Essential Elements for the Commonwealth of Virginia

Crisis Intervention Team Programs (CIT)

CIT Program Development Guidance
Virginia CIT Coalition
September 8, 2011 (Updated November 4, 2021)

Introduction: The CIT Concept

Crisis Intervention Teams (CIT) are programs that bring together local stakeholders, including law enforcement officers and other first responders, emergency communication officers, behavioral health treatment providers, consumers of behavioral health services and others (such as hospitals, emergency medical care facilities, non-law enforcement first responders, and family advocates). The goal is to improve the response to persons experiencing behavioral health crises who come into contact with law enforcement and other first responders. Such individuals may come to the attention of first responders due to actions or behaviors that are misinterpreted as criminal in nature, inappropriate, dangerous or violent. Additionally, law enforcement officers routinely interact with individuals with behavioral health disorders as a result of Virginia's civil commitment process. In many of these situations, it is necessary to help such individuals access behavioral health treatment, or place such persons in custody and seek either behavioral health treatment referral or incarceration for criminal acts.

Effective CIT programs enhance community collaboration, develop a stable infrastructure and provide training to improve criminal justice and behavioral health system response to individuals with behavioral health issues. The CIT model was originally developed in 1988 by the Memphis, Tennessee Police Department, and has subsequently spread throughout the country. Through the development of a widely representative stakeholders' task force, Memphis created a program to provide specialized training for a select cadre of patrol officers, as well as training all police dispatchers, and established a therapeutic treatment site as an alternative to incarceration. The 40-hour training enabled officers to more effectively communicate with and understand the particular needs of individuals with mental illness. In so doing, officers were able to reduce the potential for misunderstanding and enhance their ability to de-escalate situations involving persons with mental illness. Additionally, with education about treatment options and access to a therapeutic assessment site, officers were able to connect individuals with needed treatment, in lieu of incarceration or hospitalization, consistent with the needs of public safety and addressing the underlying issue of mental illness.

Legislative Initiative for CIT in Virginia

The 2009 Virginia General Assembly, through Senate Bill 1294, amended Sections 9.1-102, 187, 188, 189 and 190 of the *Code of Virginia* to direct the Department of Criminal Justice Services in conjunction with the Department of Behavioral Health and Developmental Services to "…support the establishment of crisis intervention team programs in areas throughout the Commonwealth." The Code was further amended during the 2020 Special Session of the Virginia General Assembly. It also established numerous criteria for the departments to use in implementing its provisions. The code sections that relate to CIT programs throughout the Commonwealth are:

§9.1-102. Powers and Duties of the Board and the Department of Criminal Justice Services

> The Department, under the direction of the Board, which shall be the policy-making body for carrying out the duties and powers hereunder, shall have the power and duty to: … 47. Assess

and report, in accordance with §9.1-190, the crisis intervention team programs established pursuant to §9.1-187.

§ 9.1-187. Establishment of crisis intervention team programs

A. By January 1, 2010, the Department of Criminal Justice Services and the Department of Behavioral Health and Developmental Services, utilizing such federal or state funding as may be available for this purpose, shall support the development and establishment of crisis intervention team programs in areas throughout the Commonwealth. Areas may be composed of any combination of one or more counties, cities, towns, or colleges or universities contained therein that may have law-enforcement officers as defined in § 9.1-101, or campus police officers appointed pursuant to the provisions of Chapter 17 (§ 23-232 et seq.) of Title 23. The crisis intervention teams shall assist law-enforcement officers in responding to crisis situations involving persons with mental illness, substance abuse problems, or both. The goals of the crisis intervention team programs shall be:

1. Providing immediate response by specially trained law-enforcement officers;
2. Reducing the amount of time officers spend out of service awaiting assessment and disposition;
3. Affording persons with mental illness, substance abuse problems, or both, a sense of dignity in crisis situations;
4. Reducing the likelihood of physical confrontation;
5. Decreasing arrests and use of force;
6. Identifying underserved populations with mental illness, substance abuse problems, or both, and linking them to appropriate care;
7. Providing support and assistance for mental health treatment professionals;
8. Decreasing the use of arrest and detention of persons experiencing mental health and/or substance abuse crises by providing better access to timely treatment;
9. Providing a therapeutic location or protocol for officers to bring individuals in crisis for assessment that is not a law-enforcement or jail facility;
10. Increasing public recognition and appreciation for the mental health needs of a community;
11. Decreasing injuries to law-enforcement officers during crisis events;
12. Reducing inappropriate arrests of individuals with mental illness in crisis situations;
13. Decreasing the need for mental health treatment in jail.

B. The Department, in collaboration with the Department of Behavioral Health and Developmental Services, shall establish criteria for the development of crisis intervention teams that shall include assessment of the effectiveness of the area's plan for community involvement, training, and therapeutic response alternatives and a determination of whether law-enforcement officers have effective agreements with mental health care providers and all other community stakeholders.

