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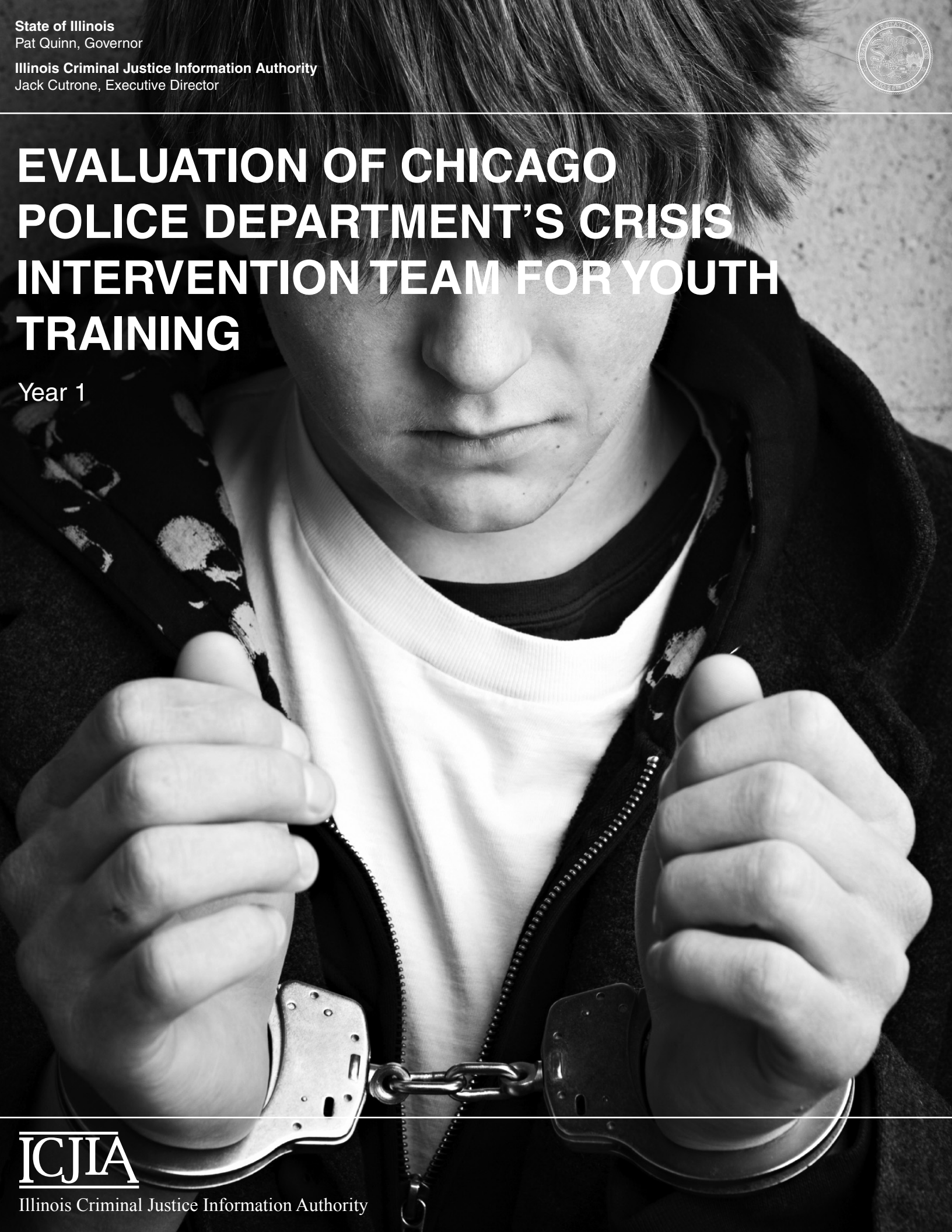
EVALUATION OF CHICAGO POLICE DEPARTMENT'S CRISIS INTERVENTION TEAM FOR YOUTH TRAINING

Year 1



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Illinois Criminal Justice Information Authority

Evaluation of Chicago Police Department's Crisis Intervention Team for Youth training

Year 1

July 2012

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This project was supported by Grant #09SUB90055 awarded to the Illinois Criminal Justice Information Authority by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions contained within this document are those of the authors and do not necessarily represent the official position or policies of the Authority or the U.S. Department of Justice.

Suggested citation: Campbell, R. R. (2012). *Evaluation of Chicago Police Department's Crisis Intervention Team for Youth training: Year 1*. Chicago, IL: Illinois Criminal Justice Information Authority.

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Acknowledgments

I would like to acknowledge the following individuals for their assistance and support throughout this evaluation process:

Suzanne Andriukaitis, National Alliance on Mental Illness-Greater Chicago
Officer Kurt Gawrisch, Chicago Police Department
Officer Dina Markham, Chicago Police Department
Lieutenant Jeff Murphy, Retired, Chicago Police Department
Officer Rhomel Owens, Chicago Police Department
Sergeant Rich Witney, Chicago Police Department

The following Authority staff should be recognized for their contributions to this evaluation project:

Lisa Braude, Ph.D
Cristin Monti Evans
Ernst Melchior
Jessica Reichert

Key findings

In 2010, the Illinois Criminal Justice Information Authority (ICJIA) provided the National Alliance on Mental Illness of Greater Chicago (NAMI-GC) with funding to implement the Crisis Intervention Team for Youth (CIT-Y) program within the Chicago Police Department (CPD). The CIT-Y program is a five-day, 40-hour course for law enforcement officers on recognizing the symptoms of youth mental disorders, assessing risk levels youth have for hurting themselves and others, applying corresponding crisis de-escalation techniques, and, when appropriate, diverting youth from the juvenile justice system to community-based treatment services. This evaluation was conducted to assess the CIT-Y training components and offer recommendations to enhance the officers' understanding of the program objectives.

Feedback from training participants

Key findings gathered from surveys and focus groups include:

- Overall, participants were very satisfied with the CIT-Y training content and delivery.
- Collectively, 57 percent of the comments on the course evaluation surveys were positive.
- Focus group participants reported applying CIT-Y techniques in their work, particularly within schools and housing developments. Application of risk assessment and crisis de-escalation techniques were most commonly referenced.
- Barriers to implementing the training curriculum included lack of program awareness and department support, inefficient hospital protocols for youth mental health assessments, and uncooperative parents, school administrators, teachers, and security personnel.
- Several focus group participants suggested creating a CIT-Y unit within CPD, establishing mental health assessment protocols with community hospitals, and diversifying the groups of professionals participating in the training.
- Some focus group participants identified topics that needed expansion in the course. They included how to appropriately respond to uncooperative teachers, parents, and supervisors, and department procedures that should be followed when transporting youth to hospitals for mental health assessments.

Recommendations

Key recommendations to enhance content, administration, and outcomes of the training include:

- Enhance curriculum by including training components that utilize video to explain technical/clinical content and incorporate more relevant examples.
- Diversify course participants by including dispatch officers, teachers, and school administrators, and supervisors of CIT-Y officers.
- Revise evaluation tools to gain a better understanding of how the course components influenced officer knowledge of crisis intervention and attitudes toward youth mental illness.

Introduction

Of the more than 2.1 million youth arrested each year in the United States, an estimated 70 percent have a mental health disorder (Skowyra & Cocozza, 2006). According to Hanger (2008), "many of these youths end up in the juvenile justice system after having failed to be identified, or gone undiagnosed, and having not received services within their communities" (p. 36). To prepare its officers to deal with this population, the Chicago Police Department (CPD) implemented the Crisis Intervention Team for Youth (CIT-Y) training program. This 40-hour course takes place over five days and introduces officers to complex issues of youth mental illness. The purposes of the training are to divert youth with mental illness from the juvenile justice system to community-based treatment services, and reduce the likelihood of violent interactions between these youth and law enforcement officers.

The crisis intervention team (CIT) model originated in Memphis, Tenn., in 1988. About 1,500 CITs exist in police departments throughout the nation (C. S. Cochran, personal communication, May 2011). CPD established its CIT in 2004. In 2009, CPD collaborated with the National Alliance on Mental Illness of Greater Chicago (NAMI-GC) to develop an advanced training curriculum that addresses the high prevalence of mental illness among delinquent youth. By 2010, CPD held the country's first five-day, 40-hour CIT for Youth course. This initiative sparked national interest, and police departments throughout the country have contacted CPD for curriculum materials.

