CIT Provider Collaboration

Melody Riefer: Welcome to the first Recovery to Practice webinar of the new year. We're really happy that you could join us today and we're so pleased that there's so many people participating. This and all the Recovery To Practice webinars are funded by the Substance Abuse and Mental Health Services Administration. We're grateful for the support and the opportunity it creates to help behavioral health and general health care practitioners improve delivery of recovery-oriented services, supports and treatment. A couple of housekeeping details before we begin. Please note that we have built in time at the end of the webinar for additional audience questions and we'll attempt to get to as many of those as we can. Our last couple of slides will give you information on the recovery to practice project, how you can sign up for the newsletter, and how you can visit our page on SAMHSA's website. And really importantly, this webinar has been preapproved for continuing education hours from NAADAC, the association of addiction professionals. To qualify for the continuing education hours, you must attend the full webinar and then at the end complete a brief quiz and the webinar evaluation. For more information, at the end of the webinar, please plan to stay through to the end if you're able.

Now, at the bottom of the screen that you're looking at, you should be able to see a pod that's labeled download materials. Inside that box are files and documents that you can download, and these include our presenter's bios as well as a pdf of the presentation slides, a certificate of participation and any other available resources, including a document that's entitled 5N5 which includes additional resources that relate to our topic being presented today. Finally, if you are a registered attendee, you'll be emailed a link to view the archived recording. This link will also be available soon on SAMHSA's RTP Website.

Now let's get on to the reason that we're here. We're beginning a three-part series that looks at key considerations for providers when criminal justice issues are a part of what the folks we work with need to address. Today we will look at working with law enforcement officers, also known as LEOs, and you might hear that term as we go through the webinar, who are following the crisis intervention team, or CIT model. This model cannot exist in a vacuum, and when providers are knowledgeable and involved, people in crisis have much better outcomes. Collaboration is key to sustaining a recovery-oriented service system. Our presenters are experts in the field and have both training and real life experience with the CIT model. Tania Woods is a clinical social worker who has worked in behavioral health her entire career. And for the past 10 years she has assisted law enforcement agencies in training officers in an up-to-date and relevant mental health training. In this role, she organizes the CIT trainings across the entire state of Oklahoma and provides mental health in service training to police officers, probation and parole officers, as well as correctional officers. She also teaches the mental health block for the basic police academy, for the Oklahoma counsel on Law enforcement education and training, as well as other academy cities. She's going to be joined by Master Police Officer Carl Pendleton who has been a police officers with the city of Norman Oklahoma since 2009. Carl has a passion for teaching and instructs multiple disciplines including domestic violence investigation, cultural awareness and bias, and teaches at the Norman Police academy. He is a CIT officer and trainer. He's reached the rank of Master Police Officer and serves as a Police Recruiter and as a Public Information Officers.

Now just before we begin, I would like to ask everyone on the call to think about this question and to respond in the boxes that just popped up under your slide. When you hear about police becoming involved in a behavioral health crisis, what pops into your mind? What word pops into your mind? We have two boxes and I invite you to type in the box related to the first initial of your last name. And feel

free to enter what it is that you think of first. Police becoming involved in a behavioral health crisis? What's your experience? What word pops into your mind? Those are great responses. Take just a moment to look over some of the words that have popped up. Are the police—do they have experience? Have they been trained? Words like, "feeling unsafe" or "feeling safer." Will the police approach this with compassion? A need for understanding. Chaos. Complicated. Confusing. Collaboration. All really important first responses to this question. So, what I'd like to do now is go back to our presentation, and let's hear from people who have experiences with this. I'm really, really happy to introduce you to the presenters and to turn over the rest of the webinar to them so that they can give us the benefit of their experience and their studies as we look at what it is like to have CIT officers involved behavioral health crisis. Tania, Carl, thanks for being here and sharing with us your skills and wisdom.

Carl Pendleton: Good afternoon everyone. We're going to just chat today about a few different things. We're going to talk about what a crisis intervention team is, how our teams are constructed here in the state of Oklahoma. We're going to talk about the strategies that have to be developed, the composition of your training team. We'll talk through different ideas about partnerships because that essential to the CIT model. Partnerships are critical. We'll also talk through some of the obstacles and challenge that come up because there is no way that this is going to exist without obstacles and challenges. That's kind of where this comes from in the beginning. But to speak about CIT in the first place, we focus CIT on teaching law enforcement officers that mental illness is not a crime. That's essential to the training. We want to let them know that this is a mental health issue—that it's a health issue overall. We're also going to let them have some type of a baseline and knowledge of what mental illnesses are; what they look like; different symptoms; but we're also specifically going to talk about myths about mental illness. We're going to make sure that we identify those implicit biases that they have about mental illness that we all have about mental illness before we're educated. And we're really going to talk about the collaboration between CIT officers and the mental health community. CIT officers cannot do what they do without the mental health community partnering. And we want to make sure that this is a collaboration and so our officers get a really good indoctrination into how to form those partnerships and what they should look like.

