From: Yasmeen Krameddine <krameddi@ualberta.ca>
Sent: Thursday, February 18, 2016 12:42 PM
To: Gregory Gelembiuk
Cc: Peter Silverstone
Subject: Re: a question about police training

Gregory,

Thank you very much for your email and for your involvement in your community's police reform.
You ask very excellent questions and I am happy to answer them for you.

What differentiates the training you've developed from typical U.S. CIT training (CIT training that includes role playing)?

Typical Crisis Intervention Team (CIT)	Our program (ProTraining)
Training is a one-time 40-hour program that focuses on training officers about **signs and symptoms** of mental health. Each CIT program usually focuses on the same premise, however each CIT session can be different depending on which organization is offering it. E.g. the topics covered in the lectures can be different. But overall it focuses on 3 things: **1) Power Point lectures to increase knowledge about mental health** (e.g. Clinical Issues Related to Mental Illnesses Medications and Side Effects Alcohol and Drug Assessment Co-Occurring Disorders Developmental Disabilities Family/Consumer Perspective Suicide Prevention and Practicum Aspects Rights/Civil Commitment Mental Health Diversity Policies and Procedures Personality Disorders Post Traumatic Stress Disorders (PTSD) Legal Aspects of Officer Liability Community Resources	Depending on the level of training needed, our program offers 3 units, to be taken in sequential order. It is recommended that officers take unit 1 and 2. **Unit 1.** **On-line training stage** (90 minutes) using a very novel and interactive approach where learners interact through video based e-learning scenarios and assessment opportunities. There are 4 modules, each portraying a different mental illness. What is unique about our training is that we want to make it as interactive as possible, and we use first-person video where the learner, gets to choose what you want to do. Depending on what you choose, determines how the interaction turns out, so it incorporates gamification into the training. **Unit 2.** **4-hour in-person session** designed to allow experiential practice of skills learned in the eLearning Unit 1 where you will be taught how to properly engage individuals with mental illness. **Unit 3.** **40-hour intensive unit** is designed for police officers that have frequent interactions with those suffering from mental

2) Onsite visits and exposure **3) De-escalation training and techniques (4 hrs) and role-play training (4hrs)**	illness and crisis negotiators. This is a more advanced course focusing again, on behaviours. (Not all officers will need to take this. We recommend police and crisis teams as well as crisis negotiators).
Length: One – 40 hour training session – taken once All **information** components are taught in a class room using power point slides.	**Length:** **3 units** – based on training need with the option for a refresher every 3 years (online and in person) **Unit 1** – (**information** component) offers the ability to learn the basic behavioural/verbal skills needed in an interaction on your own time, and at your own pace (online). A print out of the specific techniques that should be used in every interaction can be printed out after completion of training. Although our training uses learning slides at some points, we have reinforced our learning by including video's and learner interaction – keeping in engaging and interactive. E.g. In our beginning scenario, learners get to see the worst-case scenario and what could happen if they incorrectly interact (seen from the eyes of the officer) through a 2-3 minute video. Allowing the officer to see how quickly something can go wrong. The officers will have the opportunity to interact with the mentally ill individual at the end of the eLearning session again, to see if they can end with a positive outcome. This final scenario is shown through the eyes of the individual in crisis. This scenario shows some video and allows the officer to choose what they want to do/say. There is a meter on the screen that shows if you have made a correct choice (The correct choice will show the meter on the screen to go down (de-escalation) or the incorrect choice will show the meter going up (escalation).

