COMMONWEALTH of VIRGINIA

Department of Criminal Justice Services

Leonard G. Cooke
Director

1100 Bank Street
Richmond, Virginia 23219
(804) 786-4000
TDD (804) 786-8732

December 7, 2009

The Honorable R. Edward Houck
Chairman
Joint Commission on Health Care
900 E. Main Street, 1st Floor West
Richmond, VA 23219

Dear Chairman Houck:

As directed by Senate Bill 1294 (2009), the Department of Criminal Justice Services (DCJS) in conjunction with the Department of Behavioral Health and Developmental Services (DBHDS) is providing to you the initial annual report assessing the impact and effectiveness of crisis intervention team (CIT) programs in the Commonwealth.

Please feel free to contact me or Fran Ecker, Director, Office of Programs at DCJS, telephone (804) 786-3967 or Fran.Ecker@dcjs.virginia.gov if you have any questions regarding this report.

Sincerely,

Leonard G. Cooke

Leonard G. Cooke, Director

cc: The Honorable John Edwards, Senate of Virginia
The Honorable John Marshall, Secretary of Public Safety
The Honorable Marilyn B. Tavenner, Secretary of Health and Human Resources
James S. Reinhard, M.D., Commissioner, DBHDS

**Document Title**

Report to the Joint Commission on Health Care Regarding Crisis Intervention Team Program Assessment

**Author**

Department of Criminal Justice Services and Department of Behavioral Health and Developmental Services

**Enabling Authority**

Chapter 715 (Regular Session, 2009)

**Executive Summary**

§ 9.1-190. Crisis intervention team program assessment.

The Department, and the Department of Behavioral Health and Developmental Services, shall assess and report on the impact and effectiveness of the crisis intervention team programs in meeting the program goals. The assessment shall include, but not be limited to, consideration of the number of incidents, injuries to the parties involved, successes and problems encountered, the overall operation of the crisis intervention team programs, and recommendations for improvement of the program. The Department, and the Department of Behavioral Health and Developmental Services, shall submit a report to the Joint Commission on Health Care by November 15, 2009, 2010, and 2011.

(2009, c. 715.)

# Report to the Joint Commission on Health Care Regarding Crisis Intervention Team Program Assessment

DECEMBER 2009

Department of Criminal Justice Services
and
Department of Behavioral Health and Developmental Services

# Senate Bill 1294
# General Assembly Session 2009

# Report to the Joint Commission on Health Care

# Crisis Intervention Team Program Assessment
# November 15, 2009

**Prepared by:**
**Departments of Criminal Justice Services and**
**Behavioral Health and Developmental Services**

## Introduction

The 2009 General Assembly through Senate Bill 1294 amended Sections 9.1-102, 187, 188, 189 and 190 of the *Code of Virginia* to direct the Department of Criminal Justice Services (DCJS) in conjunction with the Department of Behavioral Health and Developmental Services (DBHDS) to "…support the development and establishment of crisis intervention team programs in areas throughout the Commonwealth." It also established numerous criteria for the departments to use in implementing its provisions, and directed that a status report be submitted November 2009 to the Joint Commission on Health Care, and further, that a report assessing the impact and effectiveness of Crisis Intervention Team programs be submitted to the Joint Commission on Health Care November 2009, 2010 and 2011. This report is submitted pursuant to Section 9.1-190 and assesses the impact and effectiveness of crisis intervention team programs in meeting program goals.

## Background

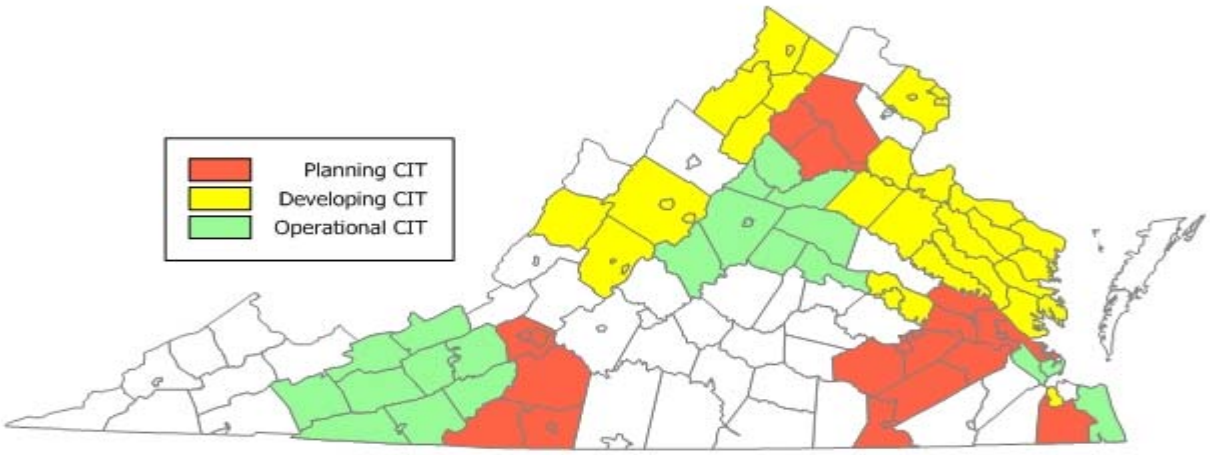
Crisis Intervention Teams (CIT) refer to programs that bring together specially trained law enforcement officers, mental health treatment providers and other stakeholders that may include hospitals, emergency medical care facilities, mental health service consumers, and community advocates. The purpose of such teams is to respond in the most effective manner to persons experiencing mental health crises, and those who may be unable to protect and care for themselves due to mental illness or disability. Often these individuals come to the attention of law enforcement and others through behavior that is inappropriate, dangerous or violent. Additionally, law enforcement officers are integrally involved with consumer interaction throughout the civil commitment process. In many cases, it is necessary to help such persons receive mental health treatment, or to place such persons in custody and seek either mental health treatment referral or incarceration for criminal acts.

CIT programs enhance community, infrastructure and training to improve criminal justice and mental health system response to individuals with mental health issues. The CIT model was originally developed by the Memphis, Tennessee Police Department, and has subsequently spread throughout the country. The impetus for its development was an incident in which a man with mental illness was shot by police during a confrontation. The incident created a public uproar and the community began to examine its procedures in such cases, seeking alternative means of addressing these situations. Eventually, through the development of a widely representative stakeholders' task force, Memphis created a program to provide specialized training for select officers and establish improved access for case appropriate therapeutic treatment alternatives to incarceration. The 40-hour training enabled officers to more effectively communicate with and understand the particular needs of those with a mental illness. In so doing, officers were able to reduce the potential for misunderstanding and enhance the ability to de-escalate situations involving individuals with mental illness. Additionally with the streamlined processes to provide access to services, officers were provided more options to connect individuals with needed treatment in lieu of incarceration consistent with the needs of public safety and balanced with the underlying issue of mental illness.

