Crisis Intervention Team

A Report with Recommendations

Submitted to

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June 2010
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PART ONE: INTRODUCTION

This report describes a Berkeley Police Department (BPD) initiative to examine and acquire a Crisis Intervention Team (CIT) based on national best practices. The work supporting this initiative began in April 2010 at the direction of Chief Meehan. BPD is motivated to acquire a CIT program to provide alternatives to incarceration for those experiencing psychiatric crises and to increase the safety of both officers and community members.

Creating a CIT program from the ground floor is a major undertaking. There are currently no CIT programs in Alameda County, which makes our project even more ambitious. Frequently, CIT is introduced as a regional initiative adding interested police agencies to a preexisting package of training and resources. CIT involves the creation and maintenance of many community partnerships as it is at its core a community-based, police-driven initiative.

CIT programs are commonly established in a hurried and ill-planned manner after a bad outcome involving police and a mentally ill individual. BPD is in the fortunate position of being able to reflectively create a program based on our city’s needs rather than being forced to react to pressing civil litigation or public outcry. The proposed CIT programs outlined here will provide BPD officers specific skills, information and resources needed to respond to those experiencing a mental health crisis.

Historical Background and Statement of Need

What is CIT?
CIT is an innovative police-based crisis intervention program with community, health care and advocacy partnerships. It provides police-based crisis intervention training to officers for assisting those individuals with a mental illness or who are in psychiatric crisis. CIT improves the safety of patrol officers, consumers, family members, and citizens.

CIT provides the foundation necessary to promote community solutions to assist mental health consumers. The CIT model reduces both stigma and the need for further involvement with the criminal justice system. The basic goals of CIT are to improve officer and consumer safety and to redirect individuals with mental illness away from the judicial system to the health care system.
In a review of CIT literature, Compton et. al. (2008) writes,

...[There exists] preliminary support for the notion that the CIT model may be an effective component in connecting individuals with mental illnesses who come to the attention of police officers with appropriate psychiatric services. Early research indicates that the training component of the CIT model may have a positive effect on officers’ attitudes, beliefs, and knowledge relevant to interactions with such individuals, and CIT-trained officers have reported feeling better prepared in handling calls involving individuals with mental illnesses. (p.52)  

The History of CIT

In 1987 a Memphis Tennessee officer shot and killed a mentally ill subject. The incident and subsequent public outrage, spurred the Memphis Police Department to collaborate with the National Alliance on Mental Illness (NAMI), the University of Tennessee Medical School, and the University of Memphis to improve training procedures for their officers. The result of this initiative was a “Crisis Intervention Team” of specially trained, self-selecting officers. The Memphis program quickly spread. It is now the most common type of Specialized Police Response (SPR)  program and is referred to as the “Memphis Model.” There are at least five hundred police agencies nationally who use the Memphis Model CIT program. Canada is quickly adopting it. It has generated interest in Europe, Australia and Israel.

In the United States there are approximately 1000 police agencies with SPR initiatives. New Mexico, Connecticut, Georgia, Iowa, North Carolina, Ohio, Oregon, Tennessee, Texas and Washington all have statewide CIT initiatives. The state of Colorado has trained a full 17% of all officers in CIT. Utah has trained approximately 11% of their officers statewide.

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2 A SPR (pronounced “SPUR” is a designation used by the U.S. Justice Dept. to describe the wide variety of initiatives aimed at improving police interactions with the mentally ill. CIT is one type of SPR.
California Counties with active CIT programs (in blue).

U.S. States with active CIT programs (in blue).
CIT has proven to be a win-win both for police agencies and the communities they serve. Anecdotal evidence has shown CIT has the following benefits:

**Reduced injuries to officers and consumers.** Some of the features of CIT training are de-escalation, patience and active listening. The use of these techniques, sometimes referred to as “validation and ventilation” by officers, reduces the need for physical force. In my survey of over 160 national and local police agencies, this reduction was noted in every department with a CIT program. In Memphis, the number of officer injuries resulting from responding to “5150” calls dropped 80% after implementing CIT. From 2007-2009 BPD documented 148 officer injuries. I expect a 15% reduction BPD officer injuries with a fully operational CIT program.

When introduced to CIT, many officers view it as a “hug a thug” program. Nothing could be further from the truth. The skills acquired through CIT training keeps officers safe. When responding to my survey, Chief Randy Cox from Somerset Borough, Pennsylvania wrote, “I firmly believe that the
quality of the CIT training my CIT officers receive never compromises officer safety…”

*During all SWAT Team responses...a call will be placed to the CIT Team Leader to respond. The CIT Team Leader will evaluate the situation for any mental health components. Because de-escalation skills taught will work on all individuals and not only those consumers with mental illness, the CIT Team Leader will consult with Negotiators and Commanders as a resource for advice and possible de-escalation of the situation.* (Steven Burke, Rochester Police Department, New York).

Many departments provide CIT training to their hostage negotiators. For example, Monterey County (CA) requires all BSHNT tactical operators to be trained. Other agencies have CIT officers respond to BSHNT call-outs. De-escalation techniques, active listening and patience can be applied to virtually every citizen contact, not just those involving mentally ill subjects.

**Improved use of police resources.** By proactive, early intervention and treatment rather than incarceration, CIT efforts have proven highly cost effective. In analyzing data they collected, the Houston Police Department reported saving approximately 690 work hours as a result of their CIT program in 2009. CIT initiatives have consistently been shown to reduce officer injuries, BSHNT type incidents, and the amount of time officers spend on calls involving mentally ill subjects. With a “no wrong door” policy (Maricopa County, Arizona) - established through MOU’s with local facilities - officers are able to drop off mental health consumers with little or no wait time. This allows them to return to their patrol duties promptly.

**Improved community relations.** Many times family members of those with a mental illness are reluctant to call the police. They want their loved one to get help but know officers unfamiliar with mental illness may exacerbate the crisis. Police officers are trained to arrive on scene, take command and solve problems, and to do so expeditiously. This approach simply does not work with individuals experiencing a psychiatric crisis. In contrast, in those agencies with an established CIT program, family members will call the police for assistance. They ask for a CIT officer

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3 Barricaded Subject Hostage Negotiation Team.

4 Police departments with best practices will be placed in parentheses.
knowing the officer coming to their home has the skills and temperament needed to resolve the crisis, and that the officer will likely do so without physical force or an arrest.

Through establishing community partnerships a renewed ethos emerges within the community that the police department is there to help. It has long been established in the police literature that, without community support, the police mission cannot succeed. CIT programs go a long way to engender wider community support for police activities.

From a narrower perspective, CIT also provides an opportunity for enhanced public relations. Local media are often brought in to CIT graduation ceremonies and notified of developing CIT initiatives.

The St. Louis, Missouri CIT Program lists the following benefits of CIT:

* Increases officer/citizen safety.
* Decreases police liability and litigation.
* Extends officers’ skills.
* Increases on-scene expertise.
* Minimizes officer “turn around” time on calls involving persons in crisis.
* Increases officer/community confidence.
* Increases professionalism.
* Empowers officers to divert person(s) with a mental illness to treatment.
* Increases cooperation between criminal justice and mental health systems.
* Establishes responsibility and accountability.
* Decreases arrest rates.
* Reduces recidivism.

**The Core Elements**

The Core Elements are the centerpiece of the Memphis CIT program. They are:

**Community partnerships.** CIT officers function as a specialized unit. One unique and challenging aspect of CIT units is that the entire program is predicated on community partnerships. “Our data strongly suggest that collaborations between the criminal justice system, the mental health system, and the advocacy community plus essential services reduce the
inappropriate use of U.S. jails to house persons with acute symptoms of illness.” Unlike BSHNT or motor officers who answer to their police supervisors, CIT officers act as partners in the community, working toward a common good. As such, CIT officers are accountable not only to their police supervisor, but also to the mental health professionals with whom they collaborate, mental health consumers and advocates whom they serve, and treatment facilities whom they refer to. This is one reason why CIT has been referred to as “community policing to the extreme.”

CIT partnerships are developed during the planning stages of the program. They require more than general support. CIT partners need to be fully invested and willing to use whatever influence they have to make the program successful. This is accomplished through mutual accountability and community ownership of the program.

Locally, two key partners in our CIT program are the National Alliance for the Mentally Ill (East Bay NAMI) and Berkeley Mental Health. In Berkeley, there are close to 100 community stakeholders, all of which - to greater or lesser degrees - need to be involved in this initiative. I have included a list of community stakeholders in Appendix F. It is not practical or necessary to have representatives from all these groups participate in the design, implementation and ongoing evaluation of the BPD CIT program. At a minimum, all community stakeholders should be aware of our CIT initiative, and updated on the progress of the program.

**CIT Training Components**

“CIT is more than training.” This phrase is uttered often by experienced CIT officers and coordinators. It requires buy-in from senior management and community partnerships, community ownership and community accountability. However, the actual 32-40 hour CIT training is required.

**CIT Training Objectives**

* Gain understanding of the major mental illnesses.
* Learn crisis de-escalation & intervention skills, problem solving strategies, and communication techniques.

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* Learn how to effectively access community mental health resources and programs.

**Nontraditional CIT Models**

While the Memphis CIT model is the most common, there are other types of CIT programs. Some of these include co-responders (e.g., Berkeley Mobile Crisis) absent in the Memphis model and some which train all officers rather than a self-selecting group as in the Memphis model\(^6\). Police chief Randy Cox (Somerset Borough, Pennsylvania) states, “I am a firm believer that not every officer will be an effective CIT officer.” This is also the contention of Maj. Sam Cochran, one of the founders of the Memphis CIT model. Ron Bruno is on the Board of Directors for CIT International, and the Program Manager for the Salt Lake City Utah CIT program. In a personal communication to me, Mr. Bruno writes, “Based on my research of Crisis Intervention Teams the following are core elements of successful CIT programs,...Volunteer.’

