

**Improving Crisis Response for Individuals with Mental Health Challenges:
West Side Community Outreach Pilot Project
Interim Report**

Background

Recognizing that police are all too often the first line of response to individuals who are experiencing a mental health crisis, law enforcement agencies across the country are examining ways to enhance mental health literacy among officers and establish inroads to local healthcare systems and providers in order to improve outcomes in mental health response. To this end, and to best help people in need, the Chicago Police Department (CPD) utilizes a specialty training program called Crisis Intervention Team (CIT). One element of the program is intensive training for select officers who volunteer to take on a specialist role in responding to individuals experiencing mental health crises. Currently, approximately 20% of officers have received this intensive 40-hour training, which gives them the tools to more safely and effectively intervene with a person undergoing a mental health crisis.

Unfortunately, however, CIT-trained officers are not always directed to emergencies where their skills are needed. For example, this can happen when 911 calls are not correctly identified as mental health-related. Often responders do not have the information necessary to connect a CIT officer to a MH crisis. Indeed, as part of its April 2016 report, the Police Accountability Task Force recommended a number of steps to increase proper identification of calls, including calling for a community education campaign to help key community members identify the signs of mental illness, request CIT-trained officers when speaking with 911 operators, and refer people to appropriate mental health services prior to a crisis.

To improve response for individuals experiencing mental health crises, The Kennedy Forum and partner organizations launched the West Side Outreach Pilot Project in January 2017. The pilot is a community-based initiative to provide free training to community members in the Austin, North Lawndale, and East/West Garfield Park communities (Police Districts 10, 11, and 15). These west side communities were selected because data provided by the City of Chicago and the Illinois Department of Public Health showed high rates of mental health-related incidents in the last five years. Outreach focused on school staff, faith leaders, and those who work in community based organizations (CBOs). These target groups were selected due to their position within the community as trusted messengers, their presumed higher likelihood of coming into contact with someone experiencing a mental health distress, and their ability to intervene before the situation becomes a crisis.

The pilot included two different types of training: Mental Health First Aid and Mental Health Awareness.¹ Mental Health First Aid Training was developed in Australia by Anthony Jorm.

¹ Mental Health First Aid is an eight-hour training that addresses signs and symptoms of a mental health issue and how to react to help someone in a time of crisis. Mental Health Awareness is a 2-2 ½ half hour training that focuses on identifying the signs and symptoms of a mental health issue and how to communicate with someone experiencing a crisis. Mental Health Awareness also offered specific trainings for some audiences. Bridges of Hope

Mental Health Awareness trainings were developed by local mental health providers. In addition to curricula focused on mental health and substance use, all instructors were trained by NAMI Chicago on how to access a CIT officer. This allowed all trainers to teach their curricula about mental health and substance use as well as CIT awareness.

The goal of this pilot was to train 200 members of CBOs, 100 members of the faith community, and 100 staff of schools (for a total of 400 community stakeholders) over an eight month period to:

1. Increase mental health literacy (knowledge of signs and symptoms of mental illness).
2. Reduce stigmatizing attitudes/beliefs about mental illness.
3. Increase requests for CIT trained officers in crisis situations.
4. Increase referrals to professional mental health services.

To help evaluate the pilot's effectiveness, the University of Illinois Chicago's (UIC) Jane Addams College of Social Work surveyed training participants to assess their level of knowledge before and after the trainings. The evaluation received Institutional Review Board approval to protect those participating in the research. All training participants reserved the right to decline participation in the evaluation. Initial data and findings from the pilot are summarized in the results section below.

This pilot was coordinated with work of the Citywide Mental Health Crisis Response Steering Committee,² which Mayor Rahm Emanuel created in January 2016. The Steering Committee was formed to improve how emergency responders respond to incidents involving an individual facing a mental health crisis and better connect people in crisis to appropriate care.

Number of Persons Trained

The pilot exceeded its target goal of training 400 community stakeholders. In total, over 500 stakeholders received mental health training, CIT awareness training, and information on where to receive help in the community. The goals for each stakeholder group were also surpassed, with nearly 300 members of CBOs and over 100 people from schools and faith communities trained (see Figure 1).

was offered to those in the faith community. Trauma and the Impact on Youth is another that was offered to audiences who work with youth population.

² Participants include Mayor Rahm Emanuel's Office, Chicago Police Department, Office of Emergency Management and Communications, Chicago Fire Department, Chicago Department of Public Health, The Kennedy Forum, NAMI-Chicago, Thresholds, The University of Illinois at Chicago, Presence Health, Sinai Health System.

Figure 1



Structure of UIC Evaluation

UIC's Jane Addams College of Social Work is conducting pre- and post-training surveys at the time of the training, as well as follow-up surveys at three and six-month intervals once the training was complete. The following data was captured from participants:

- Age
- Race/ethnicity
- Whether they lived or worked in the west side communities
- Whether they or a family member had experienced a mental health problem

In pre- and post-training surveys, participants were asked questions that assessed mental illness stigma, knowledge of CIT, comfort in requesting a CIT officer, expectation that a CIT officer will be dispatched, and confidence that a CIT officer response will result in a better outcome.