C. By November 1, 2009, the Department, and the Department of Behavioral Health and Developmental Services, shall submit to the Joint Commission on Health Care a report outlining the status of the crisis intervention team programs, including copies of any requests for proposals and the criteria developed for such areas.

§ 9.1-188. Crisis intervention team training

The Department, in consultation with the Department of Behavioral Health and Developmental Services, the Department for Aging and Rehabilitative Services, and law- enforcement, brain injury, and mental health stakeholders, shall develop a crisis intervention training program divided into the following three categories: (i) a module of principles-based training to be included as part of the compulsory minimum training standards subsequent to employment for all law-enforcement officers, (ii) a module of principles-based training to be included as part of the basic training of and recertification requirements for law-enforcement officers, and (iii) a comprehensive advanced training course for all persons involved in the crisis intervention team programs. Every locality shall establish or be part of a crisis intervention team program in accordance with the provisions of this article.

The curriculum for the basic training and recertification modules and the comprehensive advanced training course shall be approved for Department-certified in-service training credits for law-enforcement officers. All law enforcement officers involved in a crisis intervention team program shall complete the comprehensive advanced training course in accordance with clause (iii). The comprehensive advanced training course's curriculum developed in accordance with clause (ii) shall include a module on brain injury as part of the four hours of mandatory training in legal issues.

§ 9.1-189. Crisis intervention team protocol

Each crisis intervention team shall develop a protocol that permits law-enforcement officers to release a person with mental illness, substance abuse problems, or both, whom they encounter in crisis situations from their custody when the crisis intervention team has determined the person is sufficiently stable and to refer him for emergency treatment services.

§ 9.1-190. Crisis intervention team program assessment

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

Developmental Services, shall submit a report to the Joint Commission on Health Care by November 15, 2009, 2010, and 2011.

§ 2.2-213.5 Dissemination of information about specialized training to prevent and minimize mental health crisis.

The Secretary of Health and Human Resources and the Secretary of Public Safety and Homeland Security shall encourage the dissemination of information about specialized training in evidence-based strategies to prevent and minimize mental health crises in all jurisdictions. This information shall be disseminated to, but not limited to, law-enforcement personnel, other first responders, hospital emergency department personnel, school personnel, and other interested parties, to the extent possible. These strategies shall include (i) crisis intervention team (CIT) training for law-enforcement personnel and other first responders as designated by the community CIT task force and (ii) mental health first aid training for other first responders, hospital emergency department personnel, school personnel, and other interested parties. The Secretary of Health and Human Resources and the Secretary of Public Safety and Homeland Security shall encourage adherence to the models of training and achievement of programmatic goals and standards. The goals for CIT training shall include (i) training participants to recognize the signs and symptoms of behavioral health disorders; (ii) teaching participants the skills necessary to de-escalate crisis situations and how to support individuals in crisis; (iii) educating participants about community based resources available to individuals in crisis; and (iv) enhancing participants' ability to communicate with health systems about the nature of the crisis to include rules regarding confidentiality and protected health information. The goals for mental health first aid training shall be to teach the public (to include first responders, school personnel, and other interested parties) how to recognize symptoms of mental health problems, how to offer and provide initial help, and how to guide a person toward appropriate treatments and other supportive help.

Program Description for CIT in Virginia

At its core, CIT provides 1) law enforcement-based crisis intervention training for assisting individuals with a mental illness; 2) a forum to promote effective problem-solving regarding interaction between the criminal justice and behavioral health care system; and 3) improved community-based solutions to enhance access to services for individuals with a mental illness. Successful CIT programs improve first responder and consumer safety, and appropriately redirect individuals with mental illness from the criminal justice system to the health care system.

Essential Elements for Virginia's CIT Programs

DCJS and DBHDS strongly encourage CIT programs adhere to a limited number of uniform requirements, referred to as the "Essential Elements of VACIT", to assure that the basic structure of all CIT programs is consistent throughout the state. The departments created the Virginia CIT Coalition (VACIT) to support

the growth and development in all aspects of CIT programs as well as fully and effectively integrate CIT's statutory and policy goals in CIT programs throughout the Commonwealth. Participation in VACIT is encouraged for all programs, through participation in their Regional CIT Coalition.

While supporting the growth and development of CIT programs across the Commonwealth, the VACIT encourages programs to become self-sufficient and sustainable to the fullest extent possible. Mutual support among programs, through regional coalitions and other means, is encouraged but each program should strive to meet their respective ongoing needs for stakeholder engagement, CIT training, assessment site and other field operations, with internal and locally cultivated resources specific to that catchment area's program. Programs should strive to develop and maintain a local cadre of instructors through a self-directed instructor development program. Over-reliance on instructors from other programs, in the near-term, prohibits the long-term sustainability of a community's CIT program.

