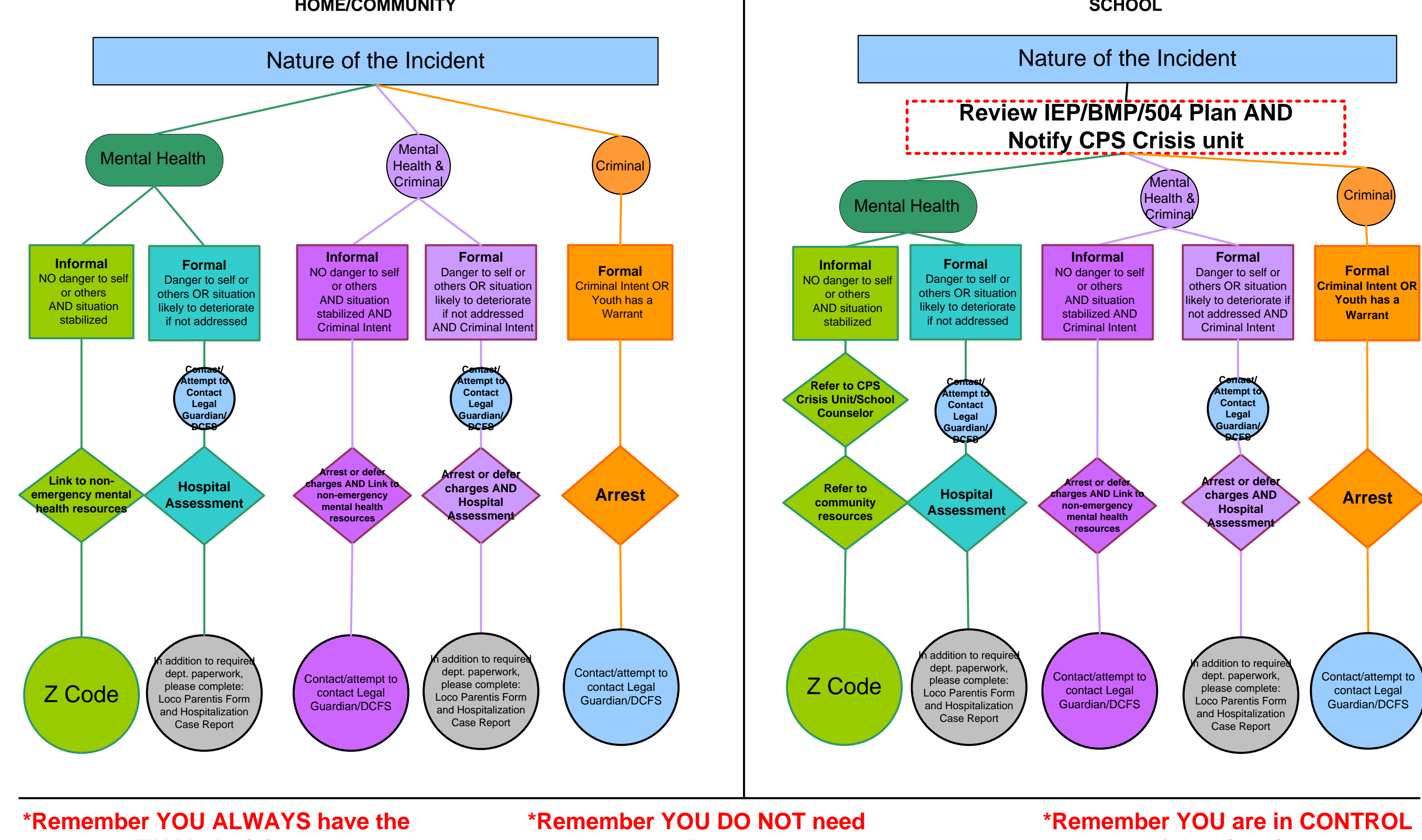
Appendix B: CIT-Y objectives



Appendix C: Service call disposition decision tree



This document was created by: Rebecca Skorek, Research Analyst, Illinois Criminal Justice Information Authority, Officer Kurt Gawrisch, Lead Instructor of Chicago Police Department's Crisis Intervention Team, and Suzanne Andriukaitis, Executive Director, National Alliance on Mental Illness of Greater Chicago

For additional information regarding this document, please contact Rebecca Skorek at Rebecca.Skorek@illinois.gov
Revised Spring 2013

Appendix D: CIT-Y training schedule and modules

<table>
<tr><th></th><th>Monday</th><th>Tuesday</th><th>Wednesday</th><th>Thursday</th><th>Friday</th></tr>
<tr><td>0800 – 0850</td><td>Introduction, Child / Adolescent Overview</td><td>Psychotropic Medications</td><td>Violence & Urban Trauma</td><td>Seamless Integration with Schools</td><td rowspan="5">Community Resource Panel

