

CIVIL GRAND JURY | 2017-2018

CITY AND COUNTY OF SAN FRANCISCO



Crisis Intervention: Bridging Police and Public Health

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Jurors 2017-2018

Lori Campbell, Foreperson

Heather Dolan, Secretary

Richard Bogan

Paul Buxbaum

Charles Dworetz

William Hannan

Rasha Harvey

Hon. Alfred Knoll (ret.)

Douglas Lam

John Lee

Paul Pferdner

Charles Raznikov

John Sandoval

Derek Schaible

P Segal

Grady Ward

Executive Summary

On December 2, 2015, Mario Woods, a man in crisis, refused to drop a knife even after several non-lethal interventions by San Francisco police. Woods was then shot and killed by five police officers who fired at and struck him more than 20 times.

The killing of Mario Woods made it clear to San Francisco and its citizens that it was time for change. San Francisco police officers needed better tools to engage with people, who from mental or emotional distress or the adverse effects of substance abuse, pose a danger to themselves or others.

The Crisis Intervention Team (CIT) comprises one version of those tools. It is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. CIT provides law enforcement-based crisis intervention training for assisting those individuals with mental illness, and improves the safety of patrol officers, family members, and citizens within the community.¹

The San Francisco Civil Grand Jury investigated the San Francisco CIT program to help identify and bridge program gaps between SFPD and the Department of Public Health (DPH). This investigation focused on review of SFPD General Order 5.21 (DGO)—“The Crisis Intervention Team (CIT) Response To Person In Crisis Calls For Service” (affirmed by San Francisco Police Commission 12/2016)—and how that DGO is working in practice. We assessed how other City agencies interact with SFPD with respect to people in crisis. We also reviewed the implementation and effectiveness of the December 2016 Interagency Memorandum of Understanding (MoU) - “SFDPH Behavioral Health Crisis Intervention Support for SFPD.”

Through this investigation the Civil Grand Jury found tangible progress in police performance in this area. We also found gaps in CIT program communication, training assessment, data collection and reporting. The Jury also found areas for improvement in the relationship between DPH and SFPD. The result is the list of findings and recommendations that appear at the end of this report.

¹ [CIT Is More Than Just Training...it's a community program](#)

Background

In the 16 years from 2000 to 2015 there were 95 shootings involving San Francisco police. Of these, 40 were fatal, and 24 of these fatal shootings (60%) involved individuals with mental health problems or erratic behavior. In both the Tenderloin and Mission Districts, use of force incidents nearly doubled between 2009 and 2015.² From 2010 to 2016, SFPD officers shot more people than officers in cities with similar sizes and demographics, including Boston, Seattle, and San Jose.³ It appears from this that SFPD has had an excessive reliance on guns and shootings to resolve some kinds of encounters.

In 2011, after another series of high profile SFPD shootings including Teresa Sheehan, a mentally ill woman who was almost fatally shot in her home, and Tony Bui, a man with schizophrenia who was shot and killed after his 15 year old niece called police to take him to the hospital, a new roadmap for more robust crisis response training was proposed by the San Francisco Police Commission. It mandated new Department General Orders (DGO), which took another 5 years to finalize.

In July 2016 the Blue Ribbon Panel on Transparency, Accountability, and Fairness in Law Enforcement published its report.⁴ And in October 2016, the U.S. Department of Justice (Office of Community Oriented Policing Services) released its assessment report on the San Francisco Police Department.⁵

By the end of December 2016 new Department General Orders for both Use of Force (DGO 5.01) and Crisis Intervention Team Response (DGO 5.21) were affirmed by the San Francisco Police Commission. While crafting these DGOs, members of the police commission, police department, and the community examined the Crisis Intervention Team (CIT) program developed and used in Memphis, Tennessee and the SMART model developed and used in Los Angeles to respond to calls for service for persons in crisis. The Police Commission decided to model the San Francisco program after the CIT program from Memphis.

While San Francisco works to evaluate, change, and improve police responses to persons in crisis, the county's increasing mental health needs mount to crisis proportions.⁶

² [San Francisco Chronicle, May 2016](#)

³ [VICE News Police Shooting data](#), December 10, 2017

⁴ [The Blue Ribbon Panel on Transparency, Accountability, and Fairness in Law Enforcement](#)

⁵ [COPS Office releases 94 findings and 272 recommendations to implement best practices at the San Francisco Police Department](#)

⁶ [Mental Health Board Annual Report 2017](#), page 3.

- Call volume to the San Francisco Suicide Prevention crisis line has increased 43% from 2012 (28,046) to 2017 (49,652)⁷
- Admissions for heroin treatment increased significantly between 2009 and 2015⁸
- Both methamphetamine hospitalizations and deaths increased significantly between 2009 and 2015⁹

Police, as first responders, are on the front lines of San Francisco's behavioral health crisis. San Francisco is attempting in many ways to help people suffering from mental illness and addiction.¹⁰ However, when citizens observe people, on the streets or at home, behaving erratically or in ways that may be dangerous to themselves or others, it's the police that they call. The SFPD Crisis Intervention Team, training, and support are critical not only for police, but also for our community as we address the behavioral health crisis.

⁷ [San Francisco Suicide Prevention](#)

⁸ [San Francisco Sentinel Community Site \(SCS\) Drug Use Patterns and Trends, 2016](#), page 4

⁹ [San Francisco Sentinel Community Site \(SCS\) Drug Use Patterns and Trends, 2016](#), page 13

¹⁰ [Mental Health Board Annual Report 2017](#)

Methodology

Previous San Francisco Civil Grand Juries have investigated policing with respect to use of force and officer involved shootings, but none have focused on crisis intervention combined with the public health component. The investigative committee interviewed:

- SFPD command staff
- SFPD district captains, supervisors, and patrol officers
- SF Department of Public Health management and clinicians
- Department of Emergency Management supervisory personnel
- CIT Working Group committee members, some of whom are San Francisco residents

In addition to observing a tactical training session at the SFPD Academy, investigative committee members walked and rode with SFPD Tenderloin district beat patrols to observe encounters with residents. The committee observed multiple meetings of the CIT Working Group and attended most of the current 40 hour Crisis Intervention Training Course. The committee performed a review of Police incident data, CIT training materials, articles, editorials, white papers, blogs, websites of other jurisdictions, and scholarly publications discussing best practices in the handling of people in crisis.

Parenthetically, our report does not include an investigation into the progress of 272 recommendations from the 2016 U.S. Department of Justice/COPS Collaborative Reform Initiative. SFPD's Professional Standards and Principled Policing Bureau is managing the implementation of these recommendations.

We conducted this investigation between November 2017 and May 2018. This report is divided into sections about SFPD Crisis Intervention and the role of the San Francisco Department of Public Health.

San Francisco Police Department (SFPD)

This discussion describes Crisis Intervention Team (CIT) operations within the San Francisco Police Department (SFPD). Department General Orders (DGO) set the department's policies and procedures for performance of day-to-day duties, and rules governing conduct. The SFPD Department General Order 5.21 is entitled "Crisis Intervention Team (CIT) Response To Person In Crisis Calls For Service".¹¹ It was affirmed by the Police Commission in December 2016. In this report the acronym DGO refers to this specific Department General Order 5.21.

The section is divided into five subsections.

- CIT Administration covers the management mandate and structure outlined in the DGO.
- CIT Field Operations includes the staffing and deployment of CIT Trained Officers in addition to describing their current tactical responsibilities, the structure of the Crisis Intervention Team, and overall program implementation.
- The Data and Technology subsection covers communications and reporting interfaces between the SFPD Technology Division, the Department of Emergency Management (DEM), and SFPD.
- Community Outreach covers CIT pin recognition, a community newsletter and a proposed SFPD departmental name change to emphasize service-oriented public safety.
- CIT Training.

Based on our investigation, this discussion includes San Francisco Civil Grand Jury analysis and findings intended to improve CIT operational efficiency and effectiveness within SFPD, and between SFPD and other agencies.

Crisis Intervention - Administration

A CIT Coordinator is selected by the Chief of Police, and manages the overall CIT program. During our investigation we determined that overall CIT administration as outlined in section 4 of the DGO is performed satisfactorily. The Coordinator has 12 primary duties including supervision of two Administrators with the rank of sergeant who provide assistance in training, implementation, and program management. The CIT Mental Health Working Group consists of mental health service providers, advocates, community members, consumers of mental health services, their families, and representatives from City departments and agencies who work in partnership with and provide advice to the Police Department, through the CIT Coordinator.

¹¹ [SFPD Department General Order 5.21 \(DGO 5.21\)](#)

Locating the CIT Coordinator office within SFPD headquarters showed the SFCGJ that CIT is important to the SFPD Command Staff. This placement also provides excellent access to SFPD Command Staff. Considering the complexity of the CIT program, we believe the CIT Coordinator is doing an admirable job. Our investigation revealed a few areas that need improvement.

- Lack of coordination between the CIT Coordinator and district stations about CIT messaging and implementation;
- Inconsistent collaboration between DPH and the CIT Coordinator;
- Lack of formality within CIT Mental Health Working Group; and
- Inadequate CIT data and reporting infrastructure that hinders high-quality information gathering and reporting, and delays transmission of CIT program analysis to stakeholders.

First, the Jury discovered there is a lack of coordination between the CIT Coordinator and district stations on CIT messaging and implementation. As an example, the Jury noticed that officers at the Tenderloin station had a clear understanding of the importance of CIT, and used tactics such as referring residents to behavioral health resources during foot and unit patrols.¹² Meanwhile, at the more suburban Richmond station, the Jury found a lack of a strong connection between the CIT Coordinator and the leadership of the station.

SFPD and Department of Public Health leadership need a sustainable long-term action plan, not just a pilot program, to replace the current “tip of the spear” policy” that places an unfair first-responder burden on SFPD alone. The Department of Public Health has no sustainable action plan to work with SFPD on CIT initiatives. DPH leadership does not regularly collaborate with SFPD. This places undue pressure on SFPD alone to immediately handle behavioral health service calls. Most of these calls eventually require referrals to DPH-related mental health care and case management.

This report’s section on the Department of Public Health provides more detail about the relationship between SFPD and DPH.

