THE HONORABLE JAMES L. ROBART

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

UNITED STATES OF AMERICA Plaintiff, vs. CITY OF SEATTLE Defendant.	CASE NO. 12-CV-1282-JLR **MEMORANDUM SUBMITTING SEATTLE POLICE DEPARTMENT CRISIS INTERVENTION TRAINING**

Pursuant to the Second-Year Monitoring Plan, approved by this Court on March 24, 2014 (Dkt. No. 129), the Monitor hereby submits the attached, proposed Seattle Police Department's ("SPD") training materials on crisis intervention ("CI").

The materials include the following:

1. SPD's CI Training Strategy, attached hereto as Exhibit A
2. CI Basic Training Curriculum and Resources:
    a. Lesson Plan, attached hereto as Exhibit B-1
    b. Facilitator Guide, attached hereto as Exhibit B-2

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c. Four e-learning modules, attached hereto as Exhibit B-3 through B-6

d. Resources Documents, attached hereto as Exhibit B-7 through B-10

3. Communications (a.k.a. "Dispatcher") Training Curriculum:

a. Lesson Plan, attached hereto as Exhibit C-1

b. PowerPoint, attached hereto as Exhibit C-2

4. CI Coverage Strategy, attached hereto as Exhibit D

After careful review and consideration, the Monitor agrees with the Crisis Intervention Committee ("CIC") and the Parties that this training represents an important advance in SPD's approach to equipping its personnel with knowledge, resources, and tactics necessary to "reduc[e] the use of force against individuals in behavioral or mental health crisis, or who are under the influence of drugs or alcohol, and to direct or refer such individuals to appropriate services where possible." Dkt. No. 3-1 at 41.

In short, the proposed training satisfies the letter and spirit of the relevant substantive provisions of the Consent Decree and the Monitor respectfully requests that this Court approve it.

BACKGROUND

The Department of Justice's ("DOJ") investigation in 2011, from which this matter sprung, found that SPD's patterns of excessive force often arose from encounters with persons with mental illnesses or those under the influence of alcohol or drugs. Dkt. No. 1 at 7. This finding was particularly troubling because, by its own estimates, 70% of SPD's use of force during that time period involved these populations. Dkt. No. 1-1 at 6.

Paragraphs 23-25 of the Memorandum of Understanding ("MOU") between the parties

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and paragraphs 130-137 of the Consent Decree (Dkt. No. 3-1) required the Department to develop policies and procedures to address these concerns. Importantly, these policies and procedures were to be developed in collaboration with the CIC, an all-volunteer advisory committee composed of the best and brightest of regional mental and behavioral health experts (providers and clinicians), advocates, academics, outside law enforcement representatives, the judiciary, and of course command-level members of the SPD. MOU at ¶ 23.

This collaboration bore fruit in the policies that this Court approved on February 10, 2014, and the institutionalization and re-vitalization of the "design and structure of its crisis intervention program," as required by the MOU. MOU at ¶ 25(e); Dkt. No. 121 (approval by Court); *see also* Dkt. No. 120 (Monitor's Memorandum Submitting the CI Policies).

Building off those achievements, and as required by the MOU and Consent Decree, the SPD and its CIC[1] set off to evaluate and develop training for:

(1) All (non-specialized) officers who confront crisis events and who will receive basic training on crisis intervention;

(2) Specialized CI-certified officers who will be highly trained, who will be dispatched to every scene where the police communications center suspects a behavioral crisis, and who, <u>for the first time</u>, will take primary responsibility at the scene of crisis events; and

(3) Dispatchers and other communications personnel so that they may more readily

[1] To aid the efforts of the CIC, the DOJ arranged for two experts to be available to consult: Randy Dupont, Ph.D., from the University of Memphis, an expert who played a crucial role in creating the CI Team for the Memphis (Tennessee) PD and dozens of other departments; and Sgt. Elisabeth Eddy (retired), who played a similarly major role in formulating a prior iteration of CIT at SPD and was a CI instructor at the Washington State Criminal Justice Training Center. Ellen Scrivner the Monitoring Team provided her knowledge of relevant issues gained as a result of her role in the creation of CIT operations at the Chicago Police Department.

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identify calls for service that involve behavioral or mental health crisis events. MOU at ¶ 25(c)-(d); Dkt. 3-1 at 133-135.

The following training accomplishes all of these goals and more as described below.

Training Presented

A. CI Training Strategy

A central insight developed over the course of several months of discussion with the CIC was that CI training had to be woven into the culture of the department, not through one-time-only training, but as a regular part of its training program going forward. The Training Strategy conceptualizes and represents the inculcation of these principles in a wave of "phases" of training.

In Phase I, with few exceptions for even more highly trained officers, all sworn SPD personnel will attend the Basic (eight-hour) Crisis Intervention Training Class currently offered by the Washington State Criminal Justice Training Commission ("CJTC"). To reiterate, this is training for all 1300 officers done in collaboration and partnership with and at the CJTC. Furthermore, this is training that is largely funded by the King County MIDD fund and, thus, a cost-effective way for the City to proceed. Officers will then complete four e-modules, described in greater detail below.

In Phase II, SPD will reinforce this training in several sessions of every officer's contractually-required 32-hour "Street Skills" training.

In Phase III, those select officers ("CI-Certified") who have shown an interest and aptitude for working with people in crisis will receive "advanced" training, on top of their required 40 hour training. The content of that training will be provided to the Court later this

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year, consistent with the Second-Year Monitoring Plan.

In Phases IV and V, this virtuous cycle is repeated for continued development and emphasis of these skills.

We wish to emphasize the following extremely important points. First, this training program begins to breakdown the "silo" SPD had created over time in which it separated itself from the best regional training initiatives. SPD is now pooling resources and collaborating with CJTC and the CIC on every step of this important initiative.

Second, the CI program they have developed (based on the "Memphis Model") represents the best practices in urban policing and, more importantly, makes the Program relevant to patrol officers and the challenges they face on the street.

B. Basic Training

Attached are the lesson plans and facilitator guides for the Basic Training that will occur at the CJTC. In order to get all 1300 sworn personnel through the Basic Training by December 31, 2014, SPD has divided personnel into "key" and "non-key" personnel (only) for purposes of CI training. "Key" personnel are those officers assigned to units that are likely to engage with this population. They will attend the smaller (no more than 50 students per class) iterations currently offered at CJTC in order to better benefit from role playing scenarios. Non-key personnel will attend Super-Sessions presented in the CJTC Auditorium with class sizes up to 400 students. This will allow all non-key personnel to have baseline knowledge of CI fundamentals by December 31, 2014.

Two additional points are particularly relevant here: first, the CJTC has been open and cooperative to changes in its lesson plans, both vis-à-vis the SPD and its CIC, even though it is

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not subject to the Consent Decree. For example, a CIC member raised concerns about how certain diagnoses were described and categorized in their lesson plan. The CJTC made changes to its program after vetting it with its own subject matter experts.

Second, and again, the CJTC training is intended for all Washington State police departments and sheriff offices. There are not "Seattle specific" parts of the training. Thus, the e-learning modules supplement that training by:

1. Describing the new CIT policies and programs unique to Seattle;
2. Describing the emergent detention (involuntary treatment) process in King County Mental Health Court;
3. Describing the many relevant resources available in King County and how to access those resources; and
4. Describing and providing some examples of SPD's unique "active listening" training.

Together the CI e-modules provide each officer the knowledge needed to ensure compliance and implementation of the new Court-approved CI policies.

Finally, as part of the development of Basic Training, the CIC's systems subcommittee developed the following resources for officers, which line officers and the SPD Training unit believed would be helpful to officers:

1. A summary of the Involuntary Treatment procedure in King County Mental Health Court;
2. Schematics of the resources available system-wide in King County;
3. A decision-making chart for officers confronted with a crisis event; and

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4. A Pocket Guide for officers to print and carry on key concepts and key resources in the County.[2]

Again, the Monitor and the Parties greatly appreciate the hard-work of the CIC and hope that the CIC finds it gratifying that its work is going directly into re-shaping the SPD.

C. Dispatcher Training

The new three hour CIT Dispatcher Training is for all 300 communications personnel. The training is intended to prepare SPD communications personnel to recognize individuals who are experiencing a behavioral crisis event and who need the assistance of a CIT-certified officer. It will also allow dispatchers to locate such an officer to address the individual.

The dispatcher training materials were originally authored by members of the SPD and submitted to the CIC. As with the other types of training, the CIC, Parties, and Monitor have engaged in a process of revision and refinement of the dispatcher training materials that has been substantial, productive, and collaborative. That process has included an SPD-initiated pilot training of Dispatchers that has allowed for the integration dispatcher feedback into the training materials.

The three-hour, in-person training course for dispatchers addresses four central elements: (i) communicating with an individual experiencing a crisis event; (ii) determining if mental illness is a factor in the incident; (iii) locating CI-certified officers; and (iv) identifying possible community mental health resources that can assist the subject in crisis. With respect to these elements, the training provides dispatchers with important instruction on critical skills. For

[2] The CIC data subcommittee has also developed a scientific survey of officer attitudes towards the CIT program, and forms and data collection plans that will revolutionize the way the department manages its officers who contact these populations going forward. These will be provided under separate cover on a later date.

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instance, although communication dispatchers necessarily do not diagnose mental illnesses, the training provides dispatchers with techniques for facially recognizing the potential signs of schizophrenia, bi-polar disorder, depression, and other mental disorders that SPD officers often encounter. The training includes instruction on active interviewing skills to enable dispatchers to de-escalate crisis situations and to cull pertinent information from the individual so that officers can respond to the scene. The submitted training also includes instruction on how dispatchers can use SPD technology quickly and effectively to identify on-duty officers who are CI-trained and can be dispatched as necessary.

Communications Dispatchers will also learn about important community resources that can assist SPD with CI events. These resources include services from the King County Mobile Crisis Team, the Crisis Clinic, and the Seattle Municipal Mental Health Court. The CIC's social service and clinical representatives have contributed significantly in ensuring that dispatchers receive necessary information about the full array of services and resources that are available to subjects in crisis.

D. CIT Coverage Strategy

Paragraph 130 of the Consent Decree (the "coverage provision") requires SPD to "ensure that CI [certified] officers are available on all shifts to respond to incidents or calls involving individuals known or suspected to" be in behavioral crisis. While it defines what training is required for an officer to become "certified," the Consent Decree does not define when "certified" officers must have completed their training, or conversely, how long ago is too long ago to be considered current on CI training.

It is a complicated matter to determine which officers should be presently considered to

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be "certified" and then to determine the effect that standard has for the coverage provision. It is not as simple as establishing a bright-line cutoff date, but must take into account the fact that some officers who were trained years ago may still be current in their skills due to continued use and the nature of their assignments. We appreciate the hard work of the CIC's various subcommittees, the SPD, the DOJ, and the Monitoring Team consultants in coming to a workable and fair solution to this important question.

The CIT Coverage Strategy sets forth a reasonable and "holistic" process to identify those officers the Department wishes to hold out as "certified." It has redundancy built in to capture those officers who should stay in the program, weed out those who do not wish to, and if there are not sufficient volunteers at this time to build a Program to meet the requirements of the Consent Decree.

Pursuant to the Second-Year Monitoring Plan, by June 15, 2014, the Department will assess the effect of the process on the coverage provision. SPD, in short, will then know how to populate its revitalized, highly trained and dedicated CIT-certified officers.

E. Conclusion

The task of the Monitor was to duly consider if the proposed CI training embody the requirements of the Consent Decree. The Monitor and the Monitoring Team have determined that the training materials submitted here do so. Accordingly, the Monitor respectfully requests that this Court approve these training materials and order SPD to proceed with training dispatchers using the materials forthwith.

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DATED this 30th day of May, 2014.

_____
Merrick J. Bobb, Monitor

IT IS SO APPROVED:

_____
HON. JAMES L. ROBART

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CERTIFICATE OF SERVICE

I certify that on the 30th day of May, 2014, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the following attorneys of record:

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DATED this 30th day of May, 2014.

/s/ Carole Corona
Carole Corona

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EXHIBIT A

Crisis Intervention Training Strategy

Goals:

1. Provide a baseline familiarity with the resources available and structure at the County Mental Health level.

2. Provide the basic tools and knowledge of requisite laws, forms, and key behavioral identifiers necessary for appropriately completing forms for mental health holds for both voluntary and involuntary evaluations.

3. Introduce crisis management and de-escalation skills which will assist officers in managing subjects in crisis.

4. Further develop advanced crisis management and de-escalation skills with expansion into many types of tactical interactions through scenario-based training.

5. Identify and provide 40-Hour CIT Certification training to select individuals who demonstrate an interest and aptitude for working with people in crisis.

6. Provide on-going crisis intervention training at both the basic and advanced level for the relevant audiences at least annually into the future.

There are two distinct groups of Sworn Seattle Police personnel identified as requiring some level of additional training in Crisis Intervention. These groups are identified as “key” and “non-key.” Key personnel are those personnel identified as being in positions likely to expose them to interaction with a person in behavioral crisis in the course of their duties. These Units would include:

All Patrol assignments (Patrol, Community Police Team, Anti-Crime, Bicycle Patrol, etc.)
Vice & High Risk Crimes Unit
Homicide Unit
Robbery & Gang Unit
Criminal Intelligence Unit
Harbor Patrol Unit
Canine Unit
SWAT Unit
All Traffic Units

All other Units are considered “non-key” personnel in the context of crisis intervention training.

Within these two groups, there are two possible levels of Crisis Intervention training: Basic and 40-Hour Certified.

Basic crisis intervention training is an eight-hour course intended to provide the rudimentary awareness and knowledge to identify a person in behavioral crisis and to react accordingly. The 40-Hour Certification course provides additional knowledge of the support systems and structure in place for assisting the mentally ill, more in-depth awareness and recognition of signs and symptoms most common to persons in behavioral crisis, as well as additional communication strategies. The Seattle Police Education and Training Section has developed an additional four e-Learning modules to provide additional information, knowledge of SPD-specific policies, and communication skills. These modules are completed by all Sworn personnel regardless of whether they complete the eight or 40-hour course.

Plan Summary:

Regardless of whether an organizational position is considered "key" or "non-key," the Seattle Police Department feels that all personnel will benefit from the skills and knowledge inherent in crisis intervention training. In addition to the defined Crisis Intervention courses, ETS has embedded related training into several facets of this and the coming years' training courses. The following plan describes in detail the training each sworn employee will receive, but briefly:

- All who are not 40-Hour certified will attend an 8-hour Basic CIT course in 2014.
- All who are 40-Hour certified will attend an 8-hour Advanced CIT course in 2014.
- All will complete four e-Learning modules related to CIT in 2014. These will be completed within 30 days of completing their CIT course.
- All will complete de-escalation as part of the two-hour Core Principles training in 2014
- All will complete a scenario with a person in crisis as part of their four-hour Team Tactics training in 2014
- All Crisis Response Team or Hostage Negotiation Team members may attend the Crisis Intervention Conference or Western State Hostage Negotiators' Conference in lieu of the Advanced CIT course.
- All Key non-40-hour certified personnel will attend an 8-Hour Advanced course by late 2015 after they have completed the Basic course.
- All will attend an 8-Hour scenario based course on de-escalation and decision making in 2015.
- All personnel who remain in key Units will continue to complete 8-hours of refresher or Advanced training as appropriate to their certification level annually.

Plan:

Phase I

All key sworn personnel will attend the Basic eight-hour CJTC Crisis Intervention Training Class currently offered by the Criminal Justice Training Commission. Key personnel will attend the smaller (no more than 50 students per class) iterations currently offered at CJTC in order to better benefit from scenario-based learning. Credit will be given to those personnel who have already attended the training based on the criteria currently being established by the Crisis Intervention Committee.

All non-key sworn personnel will attend the Basic eight-hour CJTC Crisis Intervention Training curriculum currently offered by CJTC. These personnel will attend Super-Sessions presented in the CJTC Auditorium with class sizes up to 400 students. This will allow all non-key personnel to have baseline knowledge of Crisis Intervention fundamentals by December 31, 2014. If slots are available, non-key personnel may attend the smaller Basic eight-hour CJTC Crisis Intervention Training Class in lieu of the "Super-Sessions."

All Seattle Police Sworn personnel will further complete Crisis Intervention e-learning modules tailored specifically to address Seattle-specific structure, resources, and methods, as well as a module focused on de-escalation and Active Listening. Personnel will complete these modules within 30 days of completing the 8-hour Basic course. This training will be completed by December 31, 2014.

Phase I would ensure that all Seattle Police Sworn personnel have a common, fundamental understanding of Crisis Intervention techniques, SPD specific policies and forms, and operational structure of the King County Mental Health system by December 31, 2014.

Phase II

All Seattle Police personnel will receive further instruction on de-escalation techniques in the Core Principles instruction presented as part of the Use of Force Phase II Unit to be attended in 2014.

All Seattle Police personnel will participate in de-escalation scenario-based exercises as part of the Skills II course and Tactics course also presented as part of the Use of Force Phase II Unit to be attended in 2014.

Use of Force Phase II will be presented concurrently with the proposed Crisis Intervention Phase I in Training Year 2014, so it cannot be assured that the training will occur in the ideal sequence. In any case it ensures that students are exposed to the concepts repeatedly and in different learning formats. Use of Force Phase II ensures that all Seattle Police Sworn personnel have an opportunity to apply the techniques associated with Crisis Intervention Phase I in Training Year 2014.

Phase III

The CJTC-MIDD-SPD work-group has begun development of an advanced Crisis Intervention Course to be presented to the Monitoring Team by July 16, 2014. This course will include additional training on Crisis Intervention concepts in more depth for key personnel. Preliminary meetings are underway between these groups, as well as with the Crisis Intervention Committee.

All key-personnel will be required to attend this training. Officers who have completed the 40 Hour certification course prior to 2014 and who are deemed to still be active as CIT officers will complete this course in 2014 as a refresher course. Key Sworn personnel will also attend this training at any time after they have completed the eight-hour Basic Course, but no later than Training Year 2015. Personnel who complete the 40-Hour CIT Certification course in 2014 will not be required to complete the 2014 Advanced Course.

Hostage Negotiation Team and Crisis Response Team members may substitute attendance of the Crisis Intervention Conference or Western State Hostage Negotiators' Conference to meet the Advanced Course requirement.

Phase IV

All Seattle Police Sworn personnel will attend eight-hours of scenario-based training focused on de-escalation and decision-making in 2015 as a part of their annual training. This training will continue to expand on the premise of identifying the opportunity to de-escalate a situation from the outset, as well as using learned skills to identify and implement more successful strategies to manage, de-escalate and defuse dynamic situations.

Phase V

Those personnel who have had the Basic Course and who remain in Operations-oriented Units will continue to complete annual refresher training or Advanced CIT Training as appropriate. This training will include scene management and de-escalation components in all iterations.

40-Hour Certified CIT Officer Course

Seattle Police will continue to place key personnel and others into the 40-Hour CIT Certification course. The multiple exposures to Crisis Intervention scenarios and training in the eight-hour blocks of instruction will increase the opportunities to recruit key personnel into this more comprehensive curriculum.

Officers who have completed the 40-Hour Course will be kept current through attendance at the annual Advanced Training (beginning in Phase III). There is a need for further discussion as to whether the annual and advanced training need to be separate curriculums beyond Phase IV. It may be appropriate at that time to combine both curriculums into one common 8-Hour Advanced-Refresher Block as all key personnel will have had a minimum of 24-Hours of increasingly complex CIT relevant training by this time.

Attendance Tracking

Personnel who attend each phase of training will be registered for the course by the Seattle Police Education and Training Section (ETS), regardless whether the course itself is a joint Seattle Police/Criminal Justice Training Commission course or exclusively created and offered by the Seattle Police Education and Training Section. Completion records will be maintained for each class and employee by the SPD Education and Training Section as is the case with all training associated with SPD ETS.

On-Going Review and Revisions

The Seattle Police Training Section will continue to collect data and input from the Seattle Police Crisis Intervention Team, Crisis Intervention Committee, Mental Health Professionals, and Operations Bureau to identify opportunities to improve or focus training, adjust regional resources, or otherwise meet changing needs.

The primary formal contact between the Seattle Police Department and the Mental Health Community will be the Crisis Intervention Coordinator, with assistance of the Seattle Police Crisis Response Team. Seattle Police Training will meet with the CIC Coordinator and the Crisis Response Team quarterly to ensure regular contact, identification, and dissemination of concerns, best practices, and changes.

Crisis Intervention Training Timelines (approx.)

Phase I — Present to December 31, 2014
8-Hour CJTC-MIDD SPD Basic Course (existing curriculum)
Key Personnel attending Classes of 35 – 50 students
Non-Key personnel attending Super Sessions of up to 400 students

Phase II — May to December 31, 2014
SPD Specific, De-escalation, Active listening e-learning modules
6-Hour Core Principles & Skills II De-escalation training and scenarios
All sworn personnel attending and completing

Phase III — Fall 2014 to Summer 2015
8-Hour CJTC-MIDD-SPD Advanced Course (In development))
All key-personnel attending
All CIT Certified personnel attending

Phase IV — Training Year 2015
8-Hour Scenario-based Training (scene management, de-escalation, active listening)
All sworn personnel attending

Phase V — Training Year 2016 – On Going
8-Hour Advanced-Refresher Training (scene management, de-escalation, as indicated)
All key-personnel and CIT Certified personnel

40-Hour Crisis Intervention Training
Initial attendance is currently voluntary, but encouraged

Advanced Training is Phase III — Fall 2014 to Summer 2015

HNT & CRT may attend CIT or WSHNA Conference in lieu of Advanced Course — 2014

On-Going Advanced-Refresher Training is Phase IV and V — 2015 – On Going

EXHIBIT B

CI Basic Training Curriculum and Resources:

EXHIBIT B-1

Seattle Police Department
Education & Training Section
Lesson Plan

Title of lesson or course: Crisis Intervention Team Training

Assigned Course Number:

Author: Officer Daniel Nelson #6883 via CJTC (no edits)

Date Written/Revised: 05/07/2014

Approving Authority: ***PENDING***

Overview:
Sample course is an 8-hour course which will consist of the following major blocks of instruction:

1. Identification of behaviors that are related to psychosis and intervention techniques
2. Identify behaviors indicative of an individual experiencing Bi-Polar Disorder and appropriate intervention strategies
3. Recognize individuals with Developmental Disabilities and strategies on how to communicate with them
4. Identify common indicators an individual is experiencing with PTSD and techniques that can diffuse the individual
5. Recognize common behaviors associated with Depression, Anxiety, Fetal Alcohol Syndrome and Attention Deficit Disorder
6. Identify risk factors for suicidality and what intervention strategies are most effective

Course Goal(s):
Crisis Intervention Team, or CIT, refers to specialized training for LE on how to respond to calls involving person in mental health crisis, with developmental disabilities, or other severe behavioral emergencies. Officers learn appropriate techniques to identify, assess, and resolve these calls in a safe and efficient manner.

Course Objective(s):
Upon completion of this course, participants will have demonstrated knowledge of the following:

1. Identification of behaviors that are related to psychosis and intervention techniques
2. Identify behaviors indicative of an individual experiencing Bi-Polar Disorder and appropriate intervention strategies
3. Recognize individuals with Developmental Disabilities and strategies on how to communicate with them

4. Identify common indicators an individual is experiencing with PTSD and techniques that can diffuse the individual
5. Recognize common behaviors associated with Depression, Anxiety, Fetal Alcohol Syndrome and Attention Deficit Disorder
6. Identify risk factors for suicidality and what intervention strategies are most effective

Methodology:
Students will be taught using a combination of Power-point presentations, skills training, performance of drills and or scenario training.

Target Audience:
The intended audience for the course is all sworn members of the Seattle Police Department .

Class size:
The class size is a maximum size of 30, and a minimum of 10.

Evaluation Process:
Instructors will evaluate performance during exercises and correct performance that deviate from the desired responses as stated in the lesson plan. If the student performance during an exercise cannot be remediated during the session, and when the performance is:

1. Due to an inability or unwillingness to perform up to the desired response, or;
2. A repeated violation of training safety rules, or;
3. More than one use of unnecessary or excessive force, as evaluated by two instructors using the objective-reasonable standard.

The lead training coordinator will excuse the student form training, document and immediately notify an Education and Training Section Sergeant.

Logistical Information:

Site: Criminal Justice Training Commission / SPD Education Training Section Classroom

Training Equipment:
Power-point Presentation
"Top 10 Predictors of Violence" chart
Sequential Intercept Poster

Staffing Requirements:

Instructors: 2 Law Enforcement Officers and 1 Mental Health Professional

Seattle Police Department

Crisis Intervention Team Training

Training summary:

All assigned students will arrive at the designated time, pass through the safety check point and go to the designated facility. Once the facility is secured, the participants will receive a safety briefing, overview of the training, performance or learning objectives for the training and an introduction to the material.

Training schedule:

The course will be conducted using the following schedule:

-0030-0000 Instructors on site

0000-0015 Personal introduction & Learning Objectives

0015-0030 Introduction to CIT / Sequential Intercept Model

0030-0040 SMALL GROUP EXERCISE – Predictors of Violence

0040-0100 Sequential Intercept Model

0100-0110 ***BREAK***

0110-0140 Psychosis & Intervention Strategies

0140-0210 Mental Illness: Bi-Polar Disorder

0210-0220 ***BREAK***

0220-0250 Developmental Disabilities / Autism Spectrum

0250-0300 Post-Traumatic Stress Disorder

0300-0320 Depression & Anxiety

0320-0330 ***BREAK***

0330-0340 Fetal Alcohol Syndrome & Attention Deficit Disorder

0340-0430 Personality Disorders

0430-0500 ***LUNCH BREAK***

0500-0530 Personality Disorders continued

0530-0600 Aggression and Rage Cycle

0600-0610 ***BREAK***

0610-0710 De-Escalation Techniques

0710-0720 ***BREAK***

0720-0820 De-Escalation Techniques continued, with role players

0820-0830 ***BREAK***

0830-0915 Suicidality and Intervention

0915-0930 Referral Resources

0930 ***END OF SESSION***

Seattle Police Department
Education & Training Section
Lesson Plan

Crisis Intervention Team Training

Logistical Information:

Site: Washington State Criminal Justice Training Commission / SPD Education Training Section classroom

Training Equipment:
Power-Point Presentation
"Top 10 Predictors or Violence" chart
Sequential Intercept Poster

Staffing Requirements:
Instructors: 2 Law Enforcement Officers and 1 Mental Health Professional

Seattle Police Department
Education & Training Section
Lesson Plan

Crisis Intervention Team Training

Performance/Learning Objectives:

Upon completion of this course, participants will have demonstrated knowledge of the following or be able to perform the following:

1. Identification of behaviors that are related to psychosis and intervention techniques
2. Identify behaviors indicative of an individual experiencing Bi-Polar Disorder and appropriate intervention strategies
3. Recognize individuals with Developmental Disabilities and strategies on how to communicate with them
4. Identify common indicators an individual is experiencing with PTSD and techniques that can diffuse the individual
5. Recognize common behaviors associated with Depression, Anxiety, Fetal Alcohol Syndrome and Attention Deficit Disorder
6. Identify risk factors for suicidality and what intervention strategies are most effective

Overview:

In order to complete the performance objectives or learning objectives the students will receive the following training:

1. Introduction to the material

2. Identification of behaviors that are related to psychosis and intervention techniques
3. Identify behaviors indicative of an individual experiencing Bi-Polar Disorder and appropriate intervention strategies
4. Recognize individuals with Developmental Disabilities and strategies on how to communicate with them
5. Identify common indicators an individual is experiencing with PTSD and techniques that can diffuse the individual
6. Recognize common behaviors associated with Depression, Anxiety, Fetal Alcohol Syndrome and Attention Deficit Disorder
7. Identify risk factors for suicidality and what intervention strategies are most effective

8. Review/Summary or Debrief as appropriate

Seattle Police Department
Education & Training Section
Lesson Plan

Crisis Intervention Team Training

Interest Introduction:

Crisis Intervention Team, or CIT, refers to specialized training for LE on how to respond to calls involving person in mental health crisis, with developmental disabilities, or other severe behavioral emergencies. Officers learn appropriate techniques to identify, assess, and resolve these calls in a safe and efficient manner.

Material Introduction:

This material uses some ideas and content originally developed by Ellis Amdur of Edgework PLLC and is used with permission from the author.

Program Benefits:

- Significant decline in incarceration rates with a corresponding decline in house and medical costs.
- Decrease in use of force incidents.
- Decrease in both SWAT and Hostage Negotiation Team call-outs.
- Increased collaboration and trust with both consumer and provider groups.

Officers who completed the training also find they gain empathy and tolerance for persons experiencing these issues. Consumers and family members report increased trust and faith that issues will be resolved satisfactorily.

Definition of "Normal"

- Definition of Mental Illness
- Definition of Personality Disorders

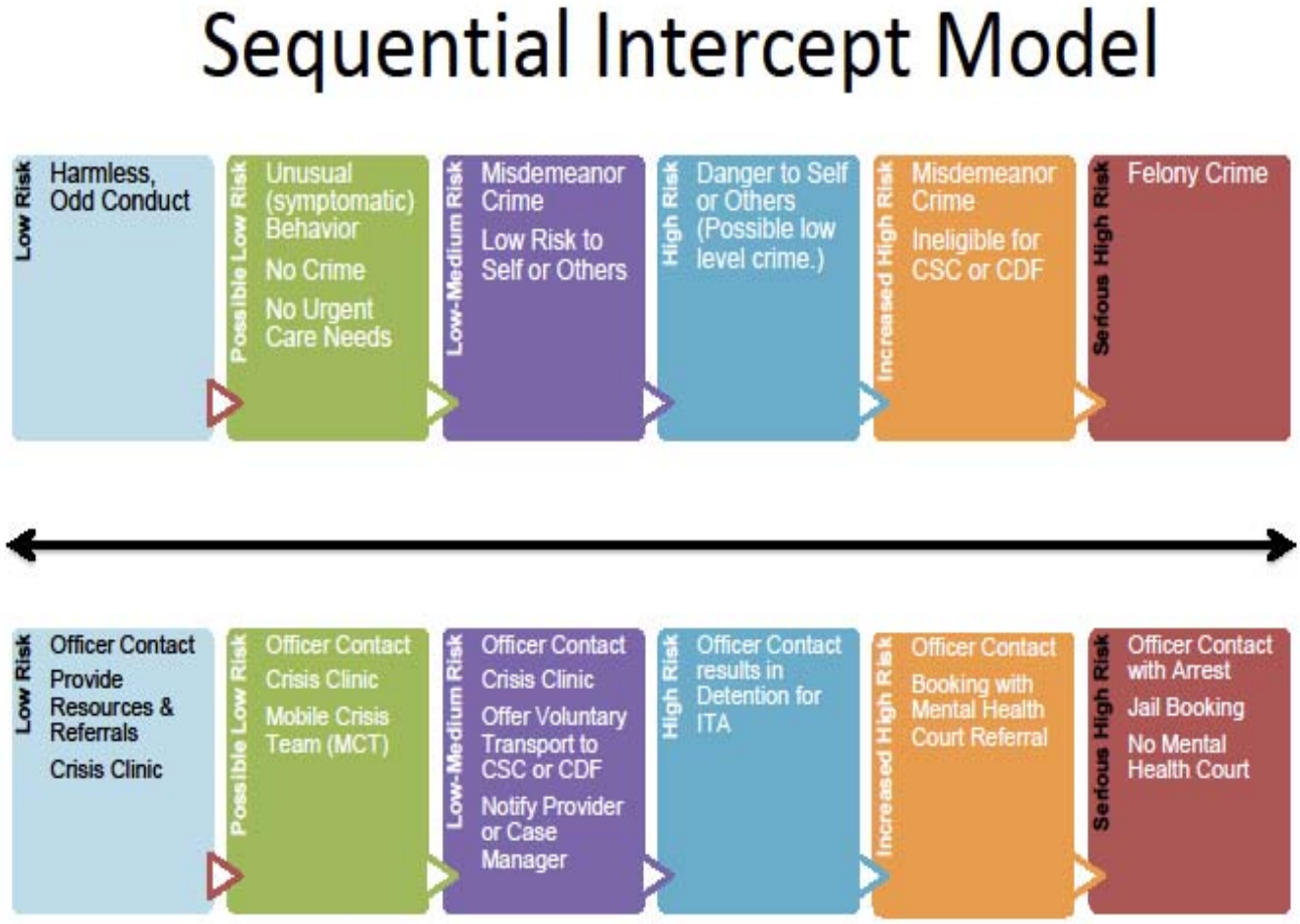
NOTE TO FACILITATOR

In presenting the Sequential Intercept Model refer to the Continuum Chart and give examples of each level

Seattle Police Department
Education & Training Section
Lesson Plan

Sequential Intercept Model:

Officers can encounter individuals across a wide spectrum of behaviors due to mental illness, just acting strangely in a park to committing a 'Class A' Felony. As one of the paths to the mental health system we can dramatically improve the outcomes for persons experiencing a crisis. The way an officer responds in these situations not only has a significant impact on the successful resolution of the specific incident, but also impacts all future contacts with this individual.



Seattle Police Department
Education & Training Section
Lesson Plan

NOTE TO FACILITATIOR

The purpose of this exercise is to get students to understand that while mental illness can be concerning in a majority of cases it is not dangerous. Students will brainstorm and come up with a list then the instructor will present the actual list, compare and discuss.

SMALL GROUP EXERCISE – Brainstorm Top Ten Predictors of Violent Behavior

Time: **10 minutes**

Materials:
- **10 Predictors of Violent Behavior: Chart**
- **Colored Pens**
- **Flip Charts**

Instructions: *(Do not reveal the Chart until after the brainstorm)*

(Have each group Brainstorm then prioritize their lists)
- Each Group Present their list
- Reveal the actual list

What are the differences in what was expected to what is actually predictive of violent behavior?

BREAK

NOTE TO INSTRUCTOR: The next several sections are types of crisis behaviors and how to recognize them. Present examples of each category of crisis behavior and ask when they might encounter that situation. We will address the intervention later in the curricula.

TYPES of CRISIS INTERVENTION:

There are many types of crisis behaviors that you may encounter across a wide range of situations. Early recognition of the behavior is important for safety and for a successful resolution. The purpose is not to have you diagnose individuals, but to recognize behaviors that might indicate roadblocks to communication, perception, or emotional functioning. By recognizing the behavior you will know what interventions have the best chance of successfully diffusing the crisis and

achieving the best possible outcome for you and the individual experiencing the crisis.

Schizophrenia: This is a prevalent mental illness and individuals suffering with this generally have increased involvement with law enforcement. This disease often creates unusual social behavior and problems distinguishing reality. These individuals will often talk to themselves or appear to be in a conversation when no one else present. They have emotional difficulty, experience social isolation and have problems with attention, motivation and have a 50% chance of also having Substance Use Disorder. Suicide Rate of 5%.