Nonetheless, the following are examples of police agencies that do provide CIT training for all officers:
* Athens Police Department (Georgia).
* Marion County Sheriff’s Office (Oregon).
* Independence Police Department (Virginia).
* Reno Police Department.
* Houston Police Department (with over five thousand sworn peace officers).
* Overland Park Police Department (Kansas).
* Austin Texas (has 40-hr training in the basic police academy and an additional 40-hr certification training post-academy).

Bay Area examples include,
* San Francisco Police Department.
* San Jose Police Department.
* Contra Costa County Sheriff’s Department.

It should be noted that many departments have a stated goal of training all their officers in CIT but, for various reasons, have been unable to meet that

\(^6\) It is possible to utilize co-responders with the Memphis model, despite Memphis P.D. not using them.
goal. Some police agencies (e.g., Monterey County, Houston, Texas) actually have a waiting list for officers wishing to receive CIT training.

One way police departments train all their officers is by adding a forty hour block to their basic police academy. San Jose P.D. is an example of this approach. The vast majority of BPD recruits attend the Sacramento County Police Academy, which does not have CIT built into the curriculum. To my knowledge there are no plans to do so.

A few departments (e.g., Austin, Texas, Reno, Nevada) offer a pay stipend for their CIT trained officers. The vast majority do not.

CIT has been in existence for twenty-two years. The demographics and politics of Berkeley are highly conducive to a CIT program. It stands to reason that if Calhoun County, Georgia, Independence, Virginia and Helena, Montana have CIT programs, Berkeley should as well.

**Statement of Need**

It is estimated that mental illness affects one out of every five families in the United States. Treatment options for those with major mental illness have dramatically improved over the last fifty years. Before that, those with serious and persistent mental illness were frequently locked in institutions. The conditions in these institutions became infamous. While in these state run psychiatric hospitals, mentally ill persons were subjected to a number of disastrous treatments. By the middle of the twentieth century, electroconvulsive therapy, insulin shock therapy, lobotomies and "neuroleptic" chlorpromazine were used in turn and combination on psychiatric patients.

An antipsychiatry movement came to the fore in the 1960s. Deinstitutionalization gradually occurred in the U.S. with isolated psychiatric hospitals closing, in favor of community based treatment. A consumer/survivor movement gained momentum. Other kinds of psychiatric medication gradually came into use, such as "psychic energizers" and lithium. Benzodiazepines gained widespread use in the 1970s for anxiety and depression, until dependency problems curtailed their popularity.
In 1963 then President John F. Kennedy signed the National Community Mental Health Services Act into law. The goal was to provide state and local governments three billion dollars to improve services to the mentally ill. Unfortunately, the bill wasn’t funded and mentally ill individuals in the tens of thousands were released without the necessary mental health infrastructure to support them.

In 1968, and the passing of the Lanterman-Petris-Short (LPS) act, California accelerated the already high rate of releasing chronically mentally persons back to their communities. These actions resulted from a number of factors. Chief among them were longstanding complaints about the conditions in state hospitals, strong advocacy for the civil rights of those inside them, and the promise of an adequately funded community mental health system. The trend was accompanied by the development of modern antipsychotic medications.

Nationally, 10% of all calls for police service involve someone with a mental illness. On the lower end, the Seattle Police Department reports that between 1-2 % of all calls for service or on-view events involve mentally ill
subjects. The large range here is likely due to Computer Aided Dispatch (CAD) limitations and/or the inability of officers to change the disposition of calls.

Deinstitutionalization has had a major affect communities across the country. According to one author, it “has helped create the mental illness crisis by discharging people from public psychiatric hospitals without ensuring that they received the medication and rehabilitation services necessary for them to live successfully in the community.” Today we have what Leifman calls “transinstitutionalization,” whereby those that used to be treated in psychiatric hospitals have been released. Then, they received little or no treatment in the community and end up in the criminal justice system. Leifman, a judge and Special Advisor on Criminal Justice and Mental Health for the Supreme Court of Florida, says “This is the one area of civil rights we’ve gone backwards on.”

Jails and prisons have become storing houses for the mentally ill. When a police officer has contact with a mentally ill subject at two in the morning, that officer frequently has no viable alternative to incarceration. Public safety demands officers respond to calls involving mentally ill subjects, and that the officer take some kind of action. Our jails and prisons are now overcrowded with mentally ill individuals, many of which have committed only minor offenses. In Miami-Dade County Florida, for example, four and five mentally disordered inmates are housed in cells designed for one person.

Criminalizing the mentally ill has proven costly for state and local governments. In Florida, one-third of all state mental health dollars are used to restore competency of incarcerated mentally ill individuals. It has also cost our society in moral currency, as countless news stories have documented the deplorable, overcrowded conditions of our jails and prisons.

Nationally, 24% of state prison inmates and 21% of county jail inmates a have recent history of serious mental illness. Sedgwick County (Kansas) noted a 15% decrease in incarcerated individuals who received mental health treatment as a result of their CIT program. Mentally ill individuals

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7 A Less Lethal Options Program for Seattle Police Department, 2000

8 From keynote address at the CIT International Conference (2010) in San Antonio, Texas.
are three times more likely to be placed in jail rather than a psychiatric hospital after contact with the police. Once in jail, they stay an average of 17 days longer than other inmates. The result is that police officers have become the default gatekeepers of the community mental health system and jail has become the default “treatment” of choice.

In Miami-Dade County Florida there are five times more psychiatric patients in jail than in psychiatric institutions. From a sociopolitical perspective, we have slid back two hundred years with our treatment of the mentally ill. If “A society may be judged by the way it treats its most vulnerable members,” we are surely failing.

**History of the Berkeley CIT Initiative**

Berkeley has long been a bastion for social justice, liberalism and tolerance. We have a significant “traveler” population, as young people from around the country view our city as a haven for alternative lifestyles. Like San Francisco, many believe Berkeley has plentiful community services. This perception is a lure for those on the fringe of society. Given our history, it’s not surprising that Berkeley has a significant mentally ill population, especially homeless mentally ill and those with coexisting substance abuse disorders (i.e., dually diagnosed).

The most common age range for a first psychotic episode is between 17-24 years. One of the precipitants to a psychotic episode is acute psychosocial stress. The fact that the city of Berkeley has a high population of residents in this age range, many of whom experience the acute psychosocial stress of homelessness or university studies, further points to a need for a CIT program.

Francesca Tennenbaum, an Alameda County patients rights advocate, states that the largest mental health institution in the state of California is the Los Angeles County Jail. Like it or not, the Berkeley Police Department is on the front line of the mental health crisis currently gripping our nation. Along with being the right thing to do, failing to adequately train our officers to manage those in crisis exposes BPD to civil litigation for “deliberate indifference.” In Canton v. Harris the U.S. Supreme Court found the Canton Police Department civilly liable by failing to offer regular first aid training to their officers. The reasoning behind this decision was
that officers so frequently encounter persons requiring first aid, failing to
train them in it was tantamount to negligence.

In February, 2007 the Berkeley/Albany Mental Health Commission made a
recommendation to the city mayor and the Berkeley City Council that BPD
train all their officers in a Crisis Intervention Team (CIT) model for
improving the police response to those in psychiatric crises. The
recommendation also called for an annual CIT training for all officers. Later
in 2007, a CIT steering committee was formed. This committee has been
meeting monthly, continuing to the present time. In April 2010, BPD in
conjunction with the Berkeley/Albany Mental Health Commission, hosted a
“Crisis Intervention Training.” While the training was a success, it was only
a first step in the development of a formal BPD CIT program.
PART TWO: KEY COMPONENTS AND BEST PRACTICES

Goals and Objectives of the BPD CIT Program

The overall goal of the BPD CIT program is to apply CIT Core Elements to our cities needs. While CIT officers will serve the city as a whole, four specific populations will be targeted through this initiative:

1. **Homeless/nomadic mentally ill.** Berkeley has a large population of those with coexisting mental health and substance abuse disorders. We have both permanent city residents as well as “travelers” who stay in our city (usually on Telegraph Ave., People’s Park or along the Shattuck corridor) for weeks or months before moving on.

These are high end users, who have entered the revolving door of our jail and hospital emergency rooms. Our goal for this population will be to connect them to city services, such as mental health, housing, and substance abuse treatment.

BPD receives a particularly high number of calls for service involving mentally disordered individuals along the Shattuck and Telegraph Ave. corridors. Areas 2 and 3 would be areas of focus for our CIT efforts.
2. **Children and youth.** In 2009 BPD received 107 calls for service at Berkeley High School, Berkeley Technology Academy, Willard Middle School, Martin Luther King Jr. Middle School and Longfellow Magnet Middle School. This number does not include incidents off campus, which are the bulk of our calls for service. A breakdown of the crimes reported are as follows:
Larceny (47%) was by far the most common offense committed on school grounds. These thefts may be understood as an opportunity to intervene with troubled youth before they graduate to more serious criminal behavior.

Berkeley High School (BHS) alone has approximately 4,000 students. BHS has consistently been a drain on patrol resources. Calls for service from BHS and B-Tech typically involve truancy, gambling, loitering, fighting and smoking marijuana. More serious crimes (robbery, aggravated assault) are also associated with high school age kids. I estimate that a significant number of youth who have contact with BPD have untreated mental health issues and are therefore eligible for city services, funded by the Mental Health Services Act (MHSA). By redirecting these youth to community mental health treatment and support, a reduction in the need for police involvement may occur. It is not clear at the time of this writing the extent to which this population needs to be a focus of CIT.

3. **College students.** Currently, our CAD data do not show how many calls for service BPD receives involving University of California, Berkeley (UCB) students. Many of these students live on campus, within the
The jurisdiction of The University of California Police Department (UCPD). However, the South Campus area of Berkeley consists of a dense housing area populated by UCB students. Like children and youth, it is unclear at this time to what extent these students should be targeted for CIT. Given the usual age range for the initial onset for major mental illness (17-24) we can surmise this group would benefit from CIT services.

One of the strengths of CIT lies in its flexibility. The program will be evaluated for its effectiveness from the beginning. Target populations, geographic emphases and delivery methods will likely change over time. The above noted target populations are based only on an initial assessment.