Another area of concern within CIT Administration is lack of formality in the Mental Health Working Group and during its meetings. Though these meetings are held regularly, attendance is not mandatory. Aside from some city personnel, Mental Health Working Group membership is voluntary and unpaid. The jury sees steady progress on initiatives, but it is dependent on members’ availability to attend meetings. Further, the lack of institutionalization or structure is

¹² Ride / Walk Along, Tenderloin Station, May 2, 2018

problematic because CIT effectiveness depends partly on how well Working Group members influence SFPD.

CIT Administration needs standard criteria for operational effectiveness. The SFPD is in the process of reviewing a CIT-specific data portal to understand the scope of crisis response calls and put information directly in officer's hands. However, the CIT Coordinator and team currently must manually obtain information on the number of CIT-related service calls and numbers of available trained officers from disparate sources. There are no standard performance criteria, which are necessary to measure CIT operational effectiveness. This poses a challenge to adequately measure CIT effectiveness across all SFPD district stations.

Seattle provides a model for San Francisco to measure CIT operational effectiveness. Seattle's police department tracks and analyses the frequency and locations of crisis response incidents, and of crisis response referrals to community mental health services to efficiently allocate resources and anticipate spikes in crisis response call volume. This allows Seattle to adequately staff crisis intervention trained officers.¹³ Seattle uses the "Crisis Events Dashboard," a useful technology tool which empowers police management to explore the disposition of crisis incidents and how many CIT-trained staff worked a particular shift.¹⁴ A similar dashboard in San Francisco would allow the CIT Coordinator to drill down into the data to reallocate resources.

Crisis Intervention - Field Operations

This subsection focuses on the staffing and district station deployment of CIT trained officers. While CIT training of over 900 officers in SFPD demonstrates commendable progress for the department, concerns remain in connection with field deployment and performance of primary CIT tactical duties once the officers have completed CIT training.

District stations retain significant autonomy in officer deployment. Officers in these stations, as expected, know their respective neighborhoods better than SFPD headquarters staff. This autonomy is at times problematic because of the lack of consistency about assigning CIT-trained officers to areas of the city with a high number of residents subject to behavioral health challenges. For example, the number of CIT trained officers in the Metro Division, in the dense eastern core of San Francisco, does not match the higher number of service calls it experiences

¹³ Seattle Police Department, ["2016 Crisis Intervention Program Report,"](#) Page 8

¹⁴ Seattle Police Department, ["2016 Crisis Intervention Program Report,"](#) Page 9

compared to the Golden Gate Division. This is confirmed by data on CIT officer training and post-training assignments.¹⁵

Regarding the composition of a Crisis Intervention “Team”, the DGO defines the roles within a team. It consists of five officers: CIT Officer; Contact Officer; Lethal Cover Officer; Less-Lethal Cover Officer; and a Resource Officer. However, in practice, except for critical and high profile incidents, many CIT incident responses fall short of requiring a full Crisis Intervention Team. As such, the SFPD does not deploy a five person team for each crisis response call despite the DGO recommendation that, if feasible, a full five officer team respond to each CIT service call. Also, there is no mechanism, such as a data tracker or descriptive field on an incident report, to establish whether SFPD deployed a full team, or a partial team, and whether the deployment was satisfactory. Consequently, SFPD determines the deployment of CIT trained officers across the 10 SFPD district stations mostly based on a traditional police staffing method instead of using a mix of methods, including a more effective data-driven analysis of incidents.

In addition, SFPD does not currently take into account the number of use of force incidents when determining the deployment of CIT trained officers to district stations. The lack of use of force information shows a gap in capturing the true “lifecycle” of CIT incidents. As mentioned previously, Seattle provides a model for San Francisco to emulate. Seattle includes use of force figures related to CIT calls in its annual CIT report.¹⁶ The Seattle crisis response use of force data also include relevant demographic information and types of force used. This is important for SFPD to equally serve all communities in a diverse cosmopolitan city.

Crisis response reports detailing crisis intervention techniques used during an incident would be a valuable tool to inform officers on how to calibrate tactical approaches during future CIT service calls. The jury recognizes SFPD is currently designing a CIT data portal to make data-driven staffing decisions. We commend SFPD for recently embracing data-driven staffing, and recommend the Department include use of force data and crisis intervention techniques when planning future field operations strategy.

Further good news is that the Department is in the process of fully implementing the CIT Liaison Officer program mandated in the DGO. The CIT Liaison Officer program will help provide common crisis intervention standards across district stations. The Program consists of two CIT Liaison Officers assigned to each district station. They are responsible for roll-call training and provide officers with CIT informational resources. Liaison Officers also participate in

¹⁵ See Appendix D

¹⁶ Seattle Police Department, [“2016 Crisis Intervention Program Report,”](#) Page 16

debriefings on CIT-related incidents and attend other meetings as indicated by the CIT Coordinator.¹⁷

The CIT Liaison Program will go a long way toward building relationships between police officers, district station captains, and the CIT Coordinator. The Jury believes it is important for district stations to take the CIT Liaison Officer duties seriously. Based on our interviews, it is unclear whether there is full buy-in from the district station captains.

Crisis Intervention - Data and Technology

Modern policing needs to be nimble; this is also true in the area of technology. In 2015 California passed two criminal justice reporting statutes. AB71 requires annual use of force reports by local law enforcement agencies. SB953 is the Racial and Identity Profiling Act of 2015 which, in part, requires state standardized reporting for each stop by a peace officer. Both are administered by the California Office of the Attorney General, California Justice Information Services (CJIS) division. These statutes require local law enforcement agencies to report accurate and timely criminal justice statistics to the public and to the state government.

SFPD acknowledges it needs major investments to modernize its data and technology capabilities, to match metropolitan peers like New York, Los Angeles, and Seattle. This need was confirmed by the publishing of 272 recommendations by the U.S. Department of Justice, Office of Community Oriented Policing Services assessment of SFPD in 2016. Many of these recommendations identified improvements for data collection and reporting.

The December 2016 DGO outlines policy for data collection and reporting with respect to crisis intervention. All these factors set the stage for SFPD to improve criminal justice reporting. In the area of crisis intervention, new data and technology facilities will buoy a successful CIT Administration and CIT Field Operations.

SFPD has a number of collection / data entry points as police officers perform their assignments, including the Department of Emergency Management (DEM) computer aided dispatch record (CAD), eSTOP (described below), incident reports, and use of force reports. Some reports require approvals by supervisory personnel. The following paragraph describes reporting requirements during a police incident lifecycle.

DEM is the first point of contact for any crisis related call. The DGO requires DEM to designate calls for service as “CR”, if a crisis response is warranted. Using records provided by the

¹⁷ [SFPD Department General Order 5.21 \(DGO 5.21\)](#)

Department of Human Resources, DEM knows what CIT resources are available across all district stations at any one time. As part of a CR service call, DEM seeks trained CIT officers. In addition to the CR designation for the service call, computer aided dispatch (CAD) records initiated by DEM often include dispatch details prior to closing a service call case. Generally, the Jury believes DEM is meeting its obligations with respect to the DGO, but given the fluid dynamics of a crisis service call, some CAD records are not being properly marked with a CR code.

Crisis Response (CR) data is not being effectively collected throughout the incident lifecycle. A lack of CR response notations, especially in incident categories such as mental health related and wellness checks, hinders measurement of CIT operational effectiveness.

Using smartphone technology, an SFPD patrol uses an application named eSTOP to report encounters between police officers and members of the public.

After a call for service and/or an eSTOP encounter, officers may initiate an incident report. If use of force was required, a separate use of force report is created. The eSTOP application includes a guide for designating crisis response outcomes. There have been discussions about equipping eSTOP to describe the crisis response, which could be transmitted directly into the incident report and/or use of force report; but this feature has yet to be implemented. Due to technology hurdles, a robust CIT-specific eSTOP templating plan was never completed.

The Jury's assessment of crisis intervention data collection and reporting is also affected by the state mandate of the Racial and Identity Profiling Act of 2015. The current eSTOP facility will be supplanted by the state's requirement for so-called Stop Data. SFPD is required to collect and report the newly formatted data to the state by April 2019.

As of April 2018, SFPD deployed an initial version of a reporting framework for use by the CIT Coordinator and police department supervisory personnel. The Jury saw a demonstration of the reporting system, but as of this report date, the full launch has yet to occur. Further, this version is missing critical sections which are outlined in the DGO. For example, incident reports do not yet record the responding officer CIT training level. Computer aided dispatch (CAD) records are not yet linked to incident reports. For a crisis response, incident reports and use of force reports could include narrative statements rating or describing the effectiveness of the crisis response, but as of today there is no established method in place to generate this data.

CIT Working Group members lack a computing background, which prevents the design of a workable and scalable data collection and reporting framework.

These information collection and reporting gaps hinder the assessment of SFPD crisis intervention effectiveness which was outlined within the DGO. The DGO also requires the CIT Coordinator to make a yearly report to the Police Commission. The lack of a full reporting framework prevents the Commission from properly assessing CIT program effectiveness.

A useful CIT reporting infrastructure would also add value to the Mental Health Working Group's meetings, and subsequent meetings between the CIT Coordinator and various stakeholders such as DPH leadership. Lack of useful reports places a burden on individual memory, placing the CIT Coordinator in an unfair position as the primary safekeeper of CIT data.

While some data collection has been occurring during 2017 and 2018, there have been gaps in the full data collection and reporting for CIT required by the DGO. These gaps include collection and reporting of eSTOP data with respect to CIT. Additional delay in reporting will occur due to implementation of the Racial and Identity Profiling Act of 2015.

Crisis Intervention - Community Outreach

SFPD and the Police Commission's leadership in issuing the DGO for crisis intervention responses would benefit from reinforcement through community outreach. There is currently no structured CIT community outreach. The jury sees SFPD making progress through the issuance of CIT pins and an annual award ceremony, which clearly identifies and recognizes officers as CIT trained. The jury noticed few officers wearing their CIT pins during our interactions. Per the DGO guidelines, wearing the CIT pin should be strongly endorsed. CIT-trained officers should be identifiable to residents and community and mental health partners assisting such officers on crisis response calls. The long-term goal is to bring visibility to the currently under-resourced yet essential CIT program.