Psychosis:

Delusions-Common Themes

- Grandiose
- Persecutory (paranoid)
- Religious (also often grandiose), sex
- Jealous
- Delusional Stalking

Hallucinations

- Distortions
- Auditory (70%)
- Visual
- Tactical & Olfactory
- Command Hallucinations

Intervention Strategies:

Change the subject, Find areas they are not delusional in, “I believe you are hearing/seeing that but I don’t. Interrupt pressured speech by presenting a question. Reassurance “I am going to make it safe for everyone”

Bipolar Disorder: Both episodes of mania and depression.
Mania--at least one week of abnormally elevated, expansive, or irritable mood Grandiosity, decreased need for sleep, rapid speech, racing thoughts, distractibility, increase in goal-directed activity, high risk activity (spending sprees, high risk sexual behavior).). Fifty percent of individuals with this will attempt suicide some time in their lives and the suicide rate is up to 20 times the general population.

BREAK

Developmental Disabilities: People with Developmental Disabilities and Autism typically do not fully comprehend nonverbal communication, such as: tone of voice, body language, eye contact, facial expression or personal space. As a result, they are typically socially awkward, have difficulty communicating, and have trouble recognizing safety hazards and understanding social norms and the law. Persons with DD and Autism are 7 times more likely to encounter the police than other individuals, because of their unique communication styles and social characteristics they may frighten or disturb some people.

Typical Behaviors:

Stimming: These are self-soothing behaviors that can present as hand flapping, body rocking, twirling, off key humming or repeating a word, phrase, vocalization or echolalia (repeating).

Acclimation: Subjects will familiarize themselves with a new environment by walking around looking or touching things to make sure their environment is safe. This could also lead to invading others personal space without regard for societal norms. (Often focused on weapons)

Delayed Response: Subjects will often react slowly to commands and it might take them up to 15 uninterrupted seconds to process the command and comply.

Lack of Eye Contact: Often subjects with these deficits will make little or no eye contact. They may appear to ignore you or not pay attention.

Attracted to Shiny Objects and Water: Persons with these disorders are often intrigued by shiny objects and/or water. They often will enter the water even when they cannot swim with a total disregard for the danger to themselves.

Post-Traumatic Stress Disorder (PTSD):

Post-Traumatic Stress Disorder (PTSD) is a mental health condition that's triggered by a terrifying event. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event. Many people who go through traumatic events have difficulty adjusting and coping for a while.

Post Deployment Symptoms:

- Enhanced Startle reaction
- Avoidance of Crowds
- Hyper vigilance

- Sleep disturbances
- Guilt, Depression and Anger
- Concentration and Memory problems
- Substance Abuse/Self-Medicating
- Suicidal Thoughts

Depression

- Psychological state of hopelessness and helplessness
- Not specialized communication style from law enforcement perspective
- Risk of suicide (seen as problem solving measure)
- Quickest "antidote" is aggression
- These two combined "suicide by cop" scenario
- Risk of homicide?

Anxiety:

- Panic disorder
- Social phobia
- Obsessive-Compulsive disorder
- Posttraumatic stress disorder
- Generalized anxiety disorder

BREAK

Fetal Alcohol Spectrum Disorders

- Lack a sense of cause and effect

Attention-deficit Disorders

- Should be given more "controversy"/Does it exist?
- Brain chemistry vs. behavior
- Behavioral Disorders – Conduct & Oppositional Defiance Disorders

Personality Disorders:

These categories of mental illnesses are marked by a perspective of the world or other people that is not supported by society or facts. Individuals with these disorders show a lack of self-insight and reflection. They most often are focused on themselves and seem have an emotional deficit or be

suffering from severe emotional pain. Some display manipulative and deceptive behaviors.

Borderline Personality Disorder:

- Self-Absorbed
- Aloneness
- Concrete thinking (Black/White, Love/Hate, no middle ground)
- Seek a reaction
- Live in the present cannot recall other feelings

Responses to BPD:

- Be warm but not attached
- Do not buy into the chaos
- Don't reward suicidality or self-abusive behaviors (Including attention)
- Do not put yourself into the protector role!

Paranoid Personality Disorder:

- Self-absorption and suspiciousness about everyone and everything
- Someone else always to blame
- Can provoke opposition, want to counterattack first
- Clipped speech

Responses to Paranoid Personality Disorder:

- Stay very matter-of-fact, not over-friendly
- Cognitive-based language, not feeling based
- Hypersensitive to your mood, be detached but clear
- Correct distance is key

BREAK

Anti-Social Personality Disorder

- Lack of any care or concern about anyone else (no morality or remorse)
- Background depression and chronic fear (but never

admitted/shown)

- Can be charming, calculating
- Chronic Liars

Responses to Anti-Social Personality Disorder?

- Consequences are no consequences, don't threaten with

what the "punishment" will be – give vague answers

- Want a reaction, remain detached, lack of eye contact
- Don't try to "out tough" them
- Do not give them breaks they will push what whatever limits you set.

Introduction to De-escalation Techniques:

Most individuals follow a predictable pattern of behaviors as they escalate from baseline to violence. As an individual escalates and becomes more emotional their thinking deteriorates and their cognitive ability decreases significantly to the point they enter a rage state or "Fight or Flight" level where they are simply reacting without thought. Students will learn in this block of instruction to recognize and intervene with individuals displaying escalating behavior.

Cycle of Aggression: Anger

Rage

Violence

Control

Congruence

Response:

As we are dealing with individuals experiencing Aggression and Rage it is important we maintain control of our own emotions and remain in our cognitive brain. We can accomplish this by remembering to breathe staying grounded and not portraying an emotional response. Remember we don't have to "Win", "Respond in Kind" and that it is not a personal attack, refusing to allow ourselves to be triggered and maintaining a calm, confident attitude.

Congruence

- Body Baseline: Maintain at least an arm length and a knife blade of spacing. Increase and escalation increases.
- SHOT stance: Standing, Hands up, Open posture, Turn
- Actively Listen: Parroting, Paraphrasing, and Acknowledging both feelings and content.

- Use their name.
- Find an area of Agreement
  - Ask them to do you a favor
  - Use "Teaming" (we)
  - Ask them for suggestions
  - Offer choices

Control

- Ladder Technique
  - Hierarchy of Danger
  - One issue at a time
- **Broken Record**
  - Repetitions
  - Simple (rule of five)

Role Plays: Note to instructors have group practice SHOT stance with subjects restricted to conversational disagreements only. No Aggressive or violent behaviors. Then select students to role play with the instructor demonstrating the de-escalation techniques. As the class picks up on the skills have students bring in experiences that the class can discuss how best to handle the situations.

Suicide Risk and Prevention:

If in the course of your duties if you have a someone allude to suicide, give you reason to believe they might harm themselves or have had others tell you the individual is suicidal ask the subject directly:

- Are you planning on killing yourself, or ending your life?
- Have you thought about killing yourself?
- You will not put this idea into someone's head that was not considering it before you asked the question. If they respond, "yes" the next step is to ask some assessment questions. Do they have a plan, do they have access to the means and when do they plan on carrying this plan out.
- How do you plan on doing it?
- Have you considered how you would end your life?
- When do you plan on doing this?
- Once you determine the eminent risk you should ask some secondary assessment questions:
- Have you tried to do this before?

- Have you tried another way before?
- Has anyone you cared about committed suicide? When?
- Have you been drinking or using drugs of any kind?
- What happened to cause you to feel this way?
- What have you done before when you have felt this way?
- Has there been someone you could talk to that has helped you with these feelings before?

Resources:

In all of these crisis situations, there are resources and referrals that can be made to improve the outcome for the individual and increase your effectiveness and "legitimacy".

Exercise: Have the class Brainstorm resources for multiple crisis scenarios. Make sure that Crisis Clinic, Mobil Mental Health Team, Crisis Diversion Facility and Crisis Solution Center are included in the list of resources that officers can use for these referrals.

- **Review of Performance Objectives of Class**

1. Identification of behaviors that are related to psychosis and intervention techniques
2. Identify behaviors indicative of an individual experiencing Bi-Polar Disorder and appropriate intervention strategies
3. Recognize individuals with Developmental Disabilities and strategies on how to communicate with them
4. Identify common indicators an individual is experiencing with PTSD and techniques that can diffuse the individual
5. Recognize common behaviors associated with Depression, Anxiety, Fetal Alcohol Syndrome and Attention Deficit Disorder
6. Identify risk factors for suicidality and what intervention strategies are most effective

- **Review of class in high points that achieved the performance objectives**

- **Officer contact information for student follow-up**

Debrief:

EXHIBIT B-2

Crisis Intervention Team Training

Facilitator Guide

Session Overview

Personal Introduction & Learning Objectives	15m
Introduction to CIT/Sequential Intercept Model	15m
SMALL GROUP EXERCISE – Predictors of Violence	10m
Sequential Intercept Model	20m
Break (as needed)	10m
Schizophrenia	20m
Psychosis & Intervention Strategies	20m
Mental Illness: Bi-polar Disorder	20m
Break (as needed)	10m
Developmental Disabilities/Autism Spectrum	30m
Post-Traumatic Stress Disorder	10m
Depression & Anxiety	20m
Break (as needed)	10m
Fetal Alcohol Syndrome & Attention Deficit	10m
Personality Disorders	50m
Lunch Break	
Personality Disorders Cont.	30m
Aggression and Rage Cycle	30m
Break (as needed)	10m
De-escalation Techniques	60m
Break (as needed)	10m
De-escalation Techniques Cont. w/Role Plays	60m
Break (as needed)	10m
Suicidality and Intervention	45m
Referral Resources	15m
End of Session	

Total Session Time: 8 hours

Main Topics of Session:

- *CIT is Officer Safety Training*
- *LE as the first line of the Mental Health System*
- *Identify MH Behaviors*
- *Appropriate Interventions*

Facilitators Needed: 2 LE & MH
Location: Classroom

Materials Needed:

- *PowerPoint*
- *Top 10 Predictors of Violence Chart*
- *Sequential Intercept Poster*

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Learning Objectives:

- Identify common behaviors an individual would exhibit experiencing Schizophrenia and the appropriate intervention strategies.
- Identify behaviors related to Psychosis and intervention techniques to successfully deal with these subjects.
- Identify behaviors indicative of an individual experiencing Bi-polar disorder and appropriate intervention strategies.
- Recognize individuals with Developmental Disabilities and effective intervention strategies to interact and communicate with them.
- Identify common indicators an individual is experiencing with Post Traumatic Stress and what officer techniques can lower tensions and diffuse the individual.
- Recognize common behaviors associated with an individual experiencing Depression, Anxiety, Fetal Alcohol Syndrome and Attention Deficit Disorder.
- Identify common behavior traits expressed by persons with the common personality disorders: Borderline, Paranoid, and Anti-Social Personality Disorder.
- Demonstrate in a role play effective strategies to De-escalate an individual expressing rage.
- Identify risk factors for Suicidality and what intervention strategies are the most effective in dealing with these situations.

NOTE TO FACILITATOR
Crisis Intervention Team Training is a widely used process that was originally developed in Memphis, Tennessee, and is universally used in law enforcement today.

SAY TO CLASS – Introductions/Foundation

Introduce facilitators and objectives, explain class agenda and process:

- Introduce Crisis Intervention Team Model
- Handouts
- Describe resources and partnering with different providers to improve outcomes for persons in crisis

What is Crisis Intervention Team Training?

Crisis Intervention Teams or CIT refers to specialized training for LE on how to respond to calls involving persons in mental health crisis, with developmental disabilities, or other severe behavioral emergencies. Officers learn appropriate techniques to identify, assess, and resolve these calls in a safe and efficient manner. The training needs to be specific to an area because it involves using local resources, shelters, and consumer groups so officers can network, establish relationships, and learn what local facilities and resources might be available.

Program Benefits:

- Significant decline in incarceration rates with a corresponding decline in housing and medical costs.
- Decrease in use of force incidents.
- Decrease in both SWAT and Hostage Negotiation Team call outs.
- Increased collaboration and trust with both consumer and provider groups.

Officers who complete the training also find they gain empathy and tolerance for persons experiencing these issues. Consumers and family members report increased trust and faith that issues will be resolved satisfactorily.

Definition of “Normal”

- Definition of Mental Illness
- Definition of Personality Disorders

NOTE TO FACILITATOR
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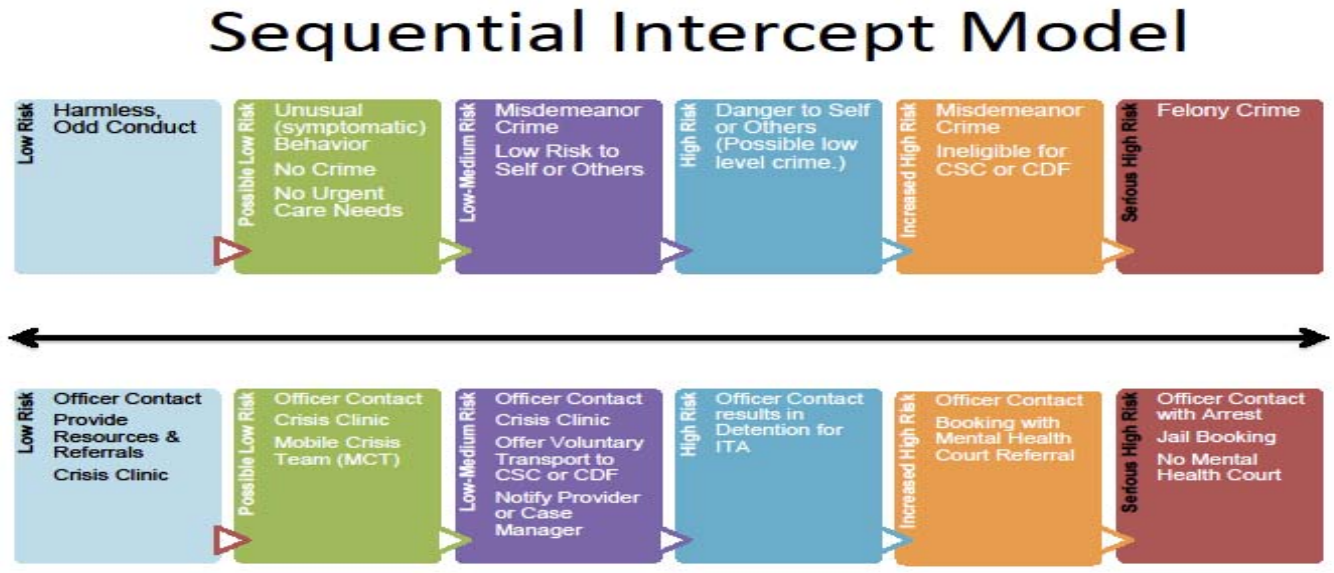
Sequential Intercept Model:

Officers can encounter individuals across a wide spectrum of behaviors due to mental illness, drug abuse, developmental disabilities, dementia and so on. This individual could be just acting strangely in a park to committing a Class A felony. As one of the paths to the mental health system we can dramatically improve the outcomes for persons experiencing a crisis. The way an officer responds in these situations has a significant impact not only on the successful resolution of this incident, but in all future contacts with this individual.



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Delusions-Common Themes

- Grandiose
- Persecutory (paranoid)
- Religious (also often grandiose), sex
- Jealous
- Delusional Stalking

Hallucinations

- Distortions
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BREAK

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Post-Traumatic Stress Disorder (PTSD):

Post-Traumatic Stress Disorder (PTSD) is a mental health condition that's triggered by a terrifying event. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event. Many people who go through traumatic events have difficulty adjusting and coping for a while.

Post Deployment Symptoms:

Enhanced startle reaction
Avoidance of crowds
Hyper vigilance
Sleep disturbances
Guilt, depression and anger
Concentration and memory problems
Substance abuse/self-medicating
Suicidal thoughts

Depression

- Psychological state of hopelessness and helplessness
- Not specialized communication style from law enforcement perspective
- Risk of suicide (seen as problem solving measure) 3.4% Lifetime
- Quickest "antidote" is aggression
- These two combined "suicide by cop" scenario
- Risk of homicide?

Anxiety:

- Panic disorder
- Social phobia
- Obsessive-Compulsive disorder
- Posttraumatic stress disorder
- Generalized anxiety disorder

BREAK

Fetal Alcohol Spectrum Disorders

- Lack a sense of cause and effect

Attention-deficit Disorders

- Should be given more "controversy"/Does it exist?
- Brain chemistry vs behavior
- Behavioral Disorders – Conduct & Oppositional Defiance Disorders

Personality Disorders:

These categories of mental illnesses are marked by a perspective of the world or other people that is not supported by society or facts. Individuals with these disorders show a lack of self-insight and reflection. They most often are focused on themselves and seem have an emotional deficit or be suffering from severe emotional pain. Some display manipulative and deceptive behaviors.

Borderline Personality Disorder (BPD):

- Self-Absorbed
- Aloneness
- Concrete thinking (Black/White, Love/Hate, no middle ground)
- Seek a reaction
- Live in the present cannot recall other feelings

Responses to BPD:

- Be warm but not attached
- Do not buy into the chaos
- Don't reward suicidality or self-abusive behaviors (Including attention)
- Do not put yourself into the protector role!

Paranoid Personality Disorder:

- Self-absorption and suspiciousness about everyone and everything
- Someone else is always to blame
- Can provoke opposition, want to counterattack first
- Clipped speech

Responses to Paranoid Personality Disorder:

- Stay very matter-of-fact, not over-friendly
- Cognitive-based language, not feeling based
- Hypersensitive to your mood, be detached but clear
- Correct distance is key

Break

Anti-Social Personality Disorder – formally "sociopaths"

- Lack of any care or concern about anyone else (no morality or remorse)
- Background depression and chronic fear (but never admitted/shown)
- Can be charming, calculating
- Chronic Liars

Responses to Anti-Social Personality Disorder?

- Consequences are no consequences, don't threaten with what the "punishment" will be – give vague answers
- Want a reaction, remain detached, lack of eye contact
- Don't try to "out tough" them
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Rage
Violence
Control
Congruence

Response:

As we are dealing with individuals experiencing Aggression and Rage it is important we maintain control of our own emotions and remain in our cognitive brain. We can accomplish this by remembering to breathe, staying grounded and not portraying an emotional response. Remember that we don't have to "Win" or "Respond in Kind" and that it is not a personal attack. We must refuse to be triggered and maintain a calm, confident attitude.

Congruence

- Body Baseline: Maintain at least an arm length and a knife blade of spacing. Increase and escalation increases.
- SHOT stance: Standing, Hands up, Open posture, Turn.
- Actively Listen: Parroting, Paraphrasing, and Acknowledging both feelings and content.
- Use their name.

- Find an area of Agreement
  - Ask them to do you a favor
  - Use "Teaming" (we)
  - Ask them for suggestions
  - Offer choices

Control

- Ladder Technique
  - Hierarchy of Danger
  - One issue at a time
- Broken Record
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  - Simple (rule of five)

Role Plays: Note to instructors have group practice SHOT stance with subjects restricted to conversational disagreements only. No Aggressive or violent behaviors. Then select students to role play with the instructor demonstrating the de-escalation techniques. As the class picks up on the skills have students bring in experiences that the class can discuss how best to handle the situations.

Suicide Risk and Prevention:

If in the course of your duties if you have a someone allude to suicide, give you reason to believe they might harm themselves or have had others tell you the individual is suicidal ask the subject directly:

Are you planning on killing yourself, or ending your life?

Have you thought about killing yourself?

You will not put this idea into someone's head that was not considering it before you asked the question. If they respond, "yes" the next step is to ask some assessment questions. Do they have a plan, do they have access to the means and when do they intend on carrying this plan out.

How do you plan on doing it?

Have you considered how you would end your life?

When do you plan on doing this?

Once you determine the eminent risk you should ask some secondary assessment questions:

Have you tried to do this before?

Have you tried another way before?

Has anyone you cared about committed suicide? When?

Have you been drinking or using drugs of any kind?

What happened to cause you to feel this way?

What have you done before when you have felt this way?

Has there been someone you could talk to that has helped you with these feelings before?

Exercise: Have the class Brainstorm resources for multiple crisis scenarios. Make sure that Crisis Clinic, Mobil Mental Health Team, Crisis Diversion Facility and Crisis Solution Center are included in the list of resources that officers can use for these referrals.

Resources:

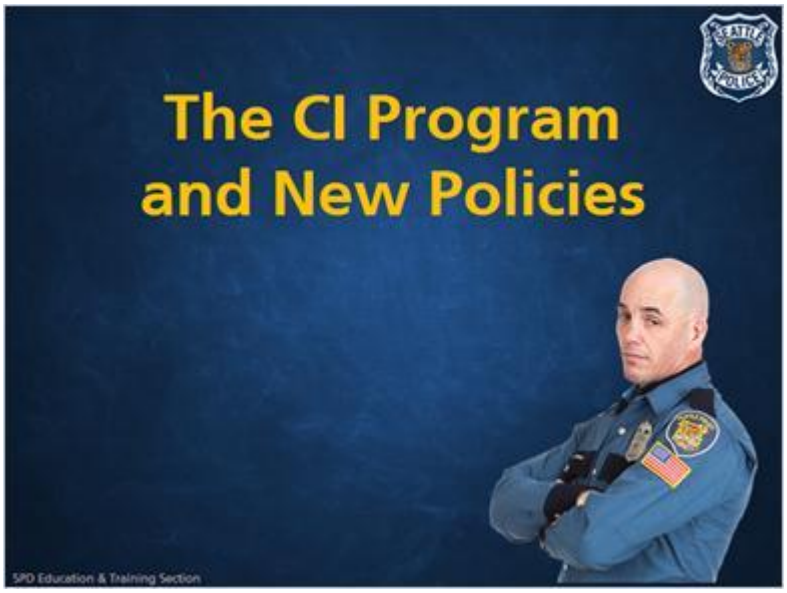
In all of these crisis situations there are resources and referrals that can be made to improve the outcome for the individual and increase your effectiveness and "legitimacy".

End of Session

EXHIBIT B-3

CIT Module 1 - CI Program and New Policy (5-30-14)

1.1 First Slide

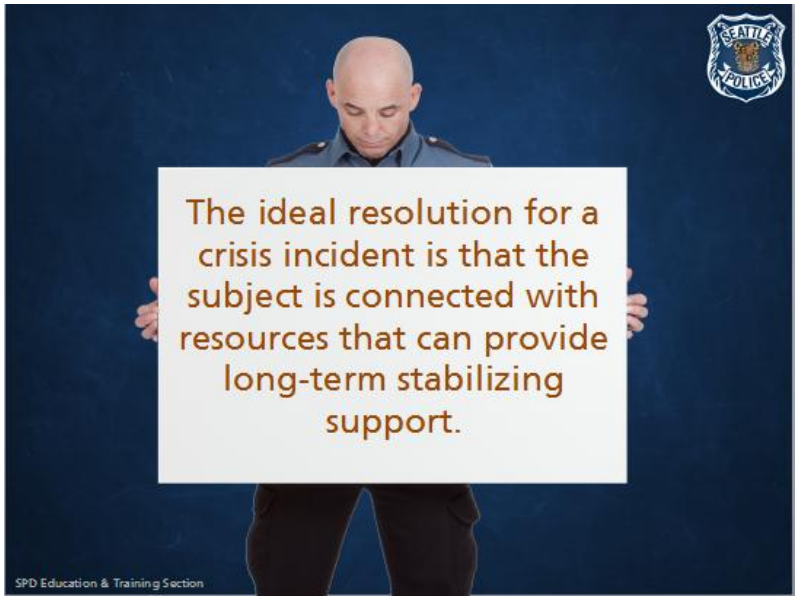


1.2 Defined

1.3 Considerations

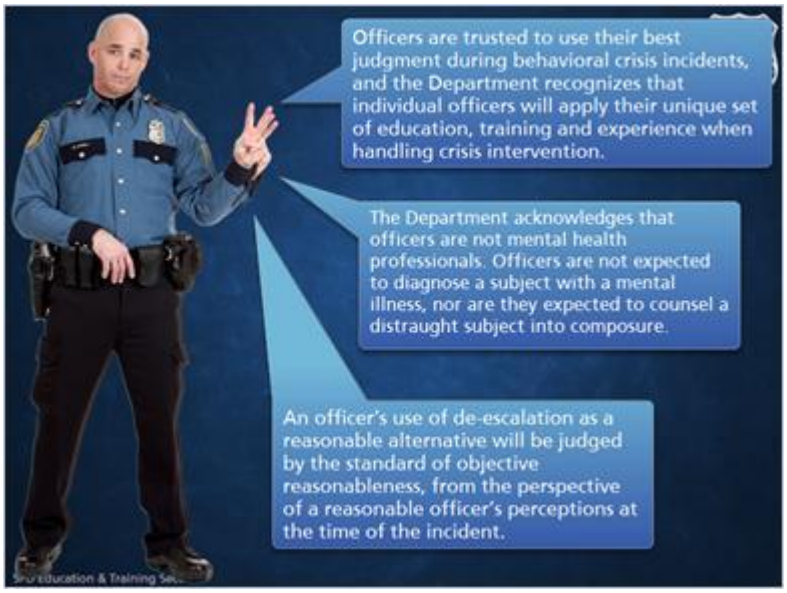
1.3 Considerations (part 2)

1.3 Considerations (part 3)



1.4 What does it mean

1.5 3 Things

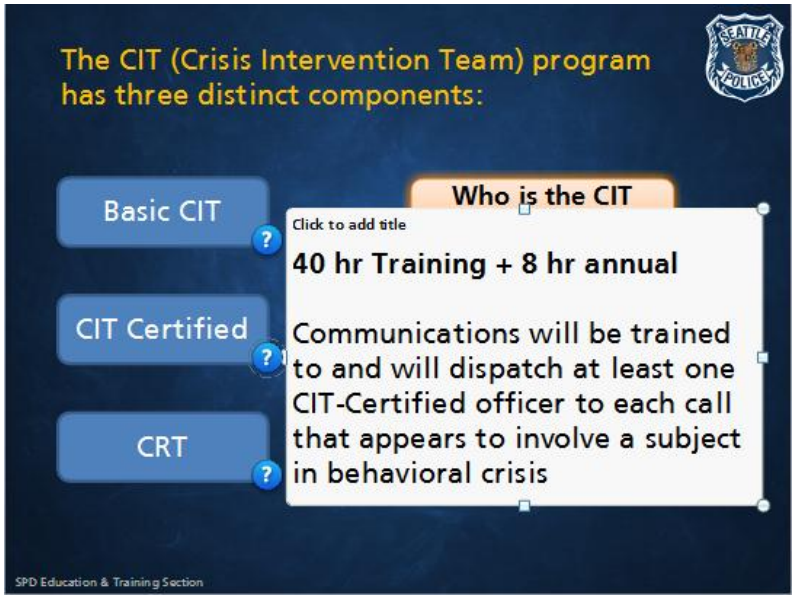


1.6 Guidelines

1.7 CIT Structure

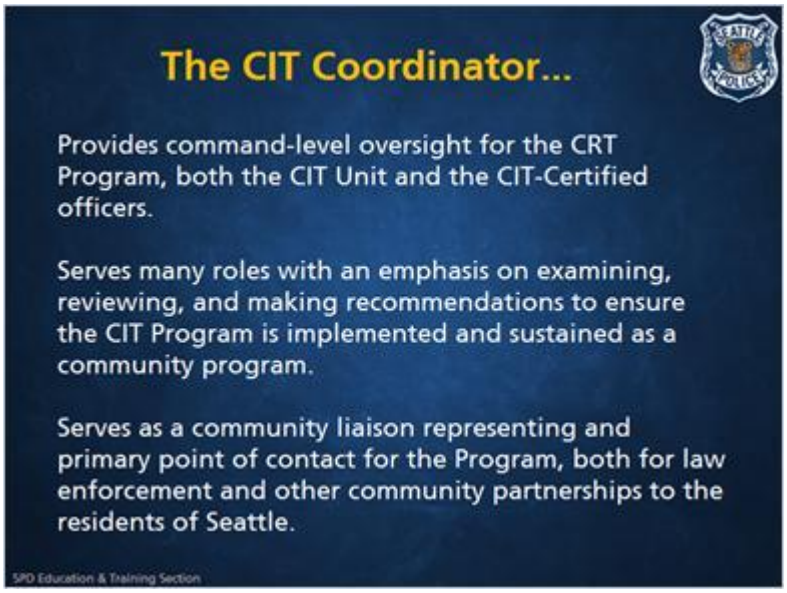
1.7 CIT Structure (Basic)

1.7 CIT Structure (CIT)



1.7 CIT Structure (CRT)

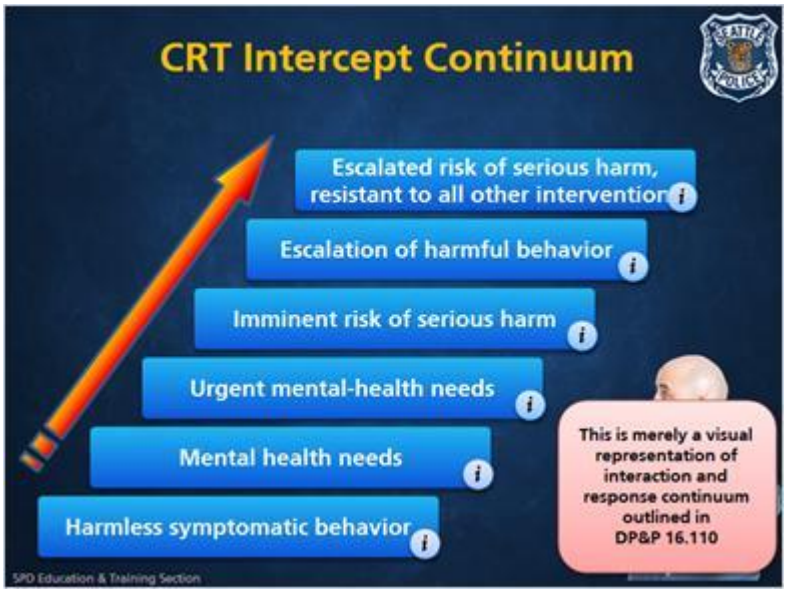
2.2 CIT Coordinator



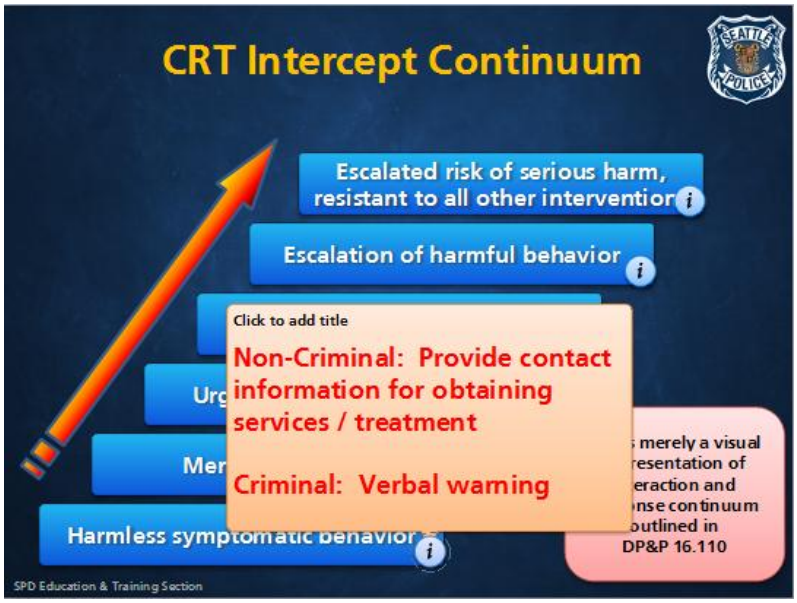
1.8 CRT does

2.1 CRT

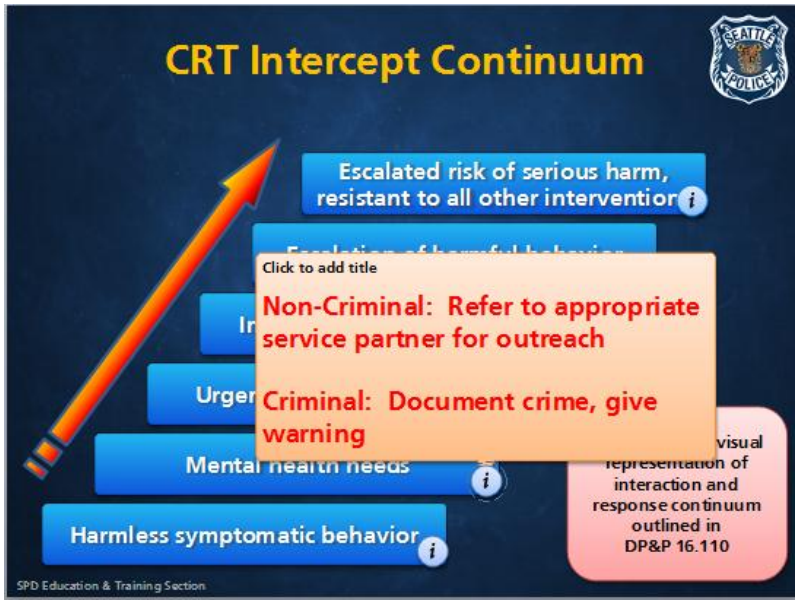
1.9 CRT does



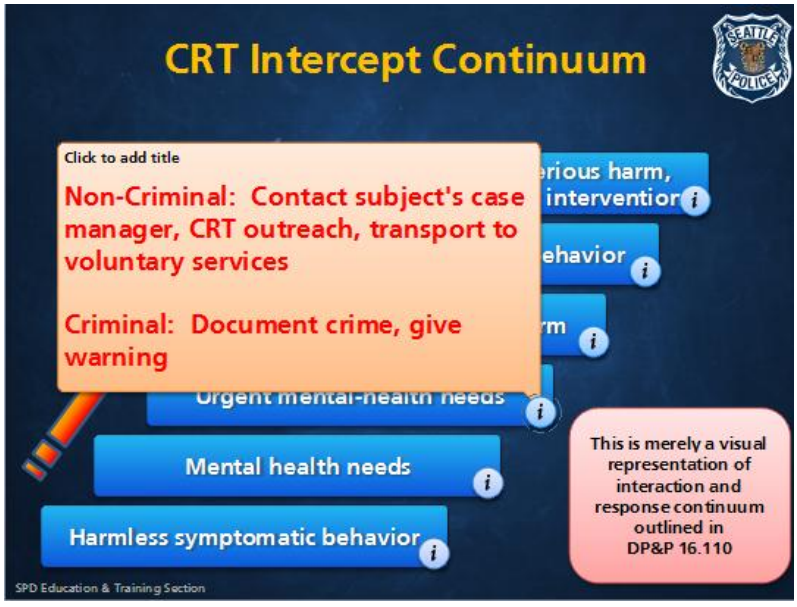
1.9 Intercept Continuum



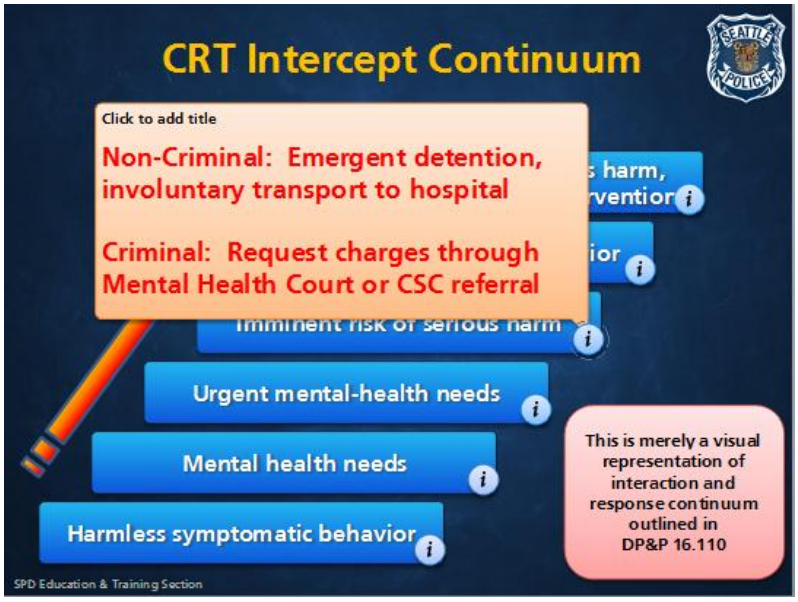
1.9 Intercept Continuum



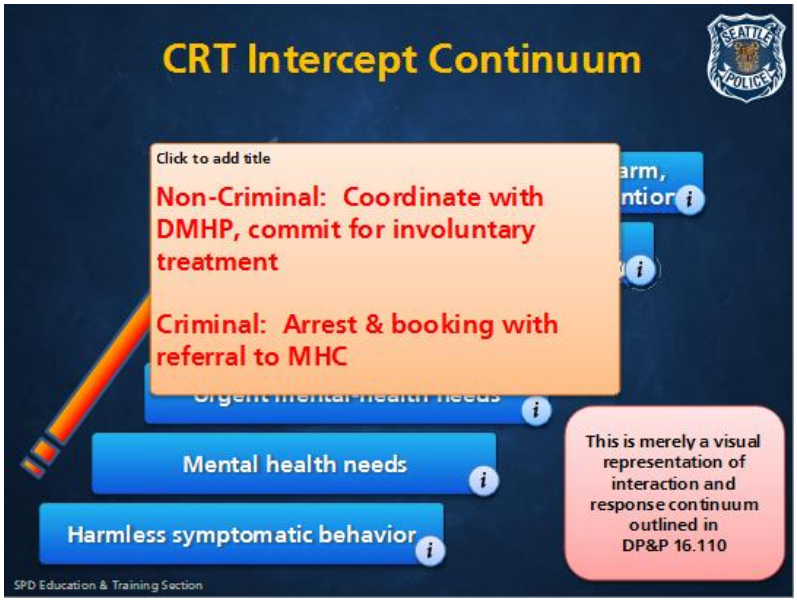
1.9 Intercept Continuum



1.9 Intercept Continuum



1.9 Intercept Continuum



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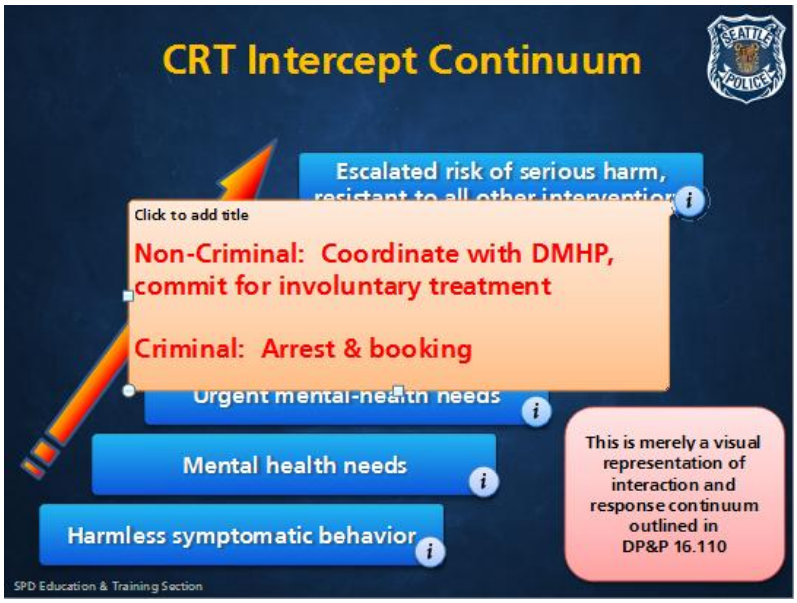

