MARYLAND POLICE AND CORRECTIONAL TRAINING COMMISSIONS
LESSON PLAN

COURSE TITLE: Crisis Intervention Team (CIT)
LESSON TITLE: Course Introduction

PREPARED BY: Elizabeth Wexler, LCSW-C **DATE:** 12/30/20
REVISED: 2/16/21

TIME FRAME	**PARAMETERS**
Hours: 60 minutes **Day/Time**: Day 1, Lesson 1	**Audience**: Experienced officers selected to be CIT certified **Number**: maximum of 25 **Space**: Education and Training classroom

PERFORMANCE OBJECTIVES	**ASSESSMENT TECHNIQUE**
1. Through facilitated discussion, officers will be able to articulate a sound understanding of the civil rights historical context of why there is a need for CIT in every community, to the satisfaction of the facilitator.	1. Facilitated Discussion
2. Through facilitated discussion, officers will have a robust discussion regarding why they chose to become CIT officers and what experiences they draw from that helped make that decision, to the satisfaction of the facilitator.	2. Facilitated Discussion
3. Through a gots/needs exercise, learners will record policy responsibilities with which they are comfortable and those which need more instruction/explanation throughout the weeklong course to the	3. Gots/Needs Exercise

satisfaction of the facilitator.	

INSTRUCTOR MATERIALS

BHA training packet

EQUIPMENT/SUPPLIED NEEDED

Flipchart & Stands
Flipchart Markers
Projector
Smartscreen
Speakers
Extension Cords/Powerstrips

STUDENT HANDOUTS

25 student copies of the BHA training packet (will this include Policy 712?)
Post-it notes for Gots/Needs
Poster paper for Gots/Needs

METHODS/TECHNIQUES

Facilitated Discussion
Lecture
PowerPoint
Participatory exercise
Discussion
Case study
Role-Playing Scenarios

REFERENCES

1. Appleby, L. et al,, Death by homicide, suicide, and other unnatural causes in people with mental illness: a population-based study. The Lancet, 358 (2001) 2110-12; Hiday, V.A. et al. Criminal victimization of persons with severe mental illness. Psychiatric Services (1999) 50, 62-68 (finding that people with severe mental illnesses are twice as likely to be attacked, raped, or mugged as the general population).

2. Compton, M.T., Demir, Oliva, J.R., Boyce, T. (2009). Crisis Intervention Team training and special weapons and tactics callouts in an urban police department. Psychiatric Services, 60, 831-833.

1. Institute of Medicine, Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC: Institute of Medicine, 2006, available at http://www.ncbi.nlm.nih.gov/books/NBK19831/#a2000e8e1ddd00068

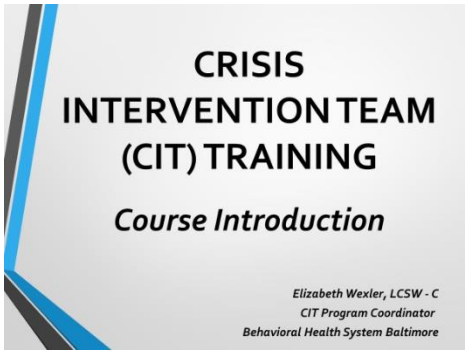
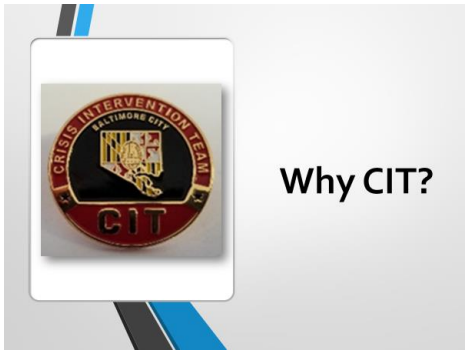
2. Michael S. Rogers, Dale E. McNiel and Renée L. Binder Journal of the American Academy of Psychiatry and the Law Online September 2019, JAAPL.003863-19; DOI: https://doi.org/10.29158/JAAPL.003863-19

GENERAL COMMENTS

This lesson plan is intended to be co-taught by 1) an experienced facilitator with a background in behavioral health(MSW, LCSW, or similar) who have an advanced understanding of recovery principles of care, and delivery of strength-based, person-centered and collaborative intervention; skilled in teaching these principles, and deep familiarity with Crisis Intervention Team and Behavioral Health Awareness training, and 2) a CIT-trained officer, with advanced skills in applying CIT training in the field.