In the past 20 years, this approach has spread nationally. The concept was first implemented in Virginia in 2002 by the New River Valley Crisis Intervention Team (NRV CIT). This program drew together 14 separate law enforcement agencies in five localities to create the nation's first rural, multi-jurisdictional adaptation of the Memphis CIT model. Police departments, sheriffs' offices, and two local campus police departments all worked together with the Community Services Board (CSB), Mental Health Association (MHA) and local chapter of the National Alliance on Mental Illness (NAMI) to establish their CIT program. That initiative was developed using federal grant funds from the Substance Abuse and Mental Health Services Administration (SAMSHA) over a three-year period and currently serves as one of three programs leading Virginia's statewide expansion initiative of these programs.

**Implementation Actions**

As of November 2009, twenty-two CIT initiatives throughout the Commonwealth representing 86 counties and cities are planning, developing or operating successful CIT programs in their localities. As of December 31, 2009, DCJS will have distributed federal Edward R. Byrne Justice Assistance Grant (JAG) funds among five different CIT program areas. In May 2009 in partnership with DBHDS, DCJS awarded CIT start-up grants to an additional five CIT initiatives. DBHDS has allocated a portion of the resources designated for jail diversion services under Item 315 (Y) of the 2009 Appropriations Act to support CIT training, services and community supports for seven CIT programs. For full funding data, see *RD 366 – Report to the Joint Commission on Health Care Regarding the Status of Crisis Intervention Team Programs in the Commonwealth (2009*). Additionally, seven other areas of the state are using local funds to support initial planning and development of CIT programs in their communities.




***Map of Virginia CIT Program status as of November 2009***

These programs represent a wide variety of partnering approaches. Most programs consist of multiple jurisdictions with numerous law enforcement agencies. Generally, they involve a CSB, and a variety of stakeholder agencies such as hospitals, other treatment facilities, consumer groups and advocacy groups.

DCJS and DBHDS require that CIT programs employ uniform minimum requirements, often referred to as the Core Elements of CIT, to assure that the nature of all CIT programs is consistent from region to region throughout the state.

To support growth and development in all aspects of CIT programs, the departments have created the Virginia CIT Coalition (VACIT). Membership in VACIT is encouraged for all programs seeking state support and state-sponsored training and services. DBHDS, DCJS and VACIT have established minimum criteria for the development and operation of CIT programs including:

- 40 hour DCJS-certified CIT training for law enforcement personnel;
- CIT Coordinator position;
- Community stakeholder partnerships and oversight;
- Therapeutic assessment location (not a law enforcement or jail facility), or procedures, to streamline access to services in lieu of incarceration (when appropriate);
- Collection of data to monitor statutory outcome measures; and
- Train-the-Trainer and Dispatcher courses for CIT program development.

Through this coalition with local programs, DCJS and DBHDS have established the Memphis Model of CIT as the official model for training of Virginia CIT program personnel. All CIT officers must complete the 40 hour training. The curriculum is

approved for DCJS-certified in-service training credits for law-enforcement officers and includes four hours of mandatory training in legal issues (see Addendum #1, *Representative 40 Hour CIT Training Curriculum Outline*, attached). Additionally, all mental health and law enforcement practitioners who will serve as CIT faculty must participate in the 40 hour training plus complete a 20 hour Train the Trainer course (see Addendum #2, *Representative Train the Trainer Agenda*, attached). A 2-4 hour dispatcher training course is recommended to improve identification of mental health related calls and effectively dispatch CIT officers to those calls (see Addendum #3, *Representative Dispatcher Training Agenda*, attached).

Each grant funded program, as well as programs developing independently with state support and involvement, is required to include the following goals:

- Provide immediate response by specially trained law-enforcement officers;
- Reduce the amount of time officers spend out of service awaiting assessment and disposition;
- Afford persons with mental illness and substance use disorders a sense of dignity in crisis situations;
- Reduce the likelihood of physical confrontation;
- Decrease arrests and use of force;
- Identify underserved populations with mental illness and substance use disorders and linking them to appropriate care;
- Provide support and assistance for mental health treatment professionals;
- Decrease the use of arrest and detention of persons experiencing mental health and/or substance abuse crises by providing better access to timely treatment;
- Provide a therapeutic location or protocol for officers to bring individuals in crisis for assessment that is not a law enforcement or jail facility;
- Increasing public recognition and appreciation for the mental health needs of a community;
- Decrease injuries to law-enforcement officers during crisis events;
- Reduce inappropriate arrests of individuals with mental illness in crisis situations;
- Decrease the need for mental health treatment in jail; and

Jurisdictions planning, developing or operating CIT programs rely on DCJS and DBHDS staff and the leadership of the VACIT Coalition to provide technical assistance, training and shared resources to support their CIT initiatives. Through this collaborative effort, both departments and CIT stakeholders throughout the Commonwealth are working together to achieve the vision of the CIT program approach to mental health crisis response.

**Assessing the impact and effectiveness of CIT**

DCJS and DBHDS began collaborating in advance of the July 1, 2009 effective date of SB1294 to develop a plan for organizing, assessing and reporting on the impact and effectiveness of CIT programs in meeting established goals. Meetings were held to formalize the efforts of VACIT, the statewide coalition of CIT programs and resources. The VACIT has met three times since a May 2008 Governor's Conference initiated the efforts of the Commonwealth Consortium for Mental Health/Criminal Justice Transformation (the Consortium). The Consortium, originally implemented pursuant to Executive Order 62 and renewed pursuant to Executive Order 98 (though June 2011), is charged with addressing a wide range of criminal justice and mental health issues, including CIT.

VACIT has been developed largely through the cooperation and leadership of three well established CIT programs – New River Valley CIT, Thomas Jefferson Area CIT, and Hampton-Newport News CIT. The CIT coordinators and CIT program stakeholders have devoted many hours working with DCJS and DBHDS to help identify needs and priorities for Virginia's CIT programs. This includes training and resource needs, assisting new programs in developing their community advisory task forces, and sharing policies, procedures, service and treatment access strategies, as well as data collection techniques. VACIT has developed a website (www.vacitcoalition.org) that makes this information readily available for others use.

VACIT established four committees to which members may belong according to their needs or interests. These are Training, Community and Infrastructure, Data and Evaluation, and Communications and Outreach. Each of these groups has met to draft recommendations for all CIT programs in these topic areas. Through this process, DCJS and DBHDS support a consensus based approach which takes into consideration the variety of local needs and resources while developing consistency regarding the nature and requirements of CIT's Core Elements.

The training committee recommendations rely heavily on curricula initially established and enhanced over time by the Memphis Police Department. These curricula have been modified with the experience and expertise of the three leading Virginia programs to specifically address Virginia's criminal justice and mental health systems and processes. DCJS certifies these courses for mandated law enforcement officer in-service training (see Addendum #1).