In 2010, the Illinois Criminal Justice Information Authority awarded NAMI-GC with an Edward Byrne Memorial Justice Assistance Grant through the American Recovery and Reinvestment Act to fund 12 CIT-Y training sessions—four training sessions per year for three years. A total of 126 CPD officers were trained in the first year. CIT-Y course participants were recruited via internal CPD communications. The post listed basic CIT training as a prerequisite and instructed officers who met this requirement to complete an application. Participants were selected by CPD's CIT training staff.

This evaluation assessed CIT-Y training components by measuring officer pre-and post-training knowledge of youth mental illness, retention of training material, satisfaction with curriculum content and delivery, intentions to use the training information, and the actual application of training components. The evaluation tools were developed by CPD CIT-Y staff and used by the evaluators as a foundation for this assessment. This allowed the evaluators to determine their validity and make appropriate modifications for an evaluation of the program's second year.

This report outlines evaluation findings and provides recommendations to enhance the CIT-Y training program's content and outcomes. In addition, the modifications made to the curriculum and evaluation tools for the program's second year are discussed.

Literature review

It is estimated that nationally 70 percent of juvenile justice-involved youth have mental health disorders (Skowyra & Cocozza, 2006). With approximately 25,000 youth arrests occurring throughout Chicago in 2011, there is potentially a large number of youth in need of additional services (ICJIA analysis of Criminal History Records Information system ad hoc datasets). Many youth with mental illness are involved in the juvenile justice system for "relatively minor, non-violent offenses," but due to unmet mental health needs, they are formally processed (Skowyra & Cocozza, p. 1).

Community mental health resources

During the 1950s, state psychiatric hospitals throughout the country were the primary care settings for persons with mental illness. That changed with the implementation of the federal Community Mental Health Centers Act in 1964. This Act provided monetary incentives for states to shift psychiatric care from hospital settings to community-based treatment facilities for the purpose of reducing hospital psychiatric-care costs from state expenditures. As a result, hospital populations of psychiatric patients fell dramatically from 559,000 patients in 1955 to 47,000 patients in 2003 (Manderscheid, Atay, & Crider, 2009). However, state hospitals often released psychiatric patients to communities that were lacking mental health treatment services due to "insufficient funding, limitations in evidence-based practices, and the lack of clear federal standards of care" (Lurigio & Harris, 2007, p. 150). Thus, the primary care setting for those with mental illnesses shifted to jails and prisons, as symptoms of untreated mental illnesses can mirror disorderly behavior and call the attention of law enforcement officers. One study found seriously mentally ill persons in the United States were three times more likely to be incarcerated than hospitalized between 2004 and 2005 (Torrey, Lennard, Eslinger, Lamb, & Payle, 2010).

In addition to deinstitutionalism, changes in law have increased the number of mentally ill individuals involved in the criminal justice system. Since the 1970s, mental health laws have been reformed by precedent cases such as *O'Connor v. Donaldson* (1975), *Rennie v. Klein* (1978), *Addington v. Texas* (1979), and *Rogers v. Okin* (1979), which placed restrictions on involuntary commitments, administering psychotropic medications, and the type of treatment services provided. According to Lurigio and Harris (2007), this resulted in an "increase in the likelihood that [persons with serious mental illnesses] will be arrested and further processed through the courts" (p. 152).

Role of juvenile justice system

According to Indiana State Bar Association (2005), society's punitive role toward youth transgressions and lacking community-based mental health resources has lead to the juvenile justice system becoming "the 'de facto' mental health treatment system for children with mental health needs" (p. 2). The first juvenile justice system in the United States was founded in Cook County in 1899 and its premise was based on the p*arens patriae* doctrine, "the authority of the state to act as a parent who provides for the needs and welfare of a youth" (Grisso, 1998, p. 273). Youth under the age of 17 were presumed unable to form criminal intent, so the court's

responsibility was not to determine guilt, but instead provide rehabilitation. The juvenile justice system has undergone two major reforms since then, amending the system to what it is today.

The first reform of the juvenile justice system took place in the mid-1960s, as a result of two U.S. Supreme Court cases, *Kent v. U.S.* (1966) and *In re Gault* (1967). Together, these cases transformed the juvenile justice system, as "the state now had to prove its allegations in delinquency cases in order to have the authority to take custody of delinquent youths to provide for their rehabilitation" (p. 4). Although the juvenile justice system had undergone its first reform, its purpose of rehabilitation remained.

Marked support for the second reform began in the 1980s, when an increase in violent juvenile offenses was recorded. States enacted juvenile justice system laws during the 1990s making it easier to transfer juveniles to criminal court and try them as adults. As a result, the role of the juvenile justice system was reframed to assert "a punitive objective as primary in cases involving serious violent offenses by juveniles" (Grisso, 1998, p. 5).

Mental illness and juvenile justice system-involved youth

Juvenile justice-involved youth are more likely to have behavioral and emotional disorders (70 percent) than those in the general population (20 percent) (National Mental Health Association, 2004). Research on delinquent youth populations suggest behaviors associated with youth mental health disorders increase the risk for juvenile justice system involvement (Grisso, 2008). For example, youth with mood disorders often present symptoms of irritability and hostility, increasing "the likelihood that they will provoke angry responses from other youth (and adults), thus augmenting the risk of events that escalate to physical aggression and result in arrests" (Grisso, 2008, p. 145). Accordingly, delinquent youth are 20 times more likely to have a diagnosis of conduct disorder than non-offending youth (Grisso, 2004). More than 30 percent of juveniles with conduct disorder also suffer from either depression or anxiety-related disorders (Dishion, French, & Patterson, 1995). Such mood disorders may result after experiencing traumatic life events, such as physical or sexual abuse, as 40 percent of detained girls and 20 percent of detained boys have endured such situations (Robertson, Dill, Husain, & Undesser, 2004).

According to Hanger (2008), juveniles with untreated mental health disorders may be at a disadvantage in terms of juvenile justice-related outcomes. Juvenile justice-involved youth with unmet mental health needs are detained longer and recidivate sooner than juvenile justice-involved youth who are not in need of mental health services (Tulman, 2004). In addition, research has documented a relationship between youth conduct problems and criminality in adulthood (Blumstein, Farrington, & Moitra, 1985; Farrington, Loeber, & Van Kammen, 1990; Kratzer & Hodgins, 1997; Robins, 1993; Robins, Tipp, & Przbeck, 1990; Stattin & Magnusson, 1993). Kratzer and Hodgins (1997) reviewed mental health and criminal records on 6,449 males identified as having conduct problems during childhood and found 75 percent had a criminal record by age 30. According to Lyons, Griffin, Quintenz, Jenuwine, and Shasha (2003), delinquent youth with mental health needs can and should be linked to community-based treatment services for "reduced risk behaviors, improved functioning, and an increase in identified strengths" (p. 1633).

Addressing delinquent youth mental health needs

Law enforcement's role is critical in diverting individuals with mental illness from the criminal justice system to community-based mental health treatment. Police officers are often identified as first-responders to mental health crises and criminal justice gatekeepers (Deane, Steadman, Borum, Veysey, & Morrissey, 1999; Teller, Munetz, Gil, & Ritter, 2006). They are mandated by mental health law to assist mentally ill persons during crisis situations, while being responsible for enforcing laws pertaining to public order offenses, such as loitering, disturbing the peace, and trespassing, which are associated with signs and symptoms of untreated, mental disorders (Borum, 2000).

Crisis Intervention Team model

The Crisis Intervention Team (CIT) model originated in Memphis, Tenn., in 1988. The Memphis Police Department wanted to provide their community with specially trained law enforcement officers skilled at implementing crisis de-escalation techniques and linking individuals with mental illness to community-based mental health services. According to Dupont, Cochran, and Pillsbury (2007), the "CIT is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships" (p. 3). Dupont et al. suggested that for a CIT to be successful, it should include the following program elements.

<u>Ongoing elements</u>

- Partnership between the law enforcement community, advocacy community, and mental health community.
- Community ownership to ensure all partners are included in key decisions.
- Policies and procedures for successful implementation of training material.

<u>Operational elements</u>

- CIT personnel of law enforcement officers, dispatch operators, and a coordinator to maintain partnerships with stakeholders.
- CIT training curriculum to convey training objectives to participants.
- Facilitation of mental health emergency services for efficient consumer transference between law enforcement officers and emergency care staff.