LESSON PLAN

TITLE: CIT Course Introduction

PRESENTATION GUIDE	TRAINER NOTES
A. ANTICIPATORY SET **Slide 1:** The facilitator will provide a brief introduction of himself/herself *(background, history with the department, etc).* The facilitator should also explain why Crisis Intervention Training (CIT) is important to them. **Slide 2:** **SAY:** You have volunteered to become certified Crisis Intervention Team members. The BPD is especially proud of its Crisis Intervention Program because we have been successful at providing meaningful and rapid intervention to individuals in crisis situations or behavior health issues. By becoming CIT officers, you will be the primary units on scenes for calls involving people in crisis or experiencing behavioral health disabilities. You will be a resource to the Agency and the community and will be expected to connect	**Time:** 15 minutes **Slide 1:**  *The purpose of the introductions in the first half of this module is:* **have the Dept thank the officers and emphasize the leadership piece of the CIT role (case study)* **engage the officers* **allow them to hear from each other why they have chosen this role* **help them to begin to build a training cohort, to carry back to patrol as leaders in crisis response* **Slide 2:** 

individuals to more supportive care and resources that will assist them with managing their behavior health or crisis issues.

These are skills that will require learning and practice beyond these 40 hours. This means taking the time to debrief and learn from our experiences. Wearing a CIT pin identifies you as having specialized skills and understanding, and we have an obligation to live up to this.

We have a greater goal with our CIT program and that is to work with system partners and primarily with the behavioral health and disability services system to mutually and safely resolve issues in the community whenever possible and to minimize use of avoidable arrests, emergency departments transports and initiation of involuntary processes.

This requires well-established, good, and routinely used lines of communication between BPD and the behavioral health system both on-scene and off-scene so that we collectively and continuously improve the crisis care experience for this community.
There is much to be proud of and yet, let's remember, this is a work in progress and you now have a chance to be a part of this program's future success

Slide 3:
Let's start with introductions. We will go around the room. Please take no more than 45 seconds to share your name, how long you have on, what your current assignment is, whatever of your BPD background you'd like to share, and why you are volunteering to be a certified CIT officer.

We want to get to everyone, and yet stay mindful of time. Think of this like a verbal bulleted list. (*call on volunteers to share their story*)

Many years ago, this program at BPD was originally called BEST (Behavioral Emergency Services Team)

Slide 3:

Allow about 45 seconds for each officer to share.

from 2004-2016, was offered to both experienced officers and training recruits at different times and has now been improved. CIT, however, is not BEST. We now have the benefit of national expertise, new policies, and – most importantly – a system that is working towards expanding its capacity and coordination to provide better care for the behavioral health community.

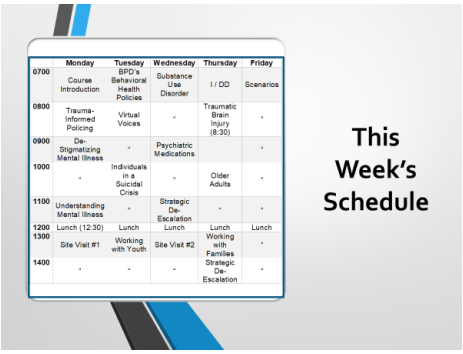
We have re-envisioned the BPD's CIT program to empower officers to serve as resources, not only to their fellow officers in defusing crisis events, but also to individuals in need of behavioral health services: BPD's CIT officers will be empowered to divert individuals away from law enforcement and towards stabilizing services that will reduce the likelihood that future crises occur.

Slide 4:
CIT Training Schedule and Expectations
This week, you will participate in a comprehensive, and well-rounded training that will explore issues surrounding behavioral health disabilities, the greater context of police interactions with individuals in Crisis, Baltimore's behavioral health system, and the BPD's philosophy behind diversion and positive outcomes.