Tania Woods: Let's talk a little bit about the history of CIT. It's a fairly new program it was born in Memphis, TN in 1988. Unfortunately, it was due to a crisis. A young man by the name of Joseph Robinson who was 27 years at the time. His family called police because Joseph was in crisis and they stated he was trying to cut his throat, maybe acting like he was on drugs. When the police arrived, Joseph did lunge at them, and so unfortunately, he was shot and killed. But because of this, the police department understood that they didn't have the training that maybe they needed, and so they reached out to NAMI CUT medical school, and the University of Memphis. And from there they created this 40 hour police specific curriculum.

Carl Pendleton: So prior to CIT law enforcement officers were just not prepared. They did not understand what to do with mental health issues. They were really concerned. Essentially, I equate it to, "what it looks like whenever someone has a mental health crisis when it comes to HIPPA. When people don't understand HIPPA, a lot of times they'll just say we can't release any information what so ever, and our officers had to become educated and give a little more information, and so essentially, we decided it had to incorporate more information in that regard. So, CIT had a lot of different options and

it really needed to teach people that in crisis family members need to be able to trust law enforcement. If family members don't trust law enforcement they won't call, and law enforcement needs to be able to help. And that's kind of where a lot of the training changed and on the Memphis model in particular and this shows you a little bit about that.

Tania Woods: We want to make sure that our goals are diversion and when possible, and you know I talk a lot about, in CIT training, with the officers that we understand as clinicians that diversion isn't always possible. So we want to make sure when it is, that these officers have the training; they have the skills to recognize the signs and symptoms that gives them the authority by law to put them into protective custody and seek an assessment. And so we also want to make sure that the officers who are being trained want to be trained. So the specialized team of officers—there is an application process. I mean just like any other specialty, any other career, we all have our kind of niches. Even as clinicians. Some of use work with children, with the elderly. And not all officers want to work with folks that have mental health issues. And that's ok. And we need to be ok with that as well. So we want to make sure that those who do want to be CIT officers, they come to our training. And so once they do that, we also want to make sure as clinicians within the mental health field, they have the resources necessary so after they have contact with somebody who is in crisis and needs assistances, that they have available referrals and appropriate community based services—kind of easy open doors for them to come in and seek that assistance. Unfortunately, jail is pretty easy to get into, we kind of always joke about that. We want to make sure that getting into the mental health system is also very easy for both the person in need and for the officers.

Carl Pendleton: And so the efficiencies of the CIT model is really important because realistically, the law enforcement officers are going to be responding already, and so they need to be able to know that since they're going to be there, let's allow them to handle the situation the best way they possibly can. If they're there, hopefully, they are trained appropriately. So let's give them the tools they need to not have to call someone else for help, or for things to not go south as much as possible so let's train them and equip them. And not only that, but this is a special priority call. And one way that I usually talk to officers is that, many officers get into the profession because they want to save lives; they want to help people. And a lot of times they envision having to run in when there's bullets flying and things like that because saving lives is usually a dangerous situation. Well a mental health crisis—this is life-saving work. And so I really impress upon them and our class really impresses upon them how important it is in this situation to step in and saves lives. On top of that, there was not very much communication or cooperation between the criminal justice system and mental health system. And so CIT has really helped the growing cooperation around—not long after the CIT model there were mental health courses that started to pop up following the drug court model and it's been very, very successful. I don't think they could have possibly been as successful as they have been without CIT. CIT has become an international model; it's gone all over. And it has, statistically, been very very effective. Police response has also—prior to CIT—caused lots of injuries, not only to law enforcement officers, but to the mental health consumers. And just as a caveat and a disclaimer, in the state law of Oklahoma, those individuals who use mental health resources, both out-patient and in-patient, by our state law are defined as mental health consumers. So if I use that term, that's because I'm speaking through the terminology that our law sets up here. Since CIT was established, our officers have become highly skilled in verbal de-escalation. And people talk about that term, and actually I saw the term show up in the popup chat, which is fantastic because we spend a lot of time asking officers to deescalate issues and think outside

the box. And now since CIT has become established and people start to understand what it is and who they are talking to, they ask specifically for CIT officers when a crisis has occurred. And so officers a lot of times will wear epilates which are basically patches that they wear on the shoulders of the uniform or there wear a pin that says CIT on it. That way those individuals in the community can identify a CIT officer. When they need them, they can go directly to them and it helps them understand that the officers are there to help and they are not there to hurt. That builds a lot of trust as well. And so essentially since CIT has occurred and has grown, people are sending folks to mental health facilities to recover rather than jail to not get better. So, when someone commits a minor offense, or even the fact that they are in a mental illness crisis and that is not a crime, not taking them to jail rather than getting them the services they need. That's the root of the issue rather than the symptom.

