A Focus Group Report:

A Conversation with CIT Trained School Resource Officers

NAMI
National Alliance on Mental Illness

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The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has over 1,000 affiliates in communities across the country who engage in advocacy, research, support, and education. Members of NAMI are families, friends and people living with mental illness such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD) and borderline personality disorder.

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Acknowledgments

NAMI deeply appreciates the support of the Lincy Foundation for this project. We acknowledge that the information, opinions and commentary in this guide are those of NAMI and do not necessarily reflect those of the Lincy Foundation.

NAMI would like to thank the focus group participants for the valuable and important information they shared. NAMI would also like to thank Lt. David Anders of the Lake Charles Police Department for organizing the focus group. Lt. Anders has shown incredible dedication to CIT and is a tireless advocate for stronger and more effective collaborations between law enforcement, families, schools and the mental health community.

Introduction

NAMI's Child and Adolescent Action Center and Crisis Intervention Team (CIT) Technical Assistance Center have combined forces to work on a national initiative to promote programs adapted from the adult CIT model that are designed to respond to youth in psychiatric crisis in both school and community settings.

Far too many youth with mental illness are landing in the juvenile justice system. Research shows that 70 percent of youth in the juvenile justice system have one or more psychiatric disorders. At least 20 percent of these youth have a serious mental illness, including those who are suicidal, struggling with psychotic disorders, and experiencing symptoms that significantly interfere with their day-to-day functioning.

The Crisis Intervention Team (CIT) model is designed to address the influx of adults with mental illness in the criminal justice system by creating collaborations between law enforcement, mental health service providers and families. Law enforcement officers receive specialized training and respond when individuals with mental illness are experiencing a psychiatric crisis, diverting them to appropriate mental health services and supports rather than to the criminal justice system.

Building on the success of the adult CIT model, NAMI collected detailed information from existing CIT programs that focused on the needs of children and youth and identified the overarching components necessary for an effective CIT for Youth program. This information was compiled into a report entitled *Supporting Schools and Communities in Breaking the Prison Pipeline: A Guide to Emerging and Promising Crisis Intervention Programs for Youth* (available at www.nami.org/cit).

NAMI is currently working with strong NAMI state leaders, CIT leaders and law enforcement agencies and other key stakeholders in Illinois, Louisiana and Utah to develop, implement and

sustain CIT for Youth. These states were strategically chosen because they have strong NAMI state organizations, have demonstrated positive experiences with adult CIT programs, have established strong community partnerships between law enforcement, mental health systems and schools and are geographically diverse.

NAMI has worked extensively with school professionals and community law enforcement and understands the pressing issues that these systems face in addressing the needs of youth with serious mental health treatment needs. NAMI has engaged Major Sam Cochran, a national expert who has received numerous awards for his leadership in CIT programs, to provide leadership, coalition-building assistance and consultation to community leaders working to bring CIT for Youth programs to their communities.

On Nov. 11, 2009, NAMI held a focus group in Lake Charles, La. with approximately 30 school resource officers (SROs), SRO supervisors and related personnel. Focus group participants consisted of SROs assigned to elementary schools (7 SROs), middle schools (15 SROs), high schools (13 SROs) and college campuses (1 SRO). Several of the SROs work in multiple school levels (elementary, middle and high schools).

The SRO participants who attended the focus group work in schools in several communities in Southwest Louisiana including Lake Charles, Calcasieu and St. Martin Parishes.

The focus group team from NAMI consisted of Major Sam Cochran, the founder of the CIT program in Memphis, Tenn., a nationally recognized expert and leader in CIT and a consultant on this project, Ron Honberg, director of NAMI's Policy and Legal Affairs and Darcy Gruttadaro, director of NAMI's Child and Adolescent Action Center.

CIT Training for SROs in Lake Charles

In June 2008, the Lake Charles Police Department (LCPD) offered Crisis Intervention Team (CIT) training. The training included a limited focus on children and adolescents and was offered to SROs working in nearby schools.

Lt. Anders, LCPD CIT coordinator, shared the curriculum for that training with the focus group team. Please see the Appendix at the back of this report for a complete listing of the topics covered during the training and the amount of time dedicated to each topic.

The LCPD partnered with McNeese State University in developing and delivering the CIT training in June 2008. The LCPD's other partners include Lake Charles Memorial Hospital, the State of Louisiana—Region V Office of Mental Health, NAMI Southwest Louisiana and the Calcasieu Parish Sheriff's Office.