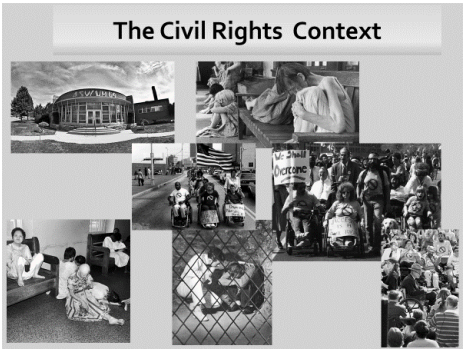
We'll discuss such issues as trauma, stigma, substance use disorder, and psychiatric medications. We'll also include specific material that addresses interactions with youth, older adults, and families. Throughout the week, each lesson plan will incorporate scenario-based learning exercises to give you the operational tools and muscle-memory to deploy this training. We won't be in the training room all week: we'll make two site visits where we'll interact directly with our partners in the behavioral health system, and on Friday, we'll spend the day participating in scenarios where you'll demonstrate all the skills you've acquired during the week.

When you receive your CIT pin, and are certified CIT officers, you will serve as the primary officer assigned to behavioral health and crisis calls. Other officers on

Slide 4:



scene, and even supervisors, will be looking to your expertise to peacefully resolve the call and promote a positive outcome. I hear that some of you shared in your introduction that you have taken training like this from the department before. That's going to be helpful, as will your sharing of your own experiences with behavioral health crisis calls, as we move through this much more advanced training. This program is based on the Crisis Intervention Team (CIT) model, which began in Memphis, TN in 1988, and is in 2700 communities nationwide. There are CIT programs in cities similar to Baltimore, like Cleveland and Milwaukee. Does anyone have police colleagues or buddies in other cities that know about CIT, or have the certification? **Ask:** Can anyone tell me what precipitated it being created back then? (*call on volunteers to share their answer*)	
CIT training is crucial because it can save lives. Sadly, the example we just mentioned happens too frequently. Let's take a step back and talk about WHY we are talking about this. WHY is law enforcement in the position of responding to behavioral health-related calls for service, and why are we a part of a national conversation regarding the appropriateness of our response to these calls?	**Desired Response:** Someone with a severe mental illness was killed by a police officer who interpreted their behavior from their symptoms as uncooperative and aggressive.
Ask: Why, also, do we encounter so many people with unmet behavioral health needs throughout our patrol shifts?	**Desired Response:** • Many people do not have access to health care and behavioral health resources that can address their

	mental and behavioral illness • Personal shame and/or embarrassment by individuals who do not want to seek help • Not fully-developed behavioral health system in the city, and/or an overreliance on 911.
II. INSTRUCTIONAL INPUT (CONTENT) **Slide 5:** In the 1970s, building on the racial civil rights movement, a new movement began to push for the rights of people with mental illness. The practice had been to lock individuals in mental institutions—sometimes for decades—with very poor living conditions, no treatment, and no hope of returning to their communities. Courts found this sort of segregation violated the rights of people with disabilities, and the nation began a process of deinstitutionalization – moving people with serious mental illness out of state-run hospitals and integrating them back into their communities. **Slide 6:** The promise was that a new system of community-based mental health services would be developed to allow people with mental illness to live successfully outside of institutions. Take a look and this slide and the next one I'm about to show you, and consider all of the wonderful things that this Act "promised" (*use finger quotes when saying the word "promised"*)	**Time:** 30 minutes **Slide 5:**  **Slide 6:**  *Click to reveal the next slide*

Slide 7:
The promises made in this Act, were all great at the time.

BUT

Ask: What do you think happened? (*call on volunteers to share their answers*)

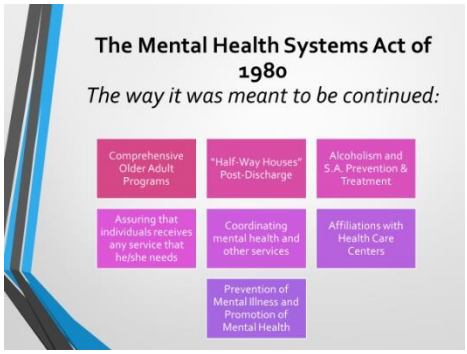
Ask: Who can tell me which promises were not kept? (*call on volunteers to share their answer*)

Ask: What is the reason, or reasons why these promises may not have been kept? (*call on volunteers to share their answer*)

Slide 8:
As you've already guessed, the promise put forth by the Act was not kept, and many of the people who were discharged from hospitals or who were diverted away from hospital care therefore never received the community-based services that they needed.

