

CASE STUDY:

Designing and delivering learning that works: Police Work and Crisis Intervention Training

Keywords:

- workplace learning
- organizational learning
- professional development
- training and development
- community conflict
- stigma and stereotyping
- facilitation
- adult learning models.

How to design a training that is politically mandated while also embraced by participants.

Training and development within organizations has to be experienced as useful and supportive to employees' job. Yet training and development often serves political or organizational needs that foster resistance and can harm the learning atmosphere.

Designing a relevant training program for Portland Police Officers to de-escalate emotionally-charged encounters with people in mental health crises.

Background

The number of fatal encounters between police and people with mental health crisis is rising. Every day across the United States, people with mental illness struggle and fail to find the health care they need to stay stable and healthy. As a result, they may find themselves in interactions with the police. Most cases end well, but in some cases, the interactions turn fatal.

Police officers have become de-facto mental health workers, but without sufficient training. Some police departments across the country have a Crisis Intervention Team (CIT) which trains officers in a more effective, compassionate, and safer approach to interacting with people who suffer a mental health crisis. In 1994 the Portland Police Bureau developed a voluntary CIT training for officers. Yet, the last several years saw an increase in the number of critical incidents involving police and people with mental illness. This came to a head in the fall of 2006, following the death in custody of a schizophrenic man well known in the social service system. In the wake of the tragedy, then Portland Mayor Tom Potter formed the Mental Health/Public Safety Initiative to improve coordination between local and regional mental-health and public-safety systems. In June 2007, Oregon Governor Ted Kulongoski signed a new law raising the standard for law enforcement training in mental illness.

I was invited to join the team at Portland Police Bureau to revise the existing Crisis Intervention Training program and create a new, mandatory one that would become a standard part of the police academy curriculum.

We had two months to redesign the program and implement a once-a-month, 40-hour CIT training to all officers and sergeants working in uniform on the streets of Portland. My role was to design the segment on crisis communication and de-escalation interventions for people in a mental health crisis.

The challenge

The Lieutenant who led the training team was committed to creating a program that would truly change minds and address the stigma and stereotyping associated with mental illness. And, she wanted it to be valued by police officers.

There were several obstacles that the team had to overcome:

- **The political climate and pressures surrounding the issue.** The training was a response to a fatal encounter with the police, and many officers experienced the training mandate as a political move in the wake of public pressure. Some officers felt they were unfairly held responsible for a failure of a social service system due to the public chronically underfunding mental health service. This political climate threatened the learning environment, and our training design had to counteract the potentially hostile classroom atmosphere this engendered.
- **Resistance and relevance.** Historically, training for dealing with special populations had neglected to consider standard defensive tactics. Police were skeptical that the CIT training would provide tools aligned with patrol procedures they had to follow. The design challenge was to integrate every piece of information and method into standard defensive tactics or else the training would lose credibility with the officers. Additionally, the original CIT training was designed and delivered by mental health advocates and consisted primarily of educating police about people living with mental illness. Many officers found the activist-centered nature of the training alienating and unhelpful. It wasn't related back to their experience, and did not help them in their work.
- **Stereotyping and stigma.** The issue of mental health involves social stereotypes and stigma. The training design had to address the stereotypes and stigma in the room, to allow officers to overcome their prejudices they held about mental illness.
- **Attitudes toward training.** Police officers joked openly that they made terrible students. As a whole, they did not like training, in particular mandatory training. They were most skeptical of training by outside experts and any training that was politically mandated. Finally, training that concerned non tactical or "soft" issues such as communication, mental health, diversity awareness, etc. were most disliked because they often neglected to take into consideration the day to day experiences of a patrol officer. Officers are not motivated when they don't see the immediate and practical value of the training.

Innovations and Interventions

- 1) **Our first task was to make mental illness personal.** We had to address the stigma of mental illness, and help officers see that mental illness is not something *others* have, but something they live with as well. Our first training innovation was to film police officers talking about mental illness in their families. This brought mental illness into the room. More than anything else we did it to overcome the stigma towards mental illness, showing police officers grappling with the issue opened the door to mental illness as a human issue. When a well known and well-liked officer on tape said he dreaded the day his sister (who had a mental disability) would have to interact with a police officer, we could hear a pin drop.
- 2) **De-criminalizing mental illness.** Decades of deinstitutionalization and under-funding mental health care has criminalized mental illness. Adding to the sense of criminalization, people in psychotic states or mental health crises can appear to be high on drugs or alcohol, and remote or unresponsive states seem hostile or resistant. It's easy to misread signals and interpret behavior as resisting arrest. The next step in the training was to explain the history of mental illness and de-institutionalization, and the story of how mental illness came to be criminalized. With the help of film clips, speakers, and video tapes of people who had been in crisis talking about their states, they were able to see the human experience behind the state, making it easier for them to understand what people are experiencing while in a remote and uncommunicative state.
- 3) **Integration into defensive tactics.** In order to make the material valuable to officers, the training used plain language, not medical jargon. We integrated every method into their defensive tactics protocol, and consistently connected material to their day-to-day work. We were guided by the questions: "Why should this matter to you?" and "How can you use it?" For instance, rather than discuss mental health crisis from a medical or mental health model, we used a communication model. We described how to intervene based on the person's communication and not on diagnosis or conditions.
- 4) **Using an adult education model.** Our priority was to help them do their jobs better. Our training had to communicate in content and delivery that their experience mattered. We saw them as the experts, on the street, day in and out. They knew the problems better than we did, and many of them had solutions and methods to teach each other. This adult education focus began in the design phase. The training team asked officers, detectives, and sergeants to critique the training content in progress. Was it useful? What was missing? Was it police specific? Every piece of training had to pass through a rigorous test: "Why would a Police Officer need to know this?"
- 5) **Feedback and responsiveness.** The last half hour of each day was devoted to a verbal and written feedback session. The officers were given time to fill in evaluations of the day's training, and time was also given to direct feedback. We asked them to let us know what helped, what didn't work, what they missed, or what they liked. We revised the training for the next day and for future groups based on their feedback.
- 6) **A classroom culture that invited conversation.** We created a classroom culture that would not only tolerate but invite complex and difficult conversations. We knew that the topic involved difficult conversations – on mental illness, stereotyping, use of force, safety, fear, etc. Instructors did not just deliver content, but opened up the floor to debate, to

engage the officers, and to facilitate learning out of the interactions that arose. We knew that the learning would come from each other as much as it would from the instructors, if not more. Our facilitation style allowed participants to become instructors for each other.

Conclusions

National studies have shown that where officers are CIT trained, officers' perceptions of people with mental illness have changed, and there is less social distance between officers and people with mental health illness, resulting in a reduction of stigma towards mental illness. In some studies, CIT training has shown that the number of mental health crisis calls increase due to the availability of specially trained officers in dealing with crisis.

The revised training in Portland was successful in several ways. The CIT coordinator for the Police Department shared the following information:

- The training has been uniformly positively received. Consistently, officers evaluate the training as some of the best they've received on the force.
- Officers are more likely to use the CIT coordinator's consultation on cases.
- The training has raised awareness in general of mental health.
- Because officers are at a much greater risk for alcohol abuse and other post-traumatic stress symptoms due to the nature of their job, the training was a significant motivator for officers to begin to think about and take action in caring for their own mental health.