<u>Sustaining elements</u>

- Evaluation and research for a better understanding of program outcomes.
- In-service training to provide CIT officers with additional knowledge of mental health-related topics.
- Recognition and honors to highlight CIT officers' accomplishments.
- Community outreach to increase development of other CIT programs.

Although, the Memphis CIT model has gained much popularity, evaluation of CIT training curriculum components is needed. Of the existing research, findings reveal CIT training

programs improve officer knowledge of and attitude toward mental illness (Compton, Bahora, Watson, & Oliva, 2008; Teller et al., 2006). However, it is unclear which components of the CIT training curriculum are responsible for such enhancements.

Crisis Intervention Team for Youth program

The Chicago Police Department (CPD) established its CIT in 2004. The department's CIT consists of more than 1,400 officers. In order for a CPD officer to be a part of the CIT, they must first complete a voluntary five-day, 40-hour, basic training course. This course teaches officers how to recognize signs and symptoms of adult mental illness and exercise skills to defuse crisis situations.

In 2009, CPD decided to expand its CIT model and collaborated with the National Alliance on Mental Illness of Greater Chicago (NAMI-GC) to develop an advanced training course addressing mental illness among the youth population. In 2010, CPD implemented the first five-day, 40-hour Crisis Intervention Team for Youth (CIT-Y) course in the country. CPD's CIT-Y training curriculum has the following goals and objectives.

<u>CIT-Y training goals</u>

- Advance officer knowledge of youth mental illness.
- Decrease the likelihood that violent interactions will occur when law enforcement officers respond to crises involving youth with mental illnesses.
- Reduce the number of mentally ill youth involved in the juvenile justice system.

<u>CIT-Y training objectives</u>

- Teach officers how to recognize signs and symptoms of youth mental illness.
- Provide officers with knowledge and skills needed to safely interact with youth in crisis.
- Inform officers of when it is appropriate to follow established field protocols and procedures for the referral of youth to emergency mental health services.

To achieve the training goals and objectives, CPD-Y staff developed the following 18 training modules.

1. *Introduction, Child & Adolescent Overview*
   - Definitions of mental illness and serious emotional disturbance.
   - Discussion on prevalence of youth mental illness.
   - Examples of how untreated youth mental disorders affect school performance and increase risk of juvenile justice system involvement.

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 youth 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 I*
   - 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. *Violence & Urban Trauma II*
   - Relationship between adverse childhood experiences and risky adolescent behavior.

7. *Risk Assessment & Crisis Intervention Skills*
   - Youth risk assessment based on levels of anxiety, anger, hostility, and violence.
   - Crisis de-escalation techniques.
   - Circumstances requiring youth transport for mental health assessment.

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

9. *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.

10. *Substance Abuse & Co-Occurring Disorders*
   - Meaning of and facts about substance abuse and co-occurring disorders.
   - Relationship between alcohol use and suicide rates.
   - Co-occurrence of mental health disorders and substance abuse.
   - Signs of adolescent substance abuse.

11. *Depression & Suicide*
   - Facts and myths about youth suicide.
   - Risk factors and warning signs for youth suicide.
   - Types and signs of youth depression.
   - Responding to depressed youth.

12. Family Perspectives

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

13. 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 illness.

14. *Juvenile Intervention & Support Center (JISC) Project*

- Background information about JISC, including goals and objectives.

15. Eating Disorders & Self Injurious Behavior

- Overview of anorexia nervosa, bulimia nervosa, and binge-eating.
- Prevalence of eating disorders among youth population.
- Types and causes of self-injurious behaviors.

16. Department Procedures & 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 untreated mental health needs.

Methodology

Approval to conduct this research was granted by the ICJIA Institutional Review Board. Three research methods were used in this evaluation project, including course evaluation surveys, pre- and post-tests, and focus groups. These methods were used to determine the extent to which:

- Officers were satisfied with the training.
- Officer knowledge of youth mental health increased.
- Officers utilized crisis intervention techniques in the field during the six months following course completion.
- Officer' intentions of applying the crisis intervention techniques coincided with actual use during the six months following course completion.
- Officers retained knowledge of youth mental health six months after course completion.

Course evaluation surveys

Anonymous course evaluation surveys were used to measure officer satisfaction with course content and delivery and obtain other feedback. The surveys were developed by Chicago Police Department's Crisis Intervention Team for Youth (CIT-Y) training staff. Surveys were distributed at the start of each day of the course. Participants were instructed to fill out the surveys periodically, as the day's training modules were presented.

At the end of the last day of the course, evaluators collected the surveys from CIT-Y staff and entered the responses into a computerized database. A total of 583 surveys (88 percent) were collected across Year 1 CIT-Y trainings. Had all 133 training participants completed each day's survey, a total of 665 course evaluation surveys would have been collected.

Pre- and post-course tests

Pre- and post-tests were used before the course started and just after it ended to measure whether officer knowledge of youth mental health increased with the training. Unique numeric codes were assigned to match each participant's pre- and post-test responses without the officers having to identify themselves.

The pre- and post-tests were developed by NAMI-GC staff with consultation from a social science professor, and modified by the evaluators. Modifications included five additional questions to gauge officers' intentions of applying what they learned during the course. Evaluators entered pre-and post-test responses into a computerized database.

Focus group and survey

A focus group is an open-ended discussion between participants on a particular topic, guided by a moderator. Focus groups are a practical way to collect input from a number of individuals in a relatively short period of time. Law enforcement officers who attended the first and third CIT-Y training sessions were asked to volunteer to participate in a focus group to be held six months

after their course ended. Objectives of the focus group and survey were to gauge officer retention of the training and implementation of techniques presented during the course. While 32 CIT-Y officers volunteered to take part in the focus group, only seven actually participated.

Once focus group participants gave informed consent, they were instructed to complete a brief survey, which was linked numerically to their pre- and post-training tests. This survey included five pre- and post-test questions to learn officer retention of youth mental health knowledge and five pre- and post-test statements about implementation of training material. Officer responses to these 10 questions were compared to those answered six months previously upon completion of the course.

Evaluation project staff held the focus groups at CPD headquarters in a private conference room. Focus group sessions lasted about 60 minutes and were audio-recorded. Evaluation project staff moderated the focus group and asked officers the following questions to generate discussion:

- 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 material?
- To what extent did you face barriers when implementing the CIT-Y material?
- What information, if any, was not addressed in the CIT-Y training that would have been beneficial?

Research limitations

This Year 1 evaluation of the CIT-Y training had research limitations due to evaluation tools and number of focus group participants. Evaluation tools included the course evaluation survey and the pre- and post-course tests. They were developed by CIT-Y training staff and adopted by the evaluators to assess their utility and make any necessary enhancements for the Year 2 evaluation.

The course evaluation surveys were completed anonymously on each day of the training making it impossible to determine how many training participants made a specific recommendation. Only the number of times a specific recommendation was made in all surveys could be determined, rather than the number of training participants who made such recommendation.

The pre- and post-course tests consisted of 25 true/false statements about youth mental health. It did not include questions based on the CIT-Y curriculum. Thus, evaluators were unable to determine the extent to which the training increased officer knowledge of crisis intervention techniques.

Two focus group sessions were held six months after the course to learn how officers applied program information and measure their retention of youth mental health knowledge, but only seven officers attended the sessions. Many officers were not able to participate due to illness, injury, or work-related obligations. As a result, focus group participant responses could not be interpreted with any statistical meaning and may not be representative of all CIT-Y officers.

Findings

A total of 126 Chicago Police Department (CPD) Crisis Intervention Team (CIT) members participated in Year 1's Crisis Intervention Team for Youth (CIT-Y) training program held between June and November 2010. In addition, five interns from the National Alliance on Mental Illness of Greater Chicago (NAMI-GC) and two guests employed at a private, non-profit therapeutic day school that serves youth with emotional, behavioral, and learning disabilities in the Chicago area attended.

The course was given four times. Participants included:

- Training 1: 31 CPD CIT officers and 2 NAMI-GC interns
- Training 2: 30 CPD CIT officers and 2 NAMI-GC interns
- Training 3: 28 CPD CIT officers and 2 therapeutic day school employees
- Training 4: 37 CPD CIT officers and 1 NAMI-GC intern

Findings related to data collected from the course evaluation surveys, pre- and post-course tests, and focus group sessions are discussed by research method.