So for law enforcement, there has to be a buy in, there has to be a benefit. Otherwise you aren't going to get them to buy in at all. And so first of all, there has been a decreased number of injuries to officers using this CIT model. They don't have to use force as often. They learned to deescalate prior to use of force. There is this old mantra within law enforcement that when it came to force, you ask someone to do something, you tell them to do it, and if those two things didn't work, then you make them do it. Well, what we make very clear is that when someone is in mental health crisis, those options need to go out the window. You need to ask many more times. You need to tell many more times. And you need to think outside the box and try different things. And so if we can use alternatives other than jail, other than arrest. Let's do that. On top of that, for the benefits: officers weren't spending as much time in ERs, weren't spending as much time in crisis unites with people who were out of control, with people who were injured because now they've got some cooperative and they've got someone where they need to be without things escalating out of control. This also helps educate officers to reduce myths within the ranks. To call out different types of mentalities that really existed prior to, that are incorrect and wrong. And the overall benefit is that law enforcement and the community get along better. When the community trusts your law enforcement, then your cooperation is going to be better overall. And the bottom line here is that it saves your community money. It saves your agencies money and it saves lives. CIT is a life saving measure and it's been very, very effective in doing that. At our agency in particular, we've had a number of SWAT team callouts over the last 5-10 years on barricaded subjects, people who are in mental health crisis, either suicidal or homicidal, and our SWAT team has come away with zero fatalities from those incidents because of having our trained negotiators being CIT officers as well. It's been very effective. So we've had a lot of success with the CIT model.

Tania Woods: Now of course there's also been a lot of benefit to us as mental health providers. We know that these officers are kind of our eyes and ears out in the community, they're our first responders to the folks that we serve and we want to make sure they know what they are looking for, that they are comfortable coming to us for questions. There is also an increased opportunity for earlier intervention and we all know that earlier intervention is key. This one of the reasons too that we want to focus and we like to focus as well on SROs, or officers that work inside of the schools, so school resource officers. Those officers are usually in middle schools, high schools, and we know a lot of mental illness comes upon that age group. We also want to make that we outreach to university police. So really any police officer that is in contact with our youth and can help identify some of these sign and symptoms early on. Not too long ago NAMI did a study that asked the consumer as well as family members who was crucial at identifying that there might be a mental health issue with their loved ones or with themselves. And surprisingly or maybe not surprisingly, law enforcement ranked higher than mental health providers.

And that just shows that there was more contact—research shows that about two to three times more contact with law enforcement before they get to us, the mental health system. So we want to make sure the officers are comfortable identifying and speaking with folks, the family members. We know that these improved relationships in Oklahoma we have officers that will pick up the phone and call the mental health providers, ask questions when they are not sure, we kind of work through problems when we need to on specific cases sometimes and really dig into it and give them the information that they need. And then individuals are less stressed by the process. Nobody likes calling the police. Even me that has worked with the police for ten years, I don't like dialing those 911 numbers. So we do want to make sure that people are comfortable with that process, that they know that a CIT officer will be on the other end, that they're there to help just like we are. And then also, there are benefits to of course the person in crisis. So, there are — it has been proven that with CIT it decreases injuries to both the person in crisis and to the officer. So when the officer is more skilled in de-escalation there are less injuries, or kind of hands on, what we call hands on, and that really is a goal of ours. The relationship between the person and the officers. About a year ago, we had one of our CIT trainings here in Oklahoma City, and in the beginning of each CIT class we ask "Why are you here?" And we get various answers of course, but this particular class, for some reason in Oklahoma City said, "Well I'm tired of responding to mental health calls and that person saying 'well you don't have that CIT badge that says that you're CIT and I want to talk to a CIT officer'" because in need was so familiar with CIT and they knew that if that officer had that that said CIT they were safe and they knew how to help and where to go. So they were there to take CIT because they want to make sure that when that person calls, that that person trusts them. So it is as simple as seeing and knowing that they are safe with that person. In training I think one of the biggest things we do is we would do stereotyping, we really try to bring in, we do bring in a consumer panel, a panel of family members, to talk to the officers about their needs. We know that the benefit to the person in crisis is that they will increase the chance that they will receive family and continuous care and that is of course important for us.