Additionally, most SFPD responses to crisis intervention calls go unnoticed by the general public despite the Department being on the front lines of San Francisco's behavioral health crisis. We believe SFPD should amplify its message about CIT to ordinary San Franciscans. Though SFPD regularly publishes community newsletters for some district stations, as recommended by the US Department of Justice Collaborative Reform Initiative for Technical Assistance (CRI-TA), newsletters rarely mention CIT highlights and successes.¹⁸ The jury urges DPH and SFPD to produce together a quarterly CIT-specific newsletter for online distribution across San Francisco

¹⁸ [Mission Local, "Mission Station, others, still fail to send newsletters to community"](#) (June 5, 2018)

to keep residents informed. Hopefully, the CIT-specific newsletter will increase civic awareness of its role in mitigating the city's behavioral health response challenges.

The jury believes CIT is a step toward service-oriented public safety in its emphasis on cooperation and de-escalation. In London, UK, the Metropolitan Police Service (the Met) provides a model to examine in the form of Police Community Support Officers (PCSO). PCSOs learn to know their communities through foot patrols and being proactive in crisis response involving antisocial behavior.¹⁹ In San Francisco, the CIT Liaison Officer program dovetails with the PCSO model because a CIT police officer is the community expert within a district station. San Francisco's CIT program deserves public recognition for its service to our community.

Crisis Intervention - Training

Background

SFPD continues to make progress in developing a culture of accountability and professionalism in response to the burgeoning mental health crisis that our community faces. This is due in large part to the multi-year evolution and commitment to training by SFPD. Continued classroom training and tactical field instruction provide SFPD new behavioral health understanding, and will likely facilitate a culture shift in SFPD.

SFPD started training officers to use crisis intervention techniques in 2001. The Police Crisis Intervention Training (PCIT) program implemented in 2001 included training in mental health crises for police officers. The Department of Public Health developed and ran this training. PCIT was stopped in 2010.

Developed in 2012, an updated SFPD CIT training curriculum leaned heavily on the critically praised Memphis CIT model. It was first offered to SFPD academy recruits and some sworn officers. In 2015, the state of California passed SB11 which set a new behavioral health instruction minimum standard (Peace Officer Standards and Training - POST) for new police recruits. Since the December 2016 adoption of DGO 5.21, a 40 hour CIT training is now an SFPD requirement for veteran officers. Newly sworn officers receive the 40 hour course after their initial patrol assignment.

The curriculum focuses on recognizing the signs of mental illness in citizens and practicing team approaches and tactical de-escalation strategies. The 40 hour course, over four days, is comprised

¹⁹ See Appendix H for more details; [London, UK: Metropolitan Police Service, PCSO Overview](#)

of 15-plus training modules ranging from 20 minutes to 5 hours in duration. In addition to the classroom instruction, the 10 hour Field Tactics unit is a single day program. The course is designed to reinforce the team approach to handling critical incidents. The curriculum relies on simulations and scenarios to give officers hands-on experience.

The curriculum subcommittee of the CIT Working Group worked closely with the Seattle Police Department to enhance the current 40 hour course. The same subcommittee, which includes mental health experts, key program directors and community members, periodically meets to change course material.

Many of the training modules are taught by highly skilled mental health professionals. CIT training schedules are managed by two CIT Administrators who are SFPD sergeants. The same administrators make curriculum and program decisions based on resource availability.

Effectiveness

SFCGJ believes prioritizing training for command staff who oversee CIT response will help SFPD fully embrace the principles of CIT and de-escalation. Trained command staff will provide de-escalation knowledge and resources to the district stations. This will also help spread the cultural values of the CIT program across the department.

The 2016 U.S. Department of Justice, Office of Community Oriented Policing Services best practice assessment of SFPD recommended that newly promoted supervisors should receive CIT training as part of their training for new assignments.

As of January 2018, only five captains have been fully CIT trained. During our investigation, multiple district station captains could not specifically identify their CIT sergeants or CIT Liaison Officers. SFCGJ witnessed first hand officers looking to their sergeants and district leadership for knowledge and guidance with unfamiliar situations.

Assessment and Evaluation

The curriculum includes a twofold training evaluation process. First, officers are given a pre/post attitudes survey developed by the National Alliance on Mental Illness (NAMI). Secondly, a brief 1-5 survey scale is completed by trainees after each instructional unit to provide feedback on the quality and usefulness of instruction.

SFCGJ read several hundred of these evaluations and witnessed the evaluation process firsthand. We observed that little time and emphasis is dedicated to the completion or analysis of the survey forms. Most evaluations are completed in a matter of seconds and the feedback section is

invariably left blank or dismissed with a few cursory comments. During our investigation, the Jury did not find that the results of the NAMI survey inform any meaningful curriculum decisions. Many instructors reported that they receive little or no feedback on the content or quality of their presentations.

There is little useful information to be gleaned from the current CIT training evaluation process and it does little to determine the quality and efficacy of training. More specific and detailed data should be collected and actively reviewed to determine the quality and efficacy of training.

Currently there is no trended (longitudinal) survey data from field operations which can be used to evaluate the CIT training program.

Classroom Interaction

An additional, and perhaps unintentional, interpersonal value of CIT training was observed by SFCGJ. Given that officers from different district station were seated together at tables, they shared experiences, resources, and personal knowledge. We saw officers engage with the instructors and staff during breaks. This built good relationships for future crisis intervention guidance. CIT training is both time consuming and expensive, but its value is multifaceted, with broad impacts.

The CIT curriculum does not explicitly inform officers of the full range of available community mental health services or other resources that may be used to assist residents who are in crisis. Once trained, officers have only a cursory knowledge of mental health resources, and minimal access to mental or behavioral health consultations in the field, unless they are confronted with high profile crises like hostage situations.

Class Scheduling

It is the stated goal of SFPD to train its entire corps of officers in CIT principles as expeditiously as possible. Although department leaders would like to increase the number of training programs offered per year, the SFCGJ investigation found that staffing shortages at the district level and difficulty retaining instructors have made it practically impossible to increase the number of training sessions.

There are seven 40 hour courses planned for the 2018 calendar year serving approximately 30 attendees per session. Some attendees volunteer for the training while others are chosen by their district station captains.

As of May 2018, 901 sworn officers (43% of patrol) have completed a 40 hour classroom course and over 1500 have taken the separate 10 hour field tactics unit. By the end of 2018, over 90% of all sworn officers will have completed field tactics unit. As a result, at the current rate, it will take 5-7 years for the entire SFPD to accomplish the department CIT training goals of both the 40 and the 10 hour courses.

SFPD command staff find it challenging to attend and complete the 40-hour CIT training program, which they need in order to lead their teams effectively in crisis intervention.

Obstacles to Training

In light of the recent Police Commission decision to mandate the 40 hour CIT training as a gateway for conducted energy devices certification.²⁰ It is important that CIT training is not delayed. In spite of assurances, the jury is concerned that the CED (Taser) certification program will diffuse or delay scheduling of the current 40 hour CIT training program.

²⁰ These devices are commonly known as a CED or Taser. Taser is a brand name of Axon.

San Francisco Department of Public Health (DPH)

This section discusses the role the Department of Public Health plays, as overseer of Community Behavioral Health Services (BHS), in de-escalating and managing crises on the streets. It discusses DPH and other mental health services available for people in crisis and how police officers interface with these services. It briefly outlines the CIT function of DPH and then examines the agreements entered into and documents published by DPH to outline its responsibilities for people in crisis.

DPH Typical Points of Service

SFPD's most frequent interaction with DPH is the Psychiatric Emergency Services (PES) at Zuckerberg San Francisco General Hospital (SFGH). To the police, PES is the best known mental health resource with a clear procedure for utilization, the "5150" 72-hour psychiatric involuntary hold.²¹ However, PES is often a source of frustration and disappointment. Police frustration stems from short hold times and frequent diversion, when patients are redirected to other emergency facilities because PES lacks available beds.

During the course of this investigation, diversion rates at SFGH PES were reduced significantly through innovations and changes made by hospital leadership and staff.^{22,23} However, the involuntary hold times are unlikely to change. The 5150 and subsequent 5152 processes are focused on patient stabilization.²⁴ After stabilizing a patient, PES often has minimal reason to continue a hold. During patient discharge, PES staff provide referrals to and recommendations for community based services and other mental health resources, but the responsibility to access these services lies solely with the patient. There is minimal wrap around case management or supervision and often no follow up after discharge. It is not unusual for police to find the same person unstable and in crisis again shortly after release from PES, and the cycle repeats.

While community based mental health services are appropriate for some patients upon exiting PES, others are best served by structured inpatient residential care. However, in California, during a time of rising population, the number of psychiatric beds decreased by almost 29%

²¹ [The Lanterman-Petris-Short Act, Welfare & Institutions Code Chapter 2 Involuntary Treatment](#)

²² CIT Working Group Presentation by PES Medical Director: [Anton Bland, MD](#), April 11, 2018

²³ SFCGJ Zuckerberg San Francisco General Hospital Tour, May 10, 2018

²⁴ http://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=5152

between 1995 and 2013.²⁵ San Francisco has fared better than many other California counties and, as of 2015, has 38.3 beds per 100,000 people, but there is still a shortage.²⁶

The jury found that Dore Urgent Care Clinic and Residence, a private non-profit and one of the many community services available to individuals in crisis, is an example of a useful community service that helps the CIT program. It relieves pressure on PES, the police, and the community by providing ongoing professional care for individuals in crisis. Dore requires a referral by PES, or by a clinic, crisis service, medical emergency room, or an arrival accompanied by SFPD. It is a “medically-staffed psychiatric urgent care clinic combined with Dore Residence, a 14-bed crisis residential treatment”. Dore serves individuals who may be in psychiatric crisis, but do not require hospitalization, involuntary treatment, seclusion, or restraint. The clinic is open 24/7 and is able to accommodate up to 12 clients at any one time. If they are the right fit for the facility, SFPD can bring clients to Dore without first going to PES for stabilization, but to do so they must be aware of Dore, the associated procedures, and availability.

One of the primary CIT program goals is to “redirect Individuals with Mental Illness from the Judicial System to the Health Care System.”²⁷ Successful redirection requires both PES and facilities like Dore Clinic. DPH recently partnered with University of California San Francisco (UCSF) and other health care providers to open the San Francisco Healing Center, a 54-bed center for patients that do not need acute care, but are not able to care for themselves. The jury hopes that this new center will provide much needed additional supportive care.²⁸

Behavioral Health Services and Crisis Intervention

Globally, CIT programs rely on the involvement and unobstructed coordination and cooperation between the police and the behavioral health community to fully realize their potential.²⁹ Partnerships and collaborations between police and DPH behavioral health organizations vary from city to city. For example, Los Angeles has a Mental Evaluation Unit (MEU) and clinicians that ride along with police officers. The Memphis model makes use of a mental health coordinator as well as a police CIT coordinator and encourages dissolving barriers to effective collaboration.