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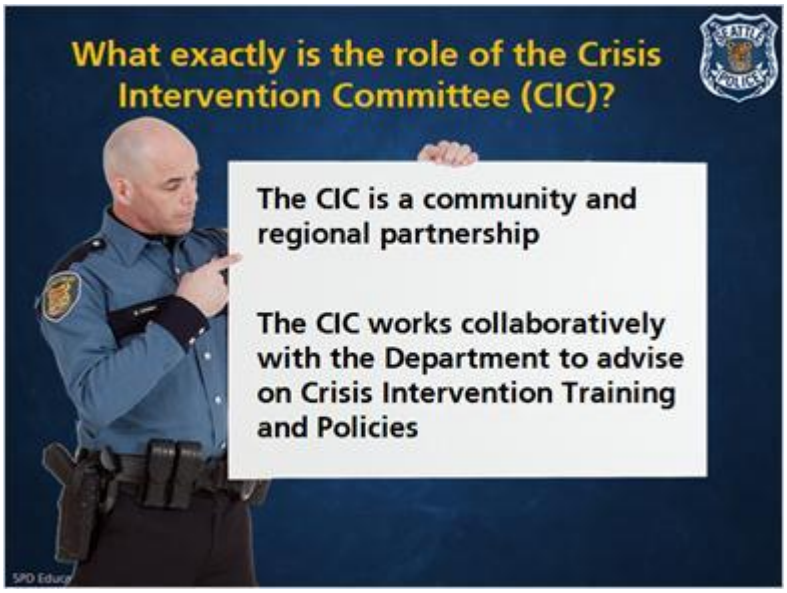
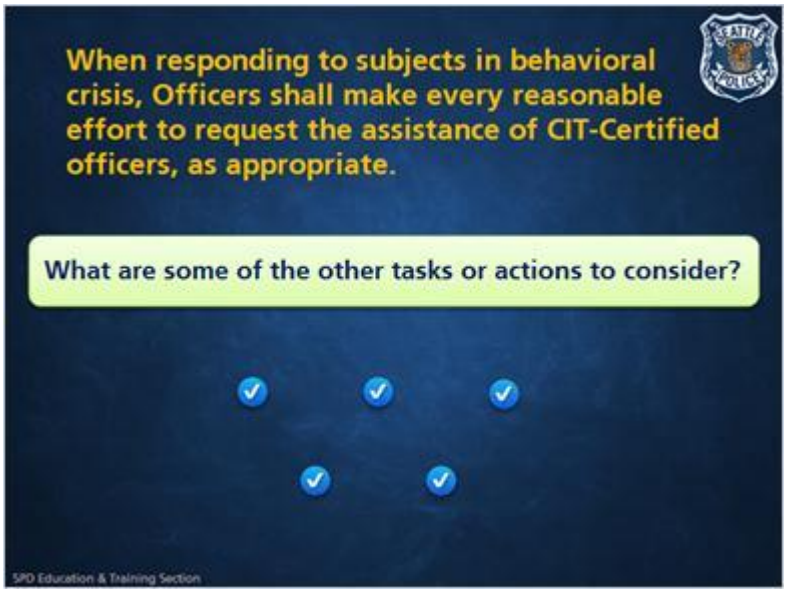


1.11 Other tasks



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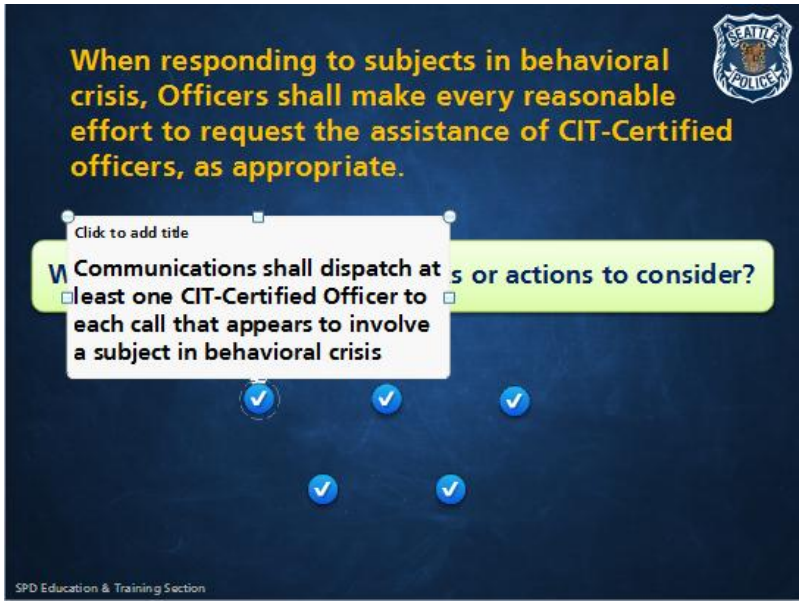

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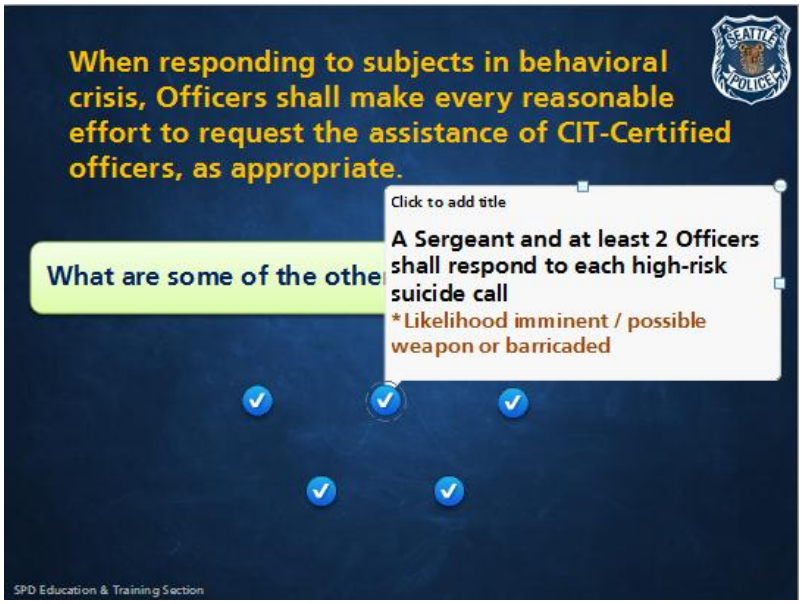

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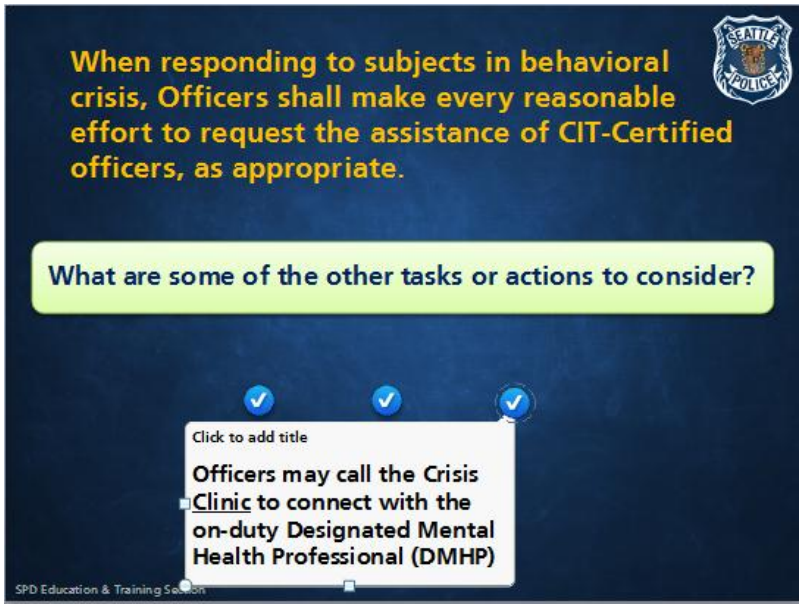

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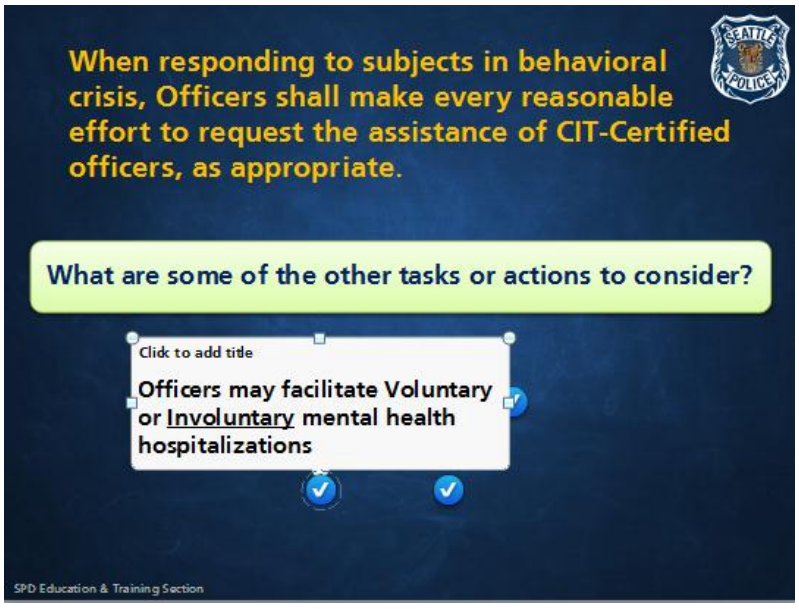

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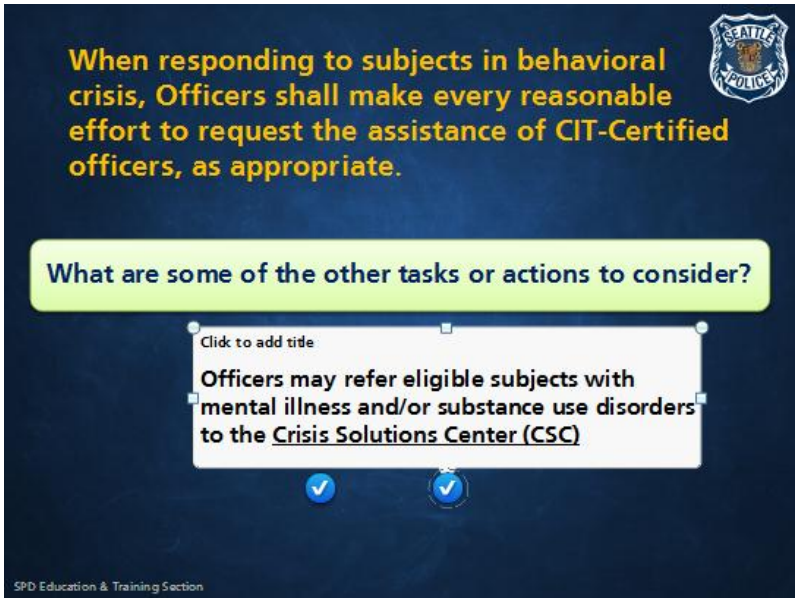
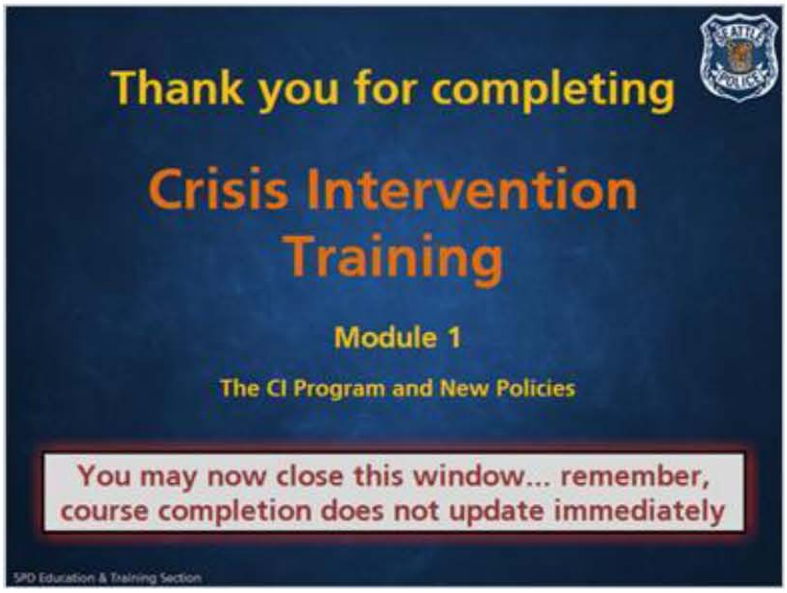


1.12 Guidelines

1.13 Last Slide



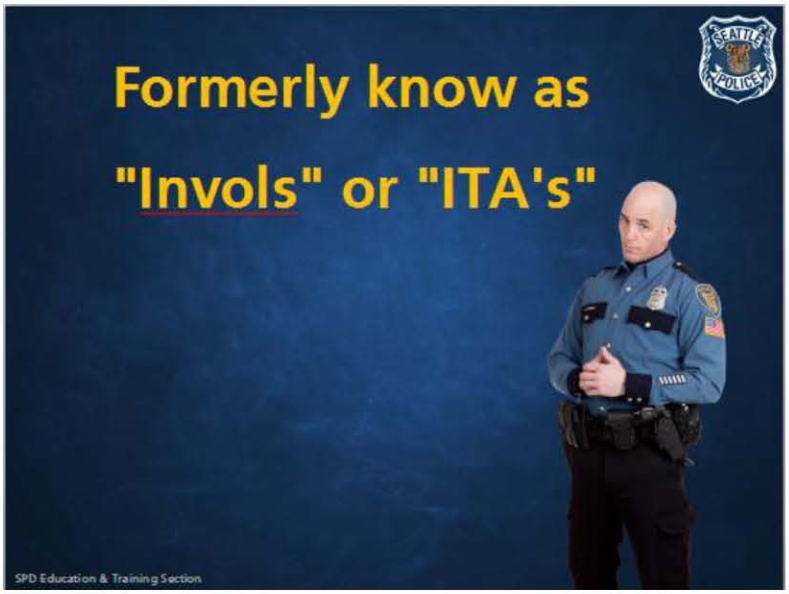
Player

EXHIBIT B-4

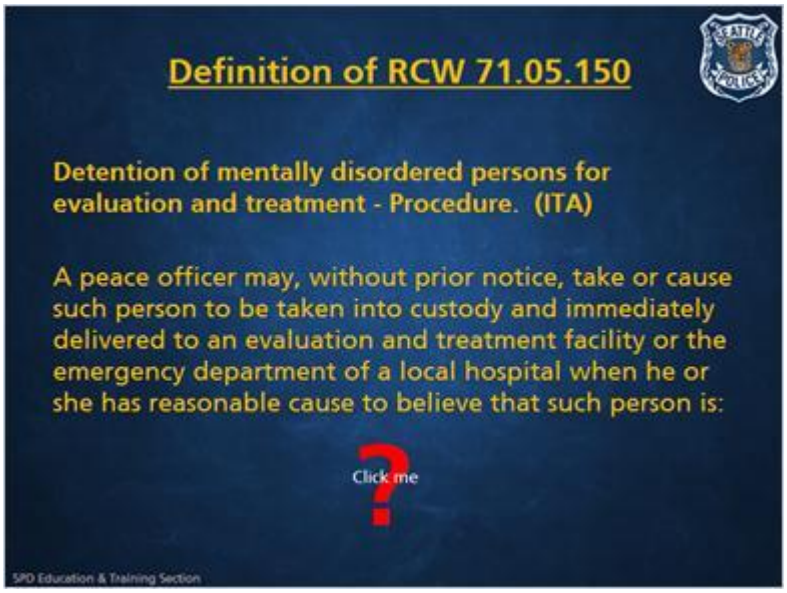
CIT Module 2 - Emergent Detentions (5-30-14)

1.1 First Slide

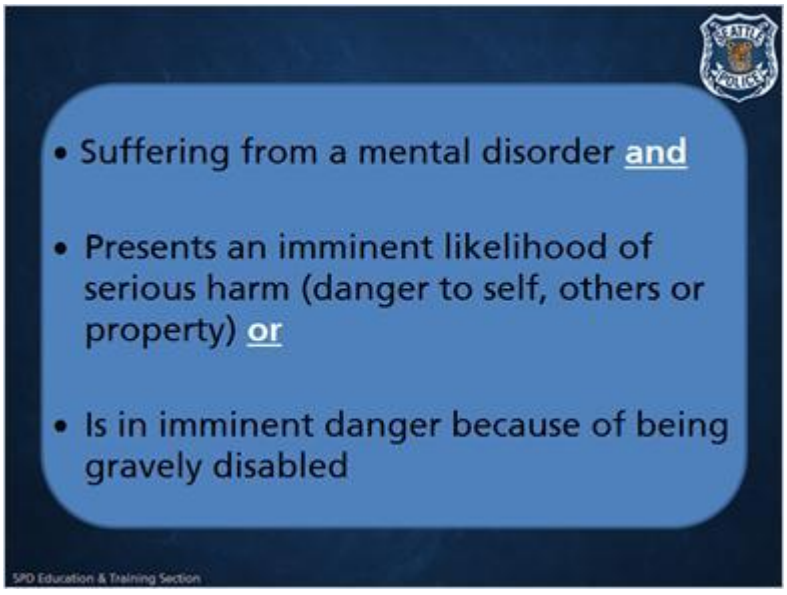
1.1 First Slide



1.2 Definition

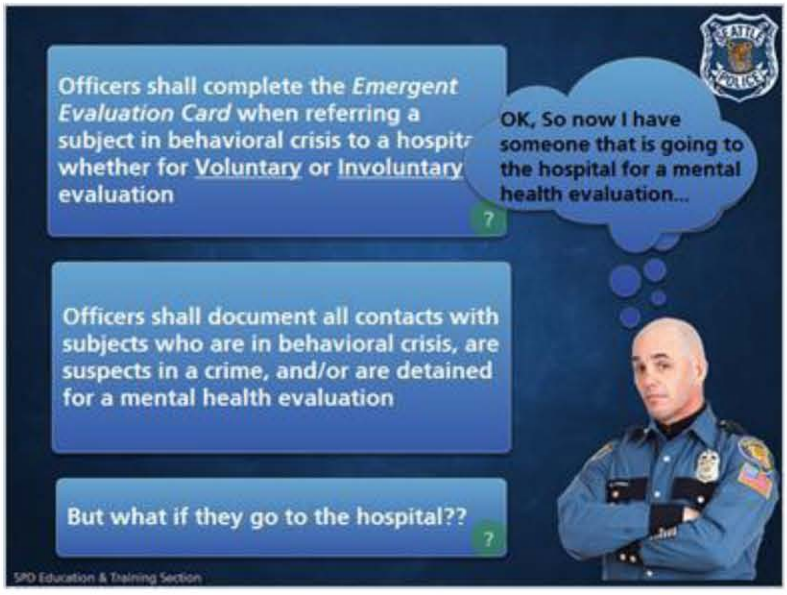


2.1 ITA criteria

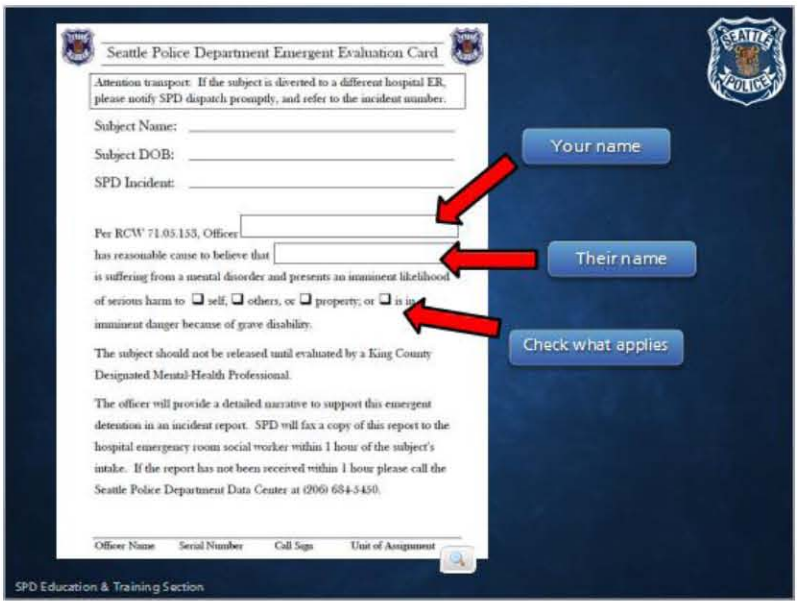


1.3 Symptoms

1.4 Eval



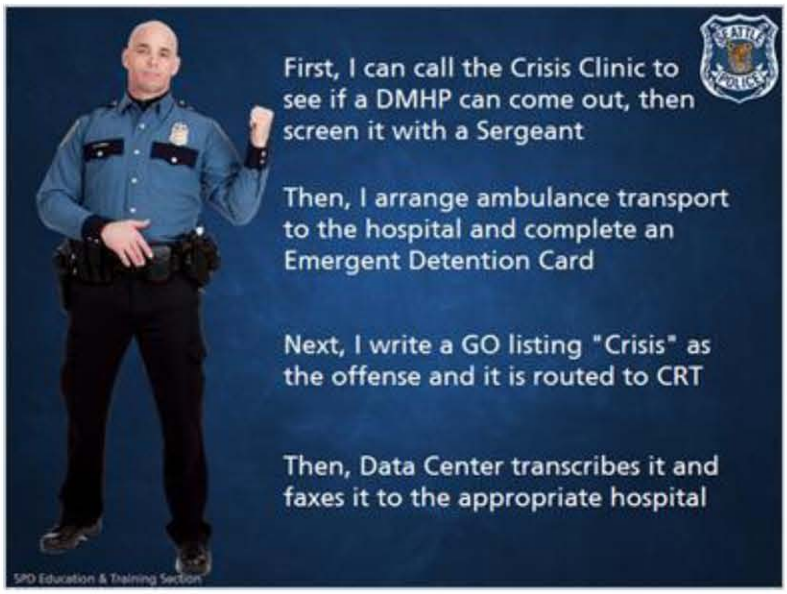
1.5 Form



1.6 Paper

1.7 Review

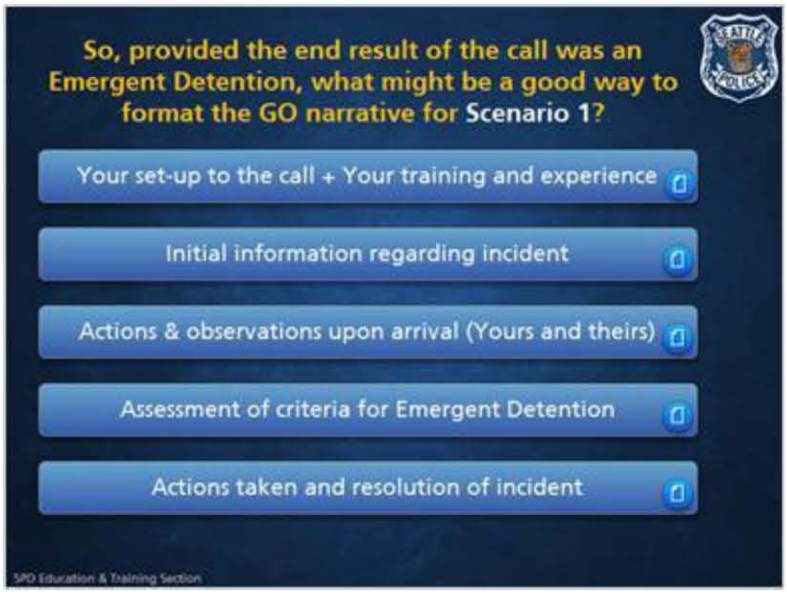
2.2 Review



2.2 Review (part 2)

1.8 Scenarios

1.9 Scenario 1



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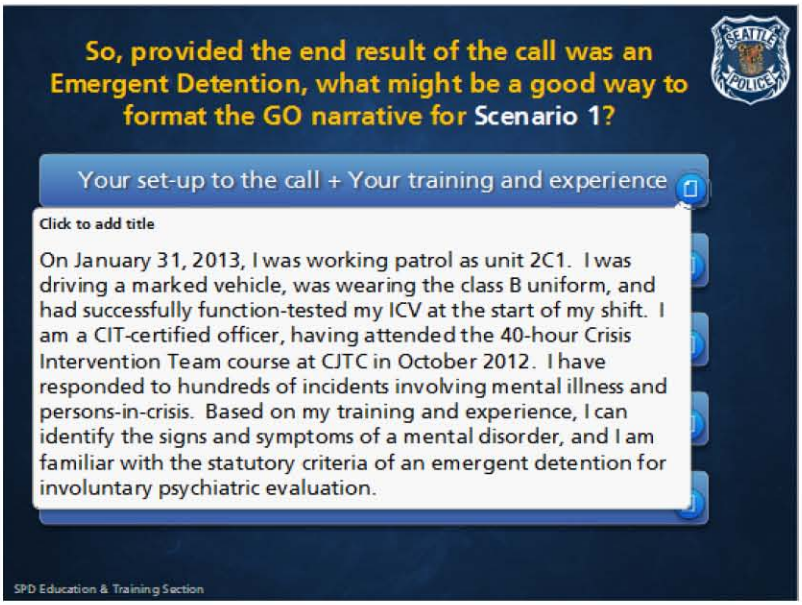

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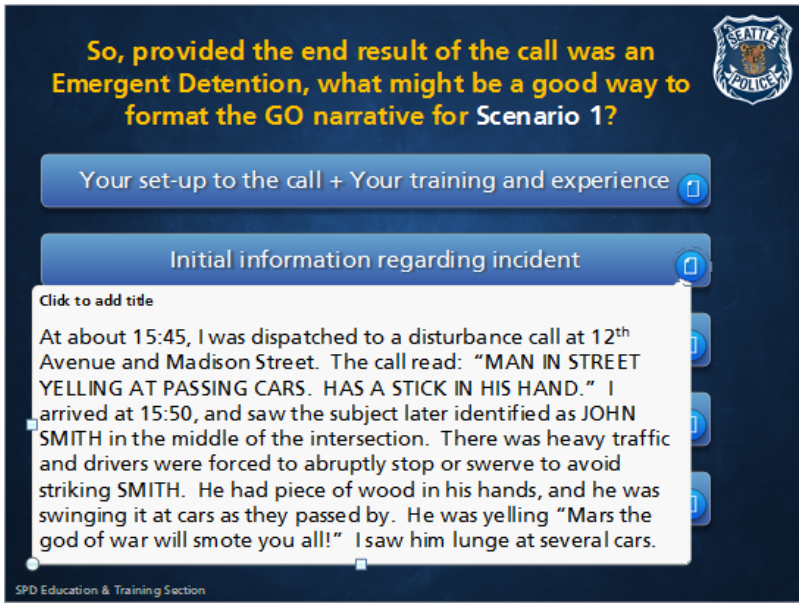

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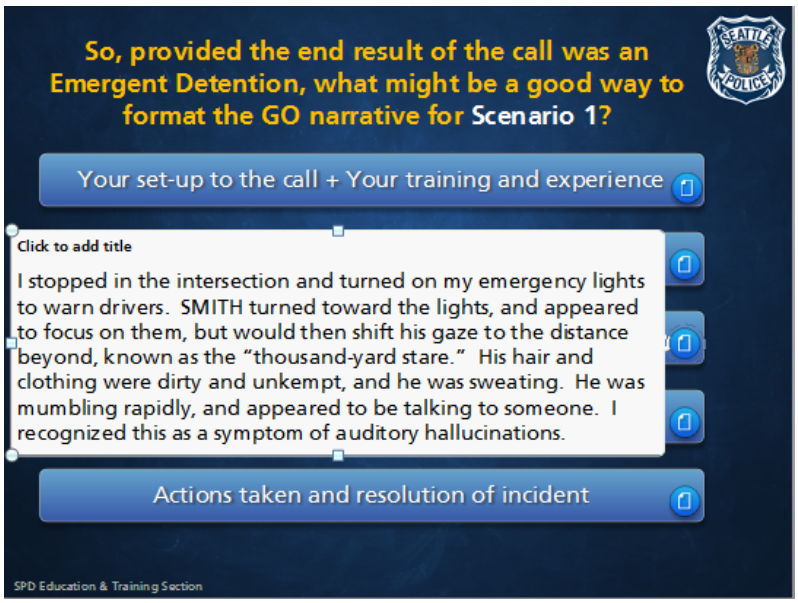

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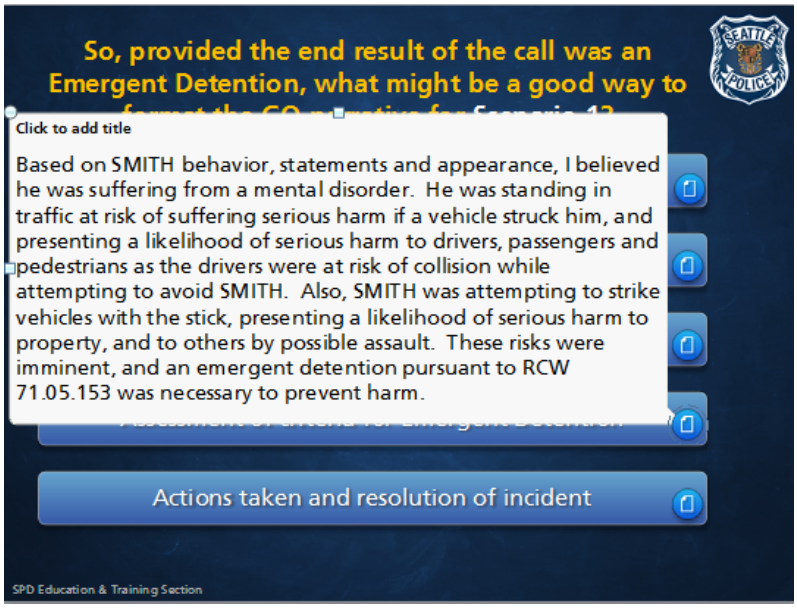
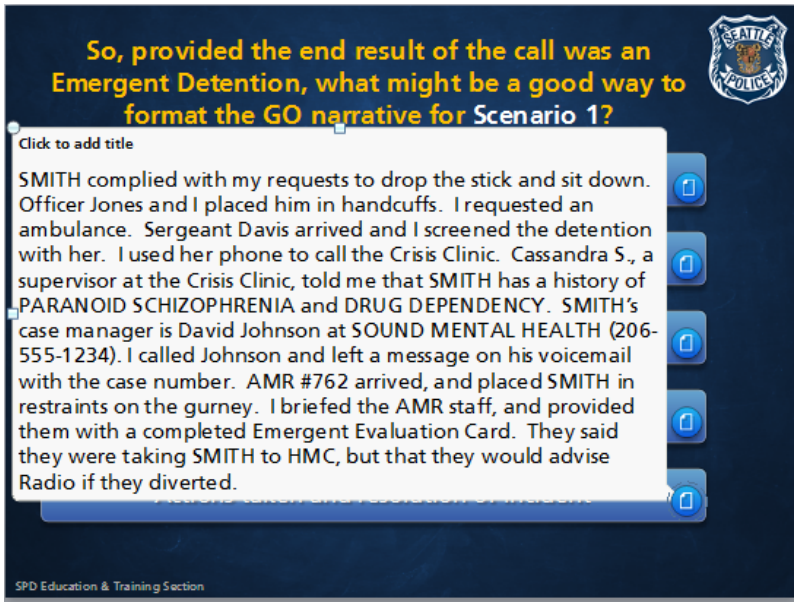


