The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners

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Abstract

As persons with mental illnesses and law enforcement become increasingly entangled, the collaboration of police and mental health service providers has become critical to appropriately serving the needs of individuals experiencing mental health crises. This article introduces the Crisis Intervention Team (CIT) Model as a collaborative approach to safely and effectively address the needs of persons with mental illnesses, link them to appropriate services, and divert them from the criminal justice system if appropriate. We discuss the key elements of the CIT model, implementation and its related challenges, as well as variations of the model. While this model has not undergone enough research to be deemed an Evidence-Based Practice, it has been successfully utilized in many law enforcement agencies worldwide and is considered a "Best Practice" model in law enforcement. This primer for mental health practitioners serves as an introduction to a model that may already be utilized in their community or serve as a springboard for the development CIT programs where they do not currently exist.

Keywords

Over the past few decades, the disproportionate involvement of persons with serious mental illnesses in the criminal justice system has captured the attention of academics, advocates, policy makers and practitioners (Fisher, Silver & Wolff, 2006; Human Rights Watch, 2003). While mental health budgets are being slashed in many states, resources are being devoted to approaches intended to stem the flow of persons with serious mental illnesses into the front door of the criminal justice system, and for those who do enter the system, provide effective intervention in hopes of reducing future criminal justice system entanglement. One "front door" approach being implemented by police departments across the country, the Crisis Intervention Team (CIT) model, is designed to improve officers' ability to safely intervene, link individuals to mental health services, and divert them from the criminal justice system when appropriate (Compton, Broussard, Munetz, Oliva, & Watso, 2011)

While there has not been enough research to date to declare CIT an "Evidence Based" practice, CIT has been called both a "Promising Practice" (International Association of Chiefs of Police, 2010) and a "Best Practice" model for law enforcement (Thompson & Borum, 2006). One of the core elements of the model is collaboration with community partners, including mental health providers (Dupont, Cochran & Pillsbury, 2007). In this article, we describe the CIT model and emerging evidence of its effectiveness. We then discuss the role of mental health practitioners in working with law enforcement and more

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specifically, CIT programs, to improve the overall response to individuals experiencing mental health crises.

NATURE OF THE PROBLEM

The most recent available data, while now over a decade old, suggests that approximately 10% of all police contacts with the public involve persons with serious mental illnesses (Deane, Steadman, Borum, Veysey, & Morrissey, 1999). There is mixed evidence on whether police are more or less likely to arrest persons with mental illnesses than those without (Engel & Silver, 2001; Teplin, 1984). However, the most recent estimates of the prevalence of serious mental illness in US jails are 14.5 percent for males and 31 percent for females (Steadman, Deane, Borum, & Morrissey, 2009), suggesting that police are arresting sizable numbers. Data on the numbers of people with serious mental illnesses that police are directing to services or providing informal disposition (e.g. resolving on the scene with no formal intervention) to is limited. However, as mental health budgets are slashed, their role as gatekeepers to both the mental health and criminal justice systems is becoming increasingly important.

Calls involving persons experiencing mental health crises can be particularly problematic for police officers. Surveys of officers suggest that they do not feel adequately trained to effectively respond to mental health crises, that mental health calls are very time-consuming and divert officers from other crime fighting activities, and that mental health providers are not very responsive (Cooper, McLearen & Zapf, 2004; Vermette, Pinals & Appelbuam, 2005; Wells & Schafer, 2006). Officers perceive mental health related calls as very unpredictable and dangerous, which without adequate training in de-escalation, could inadvertently cause them to approach in a manner which escalates the situation (Ruiz, 1993; Ruiz & Miller, 2004). As media reports confirm, on rare occasions, mental health related calls do end in horrible tragedies, with officers or persons with mental illness being seriously or fatally wounded.

THE CIT MODEL

It was a tragedy that spurred the coming together of stakeholders to develop the original CIT program in Memphis, TN. In 1988, following the fatal shooting of a man with a history of mental illness and substance abuse by a Memphis police officer (Dupont & Cochran, 2000), a community task force comprised of law enforcement, mental health and addiction professionals, and mental health advocates collaborated to develop what is now internationally known as the Memphis CIT model. The primary goals of the model are to increase safety in encounters and when appropriate, divert persons with mental illnesses from the criminal justice system to mental health treatment.