Carl Pendleton: When it gets down to it the overall goal of the training to make our officers understand this is a health condition, not a crime, people are not making choices to behave badly. I actually hate the term behavioral health, because I feel like somethings aren't – it's not a behavior necessarily, it is a mental health condition and people aren't necessarily making these choices. And so, as law enforcement we can understand this is a health condition and we can help them get the medical care they need, and so hopefully they will understand these psychiatric disorders better. And we always tell them that they are not going to become clinicians when they leave, they are not going to get any fancy letter initials behind their names, or anything like that. But when they leave the training they are going to understand psychiatric disorders better, and hopefully are going to be able to identify those verses a drug induced issue or try to see that maybe the symptom is part of a mental health issue. And so we also want to make sure they understand that there are co-occurring issues, that there are a number of individuals who will self-medicate but to see through some of those issues and to see what the root of the issue is. Also, we want our officers to become very familiar with the resources that are available for our community of mental health patients, to understand that there are a lot of things that they can provide, even if someone is in crisis and they are not ready for an inpatient stay. Well what resources can we wrap around them to make sure they don't get into that crisis situations. And overall, I know we mentioned this multiple times, but we want to reduce injuries and fatalities. That is the ultimate goal of this program, we do not want people hurt whether it is our community or whether it is our officers. If we can keep people safe that is what we want overall.

Tania Woods: Okay let's talk a little bit about CIT in Oklahoma just to show you a little bit about how we did it here. This program was started in 2002. We started it in collaboration and I say we the Oklahoma Department of Mental Health and Substance Abuse Services along with Oklahoma City Police Department and NAMI began this process. We started with 25 officers in each class and we've continued throughout the years to try to keep it right at 25. We feel it is important as part of the model and it's important for us to keep dialogue going. It is very much an interactive class, and we want to make sure the officers are comfortable with it. That first year we trained about 100 officers. We have continued on and I will say for those of you that are on the call that may be thinking about starting a CIT program in their state, it is not a popular topic I would say in law enforcement. It is definitely a little bit of an uphill battle to convince departments that this is a very important training. It is a week-long training which is rare in law enforcement, so it was a little bit of a struggle but I can tell you that now we have over 1200 officers in the state strained. We have gone from that four classes in the first year and went to having 10 this year in 2017 and when I say 10, we had to keep it at 10. We could've probably had 20 classes this year if we all had the time to do that. It is growing and growing. People are constantly calling and asking for this training. Our community mental health centers are huge partners and most of the state really is aware of the importance of this training.

Just really quick to talk a little bit about who we serve and why does this matter, why do we need to know who we serve in this state? Well we want to be able to tailor our training to the folks that law enforcement will come into contact with. We want to make sure that we are teaching what they need to know. The data, if you guys out there are not used to collecting data, it is so very important and I think kind of leads us and leads the training. We also are able to focus on recovery because a lot of officers are surprised at some of these numbers. For example, 60% of the people that we serve have a mood disorder. Officers will say I thought it was a lot more with schizophrenia. 6% of people have schizophrenia and they would have sworn it is a bigger percent of the population, but we talk about how a lot of times, unfortunately, officers are coming into contact with folks in crisis and we want to remind them that you know they are in crisis, and they often see folks that have a mental health issue but it may not be displayed in everyday life. The officers are out there, they are coming into contact whether it is for a simple speeding ticket or you know an assistance to someone but they are not telling them "Hey I'm in recovery and have been diagnosed with schizophrenia." Unfortunately, they are only seeing folks that are in crisis, and that's why the provider panel and the consumer panel, I'm sorry, the consumer panel is so important to have these folks with lived experience come to the class and talk to the officers about their experience with law enforcement, their experience with the mental health issue and how -- what things worked for them and how well they are doing. They don't get to see those folks that are doing really well often so that is really important to look at these numbers and making sure we are teaching the officers what we wanted to know.

Again, why do we want to talk about funding? We need to encourage advocacy and encourage the officers in class to become advocates. You know, in Oklahoma we are funded 46th in the nation for mental health, so when we are looking at how much we spent per capita as opposed to the national average we want to understand why maybe there is such a huge problem. And it is not always a consumer issue. When there are not services out there available for folks, there is going to be unfortunately a higher interaction with law enforcement. We want officers to understand that you know when there is no outpatient services available, especially in rural Oklahoma you might get more calls, and that is not necessarily the fault of the person in need. We need to become advocates, all officers and all CIT need to become advocates and become knowledgeable about our laws and the people that represent us and make sure they have a voice and that the voice of the officer is heard.