NAMI chose the LCPD for the focus group because of the strong CIT leadership in Southwest Louisiana. Also, NAMI recognized the value of talking with SROs who had been trained in a CIT curriculum that included a focus on youth and who had been working in area schools for more than one (1) year following the training.

Before the focus group, Lt. Anders, with the LCPD, reviewed the proposed focus group questions developed by NAMI and arranged the logistics for the focus group. As part of the focus group discussion, NAMI asked the SROs to comment on the training they had received and to share their thoughts on areas in which additional and more intensified training would be helpful as they addressed the needs of students with serious mental health treatment needs.

This report summarizes the focus group responses from the SROs and the comments and ideas that the SROs shared. The report also includes recommendations on topics that should

be covered in CIT for Youth training and changes that should be made in schools and other child-serving systems to improve the school environment for SROs, school staff and all students, especially those living with mental illness.

Questions and Responses

The following are the focus group questions NAMI developed and the responses shared by SROs and summarized by NAMI:

1. **What are the most common circumstances that you encounter as school resource officers (SROs) when it comes to students who may have mental health conditions or emerging mental disorders?**

Responses:

- Youth suicide and attempted suicide. This is especially true with middle and high school students.
- Cutting and self-injurious behavior are a major concern.
- A number of SROs expressed concern that teachers seem to know the students who are struggling with mental health challenges and diagnosed mental illness but SROs are frequently not informed about a student's mental health until after they experience a challenging encounter with that student. This is particularly a problem with new students who transfer into a school because paperwork frequently lags three to four weeks behind the actual transfer. There was a general sentiment that SROs should be informed about the unique needs of students before a crisis occurs so that they can respond more effectively to these students.
- There is a lack of mental health services in the community to refer students to.
- There are no psychiatrists to refer students to and families often lack transportation to get their child to services so when students are referred to mental health professionals they often cannot make the visits.
- There is a lack of case managers to work with families despite many families experiencing mental health crises with their children. SROs often feel like they cannot get students the mental health help they need.
- SROs are being called on to address family crises.
- SROs shared that the Family In Need of Services (FINS) Court process is used in more serious cases to get mental health services for students and their families. The FINS Court process is often used by child-serving systems to ask the court and a judge to order services and supports for families in need.
- SROs shared that Calcasieu Parish has a pilot program with an outside mental health counseling agency working in a middle school. Mental health professionals from this agency work with students up to eight (8) hours each day. They spoke very highly of this program, indicating that the program is extremely effective, however time limited, and they did not anticipate that it would be continued after the pilot period ends.

2. **What resources, training and/or support would help make your job easier in addressing the needs of students with mental health treatment needs?**

Responses:

- SROs would like licensed mental health counselors to provide mental health services in the schools.
- They believe that school counselors are often not adequately trained to meet the mental health needs of students. They focus almost entirely on standardized testing and testing for special education services and are overwhelmed with these responsibilities. They are also not effective in delivering the clinical mental health services that students need when they have existing or emerging

mental illness.

- SROs commented that families need help with their children at home. Working just with the students is not effective because families need support and help in better understanding how to address and manage their child's challenging behaviors at home. This would likely lead to better behavior in school.
- SROs believe that the FINS system is overburdened and those working with families are not following up on referrals to make sure that children and their families are connecting with mental health services and supports.
- They indicated that by the time a student's case gets to the FINs process, the child and family are in a serious crisis. The benefit of the FINs process is that the entire family, rather than just the student, receives services and supports.

3. What are ideal services and interventions you would like to have available when you encounter a student experiencing a psychiatric crisis?

Responses:

- Suicide prevention programs and crisis intervention services because they encounter 30 to 40 suicide attempts per year. In a typical scenario, when a school counselor learns that a student is suicidal, he or she calls in the SRO since the SRO has had suicide prevention training and then the SRO talks with the student. The SRO contacts the parents and then the student is transported to the hospital. Hospitals will only take students who are suicidal.
- Lake Charles and the surrounding area use Child and Adolescent Response Teams (CART) for crises. CART services are often not adequate for the needs of students.
- SROs see many cases of students self-injuring and cutting so effective services and supports should be made available to students who are self-injuring and cutting. These interventions should address the distress that most likely leads to a student's cutting. SROs often encounter two kinds of students: those with superficial cutting who need help and those who are serious about suicide.
- It is not difficult to know which students need help because these students often show signs of distress, their heads are down and/or their behavior has changed. When SROs see students in distress, they get the school counselor involved.
- School nurses can be helpful in cases involving students in distress.
- Ideally child protective services (CPS) could offer services to families who need support. However, CPS is often overwhelmed with their existing case loads so they are not in a position to help.
- SROs need effective strategies for working with families who do not seem to want help. They often find that families do not seem to want help even when it is clear that their child needs it.
- More effective training should be developed for special education teachers so that they better understand the needs of students with existing or emerging mental illness. They are not doing an effective job in addressing the needs of many students with mental illness.
- Students in special education understand how to manipulate the rules because they know that they are often protected from receiving the same punishment as students in general education.
- There was a strong consensus that an ideal school would include an academic counselor to help improve test scores and school performance and a mental health counselor to focus on improving behavior and skills development.
- When it comes to the most difficult stu-