Course evaluation surveys

The course evaluation surveys captured training participants' overall satisfaction with the course's content and delivery and with each of the 18 training modules. A 5-point scale was used to measure participant satisfaction. Ratings ranged from very dissatisfied (1.00) to very satisfied (5.00).

Overall satisfaction ratings

CIT-Y training participants were very satisfied with the overall curriculum (averaged rating of 4.94) (*Table 1*). They found the course to be informative (averaged rating of 4.89) and organized (averaged rating of 4.92). They were satisfied with the overall quality of the handouts (averaged rating of 4.95) and audio/visuals (averaged rating of 4.95). Participants also indicated the overall training curriculum was delivered by understandable (averaged rating of 4.93), qualified (averaged rating of 4.92), and enthusiastic (averaged rating of 4.88) presenters who provided examples (averaged rating of 4.91) and answered questions (averaged rating of 4.93).

Table 1
Averaged satisfaction ratings on overall content and delivery (n= 101)

Informative	Organized	Audio/visuals	Handout material	Overall
4.89	4.92	4.85	4.95	4.94
Understandable	**Qualified**	**Enthusiastic**	**Examples**	**Questions**
4.93	4.92	4.88	4.91	4.93

Satisfaction ratings by module

The following training modules had the *highest* overall satisfaction ratings for content:

1. *Family Perspectives* (averaged rating of 4.94)
2. *FBI—School Violence & School Shooters* (averaged rating of 4.89)
3. *Parents & Teachers as Allies; Eating Disorders & Self Injurious Behavior* (averaged ratings of 4.87)

The following training modules had the *lowest* overall satisfaction ratings for content:

1. *Child & Adolescent Brain Development* (averaged rating of 4.47)
2. *Medical & Developmental Disabilities* (averaged rating of 4.54)
3. *Violence & Urban Trauma I* (averaged rating of 4.59)

Table 2 provides training participants' averaged satisfaction ratings for all 18 course modules.

Table 2
Averaged satisfaction ratings on training content by module (*N*= 133)

	Informative	Organized	Audio/visuals	Handouts	Overall
Introduction	4.75	4.76	4.67	4.73	4.72
Brain Development	4.46	4.47	4.42	4.54	4.47
Signs & Symptoms	4.74	4.73	4.61	4.71	4.70
Disabilities	4.59	4.54	4.45	4.59	4.54
Violence & Trauma I	4.62	4.59	4.50	4.62	4.59
Violence & Trauma II	4.91	4.86	4.81	4.84	4.86
Risk Assessment & Crisis Intervention Skills	4.78	4.78	4.71	4.75	4.76
Psychotropic Medications	4.84	4.87	4.79	4.76	4.81
Parents & Teachers as Allies	4.92	4.89	4.83	4.85	4.87
Substance abuse & Co-occurring Disorders	4.76	4.77	4.70	4.75	4.75
Depression & Suicide	4.87	4.87	4.83	4.86	4.86
Family Perspectives	4.95	4.94	4.92	4.95	4.94
Seamless Integration w/ Schools	4.69	4.64	4.61	4.68	4.66
JISC Project	4.61	4.61	4.59	4.64	4.61
Eating Disorders & Self Injurious Behavior	4.91	4.90	4.83	4.85	4.87
Department Procedures & Special Circumstances	4.82	4.85	4.78	4.83	4.82
FBI—School Violence & School Shooters	4.90	4.89	4.84	4.91	4.89
Community Resource Panel	4.87	4.87	4.80	4.90	4.86

Training participant comments

The surveys also captured training participant comments. A total of 367 comments were found across the 583 surveys collected. Fifty-seven percent (208) were positive and 43 percent (159) were negative.

The following are some of the typical, positive comments made by training participants about the presentations.

- *"The overall training is excellent and should be implemented to all law enforcement [officers] across America and the world."*
- *"The information was definitely worth getting, due to encountering this a lot on the streets."*
- *"A majority of the information is valuable and accurate for all officers who interact with students in school."*
- *"Overall, the course was great. The information provided was fantastic. I think it will make handling CIT calls in the field a little easier."*

The following are some of the typical, negative comments made by training participants about the presentations.

- *"Instructor just read from the handout; didn't seem to offer any additional [information]; not many examples of how the material relates to our job or the world."*
- *"The Child & Adolescent block should be less technical…it was too scientific for the scope of the course."*
- *"The class is dragging and some technical or clinical material could be deleted. Police don't diagnose. We observe, react, and respond. Yes, we should be aware of symptoms, but it's getting to be information overload concerning in-depth medication use."*
- *"Not enough coverage of cultural/environmental factors and how to work within those differences…need more information on poverty/environmental issues."*

Training participant recommendations

In addition to course evaluation survey comments, participants offered 71 training recommendations. These recommendations were grouped into the following five categories. *Appendix A* provides all recommendations training participants made by category.

1. *Curriculum content (33 recommendations)*
   - Most recommendations pertained to enhancing the curriculum content with several requesting the creation of field reference materials (*Appendices B* and *C*).

2. *Satisfaction with presentation delivery (14 recommendations)*
   - Several recommendations related to training participant satisfaction with presentation delivery. Of such suggestions, many included increasing diversity among presenter professions for a variety of field experiences.

3. *CPD Awareness of CIT-Y program (12 recommendations)*
   - Several recommendations were about increasing awareness of the CIT-Y program within CPD. Specific comments of this type included a few about the need for more CPD law enforcement officers CIT-Y trained.

4. *Training accommodations (7 recommendations)*
   - Some recommendations concerned the training accommodations. Almost all suggestions urged CIT-Y training staff to address in and out of classroom distractions, which included participants engaging in side-conversations and using their mobile devices during presentations. In addition, conversations and activities occurring outside the classroom doors could be heard within the classroom.

5. *CIT-Y training participants (5 recommendations)*
   - Some recommendations were about the lack of diversity among participant professions. Two suggested recruiting more CPD supervisors to take the course.

Pre- and post-course tests

Of the 126 law enforcement officers who participated in Year 1 trainings, 94 percent (n= 118) consented to completing the pre- and post-course tests. However, 113 officers actually completed both tests. The remaining five officers were not able to complete the post-test due to not being present the last day of the training.

Of those who did consent to the pre- and post-course tests, 49 percent were male (n= 58) and 51 percent (n= 60) were female. Forty-seven percent self-identified as white (n= 55), 42 percent self-identified as black (n= 50), 3 percent identified themselves as Asian or Pacific Islander (n= 4), 3 percent said they were multi-racial (n= 3), and 5 percent did not indicate race (n= 6).