Luncheon</td></tr>
<tr><td>0900 – 0950</td><td>Child & Adolescent Brain Development</td><td rowspan="2">Risk Assessment & Crisis De-escalation Skills</td><td>Adolescents & Gangs</td><td></td></tr>
<tr><td>1000 – 1050</td><td rowspan="2">Mental Illness: Signs & Symptoms</td><td rowspan="2">Department Procedures For Mental Health Crisis</td><td rowspan="2">Department Procedures For Special Circumstances</td></tr>
<tr><td>1100 – 1150</td><td>Self-Injurious Behavior</td></tr>
<tr><td>1200 – 1300</td><td>Lunch</td><td>Lunch</td><td>Lunch</td><td>Lunch</td></tr>
<tr><td>1300 – 1350</td><td>Signs & Symptoms: Continued</td><td>Substance Abuse & Co-Occurring Disorders</td><td rowspan="2">FBI: School Violence & School Shooters</td><td>Q & A: MH Scenarios</td><td>Summary & Evaluation</td></tr>
<tr><td>1500 – 1550</td><td></td><td></td><td></td><td>Superintendent’s Ceremony</td></tr>
</table>

Appendix E: Mental health—CIT report

MENTAL HEALTH - CRISIS INTERVENTION (CIT) REPORT
CHICAGO POLICE DEPARTMENT

Date/Time Assigned
/

Address of Incident	Location Code	Beat of Occurrence	Assigned by ☐ OEMC ☐ Supervisor ☐ On-View

Event No.	RD No. (If applicable)	CB No. (If applicable)	IR No. (If applicable)

Previous Interaction ☐ Yes ☐ No	If known, list no. of times	Was Mental Health component indicated before arrival? ☐ Yes ☐ No

Subject Information

Name			Address
Sex ☐ Male ☐ Female	Date of Birth	Age	Race ☐ 1-Black ☐ 2-White ☐ 3-Black-Hispanic ☐ 7-Other ☐ 4-White-Hispanic ☐ 5-Amer. Ind/Alask. ☐ 6-Asian/Pacific Islander

Living Arrangements ☐ Homeless ☐ Family ☐ Independent ☐ Assisted Living ☐ Unknown

Hospitalization/Treatment

Prior mental health hospitalization	☐ Yes	☐ No	☐ Unknown
Prior mental health treatment	☐ Yes	☐ No	☐ Unknown
Current mental health treatment	☐ Yes	☐ No	☐ Unknown

If known, list Doctor's Name and Agency

Currently taking medication for mental illness ☐ Yes ☐ No ☐ Unknown
(If known, indicate name and last time the medication(s) were taken)

Did you observe any of the following (Check as many as apply):

☐ Nothing unusual observed
☐ Absurd, illogical thinking/talking
☐ Abnormal behavior/appearance
☐ Hearing voices/hallucinating
☐ Anxious/excited
☐ Paranoid or suspiciousness
☐ Violent behavior
☐ Severe, depressed mood
☐ Suicidal talk
☐ Suicidal gesture(s)
☐ Signs of alcohol/illegal drug use
☐ Possible developmental disability
☐ Aggressive/threatening behavior or speech
☐ Weapons, if checked ☐ Displayed ☐ Used

Member Actions

☐ Contact only: Card No. ________________
☐ Transported to ________________
Type of facility ☐ Hospital ☐ Substance Abuse Facility
☐ Homeless Shelter ☐ Community Mental Health Facility
☐ Governmental Agency ☐ Home ☐ Other ________ Specify
☐ Hospitalization ☐ Yes ☐ No
If yes, ☐ Voluntary ☐ Involuntary
Petition completed by member ☐ Yes ☐ No
Reason for Hospitalization
☐ Harm to self ☐ Harm to others ☐ Basic needs not met

Methods Used (Check all that apply)
☐ Verbal
☐ Physical restraint
☐ OC Chemical Weapon
☐ Canine
☐ Impact Weapon
☐ Taser
☐ Firearm
☐ Other ________ Specify

CIT Officers (This section to be completed by CIT Officers only)