Each autonomous program and its stakeholder group should determine its respective personnel, financial and other resource commitments necessary for program sustainability. All stakeholders should demonstrate investment in the program infrastructure. Some of these commitments may include cost-sharing for positions (e.g., CIT Coordinator), space for training, cost of law enforcement overtime and sharing or pooling of equipment/supplies necessary for training or community outreach events. Sustainability is best demonstrated by utilization of memorandums of agreement. These agreements are particularly helpful as key team members may rotate out of CIT leadership positions into other duties and it is beneficial to have these agreements in place for the arrival of new CIT leaders.

DBHDS, DCJS and the VACIT leadership and coalition members worked together to establish these essential elements for the development and operation of CIT programs:

1. Community stakeholder collaboration and oversight;
2. CIT Coordinator;
3. 40 hour DCJS-certified CIT core training for law enforcement personnel;
4. Train-the-trainer classes for CIT program sustainability;
5. Dispatcher training;
6. Policies and procedures;
7. Therapeutic assessment location (not a law enforcement or jail facility), or procedures, to streamline access to services in lieu of incarceration (when appropriate);
8. Collection of data to monitor statutory outcome measures; and
9. Active participation in VACIT and regional efforts.

These elements are central to the success of CIT programs and the achievement of CIT program goals. What follows are the recommended essential elements and a brief description of the necessary components of each element.

1. Community Stakeholder Collaboration and Oversight

Central to the formation and ongoing success of Crisis Intervention Team programs is the creation of fully integrated, collaborative community partnerships. At a minimum these partnerships need to include representatives from:

- *Law Enforcement* – local police departments, sheriffs' offices, campus police departments, other relevant law enforcement agencies and other first responders.
- *Behavioral Health* – local community services boards, educators and private providers within the behavioral health treatment and provider community.
- *Community* – dynamic community involvement should reflect the composition of the local community, with particular emphasis on the inclusion of persons with mental illness. Historically, consumer advocacy organizations (such as the National Alliance on Mental Illness or Mental Health America) are highly involved in the development of CIT programs. However, some communities within the Commonwealth do not have operating consumer advocacy organizations. Therefore, at a minimum, all CIT programs should have a strategy for consumer and family member involvement, and, where possible, should also include consumer advocacy organizations. Involvement of all other appropriate community partners is highly suggested, to include but not limited to: fire and rescue, emergency medical services, correctional officers, judges, magistrates, special justices, attorneys, emergency department directors, psychiatric hospitals, local human rights organizations, etc.

A community oversight committee of critical community partners and stakeholders is essential in order to guide the initial planning and implementation of a CIT program and to provide ongoing oversight of the program's continued operation and sustainability, including critical incident review, funding and community outreach and education. These committees have taken a variety of names across the Commonwealth, including oversight committee, advisory committee, task force, etc.

2. CIT Coordinator

Each CIT program requires a designated individual or individuals to serve as CIT Coordinator(s) in order to manage the various training and program elements, including day-to-day logistics of inter-departmental communication, data collection and management, scheduling trainings and working with the community oversight committee.

The existence of both the CIT Coordinator(s) and a community task force are considered critical to the achievement of program goals and objectives. CIT programs bring together professionals from behavioral health treatment, criminal justice and public safety, and consumers and community members in a new and unique partnership. This requires close coordination, collaboration, problem-solving, and negotiation. Without at least one person tasked with facilitating this process and a local task force of the key stakeholders to work out details, reach consensus on local policies and procedures and provide ongoing program review and adjustments, CIT programs are significantly challenged.

The ideal candidate for the position of CIT Coordinator will possess a basic understanding of the issues confronting law enforcement and emergency services and should have pre-existing relationships and connections to the law enforcement and behavioral health communities.

3. 40 Hour CIT Core Training for Law Enforcement Personnel

Community stakeholders and law enforcement have debated what makes a CIT Program a "true" Crisis Intervention Team Program. Different regions have different issues which require flexibility to develop a diverse and regionally effective version of the CIT program model. Just as Virginia has adapted the Memphis Model to its laws and needs, so, too, have rural and urban localities made additional adaptations to suit their needs. These are the central tenets of the training which must be maintained.

The following are minimum standards, although programs are strongly encouraged to exceed and expand these to enhance the scope or depth of their individual programs.

a. 40 Consecutive Hours

A basic requirement of the CIT Core training program is 40 consecutive hours of classroom training delivered over five days. Breaking the training up into blocks with a lapse of time in between interferes with the CIT training's goals, namely, to build program cohesion, and to instill in students a deeper awareness of the needs of individuals with mental illness and the capacity to utilize and integrate their newly developed skills.

b. Class Size

Class size will vary from locality to locality in regard to the maximum number of students that can be provided with effective instruction and sufficient opportunity to engage in role play exercises. Experience across Virginia demonstrates that a class size of 20-25 is ideal, and it is not recommended to exceed a class size of 30 students. Programs should always keep in mind that a larger class size can constrain students from obtaining the maximum functionality of role play exercises and participation in discussion.

c. Didactic Component

Didactic CIT training must include modules on Basic Mental Health Diagnoses or Clinical States, Basics of Substance Abuse and the Medical Model, Basics of Intellectual and Developmental Disabilities, Psychiatric Medications, Verbal De-escalation and/or Crisis Intervention Skills, Suicidality, Legal Issues (e.g., liability, CIT Code provisions, etc.) and Civil Commitment, Overview of Special Populations, and Cultural Diversity. Other topics such as Adolescent Issues, Veterans Issues, and Geriatric Issues, or other region specific or topical areas should be added by programs as needed, and as long as the basic core curriculum is provided. Required module length may vary from program to program, however, based on statutory requirements, Legal Issues and Civil Commitment must total four hours in length.