While the centerpiece of the model is 40 hours of specialized training for a select group of officers that volunteer to become CIT officers, proponents stress that CIT is more than just training (CIT International, 2012). CIT is an organizational and community intervention that involves changes in police department procedures as well as collaboration with mental health providers and other community stakeholders. According to the model, officers volunteer to receive 40 hours of training provided by mental health clinicians, consumer and family advocates, and police trainers. Training includes information on signs and symptoms of mental illnesses; mental health treatment; co-occurring disorders; legal issues and de-escalation techniques. CIT curriculums may also include content on developmental disabilities, older adult issues, trauma and excited delirium. Information is presented in didactic, experiential and practical skills/scenario based training formats. The training week may include panels of providers, family members and persons with mental illnesses as well as site visits to agencies in the community (Compton et al., 2011).

Call dispatchers are trained to identify mental disturbance calls and assign these calls to CIT trained officers. CIT officers are trained to uses de-escalation techniques if necessary and assess if referral to services or transport for mental health evaluation is appropriate. An important component of the model is a central designated psychiatric emergency drop-off site with a no refusal policy (Steadman et al., 2001). This allows the officer to transport an individual for emergency evaluation and treatment and get back out on the street to his or her other duties in a timely manner. Additionally, during training and after, CIT officers familiarize themselves with a variety of mental health services in the community that they can utilize to resolve mental health related calls.

Enthusiasm about the CIT model has spread quickly as police agencies struggle to demonstrate greater responsiveness to the significant numbers of persons with mental illness they encounter. Current estimates suggest that worldwide, there are over 1,000 CIT programs being implemented (CIT International, 2011) As dissemination of the model has grown, policy and program guidance documents have been developed and a professional organization, CIT International, has formed. Dupont, Cochran and Pillsbury (2007) have published a Core Elements document on the University of Memphis' CIT Center webpage (http://cit.memphis.edu/). Additionally, the webpage includes a posting of CIT programs and key contacts across the country. The Council of State Governments Justice Center has also published several guidance documents on police response to mental illness that highlight elements of CIT programs (Reuland, Draper & Norton, 2010; Reuland & Schwarzfeld, 2008; Reuland, Schwarzfeld & Draper, 2009; Schwarzfeld, Reuland & Plotkin, 2008). Their website (http://consensusproject.org/issue_areas/law-enforcement) also contains listings of local programs, postings of media clips from across the country related to CIT and a research document library. CIT International is a membership organization "whose primary purpose is to facilitate understanding, development and implementation of Crisis Intervention Team CIT programs throughout the United States and in other nations worldwide…" The organization maintains a website (http://www.citinternational.org), newsletter and annual conference. The CIT International Board of Directors and membership is comprised of law enforcement, mental health providers and advocates.

As there are innumerable variations in police jurisdictions, so are there variations in CIT program implementation. Some variations are intentional and planned based on the needs of the jurisdiction, others are the result of local realities that prevent the full model from being implemented as intended (Compton et al., 2010; Compton et al., 2011). For example, a key component of the Memphis program is a central, psychiatric emergency drop-off (Steadman et al., 2001) with a no refusal policy that gives police transports priority so officers can be back out on the street within 15–30 minutes. In larger jurisdictions, a central drop-off is not practical (Compton et al., 2011). For example, in Chicago, the police department maintains memorandums of understanding (MOUs) with designated emergency facilities across the city for each police district. MOUs provide for officer transports to be given priority. The City of Philadelphia has crisis centers that police can utilize for emergency transports. The centers can also assist individuals who do not meet criteria for emergency psychiatric evaluation, but are in need of other assistance such as medication refills and linkage to community providers. A survey of CIT programs found that only one-third had formal agreements with receiving facilities (Hartford, Carey & Mendonca, 2006). Some without formal arrangements may have informal arrangements that are working. However, some departments implement the 40 hour CIT training curriculum but are unable to engage local psychiatric emergency services and other providers in ongoing collaboration (Wells & Schafer, 2006). This likely creates a great deal of frustration for CIT trained officers and limits the success of CIT programs.