²⁵ [California’s Acute Psychiatric Bed Loss](#), page 2.

²⁶ [California’s Acute Psychiatric Bed Loss](#), page 4.

²⁷ [CIT Is More Than Just Training...it's a community program](#)

²⁸ <https://www.ucsf.edu/news/2018/03/409976/san-francisco-partnership-launches-mental-health-center>

²⁹ [The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Practitioners](#), page 1

San Francisco's DGO 5.21 states that CIT administration will collaborate with the Department of Public Health (DPH) as well as other agencies, but does not include specific guidelines.³⁰ The DGO outlines what the SFPD needs to do and, to some extent, how to manage and execute the CIT program. However, in doing so, it inadvertently stifles the partnership with DPH placing DPH in a subordinate and reactive role initiated by SFPD request or invitation. In order to enhance the DGO and ensure cooperation between the two departments, SFPD and DPH entered into a three year Memorandum of Understanding (MOU) at the behest of Mayor Ed Lee in December 2016.

The MOU between DPH and SFPD

The MOU, titled Behavioral Health Crisis Intervention Support for SFPD, outlines an "enhanced" partnership to assist the SFPD in police CIT crisis situations, primarily, through DPH Crisis Intervention "Specialists." DPH Specialists, "...will ensure that individuals are provided with immediate mental health crisis assessment and services...."³¹ The Specialists are to be available 24/7 by phone and to provide assistance on scene. Additional DPH Specialist responsibilities include 5150 - detention for psychiatric evaluation and treatment - criteria assessment and coordination with hospitals and jails as necessary. They are also tasked with connecting individuals to community based behavioral health services as appropriate. The MOU also outlines protocols for sharing some medical information, protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), between DPH clinicians and SFPD to resolve a crisis.³² The MOU also describes program supervision.

MOU DPH Program Implementation

After the formation of the MOU, DPH Behavioral Health Services (BHS) authored a detailed policies and procedures Manual outlining its responsibilities on January 10, 2017.³³

Crisis Intervention Specialists

The DPH Manual discusses the formation of a Crisis Intervention Specialist team. DPH was budgeted \$760,724 in order to hire five crisis intervention specialists. The corresponding press release states that the team will include five members, all of whom will be able to consult with and assist police in the field:

³⁰ DGO 5.21 Section IV, item 6

³¹ See Appendix I

³² [HIPAA](#)

³³ [Manual Number 3.02-10: Crisis Intervention Specialist Team](#)

“The team of Crisis Intervention Specialists will be made up of experienced behavioral health clinicians employed by the Department of Public Health. It will include five staff including clinical psychologists and behavioral health clinicians who are experienced and licensed in the behavioral health field. All members of the team will be capable of supporting police negotiators in the field, conducting crisis assessments, debriefing individuals affected, consulting with victims and providing other crisis response services as needed. Team members also will assist the police department with Crisis Intervention Trainings, building on the training already in place, to improve police capability to recognize people with behavioral health problems and restore safety.”³⁴

At the time of our investigation and writing, there were not five field-ready DPH clinicians or Specialists devoted to the CIT program and the San Francisco Police Department. There were, at most, three.

In 2017, a few DPH crisis intervention Specialists and SFPD’s Crisis Intervention Unit spent significant amounts of time together walking the mid-Market area to increase police presence, provide assistance to those in need, and deepen their understanding of the community. This allowed the development of meaningful, collaborative, and trusting relationships. These Specialists and the Crisis Intervention officers now call each other when confronted with scenarios that are best handled together. Several highly visible and potentially disastrous situations were successfully de-escalated and resolved as a result of this partnership and the 24/7 availability of DPH clinicians.^{35,36} This is a great demonstration of the potential effectiveness a comprehensive CIT/DPH collaboration makes possible.

CIT Program Evaluation and Supervision

The MOU states that both “SFPD and DPH will support data collection” for the purpose of reviewing and evaluating the challenges first responders face in dealing with crisis situations and continually improving the structure of the program. DPH is to report “information covering frequency and type of services provided including short term case management services, linkage to long term care, and reduction in crisis contacts.” Currently, police are working with DEM and incident data, and are in the process of creating more CIT focused data collection and reporting for their own review and analysis. However, it is unclear how SFPD and DPH are collaboratively reviewing this data in the context of a joint SFPD/DPH CIT program.

On the other hand, the few DPH crisis Specialists and the CIT police are working well together, when and where the opportunities exist. They are, to a large extent, collaboratively, experiencing successful outcomes. We do not find evidence of a similar collaborative and supportive relationship among higher ranking officers in either organization, or an effort to co-supervise as

³⁴ <https://sfmayor.org/article/mayor-lee-announces-expansion-comprehensive-crisis-services-support-police-response>

³⁵ Working Group Meeting, February 14, 2018

³⁶ Working Group Meeting, March 14, 2018

stated by the MOU. Police and the CIT Coordinator appear to supervise the CIT program almost entirely with some assistance from the CIT working group, and only nominal input from DPH.

The CIT working group, also known as the Mental Health Working Group, includes many mental health clinicians including DPH crisis intervention specialists who actively participate in the group. The jury found, however, that there is no continuous representation or involvement from DPH leadership or management. The absence of DPH leadership at the working group level reinforces the lack of collaborative program evaluation and supervision by DPH. DPH's scarce presence also results in inefficient sharing and understanding of broader public health information and priorities. When sharing and connecting does occur, it occurs because of individual committee members' determination to make it happen.

MOU Effectiveness and Expiration

After careful review of the MOU, with respect to our investigation, we see the relationship and collaboration between DPH and SFPD progressing. The individuals in both DPH and SFPD committed to crisis intervention at an operational level are engaged, dedicated and doing commendable work in reducing bad outcomes for people in crisis. However, DPH, at an organizational level, has not fully committed to the responsibilities stated in its MOU and Manual, as evidenced by its lack of Specialists, co-supervision, and program evaluation.

SFPD uses DGOs to articulate and implement policy changes. They also serve as a mechanism to hold the department accountable, with the Police Commission having oversight of both DGO compliance and field operations. There is no equivalent to a DGO for the Department of Public Health. The MOU is an attempt to codify DPH involvement of and collaboration with SFPD, and the Manual takes it a step further. However, despite these two documents, DPH commitment falls short. The jury finds that the current MOU is not an effective tool for holding DPH accountable for its part in this important collaboration.

Additionally, the current MOU expires on 12/27/2019. Expiration risks jeopardizing the progress both SFPD and DPH have made to date and risks stunting program growth. It is, therefore, critical that the existing MOU be fully executed, and then extended and renewed, if Crisis Intervention is truly to succeed in San Francisco.

DPH Expanding Support

The jury has the impression that SFPD and DPH have focused their partnership on high-profile crises, such as a person barricaded in a room threatening suicide. These major events are, of course, vitally important, but the definition of a crisis extends beyond these high-profile cases. For instance, San Franciscans often encounter people on the street who appear to be in crisis. They call 911, and SFPD officers respond first. Most trained SFPD CIT officers have only a

cursory knowledge of mental health resources. If officers have pre-existing relationships with clinicians, they can call them for help or information, but without that relationship and the resulting knowledge of and trust in the clinicians, these calls do not happen.

There are many different documents and websites available online listing DPH facilities, resources, and partners, but they are hard to find, hard to use, and not easily accessible on mobile devices.³⁷ Some appear to be out of date or include broken links.³⁸ Many cities and counties in California use a tool called “Network of Care” to build websites for quick and easy navigation of resources.³⁹ Los Angeles county uses both a “Network of Care” site and a Mental Evaluation Unit triage desk that officers can call when arriving at a scene with someone in crisis. A consolidated, easily accessible, and, ideally, dynamic list of resources with stated hours and availability, provided by DPH to police and the broader community, would be a first step toward developing resources and methods that are applicable for less extreme crises.

³⁷ [BHS Provider List 2017-2018](#)

³⁸ [San Francisco Mental Health Board Resources](#)

³⁹ [Network of Care](#)

Conclusion

The Civil Grand Jury sees SFPD making tangible progress on DGO 5.21 and use of force issues. A passionate and knowledgeable CIT working group convenes regularly to advise police. SFPD has a CIT Coordinator. There is a Crisis Intervention Unit, and behavioral health clinicians are available to help the crisis intervention police. At the time of this writing, nearly 40% of SFPD officers have completed their CIT training. District level CIT liaison officers are trained and will soon work to understand the people and places in their districts that require extra attention with the goal of preventing 911 calls and crisis incidents before they occur. Reports of use of force by SFPD were reduced in 2017, but without effective CIT data collection we do not know if de-escalation techniques were a contributing cause to this decline.⁴⁰

As previously noted, the Department of Public Health is the primary purveyor of mental health services in San Francisco. It is the epicenter of knowledge about mental health, mental disabilities and related behaviors in our city. Consequently, DPH's involvement in the CIT program is crucial to its success at every level: As trainers of the police, as the interface between the police and the mental health consumers, as the "street educators" of the police about aberrant mental health behavior, as another voice in interpreting crisis behavior, DPH is integral to the committed community partnership required for a successful CIT program.