UIC separately evaluated two types of training: Mental Health/CIT Awareness trainings and Mental Health First Aid with CIT Awareness trainings. Mental Health/CIT Awareness training participants were asked whether they had referred at least one person to mental health services in the three months prior to training or whether they had wanted to refer someone but did not know how or where to refer the person. Participants in Mental Health First Aid trainings were also asked questions that measured participants' mental health knowledge, perceived difficulty in taking mental health actions to assist someone, and self-confidence in taking those actions.

Interim Results

In June, UIC provided a report of interim results that evaluated 17 separate trainings: nine mental health awareness trainings and eight mental health first aid trainings.

Characteristics of Participants

In the nine mental health awareness trainings through early June, a total of 174 people participated in the evaluation of the trainings, though not all participants answered every survey question. Over two-thirds (68%) of respondents identified as African-American, 22% as white, 12% as Hispanic/Latino, and 9% as Asian, and about 1% each as Native Hawaiian/Pacific Islander and American Indian/Alaska Native. Ages ranged from 20 to 79 years old, with an average of about 50 years old. Eighty-percent identified as female and 20% as male.

Two-thirds (66%) worked on the west side and 32% lived on the west side, with 71% living and/or working on the west side. One-third (33%) indicated they had personally experienced a mental health problem, while nearly two-thirds (64%) said a family member had experienced a mental health problem.

Nearly one-third (32%) reported having referred one or more people to mental health services in the past month, while one-quarter (25%) reported that, in the prior three months, they had wanted to refer someone but did not know how or where to refer the person.

Characteristics of participants in the eighth Mental Health First Aid with CIT Awareness trainings were somewhat different. A total of 122 people participated in the evaluation through the beginning of June.

Just under half (46%) of respondents identified as African-American, 40% as white, 25% as Hispanic/Latino, 4% as Asian, 2% each as Native Hawaiian/Pacific Islander, Middle Eastern, and American Indian/Alaska Native. Ages ranged from 17 to 67 years old, with an average of about 38 years old. Sixty-one percent identified as female, 37% as male, and 2% genderqueer.

Seventy-one percent worked on the west side and 30% worked on the west side, with 77% living and/or working on the west side. Forty-percent reported they had personally experienced a mental health problem, while 73% reported a family member had experienced a mental health problem.

Pre- and Post-Survey Changes

Participants were assessed for stigmatizing attitudes relating to mental illness both before and after trainings. The rating scale goes from 1 to 9, with higher values indicating more negative or stigmatizing attitudes. Prior to both the Mental Health/CIT Awareness Trainings (MH/CIT Awareness) and the Mental Health First Aid with CIT Awareness (MHFA), participants had relatively low stigma scores -- 3.56 and 3.02, respectively. However, after the trainings, these scores decreased to a statistically significant degree, by 0.35 of a point and 0.21 of a point, respectively (see Figure 2).

Participants were also asked five true or false questions about CIT both before and after training. While the average number of questions answered correctly increased for both training groups (0.47 increase for MH/CIT Awareness and 0.20 for MHFA), only the increase for MH/CIT Awareness was statistically significant.

The comfort of participants in requesting a CIT officer also changed before and after the training. Using a scale from 0 - 5, comfort of MH/CIT Awareness training participants increased nearly a full point (0.92), while MHFA participants' comfort increased 0.50 of a point, both statistically significant (see Figure 3).

Participants' expectation that a CIT officer will be dispatched also increased in both training groups. Using a scale from 0 - 5, MH/CIT Awareness participants' expectation increased 0.75 of a point. MHFA participants' expectation increased 0.68 of a point. Both were statistically significant.

The survey also measured whether participants believed that a CIT officer will improve outcomes. After training, MH/CIT Awareness participants' belief that a CIT officer would improve outcomes increased by 0.69 of a point, which was statistically significant. The same belief increased only 0.19 of a point for the MHFA group, which was not statistically significant (Figure 4).

Finally, participants in the MHFA trainings were asked about perceived difficulty in taking mental health actions to assist someone, self confidence in taking those actions, and mental health knowledge. Using a scale from 0 - 5, participants' perception of difficulty score decreased significantly (meaning less difficulty) from 2.05 to 1.5. Meanwhile, self confidence in performing this actions increased significantly too, from 3.84 to 4.28. Scores on the mental health knowledge test also increased significantly after the training. Out of a possible score of 15 correct responses, the average score increased from 10.38 to 11.88.