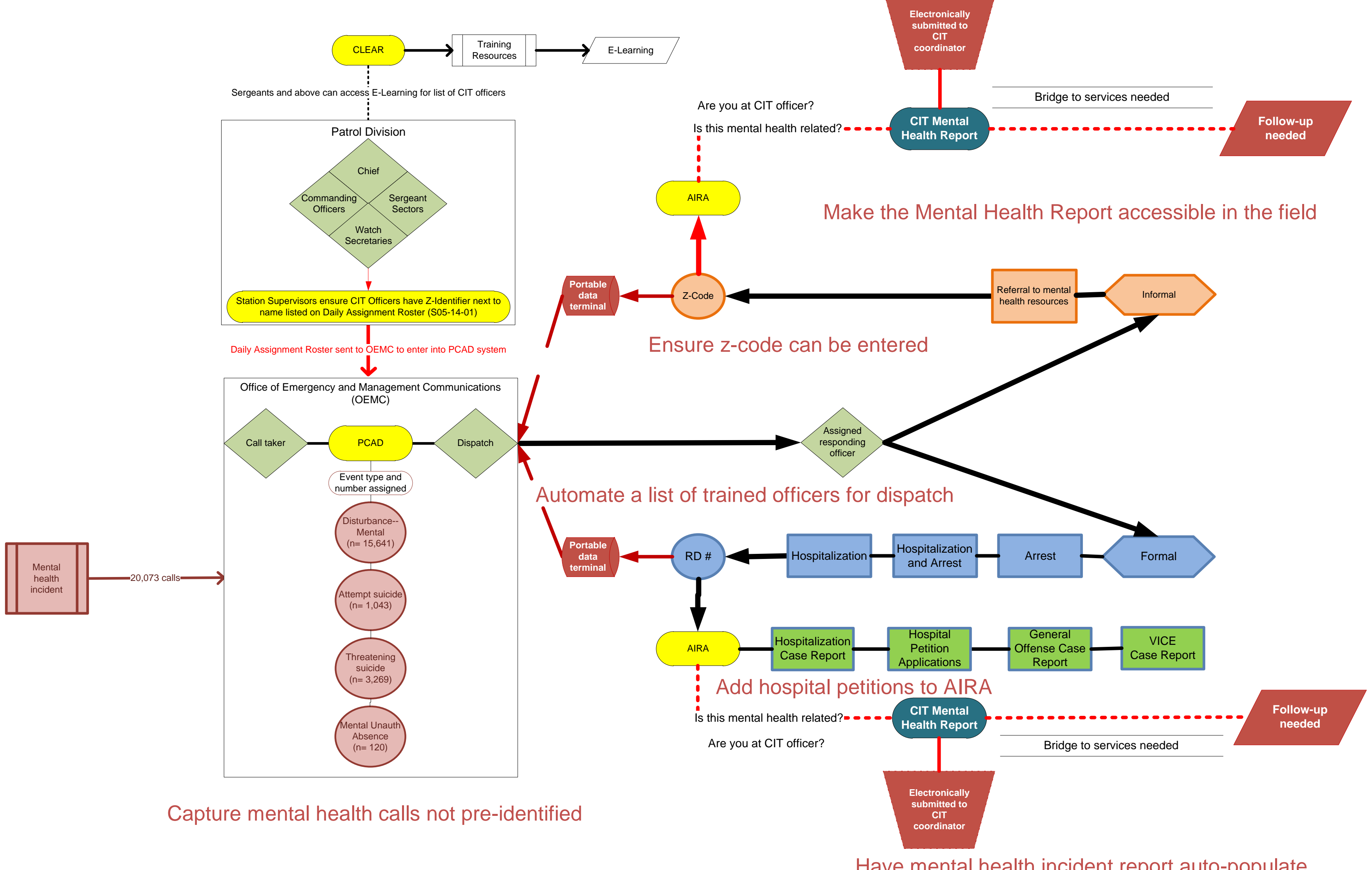
Rate highest level of subject ☐ 1- Anxiety ☐ 2- Anger ☐ 3-Hostility ☐ 4-Violence
Subject's actions ☐ Cooperative ☐ Passive Resister ☐ Active Resister ☐ Assailant
Were CIT Training Techniques Used? ☐ Yes ☐ No Were the techniques successful? ☐ Yes ☐ No

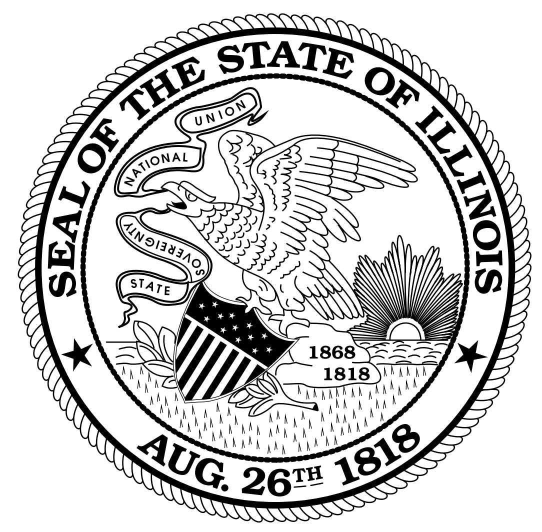
Member's Name ☐ CIT	Star No.	Beat No.	Member's Name ☐ CIT	Star No.	Beat No.

CIT Supervisor's Approval	Date/Time Completed /	Reports Attached ☐ Case Report ☐ Arrest Report ☐ TRR ☐ Other

CPD-15.520 (Rev. 5/11) Please return this report to the CIT Program, Unit 141.
Use reverse side for any additional information and attach all relevant reports.

Appendix F: Recommended CIT systems map





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