The BPD CIT initiative has three ambitious objectives:

1. Provide CIT training to officers, dispatchers and CSO’s.
2. Develop partnerships in the community to support a sustained CIT program.
3. Redirect mental health consumers away from the justice system to the community health care system.

**Method for Determining Best Practices**

CIT programs can be found in 40 of the 50 United States. To determine the best practices of these programs, I started with reading material. Several helpful and publicly available documents assisted me in this area. They included,

* Crisis Intervention Team Core Elements, *The University of Memphis.*
* A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness, *Substance Abuse and Mental Health Services Administration (SAMHSA).*
* Jackson County Crisis Intervention Teams Quarterly Report, *December 2009.*
* Missouri CIT Council: Crisis Intervention Team Program Model Introduction Book.
* Starting a CIT Program: A Step by Step Guide, *NAMI.*
I highlighted aspects of various programs that appeared promising or applicable to our city. I then contacted, by telephone 44 Bay Area police departments. In these conversations I asked questions from a survey I developed. The first question was, “Do you have a CIT program?” If the department had an existing program, I then asked a series of questions aimed at best practices (see Appendix B for survey questions).

One of the two founders of the Memphis CIT Model, Ret. Maj. Sam Cochran contacted me by phone. In this conversation he detailed the core elements of CIT and other variables that make a successful program. He also referred me to the Santa Clara County CIT program, stating they were a model. I visited the Santa Clara County Sheriff’s Office CIT program, and met with Sgt. Troy Boser, the CIT Coordinator and a psychologist supervising the clinical component of their program. I obtained useful information from this meeting as well.

I also conducted a national survey of police departments with existing CIT programs, using the Memphis Tennessee Police Department’s online registry. I created a survey form (Appendix D) and e-mailed it to 142 police agencies around the country. Forty-six responded to the questionnaire, a 32% response rate. I left my cell phone number with the request for information. Several CIT Coordinators from around the country contacted me by phone.


Specific best practices will not be explained here. Rather, they are woven into the document throughout in the applicable area (i.e., “CIT officer selection,” or “data collection”). Frequently (though not always) the name of the department using the practice will be in parentheses.

**Needs Assessment**

Being a jail diversion program, one of the primary goals of CIT is to divert mental health consumers back to the community for treatment. Ideally, a complete system of mental health care includes the following elements, from the least restrictive to the most:
**Curricula**

CIT training curricula are fairly consistent throughout the U.S. Classes typically include signs and symptoms of mental illness, de-escalation techniques, stigma associated with mental illness, psychotropic medications and scenario training. A sample CIT training curriculum is included in the Appendix H. General characteristics of CIT training is as follows,

* 32-40 hours of instruction.
* Adult learning model including didactic sessions building foundational information with anchors for practical application.
* Scenario work.
* Contact with local resources (NAMI, Bonita House, John George Psychiatric Pavilion, Harrison House).
* Blends knowledge, empathy and direct learning of skills and techniques with high transferability.

*Most officers report in their course evaluations that [scenario training] with professional actors and site visits to community psychiatric treatment facilities, which involve direct interaction with patients, have the most impact and create the biggest attitude shift as far as empathy for
people with mental illness. (Keri Fitzpatrick, Manager, Colorado Crisis Intervention Teams).

Jennifer Meade from Durham, North Carolina agreed, saying (by e-mail communication) “these interactions always receive the highest ratings on our evals.”

Dispatcher training

Dispatchers don’t need the full 32-40 hr training, as much of it does not apply to them. Georgia has a 20-hr dispatcher program. Summit, Ohio uses a 4-hr dispatcher program. Some departments have 8-hr dispatcher training. **I could not find any Bay Area police agencies that provide abbreviated training for dispatchers.** An increasing number of departments are sending dispatchers to the full 40-hr class. One cost-effective approach would be to add a CIT component to the basic dispatcher training program.

The ideal number of students in a CIT class is 28. Some places (e.g., Colorado) have pass/fail classes. A best practice for CIT training can be found in Omaha, Nebraska. They have officers complete tasks while listening to voices (simulating auditory hallucinations) in head phones.

Commission on Peace Officer Standards and Training (POST)

California POST offers certification for CIT training. After completing CIT training and submitting a resume with POST, BPD officers may be CIT instructors. The CIT program would be strengthened if a CIT trained BPD officer had completed the POST Master Instructor Development Program (MIDP). This is a lengthy (approximately one year) process requiring the candidate to complete three preliminary levels of instruction through the Instructor Development Institute. One benefit of having a MIDP instructor associated with the CIT program is that BPD could apply for increased POST reimbursement rates.

On June 9th 2010, I spoke with the POST Alameda County Regional Consultant, Don Lane. After hearing a brief description of the program we are considering, Mr. Lane said we would be eligible for a POST Plan 4 certification. This level provides for POST reimbursement for travel and per diem expenses. These would only benefit out of town students. Mr. Lane
encouraged BPD to open any in-house CIT course to neighboring police agencies. Additionally, Mr. Lane stated if we charged students less than $100.00 BPD would not have to submit a budget to POST. If we paid outside instructors (i.e. local mental health professional subject matter experts) an hourly rate (as opposed to a flat rate) we may be eligible for Plan 3 reimbursement, which includes travel expenses for students. Due to our states’ current budget situation, Mr. Lane said there was no guarantee the Plan 3 application would be accepted.

The average POST reimbursement rate for instructors is $35.00-40.00/hr. A doctoral level subject matter expert with twenty years of experience may be reimbursed up to $95.00/hr. per Mr. Lane.

The following Bay Area agencies offer POST certified CIT training courses:

1. Marin County Sheriffs Department.
   3501 Civic Center Dr. Rm. #145, San Rafael, CA 94903. (415) 499-7836.

2. San Francisco Police Department. (40-hr, $250.00/student)
   350 Amber Dr. San Francisco, CA 94131. (415) 401-4600.

3. Santa Clara County Sheriffs Department. (40-hr.)
   55 W. Younger Ave. San Jose, CA 95110. (408) 808-4628.

4. Sonoma County Sheriffs Office. (32-hr).
   2796 Ventura Ave. Santa Rosa, CA 95403. (707) 565-8882

   5. Contra Costa County Law Enforcement Training Center (32 hr, $250.00/student). (925) 427-8230.

San Rafael Police Department

On June 15th, 2010 I spoke with Ofc. Joel Faye, a Clinical Psychologist and San Rafael police officer. Ofc. Faye manages the San Rafael P.D. CIT program. He said approximately 20% of all Marin County officers have been CIT trained. He recommended that BPD make the CIT Coordinator a full-time position.
Oakland Police Department (OPD)

OPD has been considering developing a CIT program for well over a year. On June 14th, 2010 I spoke with OPD Ofc. Doria Neff about their CIT efforts. Ofc. Neff has been working on gaining full administrative support for their program, and she expressed an interest in working collaboratively with BPD for training. Given OPD’s current budget challenges it is unclear at this time if OPD will be able to move forward with CIT. I will be in further contact with Ofc. Neff regarding OPD’s CIT program.

Legal Issues

California Penal Code (PC) 13515.25 reflects the changing attitude statewide on police interactions with mental health consumers. This PC section specifically references San Francisco and San Jose’s CIT programs. It directs the POST Commission to take recommendations from them regarding the question of whether or not current POST standards provide sufficiently high standard for officers in this area. PC 13515.25 in its entirety is included in Appendix K.

Federal HIPPA regulations do not preclude community partners (e.g., Berkeley Mobile Crisis) from disclosing patient information. “The Privacy Rule only applies to ‘covered entities’ which are health plans...” However, California laws are more strict. California police officers are not privy to patient medical information, including any diagnosis they may have or even if they are receiving treatment (Welfare and Institutions Code 5328/California Civil Code 56-56.16). One of the benefits of the co-responder model proposed here is that Berkeley Mobile Crisis has access to patient records, which officers do not. This improves the delivery of crisis intervention services in the field.

Sergeants should be encouraged to receive CIT training. At the CIT International Conference one speaker suggested, without the training, departments may expose themselves to liability because supervisors are expected to have as much or more training as those they supervise.

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Organizational Resistance to CIT

As a major community-based, police-driven initiative, CIT involves some degree of organizational change. Change is predictably met with resistance, frequently taking the form of skepticism. BPD officers as a whole are more sophisticated than other police officers in handling calls involving mentally ill subjects. The sheer number of calls we respond to involving the mentally ill has elevated our baseline skills. The consensus among BPD officers is that we already do a good job at managing those in psychiatric crisis and any additional training is unnecessary. This opinion usually changes quickly after officers attend CIT training. In Omaha, Nebraska, for example, a post-training survey showed that 70% of the officers felt they did not have sufficient knowledge of mental illness before the training.

A brief roll-call training on CIT would be helpful in gaining buy-in from patrol officers, many of which would make outstanding CIT officers. Ideally, this training would be given by an experienced CIT officer from another agency, along with the CIT Coordinator. Additionally, an “all police” e-mail which includes informational CIT links may be effective at countering the expected resistance.

Unique Features

I specifically asked police departments, both nationally and locally, what unique features their CIT programs offered. Considering these responses, here are some best practices as they may be applied to BPD.

1. Target specific geographic areas (Telegraph Ave., Shattuck Ave.).
2. Add a cultural competence component to the training (Monterey County).
3. Create a CIT web site and/or newsletter (Reno Police Department).
4. Careful, ongoing data collection for program evaluation (Chicago Police Department).
5. Invite local media to graduation ceremonies.
7. Two CIT officer meetings per year to “discuss different experiences and scenarios they have had, and participate in advanced training. This allows officers a chance to reinforce and sharpen their skills, address new problems, and build cohesiveness.” (St. Louis, Missouri).
8. Community forum meetings and question and answer sessions (San Antonio, Texas).
9. Use “Mindstorm,” a virtual hallucination machine made by Janssen. The machine may be used free of charge by law enforcement.
10. Add a 4-hour citizen CIT class (clergy, BFD, mental health providers etc). (Evansville, Indiana).