There are a number of reasons, many of which you just shared in the answer to my previous question, as to why

Slide 7:



Desired Response:
They were not fulfilled

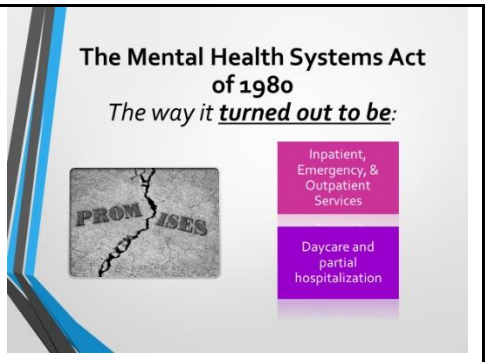
Desired Response:
Answers will vary based on each person's opinion

Desired Response:
- Nobody knew how to fulfill these promises at the federal, state, and local level.
- Lack of funding, and funding cuts in subsequent years.
- Lack of proper training
- Buy-in from partners
-

Slide 8:

these promises were not kept, and one can only speculate what the exact reason or reasons were. Certainly, one set of reasons included negative stereotypes about people with mental illness and the discrimination it bred—including about funding needed services

However, it's important to keep in mind that as a police officer, you will all encounter many people with severely untreated or inadequately treated mental illness, who are the victims of broken promises



Slide 9:
In 1990 Congress passed the Americans with Disabilities Act or the ADA.

Slide 9: *(after the question is asked, and answered, for this slide, click to reveal the four key points of the ADA shown on the slide)*

Ask: What does the Americans with Disabilities Act guarantee and provide for people with mental or physical disabilities? (*call on volunteers to share their answer*)

Desired Response:

- Protection from discrimination
- Right and access to services
- Integration in school and other public places
- Educational support
- Employment and adult independence support

A lot of what you all shared is correct. The ADA is the civil rights law protecting people with physical or mental disabilities.

The ADA guarantees people with mental health disabilities the right to receive services in the most integrated setting appropriate to their needs. That usually means services that enable people to be

integrated in their communities and to lead full lives with the supports they need In fact, there are many, many people with behavioral health disabilities living, working, and thriving in Baltimore. The people you will see and need to help are the people whose needs are not being met at the moment. Your role will be to de-escalate the immediate crisis situation and, sometimes, to connect the person to a behavioral health resource. Additionally, the ADA – Title II – requires that public entities make reasonable modifications in their policies and practices when necessary to avoid discrimination on the basis of ability. This principle should be applied in all aspects of your work. For example, what this means is: you might be required to connect someone experiencing a disability to medical services or transportation, away from a law enforcement response. Specifically, this includes police officers who are considered a governmental entity. For example, if a caller advises the dispatcher that there is a person in need of transportation (be it medical or otherwise) that uses a wheelchair, it is the duty of the dispatcher to make sure that the individual is connected with wheelchair accessible transportation. Or, if a person in crisis may be better able to interact with a trained mental health professional in order to resolve their crisis, that person should be contacted rather than or along with law enforcement. Another example could be that you may need to modify your communication strategy in order to effectively interact with someone with a cognitive or intellectual disability. Overall, it's crucial that we have an understanding of behavioral health disabilities and make the appropriate accommodations in order to avoid treating disabilities or associated behaviors as criminal, or worthy of arrest.	

Slide 10:
An important thing to remember is that when we criminalize people with mental illness this is a failure of the whole system, not simply a failure of people with these illnesses or a failure of law enforcement.
Another important thing to keep in mind is that most people with mental illness are not violent. The vast majority of individuals with a mental illness, who are not also using a substance, pose no greater risk of violent behavior than do people without mental illness.

Only 3%-5% of violent acts in the United States can be attributed to individuals living with a serious mental illness. In fact, people with mental illness are far more likely to be **victims** than perpetrators of violent crime. Still, in Baltimore and across the country, large numbers of people with serious mental illness are incarcerated—often for minor infractions.

Ask: Have you heard it said that jails and prisons are now the nation's largest mental hospitals?

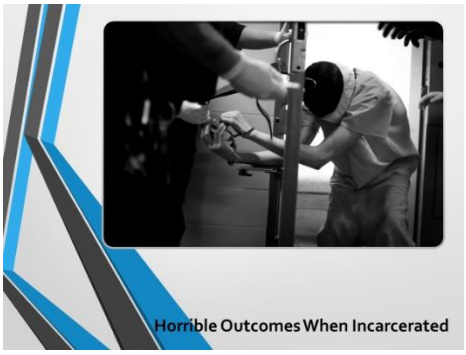
Slide 11:
In fact, correctional settings are not mental hospitals. People with mental illness do very poorly when incarcerated. Their functioning often deteriorates, and they have difficulty following the facilities' rules. As a result, they tend to serve far longer terms than people without mental illness who have committed the same offences. And when they are released, it is to the same system that offered broken promises…

This is especially important in Baltimore, where things like legalized segregation, housing redlining, and a public transport system designed to keep the city segregated are still impacting the civil rights of so many residents.