⁴⁰ See Appendix F - Use of Force by SFPD District Station (96A)

Findings

- F1 The CIT Liaison Program will strengthen relationships between police officers, district station captains, and the CIT Coordinator.
- F2 CIT Working Group members lack a computing background, which prevents the design of a workable and scalable data collection and reporting framework.
- F3 There are no standard CIT performance criteria, which are necessary to measure CIT operational effectiveness.
- F4 SFPD determines the deployment of CIT trained officers across the 10 SFPD district stations, mostly based on a traditional police staffing method instead of using a mix of methods, including a more effective data-driven analysis of incidents.
- F5 While some data collection has been occurring during 2017 and 2018, there have been gaps in the full data collection and reporting for CIT required by the DGO. These gaps include collection and reporting of eSTOP data with respect to CIT. Additional delay in reporting will occur due to implementation of the Racial and Identity Profiling Act of 2015.
- F6 Crisis Response (CR) data is not being effectively collected throughout the crisis incident lifecycle. A lack of “CR” response notations, especially in incident categories such as mental health related and wellness checks, hinders measurement of CIT operational effectiveness.
- F7 SFPD command staff find it challenging to attend and complete the 40-hour CIT training program, which they need in order to lead their teams effectively in crisis intervention.
- F8 The CIT curriculum does not explicitly inform officers of the full range of available community mental health services or other resources that may be used to assist residents who are in crisis. Once trained, officers have only a cursory knowledge of mental health resources, and minimal access to mental or behavioral health consultations in the field, unless they are confronted with high profile crises like hostage situations.
- F9 There is little useful information to be gleaned from the current CIT training evaluation process and it does little to determine the quality and efficacy of training.
- F10 Currently there is no trended (longitudinal) survey data from field operations which can be used to evaluate the CIT training program.
- F11 In spite of assurances, the jury is concerned that the CED (Taser) certification program will diffuse or delay scheduling of the current 40 hour CIT training program.
- F12 DPH has no equivalent accountability mechanism to SFPD Department General Orders (DGOs), by which DPH instructs, manages, and, thereby, holds DPH accountable for outlining its responsibilities, particularly in managing its CIT involvement, and collaborating with SFPD.

- F13 DPH has not fully and adequately filled the five budgeted clinician positions. Without these field positions, DPH cannot fulfill the mutual goals prescribed by the Mayor in his 2016 press release.
- F14 The CIT working group includes mental health clinicians, including those who work directly with CIT, but there is no consistent representation from DPH leadership/management. This results in inefficient sharing and understanding of broader public health information and priorities. The absence of DPH leadership at the working group level underscores the lack of program evaluation and supervision by DPH.
- F15 The CIT Working Group, SFPD, and DPH have improved the responses to high visibility crises in San Francisco. Application of scaled and proactive methods to manage less extreme crises has not received similar attention.
- F16 Dore Clinic and Residence is an example of a valuable and useful community service that facilitates the success of the CIT program, relieving pressure on PES, the police, and the community by providing ongoing professional care for individuals in crisis.
- F17 The individuals in both DPH and SFPD committed to crisis intervention at an operational level are engaged, dedicated and doing commendable work in reducing bad outcomes for people in crisis.

Recommendations

The San Francisco Civil Grand Jury:

- R1 Recommends that the CIT Coordinator and CIT Liaison Officers hold monthly meetings with each district station captain. Each meeting should include regular agenda items relating to district CIT incidents, high frequency clients, and outcomes. The results of each meeting should be summarized in a quarterly review with the Chief of Police. Meetings should commence no later than January 1, 2019. (F1)
- R2 Recommends that SFPD Technology Division assign a representative to attend all regular CIT Working Group meetings no later than October 1, 2018. (F2)
- R3 Recommends that SFPD, in collaboration with CIT Working Group, identify both quantitative and qualitative standards to help measure CIT operational effectiveness. Newly adopted standards should include Crisis Response (CR) incidents and jail diversion statistics. These standards should be part of the CIT annual report to the Police Commission. Standards should be adopted no later than January 1, 2019 and be set for inclusion in the 2018 CIT annual report to the Police Commission. (F3)
- R4 Recommends that SFPD command staff consider reported CIT incident outcomes in deciding CIT officer assignments. This will help deploy CIT teams in areas where they are needed most. This consideration should begin no later than January 1, 2019. (F4)
- R5 Recommends that newly identified and budgeted programming personnel for SFPD Technology Division be hired no later than October 1, 2018. (F5)
- R6 Recommends that the use of crisis intervention techniques be reported within the CAD record. This broader designation of CIT incident responses should start no later than January 1, 2019. (F6)
- R7 Recommends SFPD command staff be allowed to spread their attendance in CIT training over two or more training sessions. Flexible sessions should start by October 1, 2018. (F7)
- R8 Recommends that CIT administrators develop a department bulletin which outlines the full range of community resources to support officers who are assisting residents in crisis. The bulletin should be in place no later than January 1, 2019. (F8)
- R9 Recommends that an academic institutional partner be assigned to assess and periodically review the efficacy of the 40 and 10 hour CIT Training courses. (F9)
- R10 Recommends SFPD officers who have completed the 40 hour CIT training course be surveyed six months to one year later to reflect on the usefulness of individual modules and to determine what worked and what did not work in the training. This new survey should start no later than April 1, 2019. (F10)

- R11 Recommends the Chief of SFPD publicly state the CED (Taser) certification program will not diffuse or delay scheduling of the current 40 hour CIT training program. This public statement should occur no later than October 1, 2018. (F11)
- R12 Recommends renewal and elaboration of the current MOU between SFPD and DPH, and the associated DPH manual. An updated draft MOU should be presented to the Mayor for review no later than January 1, 2019 and adopted no later than June 1, 2019. (F12)
- R13 Recommends filling the five budgeted Crisis Intervention Specialist positions with field-ready clinicians. Clinicians should be dedicated to the CIT program and placed in the field no later than October 1, 2018. (F13)
- R14 Recommends DPH/BHS leadership and the CIT Working Group hold joint quarterly meetings to examine and analyze CIT program data, measure and assess program progress, and identify appropriate program adjustments. These meetings should begin no later than January 1, 2019. (F14)
- R15 Recommends that in addition to the Specialists referred to in Recommendation 13, DPH hire five additional Crisis Intervention Specialists by December 1, 2019. One Specialist should be assigned to each district station for coordination and collaboration with SFPD CIT liaisons in order to prevent crises before they require a 911 call. Initial assignments should be made to the stations with the greatest need, based on calls for service and incident type. (F15)

Required Responses

Pursuant to Penal Code section 933. The San Francisco Civil Grand Jury requests responses as follows:

From the following individuals:

Chief of Police, San Francisco Police Department

(F1, F2, F3, F4, F5, F6, F7, F8, F9, F10, F11, F12, F14)

(R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R14)

Director of Health, San Francisco Department of Public Health

(F12, F13, F14, F15)

(R12, R13, R14, R15)

No Respondents

(F16, F17)

Reports issued by the Grand Jury do not identify individuals interviewed. Penal Code section 929 requires that reports of the Grand Jury not contain the name of any person or facts leading to the identity of any person who provides information to the Grand Jury.

Appendices

Appendix A - Memphis Model

Adapted from cit.memphis.edu

History

In 1987 police officers were called to an area of public housing in Memphis, Tennessee where a young man was threatening people with a knife. When police officers ordered him to put down the knife, he refused. The officers eventually opened fire and the young man died of multiple gunshot wounds. The man had a history of mental illness. He was black and the officers were white. Many citizens raised their voices in angry protest against the officers with cries of racism and police brutality. Calmer voices prevailed calling for the community to develop a better way to intervene with individuals in mental health crisis. The Mayor of Memphis turned to local advocates from the National Alliance On Mental Illness (NAMI) and enlisted police, community mental health professionals, university leaders, hospital administrators, and church officials to seek a new approach to working with persons with mental illness in crisis.

Memphis Model

What emerged from this initial task force was the Memphis Police Department Crisis Intervention Team (CIT) that would become known in later years as the Memphis Model. The originators of CIT combined several insights that revolutionized how individuals with mental illness in crisis would be approached by police officers and effectively routed to appropriate mental health care facilities rather than jail. The CIT pioneers envisioned a team of uniform patrol officers selected for specialized training in basic crisis intervention. The officers would be spread throughout the city on all shifts. These officers would perform the usual duties of uniform patrol officers but would be available for immediate dispatch to mental health crisis scenes. Arriving without delay, CIT officers would be able to de-escalate the crisis, decreasing the likelihood of violence and injury to patients, family members, neighbors and police officers. With assistance from other police officers, the CIT officer would assess the individual in crisis and make the decision whether or not to transport a patient for further evaluation. The receiving facility would offer a single point of entry with referrals to resources such as community mental health services, social services and Veterans services.

Training

In order to handle these specialized duties, CIT officers received training in selected topics including mental health diagnoses, psychiatric medications, and issues of drug abuse and dependence. The officers would be trained in mental health law and cross-cultural sensitivity. Officers would spend time with individuals who experienced mental illness to learn first-hand of challenges of the illness. Most importantly, the officer would receive intensive training in verbal de-escalation skills with consistent attention to officer safety throughout all components of the CIT training.

Jail Diversion and Referral to Healthcare

As the CIT program was implemented, it became clear that CIT decreased the likelihood of an individual with mental illness ending up in the criminal justice system. CIT also increased the chances of an appropriate health care referral. Thus, the CIT program has an important side effect of jail diversion (Dupont & Cochran, 2000). These two outcomes of crisis de-escalation and appropriate referral to healthcare are part of the CIT intervention strategy (see Dupont, 2008; Compton, Badora, Watson & Oliva, 2008).

Volunteer Faculty

CIT was recognized as essential to the well-being of Memphis and it was decided the effort must be the responsibility of the entire community. Mental health professionals and educators voluntarily joined NAMI members, criminal justice professionals and individuals with mental illness to provide the necessary training and consultation to CIT Officers at no charge to the Memphis Police Department. This tradition has continued in CIT programs throughout the nation.

CIT as Community Based Model

As the CIT model spread through other cities, a steering group composed of leaders from CIT programs developed a document to identify the core elements of a CIT model. This document recognizes the importance of community involvement in maintaining CIT programs. Steering groups in newly developing CIT programs are critical to success of the CIT model. The group provides a forum for the partnerships, networking and eventual community ownership. In Memphis, and in most of the CIT programs throughout the country, the steering groups take on the role of advocacy for the various components of the crisis intervention system, often obtaining significant funding for critical components of the psychiatric emergency system and other community based mental health efforts. The steering group also allows for communication around clinical issues which can, in turn, become formal case conferences focusing on

individuals at high-risk of recidivism. The efforts of the Memphis founders of CIT led to a network of over 2700 CIT sites throughout the nation. There is also a national organization which provides a forum (CIT International) for CIT Programs to join together. The success of CIT throughout the nation is a testimony to the grassroots support generated to help those struggling with mental illness and the leadership provided by those determined to make a difference in their community.

Appendix B - The Memphis Model in San Francisco - An Interpretation

DPH has been relegated to, and has taken, a subordinate role in street crisis intervention incidents, and has not assumed the role of an “enhanced” partner to the SFPD CIT program. DPH assists with its Specialists, when called and when needed by the SFPD. The MOU seems to define DPH’s role as “...support for SFPD.” The essence of a committed, working partnership has been minimized. Why is this important? CIT is a program instituted to abate a community problem, not just a police problem. Consequently, the solution resides in a community based solution, not just a police solution.