Alright, let's talk about our kids. Unfortunately, we do also have a very large population of our children have issues with mental health. About 20% of our folks. We make sure that during our CIT training we had a child specific person come in, therapist usually come in, and speak about child specific diagnoses and behaviors. Unfortunately, a lot of officers do respond to calls with children that they believe is maybe just bad behavior or bad parenting. And so we want to talk to them about the difference between those two, and when it is time to intervene and time to assist that family with the child. Again, we talk a lot about the SROs or the school resource officers and how important it is for those officers to be trained in middle school and high school and university level to be able to recognize some of these signs and symptoms in our kids so that they are able to have early intervention which we know is so so important. When it comes to the law you know it can be a little nerve-racking for officers to think about putting an eight-year-old, for example, in protective custody. We're talking about children needing to get into a police car and that is not always comfortable and we want to make sure the officer knows what the law is, what is required of them, know where to get services and who to call if they have a question in the field when it comes to our kids, because they well, when they go out into the world, most likely in their career have many calls when it comes to children and transporting them for needs.

So, crisis intervention teams in Oklahoma. Let's talk about funding a little bit. Now you saw that we are not the best funded state in the nation, and so we have had to get very creative. Just to let you guys know, there is funding out there. We currently run our CIT program do to a grant from the bureau of Justice Assistance. We have a small grant of about $200,000. This grant pays for trainers to attend training which is an interesting concept. So what we are doing is a small figure, but we are seeing through this grant officers or departments, I'm sorry, not the officers themselves but departments to send their officers to training. Let's say somewhere in Oklahoma they send an officer and they get $400 for that person to attend training to help offset some of the cost that they might have incurred for the training. It also pays for lodging and per diem for our trainers to go to these trainings for a week so we are usually out of town, hours away and so we have to stay somewhere obviously, so it pays for lodging and per diem. The training also has helped us focus on rural Oklahoma. The last numbers we saw were that about 70% of the rural departments in Oklahoma have 10 or fewer officers. As you can imagine it is very hard for them to send even one officer to training. We like to go to them as much as possible and help them with those costs.

Carl Pendleton: Our team itself is really composed of officers from all over the state from city municipalities to sheriffs' departments and we really have a, an eclectic group of individuals who are really committed and passionate about the topic. And what we have done this year with how many trainings we are doing, we are doing 10 trainings so we divided the state into a North and South version. Our second largest city in the state in Tulsa has a number of trainers that they have offered and then we have the central training team and so we try and share the training in half, so that the top half will go to the top squad in the bottom half will go to the central squad. We kind of have a way of making it work so that everyone is not overwhelmed. Previously when we were trying to get the same group to everything it was really tiring for everyone, and the agencies were not able to send their officers all the time. And specifically, the officers who train are not specifically paid as trainers. They are paid through their agency for a normal work day but they do not make extra money for becoming trainers, and that is very intentional. One is we do not have the money for it, and two we want officers who are dedicated and committed to the program. They want to train because they have a desire to train not because they are getting paid for it. It has been very beneficial as well because the CIT group is part of officers who have a chance, who have input on laws and know what is coming down the pipe when the law changes as it does annually. It has been really really effective for law enforcement, we have changed things and have become far more familiar with the law itself. We realized a lot of our officers were doing a terrible

job creating affidavits for people going into mental health services, and so a lot of the training is training our officers to do better with the work they provide to the mental health communities. That alone has increased our cooperation with the mental health community substantially because our officers are not getting turned away as often or have to take people back home, and that frustration the grew is not happening as much. Tania mentioned earlier but it is really important to make sure the officer you choose for this training is someone who is compassionate and wants to be there -- there have been chief of police who go through the training and are ecstatic about it and love it and say I want all of my officers trained. Well that is great in theory, but in practice it is not so good. If you have an officer who is a CIT officer who does not want to be a CIT officer and goes back and burns bridges, that destroys the program. We want to make sure the officers being trained are compassionate and really want to be there and have the ability to use the de-escalation techniques.

The administration has to buy in and be willing to have someone really focused on this area and tack some the statistics within the agency to make sure that injuries are decreasing but we also have to make sure the administration is willing to build those bridges with the mental health community. Outreach with the community, the mental health community, with administrators, invite those leaders to come in and do ride a longs and facility tours and build that relationship because it is really important to get along with our mental health administrators because we have to work together. And so it is not just the officers on the street but also the administration behind-the-scenes building bridges and processes to make it smooth for everyone involved.

