Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Developing Partnerships: CIT Officers and Providers

crisis intervention team collaboration

Tuesday, January 10, 2017
1:00pm-2:00pm ET

1st of 3 webinars in the Criminal Justice and Recovery-Oriented Practices Series
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The contents of this presentation do not necessarily reflect the views or policies of SAMHSA or DHHS. The training should not be considered a substitute for individualized client care and treatment decisions.
Learning Objectives

At the conclusion of this webinar, you will be able to:

• Determine the strategy and composition of a successful CIT training team
• Identify methods for developing partnerships between law enforcement and behavioral health providers
• Describe the obstacles and challenges inherent to crisis response and systems of response when working from recovery oriented principles

“It was such a strong reinforcement of the things you shared and that she shared and how they fit together... the training [was] spot on.”

- New CIT Officer 2016 Class
What Is CIT?

Beyond learning about various diagnoses and the behavioral health system, LEO*s learn...

- Mental illness is not a crime
- Recognize and address myths about mental illness
- A collaboration between public safety and health systems to form an effective safety net for vulnerable individuals
The History of CIT

Crisis Intervention Teams

Memphis, TN 1988

• Born out of crisis
  – Joseph Robinson, 27 years old
  – Police were called for help
  – Robinson was “trying to cut his throat, acting like he’s on drugs”
  – Police responded and shot Robinson repeatedly
  – Robinson died from his injuries

• Tragedy stimulated collaboration
  – Memphis Police Department
  – NAMI-Memphis
  – UT Medical School
  – University of Memphis
Memphis Model
Crisis Intervention Team

- **Diversion** before arrest/charge
- Specialized **training** of a cadre of officers
- Centralized, **police-friendly** warm hand off/psychiatric **triage**
- Referral to **available**, appropriate **community-based** services
Efficiencies of the CIT Model

• Police already responding to all calls including crisis events
• Trained CIT officers respond immediately to crisis events
• Officers and citizens understand these calls are special priority
Prior to CIT

• Police were not prepared to help or support people appearing to be in a MH crisis
• People with in crisis and/or their family members were distrustful of the police
• Criminal justice and mental health systems were not coordinated
• Police responses more often resulted in arrests, injuries or fatalities
Since CIT Implementation

- Officers are highly skilled in verbal de-escalation techniques
- Family members/friends or consumers request CIT officers
- Crisis response is immediate
- Most people are taken to treatment facilities without charges being filed
Benefits to LEOs

- Decreased number of injuries to the officers
- Decreased use of force
- Improved use of alternatives to arrest and jail
- Decreased time officers spend in the crisis unit/ER
- Reduced myths and prejudice of mental illness among law enforcement
- Improved relationships for officers and community
Benefits to Mental Health Providers

- Extended crisis response options / systems
- Increased opportunity for earlier intervention
- Improved treatment outcomes
- Improved relationship with law enforcement
- Individuals are less stressed by the process
Benefits to the person in crisis

• Decreased number of injuries to the person in crisis
• Better relationships between the person and LEOs
• Decreased stereotyping results in decreased incarcerations or detention in local jails
• Improved access to treatment
• Increased chance that the person will receive timely and continuous care
Goals of Training

• The overall goal of the CIT training program is to treat mental illness as a health condition, not a crime.
• Increase understanding of psychiatric disorders
• Increase recognition of behaviors associated with psychiatric disorders and/or substance use
• Provide tools and techniques for supporting with people in crisis
• Reduce injuries and fatalities
• Began in 2002 with OCPD, ODMHSAS, and NAMI
  – 25 officers per class
  – 100 trained in the first year
• Annual class size of 25
• Currently over **1200** officers in the state of Oklahoma have been trained
• Continued to grow community partnerships; including CMHCs and providers
Who receives MH services in Oklahoma?

By diagnosis:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>6.3%</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>60.6%</td>
</tr>
<tr>
<td>Other Psychotic</td>
<td>10.2%</td>
</tr>
<tr>
<td>Alcohol/drug problems (co-occurring)</td>
<td>30.8%</td>
</tr>
<tr>
<td>Individuals in treatment for schizophrenia</td>
<td></td>
</tr>
<tr>
<td>reporting substance use</td>
<td>55.0%</td>
</tr>
<tr>
<td>Individuals with substance use disorder</td>
<td></td>
</tr>
<tr>
<td>and a psychiatric diagnosis</td>
<td>59.9%</td>
</tr>
</tbody>
</table>

(ODMHSAS, FY’10)
Who receives MH services in Oklahoma?