Consider the comments of Betsy Vickers, writing about the vaunted Memphis, Tennessee’s CIT program: (footnote: Police Department's Crisis Intervention Team, in Practitioner Perspectives, “*Crisis Intervention, Police Training*” (July, 2000))

Without a committed partnership among constituents affected by the needs of the mentally ill, no CIT program will get off the ground, much less succeed. In Memphis, those constituents are the families of the mentally ill, law enforcement agencies, emergency medical/psychiatric services, regional short- and long-term receiving hospitals, and the consumers themselves.

Aside from spending time together and getting along, Memphis advocates also point out that a Mental Health Crisis Assessment Center, the MED, as one of the key elements of Memphis’ CIT success. It was a 24/7 mental health facility where consumers in a mental health crisis were dropped off by CIT police officers for treatment. The MED was part of the University of Tennessee Medical Center Psychiatric Unit. It evaluated for services approximately 400-500 psychiatric consumers per month. 40-50 percent were new patients.

Lt. Col. Vincent Beasley, the Memphis CIT coordinator, opines that

“...Without the MED's open-door policy, the CIT program would not work. The synergistic system is designed to admit within 15 minutes whoever is brought in by the police. The quick transfer from officers to the mental health facility is considered the key to the program's success.” (It is also noteworthy that without the agreement of all entities in the health services sector on the MED’s clearinghouse role, turf wars could have broken out among hospitals looking for their share of regional patients requiring care.)

Lt. Col. Beasley also points out that the MED’s medical component also served the following critical functions: Officers spend less time in hospital ER; Patient violence was reduced; The need for acute hospitalization decreased from 40 to 25 percent; Health-care referrals were increased dramatically; Recidivism decreased to less than 15 percent after 1 year; It ensured

cooperation among advocates in the medical, psychological, psychiatric communities and the police department and the state hospitals. It protected against dumping--misrepresenting the situation to off-load the consumer in trouble. It gave doctors the time to assess patients—which was extremely important with co-occurring substance abuse and mental health disorders. Lastly, it provided appropriate patient care.

At the MED, the consumer was placed in protective custody with no charges, after which the doctors decided if the consumer should be transferred to the state hospital or guided to another solution. These solutions involved referral to various community resources, such as medical detoxification programs, mental health centers, rehabilitation programs, and social service agencies.

"All parts of the system encourage the flow to come through here and not the jail, and that's the bottom line," said Dr. Randy Dupont, head of the MED's psychiatric services:

If this doesn't turn out to be mental illness, but turns out to be alcohol or drugs, or dementia in the elderly, that's our problem. This is still a health-care issue, but we are not going to try to figure that out at the door.

The MED has recently been replaced by a private, non-profit vendor, Alliance Health Care, which provides similar “clearing house” functions for the Memphis CIT program that the MED provided. The annual cost to the City of Memphis is reported to be an estimated \$970,000.

SF does not have anything comparable to a designated Emergency Mental Health Receiving Facility that accepts all referrals regardless of diagnosis, similar to Memphis, thus further constraining SFPD involvement with the DPH professionals/Specialists.

Consider for a moment, should such a “clearinghouse” exist in San Francisco, the SFPD, responding to the more than 53,128 annual calls for service involving a person in crisis, would have the option of dropping off, or referring, persons to the clearinghouse. From there potential diversions abound to: Zuckerberg SF General for 5150 consideration; UCSF Center for Geriatric Care; Misdemeanor Behavioral Health Court; Women’s Resource Center; Community Assessment and Services Center; Court Accountable Homeless Services; No-Violence Alliance Project; San Francisco Sobering Center; Pretrial Diversion Services; Supervised pretrial Release; Sheriff’s Department Community Services; Navigation Centers; Hummingbird Place Peer Respite; Medical Detoxification Bed; Community based health services; Community Based substance abuse services; San Francisco Shelter Bed; to name just a few.

View Tina’s journey in this light in Appendix C.

Appendix C - Tina's Story

The SFCGJ made special arrangements for several of us to “ride/walk along” with SFPD CIT trained officers patrolling the Tenderloin: 6th & Mission, Civic Center Bart Station, UN Plaza....the underbelly of the City.

During the “walk” the cops were in full dress, we were plain clothes, the new faces, fitted with Kevlar vests, constantly asked if we were “Da Mayor”. We walked past the drug dealers, the drug users, the drug holders (those seemingly innocent bystanders, ready to swallow their product at the first sign of trouble, later to vomit it up after a slug of Monster aide), the buyers of stolen property, the sellers of stolen property, the homeless, the old Chinese woman selling food she'd collected free at Glide, the SRO for the Blind at the BART station being hassled by the drug dealers. Urinating, defecating, drug use, needles and the ubiquitous vomit completed the tableau. No hostility, many said “Hi” or waived, through the exodus down the BART steps as we passed was obvious. Life on the streets.

A few of us went on a “ride along.” Again, bullet proof vests, well used patrol car, doors that were unlocked and no seat belts for quick, easy exits. We were instructed, “If anything goes down, keep your distance.” Our companions were experienced, CIT trained, beat cops, though they complained that, typically, many CIT trained beat officers are too green to be of much help on the streets.

It was mid-morning, things were quiet. No “A” calls on the board. Our unit then responded to a DEM Dispatch coded call that a mother on Turk Street was distraught that her 12 year-old daughter, ‘Tina,’ was threatening suicide. Talked to Tina. She agreed suicide was on her priority list; It was evident she needed help; she wanted to see a doctor; wanted to go to a hospital. She was so young. Probably not eligible to go to SF General on a 5150. She was cooperative. Officer didn't know where to take her. What to do? Couldn't leave her alone, situation too delicate. Case worker not able to get traction finding in-patient or outpatient mental health help for her. Tina had also been expelled from her school, which was unable, or unwilling, to get her help. Should we take her to Juvenile Hall? Didn't feel right. Called the Sergeant for instructions. Waited. Sergeant responded that a doctor would get in touch. Waited. A DPH Specialist called. He had found a space for her at Edgewood's Crisis Stabilization Unit (CSU). We transported her there, where she was met and interviewed. Back to the Tenderloin. Time elapsed: 1-1/2 hours, 2 officers, 1 patrol car.

Appendix D - Crisis Intervention Team - Annual Report 2017

(SFCGJ abridged)



San Francisco Police Crisis Intervention Team End of Year Report to the San Francisco Police Commission on Mental Health Calls for Service

January 1, 2017 to December 31, 2017

Background:

On December 21, 2016, the San Francisco Police Commission unanimously adopted San Francisco Police Department General Order 5.21, the Crisis Intervention Team Response to Person in Crisis Calls for Service. In addition to describing detailed SFPD CIT policies, training, procedures and administrative structure, the DGO mandates a quarterly report of data to the San Francisco Police Commission of mental Health related calls for service. The following are the most up to date data on such calls:

Table #1

Call Code	Call Description	Total
800	Mentally Disturbed Person	18,245
801	Person Attempting Suicide	4,601
806	Juvenile Beyond Parental Control	457
5150	Mental Health Detention	839
800CR	Mentally Disturbed Person (Crisis Intervention Team Response)	274
801CR	Person Attempting Suicide (Crisis Intervention Team Response)	55

		24,471
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Please note that some of the 800 Mentally Disturbed Person calls turned into a 5150 Mental Health Evaluation after the subjects were contacted by officers. Additionally, Officers also responded to 28,657 calls to “Check on the Wellbeing” of individuals in distress. A grand total of 53,128 calls for service involving a potential crisis were either dispatched or on viewed by officers in the field.

San Francisco Police Department

Mental Health Detention

January 1 – December 31, 2017



From January 1 to December 31, 2017, there were a total of **4,276** Mental Health Detention incident reports, with 37 incidents involving two or more subjects¹.

ALL INCIDENTS	
TYPE	# SUBJECTS
DETAINED	4,056
CITED	95
SUSPECT	93
BOOKED	73
Total	4,317

IDENTIFIED INDIVIDUALS	
# of TIMES CONTACTED	# of INDIVIDUALS
1	2313
2	337
3	120
4	61
5	26
6	22
7	6
8	8
9	4
10	4
11	2
13	2
15	1
16	1
17	3
18	3
20	1

The incidents involved 2,914 identified individuals; 78 individuals were listed as “John Doe”, “Jane Doe”, or “Unknown;” 21% of the identified individuals were contacted more than once (601 of 2,914 individuals); 29 individuals were contacted 8 or more times.

Our officers are utilizing CIT training techniques to de-escalate incidents that had the potential for violent outcomes. Officers are de-escalating when feasible and are immediately interceding when necessary to stop the subjects from hurting themselves or others. Our 40hrs Mental Health awareness training and the 10hrs Threat Assessment Training continued to be implemented.

Crisis Intervention Team Training Curriculum

40-Hour CIT Mental Health Awareness Course:

6 classes in 2017:

One class for SF Park Rangers

7 classes scheduled for 2018

March 26th-29th

April 23rd-26th

May 14th-17th

August 27th-30th

September 24th-27th

October 15th-18th

November 12th-15th

819 members certified (40% of Patrol)

800 sworn members

19 non-sworn members

2 Commanders

5 Captains

26 Lieutenants

177 Sergeants

590 Officers

19 Civilians

10-Hour CIT Field Tactics Course:

49 classes in 2017

2 classes were recruit classes

38 classes scheduled for 2018 (87 classes total)

3 classes are recruits classes

1,311 members trained as of 2/13/2018

Members from all district stations including airport have attended this course

Police Service Aid (PSA) De-escalation Course:

7 classes in 2017 (New hires and refresher courses)

4 classes scheduled for 2018

Dispatch De-escalation Course:

4 classes in 2017

Nothing scheduled for 2018, at the moment

Dispatchers are also attending 40-Hour and 10-Hour Courses

2017 Use Of Force Statistics:

Call Type	Total	Percent
Physical Control	111	60.33%
Strike by an object/fist	22	11.96%
OC	3	1.63%
Impact Weapon	3	1.63%
ERIW - Extended Range Impact Weapon, bean bag	7	3.80%
Pointing of Firearm	37	20.11%
Firearm	0	0.00%
Other	1	0.54%
Mental Health Related/Wellness Check (total)	184	
Use of Force (overall total)	2930	
SFPD Calls for Service (total)	75,5629	

There were 2,930 Use of Force incidents in 2017. 184 or 6% were related to a Mental Health/Check on The Well-being of a person call.