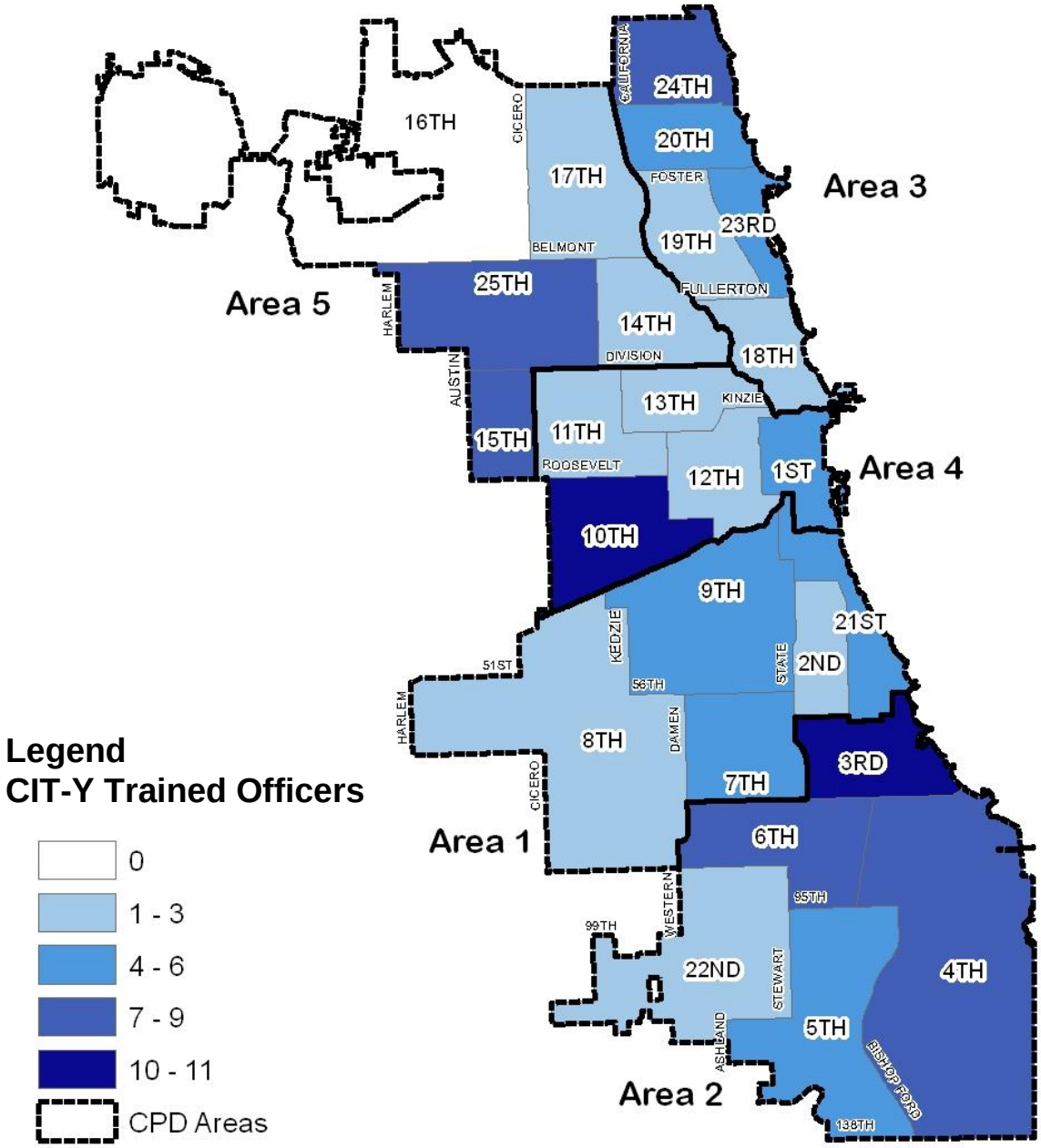
In addition, 21 percent of these participants identified themselves as Hispanic or Latino (n= 25). Ages of this sample ranged from 28 to 59 years old, but the averaged age was 43 years (*SD*= 7.7 years). These officers averaged nearly 14 years of experience with the Chicago Police Department, with amounts ranging from 2 years and 6 months to 27 years and 9 months (*SD*= 77.2 months) (*Table 3*).

Table 3
Evaluation participants by rank and years of experience (n= 118)

Rank	n	Percent	Averaged amount of experience
Police officer	**102**	**86%**	**12 years 8 months (SD= 6 years 3 months)**
Sergeant	**10**	**8%**	**19 years 5 months (SD= 4 years 6 months)**
Field training officer	**2**	**2%**	**15 years 9 months (SD= 9 years 9 months)**
Detective	**2**	**2%**	**22 years 1 month (SD= 8 months)**
Lieutenant	**2**	**2%**	**20 years 8 months (SD= 6 months)**

The ranks of these officers were slightly diverse. First rank law enforcement officers are police officers and comprised 86 percent of this evaluation's participants. Sergeants comprised 8 percent of evaluation participants. Field training officers (2 percent), detectives (2 percent), and lieutenants (2 percent) also served as evaluation participants. *Map 1* illustrates the distribution of Year 1 CIT-Y officers within CPD's 25 districts in five areas.

Map 1
Distribution of sampled CIT-Y officers by area and district



Knowledge of youth mental health

The pre- and post-course tests consisted of 25 true/false statements about youth mental health. Evaluation participants (n= 113) averaged 21 correct responses on the pre-test (21.37) and nearly 22 correct on the post-test (21.70) (*Table 4*). A paired *t*-test showed this difference was not significant ($t = 1.717$, df = 112, $p = 0.089$, two-tailed).

Table 4
Number and percent of correct responses by test condition (n= 113)

Test condition	Averaged number of correct responses	
	Mean	*SD*
Pre-test	21.37 (85%)	1.91
Post-test	21.70 (87%)	1.76

McNemar tests using binomial distributions were conducted to identify any pre- and post-test statements that had significantly different evaluation participant responses from before the training to just after. Analyses revealed their responses to seven true/false statements did significantly differ ($p < .05$) between the tests (*Table 5*).

Table 5
True/false statements answered differently pre- and post-training (n= 113)

True/false statement	Number and percent of evaluation participants who correctly answered	
	Pre-test	Post-test
Significant increase		
1. It is possible to accurately diagnose mental illness in young children, even infants. (True)	23 (20%)	57 (50%)
2. Poor performance in school can be a sign of depression in children and adolescents. (True)	104 (92%)	112 (99%)
3. Asking students if they are suicidal will just put thoughts into their heads. (False)	102 (90%)	109 (96%)
4. Children members of close-knit, tight families can develop separation anxiety. (True)	87 (77%)	99 (88%)
Significant decrease		
5. Most psychiatric drug treatments are proven effective in treating children's mental illness. (False)	62 (55%)	47 (42%)
6. Psychiatric drug treatments are safe for children. (False)	67 (59%)	45 (40%)
7. ADHD (Attention Deficit Hyperactivity Disorder) is over diagnosed in children. (True)	94 (83%)	76 (67%)

Focus group and survey

Seven CIT-Y officers served as focus group participants at six months post-training. Of these officers, four were female and three were male. Three were white, two were black, and one was Asian or Pacific Islander; the race was unknown for one focus group participant. Twenty-nine percent of the officers identified themselves as Hispanic or Latino (n= 2).

The ages of focus group participants ranged from 36 to 55 years old, with an averaged age of 45 (*SD*= 6.0 years). These officers averaged approximately 12.5 years of experience (*SD*= 4.8 years) with the Chicago Police Department.

Focus group survey

Focus group participants completed a brief survey prior to discussing their application of the training information. This was done to explore officer retention of youth mental health knowledge and compare their intentions verse actual use of training material.

Retention of mental health knowledge

The retention questions included five pre-and post-course test questions about youth mental health. The number and percentage of focus group participants who correctly responded to youth mental health questions before the training (pre-test), just after the training (post-test), and six months after the training (focus group survey) are presented in *Table 6*.

Table 6
Comparison of responses to mental health questions overtime (n= 7)

Question	Number and percent of focus group participants who correctly answered		
	Pre-test	Post-test	Focus group survey
1. Most children suffering from a mental illness are receiving some kind of treatment. (False)	7 (100%)	7 (100%)	7 (100%)
2. Children are not adequately treated for mental illness. (True)	7 (100%)	7 (100%)	7 (100%)
3. Some parents of children suffering from a mental illness may not seek help from a mental health professional because of stigma associated with mental illness. (True)	6 (86%)	7 (100%)	7 (100%)
4. Asking students if they are suicidal will just put thoughts into their heads. (False)	7 (100%)	6 (86%)	6 (86%)
5. Most youth rarely experience negative side effects from the medication they take for a mental illness. (False)	5 (71%)	7 (100%)	4 (57%)

Intentions verse actual use of training information

The post-test included five statements about officers' intentions to use the training information. These same statements were included on the focus group survey so responses could be compared. A 5-point scale was used to measure agreement and had a range of strongly disagree (1.00) to strongly agree (5.00).

The averaged intention scores were higher (4.54) than the averaged actual use scores (3.39) (*Table 7*). Intention scores on average were highest for addressing barriers from school administration (4.63) and lowest for identifying mentally ill youth (4.31). The largest differences found between the averaged intention and actual use scores were among statements pertaining to officer application of de-escalating techniques and referrals to community treatment services for youth.

Table 7
Averaged scores of intentions to use vs. use of training material (n= 7)

Statements	Intention	Actual use	Difference
1. I will use/used strategies to address barriers from my police department.	4.60	3.43	-1.17
2. I will use/used strategies to address barriers from school administration.	4.63	3.50	-1.13
3. I am confident I will be/am able to identify youth with mental disorders.	4.31	3.43	-0.88
4. I will be/am able to de-escalate juvenile mental health crises.	4.57	3.29	-1.28
5. I will be/am able to link juveniles to community mental health treatment services.	4.61	3.33	-1.28
Averaged response scores	**4.54**	**3.39**	**-1.15**

Focus group discussion

During the focus group sessions, topics were discussed to reveal aspects of the training that carried over into the field. The common themes of the focus group conversations are presented within each topic.