"In Oklahoma, we are funded 46th in the nation for mental health, despite having the third highest rate of mental illness.

Oklahoma spends $53.05 per capita, the national average is $120.56 per capita."

Commissioner Terri White, 2015
Emotional disturbances disrupt a child’s ability to interact effectively with family members, teachers, friends and others in the community.

89,278 Oklahoma children and teens were diagnosed with an emotional disturbance or behavioral impairment.

20.9% children between 8-18 have a diagnosable emotional disturbance or addiction.
Crisis Intervention Teams in Oklahoma

- Team strategy
  - Funding
  - Plan
- Team composition
  - Who is on the team?
  - Officer compensation
- Agency benefit for team members
Law Enforcement Role

How can law enforcement improve interactions with mental health services?

- Familiarity with the law
- Affidavits
  - Psychosis
- Abilities
- CIT Team selection process
  - What type of officer?
- Memphis Model Mirroring
Law Enforcement Role (2)

How can law enforcement improve interactions with mental health services?

- Administrative Buy-in
  - Attending training
  - Instruction team info
- Bridge building
  - Outreach
  - Community policing
  - Ride along
  - Facility tours
- Partner with advocacy organizations
- Citizens Police Academy
Challenges to Address

• Training/team issues
  • Instructors
  • Mental health professionals
  • 40 hour week training
    - Small agency attendance is almost impossible
• Treatment services and access
• Budget
• Cooperation
Challenges to Address (1)

- Law enforcement issues
  - Transports
  - Compassion fatigue
  - Peer support
  - Confront myths, labels, and discrimination
- Purpose and progress
  - Community education
    - Facebook page
    - Information and update
  - Challenge Coin
Outcomes: IRL (In real life)

• Facebook stories
• Letters of appreciation
• Stories shared 1:1
In Real Life

CIT Officer

• Assists a therapist who is worried
• Overcomes the person’s fear of the police with kindness
• Facilitates appropriate level of care and increases community support
In real life (cont.)

A new CIT officer suspects a ‘drug offender’ is actually in a mental health crisis.

• He asks key questions.
• He connects with the person and is able to negotiate voluntary trip to the ER.
• He works with the LPC, together they are able to help the man get emergency medical and behavioral health support. Tests showed he had NOT been using.
Recovery Principles and Community Policing

“Although effective and accessible mental health treatment will be an active component of any intervention, research evidence is increasingly suggesting that treatment alone is not sufficient.

“Justice-involved people with serious mental illness have more than just a mental illness; they are individuals with an array of challenges nested within complicated lives.“

Factors Contributing to Justice-Involvement
Catalytic Role of Trauma and Stress

The Next Generation of Behavioral Health and Criminal Justice Interventions: Improving Outcomes by Improving Interventions
http://tinyurl.com/gl3ba28
Proposed Unifying Principles: CJ/BH

1. The **person** is the focus of intervention.
2. Mental health treatment is a necessary component of any intervention and should be delivered in the **least restrictive setting** and with the **least intrusion** on individual **choice**.
3. Recovery from mental illness includes **relapses**.
4. Many **factors** contribute to criminal behavior.
5. People with SMI who engage in criminal behavior have **competing and interacting risk factors** in addition to their mental illness.
6. Many risk factors that predict criminal behavior are **intervenable**.
7. Change is a **process** and any movement forward should be interpreted as a measure of **progress**.
Coming Soon!

RTP newsletter on this topic: Recovery-oriented Practices in Criminal Justice

Sign up with RTP to get your free copy!

Two more great webinars in this series:

- **Tuesday, January 24  1:00 – 2:00 ET**
  From Recidivism to Recovery: Peer Support for Re-entry

- **Tuesday, January 31  1:00 – 2:00 ET**
  How Providers Can Help Overcome Cultural and Service Gaps in Community Support for Tribal Members within the Criminal Justice System

Registration open now!
Recovery to Practice

Through education, training, and resources SAMHSA’s Recovery to Practice (RTP) program supports the expansion and integration of recovery-oriented behavioral health care delivered in multiple service settings.
Discipline based curricula is available on the RTP website.
SAMHSA’s 10 Principles and 4 Dimensions of Recovery in Behavioral Health

- Home
- Health
- Community
- Purpose

- Hope
- Person-Driven
- Respect
- Many Pathways

- Strengths / Responsibility
- Holistic
- Addresses Trauma
- Peer Support

- Culture
- Relational
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- **Tues, Jan 24 and Tues, Jan 31**
  - 1:00-2:00 ET
  - Register now

- **Click the link for continuing ed hours from NAADAC or to download a certificate**