Another key component of the Memphis CIT model is that officers volunteer to become CIT officers and that only a portion of the force is CIT trained (McGuire & Bond, 2011). The rationale is that not all officers are cut out to be CIT officers. Those that volunteer and are accepted into the program may have a particular disposition and interest in handling mental health calls. This better prepares them to use CIT training to become effective in responding to mental health crisis calls. CIT provides officers with additional skills and identifies them as the ones who should be dispatched to mental health related calls. Initially, the Memphis team suggested that 20–25% of the police force be CIT trained to ensure 24/7 availability (Dupont, Cochran & Pillsbury, 2007). However, according to Major Sam Cochran (Ret), founding coordinator of the Memphis Police Crisis Services, it is not the specific percentage of officers that are CIT trained that is most important. Rather, it is getting the right officers trained (personal communication, August 22, 2012). Other departments have taken a different approach and are having 100% of their patrol officers complete CIT training (Reuland, Draper & Norton, 2010). The rationale for this approach is that all officers may encounter mental health crises and should be prepared to effectively respond. To date, there is no research evidence indicating whether one approach is more effective than the other.

Training of dispatch personnel to identify and appropriately assign mental health related calls to CIT officers is an important component of the model that many CIT programs struggle with (Compton et al., 2011). Emergency communications (911/dispatch) is generally a separate agency or department that the police department does not run. Thus, some CIT programs have not fully implemented dispatch protocols and training of dispatch personnel. CIT programs that have implemented dispatch training have used varied approaches. For example, in some jurisdictions, dispatch personnel go through CIT training alongside police officers. In others, dispatch personnel complete an introduction to CIT in their initial training or as a separate in-service training (Compton et al., 2011).

A number of departments have gone beyond the basic CIT model and training, creating enhancements to their programs. Annual booster trainings for CIT officers as well as advanced CIT training on topics such as responding to juveniles and veterans have been developed. Other departments have developed follow-up units to work with high risk individuals with repeated police contacts (Rosenbaum, 2010). Thus, while many departments are implementing CIT programs, there is a great deal of variation. To date, there has not been a systematic survey of CIT programs to catalogue these variations or examine the effectiveness of CIT enhancements. Nor has a fidelity measure been developed (McGuire & Bond, 2011).

EVIDENCE TO DATE

The body of research on CIT is limited, but overall it is promising. Initial reports from Memphis suggest that the CIT program has reduced arrests and increased safety and diversion to mental health services (Dupont & Cochran, 2000). Subsequent research has supported an association between CIT and lower arrests rates of persons with mental illnesses (Steadman, Dean, Borum, & Morrissey 2000) increases in the number of mental health related calls identified; increases among CIT officers in transports to the hospital for psychiatric evaluation; and increases in the proportion of transports that are voluntary (Teller, Munetz, Gil, & Ritter, 2006) In Chicago, we did not find a difference in arrest rates between CIT and non-CIT trained officers. However, CIT officers were more likely to direct persons with mental illnesses to mental health treatment and less likely to resolve calls with contact only than their non-CIT colleagues. This effect was most prominent in districts with greater availability of mental health services (Watson, Ottati, Draine, & Morabito, 2011). Only one study has examined outcomes for persons with mental illnesses beyond the immediate CIT encounter. Broner, Lattimore, Cowell, and Schlenger (2004) found that

diversion from arrest by pre-booking programs, such as CIT, increased mental health service utilization in the subsequent 12 months for persons with serious mental illnesses.

Several studies suggest that CIT improves safety outcomes. Dupont & Cochran (2000) have reported an association between CIT implementation in Memphis and decreased use of high-intensity police units such as Special Weapons and Tactics (SWAT) teams. A few studies have examined CIT's impact on use of force and injuries. Skeem & Bibeau (2008) found that CIT officers used force in only 15% of encounters rated as high violence risk and that when they did use force, they generally relied on low-lethality methods. In our study of Chicago's CIT program (Morabito, Kerr, Watson, Draine, Angell, 2012), we found that CIT officers used less force as subject resistance increased than officers that were not CIT trained. We did not find a CIT effect on injuries (Kerr, Morabito, & Watson, 2010), perhaps due to the low frequency of reported injuries over all. However, in a qualitative study (Hanafi, Bahora, Demir & Compton, 2008) officers reported that application of their CIT skills reduces the risk of injury to officers and persons with mental illness.