Tania Woods: We have kind of touched on this a little bit but just to make sure that everybody understands and hears us, look at some of the challenges to address on the training and team issue. For instructors, we want to make sure that the instructors again are passionate and we know that. We do -- most of our trainers are currently on the street. They're out there working. What to make sure that they have a pulse on the current issues, that they know what is going on out there with providers, with crisis centers, you know, and they have stories to tell. With our mental health professionals, you know, this has really been great for us. But it was a little bit of an uphill battle just to get mental health professionals involved but once we did they have been really great. We get a child specialist to come in and substance abuse specialist to come in. The provider panels are always happy to come in and work for us but I do want to say on this, when we are picking mental health professionals to stand in front of law enforcement and train, we want to make sure that they are the right person if that makes sense. I mean, we want to make sure that we don't lose the officer right away. Make sure that you find professionals that are going to connect with your police officers. We talked about treatment services and access and budget and what we needed to do with that. Obviously, we have a pretty low budget but we helped offset that with the grant.

Carl Pendleton: For law enforcement, there are additional challenges. You know, our officers are responsible for transporting those in crisis to different facilities, and when you have a decrease in funding to state agencies, the department of mental health goes down -- beds decrease, they are also spending more time transporting folk's hours away so that becomes challenging as to compassion fatigue. But one thing we have started to focus on is talking to officers about their traumatic experiences and what is going on with them and their mental health, making sure they understand the challenges they are experiencing. Any time there is a tragedy with a mental health consumer and their family, either injury to them or death, that also affects the officer and their family. So when we let them know, and have an introspective look and think about that more it helps them be compassionate towards the

folks they come into contact with. So that helps reduce the discrimination and myth and labels that they use when they realize they have challenges as well.

Tania Woods: We also want to make sure that when the officers leave the training that they always have information for all the trainers so that they can access us, call us or email or text with any questions or issues. We have a Facebook page that we have that we try to update as much as possible with continuing education, information on what is going on. Officers can get on there and ask questions, ask us question, kind of just discuss what they need to. The challenge point I kind of want to talk a little bit more about is really wanting to make sure that we acknowledge officers that are CIT officers that go above and beyond the call of duty. We have whoever, anybody can write in and nominate someone for a challenge coin and then we do present that challenge coin to them at the department in front of their peers and commands. We want to do this obviously to acknowledge them but also make an example and make sure that everyone understands how important these folks are. This also comes with a letter of thanks from our Commissioner and makes sure they are examples to the community.

Carl Pendleton: Just a couple of -- we will just share one story for the sake of time. Our officers get letters of appreciation from the community but an officer that went through our training in October wrote to us and he – the day that training ended -- he is not a new officer, a new CIT officer, but he's been an officer for over ten years, and he had an experience where he went to a call right after and there were a number of officers who had been dealing with this guy for hours and they were about to arrest this guy for public intoxication because after dealing with him over and over they were having trouble and couldn't figure out a better way to deal with them and he definitely appeared impaired to them. He realized from the training that this guy was exhibiting symptoms that were not necessarily drug or alcohol symptoms and he asked if he could take over the call and he actually talked the person cooperatively into mental health services, got him to the E.R., and lo and behold he had no illegal substances, no alcohol, no drugs whatsoever in his system and he was able to get the mental health services he needed without arrest because he wasn't committing a crime. Is a perfect success story for what we are looking for in trying to do. It was great to hear from him, who was an officer for over 10 years, he said if he had not done that training he would have supported arresting the guy for that call. So that is the ultimate goal, to make sure people get the resources they need, a healthy space that is appropriate for what they experience.

Tania Woods: Okay, and so we want to also talk a little bit about wanting to understand that it usually isn't just issues with mental health. For a person, it is kind of a big continuum and we have other challenges and folks have other challenges such as addiction issues, high criminologic risk etc. We have these proposed unifying principles that we want to look at really quick. We want to make sure the person is the focus of intervention. Mental health treatment is a necessary component, but we want to make sure it is given in the least restrictive setting and with the least intrusion on individual choice. We talk a lot about this in training, and how it is important for all of us to understand that everybody has a choice on their treatment and their treatment providers and that is something that we need to be respectful of. We also know that it is not linear, that recovery is not linear. There are relapses and that is okay, and it is not anybody's failure. We all go through that. As clinicians, we see folks go up and down and that is okay too. We need to think outside the box sometimes with folks that have issues and we tried one thing one time and you know what they are in need again so let's try something different. So, we want to make sure that effective intervention should increase the quality of life for people with SMI and enhance the safety of communities where they reside. These principles support the framework of

serving the interventions at the intersection of criminal justice and behavioral health guided toward outcomes of interests. These seven unifying principles bring together the common goal of recovery for all people. And that is it for us. Melody, we will send it back to you.