The Community and Infrastructure committee provides guidance to enhance stakeholder participation at the local level and maximize broad community engagement with each CIT program. Another important aspect of this committee's work is to identify options to enhance access to treatment and services through the establishment of therapeutic alternatives to incarceration. Members of VACIT and professional staff from DCJS and DBHDS travel throughout the Commonwealth to participate in planning and organizational meetings for communities interested in or working on CIT initiatives.

The Data and Evaluation committee works with DBHDS and DCJS to address multiple challenges in gathering like data from communities and law enforcement agencies statewide. Each locality and its law enforcement agency are locally autonomous in their operations. While similar data sets are collected by most law enforcement agencies, there remain problems in acquiring the data and comparing it across the Commonwealth. Some law enforcement agencies participate in regional dispatching operations, or share dispatching operations with one or more other agencies. In such cases, it can be problematic to acquire the specific type of data needed for the evaluation purposes of a CIT program. Establishing data collection guidelines and identifying necessary data elements is a priority for VACIT during the coming year. This will result in better compilation and comparison of statewide data with which to evaluate the success of the many CIT programs in Virginia.

Communications and Outreach includes the creation and ongoing development of a useful and effective website as a platform to share information about funding opportunities, training resources, scheduling of events, and information resources for members. It also provides access to speakers and targets information needs of localities through all stages of program planning and development.

For information concerning local program funding and grant guidelines under which awards of federal and state funding have been made, please refer to the *RD 366 - Report to the Joint Commission on Health Care Regarding the Status of Crisis Intervention Team Programs in the Commonwealth (2009).*

Assessing the impact and effectiveness of CIT in meeting statutory goals requires an integrated analysis of the three essential components of CIT: training, community investment and involvement, and infrastructure development to support the program. The following findings highlight the work that has been accomplished to date:

1. There are 22 distinct CIT initiatives currently underway in Virginia, in catchment areas covering 86 separate cities and counties. Five CIT programs are fully operational having a) an established community stakeholder task force providing program oversight and community outreach, b) a CIT coordinator, c) round the clock CIT officer response capability, d) a therapeutic assessment site or protocols to enhance access to services, e) initiated data collection policy and practices. Eleven CIT programs are in varying stages of development but are on the way to meeting the above requirements. Six programs are in the initial planning phases of CIT development, identifying their stakeholders, providing CIT training for an initial group of stakeholders and identifying how their community can move forward to achieve operational status.
2. Throughout the Commonwealth, over 1000 officers have completed the 40 hour CIT training course; 826 CIT officers are currently serving in their communities; and 129 officers and civilians have completed the Train the Trainer course to become core faculty members for their local CIT training programs. Through FY09 and the first quarter of FY10, 32 local CIT training courses have been held throughout the Commonwealth and 11 Train the Trainer classes conducted.

3. With regard to other aspects of CIT program development, 13 areas have established a CIT coordinator position; 15 have a CIT task force in place that is meeting regularly; and 11 of those task forces provide program oversight and/or community education and outreach regarding the program. Four CIT programs have a therapeutic alternative assessment site; three are actively engaged in developing such a site; 3 have formal protocols to enhance access to services; and 5 are working to develop formal protocols to enhance access to services. The other sites are not yet at an appropriate stage to address this issue.

**Program Effectiveness and Statewide Impact**

Detailed information relating to program effectiveness and statewide impact are set forth in the following tables. The tables also facilitate comparisons between local programs and help to identify the current stage of program development in each locality. DCJS and DBHDS are grateful to local program coordinators and stakeholders who have assisted in the collection and presentation of this data. It represents the most comprehensive picture of CIT on a statewide basis currently available.

Table 1, *Impact of Crisis Intervention Training in the Commonwealth,* identifies each CIT program by CSB catchment area, program name, and by the localities involved in each local program area, as well as the current status of each program. It then displays information about training accomplishments of the programs, including training of basic CIT officers and of CIT trainers (instructors). The categories of “CIT Officers Serving” and “CIT Officers Trained” refer to law enforcement officers from police departments, sheriffs’ offices, and some regional jail officers. Note that the category of “Other First Responders Trained” includes fire fighters and Emergency Medical Services (EMS) professionals. “Non First Responders Trained” includes mental health treatment professionals and others who can then serve as core faculty members for the 40 hour training, working in collaboration with law enforcement trainers.

| | Program Affiliated CSB<br>Program Name<br>*Localities* | Program Status | 40 Hour CIT Trainings Held *FY09/10* | CIT Officers Serving *As of 06/09* | CIT Officers Trained *As of 11/09* | Other First Responders Trained *As of 11/09* | Non First Responders Trained *As of 11/09* | 40 Hour Faculty Trained (TTT) *As of 11/09* |
|---|---|---|---|---|---|---|---|---|
| | STATEWIDE TOTALS | 6 Planning<br>11 Developing<br>5 Operational<br>22 Total | 32 | 826 | 1068 | 48 | 94 | 146 |
| A1 | Alexandria CSB<br>City of Alexandria CIT<br>*City of Alexandria* | Developing[1] | 0 | 0 | 0 | 0 | 0 | 0 |
| B2 | Arlington County CSB<br>Arlington County Crisis Intervention Team<br>*Arlington* | Developing | 2 | 17 | 32 | 5 | 5 | 0 |
| C3 | Chesapeake CSB<br>Chesapeake CIT<br>*City of Chesapeake* | Developing | 0 | 0 | 0 | 0 | 0 | 3 |
| D4 | Colonial CSB<br>Colonial Area CIT<br>*Charles City, James City, New Kent, York and the Cities of Poquoson and Williamsburg* | Planning[2] | 0 | 0 | 0 | 0 | 0 | 0 |
| E5 | District 19 CSB<br>District 19 CIT Initiative<br>*Dinwiddie, Greensville, Prince George, Surry, Sussex and the Cities of Colonial Heights, Emporia, Hopewell and Petersburg* | Planning | 0 | 0 | 0 | 0 | 0 | 0 |
| F6 | Fairfax-Falls Church CSB<br>Fairfax Crisis Intervention Team<br>*Fairfax and the Cities of Falls Church and Fairfax* | Developing | 2 | 200 | 150 | 0 | 0 | 2 |

[1] Developing programs are those that have a well established stakeholder task force with a CIT coordinator in place, have a significant number of trained local CIT officers and CIT faculty and are working toward the implementation of a therapeutic assessment location or establishing protocols to enhance linkage to services in lieu of incarceration.