1.9 Scenario 1



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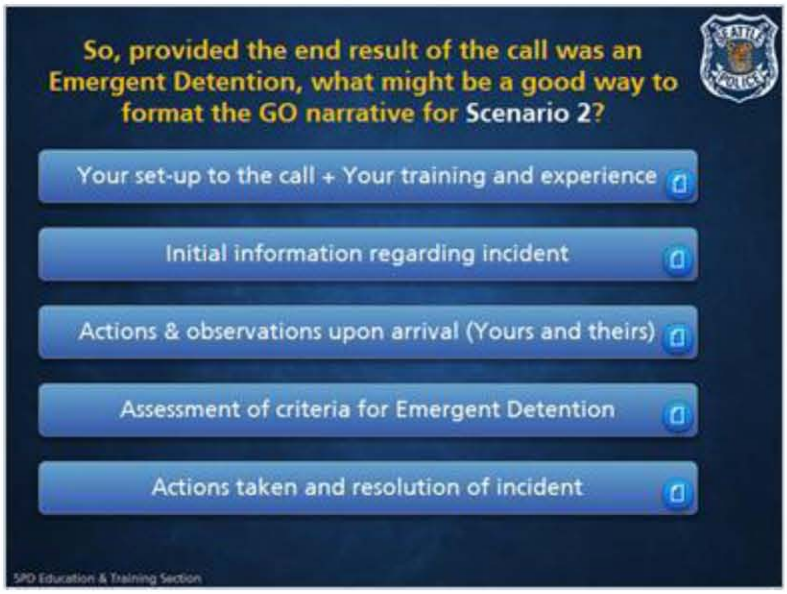
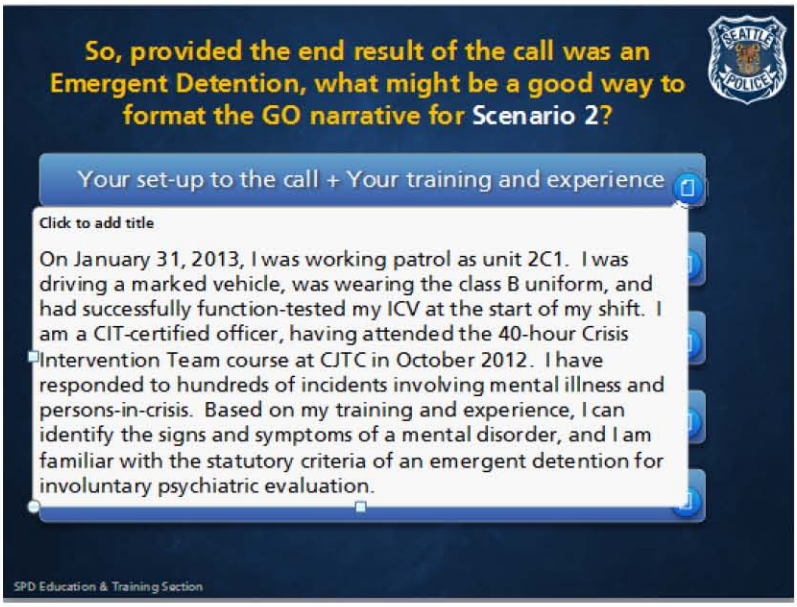


1.10 Scenario 2



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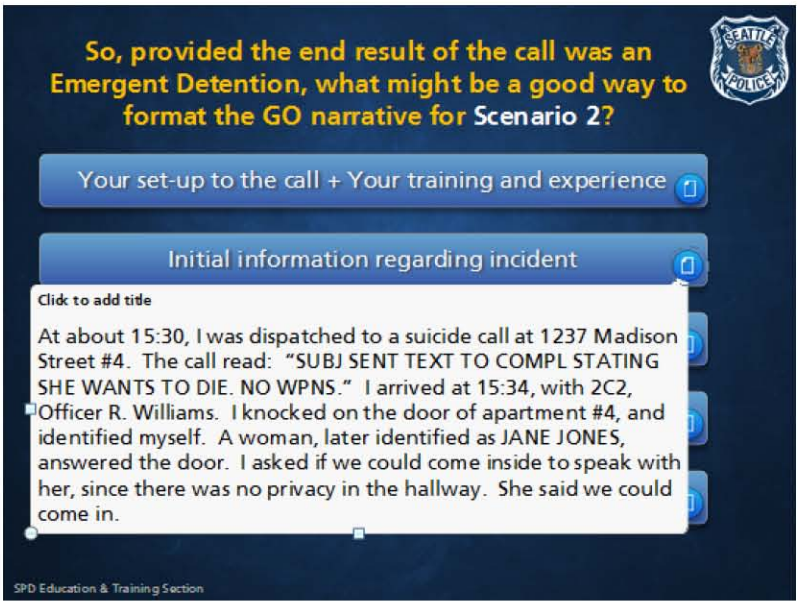

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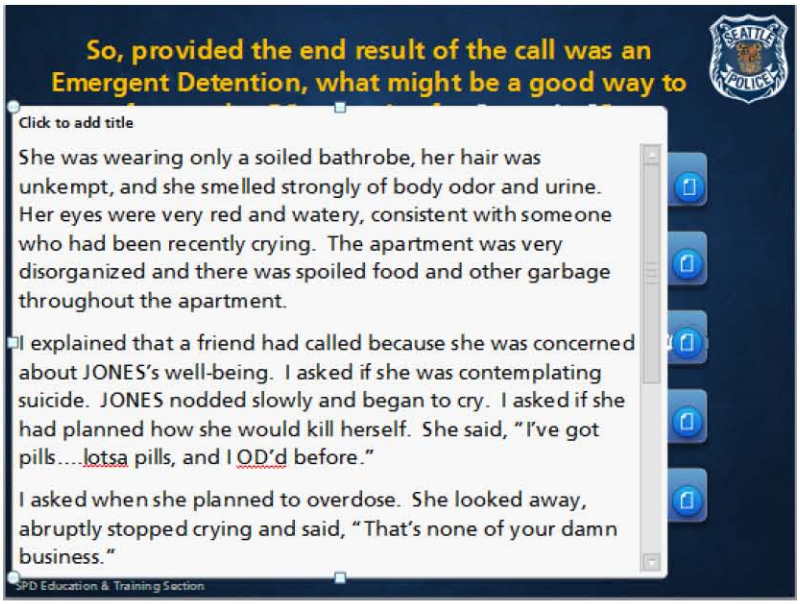
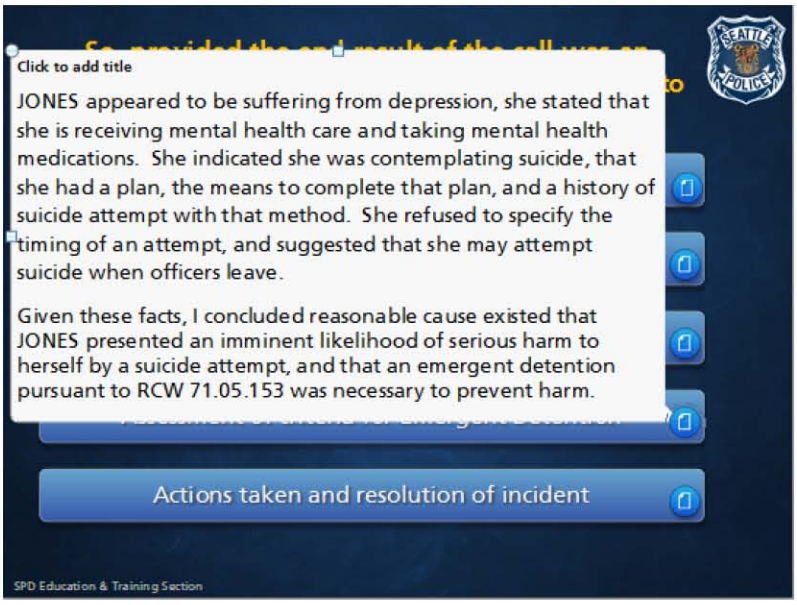
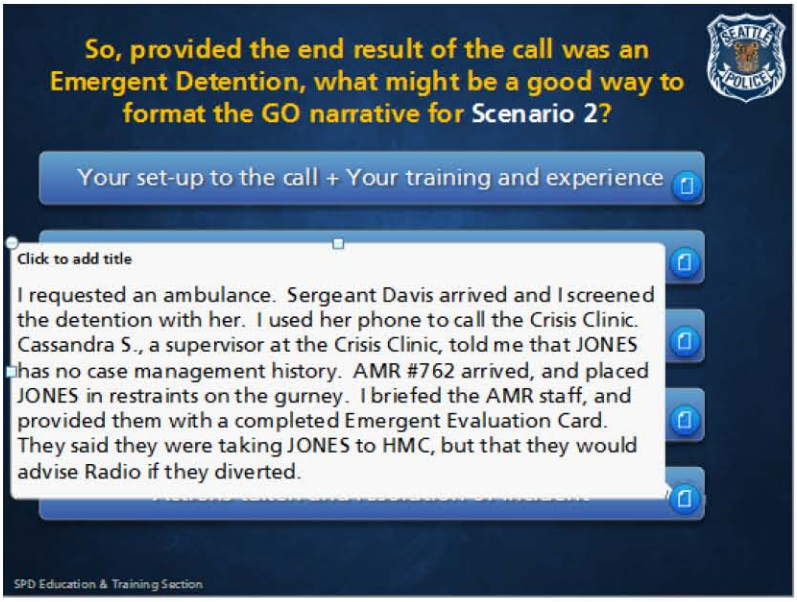


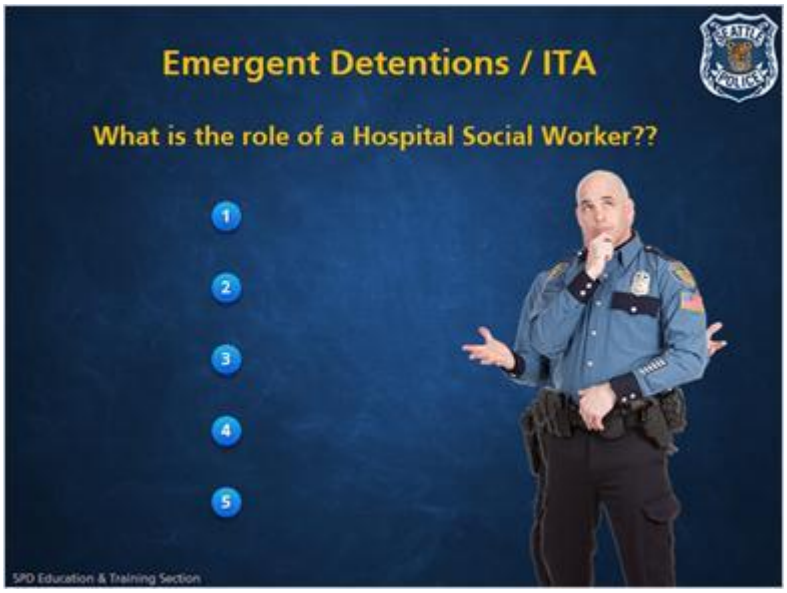
1.10 Scenario 2



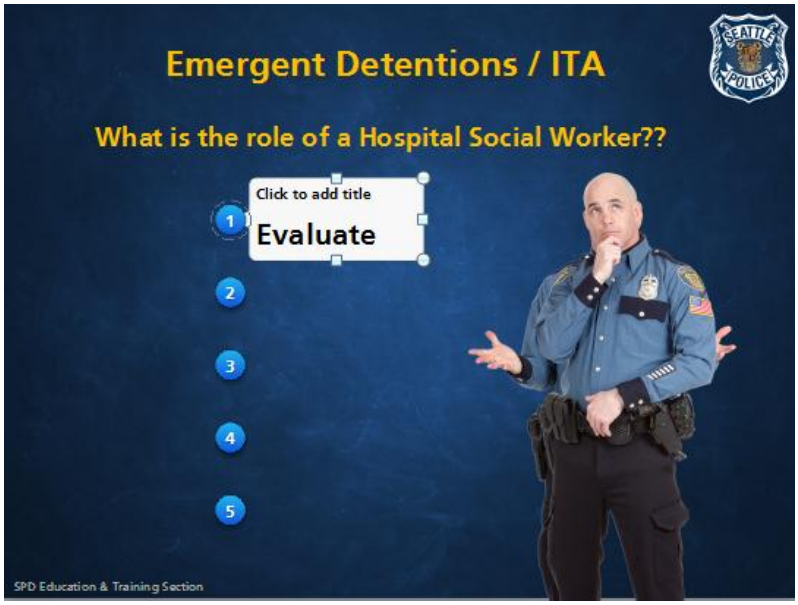
1.10 Scenario 2



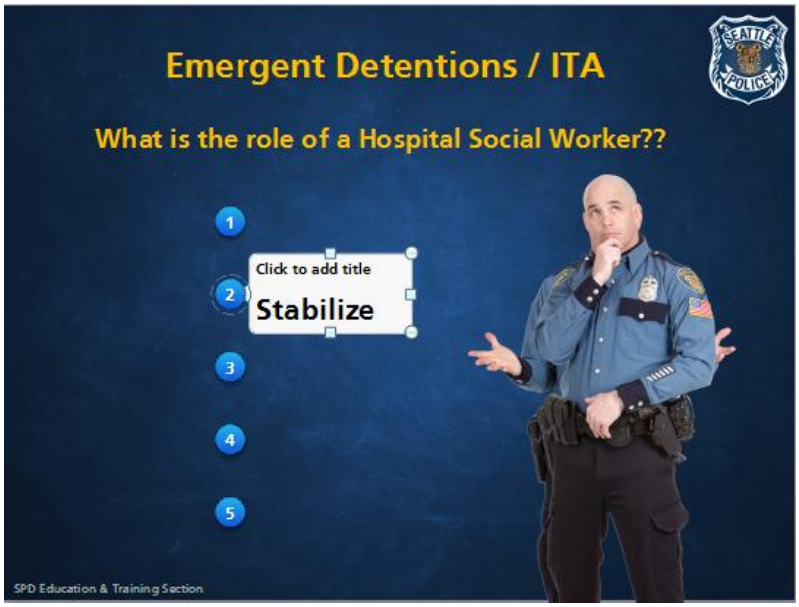
1.11 Social worker



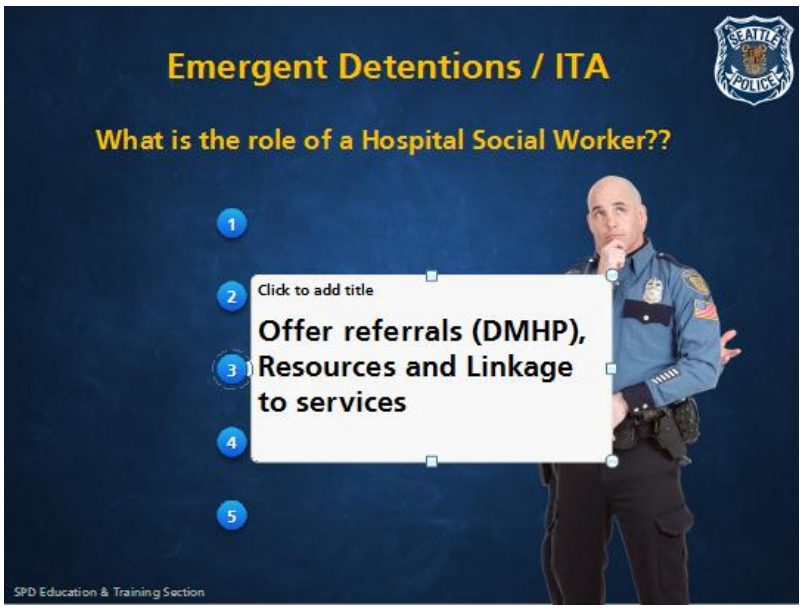
1.11 Social worker



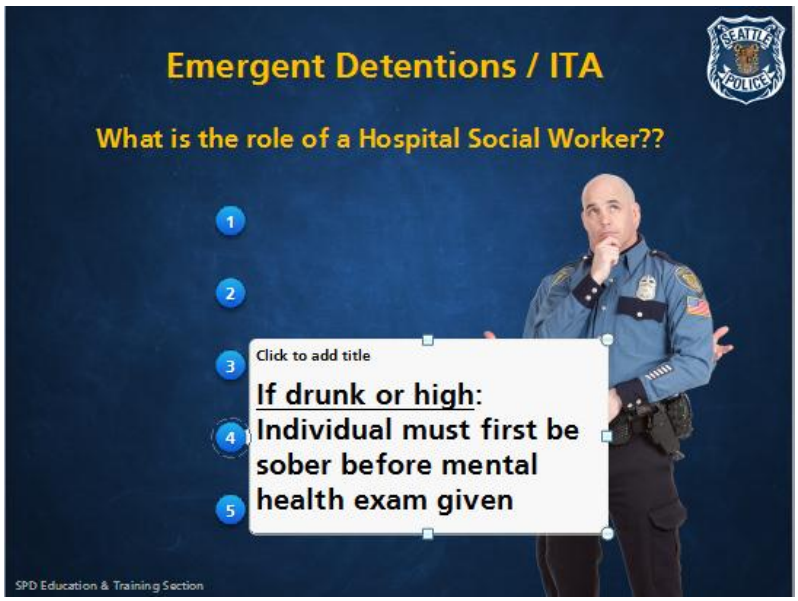
1.11 Social worker



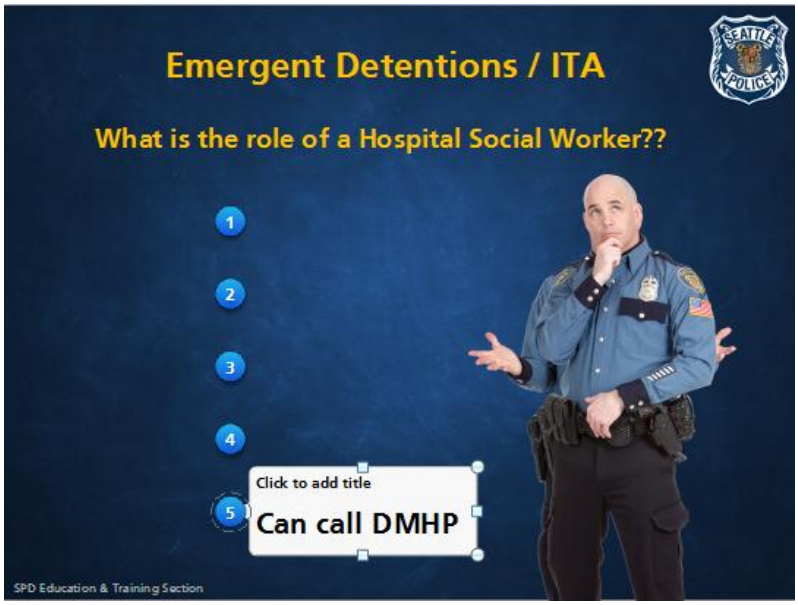
1.11 Social worker



1.11 Social worker

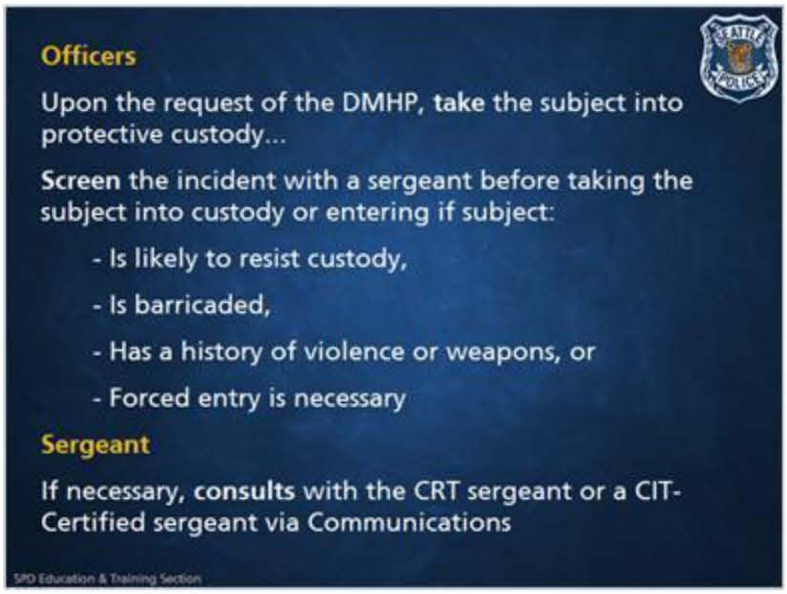


1.11 Social worker

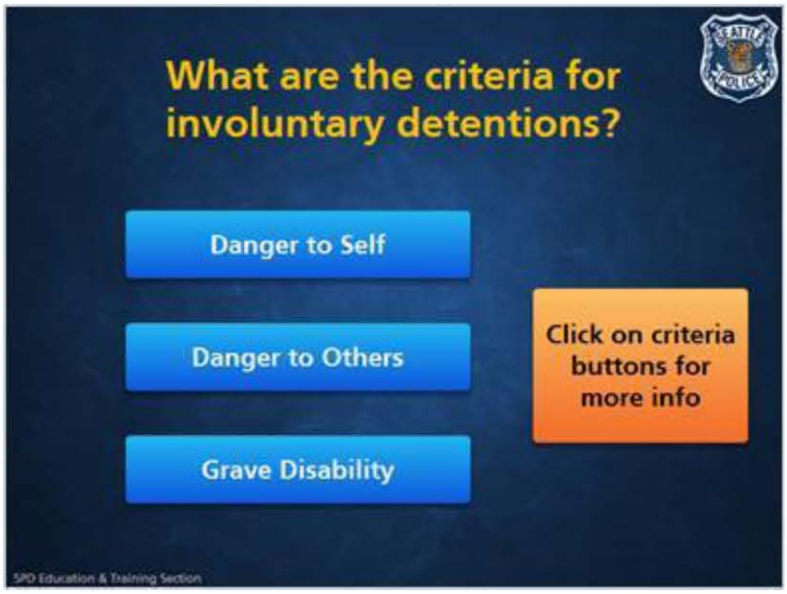


1.12 DMHP

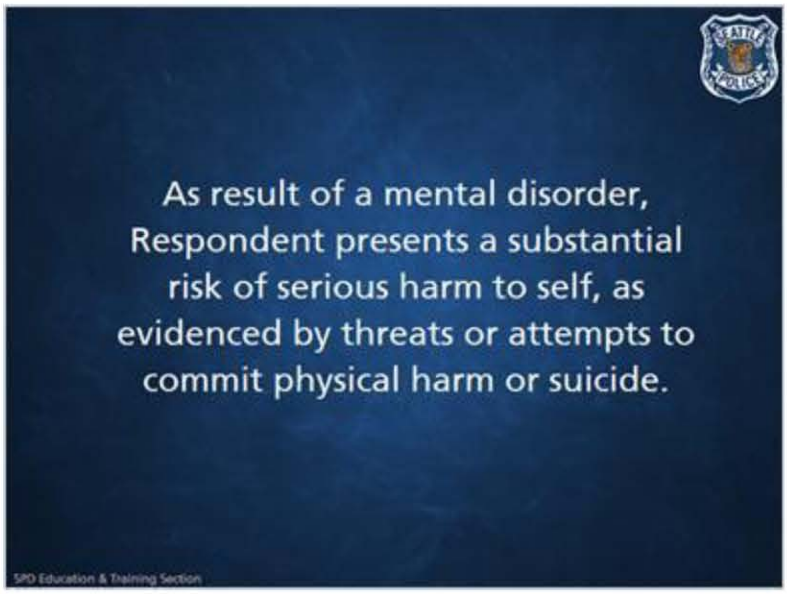
2.10 MHP



1.13 ITA

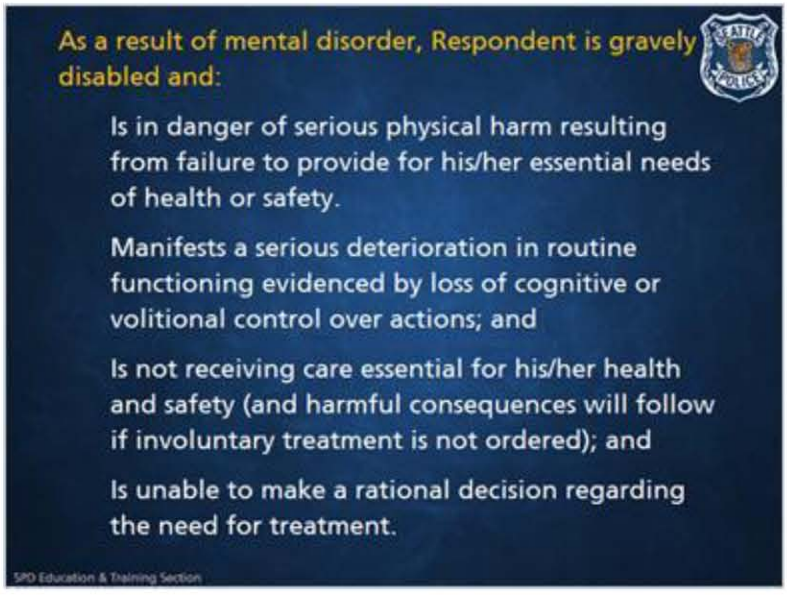


2.7 Self



2.8 Others

2.9 Grave



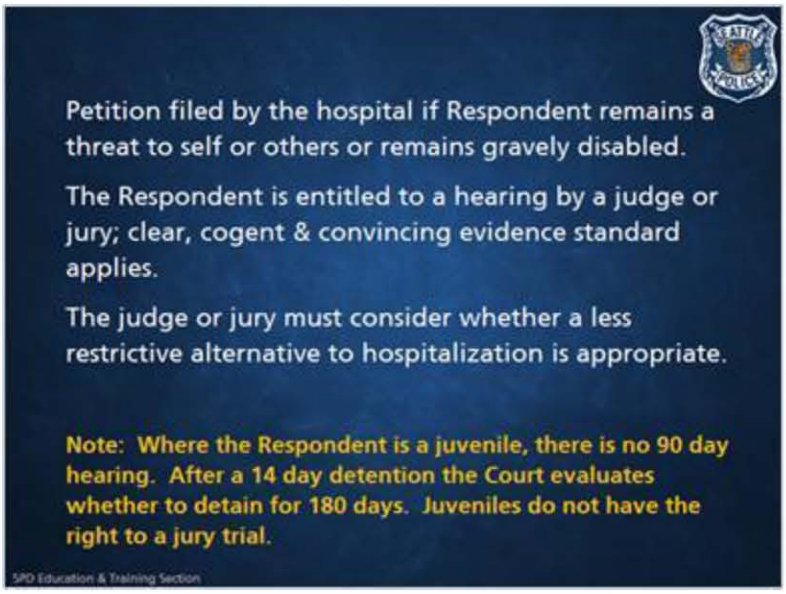
1.14 Courts

1.15 Timelines

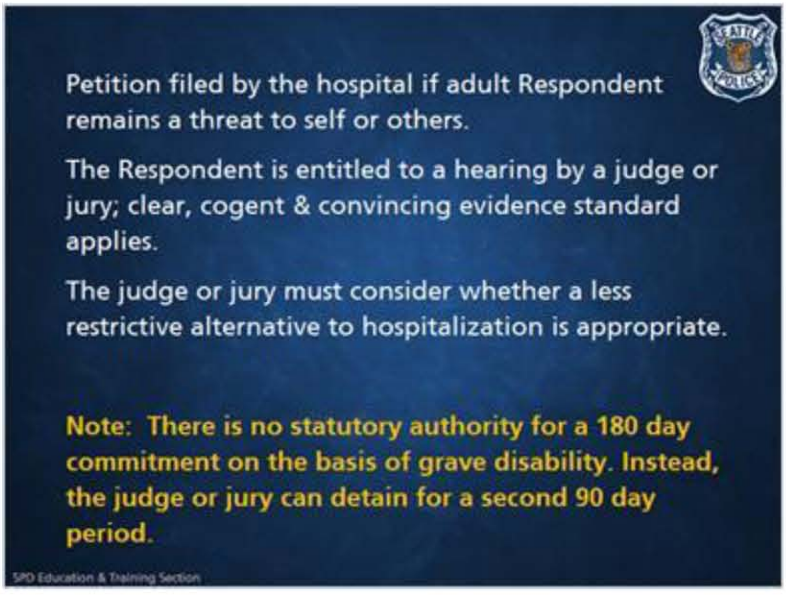
2.3 72 hr

2.4 14 day

2.5 90 day

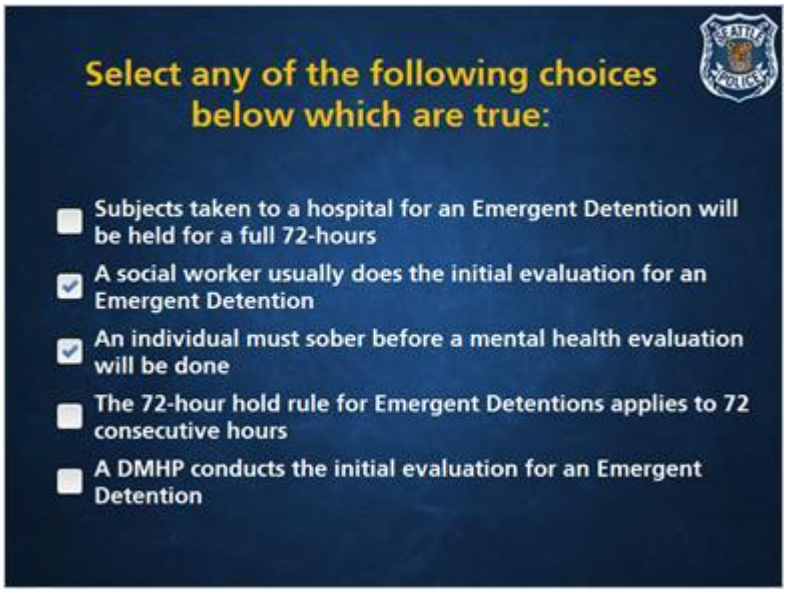


2.6 180 day



1.16 Quiz

(Multiple Response, 0 points, 3 attempts permitted)



Correct	Choice
	Subjects taken to a hospital for an Emergent Detention will be held for a full 72-hours
X	A social worker usually does the initial evaluation for an Emergent Detention
X	An individual must sober before a mental health evaluation will be done
	The 72-hour hold rule for Emergent Detentions applies to 72 consecutive hours
	A DMHP conducts the initial evaluation for an Emergent Detention

Feedback when correct:

Way to go!

Yes, a social worker generally completes the initial evaluation and, an individual CANNOT be detained for an emergent detention while drunk or high

Feedback when incorrect:

Actually...

- Subjects taken to the hospital for an Emergent Detention will NOT always be held for 72-hours

- The "72-hour" rule does NOT include weekends or Holiday's

- A social worker does the initial evaluation for an Emergent Detention

1.17 Fax

1.18 Last Slide

Player


CIT Module 2 - Emergent Detentions
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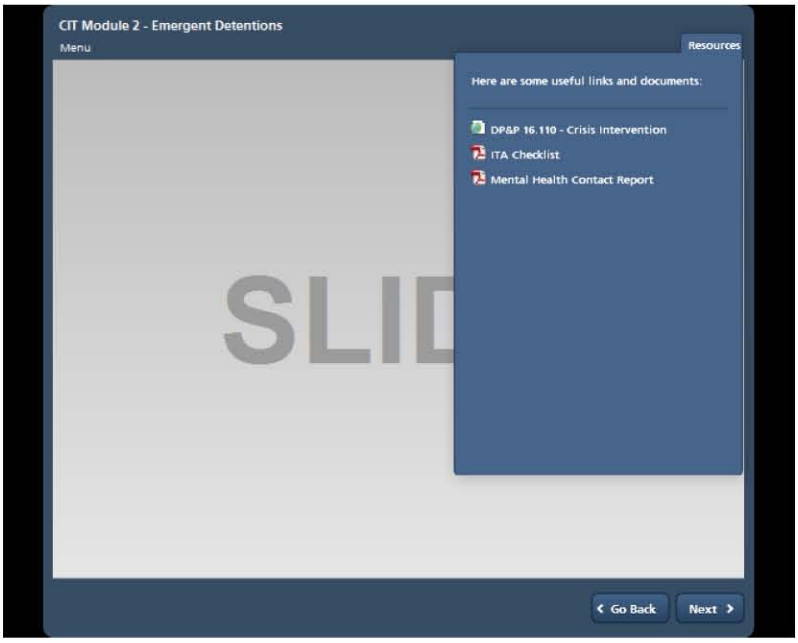
CIT Module 2 - Emergent Detentions
Menu
Resources
Here are some useful links and documents:
DP&P 16.110 - Crisis Intervention
ITA Checklist
Mental Health Contact Report
SLID
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Next

ITA Checklist:

DANGER TO SELF, DANGER TO OTHERS, AND GRAVE DISABILITY DEFINED

Danger to Self:

- As result of a mental disorder, Respondent presents a substantial risk of serious harm to self, as evidenced by threats or attempts to commit physical harm or suicide.

Danger to Others:

- As a result of a mental disorder, Respondent presents a substantial risk of serious harm to others,
  - as evidenced by behavior that has caused harm or places another in reasonable fear or harm; or
  - as evidenced by threats to physical safety of another and a history of one or more violent acts within 10 years of the petition.

Grave Disability [Prong A]:

- As a result of mental disorder, Respondent is gravely disabled and:
  - is in danger of serious physical harm resulting from failure to provide for his/her essential needs of health or safety.

Grave Disability [Prong B]:

- As a result of mental disorder, Respondent is gravely disabled and:
  - manifests a serious deterioration in routine functioning evidenced by loss of cognitive or volitional control over actions; and
  - is not receiving care essential for his/her health and safety (and harmful consequences will follow if involuntary treatment is not ordered); and
  - is unable to make a rational decision regarding the need for treatment.

ITA Checklist:

CIVIL COMMITMENT TIMELINE

Initial Detention (72 hours):

- Respondent detained for 72 hours by DMHP or by court order.
- There must be probable cause that the Respondent:
  - Presents a likelihood of serious harm to self or others or is gravely disabled; and
  - The Respondent will not voluntarily seek appropriate treatment.

14-Day Detention:

- Petition filed by the hospital if Respondent remains a threat to self or others or remains gravely disabled.
- The Respondent is entitled to a hearing by a judge; preponderance of the evidence standard applies.
- The judge must consider whether a less restrictive alternative to hospitalization is appropriate.

90-Day Detention:

- Petition filed by the hospital if Respondent remains a threat to self or others or remains gravely disabled.
- The Respondent is entitled to a hearing by a judge or jury; clear, cogent & convincing evidence standard applies.
- The judge or jury must consider whether a less restrictive alternative to hospitalization is appropriate.