**Keys to Success**

It is imperative that BPD establish and/or create solid community partnerships for the CIT project to be successful. These partnerships must include a sense of community ownership and accountability. The CIT program should not be “person dependent” but rather “service dependent.” While individual leadership and strong voices will get the program started, ultimately it is the service to the community that must sustain the program.

Additionally, we want BPD officers to be proud of their participation in the program. Nationally, most CIT officers wear “CIT” pins on their uniform. “We have found that this simple pin can have an enormous positive impact on the call.” (Chief Randy Cox, Somerset Borough, Pennsylvania). Frequently, police chief’s attend graduation ceremonies and provide short speeches on the importance of the program.

**Materials & Expenses**

What follows is a description of the materials/expenses needed to create a BPD CIT program.

**CIT Training Expenses**

1. Facility Fee (if applicable).
2. Instructor fees. CIT is generally implemented through volunteer trainers, however certain professionals work for a fee. Estimate: $600.00.
3. Professional actor/role player fees. $50.00/hour per actor. $4,500/week total.
4. Facilitators. Facilitators are CIT trained officers who coach students during scenarios. There should be one facilitator for each student during a role play. A train the trainer model may be employed thereby eliminating the need for outside facilitators. Estimated cost: $700.00.
5. Printing. Notebooks run approximately $5.00 per book (total of $150.00 for 30 students). Add $100.00 annually for ongoing revisions.

6. Office supplies/CIT Kit. This box contains the basics needed for organizing the course: tape, stapler, calculator, pens, police training signs, sign-in sheets. Estimate: $50.00.

7. Food. Bagels/refreshments provided in the morning, lunch on your own. Estimated daily cost: $60.00.

8. Administrative costs. CIT Coordinator time and overtime. The CIT Coordinator can expect to work approximately 65 hours during CIT training week. If the CIT program is overseen by a regional director (which is frequently the case) additional costs would be incurred.

One estimate (from Colorado) is that the total cost of one CIT course is $5,919.\textsuperscript{10} That estimate is from 2007.

**CIT Vehicle**

One of the keys to a successful CIT program is the ability to divert mental health consumers away from jail and into the community mental health system. This requires the ability to physically transport consumers to various treatment facilities (e.g., Sausal Creek Outpatient Stabilization Program in San Leandro). To protect the consumer’s identity, they should not be transported in a police vehicle unless it has tinted rear windows (Rochester, New York). These transports would be unique to BPD insofar as the individual transported is not under arrest. I recommend designating one patrol vehicle as the department’s “CIT” vehicle. The Corp. Yard can tint the rear windows.

Current BPD policy (G.O. I-16) precludes officers from transporting mental health consumers to treatment facilities. This policy would need to be revised. American Medical Response (AMR) only transports to psychiatric emergency rooms.

**X-26 Air Taser**

The taser has been used many times now by our CIT officers with fantastic results. No less-lethal device is fool-proof but this is as close as I have been able to find. It definitely has saved officers grief as well as suspects death

\textsuperscript{10} This does not include salary expenses.
in our community. I highly recommend it. (Michael Woody, retired Director of Training for the Akron, Ohio Police Department).

Some argue that many mentally ill subjects have died during encounters with police because of the “21 foot” rule. This standard, taught to all police academy recruits, came out of an exercise by a police trainer. He found an average person with an edged weapon could stab an officer before the officer could access his or her firearm, aim and shoot. Therefore, any armed subject inside the 21 foot officer safety area who presents a threat is exposed to justified lethal force.

Paranoid mentally ill subjects often carry edged weapons for protection from perceived (psychotically based) threats. Unlike those thinking rationally, a mentally ill person in crisis is less likely to comply with an officer’s order to drop the weapon. The result is a mental health consumer in crisis who has left the officer with no alternative to deadly force.

CIT officers, by definition, respond to a disproportionately high number of calls involving mental health consumers in crisis. More so than non-CIT officers, they interact with people at their maddest, baddest and saddest. These contacts are inherently dangerous.

CIT is about options, both in larger systems and at the micro level. CIT officers undergo intense, week-long training after having made a commitment to helping those in crisis. It is reasonable to assume they are mature enough to properly use less lethal force options, such as tasers.

The X-26 Air Taser is yellow so that it is easily recognizable and would never be confused with a firearm. Two probes that are tethered to the Taser can penetrate up to 2” of clothing and reach the subject. It delivers 26 watts of electricity that immobilizes the individual immediately. This gives the officers enough time to approach and safely place the subject in handcuffs. Tasers are an important piece of equipment for CIT officers. Approximately 95% of the departments I surveyed allowed CIT officers to carry tasers.

**CIT Officer Selection**

As we start our program, there are two ways we could go about selecting CIT officers. The first option is to educate patrol officers about CIT (through role call trainings), and explain the benefits of CIT. Personnel and Training (P&T) then would open up a new special assignment (“CIT
Applicants for CIT would be encouraged to have their supervisor write them a letter of recommendation for the program. Interviews would be conducted with representatives from P&T, Berkeley Mobile Crisis, the CIT Coordinator and a representative from NAMI. This approach assumes we are able to initially attract a significant amount of interest in the program. If our education efforts fail to generate interest within the department, we will be left in the undesirable position of then going back and hand picking the first group of CIT officers.

A second approach (which I recommend) to CIT Officer selection would be to hand select those officers and sergeants in the department who are natural CIT officers. We have many such officers and sergeants within the department, so this would be a safer approach.

Many departments report good results from having sergeants and even command staff take CIT training. Some police agencies in Colorado provide CIT training to SWAT commanders to instill a topdown approach.

In Appleton, Wisconsin “All applicants must submit a letter of interest to the Executive Director at NAMI...in order to be considered for the training.”

Officers applying for School Resource Officer should be asked about their willingness to be CIT trained.

At least one agency who responded to my survey indicated they have mandated the training for officers who have multiple sustained use of force complaints. I do not recommend requiring officers to attend CIT training. Such a practice is contrary to the spirit of CIT as a team of self-selecting, motivated and competent officers. Furthermore, requiring officers to be CIT trained may create a belief within BPD that it is a “punishment,” which would undermine the program.

**CIT Training Instructor Selection**

CIT training classes should be taught by a mix of CIT trained officers, subject matter experts from the community and advocacy groups. The mix of these groups varies by department, with some agencies preferring to use more law enforcement instructors, some less. “Facilitators” are CIT trained officers.

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11 Sgt. John Wallschlaeger, personal e-mail communication.
officers who then provide coaching to other officers in the class during scenario training.

Non-police instructors should be carefully screened to ensure they have a baseline understanding of police culture and adult learning styles. For scenario training it is common for police departments to employ professional actors. In their post-training evaluations, officers tend to report scenario training as the most helpful part of the class.

**CIT Officer Deployment**

An updated list of CIT trained officers should be maintained in the Communications Center. Trained CIT officers should be designated by the addition of “C” to their call sign (e.g., “4 Adam 4C”). To determine if there are any CIT officers in service, dispatch should ask, “Are there any ‘C’ units available?” Our chief’s designation is also “C” but is usually broadcast as “C-1.” I do not foresee any problems with confusing the chief’s designation with our CIT officers. Another option would be to lengthen the call sign to “Charles” (e.g., “4 Adam 4 Charles”).

CIT officers may be dispatched to a call in the following manners,
* Direct dispatch (Com. Center).
* Upon request of another officer.
* Upon request of Berkeley Mobile Crisis.
* Upon request of a scene supervisor.

If there are no CIT officers on duty the scene supervisor may contact the CIT Coordinator 24/7 for consultation (Rochester, New York). If possible, consultation with a clinician will also be available 24/7 (Colorado).

According to our CIT General Order (to be drafted) CIT officers would automatically take the lead when dispatched to calls involving mentally ill individuals. For calls in which both CIT officers and Berkeley Mobile Crisis are on scene, the mobile crisis clinician(s) would take the lead. If a consumer refuses BMC services the CIT officer would take the lead\(^ {12}\). In either case, BMC and CIT officers will work collaboratively.

\(^{12}\) Per BPD General Orders mental health consumers are allowed to decline BMC services.
All patrol officers would be provided laminated cards with CIT resources.

**Data Collection/Program Evaluation**

In my national and local survey I found that data collection/program evaluation is consistently the weakest part of CIT programs. Many police agencies only collect anecdotal information regarding the effectiveness of their programs. This lack greatly reduces a program’s ability to adjust to the changing needs of the community and the delivery of CIT. It also weakens their ability to secure public funding.

BPD is fortunate to have a world-class university (UCB) within walking distance from the police station. On June 7th, 2010 I spoke with Assistant Research Economist Brent Fulton from the Nicholas C. Petris Center on Health Care Markets & Consumer Welfare. Mr. Fulton’s organization, associated with UCB, has previously completed a statewide evaluation of Prop. 63 (The Mental Health Services Act). Mr. Fulton expressed an interest in partnering with BPD to perform data collection and program evaluation for our CIT program. Comprehensive, ongoing program evaluation is what separates model CIT initiatives from others.

In my telephone conversation with Mr. Fulton he stated that it would be useful to obtain data before the implementation of our CIT program. Useful pre-CIT data points may include (but are not limited to):

1. Attitudes of mental health consumers about BPD officers. One of the claims of CIT is that consumers and family members have increased confidence in the ability of officers abilities to handle crises after CIT training and are more likely to call them.
2. The number of mentally ill individuals arrested. A pre-post measure of this would get at one of the primary goals of CIT: the diversion of mentally ill individuals away from the criminal justice system.
3. Pre-post implementation data regarding use of force involving mentally ill persons.
4. Utilization of community health services before and after implementation of CIT. The goal would not only be to reduce incarceration rates, but to have those consumers use existing city services.
5. Measure officer attitudes about CIT before and after the training. We can use a helpful and free online service for this: surveymonkey.com (Halifax Nova Scotia).

Ongoing data points for evaluation include the following,

1. The number of mental health consumers arrested.
2. The number of “5150” calls for services.
3. The number of use of force incidents.
4. The number of officer injuries.