Slide 10:

Desired Response:
Yes

Slide 11:



Slide 12:
Baltimore's goal is to work towards a system in which the behavioral health system (instead of the police) will eventually respond to a greater number of behavioral health crisis calls. You are experienced officers, so you are aware that 911, and therefore police and other first responders, will always have a role in responding to some crises. For all of you here today, this program is a voluntary certification program. You are part of a cohort/learning community aimed at making Baltimore's response to behavioral health crises better and more responsive to the needs of our community members.

Currently, the city of Baltimore is making the necessary investments and reforms to expand the capacity of the city's behavioral health crisis response system, starting at 911. The landscape will change, for the better, soon! For now, we will do what we can to peacefully resolve situations, and connect individuals to the appropriate/available resources.

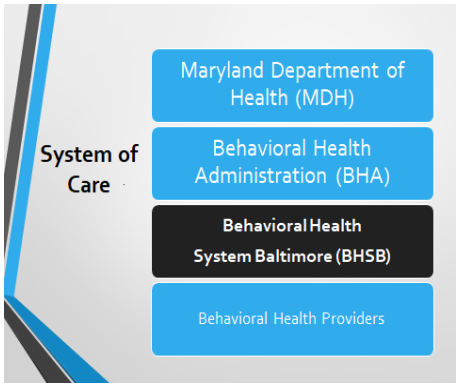
Slide 13:
Now we will take a few minutes to provide a brief overview of how the system of care is set up and some of these resources for individuals with behavioral health needs the City. In the spirit of the ADA, the goal of the service system is to provide individualized, integrated services that enable people to live fulfilling lives as productive members of their communities.

Most people with behavioral health needs who have police encounters do not have private health insurance (e.g., through their employers), and are reliant on government-funded programs.

At the state, county, and local levels, these programs have the goal of ensuring that people with BH needs have access to the treatment and support services they need to live successfully in their communities.

Slide 12:

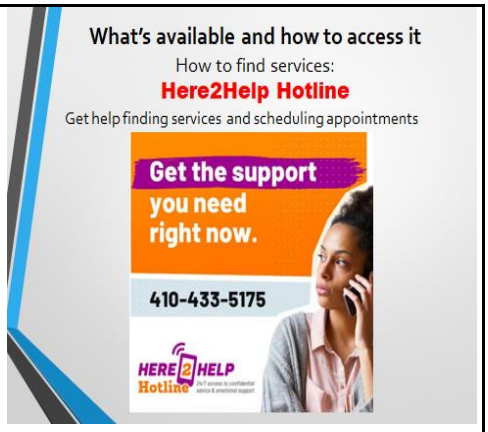
Slide 13:



Behavioral Health System Baltimore (BHSB) is the local behavioral health authority (LBHA) for Baltimore City. BHA delegates to the LBHA's many of the responsibilities associated with managing Behavioral Health services at the local level. We will talk more in the Mental Illness Overview module and throughout the course about common community-based services that are accepted as successful approaches to treatment and recovery. For now, it is important to understand that the goals of the behavioral health service system are to help people with behavioral health disabilities to recover, find stability, live successfully in their communities, and – importantly for our work – minimize experiencing crises. While occasional crises may occur, they are proven to be significantly reduced with appropriate, intensive, community-based treatment and services. However, in Baltimore and many other places around the country, these goals, particularly the goal of crisis *prevention* are not being achieved by the behavioral health system. This is often due to inadequate funding and a system that disperses responsibility among many different, uncoordinated entities. Services are often not readily available, and they tend to focus upon late-stage crisis intervention, rather than the prevention of crises and supports for housing, employment, and so on. As a result, people experience more crises more frequently, and often, police are the last-resort safety net for people in crisis. Accordingly, officers routinely are asked to intervene in BH crises that should properly have been averted by the healthcare system. **Slide 14** The City of Baltimore is working with an array of stakeholders to remedy this and to greatly reduce unnecessary police involvement in BH crises. The City is working to improve access to BH services for the public and, when police are called in, for officers, who can divert people in crisis from the criminal justice	**Slide 14:**

system to behavioral healthcare.