Note: Where the Respondent is a juvenile, there is no 90 day hearing. After a 14 day detention the Court evaluates whether to detain for 180 days. Juveniles do not have the right to a jury trial.

180-day Detention:

- Petition filed by the hospital if adult Respondent remains a threat to self or others.
- The Respondent is entitled to a hearing by a judge or jury; clear, cogent & convincing evidence standard applies.
- The judge or jury must consider whether a less restrictive alternative to hospitalization is appropriate.

Note: There is no statutory authority for a 180 day commitment on the basis of grave disability.Instead, the judge or jury can detain for a second 90 day period.

Mental Health Contact – DRAFT:

SEATTLE POLICE OFFICER'S MENTAL HEALTH CONTACT REPORT

Date: Time: CIRT / CIT / Non-CIT:

Seattle Police Incident: In-Car Video? ☐ Yes ☐ No

Location:

Subject Name:

DOB: Sex: SSN: Race:

Address:

Phone: Diagnosis (*if known*): Veteran: ☐ Yes ☐ No

☐ Call Dispatched Referred by: ☐ On-view other:

Nature of Incident (*check all that apply*):

☐ Disorderly/disruptive behavior ☐ Theft/other property crime ☐ other/Specify:
☐ Neglect of self-care ☐ Drug-related offenses ☐ No information
☐ Public Intoxication ☐ Suicide threat or attempt
☐ Nuisance ☐ Threats or other violence to others

Threats / Violence / Weapons:
Did subject use / brandish a weapon?
☐ Yes ☐ No ☐ Don't Know

Type of weapon (*check all that apply*):
☐ Knife ☐ Gun ☐ other / specify:

Did subject threaten violence toward another person?
☐ Yes ☐ No ☐ Don't Know
If so, to whom?

Prior police contacts?
☐ Yes ☐ No ☐ Don't Know Evidence of drug / alcohol intoxication?
Prior contact within 24 hours?
☐ Yes ☐ No ☐ Don't Know

☐ Yes ☐ No ☐ Don't Know
If Yes –
☐ Alcohol ☐ Other Drug / Specify ☐ Don't Know

Medication Compliance:
☐ Yes ☐ No ☐ Don't Know
Specify if known:

Complainant Relationship (*check one*):

☐ Partner/spouse	☐ Sibling	☐ Other-family member	☐ Don't Know
☐ Boyfriend/girlfriend	☐ Friend/acquaintance	☐ Police observation	
☐ Parent	☐ Business owner	☐ Other-stranger	

Behaviors Evident at Time of Incident (*check all that apply*):

☐ Disorientation/confusion	☐ Depressed
☐ Delusions – *specify if known*:	☐ Unusually scared or frightened
☐ Hallucinations – *specify if known*:	☐ Belligerent or uncooperative
☐ Disorganized speech	☐ No Information
☐ Manic	

Incident Injuries:
Were there any injuries during incident?
☐ Yes ☐ No ☐ Don't Know
If so, to whom? (Partner, Law Enforcement, Stranger, Etc.)
Disposition (*Check all that apply*):
☐ No action/resolved on scene
☐ On-scene crisis intervention
☐ SPD notified case manager or mental health agency
☐ DMHP/referral
☐ Transported to treatment facility:

Arrested:
☐ Yes ☐ No

Charges:
☐ KCJ ☐ YSC ☐ CDF

Prior to CIT would you have taken this individual to jail?
☐ Yes ☐ No
What would the charges have been?

What was reported:

Incident Narrative:

Techniques or Equipment Used:

Force Used: ☐ Yes ☐ No

WITNESS/CONTACTS/COMPLAINANT:
Name
Address
Phone
Relationship

Name
Address
Phone
Relationship

Does the individual have medications (list and describe below)? ☐ Yes ☐ No ☐ Unknown

Is individual in treatment at a mental health agency? ☐ Yes ☐ No
(*If so where?)*

Is there a chargeable offense? ☐ Yes ☐ No ☐ Unknown

If the individual is NOT detained at psychiatric emergency services, is there a police hold? ☐ Yes ☐ No

Has the individual been searched for contraband/weapons? ☐ Yes ☐ No ☐ Unknown

Hospital Transported to:

Individual Referred to County Program: ☐ MCT ☐ GRAT ☐ Shelter Other:

Supervisor Respond to scene: ☐ Yes ☐ No

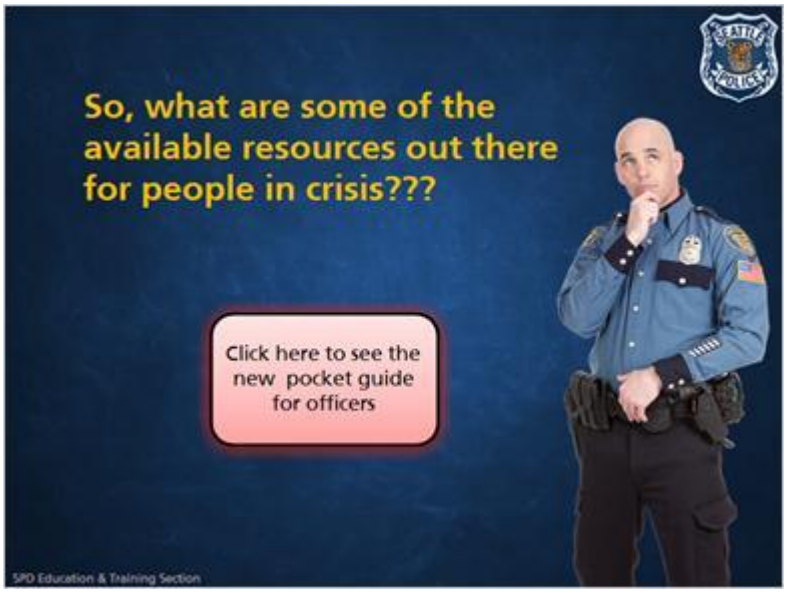
Reporting Officer: Serial: Date Place

Contact Phone: Email Address:

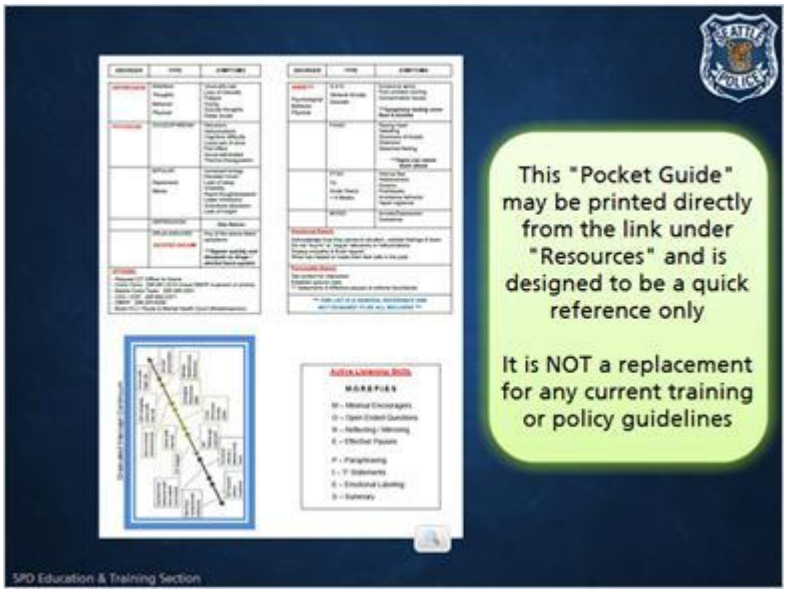
EXHIBIT B-5

CIT Module 3 – Resources (5-29-14)

1.1 First Slide



2.1 Pocket Guide

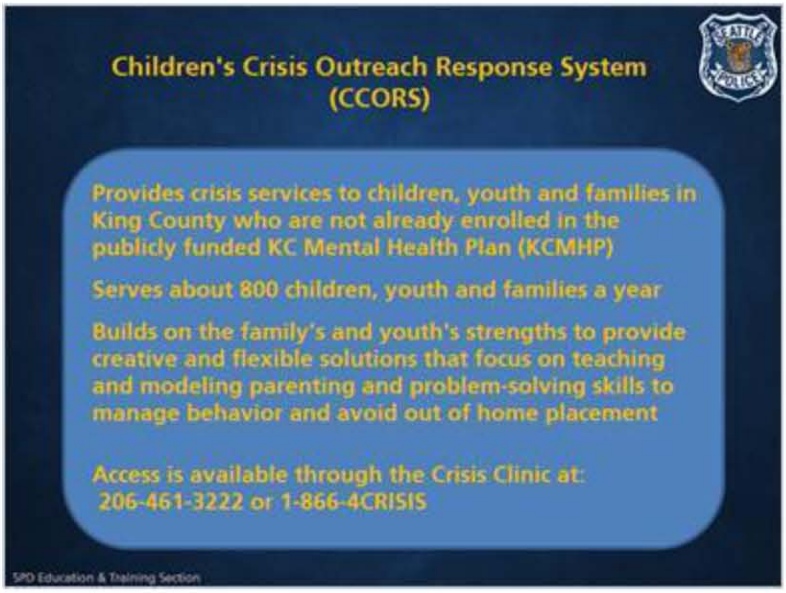


1.2 Resources

1.3 DESC

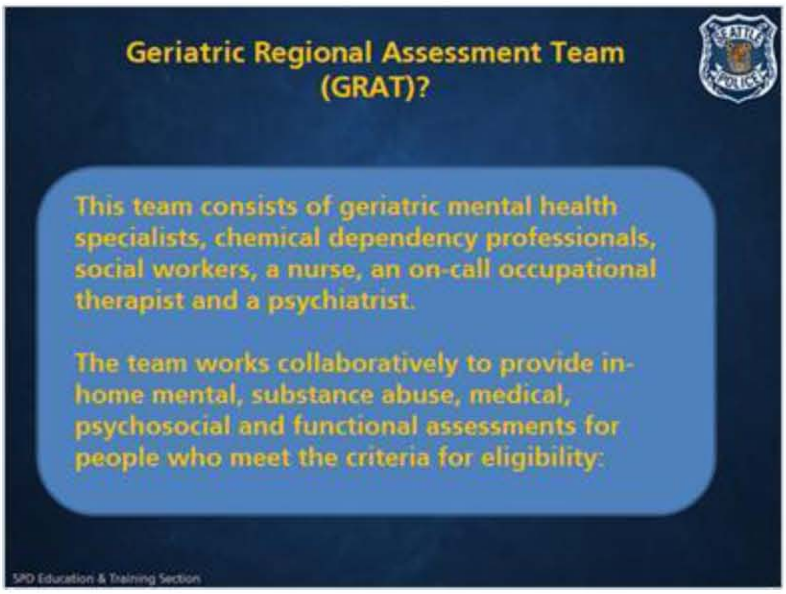
1.4 MCT

1.5 CCORS

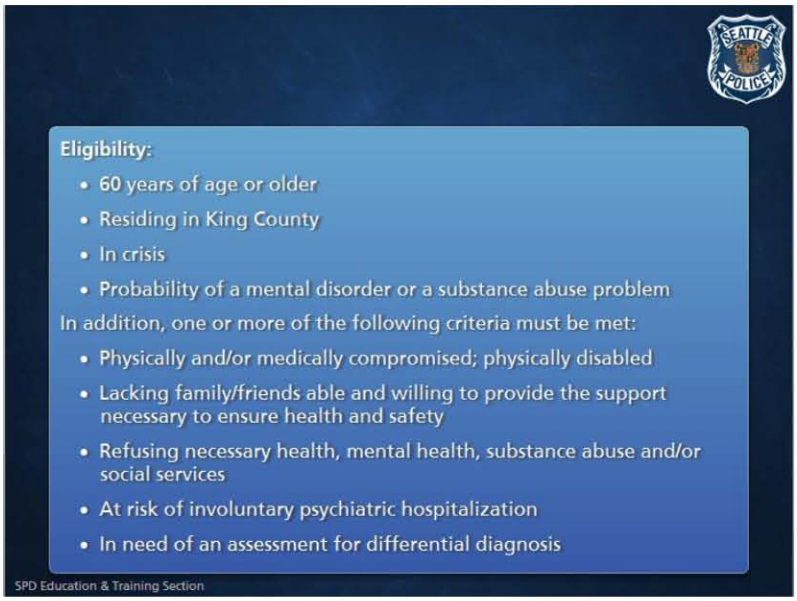


1.5 CCORS (part 2)

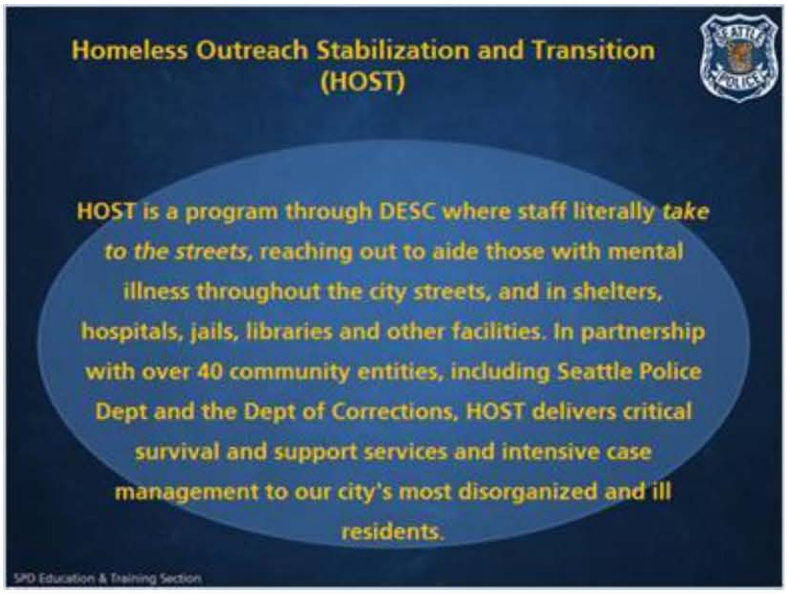
1.6 GRAT



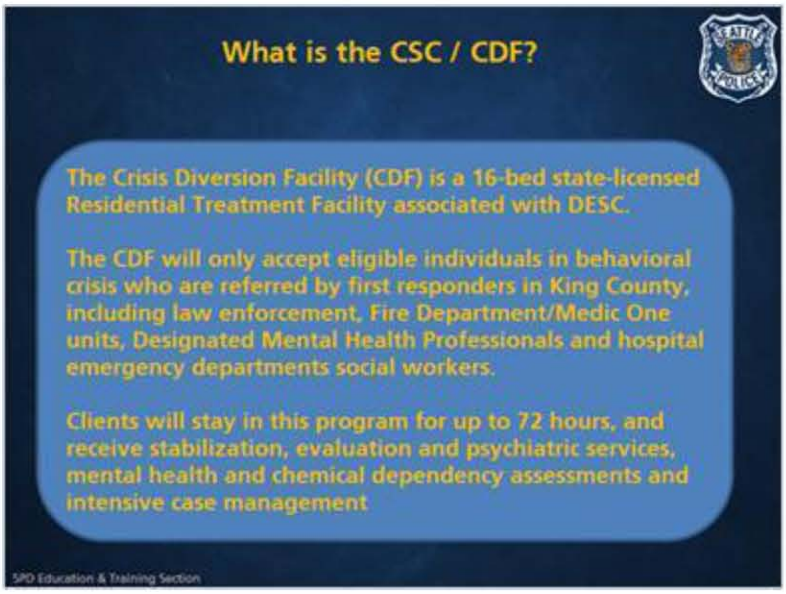
1.6 GRAT (part 2)



1.7 HOST



1.8 CSC-CDF



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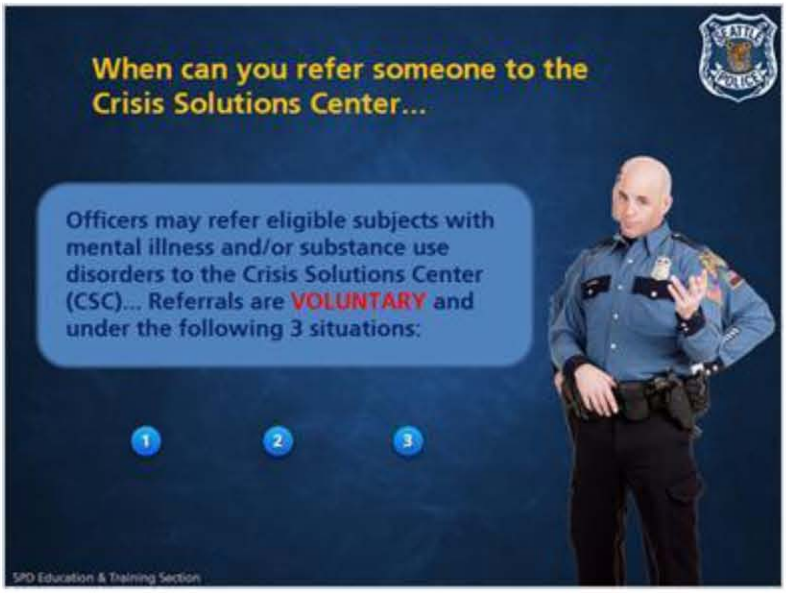

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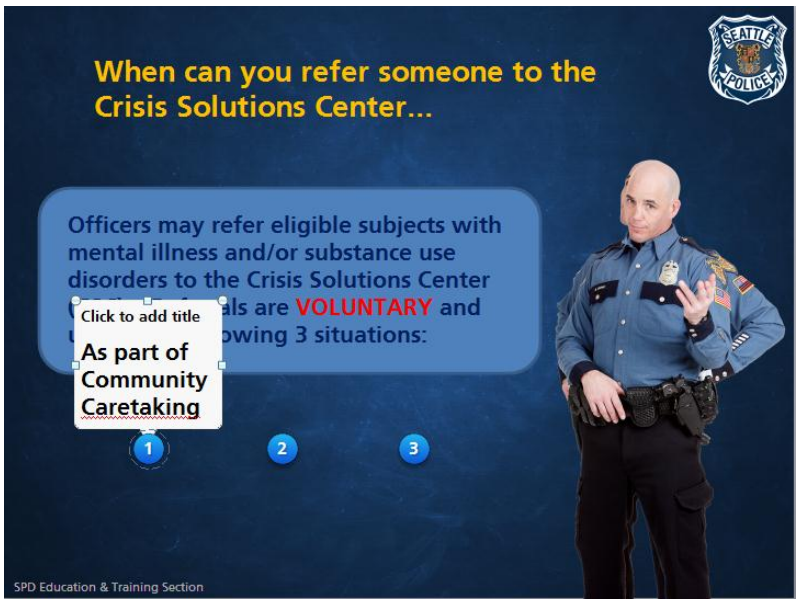

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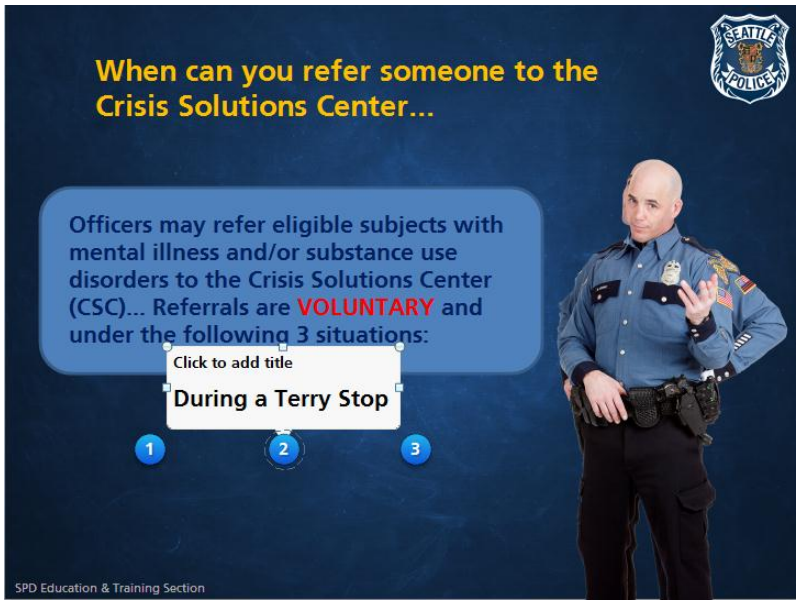
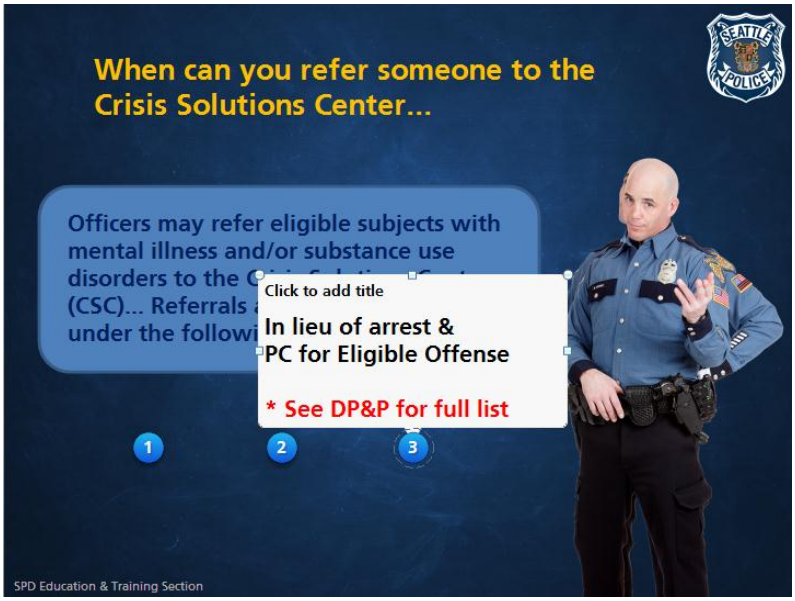
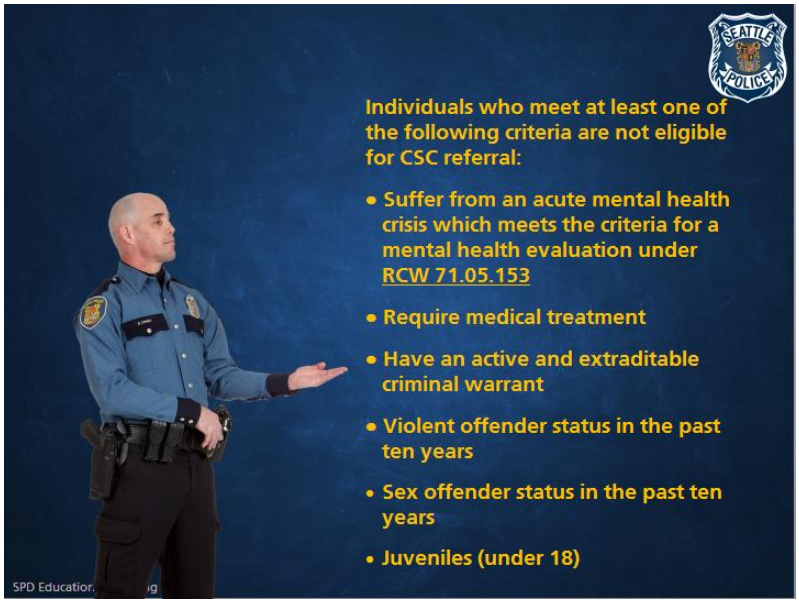


1.9 CSC-CDF (slide 2)

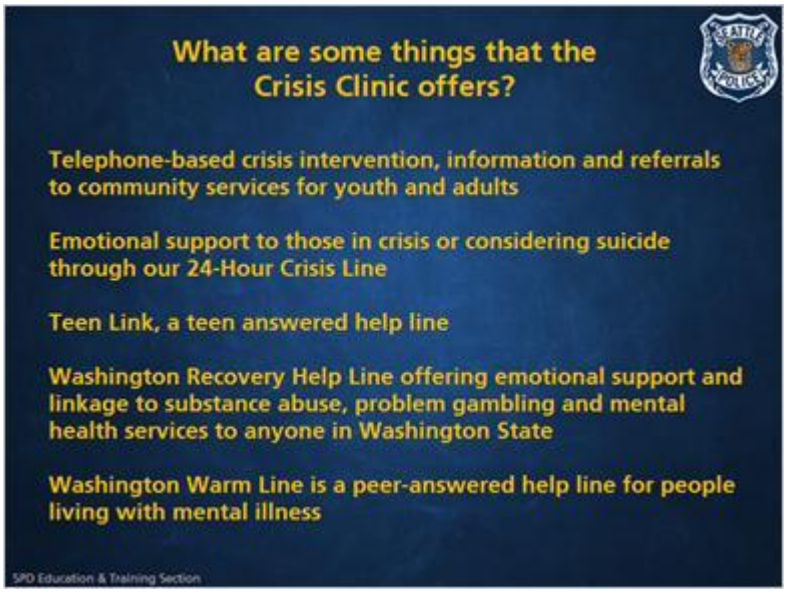


1.10 CSC-CDF (slide 3)

1.10 CSC-CDF (slide 3)



1.11 Crisis Clinic



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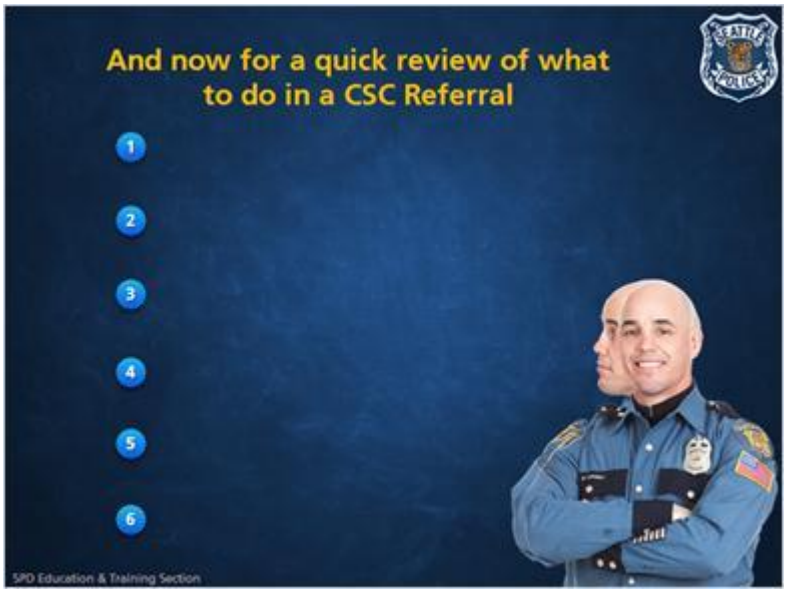
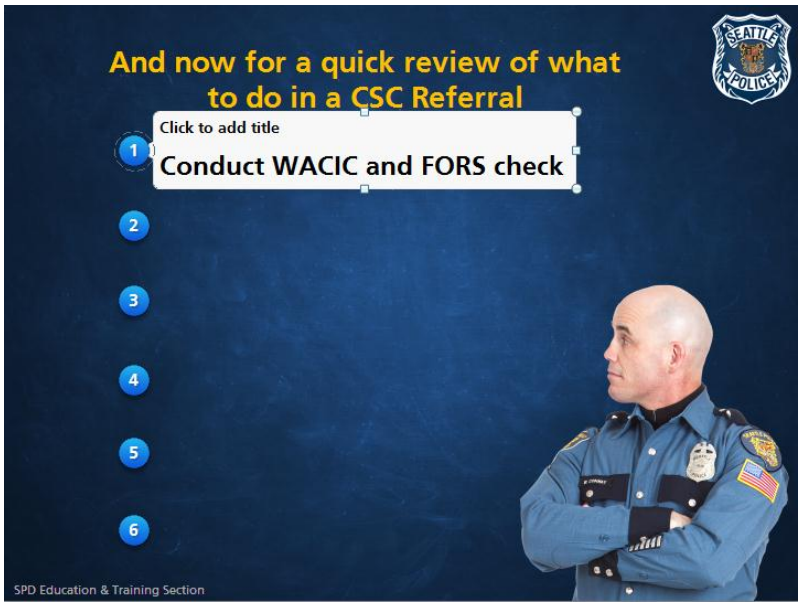


1.12 CSC Review



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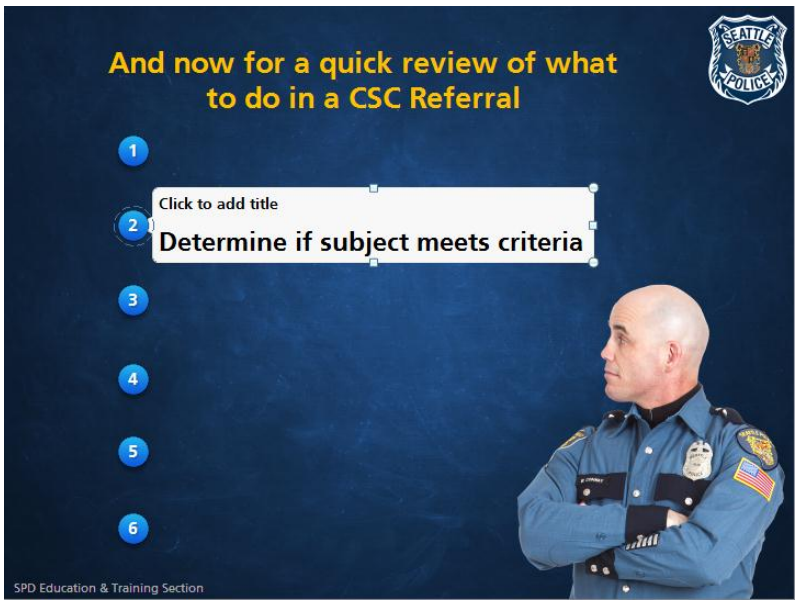

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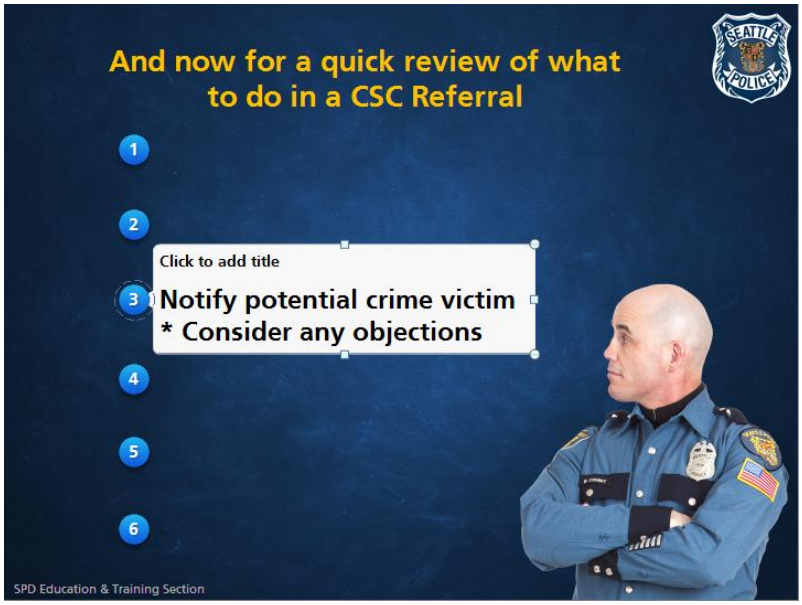

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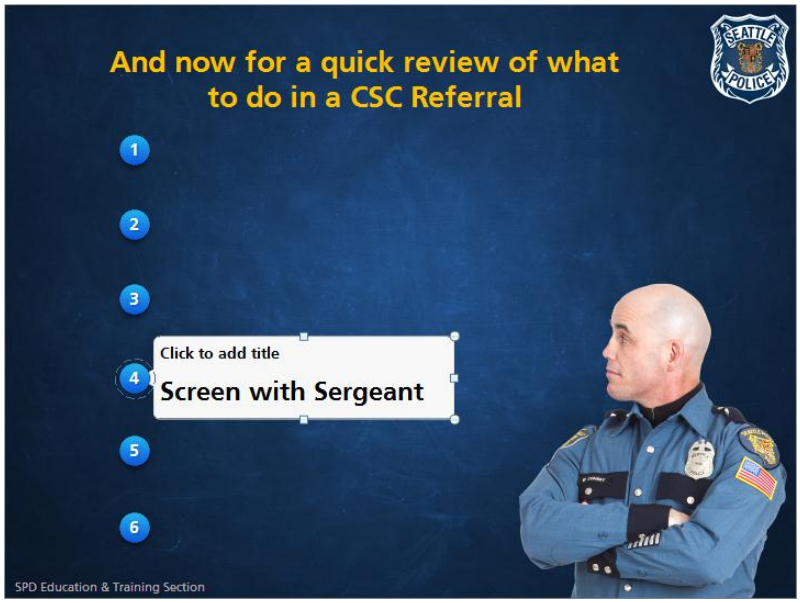

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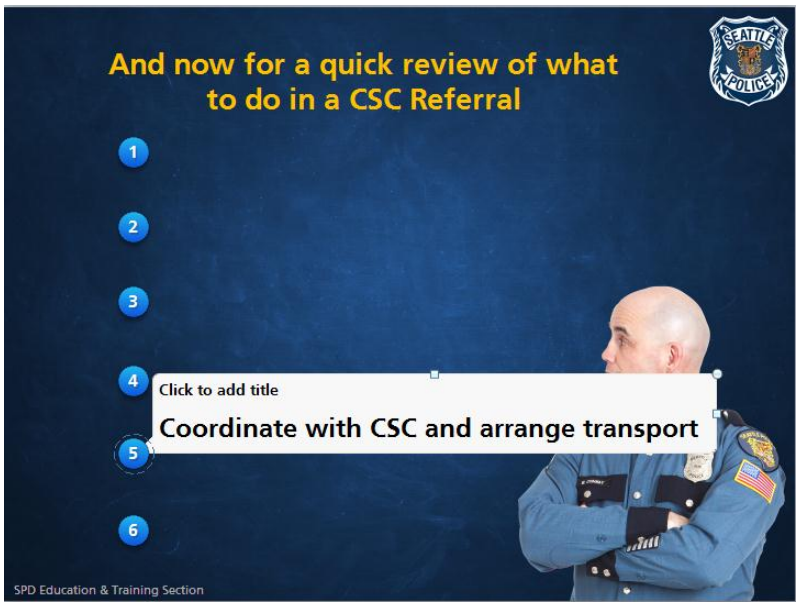