Refresher training: Most CIT organizations do not do refresher. Since CIT is 40 hours, it takes lots of time to just get all officers through it once, and putting them through a refresher can be very difficult.	**Refresher training:** Our online component makes widespread use easier and allows regular updates to training (including refreshers every 3 years) making it easier to distribute to all police members and associated civilians in a cost - effective manner. We offer refreshers to Unit 1 (online) & Unit 2 (hands-on).
Information is taught to increase knowledge about mental health (focusing on memorization of signs and symptoms of mental illness). Training is taught with the belief that changing attitudes creates a change in behaviour. This is not as true as it sounds (see below)	**Information** and practical experience is trained to improve behaviours of officers, and increase the recognition of behaviours in others. We do not want to train police officers to be psychiatrists. Police officers have to know so much information in their day-to-day, so we feel they only need to know the bare minimum of information that will improve their interactions that will keep both them and those they interact with safe. This is why our training does not focus on teaching all of the symptoms for each mental illness (like CIT does). We only focus on the behaviours that are seen most frequently in police and mental health interactions - and we teach a step by step "how-to" interact, when individuals display certain behaviours. **Thus training is taught with the belief that we must focus on behaviours to change behaviours.** E.g. - De-escalation, verbal and nonverbal communication strategies, empathy techniques to build rapport in mental health interactions, and what to do if someone is threatening, uncooperative or unresponsive. - Information on exact steps that need to be taken during and after an interaction (with practical implementation) - What would make the interaction worse and what would make it better.

	- Depending on the severity, where should the individual should be taken? - If this individual needs to go to the hospital, how do you fill in a mental health form so that this individual will be accepted into the hospital? All of the training units focus extensively on improving officer behaviour, and understanding and practicing how to interact with certain behaviours other exhibit.
Although training tends to focus on increasing knowledge (through lecture based training), there is evidence to show that **increasing knowledge and changing attitudes does not necessarily lead to a change in behaviours** (e.g. If someone knows smoking is bad for their health, they do not necessarily quit smoking) * see attached article (Krameddine & Silverstone, 2015) about attitudes and behaviours. The best way to change behaviours is to focus directly on changing behaviours, instead of training to improve attitudes and hoping that it leads to behavioural change.	
Training Creation: Members of each department usually create the training materials, some in collaboration with NAMI, some without collaboration and not based on evidence-based research.	**Training Creation:** Our training has been created with the help of an International Advisory Board of police officers, police educators, mental health professionals, academic researchers, adult educators, eLearning experts and individuals with lived experiences of mental illness from the UK, the Netherlands, Sweden, Australia, New Zealand, USA and Canada.
Evidence based evaluation: Although CIT has been around for many years (since 1988 in Memphis Tennessee), it only recently is becoming properly evaluated. In a recent (properly evaluated) evaluation by (Compton, 2014) it was found that CIT training does increase the use of de-escalation skill and referral decisions in interactions (which is great!) however, it does not show any differences between those officers who are trained and not trained in use of force, number of arrests and time per call. (I attached the Compton article.)	**Evidence based evaluation:** Our units are based on my PhD research where we trained over 650 Edmonton Police officers in mental health at the University of Alberta with a new program, similar to medical student simulations. We analyzed our program and we found evidence based success 6 months after training: 41% decrease in physical use-of-force 26% decrease in weapon force 19% increase in efficiency 41% increase in mental health awareness 23% increase in officer confidence

	Improved empathy, communication and de-escalation in officers after training. (Krameddine, 2013)
Continued evaluation: Does not exist to my knowledge, however, external groups may evaluate.	**Continued evaluation:** We offer evaluation of our program before and after organizations participate in any level of our course.
Role play component: From my research, the role-play in <u>most</u> CIT programs consists of 2-5 minutes of role-play per person (over a 4 hour period) E.g. There are 20-40 members in CIT for the week. For the 4 hour session, all members are watching one individual that is in the middle of the room, role-playing with an veteran officer for 2-5 minutes. After, all other members give feedback to this individual. It takes time for members to go through the role-play, thus in the 4 hour time it takes all members to go through the role-play training, each will only be role-playing (usually with a veteran officer) for 2-5 minutes. I am not sure if this is true for your organization, but this is the case for most others.	**Role play component:** **Our unit 2** is our role-play training. Officers will go through 4 scenarios (10 minutes of role-play in each) – allowing 40 minutes of role-play in 4 hours. (All 4 scenarios are taking place at the same time and they switch from one to the other). - After they complete their scenario they will be given 3 questions to think about. These questions focus on the 3 main learning points of every scenario (on top of how to talk to them, they learn these points). - No other officers are "watching" them role-play (alleviating stress, and producing realistic responses, and a realistic atmosphere.) **E.g.** In our scenario training, groups of 2 go through a minimum of 10 minutes of scenario role-play every hour, interacting with an actor portraying mental illness. After the role play is over, there is a debrief and feedback portion of the scenario where officers are given feedback from the Supervising facilitator, a mental health facilitator and the actors in the scenario. We focus on behaviour by: - Actors modifying their responses depending on how the officer treats them. E.g. If an actor feels they are not being treated with respect they will not give the officer any information. However, if the officer is sincere then the actor will tell the officer everything they need to know.