For program evaluation, it will be important for patrol officers to change the disposition of calls, which is currently not happening. Many calls dispatched as a “415” involve mentally ill persons in crisis. Officers will need to change the disposition of the call for accurate tracking. Currently patrol officers “dispo” calls simply by “paper” or “no paper,” along with AOD codes. Sgt. Montgomery estimates that officers should be able to change the disposition of calls using the New World System by October 2010.

For the purposes of tracking and CIT program evaluation, I recommend adding “Mary” for all calls in which mental illness is the primary issue. Dr. Fulton (UCB) should be consulted before implementing this change as he is an expert on data collection.

I met Dr. Fulton and a colleague at the PSB on June 16th, 2010. Dr. Fulton told me he would generate several proposals for evaluating our program and their associated cost, should BPD be interesting in partnering with the university.

Preliminarily, the following specific data points will help us evaluate the CIT program. If the call or contact involves a mental health consumer or person in crisis add the following:

1. Location.
2. Use of force: Y or N
3. Any injuries (officer, suspect, other)
4. Disposition (arrest, cite and release, no police action, 5150)
5. Was BMC used?
6. How many officers were needed?
7. How much time was spent on the call?

**CIT Coordinator**

Having a sworn officer act as CIT Coordinator is a basic feature of virtually every program. For mid-sized police departments like BPD the coordinator (usually an officer or sergeant) adds the administrative duties to his/her other duties.

However, it takes between 12-18 months to get a CIT program up and running. “When you start a program you will need a full-time person.” (Paul Gillies, former CIT Coordinator Minneapolis, Minnesota). From what I’ve learned about the design, implementation and evaluation of a successful CIT program, a full-time coordinator will be needed at least for this 12-18 month period and possibly longer.

If BPD uses other agencies for CIT training (i.e. Contra Costa County, San Francisco) the coordinator duties are minimized. Still, creating and maintaining relationships in the community will require a significant time commitment.

**CIT Coordinator Job Responsibilities:**

1. Oversee daily operations.
2. Oversee CIT training (scheduling, instructor selection, facilities).
3. POST coordination (certification compliance for in-house training).
4. Establish collaborative relationships with community providers.
5. Draft policy on CIT program.
6. Promote CIT program within BPD and the community.
7. Participate in CIT officer selection.
8. Engage in long term initiatives aimed at streamlining legal system (e.g., working with courts to divert consumers away from jail).

**CIT Coordinator Selection**

The CIT Coordinator should be an officer or sergeant in good standing. Additional qualifications to consider include,

1. At least three years of experience.
2. CIT trained.
3. Demonstrated skills in verbal de-escalation.
4. Excellent interpersonal communication skills.
5. Prior experience (i.e., mentally ill family member, work experience) with mental illness.
6. Educational background in psychology or related field.
7. Strong interest in community collaboration and CIT philosophy.
8. Strong organizational and leadership skills.

The CIT Coordinator may be appointed by Chief Meehan or through the usual Special Assignment procedure. In the case of the latter, a representative of NAMI, Berkeley Mobile Crisis and P&T should be included in the interview.

**Berkeley Mobile Crisis (BMC)**

BPD has a long history of working collaboratively with BMC. The BPD program will compliment and strengthen the crisis management services already provided by BMC. Halifax Nova Scotia found that consumers are more likely to get follow-up care if contacted by a mobile crisis team than if contacted by police alone. They encourage consumers to call them (mobile crisis) instead of 911. They don’t do case management but they have a more comprehensive approach than that of the officers.

Pertaining to the BPD CIT program, BMC clinicians may provide the following roles,

* Direct services.
* Consultants (assist officers with decisions about proper placement).
* CIT trainers.
* Curriculum development.
* Consulting with CIT Coordinator (e.g., CIT training curricula).

BMC’s hours of operation are from 1100-2300 hrs 7 days a week.

The following BPD CIT-BMC collaborative models should be further explored,

* Crisis Intervention Response Team (CIRT). A BMC clinician paired with a BPD CIT officer. BMC would do additional follow-up & outreach.
Forensic Assertive Case Management (FACT). Intensive treatment, rehabilitation and support services in a coordinated team approach. FACT teams have proven effective in reducing jail days, arrests and hospitalization. One FACT team in Rochester, N.Y., saved $39,518 per year due to reduced hospitalization and incarceration.
PART THREE: RECOMMENDATIONS

Summary

Option A: 25% of patrol officers, CSO’s and dispatchers CIT trained. BPD becomes regional CIT training facility. Start up cost = $102,986. Program maintenance cost= $97,511/annually.

Option B: 100% of BPD officers, dispatchers and CSO’s receive in-house CIT training. Start up cost = $671,581. Program maintenance cost = $120,936/annually.

Option C: 25% of patrol officers, CSO’s and dispatchers receive outside CIT training. Start up cost = $108,000. Program maintenance cost = $2,000.

Option D: 20% of patrol officers receive outside CIT training. Start up cost = $59,360. Program maintenance cost = $896.

OPTION A

Synopsis
1. 25% of all patrol officers (21) receive 40-hr CIT training.
2. 25% of CSO’s (3) and dispatchers (4) receive 24-hr CIT training.
3. Three patrol sergeants receive 40-hr CIT training.
4. One lieutenant staff receive 40-hr CIT training.
5. Annual recertification for all CIT trained staff.
6. BPD provides in-house POST certified CIT training.
7. BPD becomes a regional training center for Alameda County.

Narrative
Initially, 5 patrol officers would be selected for the CIT program by P&T and command staff. The original group of CIT officers would be trained at an outside agency. They would become instructors and facilitators for future BPD in-house training. After the initial group of officers is trained the BPD CIT program would be operational, though not fully operational.
In this option, the administration would select a full-time CIT Coordinator. The CIT Coordinator would be among those initially trained. He/she would immediately begin creating necessary community partnerships.

The CIT Coordinator would also,

(a) Work toward establishing BPD as a POST approved CIT training facility. 
(b) Develop a regional CIT initiative, including the establishment of a regional CIT Coordinator (usually a civilian administrator).
(c) Coordinate ongoing local “gaps analysis” and work toward a seamless full continuum of care.

In Option A, BPD would eventually share the training load with other jurisdictions in Alameda County through a Joint Power Agreement. Ventura County has used this method effectively. In this formulation, each police department contributes to the countywide initiative, based on their size. With this buy-in, the county CIT program would tap resources throughout the region.

Benefits, Key Features and Challenges of Option A

The benefits of this option are that it meets the CIT industry standard for the number of officers trained and length of training. Becoming a CIT training site would allow us the freedom to tailor the training to our needs. Over time, we could adjust the program to fit perfectly with our program goals. Option A is ideal if our goal is to become a national model of CIT. The primary challenge of this option is that it requires significant buy-in from community partners and a grass roots effort to improve our overall system of care. It also requires a significant financial investment.

CIT Program operational: **6 months.**
Full program operational: **18-24 months.**
**Initial cost:** $102,986
**Annual cost:** $97,511

Outside training for five officers is estimated to be $21,350.
After the original five officers are trained, we should be able to get all other employees trained in one class. I estimate the total cost for our in-house training to be, $81,636. Additionally, annual recertification for the CIT Team is approximately $15,875. This assumes dispatchers receive a 4-hr recertification class and everyone else receives an 8-hr class.

By charging outside agencies $250.00 per student our annual cost would be reduced. This estimate is based on having 2 BPD sponsored CIT classes annually, and allowing for 5 seats in each class for our officers.

**OPTION B**

**Synopsis**
1. 100% of all patrol officers receive 40-hr CIT training.
2. 100% of CSO’s and dispatchers receive 24-hr CIT training.
3. Seven patrol sergeants receive 40-hr CIT training.
4. One lieutenant receive 40-CIT training.
5. Annual recertification for all CIT trained staff.

**Narrative**
Option B is identical to Option A accept that all officers, CSO’s and dispatchers would be CIT trained. After creating an in-house CIT training program it would take approximately 6 full classes to train 182 employees.

The administration would select a full-time CIT Coordinator. The CIT Coordinator would be among those initially trained. He/she would immediately begin creating necessary community partnerships.

**Benefits, Key Features and Challenges of Option B**

Only 4% of the police agencies I surveyed nationally train all officers in CIT. Several of those were very small departments with 10 or fewer officers. However, some chiefs believe CIT training is so important all officers should get it. Option B meets that goal. It has the same benefits and features of Option A. A drawback of Option B is that we would not be, strictly speaking, in line with the Memphis CIT model. Other challenges presented by this option are cost, and employee resistance/resentment. It will take several years before CIT becomes part of BPD culture. Until then, it is likely that many officers will feel set upon. Staff morale may be lower. Furthermore, it will take an estimated 4-5 years to have all officers, CSO’s and dispatchers CIT trained. Finally, we would struggle to recertify officers in a timely manner with this option.

CIT Program operational: **6 months.**
Full program operational: **4-5 years.**

**Cost**
The initial cost of Option B would the same as in Option A, approximately $21,350. I project the cost of in-house training for the remaining employees would be approximately $650,231. The projected annual cost to recertify our employees annually is approximately $120,936.

**OPTION C**

**Synopsis**
1. 25% of all patrol officers (21) receive outside CIT training.
2. 25% of CSO’s (3) and dispatchers (4) receive outside 24-hr CIT training.
3. Three patrol sergeants receive outside CIT training.
4. Annual recertification for all CIT trained staff.

**Narrative**
Option C entails sending BPD officers to outside CIT training sites. Like Options A & B, after the first group of officers receive CIT training, the program would become operational. BPD would send additional officers for outside CIT training as staffing levels permit, until the 25% goal is met.

The selection process for initial CIT Officers and the coordinator would be the same as in Options A & B. The goal would be to have trained officers generate interest in the BPD CIT program and future CIT officers would be selected through the standard special assignment process. The CIT Coordinator duties would be added to the officer or sergeants’ normal duties. Discretionary overtime would be permitted for the CIT Coordinator for meetings and other program management activities.