In 2017, VACIT developed a Core CIT Training curriculum that includes a Lesson Plan and Training Aides. The VACIT curriculum, annually approved by DCJS, includes the required training modules mentioned above, as well as role play scenarios, and only covers 30 hours, or 75%, of the training's content. The other 10 hours of training content is elective and localities may include those modules that address the needs of their specific communities. When applying for training credit through DCJS or a local criminal justice training academy, programs must submit a lesson plan, training aides and instructor biographies.

d. Experiential Component

An important goal of CIT training is to increase sensitivity and awareness through direct experience. The Memphis Model utilizes the second day of the 40 hour training for site visits and other interaction with consumers to provide a personalized perspective not otherwise achievable. Virginia's model will mirror this approach. Site visits shall be conducted in person unless weather and/or facility restrictions necessitate this portion of the training be virtual. Training modules must include consumer and family presentations and virtual experience programs such as Hearing Voices Curriculum by Pat Deegan and the National Empowerment Center (preferred). This portion of the curriculum and its timing greatly enhance the overall experience of the 40-hour training.

e. Practical Component

Role Play within CIT seeks to build upon the foundation of didactic and experiential information provided earlier in the training week. Role play within CIT will in all cases begin with an overview of 'The Four Coaching Plays' of CIT. These are the essential tools for developing de-escalation and relationship building skills. Role play exercises are to be integrated into the training over each of the program's final three days with each day increasing in intensity and difficulty. This ensures practical knowledge and skill building lessons are turned into useable abilities for the CIT student. The role plays are to be utilized both as a practical experience for the responders involved and as a learning opportunity for the rest of the class by their observation and feedback in each of the exercises. Additionally, each role play must utilize a specially trained feedback panel. The feedback panel must include at least one law enforcement officer or first responder and one behavioral health representative and may also include consumer representatives when feasible to provide appropriate feedback and foster growth of the officer's confidence and abilities. Role players should be law enforcement officers, other first responders and any CIT program stakeholders using scenarios that will be created from real life experiences and NOT utilize students or professional actors. Any parties involved in role play scenarios shall have completed the CIT train the trainer course.

Prior to role play exercises, students will be asked to secure any weapons that may be in their possession. The use of live firearms and other lethal weapons is not permitted in the training environment or during role play exercises. Use of inert (training) weapons by students during role play exercises shall be at the discretion of each training program. Also, students are not permitted to go "hands on" (use physical force/defensive tactics) during role play exercises.

Should a student feel that the circumstances of the exercise require them to use force, they will be instructed to raise their hand and indicate how they would proceed if the scenario were real. There are plenty of valid arguments for the use of weapons and defensive tactics during role play exercises. However, the focus of CIT training and role play exercises is for law enforcement personnel to develop and utilize communication skills. Furthermore, the use of force and lethal weapons in the classroom pose potential safety concerns.

f. Presentation Order

As noted above, the flow and order of the training units is significant. Therefore, all 40 hour core CIT trainings will follow these guidelines for the placement and timing of specific units:

Monday

- Introduction to CIT
- Basic Mental Health Diagnoses (Clinical States)
- Hearing Voices Curriculum Practical Exercise

Tuesday

- Site Visits

Wednesday

- Basic Crisis Intervention Skills & The Four Coaching Plays (must take place immediately before Basic Role Play Exercises)
- Basic Role Play Exercises

Thursday

- Intermediate Role Play Exercises

Friday

- Advanced Role Play Exercises

g. Training Attire

Law enforcement and other first responders are strongly encouraged to wear civilian clothes throughout the duration of the training, with “business casual” as the general standard. However, it is understood that officers may have to be uniformed on occasion because of a court appearance or other obligations.

A table which lays out the Model 2017 VACIT Core Training Agenda can be found in Appendix B. Additional information about the VACIT Core CIT Training curriculum can be found on the organization's website (www.virginiacit.org).