Melody Riefer: Thanks, you guys. I have to say when we were working on developing this webinar and having the conversations to see how we could focus this, I learned so much and I thought I was pretty familiar with CIT. I had presented and represented the voice of somebody in recovery who had been diagnosed with a serious mental illness, and it was really -- I thought I just knew what was going on, but I learned so much. The numbers, kinda the realities of how the law enforcement officers have to take on so much of the responsibility for training but that the training needs to involve many more people so that all of this perspective are represented. And so just thank you so much for sharing your work. It is great for a group of providers, which is what this audience represents, to hear from people who have done this work and are doing this work day after day, year after year. Cause that is a voice we do not always get to hear from.

There are some questions from the audience, and the first one that I want to kind of bring to your attention is how have you addressed sustainability related to these programs? You mention the challenge coin, you mentioned some of the funding issues, but do agencies, do police departments or communities get retrained, is there continuing education? How do you sustain CIT programs and CIT officers?

Carl Pendleton: One of the main ways that is helpful in making sure that these programs continue in a law enforcement agency itself is making sure an agency is willing to let someone be part of the training team. That helps keep those officers up-to-date on everything that is going on, and every year every officer in our state in particular is required to do continuing education on mental health at least two hours with an update on mental health, and those officers who are CIT officers typically are responsible for that training. On top of that it is really, an individual agency has to take it upon themselves to shape and mold what their program is, because every agency is different in what they encounter. Even though the base principles of CIT are universal and can be used, every community is different in how it is implemented and so we cannot govern that for them. They have to have to govern that for themselves, because what my agency in a college town encounters is different from what a rural agency encounters with a population of 2500 when I have population of 120,000. And so, things are a little bit different so we have to leave a lot of that up to them. But the sustainability of it is, continue to make it available and continue to train officers as people get promoted and let new officers come in and join the ranks as well.

Melody Riefer: Excellent. Excellent. Is there an online option for the CIT training that you are aware of? You mentioned how difficult it is for some of the rural and frontier communities to free up their officers to attend the training. Do you know of anything like that?

Tania Woods: We have not heard of anything. We do as trainers try to go to the CIT international conference every year, so we do like to keep a pulse on what is going on nationally and that has not been something that has been done as far as we know.

Melody Riefer: Okay.

Carl Pendleton: As a law enforcement officer, I would really push against that. It would be --there are so many questions and so many nuances that are asked throughout the training that you really need

that back and forth, so I could see an interactive online version of the class, but, potentially, but the interaction that occurs within the classroom is key to the growth. And so doing it online as a lecture only would be really challenging.

Melody Riefer: Okay. That makes sense. Even with this webinar there has been so much conversation, if you will, although it is virtual, that I can appreciate where the training would benefit from being very conversation driven. Are there any steps you take on a day-to-day basis to improve the relationship between mental health providers and law enforcement?

Carl Pendleton: Absolutely. We really push and encourage our officers in the agencies to go and contact the mental health providers in their community and start to build those relationships particularly at the administrative level. We have monthly meetings between all our mental health providers in our area and we encourage others to do the same, just to discuss any issues, problems and concerns that come up. It is a relationship. Every relationship needs maintenance. And so we have monthly meetings, and those meetings are held sometimes at their facility and sometimes at ours. It is just that continual conversation to make things better. About five years ago, in our area in particular things were pretty contentious, but with CIT and law enforcement opening our eyes a little bit, it helped us realize we have a much bigger role to play in smoothing out that relationship. We took on more of the role of facilitating that things have become so much better because the mental health community realized we were not working against them and we were all working together so that monthly meeting has been really helpful. We bring in the community organizations like NAMI to help out, and we also invite each other to trainings so we invite our mental health community to our citizens police academy and other events we have going on and they in turn invite us to other events. And we try to figure out what providers are going through and what they are experiencing. And so that shared relationship has been really really beneficial.

Melody Riefer: That is great. So, how broadly do we define the term law enforcement officer within this conversation? Because, and some of the questions were who actually gets trained and I know from your bio Tania that you are involved with different kinds of law enforcement officers but, so police department, who else gets trained in CIT?