Figure 2

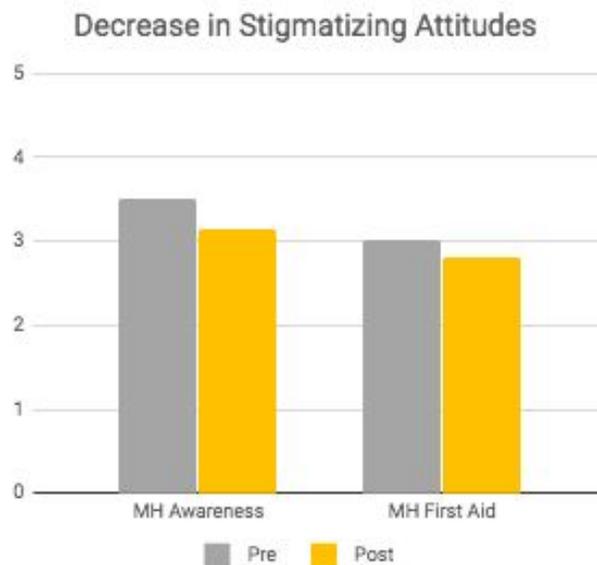


Figure 3

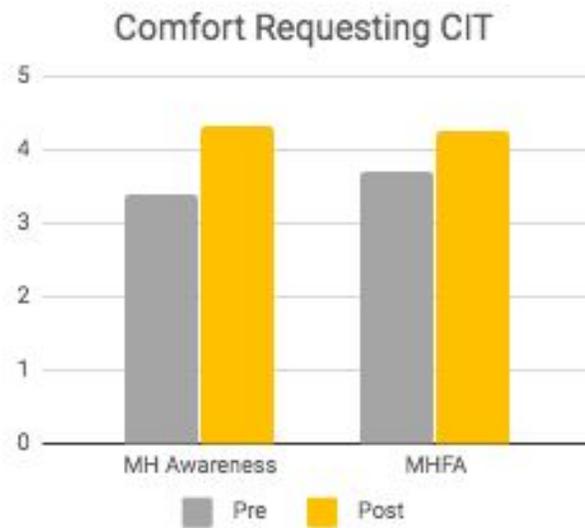
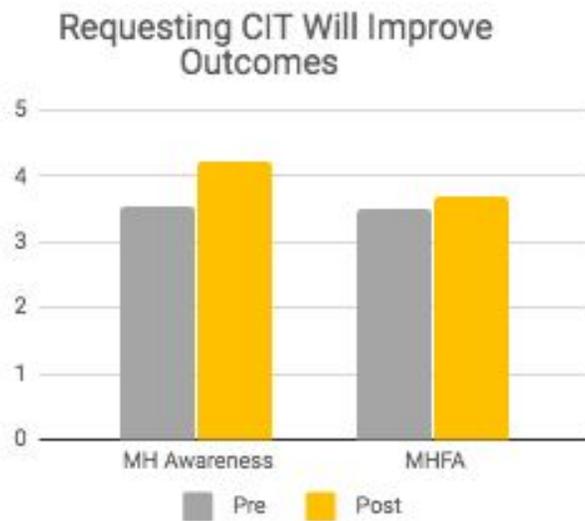


Figure 4



Next Steps

Researchers will further collect and analyze data and invite participants to complete online follow-up surveys. At the end of the study period, researchers will request Office of Emergency Management & Communications (OEMC) data to examine whether there was any changes in the identification of CIT related calls for service in the study target community. Additionally, researchers will have an opportunity to use data provided by respondents to measure referrals to mental health resources in the community.

Following the continued collection and analysis of participant surveys and data from OEMC, we will release a final report in the first quarter of 2018 with a detailed look at survey results,

pilot challenges and successes, and identify next steps to further improve mental health crisis response across Chicago.

Conclusion & Recommendations

The preliminary results of this pilot project shows that connecting and informing individuals within a community decreases stigma associated with mental health and addiction, increases knowledge and comfort in contacting a CIT trained police officer, and confidence that requesting a CIT officer will result in better outcomes in case of a mental health or addiction crisis.

The following are steps the West Side Outreach Pilot Project members recommend and will continue to plan, based on preliminary results.

Continue to train stakeholders on Chicago's west side. Various curricula exist that could help to continue the work already started on the west side. The community partners recommend a “train-the-trainer” pilot that will increase the ability of stakeholders to improve mental health for the community by decreasing stigma and increasing knowledge. The goal is to recruit individuals who previously participated in Mental Health First Aid or Mental Health Awareness training to participate in a “train the trainer” class in order to learn the skills necessary to train others in their community about mental health, CIT, and how to access resources in their community.

Implement the pilot project in other communities across Chicago. The work completed over the past 20 months has offered valuable insight, including a clear process to implement this pilot project across other communities that will deliver results similar to the West Side Outreach Pilot Project. We recommend the expansion of this pilot in communities across Chicago, prioritizing those with the greatest need and where infrastructure and capacity already exists.

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