dents, many school personnel want the SROs to address the challenging behaviors rather than address these behaviors on their own.

- SROs would like to be included at some students' IEP meetings so that they can suggest services and supports that might help these students.
- More timely and effective assistance from child protective services and other community agencies. SROs feel hamstrung in being able to respond because of a lack of service and support options to help students and their families.

4. Was the CIT training you received helpful in addressing the needs of students with mental health conditions or emerging mental illness? If so, why and if not, why not?

Responses:

- The Lake Charles CIT training did not include a significant enough focus on children and adolescents. The training only included one hour on children and adolescents and should include much more.

5. What are the most important topics that were covered in the CIT training that you received? Are there any topics that need expanding? Are there topics that should be shortened or not covered?

(**Note:** In responding to this question, focus group participants focused primarily on the most important topics that should be covered in CIT training and not the other parts of the question.)

Responses:

- Youth suicide.
- Youth alcohol and drug use and prevention.
- Cutting and self-injurious behavior—effective methods for addressing this in students.
- Mental illness in children and adolescents—what does it look like and how does it differ in children and adolescents as compared with adults?
- Effective de-escalation techniques for children and adolescents.
- Family dynamics and how to work effectively with families who may not be interested in mental health services and supports or may require effective supports to address their child's needs.
- How to work with or talk with teachers who may be provoking students who are struggling with mental health and behavioral challenges. The SROs provided examples of cases in which they witnessed teachers provoking students struggling with mental health concerns, making the circumstances more difficult for the student.

Focus group participants also shared the following comments related to CIT for Youth training:

- Role playing should include a youth focus and should be specific to the school environment.
- School counselors and principals/assistant principals should be included in CIT for Youth training so that they better understand mental illness.
- School staff and teachers should be invited to participate in CIT for Youth training in order to learn effective de-escalation strategies and how to avoid power struggles with

students, especially those experiencing mental health challenges. There should be a module in the CIT training that is specifically designed for general education and special education teachers and school counselors, along with SROs.

6. How long do you think a CIT for Youth training should be?

Responses:

- CIT for Youth training should either be part of the larger 40-hour CIT training, or developed as an in-service module that is provided to officers who have already received the standard 40-hour CIT training. In either case, the training should be a minimum of 8 hours and ideally 16 hours.

7. What behaviors in students make you first aware that a student may have a mental health condition that needs attention and what impacts your awareness of mental health conditions in students?

Responses:

- Sudden change in attitude, mood or behavior—a student who was often previously happy and smiling is now asking other students "what are you looking at?"
- Student is suicidal or cutting.
- Violent behavior—student is suddenly getting into fights.
- Student is banging his or her head on the wall.
- Student is suddenly isolated and alone. It is not hard to differentiate the students struggling with mental health issues versus those who are "bad" or acting out.
- SROs expressed frustration that they do not know more about the students they work with. They indicated that schools are cloaked in confidentiality restrictions out of concern for liability. This leads to a communication breakdown that harms rather than helps students who are struggling with mental illness.
- SROs commented that it would be extremely

helpful if schools and law enforcement agencies could work out an information sharing process so that everyone understands the challenges that students are facing and the support that is most needed to help students succeed behaviorally and academically in school.

8. What do you do when you are aware that mental illness may be a factor in a student's behavior and what has been your experience in attempting to connect students with mental health services?

Responses:

- SROs commented that there is a breakdown in the link between schools and the community mental health systems.
- There is a real lack of mental health services, especially in the more rural parts of the region. There is also a lack of transportation for students who require services.
- SROs commented that students who do not get appropriate services by age 16 or 17 often ultimately drop-out of school. They shared that many of these students will become seriously entangled with the criminal justice system and become "lifers."
- With students who are extremely violent and have mental health conditions, it is very difficult to find appropriate placements and services for these students. An SRO cited the example of a student with autism who is quite violent. Some teachers want to leave the profession because of student violence.