	There are some scenarios that end in the actor pulling out a knife (if they are treated poorly) – but the exact same scenario can end with the actor going willingly with the officer and allowing them to be handcuffed, if they are treated with the respect that they need. - Our actors are trained to give feedback to officers (in the debrief) in terms of how the officer made them feel when they acted certain ways: **Example of Actor feedback:** When you stood over me it made me feel very afraid of you. Perhaps next time, if you come down to my level and spoke to me, I would have answered all of your questions because you would have been less of a threat. Or: When you asked me "how long have you been drunk?" – I got very offended by the word "drunk". Perhaps next time you can ask "When did you start drinking" etc.
Role-play: usually veteran officers are acting – this can be difficult, as sometimes officers do not take the training seriously.	**Role-play:** done with trained actors, usually ones that have mental illness themselves, so they can speak towards how individuals with mental illness feel when officers interact with them.
Onsite mental health exposure	We do not have onsite visits however we have actors that are living with mental illness themselves as well as mental health professionals in every scenario facilitating the interaction.

In your publications, I see that your training is designed to alter officer behavior, not just attitudes or knowledge. How exactly is this done, in a way that might differ from standard U.S. CIT training?

Yes, this is true. As mentioned above the focus on behaviours is done in all Units of our training.

E.g. You enter a scene where an aggressive individual is believing that someone is watching him and going to kill him. He acts aggressive towards you.
Our approach: focus on his behaviours: he is acting in a way that shows he is afraid. Therefore what can I do to:

- make him feel less afraid?
- let him know I am here to help?
- let him know I care about his safety?

Once you de-escalate this individual, then you can focus on next steps:

- What to write on the mental health form, if you do end up taking them to the hospital
- Techniques you can use to approach the scene in a calm manner
- Words to speak and to avoid when speaking to someone who is afraid

CIT approach:
This person is having hallucinations & delusions and is suffering from schizophrenia. I know that since he has schizophrenia he needs to be taken to the hospital so my main goal is to get him to come with me to the hospital.

We do not talk about labeling a specific mental illness, we speak of behaviours others are exhibiting.

I'm wondering if there's something that's available (and ideally evidence-based) that might be more effective than the training approach currently being used with Madison police officers.

It sounds like the Madison police officers are doing constant training, which is a very good thing. Evidence suggests that training must happen every 3 years at minimum, so the more training the better - ideally with a focus on behaviours and not on memorization of signs and symptoms.

In regards to evidence based practices, currently we are evaluating our Unit 1 – online training (since it is very new), however as mentioned it has been created with international advisory board input of experts around the world. The benefit of our Unit 1 - online, interactive training is that it can be taken any time, in any place, as long as a computer is available. The easy access is valuable in the sense that no one has to wait to take training. As well it can be taken at low cost - $20 - $34.95 (depending how many units are purchased).

Our Unit 2 – hands on scenario learning using professional actors is evidence based and we travel to all parts of Canada and USA, implementing our training in police organizations. We are traveling to Chicago on August 22 & 23, 2016 to deliver our Unit 2.

With everything being said, I would strongly recommend our Unit 1-3 training programs. I have been working passionately on this project for 5 years and have

complete confidence in it. I know they can improve the relationship and interactions between police and those they interact with.

After informing you of how our program differs from CIT, I am wondering how we can best help you achieve your goals with the Madison Police?
What are your next steps, and how can we help you get there?

I am able to give you access to our Unit 1 - online training, if you wanted to experience it.
I look forward to your response, and hope I have answered your questions.

Sincerely,

Yasmeen Krameddine