Additional research on CIT has shown CIT training is associated with improvements in attitudes and knowledge about mental illness (Compton et al., 2006). It has also been shown to improve officers' confidence in identifying and responding to persons with mental illness (Wells & Schafer, 2006) and their overall confidence in their departments' response to mental health related calls (Borum, Deane, Steadman, & Morrissey, 1998).

The research to date has been limited to non-experimental and quasi-experimental designs. While a randomized controlled trial of CIT would allow us to more rigorously test the effectiveness of the model, researchers have struggled with devising a feasible approach and the resources to so (see Watson, 2010). Instead, studies have examined attitudes and knowledge pre and post CIT training, compared call data before and after CIT implementation, compared calls handled by CIT and non CIT trained officers, and surveyed or used qualitative methods to explore officer perceptions of CIT and its effectiveness. With those limitations in mind, findings to date are guardedly positive and suggest that CIT is a promising model for improving police officers attitudes and abilities to safely respond to mental health related calls, link people to mental health services, and possibly reduce the number of persons with mental illnesses entering the front door of the criminal justice system. Thus, while it is a long way from having enough support to be considered an evidence-based practice, at this juncture, it is currently considered a "Best Practice" in law enforcement (Thompson & Borum, 2006).

THE ROLE OF MH CLINICIANS IN SUCCESS OF THE MODEL

Mental health agencies often serve individuals that have contacts with the police and, at times, clinician and officer professional paths cross around client needs. These interactions may be initiated by clinicians when police assistance is needed to address safety issues. Clinicians may ask police to conduct well being checks or call them for assistance with a client in crisis. Clinicians may also advise clients and families to contact 911 for assistance in crisis situations, thus summoning the police. Police officers initiate these interactions when they transport persons in crisis to emergency rooms and crisis centers. They may also request clinician assistance, guidance and information when responding to situations involving persons in crisis. Thus, both groups frequently rely on each other for assistance. However, collaboration is often fraught with difficulties, mistrust and misunderstandings about the constraints with which the other is faced (Hatcher, Mohandie, Turner, & Gelles, 1998).

Early on in the task force meetings that eventually led to the development of the CIT Model in Memphis, it became abundantly clear that law enforcement and mental health providers

were extremely frustrated with and did not trust each other (Early, 2007). Providers felt that police officers lacked understanding of mental illness and would often exacerbate crisis situations. Police officers were frustrated that hospitals often would not provide care for people that they transported who were clearly symptomatic and likely to continue to come to police attention. Family members involved in these meetings expressed frustration with both the police and mental health providers. As each group gained an understanding of the others, they were able to work together to develop a solution in the form of the CIT model.

At its core, CIT is a model of collaboration to improve how police, mental health services, and communities respond to mental health crisis. The model brings stakeholders together to advocate for the implementation of CIT, develop a program tailored to the community, implement the training and supporting interagency agreements, and provide ongoing collaboration. As key stakeholders, mental health service providers are often, but not always, involved in these collaborative efforts from the beginning. Their expertise and experience is critical to the development of a CIT program that is tailored to the local context. Many CIT trainings utilize local clinicians to deliver the clinical modules of the CIT curriculum and include providers on panels to share their perspective on the tension (or sometimes hostility) that tends to exist between law enforcement and mental health providers. As this collaborative process unfolds, police and other stakeholders gain a greater understanding of and respect for each other. This supports the continued collaboration necessary to address emergent issues and sustain CIT programs.

CONCLUSION

While additional research is needed to establish CIT as an Evidence Based Practice, it is arguably the most well known model of collaboration to improve police response to mental health crisis. Mental health professionals can and should play an important role in these collaborations. At minimum, clinicians should be aware of what the CIT model is, if their community has such a program, and if so, how to utilize CIT officers when situations require police involvement. Going beyond the minimum to improve services to the population we serve, clinicians can become involved in CIT and related cross system initiatives. We can also stay abreast of the research evidence on CIT and if indicated, assist with modifying strategies to maximize program success.

Acknowledgments

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