[2] Planning programs are those that are establishing a stakeholder task force, studying the CIT model, providing initial officer and mental health provider training and developing partnerships to address options for implementing assessment locations or establishing protocols to enhance linkage to services.

| | Program Affiliated CSB<br>Program Name<br>*Localities* | Program Status | 40 Hour CIT Trainings Held *FY09/10* | CIT Officers Serving *As of 06/09* | CIT Officers Trained *As of 11/09* | Other First Responders Trained *As of 11/09* | Non First Responders Trained *As of 11/09* | 40 Hour Faculty Trained (TTT) *As of 11/09* |
|---|---|---|---|---|---|---|---|---|
| G7 | Hampton-Newport News CSB<br>Hampton/Newport News CIT<br>*Hampton, Newport News* | Operational[3] | 6 | 129 | 128 | 29 | 29 | 24 |
| H8 | Henrico Area Mental Health and Retardation Services<br>Henrico CIT<br>*Henrico County* | Developing | 2 | 0 | 28 | 11 | 2 | 22 |
| I9 | Middle Peninsula-Northern Neck CSB<br>Middle Peninsula Northern Neck CIT<br>*Essex, Gloucester, King & Queen, King William, Lancaster, Matthews, Middlesex, Northumberland, Richmond and Westmoreland* | Planning | 0 | 0 | 0 | 0 | 0 | 0 |
| J10 | Mount Rogers CSB<br>Mount Rogers Community Services Board Crisis Intervention Team<br>*Bland, Carroll, Grayson, Wythe, Smyth, City of Galax* | Operational | 3 | 94 | 112 | 0 | 0 | 17 |
| K11 | New River Valley Community Services<br>New River Valley CIT<br>*Floyd, Giles, Montgomery, Pulaski and City of Radford* | Operational | 3 | 119 | 250 | 0 | 30 | 9 |
| L12 | Northwestern Community Services<br>Northwestern CIT<br>*Clarke, Frederick, Page, Shenandoah, Warren and the City of Winchester* | Developing | 1 | 21 | 8 | 0 | 0 | 10 |

[3] Operational programs have a stakeholder task force which meets regularly and provides program oversight and educational outreach, has a CIT coordinator in place, has trained the number of CIT officers necessary to provide 24/7 CIT response capability, has an established therapeutic assessment location or protocol in place and has begun collecting data to assess the efficacy of the program.

| | Program Affiliated CSB<br>Program Name<br>*Localities* | Program Status | 40 Hour CIT Trainings Held *FY09/10* | CIT Officers Serving *As of 06/09* | CIT Officers Trained *As of 11/09* | Other First Responders Trained *As of 11/09* | Non First Responders Trained *As of 11/09* | 40 Hour Faculty Trained (TTT) *As of 11/09* |
|---|---|---|---|---|---|---|---|---|
| M13 | Piedmont Community Services<br>Piedmont Area CIT Initiative<br>*Franklin, Henry, Patrick and the City of Martinsville* | Planning | 0 | 0 | 0 | 0 | 0 | 0 |
| N14 | City of Portsmouth Dept. of Behavioral Healthcare Services<br>Portsmouth CIT<br>*Portsmouth* | Developing | 2 | 23 | 23 | 0 | 0 | 4 |
| O15 | Rappahannock Area CSB<br>Rappahannock Area Crisis Intervention Team<br>*Caroline, King George, Spotsylvania and Stafford Counties; City of Fredericksburg* | Developing | 1 | 22 | 20 | 0 | 3 | 3 |
| P16 | Rappahannock-Rapidan CSB<br>Rappahannock-Rapidan CIT<br>*Culpepper, Fauquier and Rappahannock* | Planning | 0 | 0 | 0 | 0 | 0 | 0 |
| Q17 | Richmond Behavioral Health Authority<br>City of Richmond Crisis Intervention Team<br>City of Richmond | Developing | 0 | 1 | 0 | 2 | 0 | 5 |
| R18 | Blue Ridge Behavioral Health Care<br>Roanoke Valley CIT<br>*Roanoke and the Cities of Salem and Roanoke* | Planning | 2 | 16 | 40 | 0 | 0 | 0 |
| S19 | Rockbridge Area CSB<br>Rockbridge Crisis Intervention Team<br>*Bath, Rockbridge and the Cities of Lexington and Buena Vista* | Developing | 0 | 4 | 0 | 0 | 3 | 0 |

| | Program Affiliated CSB<br>Program Name<br>*Localities* | Program Status | 40 Hour CIT Trainings Held *FY09/10* | CIT Officers Serving *As of 06/09* | CIT Officers Trained *As of 11/09* | Other First Responders Trained *As of 11/09* | Non First Responders Trained *As of 11/09* | 40 Hour Faculty Trained (TTT) *As of 11/09* |
|---|---|---|---|---|---|---|---|---|
| T20 | Region 10 CSB<br>Thomas Jefferson Area CIT<br>*Albemarle, Fluvanna, Goochland, Greene, Louisa, Madison, Nelson, Orange, City of Charlottesville* | Operational | 5 | 178 | 202 | 0 | 11 | 28 |
| U21 | Valley CSB<br>Blue Ridge Crisis Intervention Team<br>*Augusta, Cities of Waynesboro and Staunton* | Developing | 0 | 2 | 0 | 0 | 0 | 3 |
| V22 | Virginia Beach Human Services<br>Virginia Beach CIT<br>*Virginia Beach* | Operational | 3 | 0 | 75 | 1 | 11 | 16 |

**Key Elements of CIT Programs Status**

The existence of both the CIT coordinator and a community task force has proven critical in achieving program goals and objectives. CIT programs bring together professionals from mental health treatment and services providers and from criminal justice and public safety as well as consumers and community members in a new and unique partnership. This requires close coordination, collaboration, problem-solving, and negotiation. Without one person tasked with facilitating this process and a local task force of the key stakeholders to work out details and reach consensus on the policies and procedures needed to reach those goals, the programs are significantly challenged.

A therapeutic treatment alternative may consist of an actual physical location to which persons experiencing a mental health crisis may be taken for emergency treatment or stabilization, or it may consist of some other set of alternative means for handling people in this situation. Sometimes, it is a combination of the two. The ideal for a CIT program is to have a physical location that is *not* a jail or criminal lock up, always available, to which an officer can deliver a person in crisis and turn over custody to someone trained to assist that person. This releases the officer to return to other duties and provides the treatment options needed by the consumer. This description presumes that the person in crisis has not committed a serious crime for which he or she would be required to be incarcerated. Of course, a person for whom a therapeutic community based alternative is not appropriate due to the nature of a crime charged, may well need mental health treatment and care provisions at the jail facility to which he is taken. Under those circumstances, effective CIT involvement is likely to reduce the difficulties which a jail might encounter with such a person who has been effectively identified as having a mental health issue or been involved in an appropriate CIT de-escalation.

Therapeutic treatment alternative sites are often the most challenging element for a CIT program to establish. The concept of a locally available, round the clock, secure facility for civil commitment assessment under an Emergency Custody Order (ECO) is new to Virginia. They are not common in most localities, utilize different protocols where they do exist and are often challenged when it comes to providing the appropriate staffing levels, both from a security and a treatment resources aspect.