Here to Help is an important doorway for this. The Here2Help Line is the recommended first and primary point of access for someone in Baltimore looking for public services. They can determine what service would be the best match for someone through a more in-depth phone screening and use their expertise to guide the person to the most appropriate service.



Slide 15:
The types of services individuals need depend on a number of factors such as their mental health status, the level of support they require, and their individual goals.

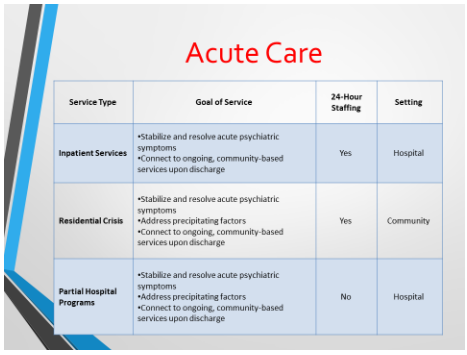
Acute care provides services to individuals who are experiencing a crisis or whose mental health becomes so unstable that their symptoms cannot be stabilized in their current level of care. Acute care provides short-term intensive services in a highly monitored environment such as a hospital but can also be provided in a less institutional setting, where crisis stabilization may be more effective.

In general, evidence-based treatment models promote utilizing the least restrictive setting appropriate. Whenever possible, community-based services are preferred to inpatient settings so that individuals can access family and other social support systems, and be more integrated into the community–which has been shown to support long-term recovery. Long-term treatment services are not time-limited and might include mental health treatment, rehabilitation, case management, permanent supported housing, and peer supports.

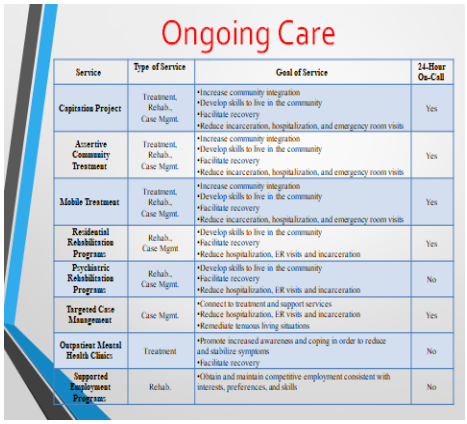
Slide 15:

Slides 16 and 17:
Many individuals with behavioral health disabilities require ongoing services to live productive, meaningful lives. The services described on this slide provide individualized levels of treatment, rehabilitation, and support at a lower level of intensity and restrictiveness than acute care. As you can see, there is a wide variety of services available designed to provide the level of support and in the most appropriate setting to meet the unique needs of the individuals in need of behavioral health services.

Slide 16:



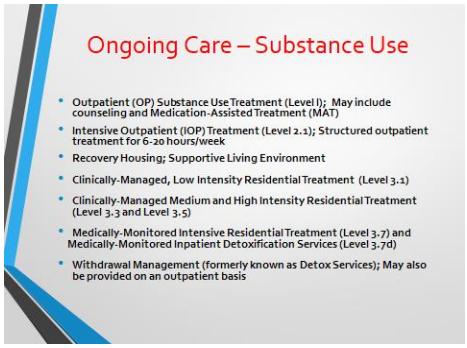
Slide 17:

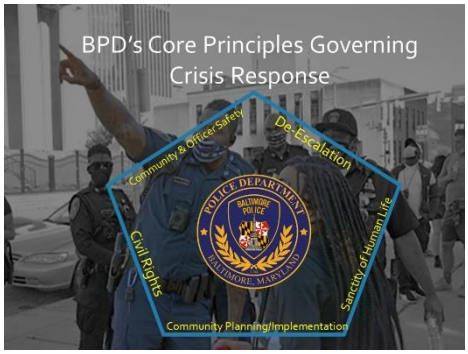


Slide 18:
Similarly, for people with Substance Use Disorders, there is a wide continuum of treatment services available, both outpatient and residentially based.