9. Is your school proactive in teaching school personnel about mental illness or how to effectively address mental health related concerns?

Responses:

- Stigma remains a major barrier. Most families will not ask for help for their children.
- Most schools will not acknowledge that their failure to better address mental health concerns in students is a concern because it makes them look bad.
- Schools do not teach students or personnel about mental illness. They ignore that it is a problem.
- SROs introduced suicide prevention week in St. Martin's Parish.
- Schools should make mental illness awareness a priority.
- A seminar on mental illness should be provided in schools for SROs and all school personnel. It was noted that teachers are not always committed to participating in these programs. For example, teachers were invited to participate in CIT training in Calcasieu Parish but most did not stay.
- It is important to reach out to the faith-based community, especially in training pastors and other religious leaders on mental illness, raising awareness about mental illness with families and working to eliminate stigma related to mental illness. Ideally there would be a CIT like training for religious leaders.

10. Is mental illness a priority in your school?

Responses:

- The unanimous response was "NO."
- Alternative schools have become the dumping ground for students with mental illness and teachers there are not well trained on how to address the needs of students with mental illness.
- Alternative schools should have a psychiatrist on staff or should contract with a psychiatrist to work with students with the most serious mental health needs.
- Schools should be far more proactive in addressing the needs of students with mental illness. This is especially true for alternative schools where about 90% of the students have serious mental health conditions.

11. What other topics are important for CIT for Youth training and addressing the needs of students with mental illness?

Responses:

- Financing care is a major issue when it comes to mental health services and supports. Families do not have the money to seek services and if there is a co-payment, they will go without the mental health services that their child and family need.
- Suicide prevention needs to receive more attention.
- Programs should focus on debunking persistent myths about mental illness.
- There is not enough case management to help families struggling with their children.
- Schools are very individualized and the top administrator or principal sets the culture and tone for the school. If mental health is going to be a priority, it must start at the top.
- SROs stressed the importance of involving the faith-based community in awareness raising, stigma busting, outreach to families and more.

Focus Group Participant Recommendations

The SROs who participated in the focus group provided extremely valuable information about the topics that should be covered in CIT for Youth training. They recommended two options for including more focus on youth issues within the CIT training.

The first option would be to spend 8 to 16 hours on youth issues within an existing, standard 40-hour CIT training. This would require communities to restructure their CIT training to add more of a youth focus.

The second option would be to develop an 8 to 16-hour in-service training that is an add-on to the 40-hour CIT training and would be provided to SROs and law enforcement officers who have already received the standard 40-hour CIT training.

This in-service training could be done as annual updates or as a refresher course every year. This would likely work well for SROs during the summer months when it would not conflict with their school duties.

Based on the SRO focus group responses, NAMI recommends that the issues identified in the following tables should be addressed in CIT for Youth training. The following topics would be above and beyond those typically covered in the standard 40-hour CIT training.

Topics to Include in CIT Training

- Youth suicide and effective crisis interventions to use with youth who are suicidal.
- Youth alcohol and drug use and prevention.
- Cutting and self-injurious behaviors.
- Mental illness in children and adolescents and how it compares with and is different from mental illness in adults. This should include signs, symptoms, typical age of onset, effective treatment and related issues for the various disorders.
- Effective de-escalation techniques for children and adolescents.
- Family dynamics and strategies for effectively working with families who do not want help, even when their child clearly needs it.
- Role playing with a youth focus and in a school setting.

NAMI Recommendations for CIT

- NAMI recommends that CIT for Youth training be implemented broadly around the country either as part of an existing, standard 40-hour CIT training or as a stand-alone training program. Communities should assess their level of training needs and resources to determine what is most appropriate. Currently, there are three approaches that might be considered:
  1. Include a stand-alone training module for law enforcement officers and SROs who have already received the 40-hour CIT training. The training module on youth would be offered as a refresher course or as an in-service training and should be a minimum of 16 hours;
  2. Include a youth focus within the existing 40-hour CIT training program, incorporating a youth focus in as many of the existing modules as possible (*e.g.*, mental health diagnoses and treatment, crisis de-escalation techniques, role plays, etc.).
  3. Include a 40-hour CIT for Youth training program for law enforcement officers and SROs who have already received the standard 40-hour CIT training. For example, the Chicago Police Department has developed a 40-hour CIT for Youth training program for those who have already had the standard 40-hour CIT training. This is a strong approach, however, we recognize that some communities may not have the resources or the capacity to commit to a separate 40-hour training on youth on top of the standard CIT training.
- Include the topics identified by SROs in response to focus group question five, along with other youth-focused topics.