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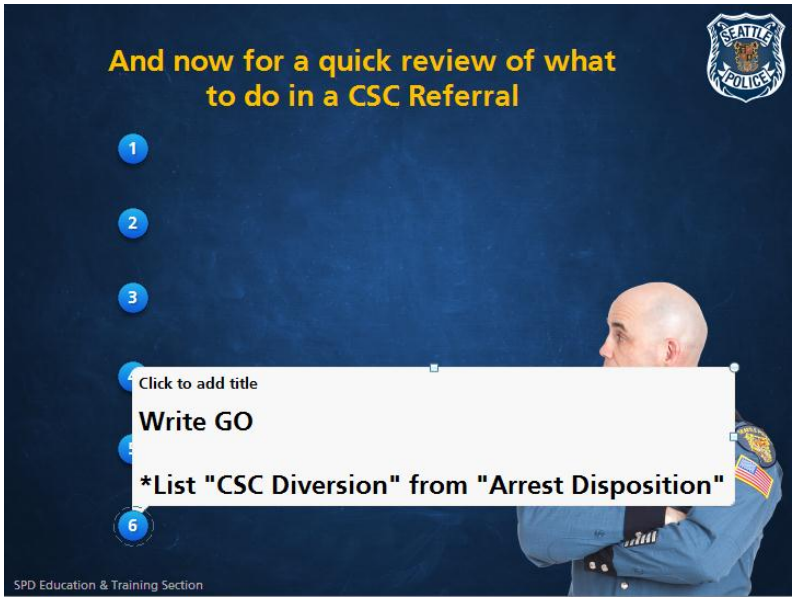

1.13 Last Slide

Player


CIT Module 3 - Resources
Menu
Resources
SLIDE
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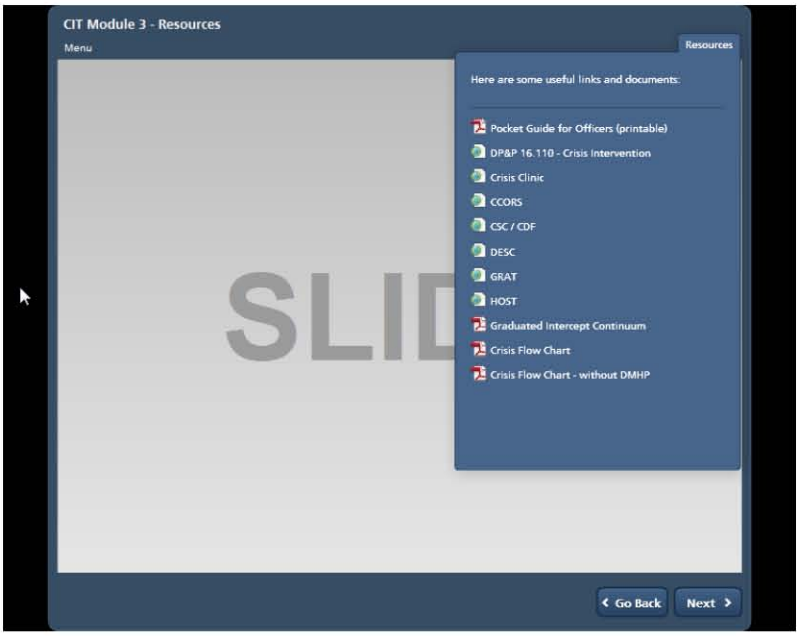
Next


CIT Module 3 - Resources
Menu
Resources
Here are some useful links and documents:
Pocket Guide for Officers (printable)
DP&P 16.110 - Crisis Intervention
Crisis Clinic
CCORS
CSC / CDF
DESC
GRAT
HOST
Graduated Intercept Continuum
Crisis Flow Chart
Crisis Flow Chart - without DMHP
Go Back
Next

Pocket Guide:

DISORDER	TYPE	SYMPTOMS
DEPRESSION	*Emotions* *Thoughts* *Behavior* *Physical*	Unusually sad Loss of interests Fatigue Crying Suicidal thoughts Sleep issues
PSYCHOSIS	SCHIZOPHRENIA	Delusions Hallucinations Cognitive difficulty Loss/Lack of drive Flat Affect Social withdrawal Thermo-Disregulation
	BIPOLAR *Depression* *Mania*	Increased energy Elevated mood Lack of sleep Irritability Rapid thoughts/speech Lower inhibitions Grandiose delusions Lack of insight
	DEPRESSION	*-See Above-*
	DRUG-INDUCED EXCITED DELIUM	Any of the above listed symptoms ***Appear quickly and dissipate as drugs / alcohol leave system*

Resources:

- Contact CRT via Communications
- Crisis Clinic: 206-461-3210 (Have DMHP in-person or phone)
- Mobile Crisis Team: 206-245-3201
- CSC / CDF: 206-682-2371
- DESC: 206-464-1570
- CCORS: 206-461-3222

DISORDER	TYPE	SYMPTOMS
ANXIETY *Psychological* *Behavior* *Physical*	G.A.D. *General Anxiety Disorder*	Excessive worry Poor problem solving Concentration issues ****Symptoms more than 6-mo*
	PANIC	Racing heart Sweating Shortness of breath Dizziness Detached feeling *****Can mimic heart attack*
	PTSD Vs. Acute Stress *< 4 Weeks*	Intense fear Helplessness Dreams Flashbacks Avoidance behavior Hyper-vigilance

Options:

- CSC / CDF: For eligible offenses (screen prior)
- Book KCJ / Route to Mental Health Court (Misdemeanors)

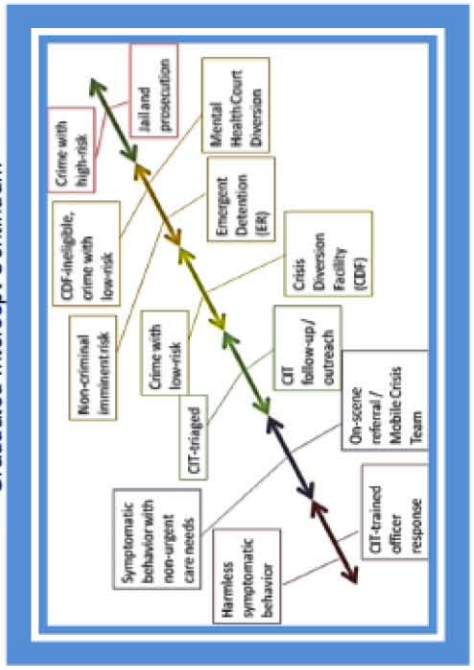
Emotional Based:

Acknowledge how they perceive situation, validate feelings & fears
Do not "buy-in" or "argue" delusions or hallucinations
Display empathy & Build rapport
What has helped or made them feel safe in the past

Personality Based:

Set context for interaction
Establish ground rules
"I" Statements & Effective pauses to enforce boundaries

*** *THIS LIST IS A GENERAL REFERENCE AND NOT DESIGNED TO BE ALL INCLUSIVE* ***



Active Listening Skills

M.O.R.E P.I.E.S

M – Minimal Encouragers
O – Open Ended Questions
R – Reflecting / Mirroring
E – Effective Pauses

P – Paraphrasing
I – "I" Statements
E – Emotional Labeling
S – Summary

ITA Checklist:

DANGER TO SELF, DANGER TO OTHERS, AND GRAVE DISABILITY DEFINED

Danger to Self:

- As result of a mental disorder, Respondent presents a substantial risk of serious harm to self, as evidenced by threats or attempts to commit physical harm or suicide.

Danger to Others:

- As a result of a mental disorder, Respondent presents a substantial risk of serious harm to others,
  - as evidenced by behavior that has caused harm or places another in reasonable fear or harm; or
  - as evidenced by threats to physical safety of another and a history of one or more violent acts within 10 years of the petition.

Grave Disability [Prong A]:

- As a result of mental disorder, Respondent is gravely disabled and:
  - is in danger of serious physical harm resulting from failure to provide for his/her essential needs of health or safety.

Grave Disability [Prong B]:

- As a result of mental disorder, Respondent is gravely disabled and:
  - manifests a serious deterioration in routine functioning evidenced by loss of cognitive or volitional control over actions; and
  - is not receiving care essential for his/her health and safety (and harmful consequences will follow if involuntary treatment is not ordered); and
  - is unable to make a rational decision regarding the need for treatment.

Graduated Intercept Continuum:

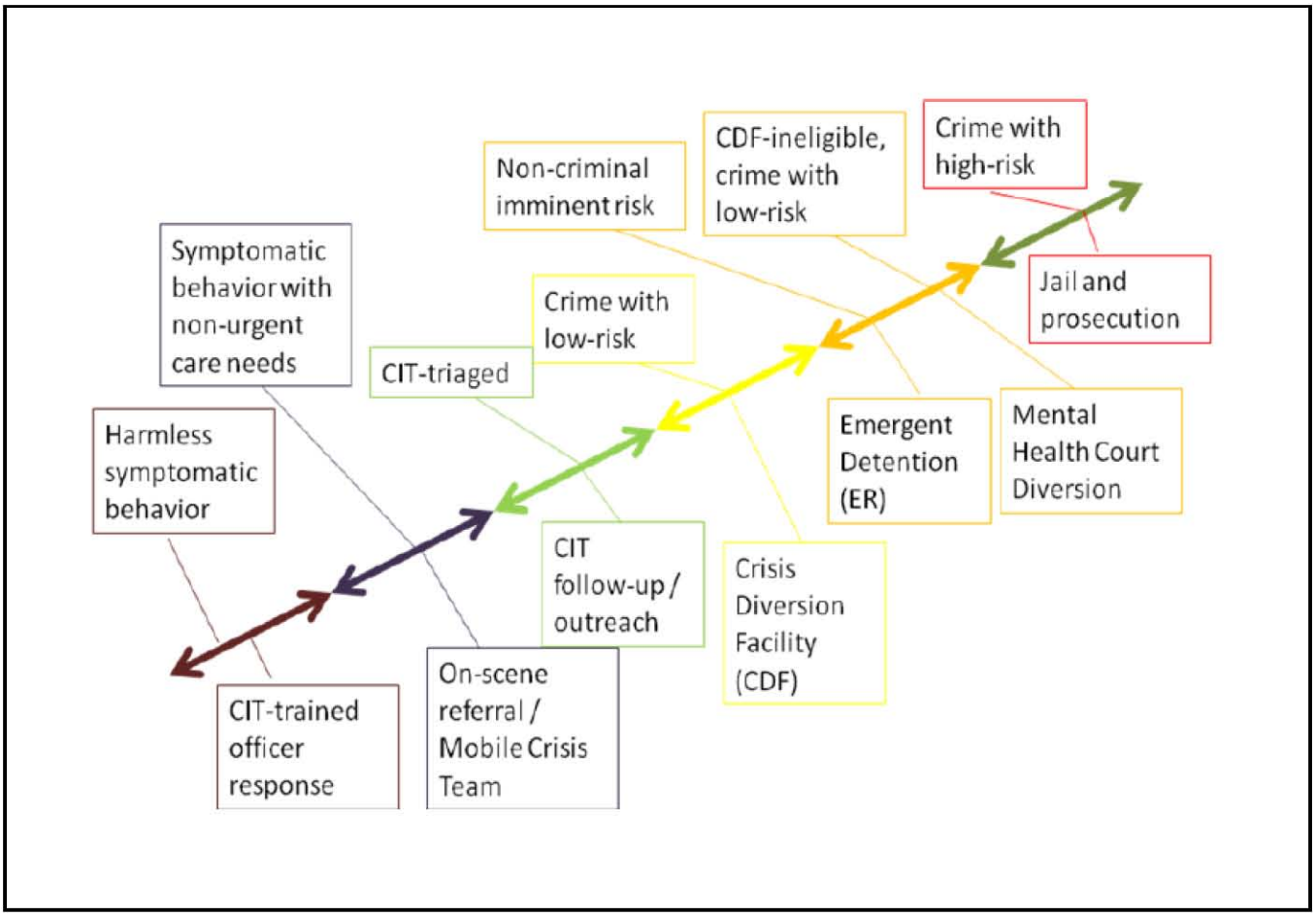
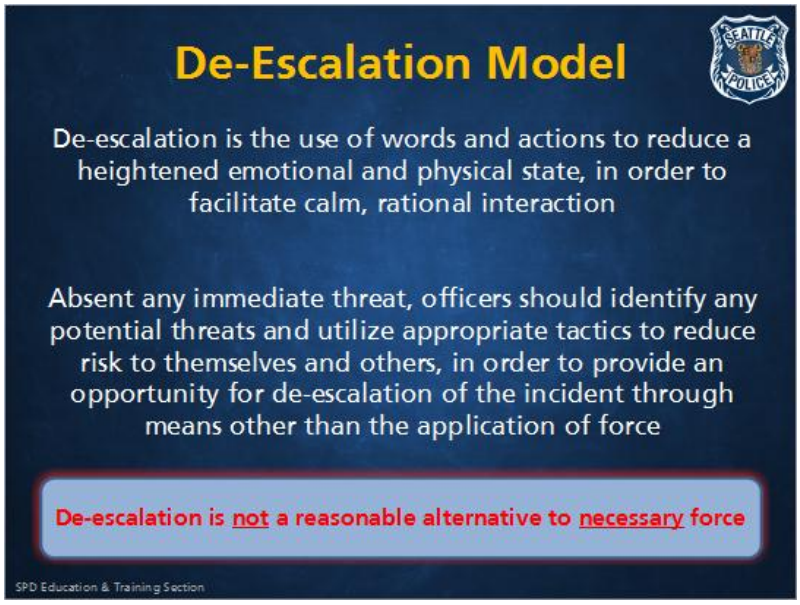


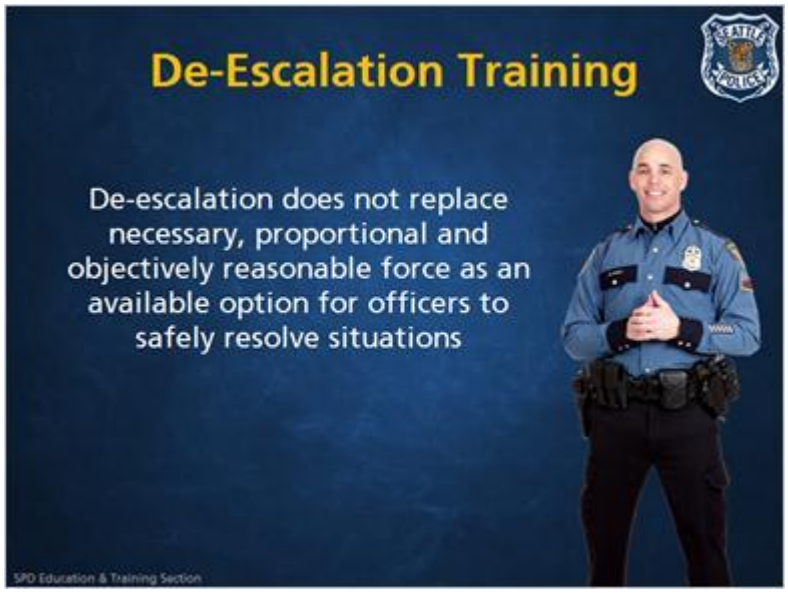
EXHIBIT B-6

De-Escalation & Active Listening Skills (5-30-14)

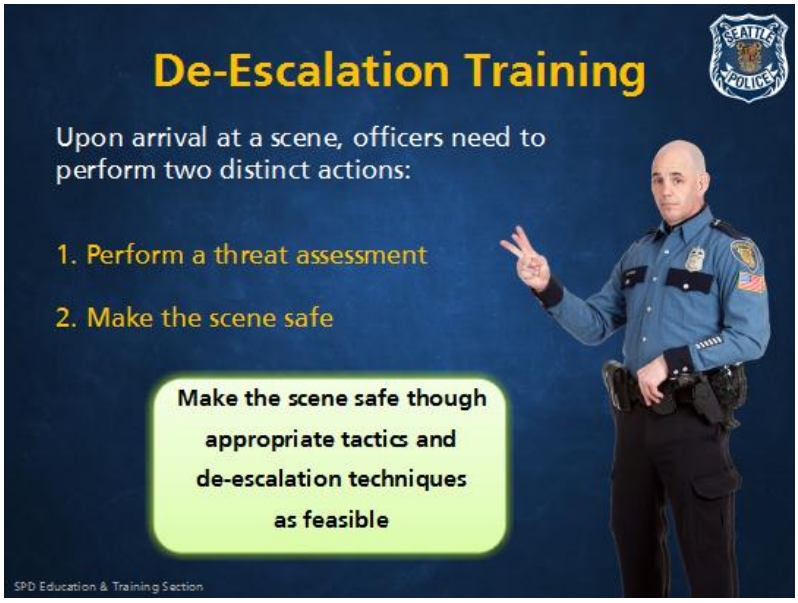
1.1 Title



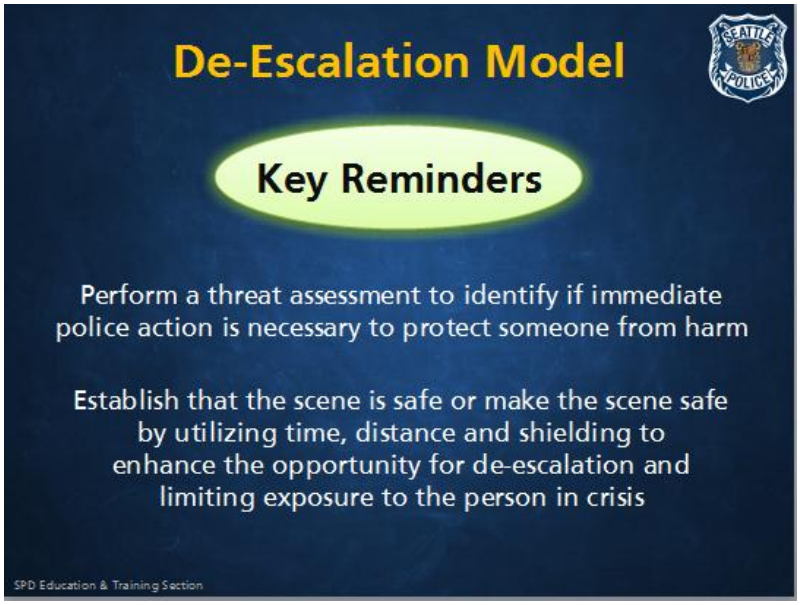
1.2 Reminder



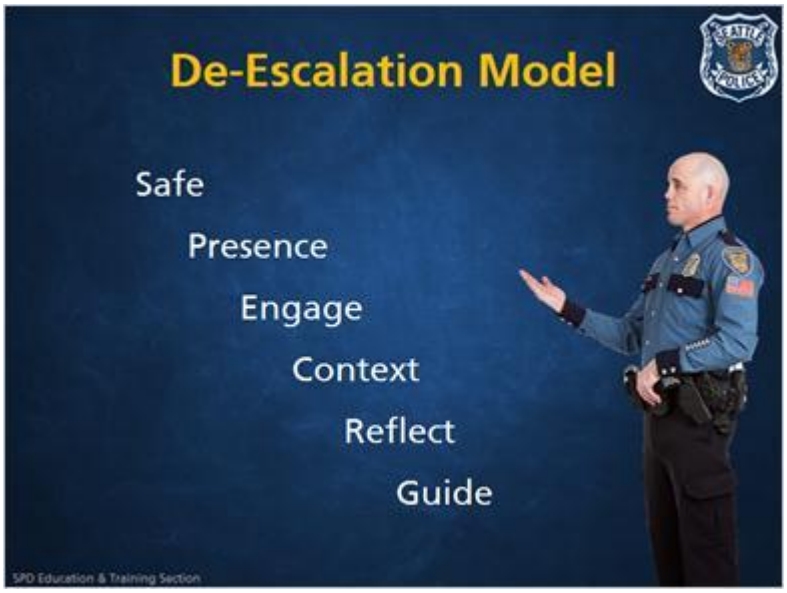
1.3 Two things



1.4 Keys

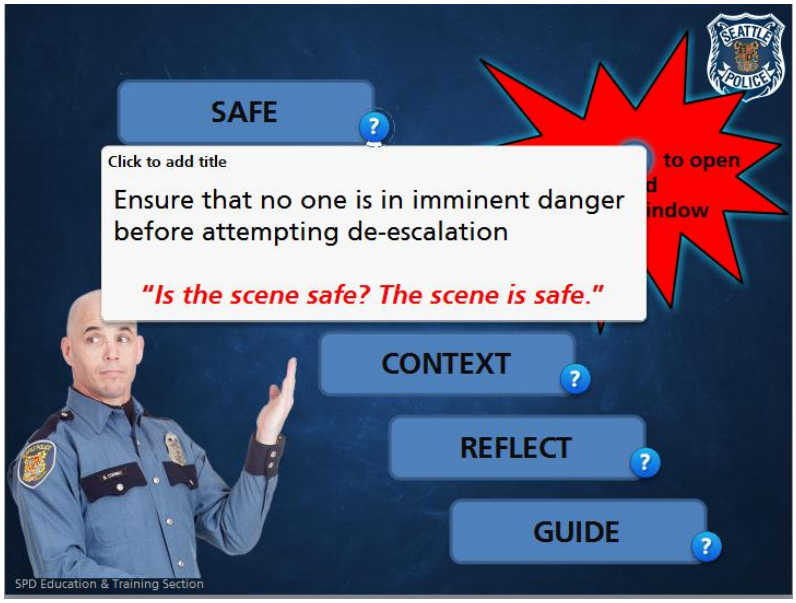


1.5 Model intro



1.6 Model - info

1.6 Model – info



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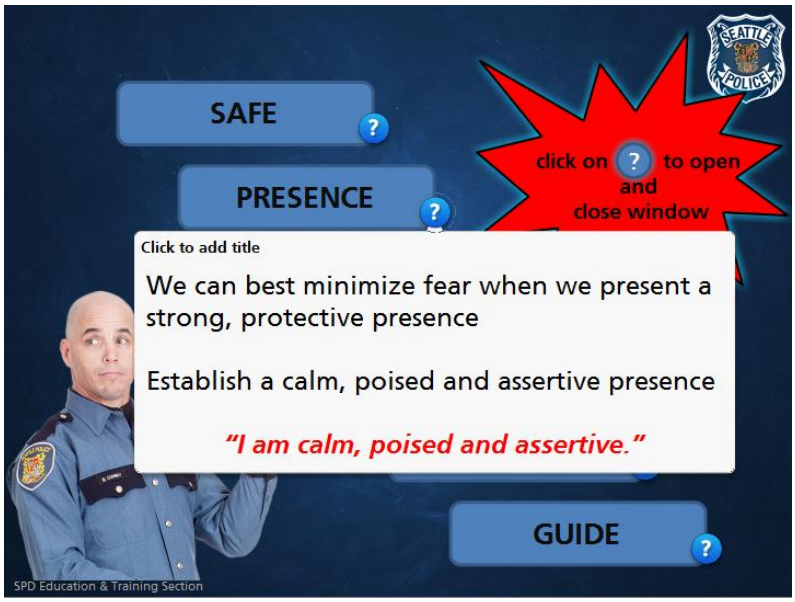

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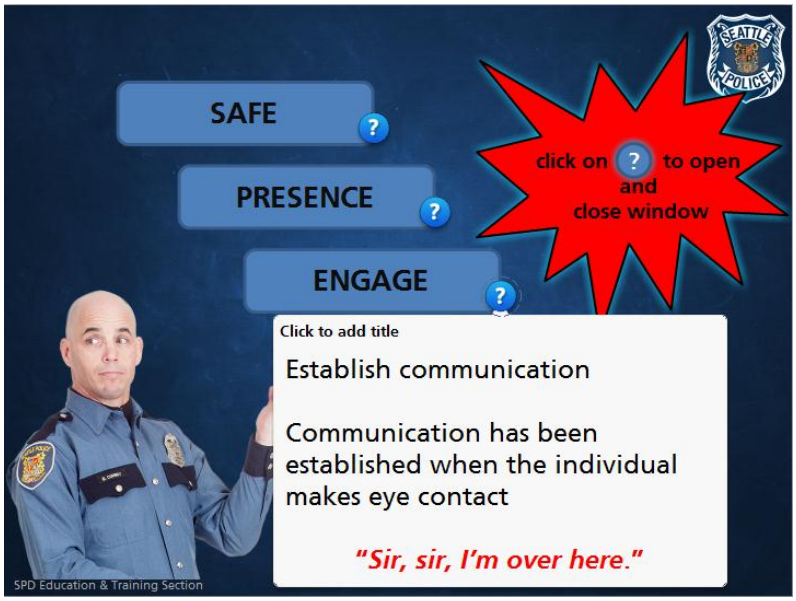

1.6 Model – info

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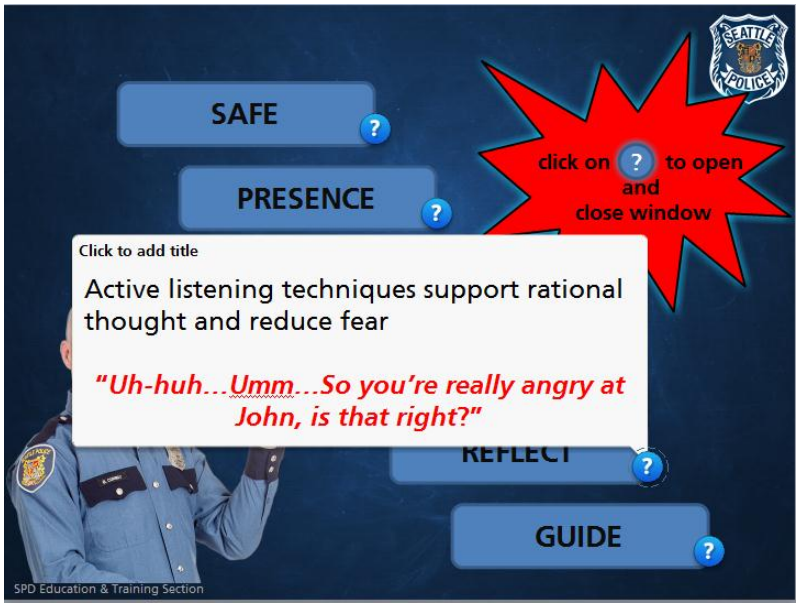
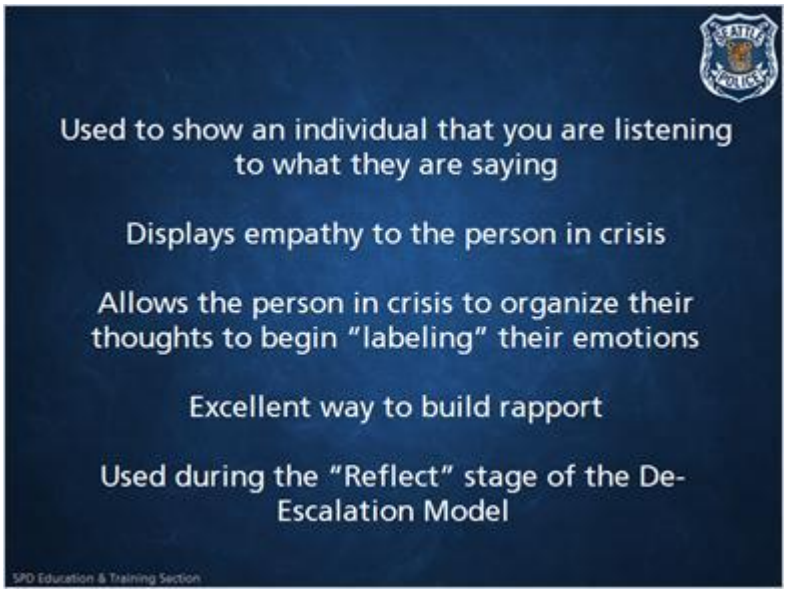


1.6 Model – info

1.7 ALS

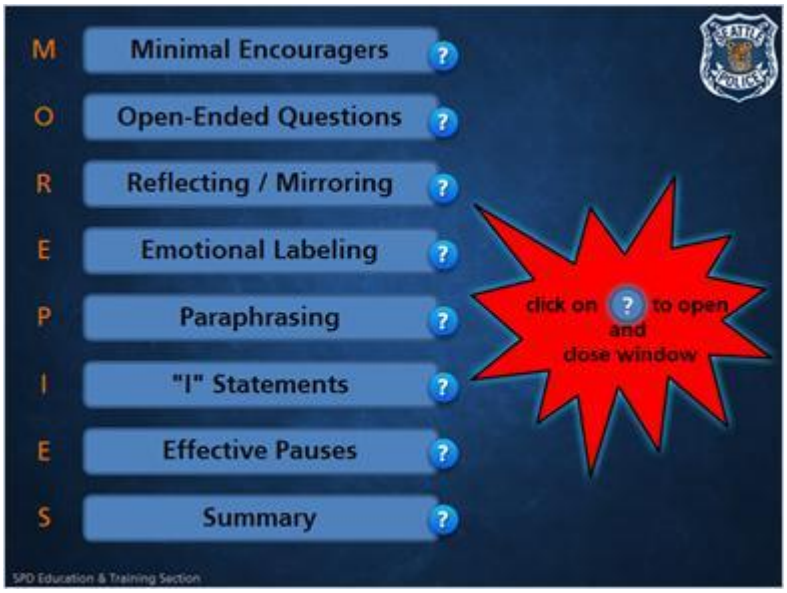
2.1 ALS Slide



1.8 ALS acronym

2.2 MOREPIES

1.9 MOREPIES model



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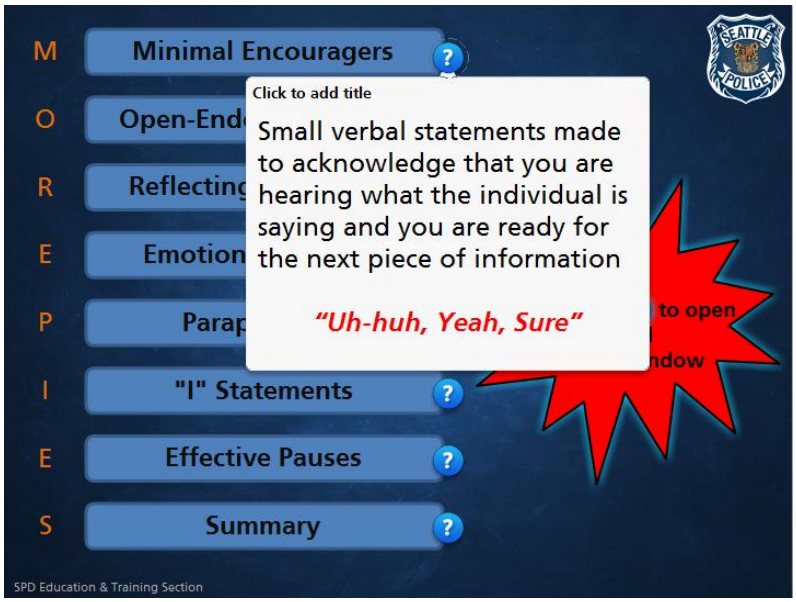

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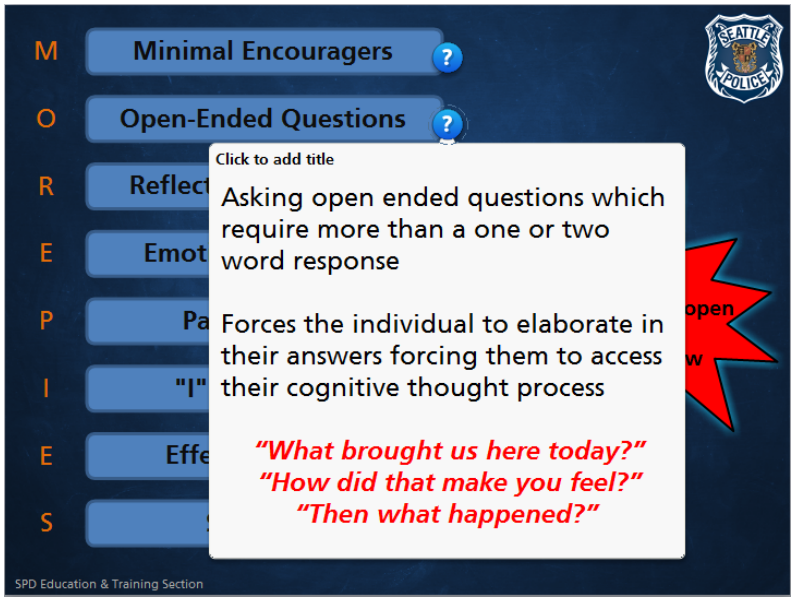

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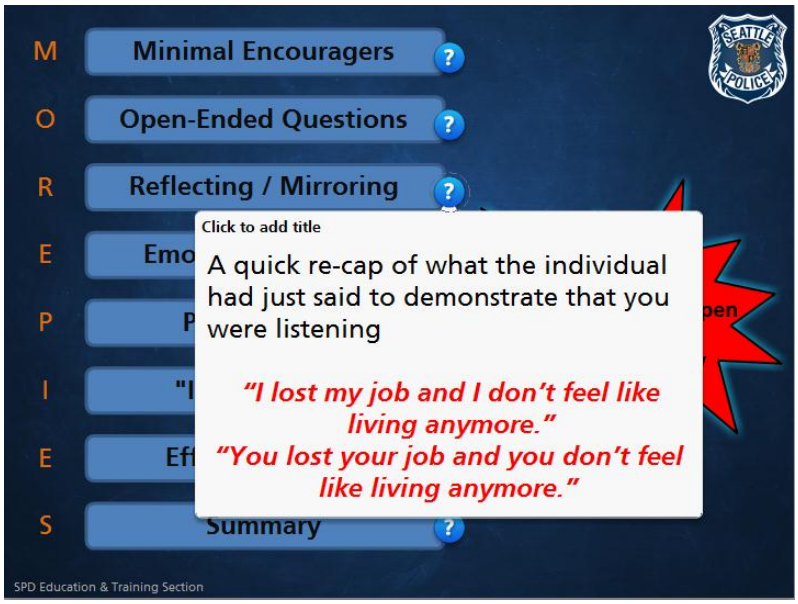

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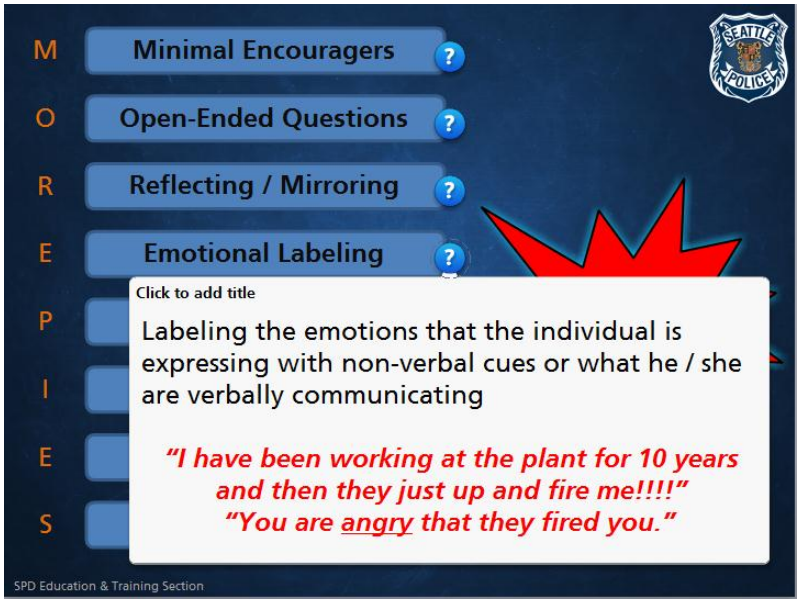