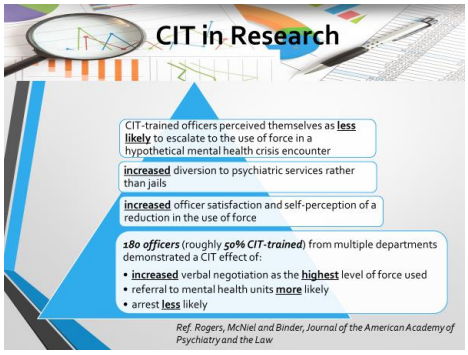
The people you will see and need to help are often the people whose needs are not being met at the moment. Your role will be to de-escalate the immediate crisis situation and, sometimes, to connect the person to a behavioral health resource.

Slide 18:



Slide 19: So what does this all mean for us, as BPD officers? What does this historical context and the larger picture of Baltimore's crisis response system have to do with how we discharge our duties? All of this is important because it informs how we're approaching our crisis intervention program. We can distill our approach to behavioral health and crisis response into 5 Core Principles. You should be familiar with these from other departmental trainings. **Ask:** Civil Rights, which we just discussed in detail, can I have a volunteer share with me the importance of Civil Rights as a Core Principle? **Ask:** Community Planning and Implementation, same question as before, can anyone tell me in their own words why this is so important? **Ask:** What about Sanctity of Human Life? **Ask:** And De-Escalation?	**Slide 19:**  **Desired Responses:** - Civil Rights: Protecting the civil rights and constitutional protections afforded to individuals with disabilities, and providing the reasonable accommodations described in the ADA. **Desired Response:** Community Planning & Implementation: BPD is a part of a broader system seeking to improve/coordinate, and eventually, provide a more appropriate response to behavioral health crises than through law enforcement. **Desired Response:** Sanctity of Human Life: The BPD's mission statement, we will always strive to protect the sanctity of human life. **Desired Response:** De-Escalation: We will take our time to de-escalate, to communicate, to bring someone down from a crisis-level, and

	determine the best possible outcome for them that respects their dignity, wishes, and civil rights.
Ask: And finally, Community & Officer Safety – why is it so important?	**Desired Response:** Community and Officer Safety: by responsibly intervening in crisis situations, we'll preserve the safety of the individual and our own safety.
This is an advanced training, meant to hone your already-existing skills in responding to crisis situations, conditions and disabilities, with the goal of you showing leadership in the department when it comes to these kinds of issues in our community. This is formalized in the policy: you will be in charge of the scene when you are called to a behavioral health crisis. So, again, what does this mean for us? Each of you are volunteering to be certified as a CIT officer. You filled out the paperwork, you interviewed, and you are taking a week-long course to be the units assigned to respond to behavioral health crisis calls for service.	
Ask: Why do we have a CIT program? Does anyone have any ideas why the BPD has specialized CIT program?	**Desired Responses:** BH calls for service are common, but require specialized skills and training. Our approach to BH calls for service are different.
Ask: And why is our approach different? What have we discussed so far that would give you an idea of the BPD's approach to BH Calls for service?	**Desired Response:** BH calls for service require the least police-involved approach based on BPD policy and our core principles. Based on our discussion of the history of mental illness and civil rights, we understand that further involvement in law enforcement does not promote positive outcomes for individuals in crisis. Further, individuals in

	crisis or with unmet behavioral health needs need stabilizing support, and since we're frequently in the position to interact with them – owing to the gaps in the city's support system – we can play an active role in connecting them to those supports.
This is a key point. While we're hopeful that the role of law enforcement in behavioral health calls for service will decline, we're still at a point in the improvement of the system where law enforcement has a crucial role to play. We can bridge a systemic gap with a well-trained, fully-staffed CIT program. And we're aiming for 30% of patrol to be certified CIT officers: that would give us adequate coverage in every district, every shift.	
Slide 20: Roughly 10% of all police contacts with the community involve individuals with behavioral and mental illnesses. Currently, there is limited research regarding the adequacy of CIT and why it works. However, utilization of Crisis Intervention Teams has been positive. Across the nation, many police departments with Crisis Intervention Teams have reported a downward trend for use of force when responding to calls regarding persons in crisis. An increased use of verbal negotiations, increased referrals to mental health resources, and decreases in arrests have also been documents in recent research. Crisis Intervention Teams have also shown to improve the attitudes among police officers. Officers have reported feeling better about themselves and their jobs whenever there is a reduction in the use of force in such interactions. CIT trained officers also see themselves as less likely to escalate to the use of force in mental health crisis encounters.	**Slide 20:** 

One statistic which may point towards broader use in the future is the financial impact of such programs. While there may be a heavier cost up front in implementation, overall, it may reduce the financial burden on society in general. Increased diversion to mental health services will reduce the costs associated with arrest, prosecution, and incarceration.