**Benefits, Key Features and Challenges of Option C**

A benefit of Option C is that it would meet the CIT industry standard for the number of officers trained and the length of training received. We could still make changes to the program internally. As in the other options, we could use U.C. Berkeley for program evaluation which would elevate the overall quality of the program. A challenge to Option C is that, by sending our officers to outside agencies for training, we relinquish control of the curricula. We also lose control over the type (law enforcement v.s. civilian) and quality of instructors. This may not be a problem as CIT training curricula are fairly standard. The Bay Area programs I’ve surveyed all appear to have good quality instructors and curricula. Another drawback to Option C is that it would take an estimated 2-3 years before we reached the goal of 25% of officers trained. This time could be shortened if it were a departmental priority.

CIT Program operational: **6 months.**
Full program operational: **24-36 months.**

**Cost**
The initial projected cost of this option is $108,749. It will cost approximately $2,000 annually for recertification.
OPTION D

Synopsis
1. Train 20% (16) of all patrol officers at outside agencies.
2. Train 2 dispatchers at outside agencies.
3. Annual recertification for CIT trained staff.

Narrative
This option meets the CIT industry standard for number of officers trained and length of training. It also provides for annual recertification training. The goal in this option would to have the entire CIT trained within three years. The CIT Coordinator duties would be added to the officer or sergeants’ normal duties. Discretionary overtime would be permitted for the CIT Coordinator for meetings and other program management activities.

Benefits, Key Features and Challenges of Option D

This is the least expensive option for having a full CIT program. The 36 month time allows maximal breathing room for the department in general, and Personnel & Training in particular. We could still use UCB for program evaluation/data collection (though the cost of that is not included in this projection). A limitation of this option is that no supervisors would be CIT trained. We would have no control over training curricula or instructors.

CIT Program operational: 6 months.
Full program operational: 36 months.

Cost
The initial projected cost to train all CIT officers in this option is $59,360. The ongoing annual recertification cost would be approximately $896.

Important Information about these Projections

Assumptions
* The above budget projections are based on a standard 40-hr CIT course.

* The average CIT course through outside agencies is $250/student. Dispatcher training, where available, is less expensive. However, I included it in the budget at full cost because at this time I am unsure how much these classes cost or all the agencies that offer it.
Variable factors
* Hotel accommodations. Budget projections for options B-D do not include the cost of hotel accommodations. This is based on the assumption that we can use Contra Costa County, San Rafael and/or San Francisco.
* 32-hr in-house CIT training (Contra Costa County and San Rafael are the only Bay Area agencies I’m aware of that use a 32-hr format). Contra Costa County only offers 1 CIT course annually, usually in March or April. I do not believe the cost savings for 32-hr classes would be significant.

Not included
* Any POST (i.e., for a BPD training facility) fees are not included in these estimations.
* Except for Option B, CIT training for CSO and dispatch supervisors are not included here. These options assume CIT trained dispatchers and CSO’s will be called upon as needed for situations requiring a CIT trained employee. Regarding the Communication Center I recommend CIT trained dispatchers work as call takers whenever possible.

Additional options
* **Collaboration with U.C. Berkeley for our program evaluation.** The projected cost of this would be $50,000-150,000 annually.
* Mandate CIT training for all Hostage Negotiators and School Resource Officers.
* Another option is to have all patrol officers attend an annual in-house 8-hr Crisis Intervention Training course. If this was the extent of our training ours would not, strictly speaking, be a CIT program.

Funding
Santa Clara County uses Prop. 63 (the Mental Health Services Act) money to fund their program. My understanding at the time of this writing is that the Berkeley Department of Health Services currently uses this money, and that it is not available for our CIT program.

The Bureau of Justice Assistance Grant (JAG) supports local law enforcement initiatives.
Another funding option is the federal Justice & Mental Health Collaboration Grant. This money comes from the Mentally Ill Offender Treatment and Crime Reduction Act passed in 2004.

**Plan Comparisons**

- **Option A**
- **Option B**
- **Option C**
- **Option D**

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APPENDIX A: Local Agencies Contacted.

BART 510 465-2278
PIEDMONT (510) 420-3000
OAKLAND 777-3552
EL CERRITO 510-215-4400
RICHMOND 510-233-1214
ALAMEDA COUNTY SO (510) 272-6878
SAN PABLO PD (510) 215-3130
MARTINEZ PD 925-372-3440
CONCORD PD (925) 671-3200
PLEASANT HILL (925) 288-4600
WALNUT CREEK (925) 943-5844
CONTRA COSTA COUNTY SO (925) 335-1500
ALAMEDA P.D. (510) 337-8340
SAN LEANDRO (510) 577-3217
HAYWARD
(510) 583-4600
UNION CITY 510) 471-1365
FREMONT (510) 790-6800
NEWARK 510) 471-1365
PLEASANTON 925.931.5100
LIVERMORE 925-371-4900
MILPITAS (408) 586-2400
SAN JOSE 408) 277 - 4113
SUNNYVALE (408) 730-7100
SANTA CLARA COUNTY SO (408) 868-6600
SAN MATEO COUNTY SO (650) 363-4911
SAN FRANCISCO
APPENDIX B: Local police agency questionnaire.

1. How many sworn officers do you have?
2. Do you have a CIT or similar program?
3. What’s it called?
4. Do you train all your officers or have a special team?
5. What kind of training do they receive?
6. Do you employ a co-responder model?
7. Who funds the program?
8. What type of data do you collect?
9. How do you measure success?
APPENDIX C: National police agencies contacted.

The following departments have been listed in the national registry of Memphis Model Crisis Intervention Teams.

Maine
Piscataquis County Sheriff’s Department.
Bangor Police Department.
Kennebec County Sheriff’s Department.
Winthrop Police Department.
Portland Police Department.

New Hampshire
Dover Police Department.
Rochester Police Department.

Connecticut
Plainfield Police Department.
Putnam Police Department.
Willimantic Police Department.
Groten Police Department.
New London Police Department.
Norwich Police Department.
Waterford Police Department.
Canton Police Department.
Farmington Police Department.
Hartford Police Department.
Rock Hill Police Department.
Simsbury Police Department.
Wethersfield Police Department.
Windsor Police Department.
Branford Police Department.

Maryland
Baltimore County Mobile Crisis Response Team
Baltimore Sheriff’s Department.
Montgomery County Police Department.

Ohio
East Lake Police Department.
Gates Mills Police Department.
Lake County Sheriff’s Department.
Mentor Police Department.
Painesville Police Department.
Willoughby Police Department.
Geauga County Sheriff’s Department.
Middlefield Police Department.
Akron Police Department.
Scioto County Sheriff’s Department.
Fremont Police Department.
Athens City Police Department.

Virginia
Leesburg Police Department.
Prince William County Police Department.
Warren County Sheriff’s Department.
Albemarle County Police Department.
Independence Police Department.
Suffolk Police Department.
Virginia State Police.

North Carolina
Greenville Police Department.
Moore County Sheriff’s Department.
Forsyth County Sheriff’s Department.
Durham County CIT Program.

Indiana
Fort Wayne Police Department.

Georgia
Kingsland Police Department.
Calhoun County Sheriff’s Department.
Warner Robins Police Department.
Columbus Police Department.
Statesboro Police Department.
Savannah Chatham Metropolitan Police Department.
Union County Sheriff’s Department.
Cherokee County Sheriff’s Office.
Cobb County Police Department.

Florida
Miami-Dade Sheriff’s Department.
Ft. Lauderdale Police Department.
Collier County Sheriff’s Office.
Fort Myers Police Department.
West Palm Beach Police Department.
Martin County Sheriff’s Office.
Ft. Pierce Police Department.
Daytona Beach Police Department.
Hillsborough County Sheriff’s Office.
Tallahassee Police Department.
Santa Rosa Sheriff’s Office.

Mississippi
Southhaven Police Department.

Louisiana
Lake Charles Police Department.
Union Parish Sheriff’s Office.
Concordia Parish Sheriff’s Department.
Jackson Parish Sheriff’s Office.
Alexandria Police Department.

Texas
Dallas Police Department.
San Antonio Police Department.
Austin Police Department.
Houston Police Department.
Tyler Texas Police Department.

Oklahoma
Oklahoma City Police Department.

Missouri
St. Louis County Police Department.
Cottleville Police Department.
Lees Summit Police Department.
Jackson County Sheriff’s Office.

Illinois
Chicago Police Department.
Oak Park Police Department.

Wisconsin
Milwaukee Police Department.
Oak Creek Police Department.
Appleton Police Department.

Minnesota
Minneapolis Police Department.
Rochester Police Department.

Iowa
Waterloo Police Department.
Nebraska
Douglas County Sheriff’s Office.

Kansas
Overland Park Police Department.
Sedgwick County CIT Team.
Buhler Police Department.
Reno County Sheriff’s Office.

New Mexico
Las Cruces CIT Program.

Colorado
Durango Police Department.
La Plata County Sheriff CIT.
Pueblo Police Department.
Pueblo County Sheriff CIT.
Colorado Springs Police Department.
Manitou Springs Police Department.
El Paso Sheriff CIT.
Fountain Police Department.
Brighton Police Department.
Aurora Police Department.
Boulder Police Department.
Boulder County Sheriff CIT.
Loveland Police Department.

Wyoming
Park County Sheriff’s Office.

Montana
Gallatin County Sheriff’s Office.
Helena Police Department.
Ravalli County Sheriff’s Office.

Idaho
Boise Police Department.

Utah
Brigham City Police Department.
Tooele Police Department.
Provo Police Department.
Logan Police Department.
Wasatch County Sheriff’s Office.
Cedar City Police Department.
Arizona
Mesa Police Department.
Phoenix Police Department.
Tucson Police Department.
Pima County Sheriff's Department.

Washington
Vancouver Police Department.
Olympia Police Department.
Seattle Police Department.
Wenatchee Police Department.

Oregon
Portland Police Department.
Marion County Sheriff's Office.

Nevada
Reno Police Department.
Las Vegas Police Department.