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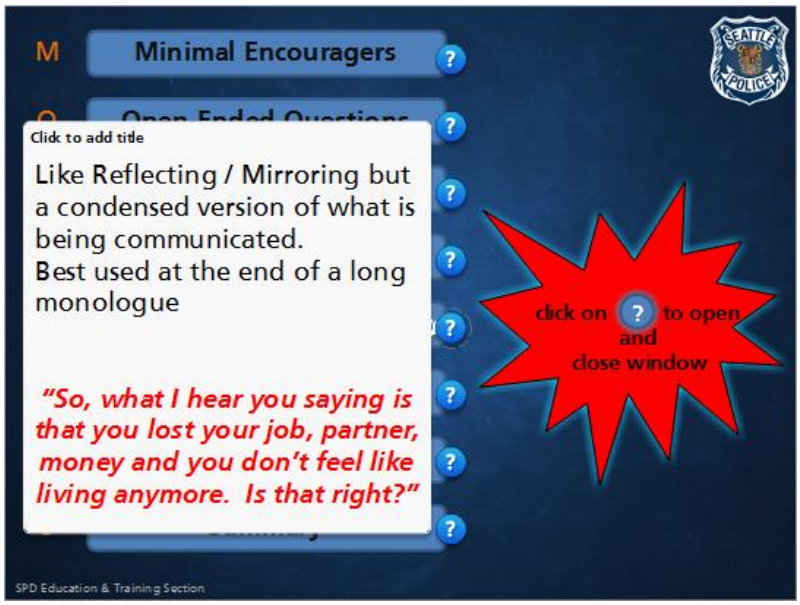

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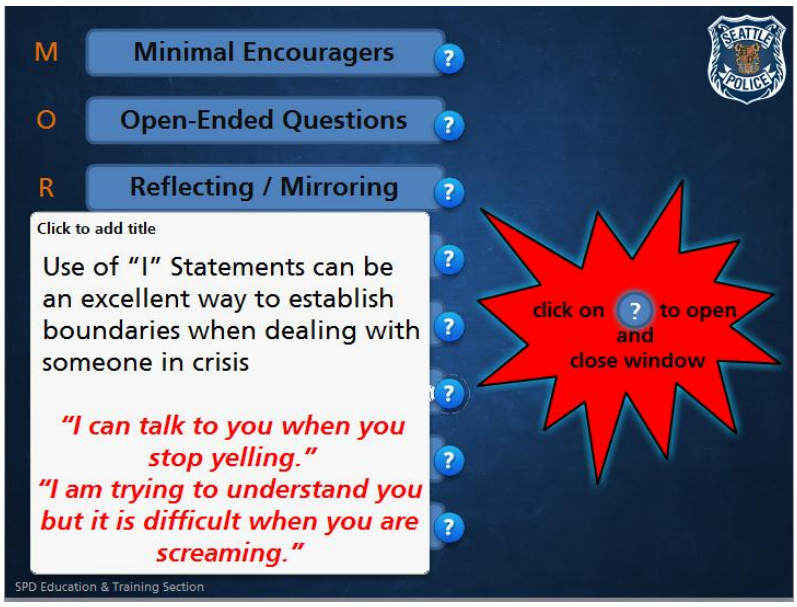

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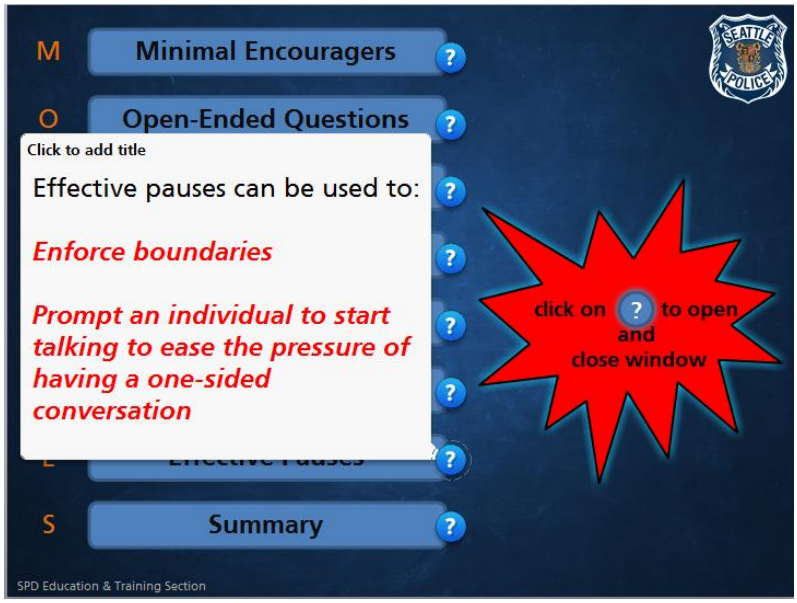

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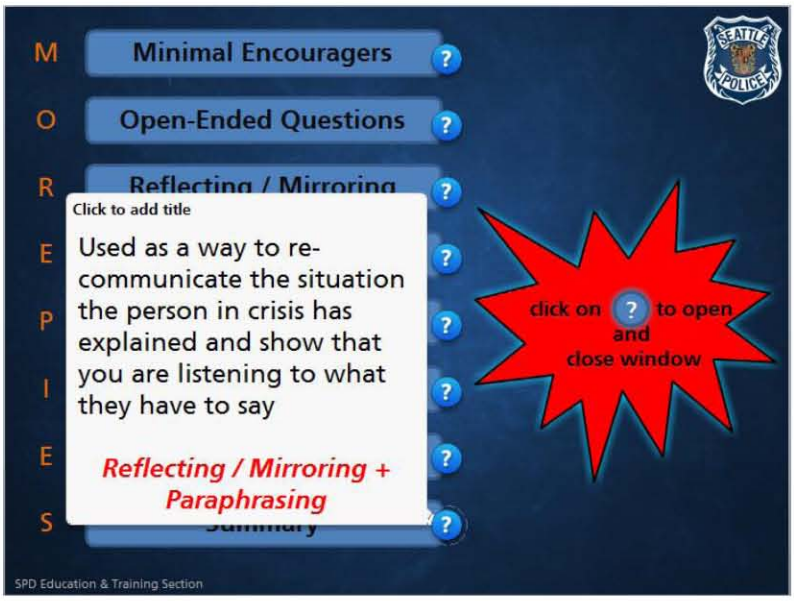
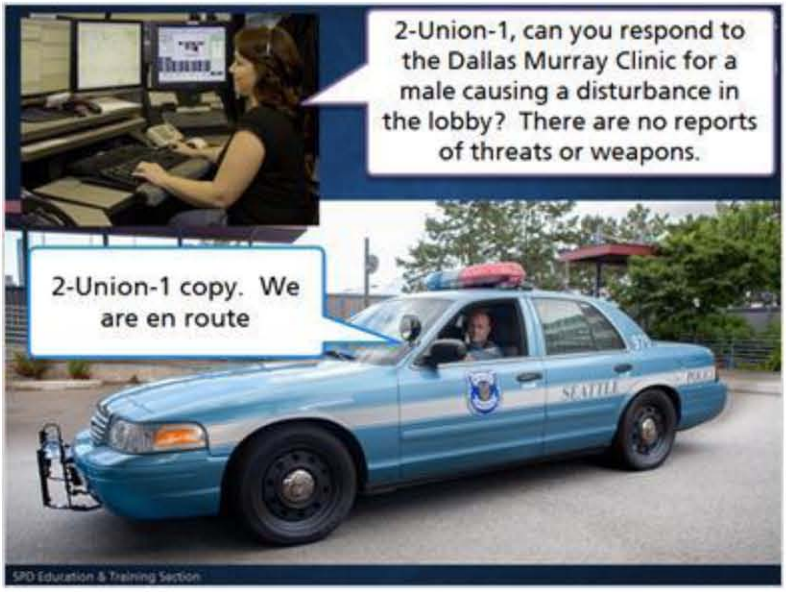


1.10 Slide

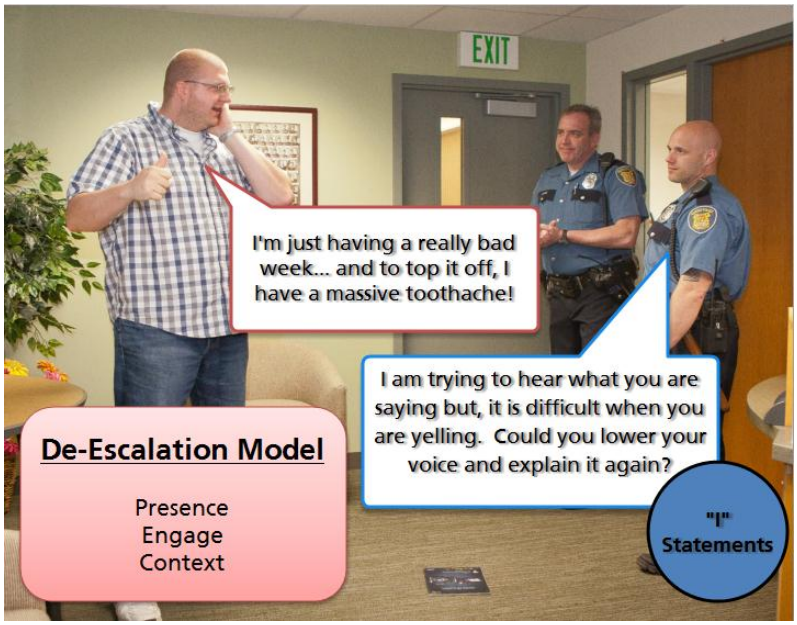
1.11 Slide

1.12 Slide

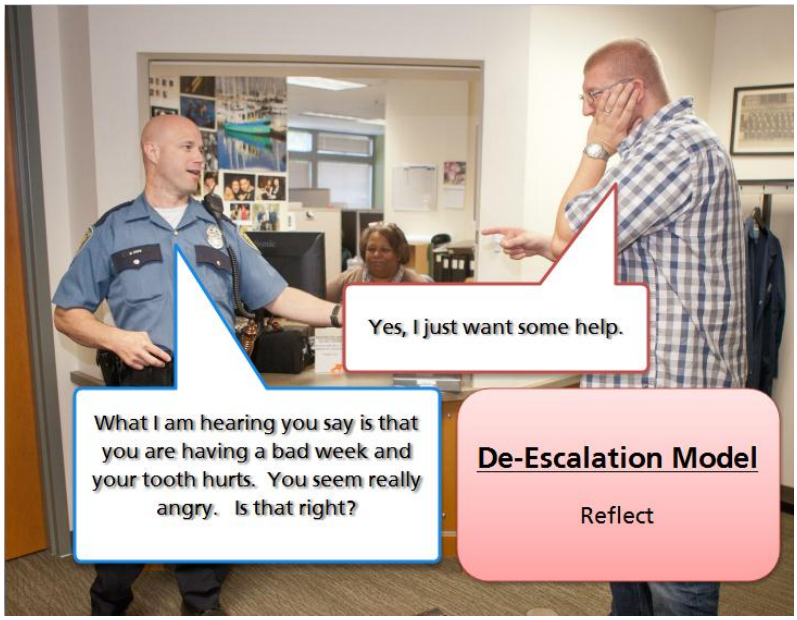


1.13 Slide

1.13 Slide (part 2)



1.14 Slide



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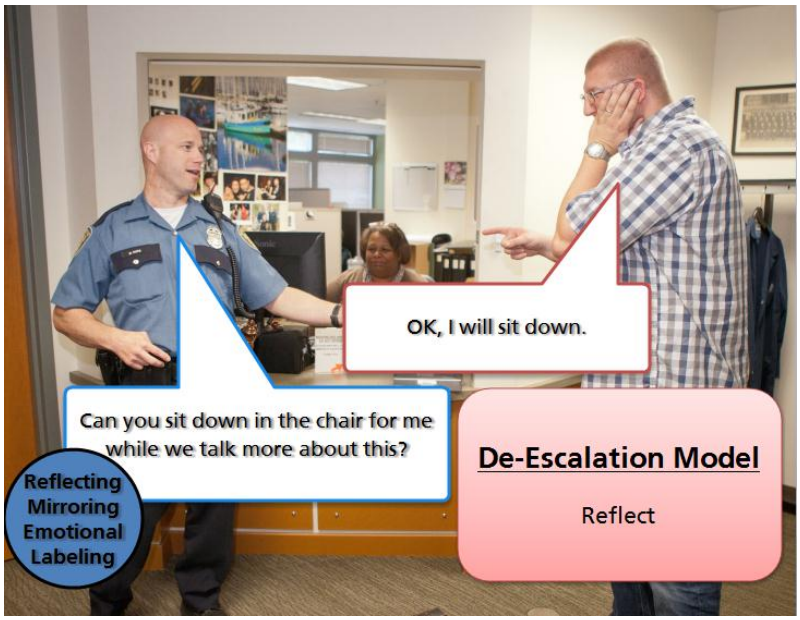

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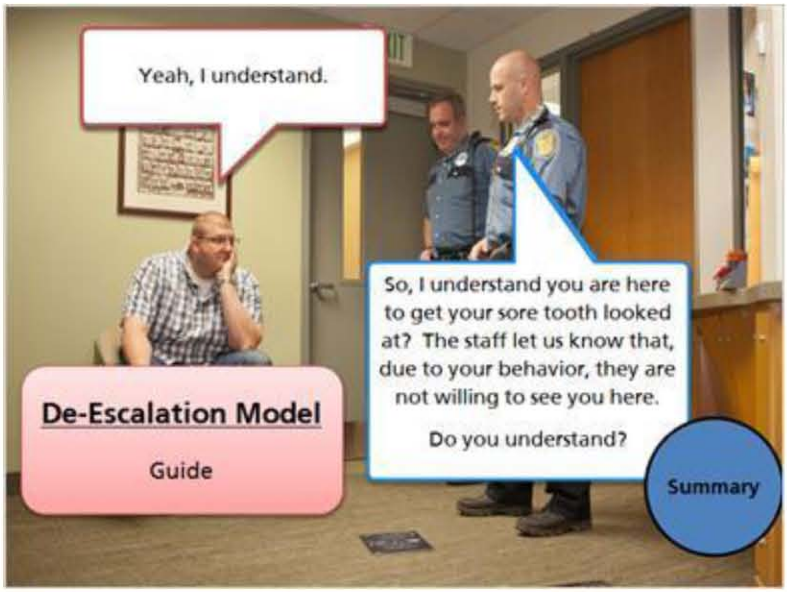

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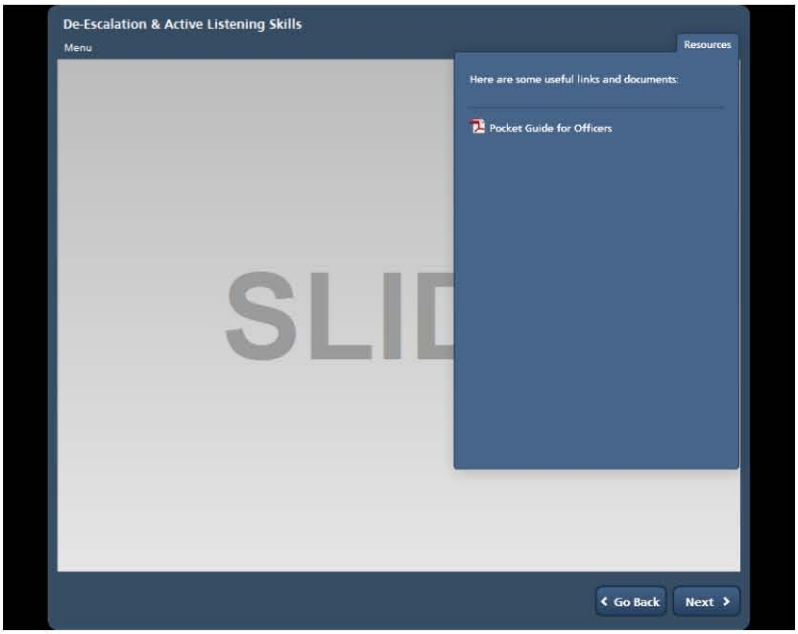
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Here are some useful links and documents:
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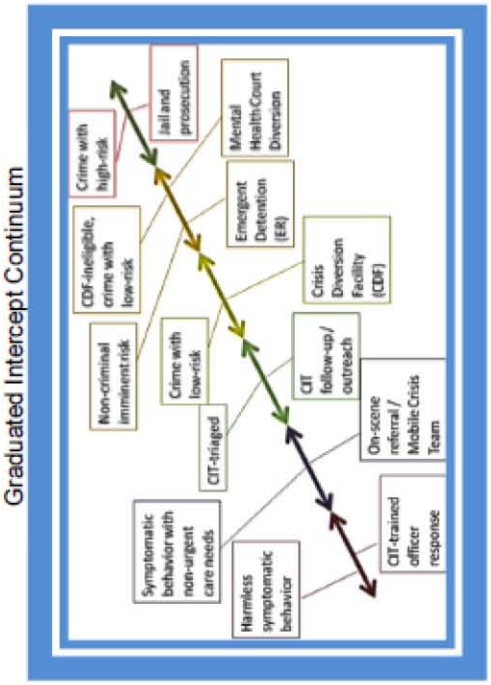
Pocket Guide

DISORDER	TYPE	SYMPTOMS
DEPRESSION	*Emotions* *Thoughts* *Behavior* *Physical*	Unusually sad Loss of interests Fatigue Crying Suicidal thoughts Sleep issues
PSYCHOSIS	SCHIZOPHRENIA	Delusions Hallucinations Cognitive difficulty Loss/Lack of drive Flat Affect Social withdrawal Thermo-Disregulation
	BIPOLAR *Depression* *Mania*	Increased energy Elevated mood Lack of sleep Irritability Rapid thoughts/speech Lower inhibitions Grandiose delusions Lack of insight
	DEPRESSION	***See Above-***
	DRUG-INDUCED ***EXCITED DELIUM***	Any of the above listed symptoms ****Appear quickly and dissipate as drugs / alcohol leave system***
Resources: - Contact CRT via Communications - Crisis Clinic: 206-461-3210 (Have DMHP in-person or phone) - Mobile Crisis Team: 206-245-3201 - CSC / CDF: 206-682-2371 - DESC: 206-464-1570 - CCORS: 206-461-3222		

DISORDER	TYPE	SYMPTOMS
ANXIETY *Psychological* *Behavior* *Physical*	G.A.D. *General Anxiety Disorder*	Excessive worry Poor problem solving Concentration issues ****Symptoms more than 6-mo***
	PANIC	Racing heart Sweating Shortness of breath Dizziness Detached feeling ****Can mimic heart attack***
	PTSD Vs. Acute Stress *< 4 Weeks*	Intense fear Helplessness Dreams Flashbacks Avoidance behavior Hyper-vigilance
Options: - CSC / CDF: For eligible offenses (screen prior) - Book KCJ / Route to Mental Health Court (Misdemeanors)		
Emotional Based: Acknowledge how they perceive situation, validate feelings & fears Do not "buy-in" or "argue" delusions or hallucinations Display empathy & Build rapport What has helped or made them feel safe in the past		
Personality Based: Set context for interaction Establish ground rules "I" Statements & Effective pauses to enforce boundaries		
***** *THIS LIST IS A GENERAL REFERENCE AND NOT DESIGNED TO BE ALL INCLUSIVE* *****		



Active Listening Skills

M.O.R.E P.I.E.S

M – Minimal Encouragers
O – Open Ended Questions
R – Reflecting / Mirroring
E – Effective Pauses

P – Paraphrasing
I – "I" Statements
E – Emotional Labeling
S – Summary

EXHIBIT B-7

DANGER TO SELF, DANGER TO OTHERS, AND GRAVE DISABILITY DEFINED

Danger to Self:

- As result of a mental disorder, Respondent presents a substantial risk of serious harm to self, as evidenced by threats or attempts to commit physical harm or suicide.

Danger to Others:

- As a result of a mental disorder, Respondent presents a substantial risk of serious harm to others,
    - as evidenced by behavior that has caused harm or places another in reasonable fear or harm; or
    - as evidenced by threats to physical safety of another and a history of one or more violent acts within 10 years of the petition.

Grave Disability [Prong A]:

- As a result of mental disorder, Respondent is gravely disabled and:
    - is in danger of serious physical harm resulting from failure to provide for his/her essential needs of health or safety.

Grave Disability [Prong B]:

- As a result of mental disorder, Respondent is gravely disabled and:
    - manifests a serious deterioration in routine functioning evidenced by loss of cognitive or volitional control over actions; and
    - is not receiving care essential for his/her health and safety (and harmful consequences will follow if involuntary treatment is not ordered); and
    - is unable to make a rational decision regarding the need for treatment.

CIVIL COMMITMENT TIMELINE

Initial Detention (72 hours):

- Respondent detained for 72 hours by DMHP or by court order.
- There must be probable cause that the Respondent:
  - Presents a likelihood of serious harm to self or others or is gravely disabled; and
  - The Respondent will not voluntarily seek appropriate treatment.

14-Day Detention:

- Petition filed by the hospital if Respondent remains a threat to self or others or remains gravely disabled.
- The Respondent is entitled to a hearing by a judge; preponderance of the evidence standard applies.
- The judge must consider whether a less restrictive alternative to hospitalization is appropriate.

90-Day Detention:

- Petition filed by the hospital if Respondent remains a threat to self or others or remains gravely disabled.
- The Respondent is entitled to a hearing by a judge or jury; clear, cogent & convincing evidence standard applies.
- The judge or jury must consider whether a less restrictive alternative to hospitalization is appropriate.

Note: Where the Respondent is a juvenile, there is no 90 day hearing. After a 14 day detention the Court evaluates whether to detain for 180 days. Juveniles do not have the right to a jury trial.

180-day Detention:

- Petition filed by the hospital if adult Respondent remains a threat to self or others.
- The Respondent is entitled to a hearing by a judge or jury; clear, cogent & convincing evidence standard applies.
- The judge or jury must consider whether a less restrictive alternative to hospitalization is appropriate.

Note: There is no statutory authority for a 180 day commitment on the basis of grave disability.Instead, the judge or jury can detain for a second 90 day period.

EXHIBIT B-8

Behavioral Crisis Event occurs

Individual arrives at local hospital, including the VA

A hospital Mental Health Professional (MHP) assesses the individual and deems that hospitalization is warranted and individual is willing to go

A hospital MHP assesses individual and deems that hospitalization is not necessary, and client can be maintained with less-restrictive community-based services

A hospital MHP assesses the individual and deems that an evaluation for detention is warranted

If individual is under 18, the MHP contacts CCORS

Call to Crisis Clinic or King County Crisis and Commitment Services (CCS)

Screener reviews information criteria to determine need for CCS or voluntary crisis response services

Contact with Law Enforcement, CIT trained officers requested to scene if available/appropriate

Release, clear with a "union"

Officer identifies voluntary crisis response or referrals to community-based services as appropriate

No arrest

Arrest

Contact Crisis Clinic to assist with appropriate referrals (treatment, veterans' services, shelter beds, food banks, crisis line/teen-link etc.) or to access relevant information and possible crisis outreach by mental health provider; or dispatch Children's Crisis Outreach Response System. (CCORS)

Contact the Mobile Crisis Team, Crisis Solutions Center, Geriatric Regional Assessment Team, or the Emergency Services Patrol/Sobering Center for outreach services

I&R with referral to Crisis Response Team (CRT) for possible follow-up

Voluntary crisis response services contacted to assist with voluntary crisis episodes and possible voluntary hospitalization.

No criteria for hospitalization; crisis stabilization services, referrals and resource information provided

An MHP assesses the individual and agrees that hospitalization is appropriate

An MHP assesses individual and determines that hospitalization is not necessary, and client can be maintained with less-restrictive community-based

MHP locates and secures an available voluntary bed at a psychiatric hospital

CCS contacted to perform evaluation to determine if individual meets criteria for involuntary detention

A Designated Mental Health Professional (DMHP) from CCS evaluates the individual and agrees that criteria for involuntary hospitalization

The person is evaluated by a DMHP and determined not to meet criteria for involuntary detention

I&R with request for charges through Mental Health Court (MHC)

Invol to hospital

Jail booking with potential MHC flag

Request charges through MHC

Hospital guard for booking (felonies)

Least restrictive options identified client released to community

Least restrictive options are explored as alternative to hospitalization

The person may be detained for an initial 72 hour hold as determined by the DMHP

The individual is released to the community and may be given referrals for mental health resources

Individual agrees to voluntary hospitalization and meets medical necessity

Case is reviewed at the end of the commitment order to determine continued treatment at this level of care

Client is transferred to Western State Hospital

Court orders the detention on an inpatient basis for 90 or 180 days

Court hearing after 14 day commitment process to determine if the person continues to require involuntary treatment

Court orders the commitment on an inpatient basis for an additional period of up to 14 days

After the decision to detain the individual is made, the DMHP attempts to find an available bed

Court orders the person to a 90-day LRO

Court dismisses the petition and the individual is released to the community

Community provider agency staff are responsible for monitoring the LRO

Court orders the person to a 90-day Less Restrictive Order (LRO)

Individual is entitled to a court hearing within 72 hours of the initial detention to determine if the person continues to require involuntary treatment by meeting commitment criteria

Order can be revoked if individual is found not to be in compliance with treatment requirements and decompensating

Court dismisses the petition

The individual is released to the community

- Initial response points
- Voluntary response options
- Law enforcement non-arrest/voluntary options
- Law enforcement arrest/involuntary options
- Involuntary detention referral process (DMHP)
- Less restrictive options identified by DMHP
- Dismissed petitions/orders or placed on LRO

04.15.2014

EXHIBIT B-9

Behavioral Crisis Event Occurs

Individual arrives at local hospital, including the VA

Contact with Law Enforcement, CIT trained officers requested to scene if available/appropriate

Release, clear with a "Union"

Call to Crisis Clinic or King County Crisis and Commitment Services (CCS)

Officer identifies voluntary crisis response or referrals to community-based services as appropriate

No arrest

Arrest

A hospital Mental Health Professional (MHP) assesses the individual and deems that hospitalization is warranted and individual is willing to go

A hospital MHP assesses individual and deems that hospitalization is not necessary, and client can be maintained with less-restrictive community-based services

A hospital MHP assesses the individual and deems that an evaluation for detention is warranted

Screener reviews information criteria to determine need for CCS or voluntary crisis response services

Contact Crisis Clinic to assist with appropriate referrals (treatment, veterans' services, shelter beds, food banks, crisis line/teen-link etc.) or to access relevant information and possible crisis outreach by mental health provider; or dispatch Children's Crisis Outreach Response System (CCORS)

Contact the Mobile Crisis Team, Crisis Solutions Center, Geriatric Regional Assessment Team, or the Emergency Services Patrol/Sobering Center for outreach services

I&R with referral to Crisis Response Team (CRT) for possible follow-up

If individual is under 18, the MHP contacts CCORS

Voluntary crisis response services contacted to assist with voluntary crisis episodes and possible voluntary hospitalization.

CCS contacted to perform evaluation to determine if individual meets criteria for involuntary detention

No criteria for hospitalization; crisis stabilization services, referrals and resource information provided

An MHP assesses the individual and agrees that hospitalization is appropriate

An MHP assesses individual and determines that hospitalization is not necessary, and client can be maintained with less-restrictive community-based services

A Designated Mental Health Professional (DMHP) from CCS evaluates the individual and agrees that criteria for involuntary hospitalization

The person is evaluated by a DMHP and determined not to meet criteria for involuntary detention

I&R with request for charges through Mental Health Court (MHC)

Invol to hospital

Jail booking with potential MHC flag

MHP locates and secures an available voluntary bed at a psychiatric hospital

Least restrictive options identified client released to community

Least restrictive options are explored as alternative to hospitalization

The person may be detained for an initial 72 hour hold as determined by the DMHP

The individual is released to the community and may be given referrals for mental health resources

Individual agrees to voluntary hospitalization and meets medical necessity criteria

Request charges through MHC

Hospital guard for booking (felonies)

- Initial response points
- Voluntary response options
- Law Enforcement non-arrest/voluntary options
- Law Enforcement arrest/involuntary options
- Involuntary detention referral process (DMHP)
- Less restrictive options identified by DMHP

04.15.2014

EXHIBIT B-10

DISORDER	TYPE	SYMPTOMS
DEPRESSION	*Emotions* *Thoughts* *Behavior* *Physical*	Unusually sad Loss of interests Fatigue Crying Suicidal thoughts Sleep issues
PSYCHOSIS	SCHIZOPHRENIA	Delusions Hallucinations Cognitive difficulty Loss/Lack of drive Flat Affect Social withdrawal Thermo-Disregulation
	BIPOLAR *Depression* *Mania*	Increased energy Elevated mood Lack of sleep Irritability Rapid thoughts/speech Lower inhibitions Grandiose delusions Lack of insight
	DEPRESSION	***-See Above-***
	DRUG-INDUCED **EXCITED DELIUM**	Any of the above listed symptoms ******Appear quickly and dissipate as drugs / alcohol leave system***

Resources:

- Contact CRT via Communications
- Crisis Clinic: 206-461-3210 (Have DMHP in-person or phone)
- Mobile Crisis Team: 206-245-3201
- CSC / CDF: 206-682-2371
- DESC: 206-464-1570
- CCORS: 206-461-3222

DISORDER	TYPE	SYMPTOMS
ANXIETY *Psychological* *Behavior* *Physical*	G.A.D. *General Anxiety Disorder*	Excessive worry Poor problem solving Concentration issues ******Symptoms more than 6-mo***
	PANIC	Racing heart Sweating Shortness of breath Dizziness Detached feeling ******Can mimic heart attack***
	PTSD Vs. Acute Stress *< 4 Weeks*	Intense fear Helplessness Dreams Flashbacks Avoidance behavior Hyper-vigilance

Options:

- CSC / CDF: For eligible offenses (screen prior)
- Book KCJ / Route to Mental Health Court (Misdemeanors)

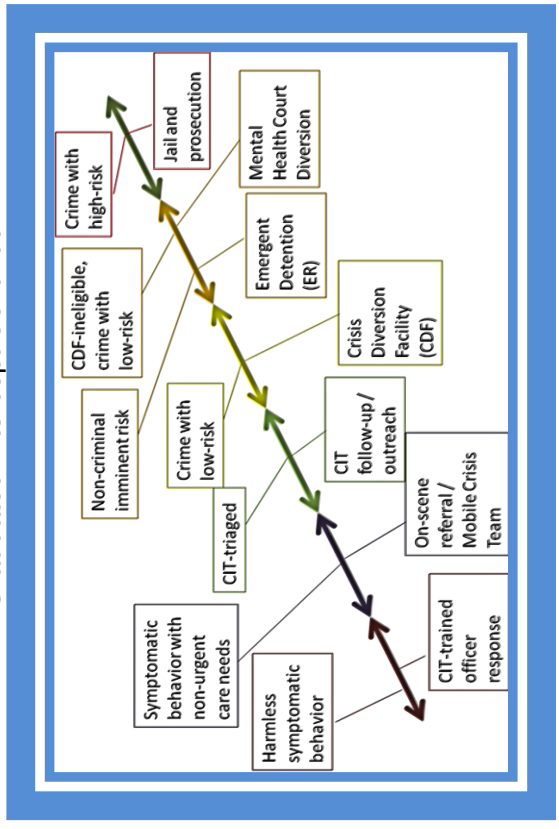
Emotional Based:

Acknowledge how they perceive situation, validate feelings & fears
Do not "buy-in" or "argue" delusions or hallucinations
Display empathy & Build rapport
What has helped or made them feel safe in the past

Personality Based:

Set context for interaction
Establish ground rules
"I" Statements & Effective pauses to enforce boundaries

**** THIS LIST IS A GENERAL REFERENCE AND NOT DESIGNED TO BE ALL INCLUSIVE ****



Active Listening Skills

M.O.R.E P.I.E.S

M – Minimal Encouragers
O – Open Ended Questions
R – Reflecting / Mirroring
E – Effective Pauses

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EXHIBIT C

Communications (a.k.a. “Dispatcher”) Training Curriculum:

EXHIBIT C-1

Seattle Police Department
Education & Training Section
Lesson Plan

Title of lesson or course: Crisis Intervention Identification Course (CIIC)

Assigned Course Number:

Author: **Officer Daniel Nelson #6883**

Date Written/Revised: **04/03/2014**

Approving Authority: **PENDING**

Overview:
CIIC course is a 3-hour course which will consist of the following major blocks of instruction:

1. Determination that behavioral crisis is a primary factor in the incident.
2. Skills to communicate better with persons in crisis
3. Dispatch of Crisis Intervention-trained (CI-trained) officers to the incident.

Course Goal(s):
Enhance the ability of the participants to identify if mental illness is a primary factor in the call for service, and for dispatch of appropriate SPD resources.

Course Objective(s):
Upon completion of this course, participants will:

1. Identify features and symptoms that indicate behavioral crisis is a primary factor in the incident.
2. Identify Crisis Intervention-trained (CI-trained) officers to dispatch to the incident.
3. Use techniques like active listening skills, while communicating with someone in crisis.

Seattle Police Department
Education & Training Section
Lesson Plan

Methodology:
Students will be taught using a combination of lecture, handout materials, PowerPoint presentation and an open-discussion period.

Target audience:
The intended audience for the course is all assigned communication employees.

Class size:
The class size is a maximum size of 10, and a minimum of 25.

Evaluation process:
Instructors will evaluate performance during a review of a written test at the completion of the training.

Logistical information:

Site: Communications training room

Training Equipment:
Student handout materials
PowerPoint presentation
Written test and Answer key

Staffing Requirements:

Instructors: 1
Tactics Cadre Operator role player: 0
Safety Officer: 0

Seattle Police Department
Education & Training Section
Lesson Plan

Crisis Intervention Identification Course (CIIC)

Training summary:

Students will arrive at the designated time to the facility. Once the facility is secured, the participants will receive an overview of the training, performance or learning objectives for the training and an introduction to the material.

Training schedule:

The course will be conducted using the following schedule:

-0030-0000 - Instructors on site, set-up materials

0000-0010 - Introduction

0010-0040 – Identification of persons in behavioral crisis

0040-0055 – Identify "CI Trained" personnel to dispatch to an incident

0055-0100 - Break

0100-0110 - Active Listening Principals (MOREPIES)

0110-0210 – Active Listening Video

0210-0215 – Break

0215-0230 – Written Test

0230- 0300 – Community Resources, CIT Org Structure

Seattle Police Department
Education & Training Section
Lesson Plan

Crisis Intervention Identification Course (CIIC)

Logistical Information:

Site: Communications Training Room

Training Equipment:
PowerPoint Presentation
PowerPoint Handout

Staffing Requirements:
Instructors: 1
Tactics Cadre Operator role player: 0
Safety Officer: 0

Seattle Police Department
Education & Training Section
Lesson Plan

Crisis Intervention Identification Course (CIIC)

Performance/Learning Objectives:

Upon completion of this course, participants will have demonstrated knowledge of the following or be able to perform the following:

1. Determination that behavioral crisis is a primary motivating factor in the incident.

2. Identify Crisis Intervention-trained (CI-trained) officers to dispatch to the incident.

3. Utilize active listening principals while communicating with someone in crisis.

Overview:

In order to complete the performance objectives or learning objectives the students will receive the following training:

1. Identification of a person in behavioral crisis

2. Identification of Crisis Intervention trained (CI Trained) officers to dispatch to the incident.

3. Active listening principals (MOREPIES) while communicating with someone in crisis.

Crisis Intervention Identification Course (CIIC)

Interest Introduction:

Why is this training important to them-stories, videos, that make the student want to learn what is being trained

Instructor introductions and credibility as appropriate

Material Introduction:

This training was developed to give communications personnel additional tools for dealing with individuals who are emotionally distressed or are currently suffering from symptoms of mental illness.