Application of training material
Focus group participants were asked to report the extent to which they used what they learned in the CIT-Y training. Focus group participants said they used the training information on a consistent basis, some reporting daily use. Participants reported applying crisis de-escalation techniques. One participant shared, "I just ask [students] to come [to the school office] and they usually comply. In [the] past, when [school administration] would call for the police [the] police would rush in and grab the student. Then it becomes a battle."

Some focus group participants also said the training helped them identify signs and symptoms of youth mental illness, causing them to less likely label a youth as delinquent and process them formally. One participant said, "I have been able to refer some parents to [a community hospital] instead of making it a criminal issue."

Helpful and least helpful training components
Focus group participants were asked to identify the most and least helpful training components. The most helpful training components identified were the *Community Resource Panel* and *Risk Assessment & Crisis De-escalation* modules. The reported least helpful component of the training was the *Psychotropic Medications* module, which participants described as too long and too technical. Said one, "We're not doctors. My question is 'When was the last time the child took his meds?' If it's been awhile, okay then off he goes [to the hospital]."

In addition, focus group participants found the *Department Procedures & Special Circumstances* module to be somewhat helpful. Some focus group participants thought it did not enhance their understanding of police officer rights and protections. One said, "There is this big myth of getting sued [if a youth is transported for a hospital mental health assessment without guardian consent]."

Participant preparedness for field application

Focus group participants were asked to describe the degree to which they were prepared to implement the CIT-Y material. Focus group participants generally reported they felt prepared to implement training objectives, but were confused about their legal responsibilities and protections as CIT-Y officers. For instance, some focus group participants said the training curriculum enhanced their ability to de-escalate youth crises, but failed to explain when it is necessary to transport a youth for a hospital assessment and what legal protections law enforcement officers have when doing so. One participant said, "Get an officer to train other officers [about youth hospital transports for mental health assessments]. A lot of officers don't know how to do that." Said another, "I think officers would be more receptive if they had a clear cut chart of what they could do."

Barriers of implementation

Focus group participants were asked to recall barriers they faced when using the CIT-Y course material. One barrier reported was lack of department support, as focus group participants reported some CPD supervisors want CIT-Y officers to "just cuff [the kids] and get them to where they need to be." Another barrier reported was conflicting response styles between CIT-trained and non-CIT-trained officers. One participant said, "My biggest problem is other officers who are not CIT-trained. We had a 14-year-old [with] a knife to the grandmother. [I] was able to talk him down, but officers want[ed] to tase the kid and take him down. Other officers think he's a bad kid [with] a behavior problem, but he was off his meds." Lack of program awareness created another barrier. "It should be automatic for the call-takers to [inform] dispatchers that CIT officers are needed to handle a situation," said one.

Lack of cooperation among school administration, teachers, and security officers, as well as parents and hospital staff created a significant barrier to implementation, according to the focus group. Participants said school personnel often challenge and disagree with CIT intervention techniques. In regard to lack of cooperation among parents, one officer reported, "Very rarely do you get a call from very supportive and educated parents. Usually it's the [parents] that don't care, don't have time to come get [the child], don't feel like dealing with [child's mental illness] anymore." Finally, officers reported inefficient hospital protocols when transferring youth custody for mental health assessments. Said one, "[Hospital staff makes] you wait. I have 52 schools. I can't be sitting there with a kid for three, four hours. I feel I should have precedence when I walk in that door."

Training information not addressed

Prior to concluding focus group sessions, participants were asked what information, if any, was not addressed in the training that would have been beneficial. Some focus group participants indicated that more information was needed on dealing with uncooperative parents and school staff, and some requested information on what department procedures to follow when transporting youth for hospital mental health assessments. As a solution, focus group participants suggested CIT-Y staff incorporate a question and answer component during the course training, where participants could hear first-hand from CIT-Y officers about how they overcame these situations.

Focus group participant recommendations

Focus group participants provided the following recommendations to enhance the CIT-Y training program:

- Create a directory of CIT officers for CPD call-takers and dispatchers.
- Provide a refresher course.
- Create a field reference sheet listing officer legal rights.
- Require CPD school officers to participate in CIT-Y training.
- Make CIT its own unit.
- Create a field reference guide providing protocols for common crisis situations.
- Attend roll-calls to educate other officers on CIT.
- Invite more professions and law enforcement officers to participate in the trainings, including probation officers, principals and teachers, and CPD squadrol officers, recruits, and supervisors.

Implications for future training and evaluation

The goal of this evaluation was to assess Chicago Police Department's Crisis Intervention Team for Youth training and offer recommendations to enhance the program. Findings from the course evaluation survey, pre- and post-course tests, and focus group discussion and survey led to the following recommendations for training and future program evaluation.

Recommendations to enhance training

Training recommendations fall into two broad groups:

1. Improve officer knowledge of course material, such as learning how to identify signs and symptoms of youth mental disorders, applying appropriate intervention skills and techniques to safely interact with youth in crisis, and determining when it is appropriate to follow established field protocols and department procedures to transport youth for hospital mental health assessments.
2. Increase officer application of what is learned in the course within the field. If officers are not able to incorporate information provided during the course into their field work, the CIT-Y training goals of decreasing the likelihood of violent interactions occurring when law enforcement officers respond to youth mental health crises and diverting youth with mental illnesses from juvenile justice system involvement to more appropriate services that meet their mental health needs will not be achieved.

Recommendations to improve officer knowledge of course information

Regulation of training accommodations

- Address distractions within learning environment. Training participants specifically requested CIT-Y staff remind training participants to turn-off cell phones and refrain from side conversations.

Revision of curriculum content

- Incorporate videos when teaching scientific/clinical training information. Videos may be used to help officers understand technical information provided in the *Child & Adolescent Brain Development* module, and depict youth mental illnesses highlighted in the *Signs & Symptoms of Youth Mental Illness* module.
- Relate course material to real-world scenarios that better inform training participants of how the curriculum content can be incorporated into their law enforcement responsibilities. Officers reported that the *Risk Assessment & Crisis Intervention Skills* module may be enhanced if relevant examples on applying such information were provided.
- Provide a better understanding of officer rights and department procedures regarding the transport of youth to emergency mental health treatment services. One focus group participant recommended a demonstration of completing the paperwork necessary for

officers to transport youth for emergency mental health assessments as part of the *Department Procedures & Special Circumstances* module.
- Incorporate a Q&A module to allow for discussion between training participants and experienced CIT-Y officers.

Enhancement of curriculum delivery
- Increase diversity among professionals presenting curriculum modules for a variety of field experiences. For example, training participants requested the presence of professionals from the Department of Child and Family Services and the Chicago Police Department Special Victims Unit during the *Department Procedures & Special Circumstances* module.
- Ask presenters to refrain from discussing information not included in the presentation's curriculum.
- Have back-up presenters on call to ensure presentations are presented by qualified instructors.

Recommendations to increase officer application of course information

Fostering knowledge of CIT-Y goals and objectives post-training
- Offer a yearly refresher course to CIT-Y officers to increase their understanding of youth crisis intervention, identify and provide solutions to implementation barriers, and address CIT-Y officer questions/concerns.
- Create field reference guides for CIT-Y officers to use when responding to common youth crisis situations. (*Appendices B* and *C*).
- Create an internal CPD CIT website for CIT training staff to communicate with CIT-Y officers. The website could be used to distribute field reference tools, update CIT-Y officers of department policy changes, and/or answer CIT-Y officer questions.

Building support within the department
- Establish CIT as its own unit within CPD to ensure CIT officers respond to mental health-related calls.
- Include notifications about CIT training programs in CPD Police Academy curriculum to inform recruits about the program's existence and goals.
- Attend roll calls within each CPD district to educate non-CIT officers about the CIT program.
- Address the cause of CIT-Y officers not being dispatched to youth mental health-related calls. This may be achieved if the department implements a protocol informing CPD call-takers and dispatchers to utilize a directory of CIT officers on each shift.

Promoting awareness of CIT-Y program
- Inform the public of the CIT-Y program by providing information on CPD's website. Program information posted should include a description of the program, how CPD officers can become a CIT-Y officer, and how CIT-Y officers can be requested by the public to respond to a youth in crisis.
- Establish protocols with community hospitals to increase efficiency when law enforcement transport youth for mental health assessments.

Diversifying CIT-Y training participants

- Include more professionals and law enforcement officers to participate in the course, such as probation officers, school administrators and staff, and CPD squadrol officers, recruits, and supervisors. Having key partners informed about the CIT-Y program may increase the likelihood CIT-Y officers apply intervention strategies in the field.