There were 53, 128 Mental health Related/Check on the Well-being calls for service in 2017. Force was used on 184 (0.35%)

There were 755,629 total calls for service by SFPD in 2017. 53,128 (7.%) were related to Mental Health/Check on the Well-being of a person. Force was used in 184 (0.02%) calls.

CIT/DPH Working Model: Case Conferences, Site Visits, Foot Beats, and Subject-Specific Outreach

The CIT field unit has been working to cultivate engagement strategies with clinicians at DPH so as to better exchange information regarding subjects who require further consideration for services and outreach.

On Wednesdays and Thursdays each week, Clinicians at DPH are meeting with the CIT Unit for specific "case conferences" regarding high-users of the emergency services, high-risk subjects who present a danger to themselves or the public, and gravely disabled subjects who are in need of serious medical or clinical intervention. At these designated case conferences CIT and DPH discuss cases and work to create action 'plans' for each subject with an attempt to provide optimal strategies to assist subjects who require immediate intervention and assistance. Additionally, the general aspiration of the CIT/DPH working model is to help specified subjects transcend the dire and inefficient cycle of "acute care" within City Emergency Services, into a phase of more substantive and "long-term care", outreach, and case management. Every week CIT and DPH present cases of subjects who are of significant interest and concern.

The CIT Field Unit and DPH Clinicians then respond to specific and/ or general locations to conduct site visits, foot beats, and engagement strategies with both the community and service providers. In the field CIT and DPH meet with reporting parties and subjects who require further consideration, engagement, and support. The goal is to encourage subjects to speak with DPH clinicians who can 'triage' their issues and needs in the field and further direct them to the most appropriate level of care and case management.

Appendix E - Calls for Service - Police and Fire

San Francisco Police Department

District Station	2017	2016	2015	2014	2013
Bayview	257	301	329	267	279
Central	441	429	571	529	338
Ingleside	355	343	380	382	352
Mission	634	700	672	745	651
Northern	444	493	488	472	449
Park	281	240	218	188	242
Richmond	226	244	190	235	172
Southern	956	1052	1009	1127	1036
Taraval	409	331	380	356	316
Tenderloin	390	434	449	467	544
Aided Case Mental Disturbed (total)*	4393	4567	4686	4768	4379
Non-criminal Incidents (total)	154260	150882	156526	150128	152806
Percentage of non-criminal incidents	2.85%	3.03%	2.99%	3.18%	2.87%

*Search Criteria - Aided Case Mental Disturbed

Source: SF Open Data

San Francisco Fire Department - Four Most Common Calls for Service (by percentage)

Call Type	2017	2016	2015	2014	2013
Alarms	8.51%	8.16%	8.75%	8.63%	8.37%
Medical Incident	84.15%	82.84%	82.38%	80.74%	80.62%
Structure Fire	3.66%	5.21%	4.94%	6.65%	6.85%
Traffic Collision	3.67%	3.79%	3.94%	3.98%	4.15%

San Francisco Fire Department - Four Most Common Calls for Service (totals)

Call Type	2017	2016	2015	2014	2013
Alarms	11445	10569	10806	9782	9254
Medical Incident	113125	107316	101731	91526	89161
Structure Fire	4923	6749	6097	7542	7579
Traffic Collision	4935	4914	4862	4510	4594
Top Four Totals	134428	129548	123496	113360	110588

Appendix F - Use of Force by SFPD District Station (96A)

(adapted from SFPD Quarterly 96A Reports)

District Station	Q1-2018	Q4-2017	Q32017	Q2-2017	Q1-2017	Q4-2016	Q3-2016	Q2-2016
Central	50	62	-62	94	72	113	73	104
Southern	143	84	74	84	108	167	121	89
Bayview	146	112	91	191	119	103	223	136
Mission	145	110	139	161	167	131	123	173
Northern	90	41	57	22	55	80	103	89
Park	28	3	25	35	28	12	14	27
Richmond	29	27	28	45	29	36	24	41
Ingleside	58	111	59	82	35	106	78	124
Taraval	49	18	23	40	44	94	26	14
Tenderloin	62	43	47	111	127	70	101	96
Airport	4	3	7	4	6	8	8	7
Outside SF	7	19	10	4	12	33	22	26
Totals	811	633	622	873	802	953	916	926

Sources:

[2018 Admin Code 96A Reports](#)

[2017 Admin Code 96A Reports](#)

Appendix G - SFPD Department General Order 5.21

The Crisis Intervention Team (CIT) Response To Person In Crisis Calls For Service

The San Francisco Police Department's highest priority is safeguarding the life, dignity and liberty of all persons. Officers shall demonstrate this commitment in their daily interactions with the community they are sworn to protect and serve. The Department is committed to accomplishing this mission by using rapport-building communication, crisis intervention, and de-escalation principles, whenever feasible, before resorting to force.

The Department is dedicated to providing the highest level of service to all communities, including individuals diagnosed with mental illnesses or other disabilities, as well as those suffering from the adverse consequences of substance abuse and personal behavioral crisis.

The Department has adopted the Crisis Intervention Team (CIT) program to address persons in crisis incidents. CIT members shall use tactics consistent with CIT training to address persons in crisis incidents, with the safety of all of persons being considered.

This order establishes the Department's policy and procedures for the Crisis Intervention Team Response to Person in Crisis Calls for Service.

I. POLICY

It is the Department's policy to develop, implement and incorporate the CIT program within the district stations daily operations in a manner that prepares members to respond to persons in crisis incidents and, as a team, formulate a plan, establish rapport, and use de-escalation tactics (including tactical repositioning and creating time and distance), whenever possible. The goal of this order is to safely resolve person in crisis incidents without the use of force, whenever possible, and to refer persons in crisis to community mental health service providers or other resources, as appropriate.

II. TERMS AND DEFINITIONS

A CIT Mental Health Working Group: A group consisting of mental health service providers, advocates, community members, consumers of mental health services, their families, and representatives from City departments and agencies who work in partnership with and provide advice to the Police Department, through the CIT Coordinator, on crisis intervention training and policies.

B. Person in Crisis: A person who is experiencing mental and/or emotional distress, including people suffering from the adverse effects of substance abuse, who is in need of assistance and/or poses a danger to the community or themselves.

C. Crisis Intervention Training: 40 Hour California Peace Officer Standards & Training (POST) certified course of instruction which includes, but is not limited to, crisis de-escalation, signs and symptoms of mental illnesses and substance abuse, and recognizing persons in behavioral crisis.

D. CIT Coordinator: A sworn member, designated by the Chief of Police, to oversee the CIT program and CIT administrator.

E. CIT Administrator: A sworn member assigned to complete the administrative tasks of the CIT program, such as, scheduling training, data collection, program evaluations, officer applications, reports and webpage development.

F. CIT Liaison Officers: District Station Captains shall designate, at a minimum, a sergeant and an officer to serve as the CIT Liaison Officers who will network with the CIT Administrator and Coordinator. The CIT Liaison Officers shall provide CIT roll-call training, provide members information on CIT resources, participate in debriefings on CIT-related incidents, and attend other meetings as indicated by the CIT Coordinator.

G CIT Member: CIT POST certified officer who responds to person in crisis incidents as a contact officer, lethal, less-lethal or resource officer in an effort to resolve the incident.

H. Crisis Intervention Team: CIT team members are officers who respond to a person in crisis incident utilizing CIT team concepts in an effort to resolve the incident. All members who attend the POST 40 hour Crisis Intervention Training and the 10 hour CIT Field Tactics training will be designated as a Crisis Intervention Team member and may be assigned to CIT team responsibilities outlined in this order.

I. Contact Officer: The CIT trained officer who contacts a person in crisis (utilizing the T.A.C.T. approach: Tone, Atmosphere, Communication, and Time) to establish rapport with that individual in an effort to resolve crisis incidents and refer the individual to services, as appropriate.

J. Lethal Cover Officer: An Officer designated to protect the Contact and Less-Lethal Cover Officer and to have ready to deploy, if necessary, lethal force options.

K. Less-Lethal Cover Officer: An officer designated to have ready and deploy, if necessary, the Extended Range Impact Weapon or other less-lethal force options.

L. Resource Officer: Officer assigned to brief the supervisor and other arriving units at the scene. As directed by a sergeant or superior officer, the Resource Officer will coordinate traffic control, crowd control, etc. and request additional resources, (i.e., Hostage/Crisis Negotiations Team, Tactical Units, additional officers).

III. PROCEDURES

A. The Department of Emergency Management (DEM) will identify calls for service that involve a person in crisis and will request a CIT member respond to such calls for service.

B. Response:

1. CIT officers are expected to perform their regularly assigned duties and respond to person in crisis related calls as soon as practical. CIT members shall, if feasible, respond immediately to CIT calls for service and assume the roles of Contact Officer, Lethal Cover Officer, Less-Lethal Cover Officer, or Resource Officer.
2. When non-CIT officers are dispatched to or on-view a person in crisis incident, the non-CIT officer shall request a CIT officer, as soon as possible. If no CIT member is available in the district of the occurrence, officers shall have the DEM dispatcher broadcast a city-wide request for CIT members. Under no circumstance will the absence of a CIT member delay the assignment or response to a call regarding a person in crisis.

C. Engagement: CIT officer shall, when practical, utilize tactics consistent with CIT training, such as, the T.A.C.T. approach: Tone, Atmosphere, Communication, and Time to address persons in crisis incidents with the safety of all of persons being considered.

D. Detention/Transport: When detaining an individual for a psychiatric evaluation and no criminal charges are pending, officers shall, when feasible, explain to the person in crisis they are not under arrest, but only being transported to a medical or mental health facility for evaluation. Officer should also explain that it is necessary to search and temporarily handcuff them for their safety while being transported to the facility.

E. Referral: Individuals who are in mental health distress but do not meet the criteria for a 5150 W&I detention should be referred to available mental health resources.

F. DEM: DEM will designate any call for service that involves a person in crisis with the added “CR” Computer Assisted Dispatch (CAD) designation to identify Crisis Intervention Team Response calls for service.