4. CIT Train the Trainer Training (TTT)

Just as Crisis Intervention Team Core Training has basic elements, so does CIT Train the Trainer Training (TTT). TTT develops the local 40 hour training faculty to enhance their capacity and expertise to provide the 40 hour CIT training consistently for their team. CIT TTT ensures uniformity among trainers involved with creating and participating in CIT Role Play, developing effective presentation and proficient feedback skills for students. Subject Matter Experts instructing clinically-focused didactic modules are not required to take a TTT course as there is a line between didactic classroom instruction and the practical methodology of CIT skill building. However, behavioral health instructors who are involved in the 40 hour role play training component are to participate in the TTT course. Officer instructors need special attention to ensure they understand and emulate the proper CIT role play model. Behavioral health instructors engaging in role play likewise require special attention to ensure that their message carries the proper tone, being neither too clinical nor too simplistic, for the trainees. It is important to note that while a student taking the CIT TTT class will be adequately prepared to assist with a 40 hour Core CIT Training, it will require ongoing observation, assistance and tutoring with TTT veteran instructors before that student is a veteran instructor and sufficiently prepared to teach a TTT class.

The CIT TTT is a 20 consecutive hour program, provided over two and a half days, for no more than 18 students at a time. Individualized attention is critical, hence the smaller class size. The first day consists of classroom instruction on CIT fundamentals of theory, public presentation, and methodology required to instruct CIT Core students. Elements that are required include CIT theory from a process perspective, public speaking, effective role play, feedback skills and 'The Four Coaching Plays.'

The second and third day will focus on CIT role play development and implementation. Students will develop, plan and perform scenarios developed under instructor supervision. Student developed scenarios will gradually increase in complexity to better prepare the class to teaching in a full CIT Core class. Instructors will act as mock students to ensure that participants are exposed to a wide variety of potential situations and problems.

Prerequisite for the TTT is successful completion of the CIT 40 hour core training to ensure that officers have the message and foundational skills that the TTT will further develop and build upon. It is strongly recommended that students have a solid experience base after completing the training and becoming a CIT Officer before attending the CIT TTT.

5. CIT Dispatcher Training

Dispatcher training is an important piece of CIT that ensures trained officers on duty are properly utilized in the community. Dispatcher training in Virginia is minimally a four hour course whose key elements include basic CIT concepts, Clinical States, Experiential Exercises and Role Play. Role plays for dispatchers must provide for no visual contact between dispatcher trainee and subject. Some CIT

programs in Virginia offer CIT Dispatcher training as six, eight or sixteen hours. A longer, more intensive training program is advantageous and more desirable. It should be noted that CIT Dispatcher training of four hours is viewed as an absolute minimum that may be built upon. Four hours to instruct 10 students is adequate where four hours to instruct 20 is not. A larger class will require more time and coordination of these efforts should be made accordingly. (Sample eight hour schedule provided in Appendix C, with a target student capacity range 15 to 20)

6. Policies and Procedures

Policies and procedures are a necessary component of CIT. They provide a set of local guidelines that direct the actions of law enforcement and other first responders, dispatch and behavioral health providers. Due to the large number of stakeholders in CIT, it is important that these guidelines be designed by all agencies and individuals affected.

Each CIT program or law enforcement agency will develop their own policies regarding the size of their CIT-trained patrol division. The number of trained CIT officers available to each shift must be adequate to meet the crisis response needs of the community. Experience suggests that a successful CIT program will, at a minimum, have trained 20—25% of the agency's patrol division, which will likely result in 24/7 CIT officer coverage. There are differences that exist between large urban communities and small rural communities. Smaller agencies may need to train a higher percentage of officers to attain optimal coverage. The ultimate goal is to have an adequate number of patrol officers trained in order to ensure that CIT-trained officers are available at all times. Ideally, 100% of dispatchers should be trained to appropriately elicit sufficient information to identify and respond to a behavioral health-related crisis.

While the Memphis Model of CIT advocates for a model where officers volunteer and apply for the opportunity to become a CIT Officer, reflective of the suggested minimum or 20-25% being trained. In this approach, individuals who have an interest and desire to receive the training would be interviewed, approved by a supervisor, and selected based on experience. It is also understood, under this model, that policies and procedures would be put into place which would specify those whom are CIT-trained on each shift, be dispatched and designated as the lead officer or responder on scene in mental health crises. The VACIT supports the Memphis Model of CIT but recognizes that each agency, in collaboration with their designated CIT program, is responsible for formulating their own policies and procedures as it relates to numbers trained and guidelines to direct the actions of the first responders. For more information about the perceived concerns regarding the training of 100% of law enforcement personnel, CIT International has developed some position papers on the topic (www.citinternational.org/Position-Papers). In some instances, the training of 100% of law enforcement personnel without other necessary CIT components has resulted in Consent Decrees from the U.S. Department of Justice (http://www.portlandoregon.gov/police/62044).

It is also important for each agency, in collaboration with their designated CIT program, to formulate polices and procedures regarding those students who, once in the midst of the CIT 40-hour course, may exhibit behavior that is not in alignment with the CIT values and mindset. As CIT is not intended to correct a first responder who may not have a well-developed set of interpersonal skills, policies and

procedures should be supportive of actions being taken which will uphold the integrity of the CIT programs.