Data collection is critical to measuring the progress and impact of CIT programs. It is made difficult by many factors, including the diversity of local data gathering systems and sharing capacities. Each locality has a great deal of autonomy in the design and functioning of their law enforcement and public safety agencies. This has led to development of localized communications and management information systems that are not required to be uniform and consistent from one locality to the next, even in the same county. While all incidents handled by law enforcement officers are typically reported and captured in some data bank, the elements of an incident which may identify it as involving a person with mental illness are not always known or identifiable. Without a CIT program in place in a community, it is believed that many incidents that typically lead to arrest and injuries may have resulted from contact with persons experiencing mental health crises for which the responding officers were not well

trained, or prepared to handle with alternatives to physical arrest. Identifying such incidents and alternative resolutions employed, is critical to measuring the success of a CIT program. Initial focus for data collection involves implementing a statewide data collection effort regarding four key statutory concerns in mental health related calls: 1) how CIT officers are linked to such calls; 2) how long a CIT officer remains involved in the call; 3) the number of injuries involved, if any; and, 4) the final disposition of the call (see Addendum #4, *Initial Data Elements*, attached).

Table 2, *Impact of Crisis Intervention Team Community and Infrastructure Development in the Commonwealth of Virginia*, reports on the status and progress of four key elements of the CIT programs. They are the presence of a CIT Coordinator, the ability to collect and report data, the presence of a therapeutic treatment alternative or protocol, and the existence and work of a community task force.

**Table 2: Impact of Crisis Intervention Team**
**Community and Infrastructure Development in the Commonwealth of Virginia**
**November 2009**

| | Program Affiliated CSB<br>Program Name<br>*Localities* | CIT Program Coordinator | Data Collection Process in Place | Therapeutic Assessment Alternative Options | CIT Task Force |
|---|---|---|---|---|---|
| A1 | Alexandria CSB<br>City of Alexandria CIT<br>*City of Alexandria* | Yes | Yes | • Yes<br>• Existing Memoranda Of Understandings (MOU)<br>• Enhanced access to services in place | • Meet quarterly<br>• All CJ/MH stakeholders represented<br>• Program oversight and public outreach |
| B2 | Arlington County CSB<br>Arlington County Crisis Intervention Team<br>*Arlington* | No | Yes | • No<br>• Planning underway for therapeutic assessment site<br>• Enhanced access to services in place | • No formalized CIT Task Force |
| C3 | Chesapeake CSB<br>Chesapeake CIT<br>*City of Chesapeake* | Yes | No | No | • Meet monthly<br>• All CJ/MH stakeholders represented<br>• Program oversight and public outreach<br>• Cross Systems Mapping completed |
| D4 | Colonial CSB<br>Colonial Area CIT<br>*Charles City, James City, New Kent, York and the Cities of Poquoson and Williamsburg* | No | No | No | • CCJB involved in planning<br>• Cross Systems Mapping completed |
| E5 | District 19 CSB<br>District 19 CIT Initiative<br>*Dinwiddie, Greensville, Prince George, Surry, Sussex and the Cities of Colonial Heights, Emporia, Hopewell and Petersburg* | No | No | No | • CCJB involved in planning<br>• Cross Systems Mapping completed |
| F6 | Fairfax-Falls Church CSB<br>Fairfax Crisis Intervention Team<br>*Fairfax and the Cities of Falls Church and Fairfax* | Yes | No | • No<br>• Enhanced access to services in place | No |
| G7 | Hampton-Newport News CSB<br>Hampton/Newport News CIT<br>*Hampton, Newport News* | Yes | Yes | • Yes<br>• Therapeutic assessment site | • Meet quarterly<br>• All CJ/MH stakeholders represented<br>• Program oversight and public outreach |

| | Program Affiliated CSB<br>Program Name<br>*Localities* | CIT Program Coordinator | Data Collection Process in Place | Therapeutic Assessment Alternative Options | CIT Task Force |
|---|---|---|---|---|---|
| H8 | Henrico Area Mental Health and Retardation Services<br>Henrico CIT<br>*Henrico County* | No | Yes | • No<br>• Planning underway for therapeutic assessment site | • Meet quarterly<br>• All CJ/MH stakeholders represented<br>• Program oversight and public outreach |
| I9 | Middle Peninsula-Northern Neck CSB<br>Middle Peninsula Northern Neck CIT<br>*Essex, Gloucester, King & Queen, King William, Lancaster, Matthews, Middlesex, Northumberland, Richmond and Westmoreland* | Yes | No | No | No |
| J10 | Mount Rogers CSB<br>Mount Rogers Community Services Board Crisis Intervention Team<br>*Bland, Carroll, Grayson, Wythe, Smyth, City of Galax* | Yes | Yes | • Yes<br>• Planning underway for therapeutic assessment site<br>• Enhanced access to services in place | • Meet bi-monthly<br>• All CJ/MH stakeholders represented<br>• Program oversight and public outreach |
| K11 | New River Valley Community Services<br>New River Valley CIT<br>*Floyd, Giles, Montgomery, Pulaski and City of Radford* | Yes | Yes | • Yes<br>• Existing Memoranda of Understandings (MOU)<br>• Enhanced access to services in place | • Meet quarterly<br>• All CJ/MH stakeholders represented<br>• Program oversight and public outreach |
| L12 | Northwestern Community Services<br>Northwestern CIT<br>*Clarke, Frederick, Page, Shenandoah, Warren and the City of Winchester* | Yes | No | No | No |
| M13 | Piedmont Community Services<br>Piedmont Area CIT Initiative<br>*Franklin, Henry, Patrick and the City of Martinsville* | No | No | No | • Meet regularly<br>• All CJ/MH stakeholders represented<br>• Cross Systems Mapping completed |
| N14 | City of Portsmouth Dept. of Behavioral Healthcare Services<br>Portsmouth CIT<br>*Portsmouth* | No | No | • Yes<br>• Therapeutic assessment site alternative<br>• Enhanced access to services in place | • Meet bi-annually<br>• All CJ/MH stakeholders represented<br>• Public outreach |