California
San Diego County PERT.
Riverside Police Department.
San Bernadino County Sheriff's Office.
Ventura County CIT Program.
Monterey County Crisis Intervention Training.
Modesto Police Department.
Stanislaus County Sheriff's Office.
Sgt. Jones (example)

Hello. My name is Ofc. Jeff Shannon with the city of Berkeley, CA police department. I am developing a CIT program for our department based on the best practices of existing programs.  

I am hoping you can take a few minutes out of your day to help me. Below is a list of questions regarding your CIT program. It would be very useful to me if you could describe your program by answering the questions.

Thank you in advance for any assistance you can provide.

Best regards,

Jeff Shannon #120

Berkeley Police Department
2100 Martin Luther King Jr. Way
Berkeley, CA 94702
(510) 390-28964

Name of your department:

How many sworn officers do you have?:

What do you call your CIT program?

How many have been CIT trained?:

How are CIT officers selected?:

Briefly describe the training (i.e., how many hours is the course):

Do you use a “co-responder” model (i.e., work with civilian mental health professionals)? If so, please explain how civilians work with CIT officers:

Do CIT officers get a pay differential (i.e., 5% when working as a CIT officer)?:
In what ways do you acknowledge your CIT officers (i.e., “CIT” pins etc) if any?:

Do you allow CIT officers to carry tasers?:
Do you allow other patrol officers to use tasers?:

How do you measure the success of your program (i.e., do you collect certain data related to the program?):

What, if any unique features does your CIT program have?:

In your opinion what are the essential ingredients of a successful CIT program?:
### APPENDIX E: Budget spreadsheets.

#### Option A (initial cost)

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APPENDIX F: Community partners.

The following is a list of community stakeholders for the Berkeley CIT program. As the community system of mental health care changes, so will our partnerships. Some will be added, some removed. It’s important to note that this list is not static.

2. Berkeley Police Department.
3. Local mental health consumers.
4. Homeless and housing advocates.
5. Alta Bates, Herrick and John George Hospitals.
6. Options Recovery.
8. Family advocacy groups (NAMI East Bay)
10. Alameda county Patients Rights.
11. Alameda county Probation Department.
12. California Department of Corrections (parole).
13. UC Berkeley.
15. Northern County.
17. Rubicon’s.
18. Vocational Rehabilitation.
20. East Bay Community Law Center.
24. Highland Hospital Drug Treatment.
27. New Bridge Foundation.
28. Salvation Army Adult Rehabilitation Center.
29. STEPS.
30. Thunder Road.
31. Woodroe Place.
32. Pacific Center Queer Youth Program.
33. Young Adult Project (city of Berkeley).
34. Berkeley Mental Health.
35. Berkeley Mobile Crisis.
37. Telegraph Avenue Business Improvement District.
39. Berkeley Drop in Center (BDIC).
40. Multi-agency Service Center (MASC).
41. Center for Independent Living (CIL).
42. Peer Counseling Collective (Berkeley Free Clinic).
43. Pacific Center for Human Growth.
44. Battered Women's Shelter.
45. Therapeutic Nursery School.
46. A Safe Place.
47. Family Violence Law Center.
48. Safe Alternative Against Violence.
49. Coalition for Alternatives in Mental Health.
50. Homeless Outreach Team (BMH).
51. Multi-Service Center (MSC).
52. Women’s Resource Day Services.
53. Head Start.
54. Berkeley Youth Alternatives Counseling Center.
55. Planned Parenthood Golden Gate.
56. All Souls Episcopal Church.
57. Dorothy Day House & Quarter Meal at Trinity Church.
58. St. Mark's Episcopal.
59. St. Paul AME Church.
60. St. Mary Magdalene.
61. Shattuck Avenue United Methodist Church.
62. South Berkeley Community Church.
63. Transitional House.
64. General Assistance.
65. Mental Health Advocates.
67. Berkeley Free Clinic.
68. HIV Access - Berkeley Primary Access.
69. Advice Nurse (city of Berkeley).
70. Berkeley Health Center for Women and Men.
71. Berkeley Primary Care.
72. The Lifelong Clinic (Alta Bates).
73. Suitcase Clinic (UCB).
74. West Berkeley Family Practice.
75. Harrison House.
76. ECHO Housing Homeless Prevention Program.
77. Affordable Housing Associates.
78. Alameda County In-home Support Services.
79. Shelter Plus Care (city of Berkeley).
80. Global Ministries.
82. McGee Avenue Baptist Church.
83. Victim Assistance Program - State of California.
84. Suicide Prevention/Crisis Hotline.
85. Berkeley Youth, Engagement, Advocacy and Housing (YEAH).
86. American Medical Response (AMR)
88. Citizen groups.
89. Local mental health program administrators.
90. Catholic Charities of the East Bay.
91. Center for Aids Services.
92. Family, Youth & Children (BMH).
93. City of Berkeley Department of Health and Human Services.
95. Alameda County Behavioral Health Court
APPENDIX G: Sample General Order

WEST PALM BEACH POLICE DEPARTMENT

III-6 CRISIS INTERVENTION TEAM

EFFECTIVE: 01/01/2005 CALEA Standards: 41.2.8 CFA Standards: N/A

I. PURPOSE: This policy is to establish guidelines for members assigned to the Crisis Intervention Team by outlining specific training and deployment procedures.

II. DEFINITIONS:
A. Crisis Intervention Team (C.I.T.) - A group of officers trained to handle situations involving the mentally ill in crisis.
B. A Crisis - could consist of a person having delusions, refusing to take prescribed medications, erratic behavior, causing a disturbance, talking to themselves or other activity or behavior that causes alarm or concern to a reasonable person.
C. Crisis Intervention Officer - An officer trained to deal with mentally ill individuals in a disturbance/crisis event.

III. OBJECTIVES:
A. Pre-arrest diversion of the mentally ill from the criminal justice system
B. Providing law enforcement with the tools needed to handle encounters with mentally ill persons.
C. Delivery of proper care for the individual in crisis through a collaboration of mental health and criminal justice systems.

IV. MENTAL ILLNESS:
A. A range of conditions, each with its own specific characteristics, including but not limited to:
   1. Schizophrenia
   2. Bipolar disorder (manic depression)
   3. Major depression
   4. Schizoid-affective disorder
   5. Panic disorder
   6. Obsessive-compulsive personality disorder
   7. Borderline personality disorder
   8. Other mental illnesses as defined in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders as published by the American Psychiatric Association, most current edition) that can cause disturbances in thinking, feeling, and relating with others or the environment.

V. CRISIS INTERVENTION TEAM COMMANDER/COORDINATOR:
A. The Crisis Intervention Team (CIT) Commander will be designated by the Chief of Police.
B. The team shall also have a CIT Training Coordinator to assist with administrative and operational activities.

VI. TEAM MEMBER SELECTION:
A. Members of the Crisis Intervention Team will be sworn members of the Department who have volunteered to serve on the team. The selection of members for the Crisis Intervention Team will be made by a committee composed of the CIT Commander, CIT Training Coordinator and any other member of the team assigned to serve on the committee by the CIT Commander. All selections for CIT will be approved by the Chief of Police.
B. The following traits may be considered when selecting an applicant to fill a vacancy on the CIT:
   1. Communication skills
   2. Active listening skills
   3. Ability to work well under pressure
   4. Ability to maintain a positive attitude under stressful conditions
   5. Ability to absorb verbal abuse without negative responses
   6. Ability in exercising good judgment and decision-making skills

VII. TRAINING:
A. Each member will be required to attend a basic 40 hour CIT training class. With the approval of the CIT Commander, the CIT Training Coordinator shall be responsible for scheduling all training sessions.
B. The CIT Commander or designee will maintain a log of all training conducted involving team members.
   - Type of instruction
   - Instructor
   - Location
   - Date
   - Time
   - Attendees
C. A copy of these records shall be provided to the Training Section for inclusion in the member’s Training File.
D. CIT training is mandatory. If a member is unable to attend training, he/she must notify the CIT Commander or designee as soon as possible.
   1. Repeated absences from training shall result in the member’s removal from the team.

VIII. UTILIZATION OF A CRISIS INTERVENTION TEAM MEMBER:
A. When available, a Crisis Intervention Team member shall respond to all calls or incidents involving a confirmed or suspected mentally ill person in crisis.
B. The CIT Commander will provide Communications and the Shift/Unit Commanders with a list of all current CIT members. The daily schedule submitted to communications shall have the names of CIT members on duty.

1. Communications may refer to the list for dispatch or may request a CIT officer over the radio.

C. The Hostage Negotiations Team will be deployed to incidents involving the mentally ill that meet the criteria in SOP IV-26

D. Members of the Crisis Intervention Team may be dispatched as first responders prior to the arrival of the Hostage Negotiations Team.

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CRISIS INTERVENTION TEAM SOP # III-6 IX. OFFICER ON SCENE:

A. The first CIT officer on the scene shall be responsible for the entire call or incident, to include dialogue with the mentally ill person, determining appropriate action to be taken and all necessary paper work. Other officers on the scene shall provide necessary backup as needed. The CIT officer shall maintain responsibility for the call or incident unless otherwise directed by a supervisor. The supervisor then takes full responsibility of the scene and must submit a report to the CIT Commander before the end of the shift.

B. In all cases, the Crisis Intervention Team member will complete the Crisis Intervention Statistical Form and submit the form with copies of any supporting paperwork to the CIT Coordinator. This form is not to be included with any incident report or submitted to the Records Section.

C. Crisis Intervention Team members will be dispatched where the mentally ill consumer, family or a recognized agency specifically request a CIT trained officer.

X. DISPATCH PROTOCOL:

A. The call taker will ascertain as much information as possible with regards to weapons, violent tendencies, types of mental illness, co-occurring disorder (alcohol or drug abuse), name of person in crisis, names of any prescribed medications, local doctor/psychiatrist name, history of suicide attempts, and any other information as available.

B. If the initial call to Communications indicates the person involved suffers from a mental illness, an on duty CIT member will be dispatched.