Crisis Intervention Team agencies may see the value in training a high percentage of a patrol staff in complementary behavioral health awareness or skills-based training such as the evidenced-based practice Mental Health First Aid training program disseminated by the National Council for Behavioral Health. This approach offers agencies the opportunity to augment the training received in a law enforcement basic school, delivering core content in a concise, time limited format which is less taxing when staffing personnel training.

Within the law enforcement community, policies are needed in order to provide guidelines regarding how to safely and respectfully transport consumers and how to develop supportive program infrastructure through a system of partnerships and inter-agency agreements. Policies must be in place to address the actions of both emergency dispatchers and patrol officers. Emergency dispatcher policies should clearly define and describe the role of dispatchers in the CIT program, which is to identify and dispatch the nearest available CIT Officer to respond to the crisis. Additionally, it is recommended that the responding CIT Officer leads the intervention, regardless of rank, except under unique or complicated circumstances that dictate otherwise. Policies and procedures that maximize the CIT Officer's discretion are critical. CIT Officers should be allowed to integrate their wide range of law enforcement training when handling CIT calls. Please note that CIT provides de-escalation training and should not replace other trainings or policies with which agencies train their staff when responding to calls for service in the community. CIT and verbal de-escalation may not be appropriate to all interventions encountered by law enforcement and other first responders. Personnel should always follow their agency's policy.

Within the behavioral health community, policies must accommodate consumers in the least restrictive setting and allow for a wide range of inpatient and outpatient referral sources. Barriers that prevent officers from accessing immediate behavioral health care for an individual should be examined and processes put in place to reduce or eliminate the amount of time officers spend off the road when involved in a behavioral health call.

<u>7. Therapeutic Assessment Location or Procedures to Streamline Access to Services</u>

While the statewide model for CIT is currently built upon the Memphis CIT model, which includes the utilization of a therapeutic assessment center, each community must assess their available resources, context, and the practicality or reality of operating a fully functioning receiving facility. Each locality or program at a minimum must develop a diversion mechanism or protocol that is an agreement-based process incorporating the community's strengths, resources and needs, in order to divert individuals into community care and treatment while also reducing officer involved time.

A therapeutic treatment alternative may consist of an actual physical location to which persons experiencing a behavioral health crisis may be taken for emergency treatment or stabilization, or it may consist of some other set of alternative means for providing appropriate interventions to individuals in crisis. Sometimes, it is a combination of the two. CIT programs are discouraged from utilizing criminal

justice facilities, such as a police department or sheriff's office, for assessing or triaging the treatment needs of behavioral health clients, absent a significant threat to public safety or incarceration on criminal charges, or when other mitigating circumstances dictate.

The ideal for a CIT program is to have a physical location that is *not* a jail or criminal lock-up always available to which an officer can deliver a person in crisis and turn over custody to someone trained to assist that person. This releases the officer to return to other duties and provides the treatment options needed by the consumer. A person for whom a therapeutic, community-based alternative is not appropriate due to the nature of the crime charged, may well need behavioral health treatment and care provisions at the jail to which he or she is taken. Under those circumstances, effective utilization of de-escalation skills by a CIT officer is likely to reduce the difficulties which a jail might encounter.

The following six components represent the ideal elements which are necessary to achieve the most successful type of triage/assessment site:

- 24/7 availability of the assessment site for law enforcement to use as an access point for services as an alternative to incarceration;
- 24/7 availability of emergency services personnel who can determine clinical status and assess treatment needs for the individual;
- 24/7 availability of on-site trained security to support the site by accepting transfer of the individual and to provide for the safety of all persons involved;
- 24/7 access to medical screening for individuals in crisis;
- 24/7 access to dispositional options including psychiatric beds available to accept voluntary individuals and those under behavioral health detention orders, crisis stabilization units, detox, and other community-based services; and
- 24/7 availability of peer support for individuals awaiting evaluation or transportation to dispositional options during the site's operational hours.

As of July 2020, the Department of Behavioral Health and Developmental Services provides funding for 42 assessment sites across the Commonwealth of Virginia. Each assessment site is unique in terms of its hours of operation, staffing and location. While the ideal standard is a site that operates 24/7, numerous programs operate sites on a 12 or 16 hour model, 7 days a week. In terms of security staffing, most sites utilize sworn law enforcement officials, either as a duty or off-duty assignment. A small number of sites use private security officers. Most assessment sites are co-located on a medical center campus or within a hospital emergency department, although a few are standalone facilities. Despite the variation in hours, staffing and location, every CIT assessment provides an alternative to arrest for law enforcement officials and supports the Commonwealth of Virginia's commitment to the principles of recovery.

8. Data Collection

Data collection is critical to measuring the progress and impact of CIT programs. It is made difficult by many factors, including the diversity of local data gathering systems and sharing capacities. Each locality has a great deal of autonomy in the design and functioning of their law enforcement and public safety agencies. This has led to development of localized communications and management information

systems that are not required to be uniform and consistent from one locality to the next. While all incidents handled by law enforcement officers are typically reported and captured in some data bank, the elements of an incident which may identify it as involving a person with mental illness are not always known or identifiable. Without a CIT program in place in a community, it is believed that many incidents that typically lead to arrest and injuries may have resulted from contact with persons experiencing a behavioral health crisis for which responding officers were not well trained or prepared to handle with alternatives to physical arrest. Identifying such incidents and emphasizing alternative resolutions is critical to measuring the success of a CIT program.