Tania Woods: We have also trained probation and parole officers. So, what we have done in that instance is we held a specialty training for them so we did a little to make sure that we addressed their needs, kind of in specialty, and then we also have trained correctional officers inside prisons and jails. That is a different population, prisons as opposed to jail, and again we have trained them and tweaked a little bit when it came to what their specific needs are when it comes to somebody that is incarcerated, but unfortunately a lot of our folks are incarcerated whether in jail or prison and these correctional officers need to have the skills to also work with them and make it safer for both the correctional officer and the person in need. And so, we definitely try to train as many as we can -- we have had fire come in before and we've trained those folks. So, they are often first responders -- hospital security is a big one. Folks come in sometimes just on their own, and so we do tons of training with hospital security and also with dispatchers. We want to make sure that dispatches understand when a call might be mental health-related. It is not always, they do not always get a call that says my loved one has a mental health issue, I need a CIT officer. It is not that clear, so we want dispatchers to be able to ask the questions that need to be asked to decipher that I think I might need a CIT officer out on this call.

Melody Riefer: Wow, that is great. We are quickly running out of time but I am wondering if there is something you could suggest to those of us who are providers -- what can we do to help bring CIT to our communities?

Tania Woods: I think, you know, first of all a partnership with the local law enforcement. I think starting small at first and getting with the Department of mental health, getting with their local police department, getting with the advocacy groups in NAMI. Doing it without NAMI would not work. So make sure that we get with NAMI and you can start small and make sure there is funding available. I really wanted encourage the CIT conference you know you can Google that and I don't know if we can maybe put that information up somewhere but it is somewhere different every year. I'm not sure where it is this year but a lot of this breakout sessions have to do with starting your own program and how to do it. It would be really beneficial to start there, but making sure there is enough funding to do it right as well. Because a lot of folks think well forty hours is a long time, maybe we can do this that or the other, and I think keeping it to the model, and faithful to the model is so important. I'm one of those who do not like to deviate from evidence based models so I really feel it is important if we are going to do it, let's do it right.

Melody Riefer: Wow there is some wisdom there. Thank you for saying that. So, checking out the national conference as a resource and somebody just provided a link to the CIT international organization, and, then Laurie just put a link up in the participant chat to the 2017 conference and finding out about that. That is going to be in Fort Lauderdale in August which means it is going to be humid but that would be a good reason to stay inside and attend those sessions. You guys, thank you so much for your expertise. I want to share some information with everybody about what they can do next.

Recovery to Practice has a quarterly newsletter that is available. The next issue is focused on criminal justice and explores other areas. You can get a free copy. All you have to do is sign up on the Recovery to Practice website. We have two more webinars that I have already mentioned that are going to be looking at other dynamics inside criminal justice that includes peer support for reentry and addressing service gaps and cultural considerations within services provided to people who are tribal members. I want you to know that Recovery to Practice has been around for a while and we are working on making sure that providers have the resources and access to current information so that they can deliver recovery oriented behavioral health practices. We go from talking about theory and actually do things differently so that we can meet people's needs. There are curriculums that are discipline specific, so if you are a psychiatrist or psychologist or social worker or peer specialist you can get access to the curriculum related to Recovery to Practice at our website. All of this is based on and driven by SAMHSA's ten principles and four dimensions about recovery in behavioral health. And I would encourage you to access that information if you are not familiar with it. But recovery has to touch on home health community and purpose in order for people to sustain their recovery and wellness.

We want to help you all develop the expertise that you need in these areas. So that at whatever level you are involved with behavioral health services, whether you are working in an inpatient facility or providing community-based case management, or you are a peer-bridger, or you are a psychiatrist working part-time at several different clinics, we want to help you provide services that are hopeful and helpful and recovery oriented. You can do that by checking out our webinars. We have a slew of webinars that are available as recordings so if you've missed our resources, check it out. You can, as I mentioned, subscribe to the newsletter and you can get access to information via our website.

If you need continuing education hours, NAADAC has approved this hour that you've spent with us. There is a link that will be available for you to click on so that you can take the quiz and so that you can get a certificate for your participation. That will be available immediately following this presentation. Join us in two weeks for our next webinar. If you have not registered I trust that you will be able to do that as soon as you get off of this one. In the meantime, think about the information you've heard and how you can apply it and become an advocate for having trained and supported law enforcement officers in your community. We need to make sure that first responder understands and has the skills and connections to be able to help people to have their needs met. Thanks for joining us today. Tania and Carl thank you for your expertise and time. We appreciate you very much. Ya'll have a great day. Bye bye.