C. If the call event describes the situation as threatening/tense or unstable circumstances, the nearest CIT officer shall be dispatched.

D. When no CIT officer is available (citywide), the appropriate number of officers will be sent to the call. The dispatcher is to advise the responding units that no CIT units are available. The first officer(s) on the scene of a mental disturbance where a CIT officer(s) is not available for that response will weigh the situation based on the information and circumstances as presented and/or known. If in a situation that the officer reasonably concludes that a CIT officer(s) is necessary, the scene officer(s) will request the dispatcher to clear a CIT officer. The dispatcher, in accordance with the officer=s request, will contact the closest CIT officer that is available to clear and dispatch the CIT officer to the requested scene.

E. CIT shall not be dispatched on any overdose call (intentional or accidental) that has occurred where the individual is not reported or diagnosed as having a mental illness, and the individual is not violent/combative. Unless the call takes place in the CIT Officer=s assigned area.

F. CIT shall not be dispatched if the individual is being transported to a medical facility on a voluntary basis, or the caller is requesting transportation to a mental health facility.

G. A CIT Officer may volunteer to handle a call that he/she believes it to be CIT in nature. The CIT officer may know the person to be mentally ill, knows the location to be a residence / outpatient home of the mentally ill.

H. A request for a CIT Officer outside the parameters of this section should be brought to the attention of a CIT Field Supervisor for Approval, if none available then the Field Supervisor in that District should be contacted for approval.

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CRISIS INTERVENTION TEAM SOP # III-6 XI. REFERENCE:

• SOP # IV-25 Swat Team Function • SOP # IV-26 Hostage Negotiations

Delsa R. Bush, Chief of Police

Original issue: 01/01/2005 I.D. # 1337

History: SOP # changed to III-6 on 01/01/2005 Old SOP # 21.02 Revision Dates: 02/15/2004, 01/01/2005

Job Title Task Files: Operator, Shift Commander, Training Sergeant, Patrol Supervisor, Hostage Negotiations Commander

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APPENDIX H: Sample CIT Training Curriculum.

**Day 1**
Introduction to Crisis Intervention Team
Mental Health Pre-test
Emergency Custody Order (ECO) Process
Temporary Detention Order (TDO) Process
Mental Commitment Process in Virginia
Mental States and Criminal Responsibility
Dementia
Co-occurring Disorders
Hearing Voices

**Day 2**
Individuals and Family Perspectives
Community Resources
Site Visits to Local Providers and Community Resources
Site Visit Review

**Day 3**
Overview of Mental Health Professionals
Basic Crisis Intervention Skills
Suicide Intervention Skills
Verbal De-escalation Techniques and Role-play Scenarios

**Day 4**
Psychological Effects on War Veterans
Homelessness and Poverty Issues
Mental Health Stigma
Officer Role-play Scenarios

**Day 5**
Adolescent Issues
Intellectual Disabilities
Introduction to Psychopharmacology
Officer Role-play Scenarios
Review, Summary, and Graduation
**APPENDIX I:** Sample CIT pins.
APPENDIX J: Penal Code 1315.25.

1315.25. (a) By July 1, 2006, the Commission on Peace Officer Standards and Training shall establish and keep updated a continuing education classroom training course relating to law enforcement interaction with mentally disabled persons. The training course shall be developed by the commission in consultation with appropriate community, local, and state organizations and agencies that have expertise in the area of mental illness and developmental disability, and with appropriate consumer and family advocate groups. In developing the course, the commission shall also examine existing courses certified by the commission that relate to mentally disabled persons. The commission shall make the course available to law enforcement agencies in California.

(b) The course described in subdivision (a) shall consist of classroom instruction and shall utilize interactive training methods to ensure that the training is as realistic as possible. The course shall include, at a minimum, core instruction in all of the following:

(1) The cause and nature of mental illnesses and developmental disabilities.

(2) How to identify indicators of mental disability and how to respond appropriately in a variety of common situations.

(3) Conflict resolution and de-escalation techniques for potentially dangerous situations involving mentally disabled persons.

(4) Appropriate language usage when interacting with mentally disabled persons.

(5) Alternatives to lethal force when interacting with potentially dangerous mentally disabled persons.

(6) Community and state resources available to serve mentally disabled persons and how these resources can be best utilized by law enforcement to benefit the mentally disabled community.

(7) The fact that a crime committed in whole or in part because of an actual or perceived disability of the victim is a hate crime punishable under Title 11.6 (commencing with Section 422.55) of Part 1.

(c) The commission shall submit a report to the Legislature by October 1, 2004, that shall include all of the following:

(1) A description of the process by which the course was established, including a list of the agencies and groups that were consulted.

(2) Information on the number of law enforcement agencies that utilized, and the number of officers that attended, the course or other courses certified by the commission relating to mentally disabled persons from July 1, 2001, to July 1, 2003, inclusive.

(3) Information on the number of law enforcement agencies that utilized, and the number of officers that attended, courses certified by the commission relating to mentally disabled persons from July 1, 2000, to July 1, 2001, inclusive.

(4) An analysis of the Police Crisis Intervention Training (CIT) Program used by the San Francisco and San Jose Police Departments, to assess the training used in these programs and compare it with existing courses offered by the commission in order to evaluate the adequacy of mental disability training available to local law enforcement officers.

(d) The Legislature encourages law enforcement agencies to include the course created in this section, and any other course certified by the commission relating to mentally disabled persons, as part of their advanced officer training program.

(e) It is the intent of the Legislature to reevaluate, on the basis of its review of the report required in subdivision (c), the extent to which law enforcement officers are receiving adequate training in how to interact with mentally disabled persons.
APPENDIX K: Sample BPD CIT Brochure.

Berkeley Police Department
Crisis Intervention Team

Background

In 1988, the Memphis Police Department joined in partnership with the Memphis Chapter of the Alliance for the Mentally Ill (AMI), mental health providers, and two local universities (the University of Memphis and the University of Tennessee) in organizing, training, and implementing a specialized unit. This unique and creative alliance was established for the purpose of developing a more intelligent, understandable, and safe approach to mental crisis events. This community effort was the genesis of the Memphis Police Department’s Crisis Intervention Team.

The Berkeley Police Department Crisis Intervention (CIT) program will follow Memphis Police Department’s example by creating a community partnership working with mental health consumers and family members. Our goal will be to set a standard of excellence for our officers with respect to treatment of individuals with mental illness. Establishing individual responsibility for each event and overall accountability for the results will do this. Officers will be provided with the best quality training available, they will be part of a specialized team which can respond to a crisis at any time and they will work with the community to resolve each situation in a manner that shows concern for the citizen’s well being.

Mission

The mission of the Crisis Intervention Team is to use understanding and skills gained through specific training to identify and provide the most effective and compassionate response possible to police situations involving people in a mental health crisis.

Overview

The CIT will be made up of volunteer officers. CIT officers will be called upon to respond to crisis calls that present officers face-to-face with complex issues relating to mental illness. CIT officers will also perform their regular duty assignment as patrol officers.
CIT will teach officers and communications dispatchers, who are often the first point of contact for the mentally ill, how to deal with people in crisis, how to recognize different types of mental illness, and how to get the person the most appropriate help. The minimum goal of the CIT program should be to provide Crisis Intervention training to at least 10% of police officers and all dispatchers.

The Berkeley CIT program is a community effort enjoining both the police and the community together for common goals of safety, understanding, and service to the mentally ill and their families. It is to these goals the Berkeley Police Department stands committed.

The CIT program will provide an avenue for the development of community partnerships and the collaboration of working together for community interest of service and care. CIT is about doing the right thing for the right reasons. CIT will recognize a special population that deserves special care, treatment, and service. CIT is not about fame, fortune, nor glory, but rather, one of honor and service.

Traditional police methods, misinformation, and a lack of sensitivity cause fear and frustration for consumers and their families. Too often, officers’ respond to crisis calls where they felt at a disadvantage or were placed in a no-win situation. By offering an immediate humane and calm approach, CIT officers reduce the likelihood of physical confrontations and enhance better patient care. As such, the CIT program is a beginning for the necessary adjustment that law enforcement must make from traditional police responses to a more humane treatment of individuals with mental illness.

**Program Benefits**

Some of the benefits of a MHRT program are listed below.

- Specially trained officers to respond immediately to crisis calls
- Arrests and use of force statistically has decreased in other agencies
- Underserved mental health consumers are identified by officers and provided with care
- Patient violence and use of restraints in the ER has decreased
- Officers are better trained and educated in verbal de-escalation techniques
- Officer’s injuries during crisis events have declined
- Officer recognition and appreciation by the community has increased
- Less “victimless” crime arrests
- Cost savings

Most importantly, CIT officers will give mental health consumers a sense of dignity. This dignity generates a new respect and outlook on the police and the mental health systems.
The Berkeley Police Department CIT training will be a specialized, multidisciplinary, 40 hour course of study. It should be instructed and supervised by mental health service providers, family advocates (NAMI), and consumer/survivors of mental illness. The training will provide skills, tools, and tactics for law enforcement personnel to safely deescalate persons in mental illness or developmental disability crisis. Officers will receive information about different mental illnesses, developmental disabilities, crisis intervention techniques, community resources, and all major areas useful in interacting with persons in crisis. This training will produce confident CIT officers who professionally respond in an empathetic and calming manner.

The CIT should be made up of officers/sergeants who volunteer to take the 40 hour training. These CIT members then serve in a uniform patrol capacity and are available to respond to mental health/developmental disability crisis incident calls. They also serve their peers as problem solving resources and technical advisors in working within the mental health system. CIT members perform their regular duty assignments as patrol officers/sergeants when not involved in such incidents.
APPENDIX L: Further Information.

CIT Program Development

   Includes helpful video on CIT.

2. http://cit.memphis.edu


   “A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness.

   “Improving Responses to People with Mental Illnesses.”

Funding

   Federal Justice and Mental Health Collaboration Program.


   Federal JAG grant information.

Research


2. http://www.jaapl.org/cgi/content/full/36/1/47.