Implementation of training recommendations

Evaluation findings and recommendations were presented to CPD CIT-Y trainers in February 2011. CPD CIT-Y training staff welcomed feedback and set corresponding goals to improve officer knowledge of CIT-Y training objectives. The following bullet points describe the revisions CPD CIT-Y staff made for Year 2 training.

Training curriculum improvements

- More field examples were included in the curriculum to enhance officer knowledge of how and when to apply crisis intervention techniques. For example, the *Department Procedures & Special Circumstances* module will include a demonstration of how to complete the department paperwork needed for officers to transport youth for hospital assessments.
- A *Q & A with CIT-Y Officers* module will be added to the curriculum. This will give course participants the ability to ask CIT-Y field-related questions and learn about their field experiences as a CIT-Y officer.
- Video material will be incorporated to explain technical/scientific course material. In the *Child & Adolescent Brain Development* module the amount of technical/scientific information taught via PowerPoint will be limited and videos will be added.

Program model improvements

- Field reference guides were created by the evaluators and CPD CIT training staff for officers when they respond to youth crises in the field (Appendices B and C).
- Police departments have specific codes for communicating types of service calls. CIT training staff requested that CPD implement a mental health code and approval was granted. Not only will this code allow CPD dispatch officers to inform officers of mental health service calls, but CPD will have the data to measure the extent to which they respond to mental health-related situations.
- CIT training staff has worked with four Chicago-area hospitals to implement protocols to more efficiently address youth in need of mental health assessments. According to CPD CIT training staff, this collaboration has reduced the amount of time officers spend transferring youth custody from more than 4 hours to less than 30 minutes.

Recommendations to enhance evaluation

The evaluation project staff will modify the Year 1 evaluation tools and conduct a Year 2 evaluation to explore how the CIT-Y training influenced officer knowledge of how to address youth in a mental health crisis. The Year 2 evaluation began in January 2012 with completion of data collection planned for October 2012. A report of Year 2 evaluation findings will be published online by ICJIA.

Year 1's pre- and post-course test included 25 true/false statements about youth mental illness. Findings revealed the test asked common knowledge questions about youth mental illness and is not a valid tool to for measuring officer knowledge of training information. Unlike the pre- and post-course tests, the Year 1 course evaluation surveys were not linked to participants. Instead they were anonymous making it impossible to determine whether training participants' comments were isolated or had consensus.

The following Year 1 to Year 2 evaluation research method modifications were made as an effort to better understand officer knowledge of CIT-Y training information, as well as identify curriculum components responsible for any increased knowledge of training objectives.

Year 2 pre- and post-course tests

- Include questions to gather information about training participant demographics, law enforcement experience, amount of field work spent responding to youth mental health crises, and knowledge of course information.
- Contain agree/disagree statements to gauge the officers' attitudes about community mental health services and mental illness

Year 2 course evaluation surveys

- Numerically linked to training participants.
- Collect training participants' self-reported pre- and post-presentation knowledge of course material.
- Collect officer satisfaction with training accommodations, curriculum materials, and presentation delivery.

Year 2 online survey for comparison group

An online version of the pre-test will be sent via email to a random sample of Chicago Police Department law enforcement officers who have no CIT training. This will allow evaluators to make comparisons between CPD CIT officers and CPD non-CIT officers in terms of their time spent responding to youth mental health-related calls, their attitudes about mental illness and community mental health resources for youth, and their knowledge of information taught in the CIT-Y training. The inclusion of a comparison group may help evaluators better understand how the CIT basic training prepares officers for the CIT-Y course and the extent to which the CIT-Y course consists of information that is not already known by law enforcement.

Conclusion

The Crisis Intervention Team for Youth training program was created by the Chicago Police Department and the National Alliance on Mental Illness of Greater Chicago. It is an advanced course that teaches law enforcement officers how to recognize signs and symptoms of youth mental disorders, safely interact with youth in crisis, and, when appropriate, divert youth to community-based mental health treatment services.

This evaluation assessed the CIT-Y training curriculum and led to recommendations for enhancing the program. The three research methods used were a course evaluation survey, pre- and post-course tests, and focus groups. The course evaluation survey gauged officer satisfaction with the training curriculum, the pre-and post-course tests measured officer increase of youth mental health knowledge, and the focus groups were held to learn officer application of training information in the field.

A total of 583 course evaluation surveys were collected and revealed officers found the training to be extremely relevant to police work and knowledge enhancing. The course evaluation survey also allowed for feedback. Officers suggested many ways the training curriculum could be improved.

Course evaluation surveys will be modified for the Year 2 evaluation to measure the extent to which the curriculum conveys its training objectives to participants. Course evaluation surveys will still include questions to learn officer satisfaction with training accommodations, curriculum materials, and presentation delivery.

The pre- and post-course tests were created by NAMI-GC staff, who consulted a social science professor. Findings revealed the test questions had answers that were common knowledge and were not related to the course curriculum, as pre-course test scores averaged a high of 85.5 percent and the post-course test scores remained nearly the same at 86.8 percent. The pre- and post-tests will be revised by the evaluators for the Year 2 evaluation, as an attempt to measure officer knowledge of training information.

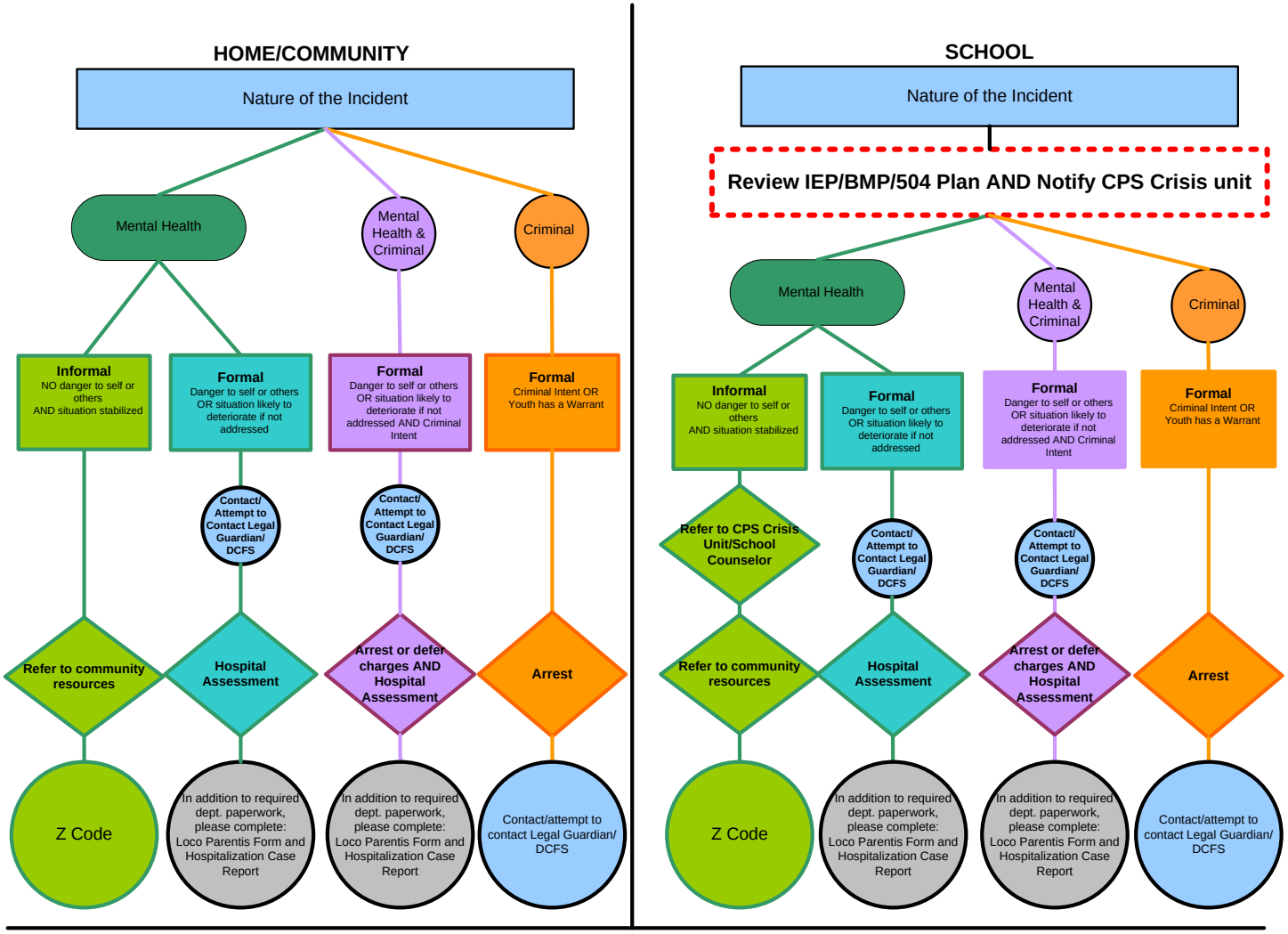
Seven CIT-Y officers served as focus group participants. A focus group survey was completed before the moderator initiated discussion. Findings revealed focus group participants' intentions to use the training information were higher than actual use in the field. The moderator asked the focus group participants five questions to generate information about how the course enhanced their ability to respond to youth crises. The focus group discussion revealed ways in which officers applied the crisis intervention skills and the barriers they encountered when attempting to apply techniques learned.