- Those implementing CIT training with the youth module should consider inviting school personnel (general and special education teachers, school mental health staff, administrators and others), leaders in the faith-based community and others who impact the lives of youth with mental health needs to participate in the youth module portion of the training.

- Those organizing CIT training should also consider including school counselors, school administrators and other school staff in the modules that would help school staff better understand mental illness in children and adolescents. This also promises to help school staff better understand the need to avoid provoking students and engaging in power struggles.

The SRO participants also raised several other important issues that NAMI has heard from a variety of stakeholders over a number of years.

Based on SRO focus group responses and feedback, NAMI has received from families and other stakeholders around the country, NAMI firmly believes that the time is long overdue to address the issues listed on the next page in schools and communities.

These issues must be addressed if we are to see improvements in the academic and behavioral functioning of students with mental health treatment needs.

The focus group provided NAMI with the opportunity to spend time with a group of SROs who work every day with students with emerging and existing mental illness at the elementary, middle and high school levels. NAMI greatly appreciates the time that these SROs spent with us and their candor in sharing their experiences in working in a variety of schools in Southwest Louisiana.

The information provided by focus group participants was extremely valuable and will be used by NAMI to advocate for positive change in our nation's schools, in communities and on behalf of children and adolescents with mental illness and their families.

Recommendations for Schools

- Increase and improve in-school mental health services and supports for students with mental health treatment needs.

- Consider contracting with mental health providers to provide effective in-school clinical services for students with serious needs.

- Increase the services and supports available to children with serious mental health treatment needs and their families. It is not enough to provide services and supports just to students. Families need effective strategies to help them manage their child's challenging behaviors in their homes, which promises to improve behavior in-school and in other settings.

- Provide more effective training for special education and general education teachers so they better understand the academic and functional needs of students with mental illness. Higher education and graduate programs should also provide more effective training so that teachers who start working in the education profession are better equipped to meet the needs of students living with mental illness.

- Consider that there are two kinds of counselors needed in our nation's schools. Students need school counselors to help them meet their academic and testing needs. However, they also need school mental health counselors who can provide effective interventions when they are struggling with a mental illness. It may be most cost effective for schools to contract with the community mental health system for school-based mental health services. Ignoring the need for these services is doing a tremendous disservice to school staff, students and the entire school community with consequences including staff turnover, poor morale, suicides that impact the entire community, high drop-out rates, youth who become entangled with the juvenile justice system and the loss of critical developmental years that cannot be recaptured.

- Locate mental health services and supports in schools to help solve transportation and related barriers that often prevent students who need mental health services from accessing them. The pilot program that focus group participants described that produced positive results is a testament to the real potential of these programs.

- Commit to broader education and awareness across the school community about mental health related issues as a stigma reduction measure. Mental illness remains shrouded in secrecy and shame in too many communities. A strong commitment to raising broader awareness about mental illness targeted both to students and school personnel would be a very positive step forward.

- Develop a stronger link between schools and the community mental health system so that school staff and SROs know which mental health services and supports are available to students and their families. This is happening in more communities, however progress must continue to ensure that young people who require mental health services are connected to these services.

- Cross train school personnel and community mental health providers on how to work most effectively together. This training should include information about laws governing privacy and confidentiality so that steps can be taken to facilitate more effective sharing of information.

Appendix

The Lake Charles Police Department's CIT training for SROs included the following topics:

Day One

- Welcome: Video and Overview (half an hour)
- Clinical Issues Relating to Mental Health (1 hour)
- Psychotropic Medications and Side Effects (3 hours)

Day Two

- Co-occurring Disorders (2 hours)
- Community On-site Learning Visits (7 hours)

Day Three

- Family and Consumer Perspective (1 hour)
- Suicide Intervention/Role Play (3 hours)
- Basic Primer to Mental Illness: Axis II Personality Disorder (2 hours)
- Basic Primer to Mental Illness: Axis I Clinical Disorders (2 hours)

Day Four

- Less Lethal Means (1 hour)
- Crisis Intervention with Adolescents (1 and a half hours)
- Post Traumatic Stress Disorder (2 hours)
- Listening and Responding in Crisis Intervention Role Playing (4 hours)

Day Five

- Mental Health Issues for Law Enforcement Officers (1 hour)
- Alcohol and Drug Assessment (2 hours)
- Crisis Intervention and Understanding Mental Health Diversity and Role Playing (3 and a half hours)
- Awards Ceremony and Closing (1 hour)

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