Slide 21:

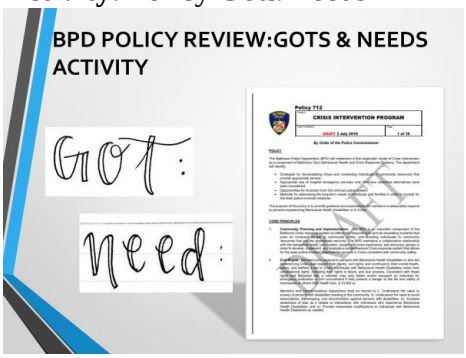
Within Baltimore, the BPD's CIT program is overseen by Lt. Joanne Wallace and has two components: Patrol CIT and our Crisis Response Team (CRT).

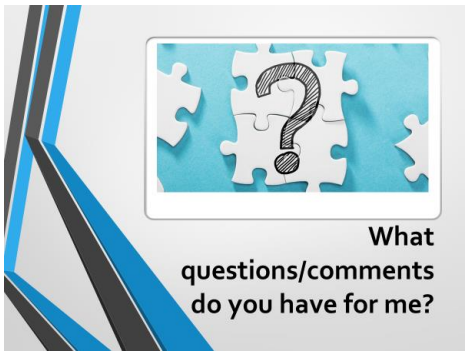
CIT: CIT are you all, specially trained and certified volunteer patrol officers who are dispatched to respond to calls for service for persons with the objective of diverting them from the criminal justice system.

CRT: A specialized unit, co-response of certified officers and licensed mental health professionals who assist persons in Crisis. The CRT serves as backup support to members and to assist in peacefully resolving complex situations with the least restrictive techniques, interventions, and resources possible while maintaining the safety and wellbeing of the individual or family and others involved in the crisis, BPD personnel, and the community.

CRT respond to acute crisis incidents, suicide attempts, and emergency petition situations. They can be reached via CityWide channel from 11-7 every day.

Slide 21:

III. EVALUATION/CLOSURE **Slide 22**: So, what exactly will be expected of us as CIT officers responding to behavioral health calls for service? Our on-scene responsibilities can be found in Draft Policy 712, *Crisis Intervention Program*. The policy is available for you on PowerDMS, and I have paper copies available here. Starting on page 5 are the Directives for CIT officers. Take a moment to read through the Directives, and when you're finished, take two (2) post-it notes. On one, write a responsibility that you're confident you can accomplish with your current level of expertise. On the other, write a responsibility that you aren't entirely confident you could perform without additional training. You can absolutely use more than 1 post-it for the 2nd one; this is just the 1st day of a week-long training. The directive you're confident you could perform is your GOT. The other(s) is your NEED. Once you're done, bring them up to the front of the room and place the post-it under the heading for GOT or NEED as appropriate. I'll give you a few minutes to write and bring them up to the front. Ok, let's take a few minutes to review your Gots and Needs.	**Time:** 15 minutes **Slide: 22** **Activity**: Policy Gots/Needs  *Distribute to each learner a paper copy of Policy 712 (dated 3 July 2019). Give the learners a minute to read through the directives, then prompt the Gots/Needs activity* *Once all of the learners have brought their Gots/Needs to the board, begin to read all of them to the whole room.* *Facilitator should group Gots/Needs that are similar. For NEEDS that are explicitly addressed in the week's schedule, tell the room that we will address this issue during training, and specify which module.*

Thank you for sharing your Gots and Needs. I will leave these up here for the week, and we will return to this board to make sure all of our NEEDS become GOTS.	*For NEEDS that will NOT be explicitly referenced, keep the Post-It in the room and address the issue during downtime or during a related lesson plan.*
Slide 23: In this introduction, we have discussed the importance of CIT officers in the department, how you will be leaders on crisis calls, why you are each here, the historical civil rights context for this work, and what you can expect to learn throughout our week together. **Ask**: What thoughts, questions, or comments about what we've discussed today do you have for me?	**Slide 23**:  *The facilitator should answer any questions or address any comments posed by the students.*