Several recommendations for training and evaluation improvement were shared with CIT-Y training staff. After evaluators shared preliminary findings, training staff initiated changes to improve the training.

Appendix A: Course evaluation survey recommendations (71)

<table>
<tr><th>Training accommodations (7)</th><th>Training program curriculum (33)</th><th>Participant satisfaction of presentation delivery (14)</th><th>CPD awareness of CIT-Y program (12)</th><th>Training participants (5)</th></tr>
<tr><td rowspan="2">Address in-classroom distractions (4)</td><td>Create field reference materials (5)</td><td>Inform presenters of material covered throughout training to reduce repetitiveness (1)</td><td rowspan="3">Increase CPD district-level recognition (3)</td><td rowspan="3">Include CPD squadrol officers (1)</td></tr>
<tr><td>Incorporate discussion between state’s attorney and participants on prosecuting mentally ill youth (1)</td><td rowspan="2">Provide presenter qualifications to increase reputability (1)</td></tr>
<tr><td rowspan="3">Address outside classroom noises (2)</td><td>Revise training material to address youth cultural awareness (1)</td></tr>
<tr><td>Include a self-relaxation module instructing officers on self-care techniques (1)</td><td>Have back-up presenters on call to ensure modules are delivered by individuals knowledgeable of topic material (1)</td></tr>
<tr><td>More training information on:
Advocacy (1)
Accessing youth school records (1)
CIT-Y officer use of JISC intervention services (1)
Applying de-escalate techniques (1)
CPS’ Student Code of Conduct (1)
Distinguishing criminal behavior from signs/symptoms of mental illness (1)
Techniques for addressing mentally ill parents/guardians (1)</td><td>Include references and data supporting presentation content, so presenters are not viewed as discriminating (1)</td><td>Appoint CIT-Y liaisons within each CPD district to hold monthly training session (2)</td><td>Include CPS teachers (1)</td></tr>
<tr><td rowspan="9">Increase amount of break-time (1)</td><td>Include information on officer access to schools’ court files of youths’ domestic violence –related cases in Seamless Integrations with Schools module (1)</td><td rowspan="9">In addition to presenters, included individuals who have related field experience, so participant questions can be answered:
Include DCFS and SVU in Department Procedures & Special Circumstances module (5)
Have a psychiatrist present Psychotropic medications module (1)
Include youth-division police officers, youth detectives, psychologists, nurses, and clinicians in training modules (3)
Have JISC representatives present JISC module (1)</td><td rowspan="9">Train more CPD law enforcement officers (4)</td><td>Include CPD supervisors (2)</td></tr>
<tr><td>Increase number of youth and family members in consumer panel (4)</td><td rowspan="8">Include CPS security and principals (1)</td></tr>
<tr><td>Remove FBI School Violence & School Shooters module (1)</td></tr>
<tr><td>Increase font sizes of training material text (4)</td></tr>
<tr><td>Make CIT-Y training references accessible online (1)</td></tr>
<tr><td>Extend the 40-hour training (1)</td></tr>
<tr><td>Increase engaging activities (4)</td></tr>
<tr><td>Include training information on homeless youth (1)</td></tr>
<tr><td>Establish method to update CIT-Y officers (1)</td></tr>
</table>

Appendix B: CPD's CIT-Y disposition chart



***Remember YOU ALWAYS have the FINAL decision** ***Remember YOU DO NOT need parental consent** ***Remember YOU are in CONTROL of the situation**

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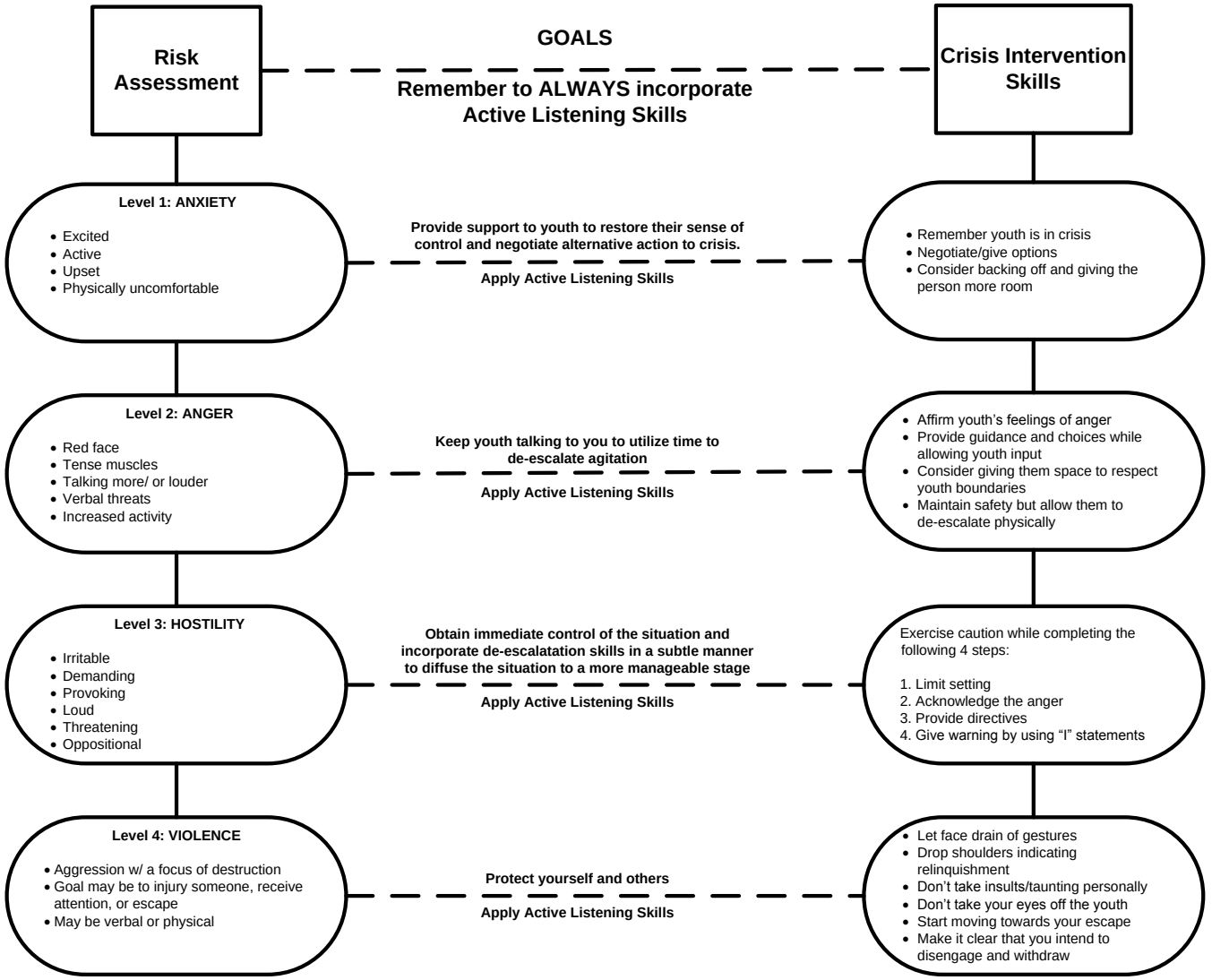
Summer 2011

Appendix C: CPD's CIT-Y risk assessment and crisis intervention skills field guide



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