In Virginia, CIT programs are encouraged to collect the following core data elements for all law enforcement interventions that involve an individual in crisis: 1) how CIT Officers are dispatched to such calls (i.e., call type); 2) how long a CIT Officer remains involved in the call (time in service); 3) the number of injuries involved, if any; 4) the final disposition of the intervention.

Additionally, CIT programs that receive funding for an assessment site are required to provide data to the Department of Health and Developmental Services on a quarterly basis. For each individual who is assessed at the site, in addition to the core data elements above, program must report the following data:

1. Date and Time
    a. Arrival at Assessment Site
    b. Transfer of Custody Occurs
    c. Departure from Assessment Site
2. Referral Information
    a. Referral Source
    b. Field Disposition and Location
    c. Primary Officer Agency
    d. No Transfer Explanation, if applicable
    e. ECO Type, if applicable
    f. Alternative to Arrest
3. Outcome
    a. Clinical Disposition
    b. Agency Transporting TDO, if applicable
    c. Receiving Hospital, if applicable
    d. Length of Transport

The Department of Behavioral Health and Developmental Services uses this data to monitor each program and to report the overall program’s success to the General Assembly.

<u>9. Active participation in VACIT and Regional efforts</u>

The VACIT is a board of individuals who were elected by representatives selected by CIT programs within the five regions. It is intended that the regional CIT coalitions be a conduit of information to and from

the VACIT. For this reason, it is considered essential for representatives from each CIT program in the Commonwealth participate in the regional meetings and communications. While it would be preferred for the Coordinators of each program be involved and in attendance, when that is not possible, it is expected that an active and influential representative from each CIT program make every effort to participate. More details regarding the structure and function of the VACIT can be found in the By-laws on the virginiacit.org website.

Recommended optional components of CIT programs in Virginia

1. CIT for jail staff and corrections personnel
2. CIT for non-law enforcement first responders and behavioral health treatment personnel
3. CIT Refreshers/Recertification
4. CIT Advanced and In-service Training Courses
5. Specialized CIT response unit
6. Self-review of CIT program on regular basis
7. Awards and recognition

These elements are suggestions for CIT programs to consider as ways to broaden their programs and the intended purpose of improving first responder interactions and outcomes for individuals in crisis. What follows are these suggested elements and a brief description of each.

1. Crisis Intervention training for jail staff and correctional officers: While CIT was originally created as a law enforcement based first responder program, there is a large population of incarcerated persons with mental illness in Virginia jails who are not appropriate for jail diversion through CIT. Utilization of the 40-hour core CIT training curriculum for jail staff and correctional officers can have a positive impact for local jails. CIT training and utilization of de-escalation techniques for local jail personnel may diminish the risk of injuries to consumers and jail staff as well as reducing the incidence of persons receiving additional charges as a result of symptomatic behaviors. Programs may choose to include jail staff and correctional officers in their 40-hour core CIT trainings. This is a worthwhile use of resources while developing and furthering a working partnership amongst agencies.
2. Crisis Intervention training for non-law enforcement first responders (i.e., Fire/EMS) and behavioral health treatment personnel: Elements of CIT may easily be applied to other first responders dealing with consumers in the community. While CIT is primarily designed for law enforcement, Virginia should continue to offer training to these other groups to enhance the effectiveness and safety of all public service persons and the public. Programs may choose to include non-law enforcement first responders and behavioral health treatment personnel in their 40-hour core CIT trainings. This is a worthwhile use of resources while developing and strengthening a working partnership amongst agencies. Programs could also consider including additional partnering agencies such as: Magistrates, Assessment site Nurses, Probation and Parole, etc.
3. CIT Refreshers or Recertification should be considered by established programs. The refresher course should re-emphasize the use of the CIT skills, renew familiarity with relevant legal codes,

understanding of updated policies and procedures, and an awareness of area resources. (Refer to a sample curriculum in Appendix D)

4. Advanced and In-service Training Courses for all CIT-Trained Personnel is encouraged in order to provide further training and awareness on relevant topics. Advanced trainings should provide more in-depth exploration of topics which are covered in the 40-hour training week or additional topics which may be relevant.
5. A specialized CIT Co-Response Unit is suggestive of select CIT-trained first responders from law enforcement, fire/EMS, behavioral health, and other relevant community agencies who collaborate a coordinated response. This coordinated effort engages individuals who may be high-end users of 9-1-1 services. Additionally, co-response units are used to connect individuals with resources and support in order to avoid reaching a point of crisis that may warrant an emergency custody order or other involuntary measures. Often co-response units are utilized to augment CIT programs through the provision of follow-up crisis care or ongoing crisis management.
6. Self-Review of Each CIT Program on an annual basis is strongly encouraged by the VACIT. A sample review form (Appendix E) which was adapted from a tool developed by the Florida CIT Coalition, will allow for programs to self-monitor and be reminded to maintain those elements deemed valuable by the VACIT.
7. Awards and Recognition are strongly encouraged by the VACIT as well as the Memphis Model of CIT. Each program should explore ways to provide recognition to those in their community (partnering agencies, individual responders, community groups, stakeholders, etc.) who are demonstrating the skills and mindset of CIT.