G. CAD Disposition: Members shall use the most appropriate CAD disposition code whenever they clear a dispatched or on-view call for service involving a person in crisis. When a member determines an incident involves a person in crisis, the officer should notify dispatch so that CAD can be updated to reflect the “CR” designation in the call for service (i.e., 219CR, 245CR, 217CR, 800CR).

H. Supervisory Response: Supervisors shall immediately respond to any person in crisis incident involving a weapon and assume command. The supervisor should consider, where appropriate, developing arrest, crowd control and traffic control teams and evaluate the need for additional resources, such as, H/CNT, Tactical Company, additional officers. Supervisors should consider and evaluate the need to contact and consult with the person’s mental health professionals, family members or other individuals, if this may assist in resolving the incident.

I. Documentation: At the direction of a supervisor, the following documentation shall be completed:

- a. Incident Report: The initial unit at the scene is responsible for completing the incident report, if required, or another officer may do so at the direction of a supervisor.
- b. CIT Database: The initial unit assigned to the call for service, or any member designated by a supervisor, shall enter the required incident information into the CIT database through the Department smartphone, MDT, or desktop computer.

IV. CIT ADMINISTRATION

A. The Chief of Police shall designate a member of the Department, at the rank of lieutenant, to serve as the CIT coordinator. The CIT coordinator’s responsibilities include but are not limited to:

1. Implement and evaluate the CIT program.
2. Develop and/or coordinate CIT (introductory, advanced, and in-service) related training.
3. Supervise the CIT administrator.
4. Collaborate with and provide the District Station CIT Liaison Officers with CIT roll call training, information on emerging issues, and provide briefings on recent CIT related incidents.
5. Attend CIT Mental Health Working Group meetings and maintain partnerships with mental health providers, mental health consumers, and mental health advocates and engage in community outreach.

6. Collaborate with other agencies (DEM, DPH, etc.) to identify and recommend best practices for inter-agency responses to person in crisis calls.
7. Establish CIT screening criteria.
8. Coordinate, review and analyze CIT data.
9. Coordinate/Update the CIT website.
10. Provide reports and recommendations, in consultation with the Mental Health Working Group, to the Chief of Police, the Command Staff, and the Police Commission on the Department's response to person in crisis incidents on a quarterly basis.
11. The CIT coordinator will meet with stakeholders, subject matter experts and the CIT Mental Health Working Group to identify best practices for interacting with persons in crisis incidents and make recommendations to the Chief and the Command Staff.
12. The Department shall make reasonable efforts to ensure a minimum of 20-25% of the Patrol Divisions are CIT trained.

B. A CIT Administrator shall be assigned to assist the CIT Coordinator with the administrative tasks of the CIT program, such as, training and scheduling, data collection, webpage management, program evaluations, incident debriefings and report review and any other duties as designated by the CIT coordinator.

C. CIT trained members shall be identified in the Human Resource Management System (HRMS) special skills report under CIT.

D. CIT trained members will be identified by a CIT pin worn above their uniform nameplate.

E. A CIT awards ceremony will be held annually to recognize officers who demonstrate excellence in the use of CIT principles.

F. **CIT OFFICER SELECTION CRITERIA:** Officers must have completed Department probation and have a positive work history as reflected by supervisory recommendations, personnel records, complaint and lawsuit history and Department Accident Board of Review records.

V. CIT DATA COLLECTION AND REPORTING

The Department shall develop a data collection system to allow officer to input information on person in crisis incidents and allow for the review and analysis of CIT data.

A. The Department CIT Data collection program includes, but is not limited to, the type and location of person in crisis call for service (PIC calls), whether or not the responding officer(s) are CIT trained, the disposition of the call (arrest, 5150 detention, no police action, referral to services), if force was used, any injuries sustained (officer, detainee, other), presence of weapons on the part of individual, including type of weapon, complaints, commendations and/or legal action arising from the incident.

B. The CIT Coordinator shall develop and provide a yearly report to the Police Commission on the status of the CIT training program, analysis of data reviewed (including, but not limited to the data listed in section A above), and make any recommendations that enhance the Department response to person in crisis calls. This report shall be provided to the Office of Citizen Complaints two weeks prior to release, made public and posted on the CIT and Police Commission webpage.

VI. TRAINING

The Department will provide ongoing Peace Officer Standards & Training (POST) certified courses on Crisis Intervention or other similar training on crisis de-escalation, signs and symptoms of mental illnesses, recognizing persons in crisis, and team response concepts for all officers.

The CIT Coordinator will develop and assist the Training Division in facilitating the CIT training curriculum in the following courses: Introductory, Advanced, roll call, Advanced Officer/Continuing Professional Training and Field Training Officer (FTO) programs.

References:

Department General Order 5.01 (Use of Force)

Department General Order 6.14 (Psychological Evaluation of Adults)

Department General Order 7.02 (Psychological Evaluation of Juveniles)

Penal Code section 13515.26 (Identification of Areas Where Additional Training is needed to Effectively Address Incidents Involving Mentally Disabled Persons).

Penal Code section 13515.27 (Establishment of Classroom-based Continuing Course Relating to Interaction with Persons with Mental Illness, Intellectual Disability, and Substance Use Disorders).

Appendix H - A Viewpoint on Service-Oriented Public Safety

SFPD may consider reframing itself as a public safety service provider now that Crisis Intervention Training is a salient element of the police force. A perspective along these lines is for the Department to consider changing its name to the San Francisco Police Service. The current CIT program lacks a clear public image in the community. A departmental name change to emphasize service is a significant step toward putting crisis intervention and prevention at the heart of public safety enforcement in San Francisco. There is precedent for the inclusion of “Service” in the name of a major law enforcement agency, for example the Metropolitan Police Service in London, UK. London’s Metropolitan Police Service has a valuable contingent of [Police Community Support Officers](#) (PCSO) to emphasize this noble officer and service ethos. These unarmed officers are responsible for assisting officers with identifying community issues and building relationships. Service to the community using de-escalation and referrals to behavioral health services is central to the Crisis Intervention Team’s mission. This dovetails with [the PCSO Safer Neighborhood Teams’ focus on crime and anti-social behavior in the community](#). Based on the London example, a name change to the San Francisco Police Service makes this commitment visible to the community.

Appendix I - SFDPH / SFPD MOU

**SAN FRANCISCO POLICE
DEPARTMENT**



**SAN FRANCISCO DEPARTMENT
OF PUBLIC HEALTH**

INTERAGENCY MEMORANDUM OF UNDERSTANDING
SFDPH Behavioral Health Crisis Intervention Support for SFPD

A "crisis" for purposes of this MOU, is any situation in which a person's behaviors put them at risk of hurting themselves or others and/or when due to a grave mental health disability the person is not able to resolve the situation with the skills and resources available. As defined by California law, a mental health crisis is an incident when an individual due to a mental disorder, is a danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services.

The HIPAA Privacy Rule allows covered entities to disclose protected health information to law enforcement officials in order to prevent, or lessen, a serious and imminent threat to the health and/or safety of a person or the public. (45 CFR 164.512(j)(1)(i).)

Except when otherwise required by law, SPECIALISTS may only disclose the "minimum necessary" information in the context of the specific crisis incident to provide an appropriate assessment of, and related services to the individual (45 CFR 164.502(b), 164.514(d).)

Moreover, if the law enforcement official making the request for information is not known to the SPECIALIST, the SPECIALIST must verify the identity and authority of such person prior to disclosing the information (45 CFR 164.514(h).)

Following the resolution of the individual's crisis, SPECIALISTS will not be permitted to share protected health information with SFPD without a HIPAA-compliant authorization to do so.

V. ACTIVITIES UNDER THIS AGREEMENT

a. Crisis Response:

1. SFPD will notify the designated DPH Crisis Intervention Specialist Team Director when support is needed at an incident, describing the situation in as much detail as possible to allow the SPECIALIST to determine the minimally necessary protected health information that can be shared orally, to the extent the SPECIALIST may have such protected health information relevant to resolving the situation.
2. DPH SPECIALISTS will show official identification upon arriving at a scene and will check in with the Operational Commander on site.
3. DPH SPECIALISTS will function as mental health professionals in a police crisis situation to provide support to Operational and/or Tactical Commands, and will follow the instructions of the Operational Commander to preserve the SPECIALISTS' and the public safety.
4. DPH SPECIALISTS will provide crisis intervention support and/or debriefing to individuals affected by a crisis situation (e.g., individual, family, community members) to determine how best to meet individual needs both short and long term.
5. DPH SPECIALISTS will provide additional support, including case management and/or therapy services to support reduced contacts between the individual and SFPD and the need for crisis intervention services.
6. DPH SPECIALISTS will rotate on-call staff to ensure a response 24 hours a day, 7 days a week.

INTERAGENCY MEMORANDUM OF UNDERSTANDING
SFDPH Behavioral Health Crisis Intervention Support for SFPD

b. Planning and Strengthening System:

1. SFPD and DPH will work together to further develop and continue SFPD's Crisis Intervention Team (CIT) training efforts.
2. SFPD and DPH will work together to address program evaluation efforts, including gathering and evaluating data to document program's progress.
3. Leadership of the San Francisco Department of Public Health's Crisis Intervention Specialist Team, San Francisco Police Department and the San Francisco Mayor's Office will work together to continually improve this joint program.

VI. EVALUATION.

The DPH and SFPD will support data collection as allowed by confidentiality regulations to evaluate the magnitude of challenges facing first responders in crisis situations and to design a crisis intervention structure to work effectively in critical incidents where there is a behavioral health component. Evaluation data will include demographics of those served by the program, outcomes of negotiations and crisis assessments, and de-identified (as approved by the DPH Privacy Officer) DPH information covering frequency and type of services provided including short term case management services, linkage to long term care, and reduction in crisis contacts.

VII. TERMINATION.

This agreement can be mutually terminated in writing upon agreement between DPH and SFPD, but expires three years from the most recent signature date below.

The signatures below confirm agreement to the terms of this Memorandum by all parties concerned.

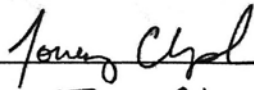
Signed

Signed



Barbara A. Garcia, MPA
Director of Health
San Francisco Department of Public Health

Date: 12/7/16



Print: Toney Chaplin
Chief Police Officer
San Francisco Police Department

Date: 12/27/16