In 2012 over 5,000 cases were sent to the Crisis Intervention Unit for additional follow up. This number shows that the frequency at which officers are interacting with individual who are either emotionally distressed or suffering from some sort of mental illness is happening at a much greater frequency.

Additionally, the number of members returning from various overseas deployments for wartime operations is also increasing. Statistics show that multiple deployments to wartime operations dramatically increase the likelihood of members of the armed forces suffering from symptom of Post-Traumatic Stress Disorder (PTSD).

This material was gathered after intensive research as well as field-tested techniques. This curriculum was compiled after consulting with partners in mental health field.

- Nobody chooses to develop a mental illness. One in four families is affected.
- Mental illness is a biological illness just like heart disease, cancer of diabetes.
- There is no cure, but many people reach recovery and live full, productive lives.

- Many medication of mental illness create very negative side effects, including kidney and liver disease, diabetes, tardive dyskinesia (involuntary movements of the tongue, lips, face, trunk, and extremities) (Brasic) and death. These factors make medication compliance very difficult. Suggestions like, "Just take your meds" are viewed as insensitive to how difficult this is.
- People with mental illness experience a high level of stigma and social isolation, which inhibits seeking treatment.
- Most people, even in the middle of a mental health crisis, respond positively to kind and patient behavior.
- Chemical Dependency is a form of mental illness. This includes abuse of both prescription and street drugs / other chemicals.
- Prescription drug abuse can be equally toxic and if mixed into a synthetic drug mix, the individual can become extremely violent.

Identification of persons in behavioral crisis:

This policy applies to the Department's response to subjects in behavioral crisis. This includes people diagnosed with mental illness, as well as people suffering from substance abuse and personal crises. (For fuller definition, see 16.110-POL-5.9.) The Seattle Police Department recognizes the need to bring community resources together for the purpose of safety and to assist and resolve behavioral crisis issues. The Department further recognizes that many people suffer crises and that only a small percentage has committed crimes or qualifies for an involuntary evaluation. Persons suffering crises will be treated with dignity and will be given access to the same law enforcement, government and community service provided to all citizens.

Seattle Police officers are instructed to consider the crises that subjects may be experiencing during all encounters. Officers must recognize that subjects may require law enforcement assistance and access to community mental health and substance abuse resources. The ideal resolution for a crisis incident is that the subject is connected with resources that can provide long-term stabilizing support.

Officers are trusted to use their best judgment during behavioral crisis incidents, and the Department recognizes that individual officers will apply their unique set of education, training and experience when handling crisis intervention. The Department acknowledges that officers are not mental health professionals. Officers are not expected to diagnose a subject with a mental illness, nor are they expected to counsel a distraught subject into composure. When officers need to engage with a subject in behavioral crisis, the Department's expectation is that they will attempt to de-escalate the situation, when feasible and reasonable. The purpose of de-escalation is to provide the opportunity to refer the subject to the appropriate services. This expectation does not restrict an officer's discretion to make an arrest when probable cause exists, nor are officers expected to attempt de-escalation when faced with an imminent safety risk that requires immediate response. An officer's use of de-escalation as a reasonable alternative will be judged by the standard of objective reasonableness, from the perspective of a reasonable officer's perceptions at the time of the incident.

The intent of this policy is to provide all officers with resources to deal with subjects who are in behavioral crisis. The CIT (Crisis Intervention Team) program has three distinct components: officers who have undergone basic CIT training; officers who have undergone advanced CIT training (hereafter referred to as "CIT-Certified officers"); and a squad of officers, the Crisis Response Team (CRT), dedicated to following-up on criminal investigations where mental illness is suspected, crisis events, and people who

have been identified as being a risk to themselves or others. CRT and CIT-Certified officers are available as a resource, and officers shall make every reasonable effort to request their assistance as appropriate**. As described below, communications will be trained to and will dispatch at least one CIT-Certified officer to each call that appears to involve a subject in behavioral crisis and CIT-Certified officers will take primary at the scene of crisis events.** After the event has been stabilized, the CRT will engage follow-up.

Objective: Identify common observable signs and symptoms of a person suffering from mental illness.

What specific OBJECTIVE evidence is present to assist in reaching a conclusion that a person is in crisis or suffering from a mental illness?

Diagnosis is defined as a cluster of symptoms.

Schizophrenia - Symptoms of schizophrenia typically begin between adolescence and early adulthood for males and a few years later for females, and usually as a result of a stressful period (such as beginning college or starting a first full time job). Initial symptoms may include delusions and hallucinations, disorganized behavior and/or speech. As the disorder progresses symptoms such as flattening or inappropriate affect may develop.

- Odd behavior
- Poor eye contact, flat affect
- Disorganized speech, non-sensical statements
- The individual appears to be responding to internal stimuli
- The individual makes odd statement of has a fixed unrealistic belief in something
- Paranoia, persecutory statements

Bi-polar Disorder - Bipolar I: For a diagnosis of Bipolar I disorder, a person must have at least one manic episode. Mania is sometimes referred to as the other extreme to depression. Mania is an intense high where the person feels euphoric, almost indestructible in areas such as personal finances, business dealings, or relationships. Mania is also experienced as a terrifying loss of control, because of the extended sleeplessness and also due to some individuals experiencing psychosis. Individuals may have an elevated self-esteem, be more talkative than usual, have flight of ideas, a reduced need for sleep, and be easily distracted. The high, although it may sound appealing, will often lead to severe difficulties in these areas, such as spending much more money than intended, making extremely rash business and personal decisions, involvement in dangerous sexual behavior, and/or the use of drugs or alcohol. Depression is often experienced as the high quickly fades and as the consequences of their activities becomes apparent, the depressive episode can be exacerbated.

Depression - Symptoms of depression include the following:

- depressed mood (such as feelings of sadness or emptiness)
- reduced interest in activities that used to be enjoyed, sleep disturbances (either not being able to sleep well or sleeping to much)
- loss of energy or a significant reduction in energy level
- difficulty concentrating, holding a conversation, paying attention, or making decisions that used to be made fairly easily
- Suicidal thoughts or intentions.

PTSD - Post-traumatic Stress Disorder (PTSD)

Symptoms include re-experiencing the trauma through nightmares, obsessive thoughts, and flashbacks (feeling as if you are actually in the traumatic situation again). There is an avoidance component as well, where the individual avoids situations, people, and/or objects which remind him or her about the traumatic event (e.g., a person experiencing PTSD after a serious car accident might avoid driving or being a passenger in a car). Finally, there is increased anxiety in general, possibly with a heightened startle response (e.g., very jumpy, startle easy by noises).

- Symptoms include re-experiencing the trauma through:
- Disturbing dreams or nightmares, distressing and intrusive memories
- Flashbacks (sensory re-experiencing of trauma)
- Dissociation
- Panic / Distress / physiological reaction upon exposure to trauma triggers
- Difficulty sleeping
- Anger, difficulty concentrating, hyper-vigilant, paranoid, avoidance / emotional numbing
- Exaggerated startle response
- Diminished interest in activities, isolating, alienating from others, flat affect, depression
- Sense of foreshortened future
- Substance abuse

These illnesses may all include:

Hallucinations: False Sensory perceptions

Persons experience events that have no objective source, but are very real to him or her most common hallucinations are seeing or hearing things, but can involve any of the senses: feel, smell, taste, hearing, sight can be induced by drugs or alcohol

Delusions: False fixed belief Personal beliefs that are not based on reality

Often focus on persecution (e.g. believes others are trying to harm him or her) or grandeur (person believes he or she is God, a saint, a famous person, or possesses a special talent or beauty

Borderline Personality Disorder –

The major symptoms of this disorder revolve around unstable relationships, poor or negative sense of self, inconsistent moods, and significant impulsivity. There is an intense fear of abandonment with this disorder that interferes with many aspects if the individual's life. This fear often acts as a self-fulfilling prophecy as they cling to others, are very needy, feel helpless, and become overly involved and immediately attached. When the fear of abandonment becomes overwhelming, they will often push others out of their life as if trying to avoid getting rejected. The cycle most often continues as the individual will then try everything to get people back in his or her life and once again becomes clingy, needy, and helpless.

The fact that people often do leave someone who exhibits this behavior only proves to support their distorted belief that they are insignificant, worthless, and unloved. *At this point in the cycle, the individual may exhibit self-harming behaviors such as suicide attempts, mock suicidal attempts (where the goal is to get rescued and lure others back into the individual's life), cutting or other self-mutilating behavior.* There is often intense and sudden anger involved, directed both at self and others, as well a difficulty controlling destructive behaviors

- Cutting, scratching, or pinching skin enough to cause bleeding or a mark that remains on the skin
- Banging or punching objects to the point of bleeding
- Ripping and tearing skin
- Carving words or patterns into skin
- Burning self with cigarettes, matches, hot water
- Pulling out hair
- Overdosing on medication but it was NOT meant as a suicide attempt
- Attention seeking behavior
- Dramatic behaviors
- Individual seems to be overly involved in others

Should this be a CIT call? What factors help the call taker/dispatcher determine that?

1)Are there elements of mental illness?

Reported/observable behaviors

Stated knowledge, ie from a family member or case manager?

2)Are there elements of severe behavioral crisis?

Actions of subject? Words/language being used?

Seattle Police Department
Education & Training Section
Lesson Plan

Identification of Crisis Intervention trained (CI Trained) officers

When an incident is received by call takers a quick evaluation should be conducted to determine if a CIT (or "CI-trained") officer should be dispatched. A CI-trained officer has additional training in how to identify and communicate with a person in crisis. The type of crisis does not matter. A CI-trained officer can assist with individuals who are suffering from symptomatic behavior associated with a diagnosed (or undiagnosed) mental illness or an individual without a diagnosis who is suffering from a large amount of life stressors.

If an officer has attended the WSCJTC 40-hour CIT course, it will be listed in the "Skills" section of their CAD sign in.

When the dispatcher receives a call, and the call taker has indicated that behavioral crisis, or mental illness is a primary contributor to the call, the dispatcher shall ensure that a CIT certified officer (one who has taken the 40 hour course, and is so designated upon log in), is dispatched to the scene, per SPD policy.

Active listening principals (MOREPIES)

M - Minimal Encouragers - Small verbal statement to acknowledge that you are hearing what they the individual is saying and you are ready for the next piece of information.

"Uh-huh, Yeah, Sure"

O – Open-Ended Questions - Asking open ended questions which require more than a one or two word response forces the individual to elaborate in their answers forcing them to access their cognitive (forebrain) thought process.

"What brought us here today? How did that make you feel? Then what happened?"

R – Reflecting / Mirroring - A quick re-cap of what the individual had just said to show that you were listening to what he / she is communicating.

"I lost my job and I don't feel like living anymore. You lost your job and you don't feel like living anymore."

E – Emotional Labeling - Labeling the emotions that the individual is expressing with non-verbal cues or what he / she are verbally communicating.

"I have been working at the plant for 10 years and then they just up and fire me!?"
"You're angry that they fired you."

P – Paraphrasing - Like reflecting / mirroring but a condensed version of what is being communicated. This is best used at the end of a long monologue.

"I lost my job, my partner left me, I am out of money and I don't feel like living anymore."
"What I hear you saying is that you lost your job, partner, money and you don't feel like living anymore."

I – Use of "I" Statements - Use of "I" Statements can be an excellent way to establish boundaries when dealing with someone in crisis.

"I can listen to you when you stop yelling."
"I can talk to you when you put down the stick."
"I am trying to understand you but it is difficult when you won't communicate with me."

E - Effective Pauses - Effective pauses can be used as a tool to enforce boundaries that have been established, or to prompt an individual in crisis to start talking. Natural speech patterns in a conversation have "back and forth" which require input from all parties. When one of the parties stops communicating it places pressure on the other party to continue talking to ease the tension.

S – Summary - This is used as a way to re-communicate the situation, as he / she had explained it, to show that you are listening to what they have to say.
Reflecting / Mirroring + Paraphrasing

Communicating with persons in Crisis

Calm voice

Only one request/question at a time

Give them time to answer

Be respectful

No sarcasm

Watch your rate of speech (not too rapid)

Communicating with someone who is hallucinating or delusional

- Acknowledge how they perceive the situation and validate their feeling
- Acknowledge their fear/anger, whatever emotion you hear
- If need be, ask what has made them feel safe in the past
- If need be, ask what has helped calm them before
- Try to assure them they are safe
- Do not "buy in" to their delusion or hallucination

For the Call Takers:

- Listen carefully
- Ask the caller about mental health history, if appropriate
- Ask the about substance abuse history if appropriate
- Ask about veteran/deployment status, if appropriate
- Put into call ALL available info

For the Dispatcher:

- Do you see the words "mental health, mental illness, emotional crisis", etc. in the call?
- Do you see elements of behavioral crisis in the call?
- Does it look like CIT would be useful on the call?
- Dispatch CIT.

Active Listening Video (d'Logo)

Facilitate the d'Logo active listening video while skipping the "grading" portion of the exercise. Also, do not show clips #6 in all of the categories. The clip is entirely non-verbal and not applicable for communications personnel.

After the student is done with their assessment of the actor's emotions, solicit the class for other emotions, open-ended questions, I-statements. Often time others in the class will perceive the actors message differently. Additionally, this will keep everyone engaged with the video for the entirety of the exercise.

Community Mental Health Resources

Seattle Municipal Mental Health Court Tracking

The Seattle Municipal Mental Health Court (SMMHC) only takes cases which occur in the City where mental illness is a primary motivating factor in misdemeanor and gross misdemeanor cases. The SMMHC is a collaborative court which engages the subject in court-supervised treatment and probation monitoring.

Referral process:

- List "Seattle Municipal Mental Health Court" in the "Court" block of the KCJ Super-form.
- Indicate in the narrative of the general offense report and affidavit of probable cause that you believe that "mental health issues are a primary motivating factor in this incident" and request the case be screened through the Seattle Municipal Mental Health Court.

CSC/CDF -Eligible Crime and Voluntary

The Crisis Solution Center and Crisis Diversion Facility (CSC / CDF) is a program where individuals whose behavior does not rise to the level of a mandatory mental health evaluation, can receive emergency mental health care. The diversion facility portion of the program focuses on having individuals arrested for non-violent misdemeanor and gross misdemeanor crimes, who meet the criteria, admitted in lieu of booking at King County Jail (KCJ). The purpose of the CDF is to allow quicker access to services for individuals with mental health concerns. Both the CSC and CDF are completely voluntary programs.

Referral process:

- Determine if an eligible crime has been committed.
- Screen the suspect through FORS for, Felony, Sex Offender status in last 10 years or has an active (extraditable) warrant.
- Suspect over 18 years of age.
- Suspect agrees to voluntarily participate.
- Screen through the MCT for referral, SPD Radio if MCT is unavailable.
- Document the investigation and outline the elements of the crime in a general offense report as you normally would.

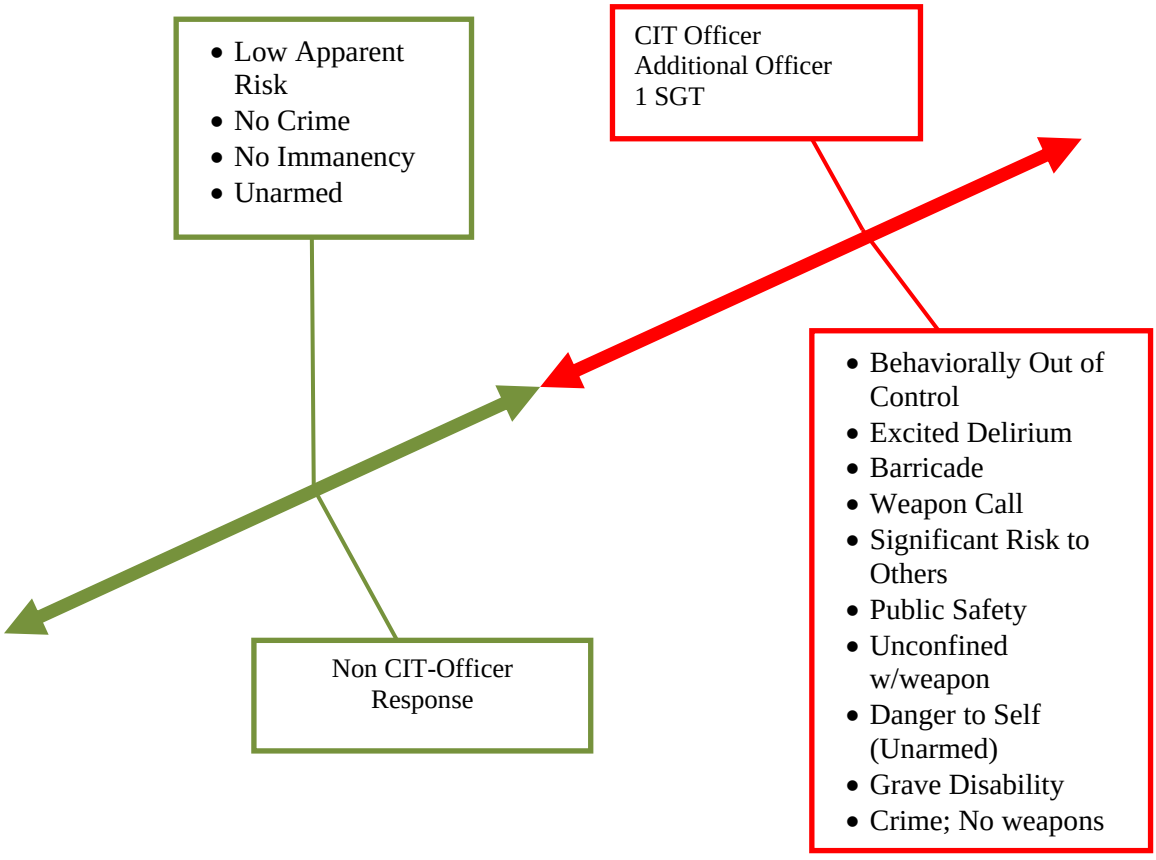
MCT

The mobile crisis team (MCT) is one of the programs available as part of the CSC / CDF. The MCT is a team of 2 Mental Health Professionals (MHP's) who area available to respond directly

to the field at the request of officers at an incident. The MCT is requested through the zone dispatcher. The MCT is available 24/7.

Crisis Clinic

The crisis clinic is a telephonic resource to officers in the field. When interacting with an individual who may be in crisis or suffering from a mental health related issue, the crisis clinic can offer suggestions or possibly provide pertinent information about the individual (if he/she is working with a county funded mental health organization). A supervisor can relay if the individual is working with a case manager and provide the case managers contact information.



Seattle Police Department
Education & Training Section
Lesson Plan

Written Test:

Administer the 10 question multiple choice test on presented materials. Allow 15 minutes for student completion.

Review:

1. Review of Performance Objectives of Class

    1) Determination that mental illness is a primary motivating factor in the incident.

    2) Identify Crisis Intervention trained (CI Trained) officers to dispatch to the incident.

    3) Utilize active listening principals while communicating with someone in crisis.

2. Review of class in high points that achieved the performance objectives

3. Officer contact information for student follow-up

Debrief:

EXHIBIT C-2

Seattle Police Department

Crisis Intervention Identification Course

(CIIC)

Administrative Briefing

- Please ensure that you sign the Training Roster.
- This is an interactive class which requires audience participation.

Overview

- This is an 3-hour course designed to provide basic essential informational to communications personnel on identifying behaviors associated with persons in behavioral crisis and tools to assist call takers in de-escalating the subject.

Per SPD Policy via MOU

- SPD Communications (9-1-1 and dispatch) will be trained to identify crisis events *and*
- Dispatch at least one CIT-Certified officer to each call that appears to involve a person in behavioral crisis

The course will consist of the following:

- Active listening principals
- Determination if mental illness is a primary motivating factor in the incident
- Dispatch of Crisis Intervention-trained (CI-trained) officers to the incident if needed
- Community Mental Health Resources

Course Objective(s):

- Communicating with someone in crisis
- Is mental illness is a primary factor in the incident? (or severe behavioral crisis?)
- Who Are Crisis Intervention-Trained (CI-trained) officers?
- Identifying community mental health resources

Introduction

- To provide communications personnel skills for communicating with individuals who are in behavioral crisis.

Introduction

- In 2012 over 5,000 cases were sent to the Crisis Intervention Unit for additional follow up.

Introduction

- Additionally, increasing numbers of military members affected by PTSD are returning from deployments

Behavioral Health Crisis

A behavioral health crisis is defined as an episode of mental and/or emotional distress in a person that is creating significant or repeated disturbance and is considered disruptive by the community, friends, family or the person themselves.

Mental Illness

- Nobody chooses to develop a mental illness.
- Mental illness is a biological illness just like heart disease, cancer or diabetes.
- Many medications for mental illness create very negative side effects.
- Chemical Dependency is a form of mental illness. This includes abuse of both prescription and street drugs / other substances.
- Prescription drug abuse can be equally toxic and if mixed into a synthetic drug mix, the individual can become extremely violent.

Mental Illness

- People with mental illness experience a high level of stigma and social isolation, which inhibits seeking treatment.
- Most people, even in the middle of a mental health crisis, respond positively to kind and patient behavior.

Field evaluation of persons in crisis

- How do you do a "phone" evaluation?
  - disadvantage of no visual cues
- What specific OBJECTIVE evidence is present to assist in reaching a conclusion that a person is in crisis or suffering from a mental health related concern?

Commonly Encountered Diagnoses

- Schizophrenia
- Bi-polar Disorder
- Depression
- PTSD- Post-traumatic Stress Disorder (PTSD)
- Personality Disorders

Schizophrenia

Symptoms of Schizophrenia typically begin between adolescence and early adulthood for males and a few years later for females.

Behaviors seen in Schizophrenia

- Odd behavior
- Disorganized speech, non-sensical statements
- The individual appears to be responding to internal stimuli
- The individual makes odd statement or has a fixed unrealistic belief in something
- Paranoia, persecutory statements

Bi-polar Disorder

For a diagnosis of Bipolar I disorder, a person must have at least one manic episode.

Behaviors seen in Bi-Polar Disorder

- Extreme irritability and/or euphoria
- Agitation
- Surges of energy
- Reduced need for sleep
- Extreme talkativeness (hyper-verbal)
- Pleasure seeking
- Increased risk taking behaviors
- Hyper-sexuality
- Excessive spending, cleaning, purchasing

These illnesses may include

- Hallucinations
  - False sensory perceptions
- Delusions
  - Fixed, false beliefs

Depression

Symptoms of depression include the following:

- Lethargy
- The individual says they are depressed
- Excessive yawning / sighing loudly
- Crying spells / moved to tears easily
- Make negative statements about self

PTSD - Post-traumatic Stress Disorder (PTSD)

Symptoms include re-experiencing the trauma through:

- Flashbacks (sensory re-experiencing of trauma)
- Panic / Distress / physiological reaction upon exposure to trauma triggers
- Difficulty sleeping
- Anger, difficulty concentrating, hyper-vigilant, paranoid, avoidance / emotional numbing
- Exaggerated startle response
- Diminished interest in activities, isolating, alienating from others, flat affect, depression

Personality Disorders

The major symptoms of this disorder revolve around unstable relationships, poor or negative sense of self, inconsistent moods, and significant impulsivity.

Behaviors seen with Personality Disorder

- Severe Cutting, scratching, or pinching skin
- Carving words or patterns into skin
- Burning self with cigarettes, matches, hot water
- Overdosing on medication but it was NOT meant as a suicide attempt
- Attention seeking behavior
- Dramatic behaviors
- Individual seems to be overly involved in others

Should this be a CIT call?

- Call taker receives call:
  1) Are there elements of mental illness?
  2) Are there elements of severe behavioral crisis?
- If so, flag as CIT call

Identification of CI-Trained Officers

- CIT officers have specialized training to assist in calls involving mental health or severe behavioral crisis

Identification of CI-Trained Officers

- If an officer is considered certified in the 40-hour CIT course, it will come up when commanded to show all officers with CIT skills when conducting a Duty Roster Query.

BREAK

Active Interviewing Skills

- Demonstrates you are listening
- Shows empathy
- Helps to build rapport
- Validates the caller

Active Interviewing Skills

M.O.R.E.P.I.E.S.

- M – Minimal Encouragers
- O – Open-ended Questions
- R – Reflecting / Mirroring
- E – Emotional Labeling
- P – Paraphrasing
- I – Use of "I" Statements
- E – Effective Pauses
- S – Summary

Active Interviewing Skills

M – Minimal Encouragers

- Small verbal statements made to acknowledge that you are hearing what the individual is saying and you are ready for the next piece of information.

"Uh-huh, Yeah, Sure"

Active Interviewing Skills

Open-Ended Questions

- Asking open ended questions which require more than a one or two word response.
- Forces the individual to elaborate in their answers forcing them to access their cognitive thought process.

"What brought us here today?"

"How did that make you feel?"

"Then what happened?"

Active Interviewing Skills

Reflecting / Mirroring

- A quick re-cap of what the individual had just said to demonstrate that you were listening.

"I lost my job and I don't feel like living anymore."

"You lost your job and you don't feel like living anymore."

Active Interviewing Skills

Emotional Labeling

- Labeling the emotions that the individual is expressing with non-verbal cues or what he / she are verbally communicating.

"I HAVE BEEN WORKING AT THE PLANT FOR 10 YEARS AND THEN THEY JUST UP AND FIRE ME!!!!"

"You are angry that they fired you."

Active Interviewing Skills

Paraphrasing

- Like Reflecting / Mirroring but a condensed version of what is being communicated.
- Best used at the end of a long monologue.

"I lost my job, my partner left me, I am out of money and I don't feel like living anymore."

"What I hear you saying is that you lost your job, partner, money and you don't feel like living anymore. Is that right?"

Active Interviewing Skills

Use of "I" Statements

- Use of "I" Statements can be an excellent way to establish boundaries when dealing with someone in crisis.

"I can talk to you when you stop yelling."

"I can talk to you when you put down the stick."

"I am trying to understand you but it is difficult when you are screaming."

Active Interviewing Skills

Effective Pauses

- Effective pauses can be used to:
  - Enforce boundaries
  - Prompt an individual to start talking to ease the pressure of having a one-sided conversation.

Active Interviewing Skills

Summary

- Used as a way to re-communicate the situation the person in crisis has explained and show that you are listening to what they have to say.

Reflecting / Mirroring + Paraphrasing

Communication with persons in Crisis

- Use short, simple phrases
- Make only one request/question at a time
- Give them time to answer
- No sarcasm
- Be respectful
- Keep your voice calm
- Watch your rate of speech

Communicating with someone who is hallucinating or delusional

- Acknowledge how they are perceiving the situation, and validate their feeling
- Acknowledge their fear (anger…etc)
- Ask what has made them feel safe in the past
- Ask who or what has helped calm them before
- Try to assure them they are safe
- Do not "buy in" to their delusion or hallucination

Scenarios

Active listening video here

Community Resources

- *CSC/CDF -Eligible Crime and Voluntary*
- *Mobile Crisis Team*
- *Crisis Clinic*
- *Seattle Municipal Mental Health Court*
- *Graduated Intercept Continuum*

Community Resources

Crisis Solution Center/ Crisis Diversion Facility

- The Crisis Solution Center and Crisis Diversion Facility (CSC / CDF) is a program where individuals whose behavior does not rise to the level of a mandatory mental health evaluation, can receive emergency mental health care.
- The diversion facility portion of the program focuses on having individuals arrested for non-violent misdemeanor and gross misdemeanor crimes, who meet the criteria, admitted in lieu of booking at King County Jail (KCJ).
- The purpose of the CDF is to allow quicker access to services for individuals with mental health concerns. Both the CSC and CDF are completely voluntary programs.

Community Resources

Referral process:

- Suspect over 18 years of age.
- Suspect agrees to voluntarily participate.
- Screen through the CSC for referral and to assess for open bed-space. CSC contact phone is (206) 682-2371.

Community Resources

Mobile Crisis Team:

- The mobile crisis team (MCT) is one of the programs available as part of the CSC / CDF.
- The MCT is a team of 2 Mental Health Professionals (MHP's) who area available to respond directly to the field at the request of officers at an incident.
- The MCT is available by calling (206) 245-3201.
- The MCT is available 24/7.

Community Resources

Crisis Clinic:

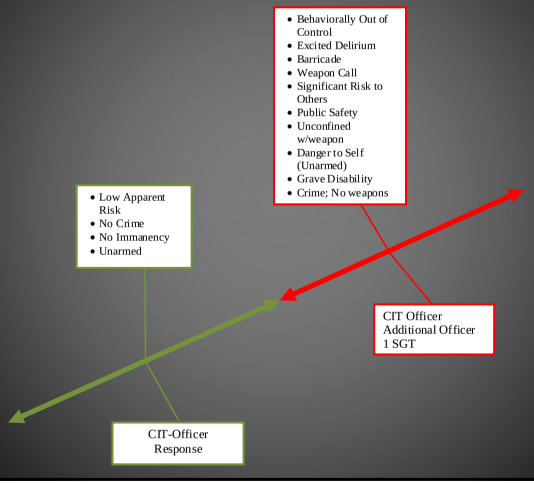
- The crisis clinic is a telephonic resource to officers in the field. When interacting with an individual who may be in crisis or suffering from a mental health related issue, the crisis clinic can offer suggestions or possibly provide pertinent information about the individual (if he/she is working with a county funded mental health organization).
- A supervisor can relay if the individual is working with a case manager and provide the case managers contact information.

Community Resources

Seattle Municipal Mental Health Court

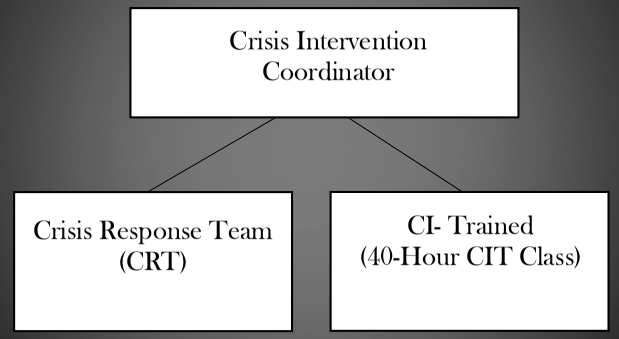
The Seattle Municipal Mental Health Court (SMMHC) only takes cases which occur in the City where mental illness is a primary motivating factor in misdemeanor and gross misdemeanor cases. The SMMHC is a collaborative court which engages the subject in court-supervised treatment and probation monitoring.

Graduated Intercept Continuum



Written Test

Crisis Intervention Org Chart



CIT Coordinator

Lt. Martin Rivera

Review

- Determination that behavioral crisis is a primary motivating factor in the incident
- Identify Crisis Intervention-Trained (CI-trained) officers to dispatch to the incident
- Utilize active listening principals while communicating with someone in crisis
- Community Resources

For Call Takers

- Listen carefully
- Ask the caller about mental health history
- Ask about substance abuse history
- Ask about veteran status, if it seems appropriate
- Put into call ALL info that is helpful

For Dispatchers

- Do you see the words “mental health, mental illness, etc" in the call?
- Do you see elements of severe behavioral crisis in the call?
- Does it look like CIT would be useful on the call?
- If so, dispatch CIT officer

Questions?

Contact Information

Please direct any questions or comments to either:

- LT. Martin Rivera
- Jamie McMurray
- A/SGT Dan Nelson

End of Training

EXHIBIT D

Proposal for Certifying CIT Officers
May 15, 2014

The second year Monitoring Plan requires that SPD provide, by May 15, 2014, a proposed standard for how recently an officer must have undergone the CIT 40-hour course to be considered "CIT Certified." The SPD has worked in consultation with the Crisis Intervention Committee, the Department of Justice and the Monitoring Team to determine the appropriate combination of training necessary, and the appropriate time span in which that training should have been obtained. Those discussions inform the following proposal.

Crisis Intervention Training

In discussions with the CIC, the definition of CI trained has been refined to include 'basic' and 'certified'. Basic CI training includes 8 hours of introductory CI training and a series of four e-learning courses, which will be provided to all sworn SPD personnel by the end of 2014, with the exception of even more highly trained personnel, as discussed below.

The Settlement Agreement and policy also require that to be considered "CIT Certified," an officer must have undergone comprehensive 40-hour training, followed by eight hours of annual in-service training. What the Settlement Agreement does not define regarding certified officers is when must officers have completed their training, or conversely, how long ago is too long ago to be considered current on CI training.

In consultation with the CIC, the proposed standard is more holistic than a bright-line cutoff date, taking into account the fact that some officers who were trained years ago may still be current in their skills due to continued use and the nature of their assignments. Officers who have had the 40 hour training, provided through the CJTC, in the past five years will be considered CIT-Certified. These officers will be expected (a) to review the new Crisis Intervention Policy (SPD Manual 16.110), (b) confirm that they understand the modified responsibilities of CIT officers going forward and (c) still complete the series of four e-learning modules. The option to forgo CIT certification will be permitted, but not encouraged, if an officer does not want to accept the increased responsibilities after reviewing the new policy. These officers further will be provided the annual 8-hour refresher training, which is addressed under separate cover. In addition to these officers, SPD proposes that officers working in the dedicated Crisis Response Team, and Hostage Negotiation Team be considered CIT-Certified because of their specific and daily utilization of these skills. There are 19 officers in these combined units, and they will also be provided refresher training specific to their assignment, namely, to attend the CIT Conference in August 2014 or the Hostage Negotiators Conference in Summer 2014 in lieu of the 8-hour Advanced course. The reasoning for this was that both of those conferences present at least 16-hours of material that will be more job-specific and at least as in-depth as the Advanced course is likely to be.

Using this proposed methodology for certifying CI trained officers, SPD would retain 195 certified officers.

There are 281 other officers who have received their CIT 40-hour training longer than 5 years ago. For some of those officers, the expectation is that they are proud of their CI training, they

have continued to use their skills, they would want to remain a certified officer, and they would be an asset to the Department if they continued to serve in that role. SPD will reach out to those officers with a three wave approach, letting them know that the Department is enhancing its CIT program, so if they wish to remain a CIT-Certified officer, they will need to respond and indicate their interest in remaining CIT-Certified, assume the associated responsibility of being assigned crisis calls, and attend an annual 8-hour refresher or advanced Crisis Intervention course at the CJTC within a year of their being notified. Officers who do not complete these requirements by that time, will no longer be considered CIT Certified on that date.

An initial email will be sent to the entire department, asking that any officer that has received CI training more than 5 years ago, please contact the CI Coordinator and the Compliance Unit with the dates of their training (which will be verified) and their desire to remain certified. We will follow-up the initial e-mail with roll call announcements soliciting the same information, but will also provide the watch commanders list of the potentially de-certifying officers so the message can be delivered more specifically. Finally, we will follow-up with e-mail directly to the officers who might potentially de-certify and have not contacted us so the intentions of 100% of the currently designated CIT officers are known.