APPENDIX A: Model 2017 VACIT Core CIT Training Agenda

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:00 am	**Unit 1** Introduction to CIT & Basic Mental Health Concepts *Sugg: Law Enforcement Faculty and Mental Health Professional/ Emergency Services Clinician*	**Unit 7** Site Visits	OPEN	**Unit 11** Suicide Intervention Skills *MH Professional*	OPEN
8:30 am					
9:00 am			OPEN		**Unit 15** Professional Liability & Legal Issues *Sugg: Commonwealth Attorney.*
9:30 am	**Unit 2** Introduction to Clinical States *Mental Health Professional/Emergency Services Clinician*				
10:00 am			OPEN	**Unit 12** Verbal De-Escalation Techniques *Law Enforcement Faculty and Mental Health Professional/ Emergency Services Clinician*	OPEN
10:30 am					
M11:00 am			OPEN		
11:30 am	**Unit 3** Psychotropic Medications *MH Professional*			Lunch *(on your own).*	
12:00 pm	Lunch *(on your own)*		Lunch (*on your own*)		Lunch (*provided*)
12:30 pm				**Unit 13** Civil Commitment Procedures & Related Issues *Sugg: Head Magistrate and Special Justice*	**Unit 16** Advanced Role Play Exercises *CIT Faculty*
1:00 pm	**Unit 4** "Hearing Voices" Audio Exercise *Sugg: Law Enforcement Faculty and Mental Health Professional/Emergency Services Clinician*				
1:30 pm			**Unit 9** Basic Crisis Intervention Skills *Law Enforcement Faculty and Mental Health Professional/ Emergency Services Clinician*		
2:00 pm	OPEN			**Unit 14** Intermediate Role Play Exercises *CIT Faculty*	
2:30 pm		**Unit 8** Site Visit Review *Sugg: Law Enforcement Faculty and Mental Health Professional*	**Unit 9 (cont)** Four Coaching Plays *CIT Faculty*		
3:00 pm	**Unit 5** Dual Diagnosis (Mental Health & Substance Abuse) *MH Professional*		**Unit 10** Basic Role Play Exercises *CIT Faculty*		
3:30 pm		OPEN			
4:00 pm	**Unit 6** Peer/Family/Consumer Perspectives				
4:30 pm					
5:00 pm					

APPENDIX B:

Model CIT Train the Trainer (Instructor School) Agenda

DAY ONE

0900-1000	Developing a Self-Sustaining CIT Program
1000-1015	BREAK
1015-1200	Public Speaking
1200-1300	LUNCH
1300-1400	Role Play Presentation
1400-1415	BREAK
1415-1515	Role Play Presentation (Cont'd)
1515-1530	BREAK
1530-1700	Four Coaching Plays Presentation

DAY TWO

0800-0900	Creating Role Play Scenarios in Mentored Workgroups
0900-0915	BREAK
0915-1015	Role Play Development in Mentored Workgroups (Cont'd)
1015-1030	BREAK
1030-1200	Role Play Implementation and Practice
1200-1300	LUNCH
1300-1445	Role Play Implementation and Practice
1445-1500	BREAK
1500-1700	Role Play Implementation and Practice

DAY THREE

0800-1100	Role Play Implementation and Practice
1100-1130	BREAK
1130-1230	Debrief with New Faculty

APPENDIX C:

Model Emergency Communications Officer CIT Training Agenda

8:00 AM Welcome/Awareness of Mental Health Issues

9:00 AM Introduction to Clinical States

11:00 AM Emergency Custody Orders/ Temporary Detention Orders

12:00 PM Lunch

(Video- Beyond Silence)

1:00 PM Hearing Voices

2:00 PM Four Coaching Plays & Verbal De-Escalation

3:00 PM Scenarios

5:00 PM Certificates & Adjourn

APPENDIX D:

Model CIT Refresher Course Agenda

Time	Topic	Presenter/required staff
8-9 Unit 1	BRIEF reminder/intro of CIT program/initiatives Current Issues (i.e., regarding policies and procedures, assessment site, data collection, specific challenges relevant to region) Review of Coaching plays	Lead instructors/Cadre
9 – 11 Unit 2	Legal update (review relevant code, changes in code) Legal panel (questions related to issues, changes, case studies)	Attorney Attorney, magistrate, rep from each agency
11-12:00 Unit 3	Specialty topic of choice	Subject matter expert related to topic to be covered