| | Program Affiliated CSB<br>Program Name<br>*Localities* | CIT Program Coordinator | Data Collection Process in Place | Therapeutic Assessment Alternative Options | CIT Task Force |
|---|---|---|---|---|---|
| O15 | Rappahannock Area CSB<br>Rappahannock Area Crisis Intervention Team<br>*Caroline, King George, Spotsylvania and Stafford Counties; City of Fredericksburg* | Yes | Yes | • Yes<br>• Therapeutic assessment site alternative under development<br>• Enhanced access to services in place | • Meet quarterly<br>• All CJ/MH stakeholders represented<br>• Program oversight and public outreach |
| P16 | Rappahannock-Rapidan CSB<br>Rappahannock-Rapidan CIT<br>*Culpepper, Fauquier and Rappahannock* | No | No | No | No |
| Q17 | Richmond Behavioral Health Authority<br>City of Richmond Crisis Intervention Team<br>City of Richmond | Yes | Yes | • No<br>• Therapeutic assessment site alternative under development<br>• Enhanced access to services in place | • Meet quarterly<br>• All CJ/MH stakeholders represented<br>• Program oversight and public outreach<br>• Cross Systems Mapping completed |
| R18 | Blue Ridge Behavioral Health Care<br>Roanoke Valley CIT<br>*Roanoke and the Cities of Salem and Roanoke* | No | No | • No<br>• Enhanced access to services in place | • Meet quarterly<br>• All CJ/MH stakeholders represented<br>• Cross Systems Mapping completed |
| S19 | Rockbridge Area CSB<br>Rockbridge Crisis Intervention Team<br>*Bath, Rockbridge and the Cities of Lexington and Buena Vista* | Yes | No | • No<br>• Planning underway for therapeutic assessment site and/or develop protocols to enhance access to services | • Meet quarterly<br>• All CJ/MH stakeholders represented<br>• Program oversight and public outreach |
| T20 | Region 10 CSB<br>Thomas Jefferson Area CIT<br>*Albemarle, Fluvanna, Goochland, Greene, Louisa, Madison, Nelson, Orange, City of Charlottesville* | Yes | Yes | • Yes<br>• Therapeutic assessment site alternative<br>• Enhanced access to services in place | • Meet quarterly<br>• All CJ/MH stakeholders represented |

| | Program Affiliated CSB<br>Program Name<br>*Localities* | CIT Program Coordinator | Data Collection Process in Place | Therapeutic Assessment Alternative Options | CIT Task Force |
|---|---|---|---|---|---|
| U21 | Valley CSB<br>Blue Ridge Crisis Intervention Team<br>*Augusta, Cities of Waynesboro and Staunton* | Yes | Yes | • Yes<br>• Therapeutic assessment site alternative being developed<br>• Memoranda Of Understandings (MOU) in place<br>• Enhanced access to services in place | • Meet quarterly<br>• All CJ/MH stakeholders represented<br>• Program oversight and public outreach |
| V22 | Virginia Beach Human Services<br>Virginia Beach CIT<br>*Virginia Beach* | Yes | Yes | • Yes<br>• Therapeutic assessment site alternative<br>• Enhanced access to services in place | • Meet bi-monthly<br>• All CJ/MH stakeholders represented<br>• Program oversight and public outreach |

For the reasons previously mentioned, data gathering has been slow to accomplish for statewide evaluation purposes. The type of data being sought is illustrated in the following charts that were prepared using data from New River Valley CIT and from Arlington County CIT. Data from other CIT programs were not available prior to preparation of this report. In future years, gathering this same type of information from programs across the Commonwealth will help to identify strengths and weaknesses, as well as program needs of CIT.

**FY10 First Quarter Data New River Valley and Arlington CIT Programs**

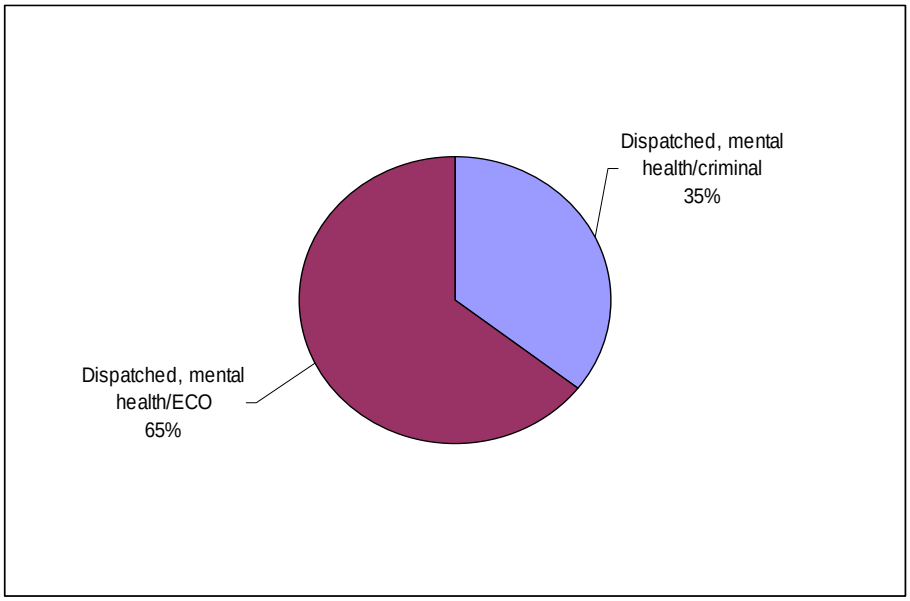



**Figure 1 Call Type (n=31)**

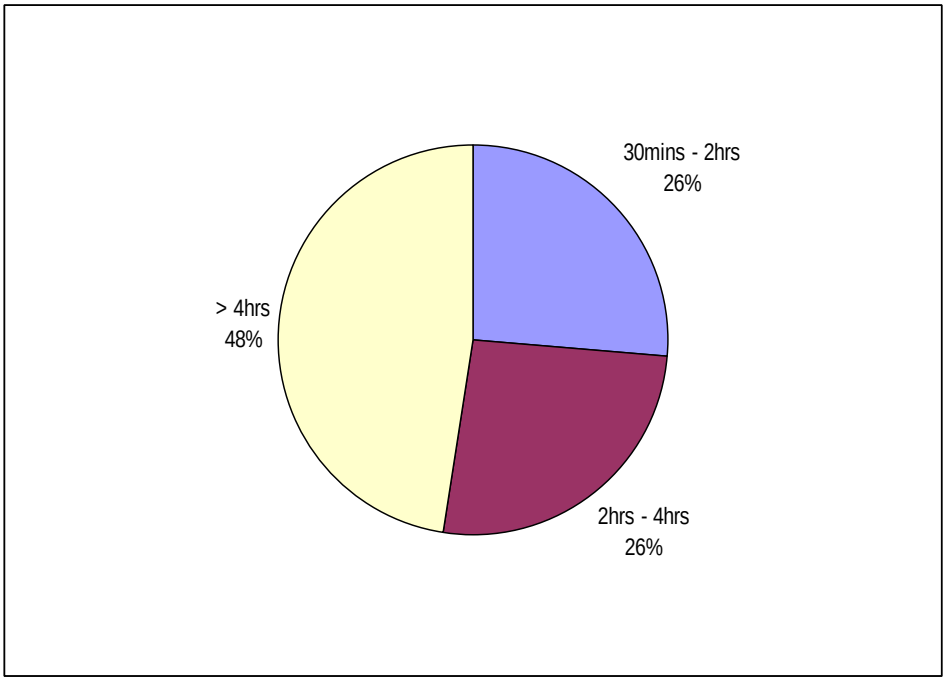



**Figure 2 Officer Time (n=38)**

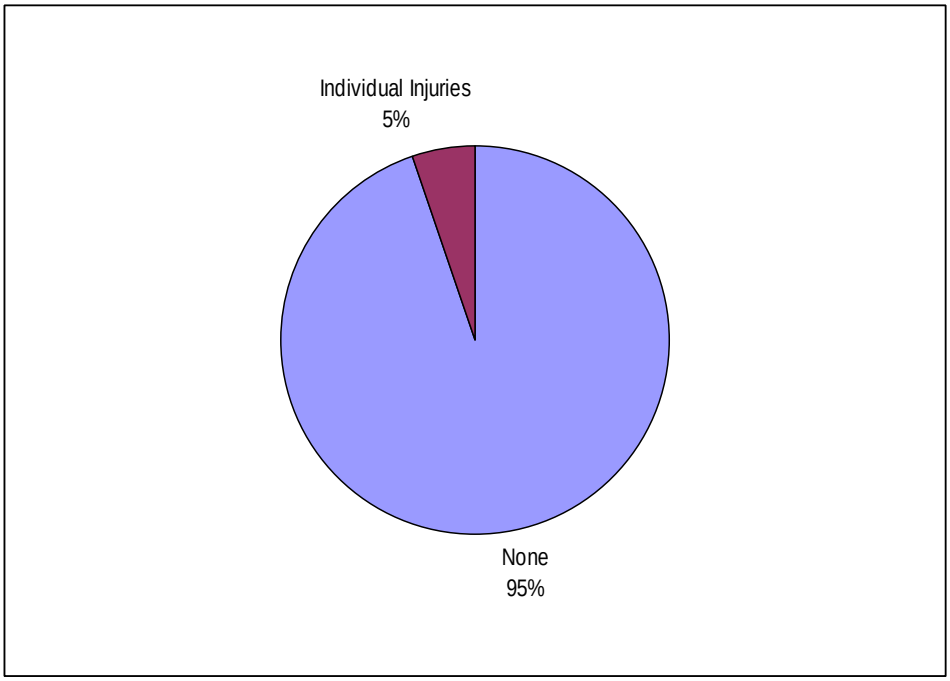



**Figure 3 On-scene Injuries (n=38)**

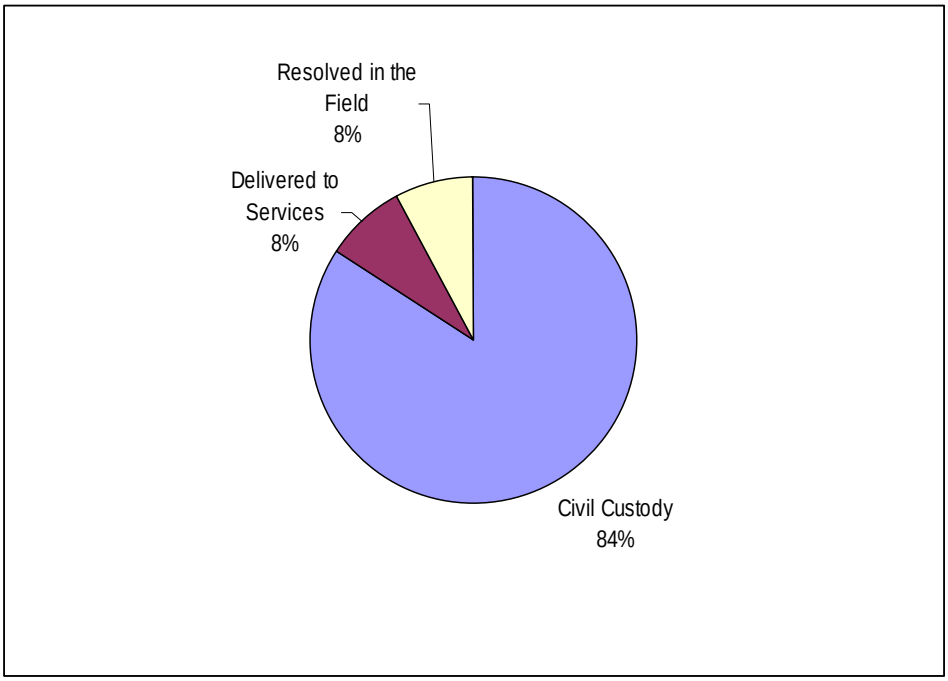



**Figure 4 Call Disposition (n=38)**

## Summary

Since the effective date of Senate Bill 1294 on July 1, 2009, a great deal of progress has been made by DCJS and DBHDS to build the necessary infrastructure to support the development of CIT programs statewide. The VACIT coalition has also proven to be a useful and effective means of bringing together key staff and stakeholders from all programs. This continued collaboration will enable us in future years to report comprehensively on all aspects of CIT programs, including, but not limited to, consideration of the number of incidents, injuries to the parties involved, successes and problems encountered, the overall operation of the crisis intervention team programs, and recommendations for improvement of the program.

# ADDENDA

**Addendum #1:** *Representative 40 Hour CIT Training Curriculum Outline*

## NEW RIVER VALLEY CIT TRAINING SCHEDULE
## SEPTEMBER 21-25, 2009

| TIME | MONDAY-21 | TUESDAY-22 | WEDNESDAY-23 | THURSDAY-24 | FRIDAY-25 |
|---|---|---|---|---|---|
| 8:00 am<br>8:30 am | Unit 1<br>Orientation to CIT Concepts & Awareness of Mental Health Issues<br>*Patrick Halpern & Lt. Kit Cummings* | Unit 7<br>Site Visits<br>▪ Southwestern Virginia Mental Health Institute<br>▪ Against All Odds Clubhouse<br>▪ Program of Assertive Community Treatment (PACT)<br>▪ New Horizons<br>▪ Carilion St. Albans<br>(see tab # 7 for complete schedule) | Unit 8<br>Site Visit Review<br>*Ellen Piilonen, LPC, M.A.Ed & Lt. Kit Cummings* | Unit 13<br>Verbal De-Escalation Techniques<br>*Lt. Kit Cummings & Melanie Adkins, LPC* | Unit 17<br>Professional Liability and Legal Issues<br>*Victoria Cochran, JD* |
| 9:00 am<br>9:30 am | Unit 2<br>Introduction to Clinical States<br>*Melanie Adkins, LPC* | | Unit 9<br>Cultural Diversity & CIT Interventions<br>*Lt. Kit Cummings* | | Unit 18<br>Dual Diagnosis (Mental Illness & Substance Use Disorder)<br>*Heather Custer, MS* |
| 10:00 am<br>10:30 am | | | | Unit 14<br>Post-Traumatic Stress Disorder<br>*Sgt. Sam Shumate* | Unit 19<br>Intervention Skills for Special Populations<br>*Heather Custer, MS* |
| 11:00 am<br>11:30 am | Unit 3<br>Suicide Intervention Skills<br>*Ellen Piilonen, LPC, M.A.Ed.* | | Unit 10<br>Intro to Psychotropic Medications<br>*Stephanie Lane, MS* | | Unit 20<br>Advanced Role Play Exercises<br>*(working lunch)*<br>*CIT Law Enforcement Faculty* |
| 12:00 pm<br>12:30 pm | Lunch *(on your own)* | | Lunch *(on your own)* | Lunch *(on your own).* | |
| 1:00 pm<br>1:30 pm | Unit 4<br>The Legal Context for CIT<br>*Lt. Kit Cummings & Cheri Warburton, LPC* | | Unit 11<br>Basic Crisis Intervention Skills & Facilitated Basic Role Play<br>*Melanie Adkins, LPC & CIT Law Enforcement Faculty* | Unit 15<br>Civil Commitment Procedures & Related Issues<br>*Paul Barnett, Esq. & Jill Long, Chief Magistrate* | |
| 2:00 pm<br>2:30 pm | | | | Unit 16<br>Intermediate Role Play Exercises<br>*CIT Law Enforcement Faculty* | |
| 3:00 pm<br>3:30 pm | Unit 5<br>"Hearing Voices" Audio Exercise<br>*Patrick Halpern & CIT Law Enforcement Faculty* | | Unit 12<br>Basic Role Play Exercises<br>*CIT Law Enforcement Faculty* | | Unit 21<br>Closing & Graduation |
| 4:00 pm<br>4:30 pm<br>5:00 pm | Unit 6<br>Consumer & Family Perspectives<br>*Margo Walter & Dawn Crigger* | | | | |

**Addendum #2:** *Train the Trainer Training Agenda*

New River Valley Crisis Intervention Team (CIT)

## TRAIN THE TRAINER TRAINING (TTT)

# AGENDA

**Day 1: 9:00 AM-5:00 PM**

***Unit 1: "Developing a Self-Sustaining CIT Program"***

Introductions and Presentation
- Faculty/Students
- Train the Trainer Goals
- CIT Review/Overview

Lecture and Discussion
- Why do we do CIT this way?
  - The learning curve
  - Checks and balances
  - Collaborative teaching
  - Being prepared for special issues
    - Officer safety, disruptive students, non-volunteers

**Break**

***Unit 2: Role Play and Lecture Assignments***

Assignment of New CIT Faculty Trainer Roles for 3 hour training:
- Deciding who will present and who will shadow mentors for each section; review of lecture topics

**Lunch Break**

***Unit 3: "How to Introduce Crisis Intervention Concepts and CIT"***

Lecture and mentored practice session

***Unit 4: "How to teach Basic Mental Health Concepts"***

Lecture and mentored practice section

**Break**

***Unit 5: "How to Teach Basic Crisis Intervention Skills"***

Lecture and mentored practice session
- "The Four Coaching Plays"

**Addendum #2:** *Train the Trainer Training Agenda*

***Unit 6: "Creating Your Own Role-play Scenarios"***

Instructions and Facilitated Discussion for Homework Assignment:
- Assigning teams to develop scenarios
- Samples and formats for developing basic, intermediate and advanced role-play scenarios

Day 2: **8:00 AM-5:00 PM**

***Unit 7: Role-play/Lecture Development Mentored Working Groups***

Faculty works with teams and individuals on role play scenario and lecture development

**Break**

***Unit 8: "Leading Role Plays and Providing Effective Feedback"***

- Setting up role plays
- Styles, rules and types of feedback for role play exercises

***Unit 9: Demonstration Role Plays/Feedback by CIT***

- Collaborative leadership and logistical issues – who does what?
- Modeling feedback approaches for beginning, intermediate and advanced role plays
- Stop and start role play training techniques

**Lunch Break**

***Unit 10: New CIT Faculty Leading Role Plays Practice Session***

Coordinating, leading and presenting role play scenarios
(TTT Faculty mentor new faculty through role plays and feedback panels, emphasizing actor/facilitator team work skills, positive and constructive vs. destructive feedback, stop and start with students)

**Break**

***Unit 11: New CIT Faculty Practices Role Plays/Lectures***

Dress rehearsal for three hour training: All facets performed by new CIT Faculty

***Unit 12: Facilitated Discussion***

Question and answer session to address issues for tomorrow's Training

**Addendum #2:** *Train the Trainer Training Agenda*

## Day 3: 8:00 AM-1:00 PM

***Unit 13: Final Preparation for 3-hour training***

Gather to go over handouts and address last minute issues (if needed)

***Unit 14: 3 Hour Training for Select Law Enforcement, Corrections and Various Personnel***

***Unit 15: Debriefing with New Faculty and TTT Evaluations***

**Addendum #3:** *Dispatcher Training Agenda*

**NEW RIVER VALLEY**
**CIT DISPATCHER TRAINING SCHEDULE**
**FEBRUARY 24, 2005**
**8:00 AM – 12:00 NOON**
**BLACKSBURG, VA**

| | |
|---|---|
| **8:00 am – 8:45 am** | **Orientation to the CIT Concept**<br>*Amy Forsyth-Stephens, M.S.W.*<br>*Executive Director, Mental Health Association of the NRV* |
| **8:45 am – 9:45 am** | **Introduction to Mental Illness and Brief Overview of Psychotropic Medications**<br>*Ellen Piilonen, LPC, M.A. Ed.*<br>*ACCESS Clinician, New River Valley Community Services* |
| **9:45 am – 10:30 am** | **Basic Crisis Intervention Skills**<br>*Cheri Warburton, M.S.*<br>*Coordinator of Emergency and Adult Outpatient Services*<br>*New River Valley Community Services* |
| **10:30 am – 10:45 am** | **Break** |
| **10:45 am – 11:30 am** | **Suicide Intervention Skills for Dispatchers**<br>*Ellen Piilonen, LPC, M.A. Ed.* |
| **11:30 am – 11:45 am** | **New River Valley Community Resources**<br>*Amy Forsyth-Stephens, M.S.W.* |
| **11:45 am – 12:00 pm** | **Wrap-up and Review**<br>*Ellen Piilonen, LPC, M.A. Ed. &*<br>*Dana Lebowitz, CIT Coordinator* |

## Initial Data Elements for CIT Impact

**1. Call type:**

CIT officer dispatched to call for assistance with possible mental health involvement
CIT officer dispatched to serve an emergency custody order
CIT officer dispatched for wellness check
CIT officer self-initiated response on scene for any of the above

**2. Time in service for call:**

CIT officer spent less than 30 minutes
CIT officer spent 30 minutes to 2 hours
CIT officer spent 2 to 4 hours
CIT officer spent more than 4hours

**3. On-scene Injuries[1]:**

No injuries reported
Injuries to officer(s)
Injuries to individual(s)
Injuries to both officer(s) and individual(s)

**4. Call disposition:**

Call cleared on scene with no additional action taken
Individual transported to community treatment or services
Individual taken into civil custody by officer (ECO)
Individual arrested

[4] On-scene injuries refers only to those that occur after the CIT officer arrives